Establishment of the Health Related Behaviours of Asylum Seekers in the Health Service Executive West Area

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ABSTRACT

In 1999, the Irish government initiated accommodating asylum seekers in direct provision centres with the objective to process applications within a six-month period. However, the majority of asylum applications are not processed within this timeframe The consequences of which are that asylum seekers reside in direct provision centres, some of which are overcrowded and unsuitable, for an undefined period

Generally in the first few years of this new century, there was an accelerated growth in the number of applications for asylum in Ireland; however, recent years have shown a down turn in the number of asylum seekers arriving in Ireland, this down turn has instigated a trend repeated across the European Union

These new arrivals can often present diverse challenges for the host society in terms of their unique needs, however in order for these needs to be met, a comprehensive analysis must first be undertaken to highlight them

This study explores the health behaviours of asylum seekers in the north west of Ireland, and is the result of extensive consultation with asylum seekers. The study population consisted of asylum seekers who are resident in the Health Service Executive west and north west. 242 asylum seekers participated in the study, comprising of both male and female participants ranging in age from 18-59 years

A number of health related factors were measured through the use of a questionnaire, which was made available in both English and French. The questionnaire was used to investigate the participant's health and health behaviours

in relation to use of tobacco, alcohol consumption, physical activity Usage of Irish health services was also examined

The results highlight a number of concerns with regard to the health of the research participants, generally physical activity levels are quite low and diets high in fat are common. On a positive note, breastfeeding rates among the asylum seeking population were high in comparison to the Irish population

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Chapter 1

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Chapter 1- Introduction

1.1 Introduction

The demographic profile of Irish society has changed significantly in recent years What was once a mono-cultural society is now considered a multi cultural society (Manandhar et al., 2006). It would be disingenuous for anyone to pretend that they have not been surprised by the pace of change in Ireland over the last ten years "Into what we comfortably assumed was a mono-cultural society, often ignoring the diversity already in our midst, a multicultural community arrived, apparently overnight, on our doorsteps" (Brehony & Clancy, 2006, preface)

There is a long history of migration both within European countries and from countries outside Europe, and Ireland is no exception to this. There are a number of different theories that will explain this phenomenon

According to Taylor (2006), the 1980's saw a new wave of migrants to Europe in the form of refugees During the 1990's the number of asylum seekers in Ireland and Europe in general gradually increased. In Ireland, the number of people seeking refugee status increased dramatically during the late 1990s and peaked in the year 2000 when 10,938 people made applications in the country to be recognised as refugees under the 1951 UN Geneva Convention Relating to the Status of Refugees (Collins, 2002). Figures from the Department of Justice Equality and Law Reform show that in 2005 there were approximately 966 successful applications for asylum in Ireland (Department of Justice Equality and Law Reform, 2006).

(See appendix 1 for a definition of common terms used throughout this thesis)

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By the end of 2003, the United Nations High Commissioner for Refugees (UNHCR, 2004) estimated the global number of refugees as 9.7 million people. This number has fallen over the last two years as a result of durable solutions to refugee problems (Taylor 2006). By the end of 2005, the global number of refugees reached an estimated 8.4 million persons, the lowest level since 1980 (UNHCR, 2007).

Patterns of migration have changed in recent years. A number of theories attempt to account for migration. One commonly cited theory relates to 'push' and 'pull' factors (Taylor 2006). In terms of refugees and asylum seekers, factors such as persecution, human rights abuses, and breakdown of infrastructure need to be considered as push factors. Pull factors such as good economic opportunities and political freedom attract people to receiving countries. Castle & Miller, (2003) argue that most push and pull theories have limitations, concentrating on economic and market factors to the relative neglect of social factors (cited in Taylor, 2006). However voluntary migration and seeking asylum are very different phenomen, asylum seekers are forced to flee, economic factors have little focus in their decision.

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The right to seek asylum in a country other than one's country of origin is a basic human right, which was set down in the United Nations Universal Declaration of Human Rights in 1948 (Collins, 2002).

"Everyone has the right to seek and enjoy,

in other countries, asylum from persecution".

(Article 14: Universal Declaration of Human Rights, 1948)

There are acknowledged inherent health risks in moves from one country to another, especially when these countries are very different culturally. So irrespective of their

legal status this emerging population sub-group in Ireland has distinctive and unique health issues and needs (Collins, 2002) Ager, (1999, cited in Taylor, 2006) defines refugee experience as the human consequences – personal, social, economic, cultural and political of forced migration. According to Taylor, (2006) there are many aspects of the refugee experience that can affect health.

Asylum seekers and refugees have specific health needs for several reasons Their pattern of disease may be different from those seen in the indigenous population. "Migrants are often on the margins of society and thus at increased risk of the diseases associated with poverty" (Abel-Smith et al., 1995, p177). The health of those seeking asylum can also be affected by many factors relating to their experience before flight, during flight (Coker, 2001) and after arrival in a new country (Taylor 2006)

Meeting the needs of cultural groups in terms of health and social care can present challenges to health and welfare services (Tilki, 2003) An approach to health and social care that is open and questioning and necessitates the adoption of transcultural health care models among health care professionals (Papadopoulos, 2006)

The diversity of the various ethnic and cultural groups coming to Ireland has the potential to enrich our society both socially and culturally. As Ireland was a country of out migration for so long, its history has given the Irish a unique understanding of what it is like to be an immigrant in a foreign country. "This should allow us to understand the importance of building a society, which values the social inclusion of people from diverse cultural backgrounds" (Brehony & Clancy, 2006, p 12)

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1.2 Who are Asylum seekers and Refugees?

The turn of the millennium marked the fiftieth anniversary of the creation of the Office of the United Nations High Commissioner for Refugees (UNHCR) and the adoption of the UN Convention Relating to the Status of Refugees (UNHCR, 2006).

The 1951 UN Convention Relating to the Status of Refugees is the internationally recognised standard aimed at protecting the rights of refugees and asylum seekers "It was given statutory effect in Irish law when the 1996 Refugee Act (as amended) was fully implemented in November 2000" (Collins, 2002, p.2).

Under article 1A (2) of the UN Convention on the Status of Refugees, a 'Refugee' is defined as someone 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 and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country, or who, not having a nationality and being outside the country of his/her former habitual residence as a result of such events, is unable, or owing to such fear, is unwilling to return to it" (Irish Refugee Council, 2002, p 1)

There are two classifications of refugees, programme refugees and convention refugees, and Ireland accepts both. A programme refugee is a person who is recognised as a refugee outside of Ireland and is invited by the state to live in Ireland as part of a United Nations sponsored humanitarian programme (Hall, 2004). A convention refugee is someone who satisfies the conditions set out in article 1A (2) of the UN Convention on the status of refugees, outlined above

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According to Ward, (2000) an asylum seeker is; a person who arrives independently in the state and asks to be recognised as a refugee under the 1951 Geneva Convention relating to the Status of Refugees and the 1967 Protocol. Manandhar et al., (2006, p.8) has acknowledged that "asylum seekers come from all parts of the globe, all walks of life and every strata of society, with significant differences created by gender, culture, socio-economic status and circumstances".

In order for an asylum seeker to gain refugee status, they must have their status officially recognised in countries that offer temporary or permanent refuge (Manandhar et al., 2006; Castillo, 2003).

The majority of those seeking asylum in Ireland are convention refugees. Unlike programme refugees they must enter the asylum process in order to have their status recognised. Throughout this thesis the author has focused on the experience of convention refugees. Convention refugees are in fact asylum seekers until they are officially recognised by the state.

If an asylum seeker is granted refugee status, their rights are similar to an Irish national. If status is denied, a deportation letter is issued. The person can choose to appeal, to apply for leave to remain on humanitarian grounds, to leave voluntarily, or to be deported (Hall, 2004).

1.3 Asylum Seekers in Ireland

"The increasing global movement of massive numbers of refugees and asylum seekers represents one of the major moral, political, and social issues facing the world today" (Manandhar et al., 2006, p.10). Few issues have generated more debate in recent years than that of applications for asylum both in Ireland (Free Legal

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Advice Centre, 2003) and in the European Union (Colville, 2006). However Hall (2004) has noted that the number of asylum seekers coming into Ireland makes up a relatively small percentage of the total immigrant population. Refugees worldwide constitute 40% of the total population of concern to the United Nations High Commissioner for Refugees (UNHCR, 2005).

"Ireland historically perceived itself, and indeed was perceived by other members of the international community, as a country of outward migration rather than a state that attracted migrants" (Wyndham-Smith, 2002, 3.1).Ward (1998) has described the situation that existed for would be migrants and refugees in Ireland up until the state joined the UN in 1956 as one of 'closure' Ireland argued in International matters that as a country of out migration and high unemployment it could not offer succour to the displaced, such as asylum seekers and refugees

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However, recent years have seen major changes in this respect. Generally, in the first few years of this new century, there was an accelerated growth in the number of applicants for asylum in Ireland. However recent figures show a down turn in the number of asylum seekers arriving in Ireland (an analysis of applications for asylum is shown in section 1 4). The Irish Refugee Council (2007), have acknowledged that applications for asylum in Ireland fell for the fifth consecutive year in 2006. Only a small proportion of asylum seeker applicants arriving in Ireland are granted refugee status. 4,314 applications were received in 2006 of these approximately 6 % are made at first hearing, and a further 11 % on appeal. Woods & Humphries (2001) have noted that more than half of the asylum seekers that are granted refugee status in recent years have obtained it at the appeal stage. This is conclusive with Irish findings in recent years (Irish Refugee Council, 2006).

According to figures released by the UNHCR (2007) there are approximately 8 9 million asylum seekers and refugees worldwide in 2005 In terms of Ireland's share, out of all asylum claims submitted in Europe between 1990 and 2003, only 1% have

been submitted in this state (UNHCR 2004) Beesley (2004) and Woods & Humphries (2001) have commented that Ireland's refugee recognition rate is less than half the average compared to other countries that accept refugees.

The recent downturn in applications for asylum in Ireland has instigated a trend repeated across the European Union, where the numbers of asylum seeker applications overall has fallen by about 20 per cent (UNHCR 2004) The demographic profile of Ireland is constantly changing as people continue to arrive, while others leave A minority of asylum seekers do not intend to permently relocate here Approximately, 20% of refugees in Ireland voluntarily return to their country of origin once it is safe for them to do so (NCCRI, UNHCR & Know Racism, 2002)

Regardless of their intended period of stay, asylum seekers have particular rights and needs that must be met while they reside in Ireland, the most imperative of which is health care. "Fleeing from their homes, leaving everything behind and adaptmg to a different culture, language, living conditions and education system is a drastic series of events that result in specialised and significant needs" (Hall, 2004, p.9).

Irish communities seem to lack an awareness of the issues that face asylum seekers, and many have a negative view of asylum seekers and refugees, fearing that their presence in the country may have an unfavorable effect on the economy and the nation as a whole (Bowers, 2004). Bowers (2004) has suggested that this negativity may be a by – product of a biased media. The Minister for Justice Equality and Law Reform, Michael Mc Dowell, has unabashedly used offensive and demeaning phrases such as 'economic queue jumpers' when referring to asylum seekers (Bowers, 2004).

Many reports and polls also unapologetically use the ethnocentric term 'non national' which implies that one is without nationality rather than simply that one is of foreign nationality.

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1.4 Irish and European Statistics

"Abuse of the asylum system is a hot topic among industrialised nations, especially in the European Union, but abuse of asylum seekers is not" (Guturres, 2006, p.2)

There are many people in our society that are of the opinion that our nation is being overrun with asylum seekers. The figures presented in this section will illustrate that although the number of applications may seem high, only a small percentage of these applicants will be successful by becoming recognised as a refugee

According to Collville (2006), statistics become a major source of distortion of the asylum issue For example, "the hostile debate in Germany in the early 1990's took place at a time when Germany received a million asylum seekers in just three years, but in countries where the numbers are far less spectacular- both in real terms and per capita, the debate has been equally if not more vitriolic" (Guterres, 2006, p 3) Yet the numbers, both of refugees and asylum seekers, are in many countries at their lowest for decades.

Colville (2006) has noted that there were genuinely very high numbers of asylum seekers in some European countries in the early and late 1990's – not surprisingly given that there were major wars taking place in Europe An example of which are the conflicts that took place in the former Yugoslavia and the political crisis in Albania, Romania and other former Eastern bloc countries (Guterres, 2006)

There are a number of occurrences which may explain the change in the number of new arrivals. The (UNHCR, 2006) has acknowledged that inter-state conflict is less prevalent today than internal and civil war, resulting in fewer refugee flows but more internal displacement People who would otherwise seek safety in neighbouring states are more frequently compelled to remain within the borders of their own

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country Although state boundaries have not been crossed, there situations are often similar to refugees. Recent years have also seen an end to long standing conflicts and the rebuilding of war torn societies, all of which will have a positive impact

1.4.1 European Profile

In the five year period between 2001 - 2005, a total of 1,946, 200 people sought asylum in Europe. 38,950 (2%) of these sought asylum in Ireland. The United Kingdom, France and Germany accounted for a combined 881,940 (45 3%), Ireland was in 13th place behind the Czech Republic and just ahead of Greece and Poland (Irish Refugee Council, 2006).

The global population of refugees of concern to the UNHCR has declined in recent years, from nearly eighteen million in 1992 to just over 9 million in 2004. Since the signing of the Luena Peace Accord in 2002, at least 300,000 refugees have returned to Angola Despite the reduction in the total number of refugees worldwide, the majority of those who remain live without any prospect of a durable solution to their plight (UNHCR, 2005) Although some countries have witnessed small increases, since 2001 the overall trend has been downwards (UNHCR, 2006).

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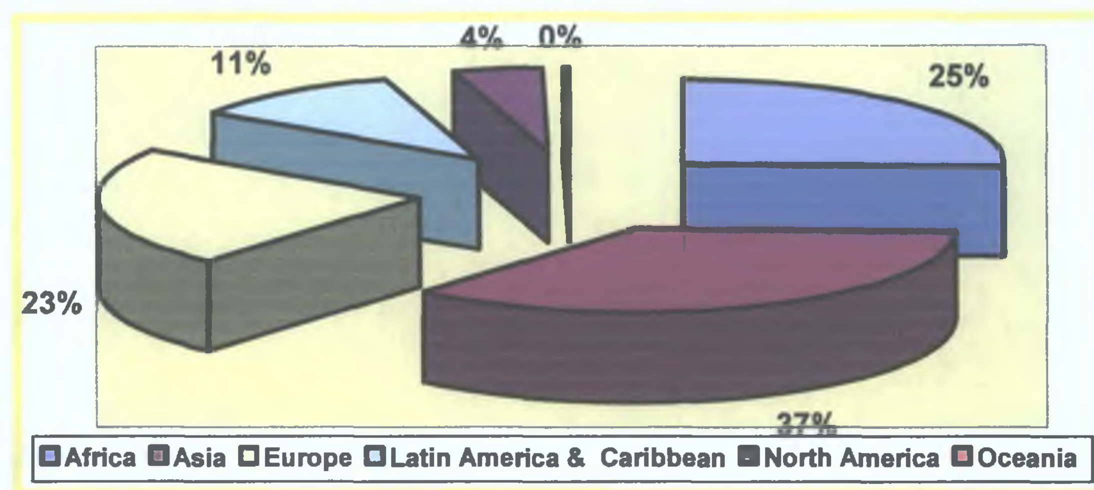
Fig 1.1: Total Population of Concern to the UNHCR by Region Jan 2005



(Source: UNHCR, 2005)

This chart refers to the total population of concern, which includes; refugees and asylum seekers, returned refugees, internally displaced people and stateless people.

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1.4.2 Irish Profile

Individuals who seek asylum in Ireland may be recognised as refugee at either the first instance by the independent Office of the Refugee Applications Commissioner (ORAC) or on appeal by the independent Office of the Refugee Appeals Tribunal (RAT) (Irish Refugee Council, 2006).

The table below illustrates the number of applications received by the Office of the Refugee Applications Commissioner. These figures represent Irish numbers up to the 30th of September 2006. It is evident from the table that a similar pattern has

occurred over the last five years, with only a small fraction of those seeking asylum receiving a positive recommendation.

Table 1.1: Asylum Applications in Ireland 2002-2006

	2002	**2003**	**2004**	**2005**	**2006**
No of new applicants for a declaration as a refugee	11,598	7,483	4,265	4,304	3,139
No of reapplications for a declaration as a refugee	36	417	501	19	57
Total Number of application for a declaration as a refugee	11,634	7,900	4,766	4,323	3,196

(Source: Office of the Refugee Applications Commissioner, 2006)

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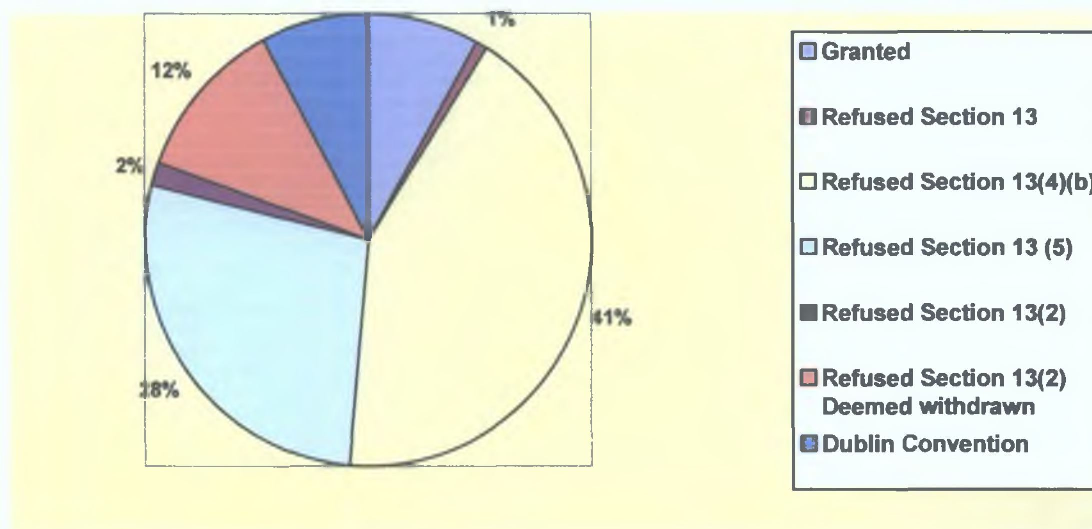
The above chart gives an overview of the determination of applications between 2002-2005, illustrating those who were deemed successful and those who were not In respect of those who were refused, reference is made to the particular section of the Refugee Act 1996 under which the determination was made (Refer to appendix 5 for a brief summary of these sections)

Fig 1.2: Successful applications for a declaration to be a refugee as at 30/09/2006



(Source: ORAC, 2006)

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Nigeria has had the highest number of refugees recognised in Ireland, in 2006 and in the previous five years. Nigerian nationals have come top of the list of those who have been successful on appeal. According to the Irish Refugee Council (2006) over 80% of Nigerians, who were recognised in this period were obliged to take their case to appeal after having had their case initially rejected by the Office of the Refugee Applications Commissioner.

The asylum seeking community in Ireland is quite a young population, only 3% of last years applicants were aged 46 years and older, and under 40% were aged 35 years and under. The majority of last year's applicants for declaration as a refugee were males. Approximately one third of applications were from females.

Asylum seekers who receive a positive determination in relation to their application for recognition as a refugee, are permitted to apply to have their spouse and any

unmarried children under 18 years of age reunited with them in Ireland. The top three countries in both 2005 and 2006 have been Somalia, Nigeria, and the Dominican Republic of Congo, respectively.

Not all those wishing to apply for asylum get the opportunity According to the Irish Refugee Council (2006) a total of 1,117 people were refused 'leave to land' in Ireland in the first quarter of 2005, i.e. they were turned away on arrival at an Irish port / airport or held in an Irish prison until a flight could be arranged for them How many of these were seeking asylum is unknown.

Ireland gives 'leave to remain' to a very small number of unsuccessful asylum seekers 'Leave to remain' can be granted on a number of grounds, at the discretion of the Minister. "Some people currently waiting for a decision on their leave to remain applications have been in Ireland – legally, since the early 1990s and the risk of being deported in the future when their status is changed to illegal immigrant hangs over them" (Irish Refugee Council, 2006, p 1)

1.5 Aim of the Study

The aim of this study is to identify the health related behaviours of adult asylum seekers, who are residing in both direct provision centres and self-catering units in seven counties located within the Health Service Executive West area

1.6 Objectives of this Study

1 To compile a profile of the asylum seeking community in the Health Service Executive west area

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2. To conduct a quantitative assessment of the health related behaviours of asylum seekers residing in the above area in relation to diet and nutrition, alcohol consumption, tobacco use, physical activity and access / usage of Irish health services.

3. To identify the key barriers that asylum seekers face in accessing Irish health services

1.7 Context of the Study

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This study was conducted to explore the health related behaviours of adult asylum seekers who are residing in both self-catering units and direct provision centres in the Health Service Executive West area, during the period September 2005-January 2007 The HSE region was chosen, as there are seven counties located in this area, namely; Co Sligo, Co Donegal, Co Leitrim, west Co Cavan, Co Roscommon, Co Mayo and Co Galway. During the period of data collection, March –August 2006, asylum seekers were residing in all of the above counties with the exception of west Co. Cavan

In total, two hundred and forty two asylum seekers participated in this research (n=242) The majority of research participants were resident in direct provision centres with a small minority living in self-catering units in the general community

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1.8 Logistics of this Study

Distinctive patterns of health related behaviours have been noted for several different ethnic (Dowda et al., 2003; Fardy et al , 2000), cultural (Penn et al., 2000), and socioeconomic groups (Sharkey & Haines, 2001). "Behaviours related to

chronic diseases including diets high in fat and low in fruit and vegetables, little physical activities, tobacco use and levels of alcohol and drug consumption Most of these behaviours have multiple health effects or can act together in pathogenetic synergy" (Weitkunat & Moretti, 2005, p 18)

This research was undertaken to explore the health related behaviours of people who are currently seeking asylum in Ireland. All adult asylum seekers in the HSE West area were invited to participate. Kasl & Cobb (1996, p.531), define health behaviours as "any activity undertaken by a person believing himself to be healthy for the purpose of preventing disease or detecting it at an asymptomatic stage" Conner & Norman (2005) and Naidoo & Wills (2000), have noted that a variety of behaviours fall within such a definition including medical usage, compliance with medical regimes and self-directed health behaviours

"Our health is strongly determined by what we do or don't do, what we eat, what we drink, how we live and work and how our society is structured" (Kerr et al , 2006, preface) Increasingly common are measurements of people's behaviour which are then used as a measure of health. People's health behaviour or lifestyles have been regarded as the cause of many modern diseases In recent years, a focus of public health and health promotion has been on modifying those aspects of behaviour which are known to have a negative impact on health (Naidoo & Wills, 2000) A number of authors has argued that health promotion is probably the most ethical

(Davies & Mac Dowell 2006), effective (Nutbeam & Harris, 2004) efficient and sustainable approach to achieving and maintaining good health

The World Health Report in 1995 (WHO, 1995) stated that; lifestyle related diseases and conditions are responsible for 70-80% of deaths in developed countries and about 40% in the developing world Examples include, cardiovascular disease, cancer, obesity, malnutrition, behavioural disorders, accidents and violence *"This* indicates that, although genes and the environment might play a certain role, behaviour is by far the most dominant risk factor for morbidity and mortality" (Weitkunat & Moretti, 2005, p.18).

Justification for the study of health behaviours is based on two assumptions, that in industralised countries a substantial proportion of the mortality from the leading causes of death is due to particular behaviour patterns, and that these behaviour patterns are modifiable It has been increasingly recognised that individuals can make contributions to their own health and well-being through adopting particular health enhancing behaviours and avoiding other health comprising behaviours. Identification of the factors which underlie such health behaviours has become a focus of research in recent years (Conner & Norman, 1995).

According to Fries et al , (1998) chronic diseases related to lifestyle account for 70% of the healthcare costs in the United States of America Negative lifestyle behaviours also "play a crucial role in the context of absenteeism, early retirement, and reduced quality of life A careful look at health related behaviours are therefore an urgent and challenging research aim" (Weitkunat & Moretti, 2005, p 18)

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1.9 Significance of this study

The last decade has seen Ireland rapidly becoming a multi-ethnic and multi-cultural country (Brehony & Clancy, 2006) With a steady inflow over the last few years of migrant workers, foreign students and asylum seekers arriving in Ireland, there has been corresponding pressure on the health system to adapt and cater for the needs of this new, diverse, and growing community (Irish Refugee Council, 2004)

In Ireland, it is estimated that immigration for the period April 2005- April 2006 was 89,900 people (CSO, 2007) The CSO estimates suggest that, m 2006, almost 46 % of migrants to Ireland were from new accession states (Irish Refugee Council, 2006) The number of asylum seekers fleeing persecution and war who come to Ireland is a small percentage of the whole (Brehony & Clancy, 2006) Chapter 2 provides a full analysis of the number of applications for asylum in Ireland

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"Movements of refugees and asylum seekers have and will always be, to some extent, chaotic and unpredictable" (Crisp, 2003, p 14) "Although the North West region of Ireland hosts the smallest number of asylum seekers m the country, it's historical and geographical peripherality and the continuing strength of traditional social structures present specific challenges for service planning and delivery to this population group" (Manandhar et al , 2006, p.15).

Prior to 1999 all asylum seekers coming to Ireland were housed in the Dublin city During the 1990's, appropriate and culturally sensitive services, although still inadequate, were developed in the Dublin area for non- Irish nationals Then, following the introduction of the direct provision in *1999*, the accommodation-driven 'dispersal' scheme was implemented This scheme was seen by many to focus on finding shelter and food, with little or no evidence to suggest that other

needs are accessed. "In particular, the lack of access to appropriately qualified and culturally sensitive care workers to access the specific health related concerns of asylum seekers, a specific group of non Irish nationals. Concerns such as guilt and anxiety about family members, uncertainty about the future, and adaptation to a new culture, has negatively impacted on the health of asylum seekers" (Irish Refugee Council, 2001, p 9)

Betchel et al , (2000), has argued that providing culturally competent and sensitive care can positively impact on health outcomes In relation to ethnic groups, there is evidence that culture influences beliefs and behaviours relating to health, (Papadopoulos, 2003, 2006); however culture is not the only determinant of health behaviour

Access to or use of appropriate health services for ethnic minority groups can be influenced by a range of issues both pre and post migration In terms of asylum seekers, experiences with official agencies prior to migration, language difficulties, lack of knowledge of services available in the new country, lack of information or understanding of entitlements (Brehony & Clancy, 2006), cultural taboos or traditions (El Safty, 2001) and fear of authority or government agencies and services (Davidson et al., 2004) may influence decisions.

Tilki (2006, p 33) has argued that health services only play a part in improving health and addressing health inequalities and "the evidence is unequivocal about the need for public health to tackle a range of interrelated social factors, which exclude certain groups of people and deny them equitable rights".

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While all health professionals should strive to provide a culturally competent and sensitive service to their clients it would be impossible for them to understand the needs of every specific group of ethnic minority "Health professionals should address their own cultural competence, in order to ensure that care is based on cultural awareness, knowledge, and sensitivity" (Papadopoulos, 2006, p 143)

"From a health service perspective it is widely acknowledged that unequal health outcomes can occur as a consequence of ethnicity" (Brehony & Clancy, 2006, p 80) Research demonstrates that such inequalities relate not only to the specific needs of ethnic groups but also to the systemic barriers within a health service which is oriented towards the health needs of the dominant group (Fanning & Pierce, 2004, cited in Brehony & Clancy, 2006)

"All nations must plan for, and meet, the special and essential health and social needs of the asylum seeking community" (Manandhar et al., 2006, p 10) As it is imperative to remember that many new arrivals will become a permanent member of Irish society

This research has been motivated by a desire to understand the specific health behaviours of asylum seekers along with the reasons why individuals perform a variety of behaviours and to acknowledge the services that they perceive as being important. It is hoped that by identifying and alleviating the problems that asylum seekers encounter when accessing these services, improvement may be made to both individual and population health

As a result of this research, an information booklet will be developed by the author This booklet will document the findings of the research and highlight areas for change The booklet will be available to both staff and residents of direct provision

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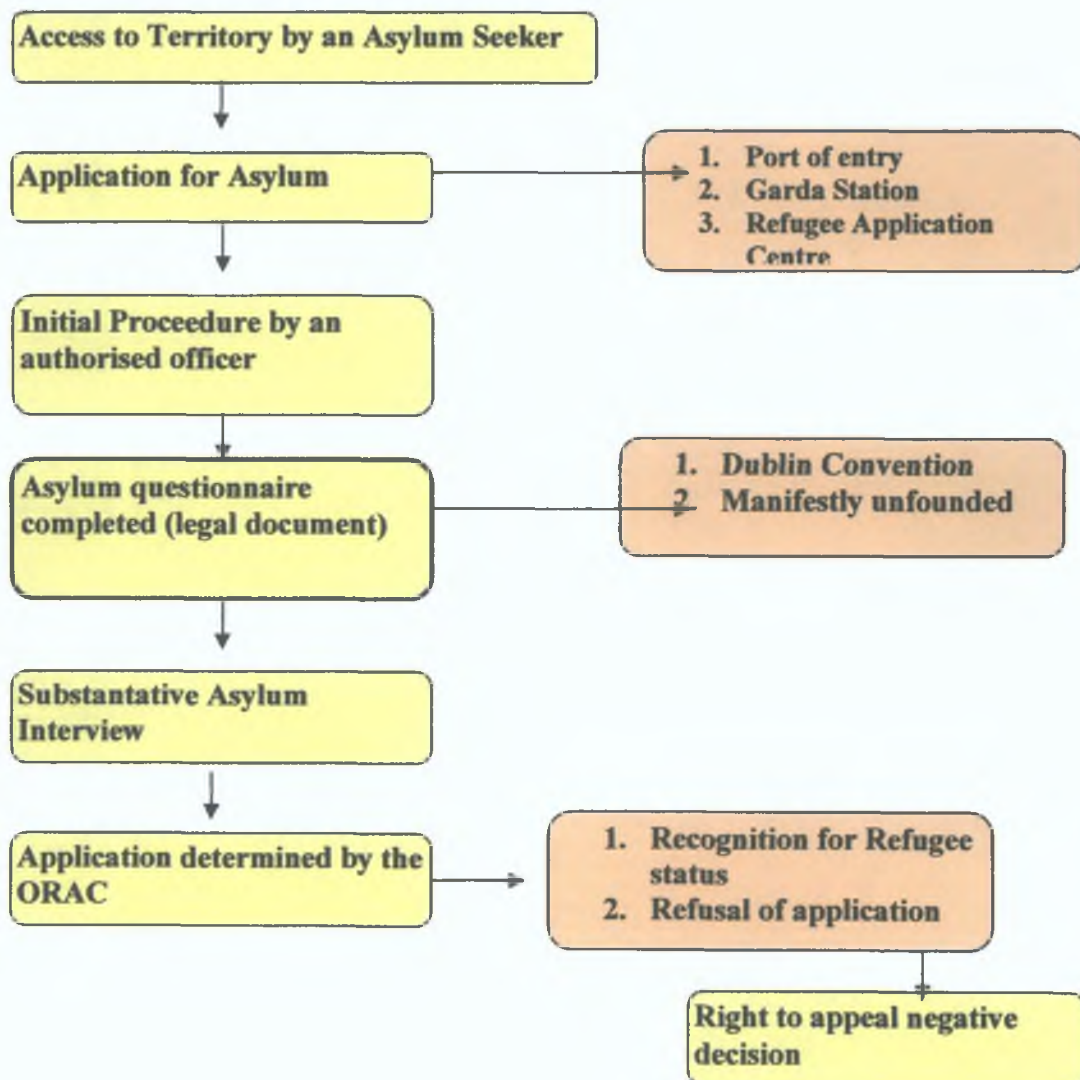
1.10 The Asylum Process in Ireland

The asylum process is a complex and lengthy set of procedures that begins with an asylum seeker making a claim for asylum (Hall, 2004). This can be made at their port of entry into Ireland or at the Refugee Applications Centre .The current UN High Commissioner for Refugees; Antonio Guterres, has acknowledged there are many aspects of the asylum system that could be improved.

Fig 1.3: Asylum Procedures under the Refugee Act 1996



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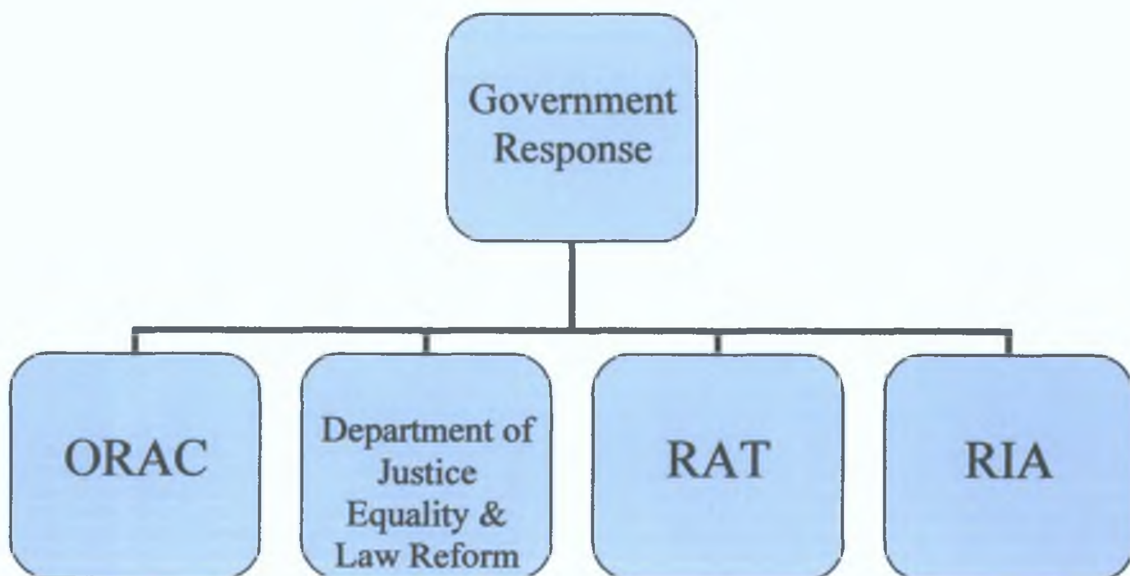
Under the Geneva Convention Relating to the Status of Refugees, refugees are also granted the right to non-discrimination, to freedom of religious practice, to acquisition of property, to access to courts, to public education and to other such humanitarian rights (UN, 1948).

In response to the arrival of asylum seekers, the Irish Government has set up a four-pillar structure, consisting of the Department of Justice, Equality, and Law Reform; the Office of the Refugee Applications Commissioner (ORAC); the Refugee Appeals Tribunal (RAT) and the Reception and Integration Agency (RIA).

Fig 1.4: Government Structure



Prior to 1996, the initial asylum determination was carried out by the Department of Justice, Equality and Law Reform, however the Refugee Act (1996) established the appointment of the independent Office of the Refugee Applications Commissioner and the Refugee Appeals Board (Irish Refugee Council, 2006).The Refugee

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Applications Commissioner is responsible for the investigation of asylum claims and makes recommendations at first instance while the Refugee Appeals Board considers and decides appeal

Figure 1.3 illustrated at the beginning of this section exemplifies procedures for asylum in Ireland, it refers to two issues, which determine the outcome of an application following completion of the asylum questionnaire, namely, The Dublin Convention and Manifestly Unfounded applications.

Anyone wishing to enter the asylum process in Ireland, must be given permission by the Minister for Justice Equity and Law Reform The Dublin Convention Order 1997 requires that an asylum seeker make only one attempt at asylum within the E.U This application should be made in the first EU country in which they arrive (Wyndham – Smith, 2002) The Convention also provides a mechanism for deciding which EU Member State is responsible for examining an application for asylum (Kenny, 2003)

Those who are not fortunate enough to receive a positive determination can apply to the Minister for Justice to remain in Ireland. ‘Leave to remain’ on humanitarian grounds can be granted by the Minister for Justice Equity and Law Reform even if an asylum seeker does not meet the criteria for the granting of refugee status This is known as humanitarian leave to remain (Wyndham – Smith, 2002)

The Refugee Act (1996) does not stipulate the criteria to be used nor the rights and entitlements thereafter. This effectively means that Ministerial discretion rather than the law, will determine most of their entitlements (Torode et al., 2001)

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1.11 Structures working with asylum seekers and refugees in Ireland

(As outlined by the Irish Refugee Council, 2002)

Office of the Refugee Applications Commissioner (ORAC)

The office of the Refugee applications Commissioner is under the leadership of the Refugee Applications Commissioner The staff of the Office of the Refugee Applications Commissioners are civil servants, answerable to the Refugee Applications Commissioner, who make first instance asylum decisions

Refugee Appeals Tribunal (RAT)

The members of the Refugee Appeals Tribunal are independent asylum appeal authority /adjudicator's Tribunal members hear appeal cases following an initial negative decision by the Refugee Applications Commissioner.

Reception and Integration Agency (RIA)

The Reception and Integration Agency under the auspices of the Department of Justice Equality and Law Reform has the responsibility for sourcing accommodation and services for asylum seekers and promoting the integration of those recognised as refugees or granted leave to remain.

Refugee Legal Services (RLS)

The RLS is an independent division of the Legal Aid Board, established in February 1999 to provide free legal advice and representation for asylum seekers, at all stages of the asylum procedure

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Human Rights Commission

Established under the Good Friday Agreement to monitor, report, investigate and make recommendations to the Government on human rights within Ireland, including asylum issues

Department of Justice Equality and Law Reform

The Immigration and Citizenship division of the Department of Justice Equality and Law Reform makes decisions on, inter alia, family reunification, and Irish citizenship

United Nations High Commissioner for Refugees (UNHCR)

The UNHCR Liaison Office in Dublin monitors the implementation of the 1951 Geneva Convention in Ireland, and provides training and advice to Irish authorities

International Organisation for Migration (IOM)

The International Organisation for Migration operates a voluntary return programme for Romanian and Nigerian asylum seekers in Ireland who wish to return to their country of origin

(See appendix 2 for a list of asylum seeker support services)

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Chapter 2

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Chapter 2 - Review of Literature

2.1 Introduction

The literature on the experience of voluntary migration is wide ranging and well documented. However, there is a definite lack of published material on the health needs of asylum seekers and refugees in Ireland This study aims to establish health behaviours among the asylum seeking community in the west and north west of Ireland. This chapter provides the reader with an analysis of the many determinants of health and explores areas where asylum seekers may be vulnerable The influence of culture on health and the importance of transcultural health is also documented

"The advent of the twenty first century marked the coming of age of public health " (Elliot et al , 2005, p 1) The publication of 'Health for All in the 21st century' emphasised the importance of each individual in society achieving their full health potential, as set out by the World Health Organisation

With the formation of the United Nations in 1945, an independent health organisation was established. At the International Health Conference, in 1946 the constitution of the World Health Organisation was approved by the participating countries (WHO, 1946) This constitution states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" (Elliot et al., 2005, p.2)

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Health has been defined by many authors, all of whom agree that it is both a complex and multi faceted phenomena that has meanings drawn from the biological or physical sciences, as well as sociology (Lalonde, 1974), psychology (Ryan, 2005) and related domains of knowledge. It is therefore hardly surprising that there is a wide range of factors that both influence and determine health and health status (Ryan et al , 2005)

"The word health itself is a derivation of an old English word, hael, meaning whole" (Naidoo & Wills, 2000, p 6) In 1946, the World Health Organisation defined health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity" (WHO, 1946)

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At one level, it could be argued that the roots of health promotion are to be found in the World Health Organisations original and classic definition of health (WHO, 1946)

The concept of health, as outlined above is almost a complete rejection of the notion of health as the absence of disease has become a fairly standard approach to defining health used by health service agencies "Whilst this concept introduces the notion of wellbeing, the suggestion is clearly that wellbeing is a state wherein there is balance and an integration of the facets of health " (Ryan et al , 2006, p 4).

Morris (1975) has acknowledged that there may be many natural differences m health in any group of people or population in society Conceptions of health and illness vary among different groups within a single society and between societies, as well as in any single society over time (Giger & Davidhizar, 2004)

Migrants including asylum seekers, often have reduced access to health services due to communication problems (Collins, 2002), lack of knowledge of available services

(Brehony & Clancy, 2006), and for some, fear that health services may be linked to immigration officialdom (Abel-Smith et al., 1995).

Bollini & Siem (1995, p 819) argue that "migrants are exposed to poor working and living conditions and they have reduced access to healthcare for a number of political, administrative and cultural reasons, for example, barriers resulting from language problems, different concepts of health and disease or racism".

Research in the U K. shows that even healthy asylum seekers report deterioration in their health status in the first two to three years after arrival, mainly due to poverty, social exclusion (Wolhuter, 2003), poor accommodation, and poor nutrition (Gammell et al , 1993) Barriers to healthcare have also been reported to exacerbate their health problems (Valley et al , 1999).

A growing body of research evidence points to the inadequate responses of developed countries to the health needs of refugees (Grove & Zwi, 2005). In many different ways, refugee populations are at risk and have been recognised as having unique and complex (Agar, 1999) health needs that require attention both upon arrival and throughout the process of resettlement (Harris & Telfer, 2001; Steel & Silove, 2001)

Grove & Zwi (2003) also acknowledges that the journey of asylum seekers from home to final destination may include multiple border crossings, arduous land journey and protracted stays in formal or informal camps, the process of applying for refugee status can be long and drawn out Authors such as , Ager & Bouchet – Saulnier (2004) and Zwi & Castillo (2003) argue that the increasingly restrictive refugee process, border closures and forced repatriation which marked the last decade, have deprived endangered communities of the option of survival through flight

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There is little doubt that immigration (including applicants for asylum) into Ireland will continue in the coming years Collins (2002) suggests that in order to meet the needs of this disparate groups of immigrants effectively and appropriately, a more cohesive, integrated, forward-looking needs and rights based national government policy on the reception, integration and health needs of asylum seekers needs to be implemented.

2.2 The Direct Provision System in Ireland

Prior to 1999, asylum seekers arriving in Ireland were accommodated in self-catering units located throughout the capital However as the number of applications for asylum rose the Irish government announced their intention to introduce a system of direct provision as a matter of extreme urgency

According to the FLAC (2003) the number of applications were spiralmg out of control, therefore there was a need for the burden to be spread throughout the rest of the country. Under the direct provision system, all asylum seeking coming to Ireland are housed temporarily (for a period of weeks) in reception centres in Dublin while their initial application is being lodged They are then transferred to one of the 64 direct provision centres located throughout the country These centres are owned and managed by private individuals or companies but are paid for by the state. The Reception and Integration Agency which is run by the Department of Justice Equality and Law Reform is responsible for monitoring these centres An asylum seeker in direct provision receives food, lodging, and a small weekly allowance of €19 10 per adult per week (see table 2 1)

The introduction of the Direct Provision system in 1999 heralded a major change in government policy with regard to the accommodation of asylum seekers It was initially thought that this new system would provide a beneficial and effective approach to accommodating these new arrivals However a number of organisations,

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such as the Irish Refugee Council and the Free Legal Advice Centre have expressed their disappointment and disapproval of this system, some of which are documented throughout this section

Since the introduction of 'dispersal' in November 1999, asylum seekers have been housed in communal accommodation centres on full board and reduced social welfare payments. It was the Governments objective that this policy would only be of a short-term nature The policy was launched nationwide in April 2000 on the assumption that all asylum applications would be definitely processed within a six-month period Therefore such stays in communal accommodation would be of a short-term nature (Irish Refugee Council, 2002). Unfortunately, the government have not accomplished this and a number of asylum seekers have been residing in direct provision for a significantly longer period (FLAC, 2003).

According to the Irish Refugee Council (2001, p 5), "huge regional variations exist in the implementation of this system Some asylum seekers have to share a room with up to five others, with no access to services, to eat food that some dislike intensely, and at a time not of their choosing, whereas others have their own bedrooms and cook their own food at a time that is convenient to them"

Initially, a number of organisations, including the Irish Refugee Council welcomed the introduction of the direct provision system These organisations felt that if the system was administered properly and the necessary infrastructure was m place, dispersal scheme would be a positive development Unfortunately, the practice of dispersing asylum seekers developed in an ad hoc manner and the experience to date has been largely negative for asylum seekers (Irish Refugee Council, 2001). The Reception and Integration Agency has been criticised for creating an environment where asylum seekers have been institutionalised and alienated from the wider community The direct provision centres have been criticised in a number of areas. Mainly m terms of over crowding.

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Organisations working on behalf of asylum seekers such as the Irish Refugee Council and the FLAC are highly critical of the current system It is the view of the Irish Refugee Council (2001) that since the implementation of direct provision in Ireland, it is clear that the principle rationale behind the policy is to ensure that living conditions in Ireland were not better that in our European partners, especially the United Kingdom "The previous and incumbent Ministers for Justice Equality and Law Reform have repeatedly expressed the view that the welfare scheme must not act as a pull factor for the non-genuine asylum seekers In its efforts to avoid such a pull factor, the Department of Justice Equality and Law Reform, through its current policy and practice runs the risk of making the experience of asylum seeking so unbearable that people are effectively forced to abandon their right to seek asylum" (Free Legal Advice Centre, 2003, p.36)

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Table 2.1: State welfare allowances and payments for asylum seekers

Place of residence for an asylum seeker	Autumn 2003	December 2004	Jan 2005	Jan 2006
In Direct Provision	€19.10 week/ adult €9 50 week/child	€19.10 week/ adult €9 50 week/child	€19.10 week/adult €9 50 week/child	€19.10 week/adult €9 50 week/child
In the community	€134 80 week / single adult €224.20 week /couple €16.80 week/ child €151 60 week / single parent	€ 134 80 week/ single adult €224 20 week /couple €16.80 week / child €151 60 week / single parent	€148 50 week / single adult €247.50 week / Couple €16.80 week / child €165 60 week / single parent	€148 50 week / single adult €247.50 week / Couple €16.80 week / child €165 60 week /single parent

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(Manandhar et al , 2006)

The above table provides an overview of the monetary contributions that asylum seekers, in different accommodation settings receive on a weekly basis. It is evident that rates for those who reside in direct provision centres have remained unchanged over the last number of years while those who reside in the community have had a slight increase. According to Manandhar et al., (2006) has highlighted that allowances for asylum seekers in Direct Provision were decided in April 2000, and have not been reviewed since

Until late 1999, asylum seekers in Ireland were eligible for the same welfare support as other persons in the state, however the establishment of direct provision brought about considerable changes and as a result asylum seekers now receive a reduced monetary allowance

2.3 The Human Impact of Direct Provision

The direct provision system in Ireland has been the focus of much criticism, since its introduction six years ago, much of this criticism relates to the inadequate level of state support in implementing policies and procedures to cater for the needs of this group

The experience of dispersed asylum seekers living in Direct Provision is well documented by many authors and generally, the picture is one of social exclusion, poverty and hopelessness (Irish Refugee Council, 2001, Free Legal Advice Centre, 2003) There are not that many organisations working in this area of minority health however, those who are all agree that the current system should be replaced with a more cohesive, forward looking system

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The nature of the full board and lodging provided under Direct Provision is a cause for concern (Free Legal Advice Centre, 2003) The government initiated accommodating asylum seekers m direct provision with the objective to definitively process applications within a six-month period, however the majority of asylum applications are not processed within this time frame. The consequences of this are that asylum seekers reside in direct provision centres, some of which are overcrowded and unsuitable for an undefined period, which in some instances can be over 24 months. This uncertainty and lack of control over their lives can give rise to an array of health issues.

Hall (2004, p 10) acknowledges that "arriving to an unknown country without a good understanding of the language, or the culture would be overwhelming. Yet the experience for an asylum seeker, who is unsure of the very process they are expected to undergo, is very much more harrowing".

A number of authors have documented that there is a strong link between the quality of housing and a person's health. In terms of asylum seekers overcrowding and enforced passivity can have negative effects on their mental health, which in turn may show in the form of physical symptoms (Dibelius, 2001) Fanning (2001), has acknowledged that severe housing deprivation produces a range of day to day tensions and pressures that affect the psychological well being (Burnett & Peel, 2001) of parents and children in reception centres

Currently in Ireland, there is a definite lack of programmes that prepare the asylum seeker for life in Ireland as a refugee Hall (2004) has noted that under Direct Provision, many of the asylum seekers daily decisions are made for them by the authorities in the accommodation centres This loss of control over their private life coupled with inactivity can result in asylum seekers becoming institutionalised, whereby they may later find it hard to live independently

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Being confined to designated accommodation centres and dependent on hostel staff has a clear impact on the self-sufficiency of asylum seekers and their ability to retain their independency and autonomy (Comhlamh, 2001). Fanning et al., (2000) noted that individuals might find it difficult to immediately switch back to independent living and employment without any sort of gradual step-down from reliance on authority and welfare. Simple tasks like cooking hot meals and dealing with every day life stressors can have a detrimental effect on psychological wellbeing for those who are unfamiliar with these practices. In essence, asylum seekers go from having everything provided for them to having nothing provided, which may give rise to vulnerability and isolation. Perceived inability to cope with their new life can also cause many ills.

Rees (2003) has described how a study of East Timorese women seeking asylum in Australia highlighted their physical and mental health needs, attributing these in part to the increased vulnerability associated with living with insecurity of tenure and significant material deprivation.

The asylum procedures may also adversely affect the applicant's health. Clarke (2004), has noted that not only do asylum seekers have to deal with the convoluted asylum process and feeling of hopelessness and restlessness they are also forced to discuss their past with potentially unbelieving interviewers. Simultaneously they must deal with current social exclusion, racial abuse and uncertainty about their future.

Many asylum seekers are fleeing from their native countries for reasons of instability or danger at home (Clarke, 2004). Some have witnessed or been victims of extreme violence, rape and human rights abuses (Burnett & Peel. 2001). There is also the problem of psychosocial distress resulting from torture to the refugee and asylum seekers themselves, or their relatives (Kemp, 1993; Coker, 2001).

A psychological condition known as cultural bereavement can occur as a result of fleeing one's country, this condition occurs where an individual is forced to recognise that they have abandoned their possessions, friends, family and native

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culture (Hall, 2004). The process of dealing with past experiences and adjusting to a new situation may stagnate as a result of continuous exposure to stress and tension (Dutch Refugee Council, 1997). "The effects of migration are more than moving from one culture to another, or one healthcare system to another. Reasons for flight such as oppression, violence, fear and poverty are factors that impact on the health of refugees" (Papadopoulos, 2006, p.143).

A number of organisations have aired their concerns regarding the impact of dispersal and direct provision on asylum applicants. The Irish Council for Civil Liberties has described the direct provision scheme as both 'discriminatory and unnecessary', (Coulter, 1999) while the Conference of Religious in Ireland has warned of the danger of 'ghettoisation'. Similarly, Amnesty International (Ireland) has stated that the scheme 'discriminates against a section of people which is already vulnerable' (Newman & Donoghue, 2000).

Poverty- proofing was introduced, in July 1998 as part of the National Anti-Poverty Strategy (NAPs, 1997). Direct provision has been highlighted is an example of the failure of government to implement poverty proofing. It has been suggested that if direct provision had been subjected to such analysis at the policy stage, it would never have been implemented (Free Legal Advice Centre, 2003).

The Irish Refugee Council has described the dispersal scheme as "inhumane, discriminatory, and economically unsound" (Irish Refugee Council, 2001). The Equal Status Act (2000) prohibits discrimination in all areas other than the workplace, such as in the provision of goods and services and education. Section 3 of the Act lists a series of circumstances referred to as 'the discriminatory grounds', where discrimination will be taken to have occurred. The Free Legal Advice Centre is of the view that the scheme of direct provision may be in contravention of the Equal Status Act 2000 (Free Legal Advice Centre, 2003).

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2.4 The Concept of health

"Health is a broad concept, which can embody a huge range of meanings, from the narrowly technical to the all-embracing moral or philosophical" (Naidoo & Will, 2000 p 5) Health has two meanings in everyday use, one negative, and one positive The negative definition of health is the absence of disease or infirmity. The positive definition of health as interpreted by the World Health Organisation is a state of well being Health is now regarded as a resource to be protected and developed to enable people to attain their maximum physical and mental capacity (DoHC, 2000a)

Pinpointing the pathways which determine health and inequalities in health has proved a very challenging undertaking globally (Burke, 2001). "As far back as 1974, LaLonde launched the idea that biology, lifestyle behaviours, social and physical environment and healthcare organisations should all share equal importance as key contributors to health and should therefore receive the same considerations as determinants of health / illness" (Ryan et al., 2006 p.56).

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In recent decades, health promotion has been conceptualised most often as disease prevention, however health promotion focuses primarily on changing individual behaviour to reduce the risk of disease and seeks to understand and strengthen the factors that create physical, psychological and social health (Stokols, 2000)

Public health seeks to address health needs through the organised efforts of society (Grove & Zwi, 2005) Beaglehole et al , (2004 cited in Grove & Zwi, 2005) have defined it as "collective action for sustained population – wide health improvement" It is therefore important to recognise that in order to promote health gain, population wide interventions should be developed and structural impediments addressed (Grove & Zwi, 2005).

This recognises the importance of developing population wide interventions and addressing structural impediments to promoting health gain (Grove & Zwi, 2005, p 11)

Public health researchers have developed a new focus on 'population health', in which the group itself, broadly defined, is the unit of analysis and can include not only geographical locations such as nations or communities "but unique segments of society such as employees, prisoners or ethnic groups" (Kindig & Stoddart, 2003, p 381). "Some authors have highlighted the importance of regarding health not only as a static condition but rather, as a characteristic of a dynamic system, a 'process' or 'a means rather than an end' that provides the resources necessary to achieve a populations goals" (Mc Dowell et al , 2004, p 390)

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2.4.1 Determinants of Health

Elliot et al , (2005) noted that following the formation of the World Health Organisation, several events changed the way health was perceived and the ways in which it could be improved The publication in 1974 of the internationally acclaimed document 'A New Perspective on the Health of Canadians' or Lalonde Report as it is generally known (Lalonde, 1974) was the first government document to suggest factors other than healthcare contribute to the health of the population (Elliot et al , 2005)

The report suggested that human biology, lifestyle, the environment, and healthcare services were all critical factors in determining health status. The report also stated that any major improvements in health would mainly come from improvements in

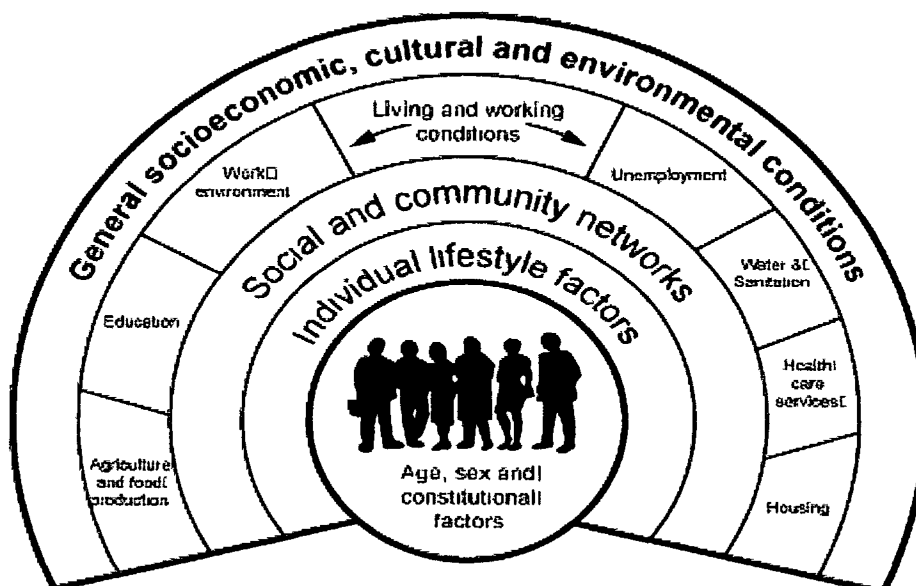
lifestyle and the environment and from a better understanding of human biology (Hancock, 1986)

Balanda & Wilde, (2003) have acknowledged that the determinants of health are diverse and wide ranging, and include economic, environmental, behavioural, social, and biological influences as well as health and personal social services

The model of Dahlgren and Whitehead (1991), also known as the layers to health provides a framework for raising questions about the size of the contribution of each of the layers The model also highlightes the feasibility of changing specific factors and the complimentary action that would be required to influence factors in other layers (Davies & Mac Dowall, 2005)

The diagram below by Dahlgren and Whitehead (1991) illustrates the determinants of health

Fig 2.1: Determinants of Health Model



(Source: Dahlgren & Whitehead, 1991)

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At the centre of this model are non-modifiable factors which are key contributors to our health such as age, gender and hereditary factors. There are also other factors affecting our health and independence over which we have potentially more control. Their impact on our health can be affected by changing individual and /or societal behaviour, (Ministry of Health, 2002) as illustrated in the model, these factors include:

Individual lifestyle behaviours- for example; whether individuals smoke, exercise, how much alcohol they consume. Ross & Wu (1996) have noted that exercise, diet, smoking, and alcohol consumption are behavioural factors commonly cited as major determinants of health, especially in later life, since the effects of lifestyle behaviours cumulate over the life course Good nutrition is vital for good health. Dietary issues are major risk factors for high blood pressure, coronary heart disease, stroke, diabetes and cancers (Wagstaff, 2002) Kelleher et al , (2003) noted that Ireland also has one of the lowest rates of breastfeeding in the world, the women who are most likely to breastfeed are the better off.

Social and Community influences –whether individuals belong to strong social networks, feel valued, and empowered to participate in decisions that affect their health and well-being "Because an individual's social position mediates both their access to societal resources and their exposure to risks, it has an enduring association with health over time and across different diseases" (Graham & Kelly,2004, p.4)

Social determinants reflect people different positions in the social ladder of status, power, and resources Evidence shows that most of the global burden of disease and the bulk of health inequalities are caused by social determinants (Taylor, 1996, Mc Ginnis et al , 2002)

Socio-economic, Cultural and Environmental conditions – the individual's position in society, including income, education, and employment, which affect their ability to participate (HFA, 2000). Some groups in society have better health than others.

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People who are poor and those how who are socially excluded are more likely to be unwell throughout their lives and to die younger than people who are not (Balanda & Wilde, 2001; Barry et al., 2001, Balanda & Wilde, 2003). Affirmation of identity, whether it be ethnic identity or sexual orientation is also closely related to health People who are psychologically confident and socially supported are more likely to adopt and maintain health related behaviours that yield long term, health benefits (Ministry of Health New Zealand, 2002).

Complex interactions between social and economic factors, the physical environment, and individual behaviour determine health throughout life (Davies & Mac Dowall, 2005). However, for refugees and asylum seekers this interaction is much more complex. Refugees will have added problems relating to their refugee experience, a result of which is that their health will be placed in triple jeopardy (Taylor, 2006).

Of particular importance in the study of factors, which influence health is the way in which these factors are distributed across the population (Marmot & Wilkinson, 1999 cited in Balanda & Wilde, 2003) According to Balanda & Wilde (2003, p 30), "their variation across the population is considerable and plays an important part in the widespread inequalities in health and mortality, which have been shown in many countries"

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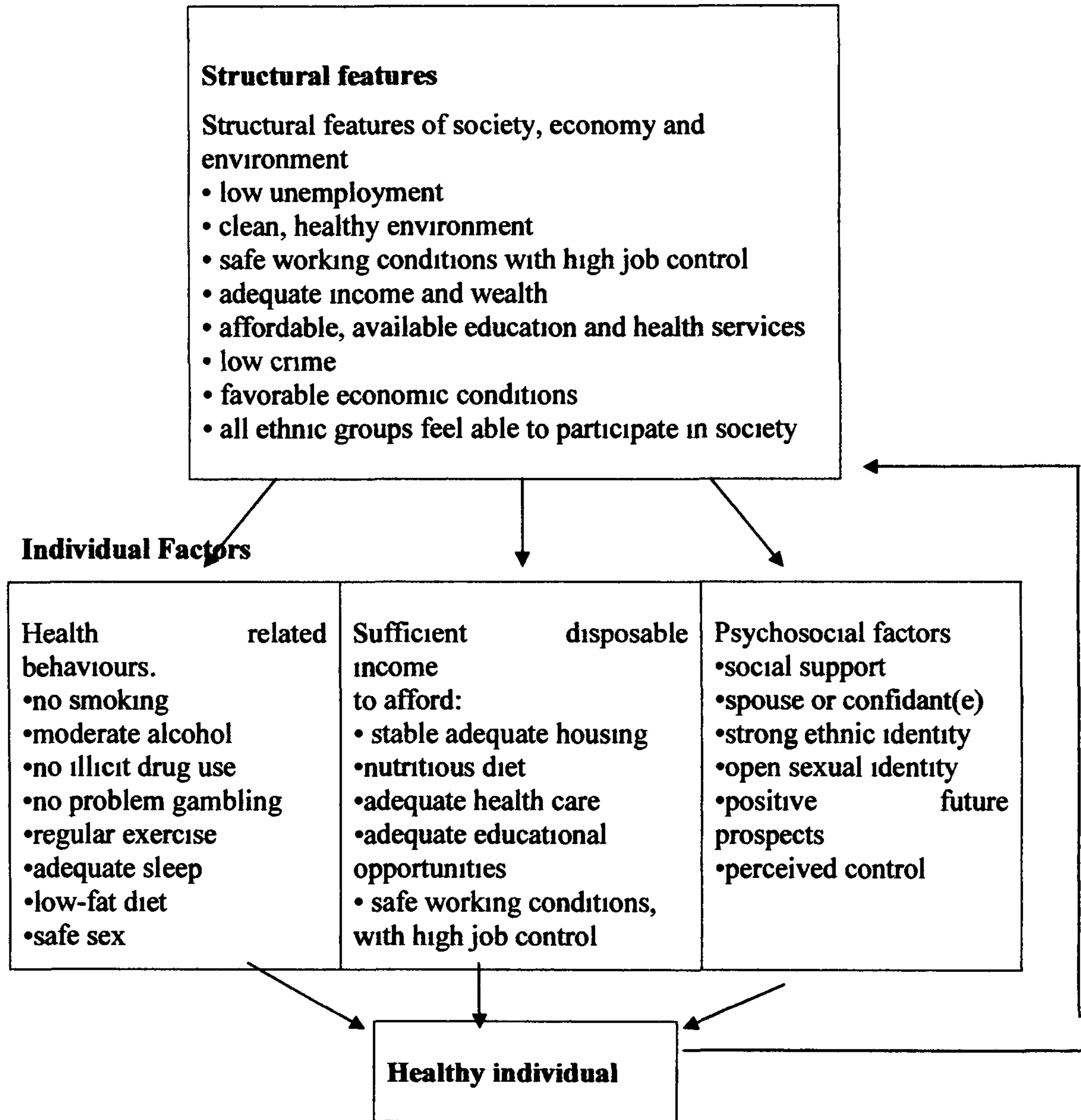
Fig 2.2: Model of the Social and Economic determinants of health



(Source: Ministry of Health NZ, 2002)

The model of the social and economic determinants of health, illustrated above in fig 2 2, recognises that it is the structure of society that predominantly determines individual behaviour. Individual behaviour and experience are clearly affected by factors such as age, gender, and genetic make up. In turn, the health of the

community and the structure of society are also influence an individual's behaviour and their experience (Ministry of Health New Zealand, 2002). Balanda & Wilde, (2003) noted that research on the effects of demographic and socio-economic characteristics has highlighted the disturbing and pervasive evidence that people in the lowest social and economic groups have the poorest health

Health and the risk of premature death are influenced by an array of socio-economic factors (as outlined in fig 2 2) acting throughout life (Wagstaff, 2002) and across generations (Ministry of Health, 2002) The findings from the National Health and Lifestyle survey, SLAN, (2002, 2007) show those in lower socio-economic groups have significantly less healthy lifestyles than those in higher socio-economic groups. As many of the main causes of premature death are now preventable through changes in lifestyle and behaviours, this information is particularly valuable (Burke, 2001)

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2.5 Inequalities in Health

"Of all forms of inequality, health inequalities are the most inhumane"
Martin Luther King Jnr

Today health remains higher than ever on the international development agenda, and health inequalities between and within countries have emerged as a central concern for the global community (Kim et al., 2000; Evans et al., 2001, Leon & Walt, 2001, WHO, 2003)

"We concern ourselves with inequalities in health because we believe that they may be a cause of social instability" (Alleyne et al., 2000, p.76). Concerns with

inequalities in health reached national and international consciousness in the 1970s and were well documented by many authors. They were emphasised in the 1978 Alma – Ata and were the focus of the Black Report (Elliot et al , 2005) (see appendix 3 for The Black Report)

Black (1982) acknowledged that inequalities in health can exist for a whole range of reasons such as geographical location, sex and gender age, ethnicity, hereditary factors and socio-economic factors. "The unequal distribution of material resources – income, education, employment and housing also creates health inequalities" (Howden – Chapman et al , 2000, p.301) This distribution is inherently unjust when it perpetuates the cycle of creating wealth and good health for many but poverty and ill health for some (Swedish Ministry of Health & Social Affairs, 2000)

Acheson, (2000) acknowledges that the weight of scientific evidence suggests that a socio-economic explanation of health inequalities is likely to be relevant for all countries rich and poor throughout the world. Although in general, disadvantage is associated with poorer health, the pattern of inequalities vary by an array of factors and differ according to which measure of health is used (Illsley & Baker, 1997)

According to Burke (2001) much of the focus on inequalities in health is on the disparities in health, which originate from socio economic factors (Burke, 2001) Health is directly affected by socio economic status (SES) (Alder et al., 1993, Roberg et al , 1995, Crompton & Kemeny, 1999; Borg & Kristensen, 2000) Socio economic inequalities in health seem to be widening rather than narrowing This is true of both the developing (Stecklov et al., 1999; Victors et al., 2000; Wagstaff et al., 2001, Vega et al , 2001) and industrialised world (Propper & Upward, 1992, Pappas et al., 1993, Mackenback & Kunst 1997, Graham, 2000; Schalick et al., 2000)

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Health inequalities became more apparent in most countries during the 1990s The report 'Independent Inquiry into Inequalities in Health Report' (Acheson) was published in 1998 The report found that, despite increasing prosperity, the health gap between social classes had widened since the 1980s. The scientific evidence showed that the roots of ill health were determined by factors such as income, employment and education, as well as material environment and lifestyle (Elliot et al , 2005).

There is widespread evidence that poor social and economic circumstances affect health throughout life (Kelly & Graham, 2004). Qualitative studies from a number of countries have shown relationships between aspects of social capital and health (Kawachi & Kennedy, 1997, Kawachi & Kennedy, 1999) These studies have stimulated considerable debate and led to growing interest in the ways in which the social environment affects our health (Balanda & Wilde, 2003)

Public health policy has recognised the growing importance of the wider determinants of health, such as income, education, housing and the environment, as well as their effect on lifestyle "Highlighted by the Black Report and the Acheson Report, much of government policy now seeks to address these issues that have been outside the health domain" (Wanless, 2004, p.36)

In countries throughout the world, inequalities in health exist between socio-economic groups, ethnic groups, and between genders. Research has shown that these inequalities are not random in all countries Those who are more socially disadvantaged have poorer health, greater exposure to health risks and poorer access to health services (Ministry of Health New Zealand, 2002)

Ethnicity also has a major role to play in the social and economic determinants of health. "From a health service perspective it is widely acknowledged that unequal health outcomes can occur as a consequence of ethnicity" (Brehony & Clancy,

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2006, p 80) Research demonstrates that such inequalities relate not only to the specific needs of ethnic groups but also to the systemic barriers within a health service which is oriented towards the health needs of the dominant group (Fanning & Pierce, 2004, cited in Brehony & Clancy, 2006)

Racism affects health partly because minority populations tend to experience less favourable social and economic circumstances and access to healthcare (Westbrook et al , 2001) and partly because of the more direct psychosocial stress that racism engenders (Davey-Smith, 2000; Jones, 2000)

"The socio economic models traces the roots of ill health far beyond the health services to such determinants as income, education, and employment as well as to the material environment and lifestyle" (Acheson, 2000, p.75).

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Mackenbach's Intervention Framework (fig 2 3) (cited in National Advisory Committee on Health and Disability, 1998) has outlined four possible points to reduce socio-economic inequalities in health, these include targeting

1 Underlying social and economic determinants of health.

2. Factors that are intermediate between socio-economic determinants of health and health, such as behaviour, environment, and material resources

3 Health and disability support services

4 The feedback effect of ill health on socio-economic position

Fig 2.3: Mackenbachs Intervention Framework

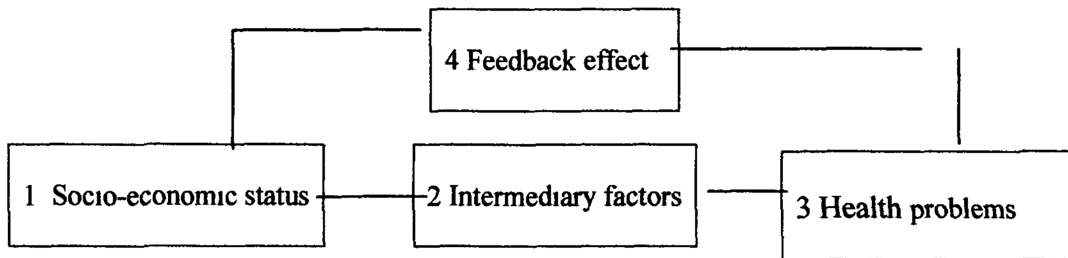

Fig 2 4 combines Mackenbachs Intervention Framework and the previous model of Social and Economic Determinants of Health The new model proposes an intervention framework to improve and reduce health inequalities (Ministry of Health New Zealand, 2002)

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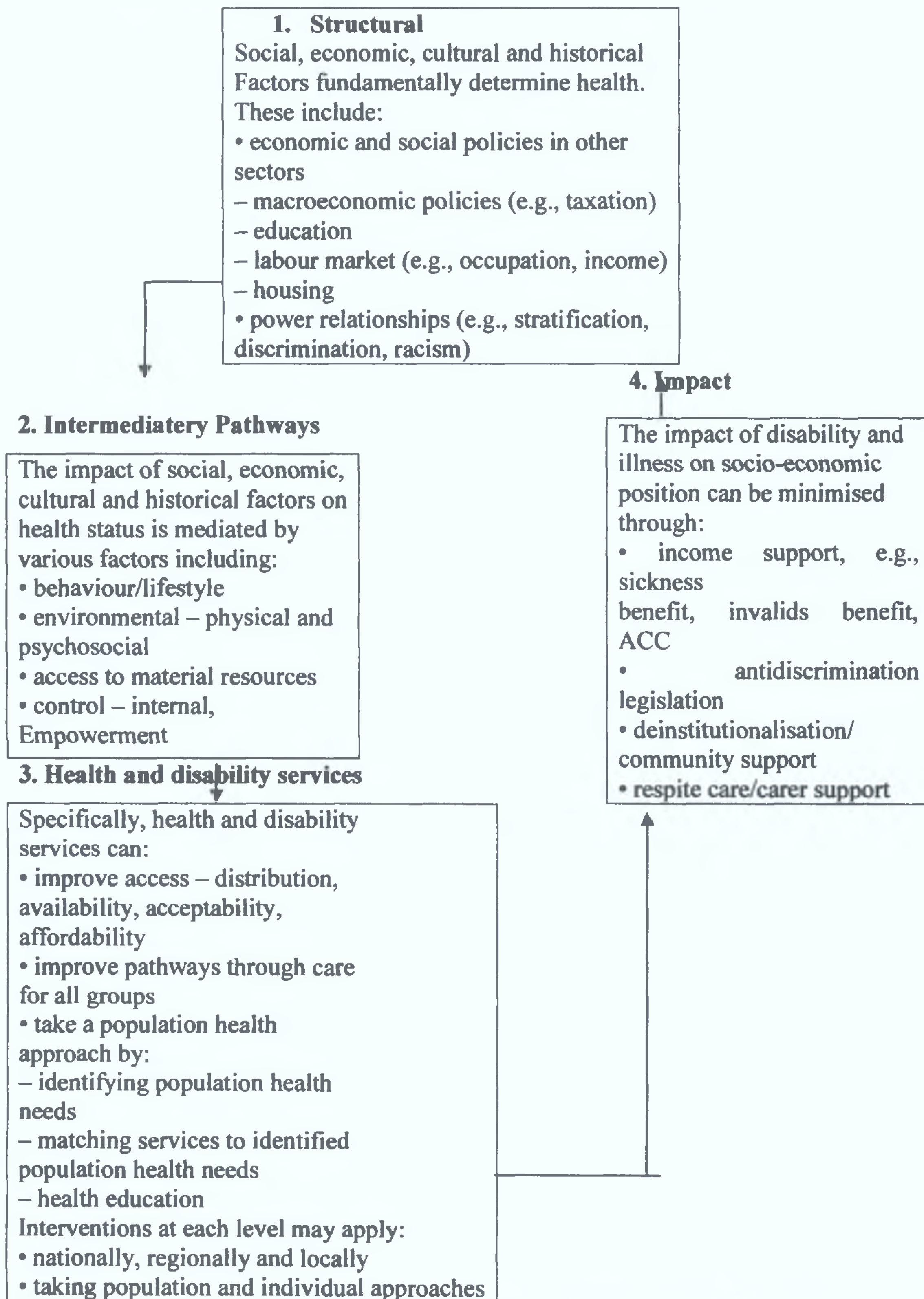
Fig 2.4: Intervention Framework to Improve Health and Reduce Inequalities



(Source: Ministry of Health, 2002).

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Level 1 of the Intervention Framework

Structural – social, economic, cultural and historical factors fundamentally determine health

According to the Ministry of Health (2002) the most fundamental approach to reducing inequalities in health is to tackle their root cause. This involves addressing the social, cultural, economic and historical inequalities that exist within society Policies directly concerned with education, occupation, income and the economy are necessary Investment in education and the social security system and the development of labour market policies that strengthen the position of those most at risk of unemployment are also important (Ministry of Health, 2002).

2.6 Social Exclusion

Both social exclusion and poverty in developed countries are complex and multi dimensional phenomena (National Anti Poverty Strategy, 1997) In the international literature, there are a range of concepts, definitions, and measurements of poverty and social exclusion in use and arguments and preferences for the use of one term over the other (Atkinson, 1987)

According to Burke (2001) the concepts of poverty and social exclusion differ in their intellectual and cultural heritages "Social exclusion is a broader concept than poverty, encompassmg not only low material means but also the ability to participate effectively in economic, social, political, and cultural life and m some characterisation alienation and distance from mainstream society" (Duffy, 1995,p 8).

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Atkinson (1987) has acknowledged that there is also a difference in their meaning, one can be poor without being socially excluded, and one can be socially excluded without being poor.

In Ireland, the term social exclusion has become widely used since the late 1990s This is evident in the two most recent National Development Plans (Burke, 2001) The 1994 National Development Plan has few mentions of the term social exclusion or exclusion, whereas the 2000-2006 plan, has a whole chapter dedicated to social inclusion The Programme for Prosperity and Fairness dedicated an entire framework to social inclusion and equality (Government of Ireland, 1993, 1999, 2000) (cited in Burke, 2001)

It has been argued by some experts that the use of the term social exclusion is helpful because takes account of new and emerging forms of poverty and disadvantage brought about by very rapid economic, social, and technological changes (Room, 1995)

Beall (2002) noted that many people suffer social exclusion on the basis of identity, at both an individual level and group level Social exclusion can take the form of stigma, or ostracism, which at a group level can take on the more sinister dimensions

2.6.1 Asylum Seekers – socially excluded in Irish society?

When direct provision was introduced, asylum seekers were dispersed from the capital, where infrastructure was insufficient, to locations where infrastructure for asylum seekers was usually non-existent This lack of infrastructure has resulted in much hardship for asylum seekers

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"A lack of planning combined with punitive benefits far less that those received by other groups in Irish society creates conditions of extreme income poverty and social exclusion for asylum seeking children and their families" (Fanning et al , 2001, p.30)

As Ireland is a cash economy, asylum seekers in direct provision are effectively obstructed from participating in almost all spheres or Irish society (Fanning et al , 2000) Hall (2004) also acknowledged that the integration of asylum seekers into Irish society is an issue of concern, as their ability to interact with the mainstream society is additionally restricted by their limited funds If people do not have the means to engage in social activities, they simple cannot afford to become part of the society of which they reside in (Lynch, 2001) Without being able to participate in society, they experience a heightened sense of social exclusion. They often lack friends or any sort of social support, which can add to the distress of the uncertainty over their family's well being and whereabouts (Kenna & Mac Neela, 2004).

A distinction between citizen rights and what Joppke (2001, p.345) refers to as"alien rights underlies a state process which allows non citizens to be treated differently from each other by the state"

Immigrant workers, immigrants with Irish born children, people with refugee status and asylum seekers are deemed by the state to have different rights and entitlements, in all cases these are less than the entitlements of citizens (Fanning et al , 2001)

It has been suggested that the exclusions experienced by asylum seekers within Irish society are largely the result of having lesser rights and entitlements to Irish citizens The barriers they face to participation in Irish society are largely those, which have been put in place by the state In effect, they are deemed to be outside of society whilst living within Irish communities (Fanning, 2001). Thus, the author suggests

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that the social exclusion experienced by asylum seekers is further exacerbated by the direct provision system (Irish Refugee Council, 2001).

The recommended central objective in the housing provision for asylum seekers was to promote self-sufficiency and independence. According to Zetter & Pearl (1999), the introduction of large communal accommodation centres are seen as totally contradicting this objective. The Irish Refugee Council have also suggested that having lived apart from the majority community, in an institutionalised setting, for an extended period of time may hinder asylum seekers from subsequently successfully integrating into Irish society (Irish Refugee Council, 2001)

The system of direct provision has been described by those working in the field as a discriminatory measure. Despite the exceptional efforts by some of the staff of the accommodation centres to create a humane environment for asylum seekers, this system socially excludes asylum seekers from the local community, both physically and financially (Irish Refugee Council, 2001)

"There is an urgent need for integration between asylum seeking policy and policies aimed at addressing social exclusion in Irish society" (Fanning et al, 2001, p 10)

The social inclusion of asylum seekers is not only important for their own well being, but for Irish society as a whole, since many asylum seekers will go on to become a permanent fixture of Irish communities (Hall, 2004).

As with any group in society who are outside of their 'proper' place of belonging and within foreign boundaries, there is a perceived threat to notions of communities and sovereignty, forcing questions of 'who is in' 'and 'who is out' and fostering thoughts of othering (Grove & Zwi, 2005) Dis-enfranchisement is core to the notion of becoming a refugee, yet processes of asylum and resettlement do not guarantee new membership or a sense of belonging elsewhere (Aleinikoff, 1995).

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Individual's cannot be understood without grasping the communities they are part of Exclusion produces feeling of anger, resentment and other negative emotions. The existence of respect between different sectors of a community has found to contribute to health (Stanfield, 1999) Reducing social exclusion is essential "It can be argued that through enhanced social cohesion, not only can human rights be protected, but health improved and hopefully peace maintained" (Tilki, 2006, p 34)

"Refugees and other immigrants living in Ireland can enrich the society around them and contribute to the continued development of Ireland They can do so by participating in the activities of the community and society, drawing on their own experiences and culture- just as the Irish emigrants have down thought the years in other countries" (Interdepartmental Working group on the Integration of Refugees in Ireland, 2000, p 3)

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2.7 Poverty

The term poverty conjures up the picture of what is commonly referred to as absolute poverty, which is a term often used to describe outright destitution. In Ireland, poverty is understood in a relative way rather than an absolute way (Burke, 2001)

It is vital to distinguish between absolute and relative poverty; even in countries where families generally have access to sufficient resources to maintain life, many are living in disadvantageous circumstances with poor housing, diet and amenities that do not live up to the expectations of society in general (Townsend, 1979)

The definition of poverty underpinning the National Anti Poverty Strategy (1997) and the NAP / inclusion is " people are living in poverty if their income and resources, material, cultural and social are so inadequate as to prelude them from having a standard of living which is regarded as acceptable to Irish society generally. As a result of inadequate income and other resources people may be excluded and marginalised from participating in activities, which are considered the norm for other people in society" (National Anti Poverty Strategy, 1997, p 3)

Poverty is a multi-dimensional phenomenon, encompassing inability to satisfy basic needs, lack of control over resources, lack of education and poor health "Poverty can be intrinsically alienated and distressing, and of particular concern are the direct and indirect effects of poverty on the development and maintenance of emotional, behavioural and psychiatric problems" (Murali & Oyebode 2004, p 216).

Relative poverty is described with reference to the prevailing socio-economic conditions of the society in question Relative poverty recognises that the unequal distribution of resources and opportunities contribute to poverty Such an understanding of poverty recognises that people have social, emotional and cultural needs as well as physical needs, it is thus recognised that relative poverty is multi-dimensional, dynamic and impacts on individuals, households and communities (National Anti Poverty Strategy, 1997)

The United Nations Human Development Report (2003) on Millennium Development Goals 'A Compact among Nations to end Human Poverty' identifies Ireland as having the best economic performance in seventeen selected OECD

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countries over the 1990-2001 period. "Even though Ireland had the best economic performance it was ranked sixteenth out of seventeen for levels of human poverty" (Johnston, 2005, p.1)

There are many different ways of measuring poverty and many different issues that need to be taken into account when doing so. Measuring poverty involves two separate elements, deciding on an indicator and deciding on a standard to apply to that indicator (Burke, 2001) Two measures of poverty are used in Ireland, relative income poverty and consistent poverty (Johnston, 2005).

People are said to be living in income poverty when they are living below a particular income threshold. This has been argued at European level as 60% of median household income (Commission of European Communities, 2001)

According to the CSO (2005) 22 7% of the Irish population, which accounts for 900,000 people were at risk of poverty (CSO, 2005) Consistent poverty is a poverty measure unique to Ireland (Johnston, 2005) This indicator was developed by the Economic Social Research Institute (ESRI) It measures the proportion of people on a low income (under 60% of the median income) and experiencing basic deprivation, in relation to eight areas, such as not having food, clothes, heat or falling into debt on everyday expenses (Commission of the European Communities, 2004)

Any person who experiences deprivation in at least one of the eight areas is regarded as being in consistent poverty. In 2003, 8.8% of the Irish population were living in consistent poverty (CSO, 2005)

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2.7.1 The Health effects of Poverty

According to Glitterberg (2004), levels of global poverty are increasing, with accompanying disparities in healthcare Poverty, the extent of relative deprivation, and the processes of social exclusion in a society have a major impact on the health of its population (Shaw et al., 1999) In 'Bridging the Gaps', the World Health Organisation (1995, p.1) states, "the world's most ruthless killer and the greatest cause of suffering on earth is extreme poverty"

The majority of evidence suggests that material conditions are the underlying root of illness, which includes being the determining factor for health related behaviours (Davey Smith, 1997) Poverty imposes constraints on the material conditions of everyday life by limiting access to the fundamental building blocks of health such as adequate housing, good nutrition and opportunities to participate m society (Wagstaff, 2002)

It has been established in this review that socio-economic factors including poverty are key in determining health status. People experiencing poverty become sick more often and die younger than those who are better off (Combat Poverty Agency, 2004) Murali & Oyebode, (2004) also identified that poverty has important implications for both physical and mental health

The European Commissioners Report on the Social Situation of the European Union, identified health as one of the main factors affecting the quality of life of European citizens. In this report health was ranked ahead of income and family life (Johnston, 2002)

Increases in inequalities in health can be interpreted as a result of increases in poverty and inequality (Shaw et al., 1999). Alleyne et al., (2000) has acknowledged

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that improvement of health status and the reduction of health inequalities are more recognised as essential ingredients for schemes to reduce poverty.

Fig 2.5 shows the influences of household resources, community factors and the health system determinants. In each of the underlying determinants of health the poor tend to be disadvantaged (Schultz, 1984, Mosley & Chen, 1984, Cebu Study Team, 1991)

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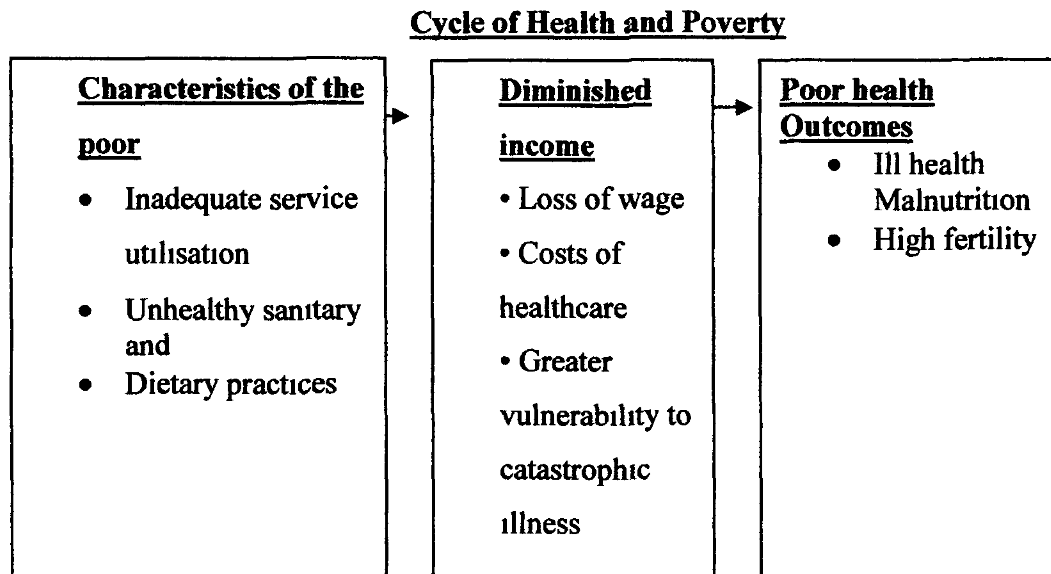
Fig 2.5: Cycle of Health and Poverty



Caused by:

- Lack of income knowledge,
- Poverty in community and social norms,
- Weak institutions and infrastructure,
- Poor and inaccessible health provision,
- Lack of key inputs, irrelevent services,
- low quality services,
- Exclusion from health finance system,
- Limited insurance co-payments

(WHO, 2002)

Fig 2 5 outlines an approach to conceptualising the various routes by which health outcome are determined (Claeson et al , 2001) and acts as a framework for

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understanding health inequalities between the better off and those less fortunate (Wagstaff, 2001)

Poor people experience ill health more than others, they are more likely to be unemployed or to be occupied in low quality employment, to have low levels of education, to live in unsanitary damp or poor quality accommodation and physical environments and have restricted access to health services "Poor people are more likely to smoke, have poor or inadequate diets and exercise less Being poor makes it difficult to access health care and can reduce the opportunity or motivation to adopt a healthy lifestyle" (Combat Poverty Agency, 2004, p 3)

According to Nolan & Whelan (1999), people experiencing poverty report higher levels of mental illness and stress The relationship between basic deprivation and psychological well-being is particularly strong People experiencing poverty also report higher levels of fatalism and lack of control over their circumstances and lower levels of satisfaction with life than the better off Murali & Oyebode (2004) have highlighted the fact that poverty and social inequality have direct and indirect effects on the social, mental, and physical well being of an individual

According to Bruce and Hoff (1994) the effects of poverty are substantially reduced when the degree of isolation from friends and family is controlled for, suggesting that social isolation mediates some of the relationships between economic status and mood disorders

There is a range of evidence that the poorer migrants and ethnic minorities have different health outcomes to those of the general population of the society in which they are living In terms of all cause mortality, Drever & Whitehead (1997) report raised rates for most ethnic groups in Britain Harding & Balarajan (1996) found that the mortality of second-generation Irish migrants living in England and Wales was

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significantly higher for most causes of death than that of all men and women, and this was only partially explained by socio-economic variables.

In Ireland there is evidence that many minority groups that experience poverty and exclusion also experience particular health inequalities (Combat Poverty Agency, 2004). In a study of one hundred homeless women in Dublin, eighty two percent had physical health problems and seventy-two percent had psychological problems Almost half of the fifty-five children living with these homeless women had not received childhood vaccinations against infectious disease (Smith et al , 2001, cited in Combat Poverty Agency, 2004)

According to Fanning, (1999) refugee and asylum seeking children are more likely to experience poverty and social exclusion than any other groups in Irish society The authors suggest that this may be a result of their dependency on the welfare system

The Living m Ireland Survey (1999) classified children living in households below the sixty per cent relative income poverty line as ‘consistently poor’ According to Fanning et al., (2001) asylum seeking families living in direct provision in Ireland, face extreme levels of income poverty, which typically place them well below the twenty per cent poverty line

Research on refugees and asylum seekers in Ireland has found malnutrition among pregnant women, diet related ill health in young babies and weight loss among children (Fanning et al , 2001) Authors such as Filmer & Pritchett, (1999) and Gwatkin et al , (2000) noted that most dietary and child feeding practices also improve with higher levels of income, as do sanitary practices. The human assets of knowledge, literacy, and education, whose levels tend to be lower among the poor also influence household decisions with regard to the proximate determinants of health Research carried out by the Cebu Study Team (1991) also found that education is strongly associated with many behaviours and choices that are

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conducive to good health, even after controlling for income. A low level of control over household resources by women, which seems especially likely in poor households often harms health outcomes for them and their families (Claeson et al., 2001, cited in Wagstaff, 2002)

2.8 Culture & Health

"Culture runs in our blood. We breathe in culture and breathe out culture" (Xu,2004, p 433). Leiniger (1995, p 109) refers to culture as "the learned and shared beliefs,values and life ways of a designated or particular group" which are generally transmitted intergenerationally and influence ones thinking and action modes

Purnell & Paulanka (1998) define culture as the totality of socially transmitted behavioural patterns, art, beliefs, values, customs, life ways, and all other products of human works and thought characteristics of a population of people that guide their worldview and decision making. In an eclectic definition, Spector (2000) summarises the characteristics of culture as a medium, declaring it partly conscious, an extension of biological capacities, a web of symbols, a device for creating and limiting human choices, and an existence mind and physical environment simultaneously

Specter (1996) contends that culture is a metacommunication system based on non-physical traits and behaviours that are shared by a group of people and are passed down from one generation to the next According to Andrews & Boyle (1996, 2002) culture represents a unique way of perceiving, behaving, evaluating the external environment and as such provides a blue print for determining values, beliefs and practices

Culture has been defined in various ways by different disciplines and for numerous purposes. There will probably never be a single definition of culture (Kao et

al.,2004). "Kluckholn & Kroeber (1952), identified one hundred and fifty definitions of culture, and the passage of time has witnessed neither consensus nor demolition of definitional diversity" (Kao et al , 2004, p 270)

Culture has been conceptualised is either a static trait characteristic of a group of people or a dynamic process; for each position, the underlying assumptions are different "In a static perspective, culture is a concrete existence, and thus is wholly external to the individual" (Kao et al., 2004, p.271)

Accordmg to Mc Rae (1994), people are merely the carriers of culture and have less power to control it. It has been widely established that within eastern and western societies there are two distinct sets of dynamic cultures Each set having their own values and traditions However, some commonalities do exist between the two categories (Xu, 2004).

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Xu (2004) has identified an example of a difference between eastern and western cultures. Many Asians believe that illness is part of life, because life is suffering after all, and should therefore be accepted with serenity In contrast, Americans believe that illness is disruptive to normal life and should be conquered.

Without a doubt, culture has an enormous impact on one's health (Xu, 2004). Our thought and belief system arise as a result of cultural values and to a large extent, determine our health behaviours (Xu, 2004). As a direct result of culture, individuals vary m health care behaviours, healthy status and health seeking attitudes (Grypma 1993, Mc Rae, 1994, Guruge & Donner, 1996) The term health status has been defined by many authors as the success with which an individual adapts to the internal and external environment in which they live (Baumens & Anderson, 1988)

Heritage consistency is a theory by Estes & Zitzow (1980, p.1) which describes

'the degree to which ones lifestyle reflects his or her respective tribal culture'

The theory has been utilised by many cultures in an attempt to study the degree to which a person's lifestyle reflects his or her tribal culture whether European, Asian, African or Hispanic (Spector, 2002). The concept of heritage consistency includes a determination of ones cultural, ethnic, and religious background Spector (2002) suggests that the deeper a person identifies with a traditional heritage, the greater the chance they will follow traditional health and illness beliefs. These beliefs and practices are derived from their ethno cultural heritage (Spector, 2002)

2.9 Transcultural Health and Cultural Competence

It is believed that demography is destiny, demographic change is reality, and demographic sensitivity is imperative

(Giger & Davidhizar, 2004)

Since the introduction of transcultural healthcare over 25 years ago, there has been a growing realisation that our understanding of health and illness has to be considered not only in terms of biological factors, but also in terms of social and cultural determinants too It is now widely acknowledged that most of us live in culturally diverse societies, where our cultural backgrounds play an important role in the construction of our health beliefs and practices. It is therefore important to educated healthcare providers in ways that will enable them to provide care that is both efficient and culturally appropriate (Papadopoulos, 2006)

Leininger (1997, p.32) defines transcultural health as "a formal area of study and practice in the cultural beliefs, values, and life ways of diverse cultures and in the

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use of knowledge to provide culture specific or culture universal care to individuals, families, and groups of particular cultures"

Papadopoulos suggests that the aim of transcultural care is to provide care that is culturally appropriate in keeping with the expectations of the person's cultural values, beliefs and practices (Papadopoulos, 2003)

According to Papadopoulos, transcultural health and nursing emphasis the importance of empowering clients to participate in health care decisions Healthcare professionals must recognise how society constructs and perpetuates disadvantage (Papadopoulos, 2003)

Transcultural nursing is directed towards holistic, congruent, and beneficial healthcare "It remains one of the most challenging and revolutionising developments in healthcare as our world becomes globally multi- cultural" (Leininger, 1999, p 9)

As the demographic and economic profile of our growing multi-cultural world changes, the long standing disparities in the health status of people from diverse ethnic and cultural backgrounds has challenged health providers to consider cultural competence as both a necessity and a priority (Campinha –Bacote, 2002)

Since the inception of cultural competence in 1989, among academic disciplines an array of theoretical or conceptual models on cultural competence have evolved (Zuwang-Shen, 2004)

Papadopoulos (2003, p.1) has defined cultural competence as "the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours, and needs".

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Leininger (2002) suggests that in order for a health professional to be culturally competent, they must be able to access and understand culture, care and health factors and use this knowledge in creative ways with people of diverse or similar life ways

A review of literature in this area reveals that there is general agreement on the term cultural competence and its definition among researchers, several identical components or constructs are also present in most of the cultural competence models There are some other terms in use, such as cultural care, cultural congruence or culturally congruent care In essence, they are conceptually synonymous with cultural competence (Burchum, 2002). Cultural assessment is also an attribute of cultural competence. A cultural assessment model therefore can be seen as a cultural competence model (Zuwang-Shen, 2004)

As a result of research on the growing cultural diversity within societies in the past decade cultural competence models have been frequently updated in response to the needs to provide culturally appropriate health care for all cultures (Zuwang-Shen, 2004)

Transcultural nursing is not the only discipline dealing with massive worldwide changes and increasing health disparities (Glitterberg, 2004). Worldwide, healthcare providers, and organisations have embraced the concepts of culturally specific care

"Increasingly, educational and service organisations have seen the need to prepare students and staff to provide culturally sensitive and culturally competent care to individuals, families and communities" (Zoucha & Purnell, 2003, xxi).

Glittenberg (2004) acknowledges that in the past 28 years, compelling evidence suggests that transcultural nurses have increased the awareness of how critical the knowledge about culture is to giving competent care And as a result transcultural nursing theories have become mainstream in nursing practice not only to nursing but also to all healthcare professionals regardless of discipline.

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Given the complexity of ethnicity and culture, it is impossible for healthcare providers to be aware of all relevant culture related details regarding clients Transcultural healthcare models provide a generic structure which can be applied to all groups The strength of these models is that they are based on human rights and human ethics and offer a holistic and congruent approach for health professionals. These models also see the health professional as continually striving to become culturally competent; an ongoing process

Transcultural theory has also been criticised for not addressing issues of sociological or political (Culley, 1996) inequalities that face minority ethnic groups with respect to the power (Mulholland, 1995) relationships in society These models are also based on free will, with the assumption that healthcare providers want to provide culturally competent care.

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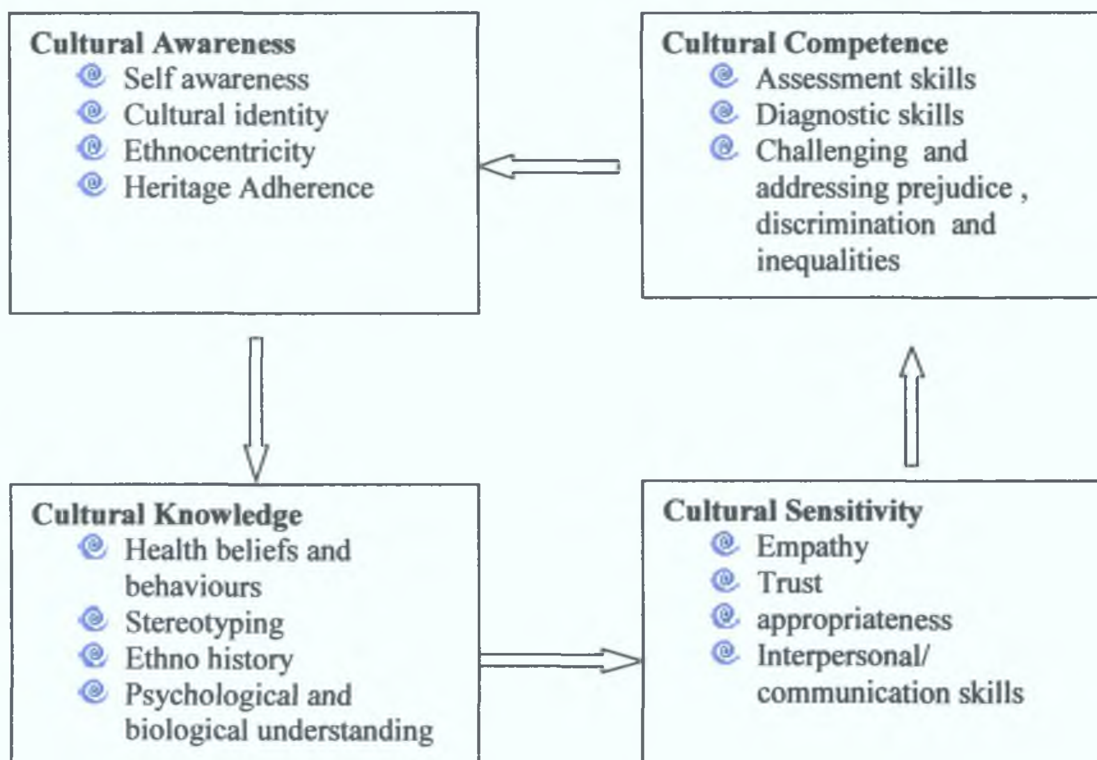
Major authors contributing to the advancement of knowledge of cultural competence models include, Giger and Davidhizar, Papadopoulos and Purnell, to name a few (Zuwang Shen, 2004) A brief overview of the Papadopoulos Model will now be given

2.9.1 Overview of the Papadopoulos Tilki & Taylor Model of Cultural Competence, 1994

The Papadopoulos Tilki and Taylor Model (1994) was developed to help healthcare providers to develop cultural competence skills. It is the view of the models authors that no other framework provides as much value on the individual as this one (Papadopoulos, 2003). The model is divided into four stages. It requires the healthcare provider to see themselves as becoming culturally competent as they go

through each stage, rather than already being culturally competent (Campinha-Bacote, 2002). The underpinning values of the model are based on human rights, sociopolitical systems, intercultural relations, human ethics, and human caring (Papadopoulos & Lee, 2003).

Fig 2.6: The Papadopoulos Tilki & Taylor Model of Cultural Competence



The first stage in the model is cultural awareness. This stage begins with an examination of the individual's personal value base and beliefs. Values and beliefs are the principles that individuals use to guide our daily lives and to make decisions

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or judgments .They are the lenses through which we view the world (Papadopoulos, 2006)

Ethno history is an important sub-construct related to cultural awareness (Papadopoulos, 2006) Leininger (1995, p 106) defined ethno history as 'all those

past facts, events, instances, experiences of individuals, groups cultures and institutions that are primarily people centered and which describe, explain and interpret human life ways within particular cultural contexts and over short or long periods of time"

Papadopoulos, (2006) suggests that in order to provide culturally appropriate care, the health professional must gain an understanding of the historical, geographical, and socio-cultural background of people in their care. Once an individual is aware of their own values and beliefs and is familiar with the ethno history of their client they can progress on to stage 2

The second stage of the model is cultural knowledge Cultural knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups Lavizzo-Mourey & McKensie, (1996) suggests that the health care provider should focus on the integration of three specific issues when obtaining this information, namely; health related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Camphina Bacote (2002) acknowledged that cultural knowledge regarding the clients health related beliefs and values can be obtained by understanding the client's worldview.

Cultural sensitivity is the third stage- this entails the crucial development of appropriate interpersonal relationships with clients Where the health professional gains the trust of the client and a professional partnership is developed This development of patient healthcare professional partnerships is based on the development of interpersonal relationships based on trust and effective

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communication (Papadopoulos, 2006) Trust, empathy and appropriate care are crucial at this stage

The fourth stage of the model is cultural competence A most important component of this stage of development is the ability to recognise and challenge racism, and other forms of discrimination and oppressive practice. In an ideal world, democratic multi-cultural societies are non-oppressive and afford all citizens equal rights Papadopoulos (2002) suggests that in the real world, this perfection does not exist, despite efforts from governments to achieve this.

2.10 Conclusion

Globalisation poses new challenges in all domains of international life Many forced migrants have fled war torn countries where access to health care may have been drastically reduced by conflicts and wars. Understanding the stories and experiences underpinning forced migrations is crucial in responding to the health needs of asylum seekers.

To many, forced migration has been presented as a source of overload on social systems. Notions that increased numbers of asylum seekers are coming to Ireland each year have been portrayed, however figures from 2006 show that asylum applications were at a 5 year low

There is a definite lack of published material in this area. The main reports referred to in this chapter are of the Irish Refugee Council and the FLAC, both of whom are highly critical of the direct provision system. The current direct provision system that all asylum seekers are forced to enter, has been the focus of much critism These centres are seen to have a clear impact on the individual's health in terms of self-

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sufficiency A number of authors have documented that asylum seekers may feel institutionalised as a result of long periods in these centres

Various definitions of health have been developed over the years that focus on the notion of health as a positive concept rather than merely the absence of disease Health is a broad concept which can embody a huge range of meaning. It is therefore no surprise that the determinants of health are diverse and wide ranging. While each determinant is important in its own right, complex interactions between social, economic factors, the physical environment and individual behaviours determine health throughout life

Many authors have documented the influence of culture on health, for example Xu (2004), Spector (2002). Culture has been defined by many authors however there is no single definition. Regardless, there is a general consensus that culture provides a blue print for determining values, beliefs, and practices and in doing so influences how an individual thinks and acts and to a large extent determines their health behaviours.

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It has been well established that health can be determined by a range of factors and that inequalities in health exist for a variety of reasons. Studies have shown that the roots of health inequalities are determined by factors such as income, the material environment and lifestyle factors Generally, those who are less well off usually have poorer health outcomes. It is also widely acknowledged that unequal health outcomes are a result of ethnicity

Asylum seekers in Ireland exist at the bottom level of immigrant groups, having less rights and entitlements than Irish citizens do Any person seeking asylum in Ireland is not permitted to partake in paid employment or third level education While they receive food, accommodation and a small weekly allowance from the State, this in some cases is not sufficient

While the terms social exclusion and poverty sound quite similar there is a large fundamental difference in their definition. Social exclusion is a much more extensive term than poverty. An individual can be poor without being socially excluded and vice versa Irish research has shown that asylum seekers experience considerable levels of poverty in relation to a number of key areas including food poverty, income poverty and the poverty of connectedness

Asylum seekers who reside in direct provision are at risk of being socially excluded from Irish society. The nature of direct provision, which accommodates asylum seekers in large hostel type centres segregates them from the local community The low weekly allowance that they receive from the Department of Social Welfare also acts as a barrier to integration The social exclusion that asylum seekers face are a result of barriers that have been put in place by the Irish Government

A growing body of research evidence points to the inadequate responses of developed countries to the health needs of refugees In today's multi-cultural society, it is imperative that health services must address issues of access, acceptability and availability of services to asylum seekers and refugees. In recent years, a number of transcultural health care models have been developed to assist health care providers to develop cultural competency skills. At the core of these models are human rights, human ethics and human caring Training in transcultural issues making health services more responsive to the needs of asylum seekers and other minority groups is a moral obligation.

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Chapter 3

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CHAPTER 3 – METHODOLOGY

3.1 Introduction

There are several important attributes, which are basic to the concept of good research. Domegan & Fleming (2000) noted that good research must be methodology led, decision driven and information orientated It should be well organised and planned in advance Boyd et al , (1981) also stated that the research involves anticipating all steps, which must be undertaken if the project is to be completed successfully It is hoped that this chapter will illustrate that the research was planned and conducted with the above practice in mind.

According to Domegan & Flemming (2000), there are six stages in the research process, these include, problem definition, research design, data collection methods and instruments, sampling, field work and analysis of data. Hussey & Hussey (1997) and Malhotra (1999) also identified research processes with stages similar to those outlined by Domegan & Flemming Throughout this chapter, the author will take the reader through each of the stages identified above

The purpose of this study was to identify the health related behaviours of asylum seekers in the north west of Ireland Initially it was agreed that only asylum seekers living Counties Sligo, Leitrim, Donegal and west Cavan would be asked to participate However due to the low numbers of adult asylum seekers residing in this region, the research area was extended to include Counties Galway, Mayo and Roscommon as well (see Fig 3 1) Manandhar (2006) identified important issues of ethics and culturally competent communication and these were taken very seriously throughout the research (Manandhar et al , 2006)

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The majority of asylum seekers living in the West and North West region of Ireland reside in direct provision centres however, there are a small number living in self-catering units in the general community. Unfortunately, not all of those living in the general population were contactable and so were not included in this research. The author has commented on this in more detail in section 3.2 of this chapter.

Fig 3.1: Map of Health Service Executive West

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During the period of data collection (March- August 2006) there were no adult asylum seekers residing in West Co. Cavan. Table 3.1 outlines the numbers of asylum seekers in the other six counties. At the time that this survey was conducted there were approximately 340 adult asylum seekers living in direct provision centres in the Health Service Executive West area with an estimated further 150 adult asylum seekers living in private self catering units. According to Manandhar et al.,

(2006, p 15) "the north western region hosts the smallest number of asylum seekers in the country".

Polgar & Thomas (2000) and Bowling (2005) have highlighted the fact that there is no magical number that they can point to as optimum sample size, as the sample size will depend on the characteristics of the investigation. In total 242 two adult asylum seekers participated in this study (n= 242) This constitutes 64% of asylum seekers living in direct provision (including children) and 9% of those residing in self catering units

There are eight direct provision centres located in the above area The researcher contacted the managers of these centres (Family Support Worker / Duty Manager / General Manager) to inform them of the purpose of the study Two information packs (see appendix 4) were then forwarded to the centres, one for the attention of the managers, which outlined the project design and content and sought permission to enter the centre to conduct the research The second pack contained posters and information sheets which were for the attention of the prospective research participants Once the managers had agreed to allow the researcher to enter the centres, the data collection phase began

Each resident was given an information sheet and encouraged to ask the researcher any questions which they may have in relation to the research. Those who wished to be included were then asked to sign a consent form (see appendix 4) The majority of research participants had good knowledge of the English language However there were some difficulties identified in reading the questionnaire, as outlined in the pilot study. The researcher felt that it would be more beneficial to administer the questions verbally to all participants, unless the participants expressed a preference to do otherwise

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3.2 The Focus of the Research

This research was conducted to explore the health related behaviours of people who are seeking asylum in the west and north west of Ireland Health behaviours were explored as they would provide the reader with an overall picture of the general health of this specific population Two distinct groups from this population were chosen to participate, namely, those who reside in direct provision and those who reside in self catering units in the area As these two setting are so very different in nature it was hoped that a comparison could be made which would highlight similarities and differences in the participants health. It was hoped that this would indicate if either of the settings were more conducive to good health

Unfortunately, this aspiration did not materialise The researcher was unable to contact those who were resident in private houses in the general community. This was due to the fact that the HSE were unwilling to provide the names and addresses of these asylum seekers As a result of this a comparison could not be made However, contact was made with 13 asylum seekers in Co Roscommon

The SLÁN (1998, 2002) questionnaire was utilised as a reference for developing the questionnaire that was used in this study The researcher decided to compare the results of the SLAN Survey with those of the asylum seekers There were only a limited number of categories where comparisons could be made, as the SLAN questionnaire is considerably longer that the questionnaire used in this survey

3.3 Quantitative Methodology

"Quantitative research focuses on measuring quantities and the relationship between attributes, following a set of scientifically rigorous procedures. It collects highly structured data and is deductive in approach" (Bowling, 2005 p 191)

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The use of questionnaires and other forms of quantitative methodology has its attractions. Quantitative methodologies present findings in the form of graphs and tables; this conveys a sense of solid, objective research. It carries with it a sense of scientific respectability (Denscombe, 1998).

There are many advantages of using quantitative methods according to Denscombe (1998), these are as follows:

- **Scientific**- quantitative data lend themselves to various forms of statistical technique based on the principles of mathematics and probability.

- **Measurement** - the analysis of quantitative data provides a solid foundation for description and analysis. Interpretations and findings are based on measured quantities rather than impressions.

- **Analysis** – large volumes of quantitative data can be analysed relatively quickly, provided adequate preparation and planning has occurred in advance.

- **Presentation** – tables and charts provide a succinct and effective way of organising quantitative data and communicating the findings to others.

A number of quantitative methods exist for measuring people's psychological attitudes, self-perceptions, and behaviour. These range from experimental studies in laboratories to interview and self-administered questionnaire surveys. A number of authors have identified that the survey is the most common quantitative method used to describe social phenomena (Polgar & Thomas, 2002).

A major advantage associated with surveys is that they are carried out in natural

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settings "Random probability sampling is often easier to conduct than for experimental studies" (Bowling, 2005, P 191). As a result statistical inferences can be made in relation to the broader population of interest This increases the external validity of the study, which aims to generalise results to a wider setting.

According to Adamson (2005, p.233) triangulation has been among one of the most cited reasons for bringing together qualitative and quantitative techniques. "The general premise is that the findings from one aspect of study can be checked against the findings of the other, therefore enhancing their validity" However, this has not gone unchallenged Authors such as Mason (1994) and Bryman (1992) suggests that triangulation cannot always used to check the validity of a research method as qualitative and quantitative components of a study tend to yield data on different phenomena and cannot always be compared

Adamson, (2005 p 242) argues that "a combined qualitative and quantitative design will not be appropriate for all health related research and we should not be tempted to use qualitative or quantitative methods in a tokenistic way to accommodate contemporary fashions" Producing good quality research to answer important questions using appropriately selected methods is the ultimate objective. The researcher felt that using one method that provided a clear, in-depth, and comprehensive analysis of the health behaviours of asylum seekers was better than attempting to use different methodologies, which would only provide an overview, due to time constraints

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3.3.1 Questionnaire Design and Layout

I keep six honest serving men

They thought me all I know

Their names are What and Why and When and How and Where and Who

(Kipling, 1903)

One of the ubiquitous forms of human communication is asking questions, as implied in the Kipling quote above, according to Peterson (2000), asking questions is perhaps second only to observation as the way people acquire knowledge The researcher chose to use the questionnaire as the method of data collection The questionnaire was chosen as a research instrument as questionnaires are relatively inexpensive and their analysis are relatively uncomplicated, it is also possible to survey a large number of people relative to the research Questionnaires offer an objective means of collecting information about people's knowledge, beliefs, attitudes, and behaviour (Oppenheim, 1992, Mc Coll & Thomas, 2000)

A basic assumption underlying the use of structured questionnaires is that researchers and respondents share the same theoretical frame of reference and interpret the words, phrases and concepts used in the same way. Care is therefore needed when designing questionnaires; the emphasis is on simplicity and on following the basic rules of questionnaire design (Bowling, 2002)

Chisnell (1997) has noted that analysis and interpretation of the data from questionnaires results in better appreciation of the problem. The national health and lifestyle survey questionnaire (SLÁN) was used as a reference to devise the questionnaire used in this survey.

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"The SLÁN questionnaire periodically collects data on health related behaviours such as general health, tobacco use, use of alcohol, food and nutrition and accidents The aim of which is to maintain a survey protocol which will enable lifestyle factors to be measured so that trends can be identified and changes monitored to assist national and regional setting of priorities in health promotion activities" (SLÁN, 2002)

The questionnaire used in this study was divided into three sections and contained thirty-three questions, (see appendix 5). In order to make the questionnaire as user friendly as possible it was important to separate the questions into different sections. Authors such as Bowling (2002, 2005) have documented the importance of using a questionnaire that is easy to comprehend, in terms of terminology and layout

Table 3.2 provides a brief outline of questionnaire As some of the questions were of a self-report nature, the researcher needed to ask several questions which measured similar aspects of the respondent's health in order to gain a comprehensive analysis. "Psychometric theory indicates that when a concept cannot be measured directly, health status, quality of life and so forth, a series of questions which tap different aspects of the same concept need to be asked and then tested for their reliability and validity" (Bowling, 2005 p 394, b)

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Table 3.2: Key areas addressed in the questionnaire

Section	Titled	Key areas covered
1	Some Information about Yourself	▪ Demographic details ▪ Experience with health professionals
2	You & Your Health	▪ Health status ▪ Quality of life ▪ Access / usage of health services ▪ Health behaviours in relation to childbirth and feeding practices
3	Lifestyle choices	▪ Physical activity ▪ Diet & nutrition ▪ Alcohol consumption ▪ Tobacco use

The questionnaire was presented in a booklet format and was printed on bright yellow paper Clear directions were given throughout the questionnaire It was hoped that all of these initiatives would entice potential respondents to participate in

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the research. According to Bowling (2002, p.268) "response rates vary widely, depending on the sponsorship and nature of the topic, its saliency, and the length of the questionnaire". For this reason, care was taken when designing the questionnaire to include only questions which the researcher felt were relevant. Doll et al., (1991) has stated that research has shown that among older people response rates increase with increasing age.

To ensure the validity and reliability of the questionnaire, each question only looked for one piece of information. The questions were kept short and in many cases respondents had to tick boxes to provide answers. This was to avoid respondents becoming confused (Foody, 1993). According to Hussey & Hussey (1997); Branick & Roche (1997) and Adam & Healy, (2000) the disadvantages with questionnaires are primarily the low response rate. Mc Neill & Chapman (2005) have acknowledged that response rates can be as low as thirty percent in some cases. In order to ensure the validity and reliability of the questionnaire, and to maximise response rates, the researcher initiated a number of different strategies, these include;

- The questionnaire was devised to include 31 relevant questions
- Use of bright coloured paper
- Clear terminology used
- Pack was translated into French (as the majority of participants were of African origin).

Before the respondents completed the questionnaires, they were given an information sheet, as outlined previously and encouraged to ask the researcher questions. Only when they were absolutely certain that they wanted to participate in

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the study were they allowed to proceed to sign the consent form The principle of informed consent states that potential study participants should be given sufficient information about a research project so that they can make an informed judgment about whether they want to participate (Tarling & Crofts, 2002)

All research participants were reassured that any information received would be held in the strictest of confidence Participants were not asked to fill in their names or identity numbers on the questionnaire, however they were asked to fill in their names on the consent form. Polgar & Thomas (2002) has stated that unless extenuating circumstances exist, the privacy of study participants must be respected by guarding their identity. If possible, study participants should be anonymous.

Both open and closed end questions were used in the questionnaire. According to Peterson (2000), the advantages of open-ended questions are usually the disadvantages of closed end questions and vice versa. It is more meaningful to consider the two question types as complementary rather than substitutes for each other. Open-ended questions were selected as they would elicit a whole range of replies, the answers received could be coded and examined for recurring themes (Burgess, 2001)

The design of the questionnaire was important as data collected was to be entered and analysed using Statistical Package for Social Science (SPSS) (Pallant, 2001).

3.3.3 Cover Letter

Questionnaire introductions differ, depending on the mode of administration used. However all introductions possess two common characteristics, firstly, they encourage potential study participants to become involved in a research project or complete a questionnaire and secondly, they legitimise a research project (Peterson, 2000). It is acknowledged that the initial appearance of the questionnaire can have

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an influence over response rates (RR) and for this reason good quality paper was used (Mc Donald et al., 2003).

Bowling (2005) recommends that all researchers should give sample members a covering letter about the study to keep for reference, with assurance that the organisation and the study are bona fide. The package containing the cover letter, consent form and questionnaire used in this study was translated into French

French was chosen as there was a high number of west Africans residents in the designated research area during the period of data collection The researcher was unsure of the level of fluency in the English language among participants and so decided to translate the pack into French as a precaution The pack was translated into French by a native French academic who is resident in Sligo Significant thought and effort was put into the design and the layout of the questionnaire so that all answers could be translated easily Participants were given the choice of either completing the questionnaire themselves, or having the researcher ask the questions verbally

The majority (99.5%) of participants choose to answer the questionnaire in English Following extensive consultation with the asylum seeking community the researcher was confident that the vocabulary used in the questionnaire would be easily understood

Bowling (2005) highlights the importance of presenting a cover letter which outlines the study aims and benefits concisely, guarantees confidentiality and one which is signed in blue ink so it is not confused with a photocopy in order to personalise it. The cover letter should also specify how participants were selected (Cohen et al., 2000) for the research along with stressing the importance and benefits of the research being conducted (Bowling, 2002). The cover letter also gave the researchers contact details, along with details of the dates that the researcher would be calling to the centre and highlighted the fact that the researcher would be willing

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to meet with potential participants in advance to discuss any issues / questions which they may have regarding the questionnaire.

3.3.4 Ethical Issues

Ethical considerations play a decisive role in research planning and execution where the research involves the participation of human subjects (Polgar & Thomas, 2002).

It is important that the researcher takes into account the fact that the respondents are subjects and not objects of research (Cohen et al., 2000). Before the residents agreed to participate in the research, the researcher stressed that participation or non-participation would have no influence on their application for asylum.

The researcher adhered to four principles of good ethical practice outlined in key international documents (Medical Research Council UK, 1992; CIOMS, 2002; World Medical Association, 2000; Nuffield Council on Bioethics 2002, cited in Manandhar et al., 2006), namely:

- Providing clear information, prior to, and at the time of, interview and during dissemination, including right to withdraw.
- Obtaining consent and allowing time for reflection, questions and refusals.
- Stating the benefits of the research for various parties involved.
- Dealing with people respectfully and with cultural sensitivity.

Any research involving children or vulnerable adults such as asylum seekers means that substantial time, effort and ingenuity must be invested in developing consent procedures and in gaining approval for their studies (Bayer & Tadd, 2000; Manning,

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2000, Osborn & Fulford, 2003; Rees & Hardy, 2003, Van Staden & Kruger, 2003, Glasziou & Chalmers, 2004)

The ethical principle governing research is that respondents should not be harmed as a result of participating in the research and they should give their informed consent to participate It is important that consent is given in writing and should only be requested after the person has been given written information about the aims of the research, confidentiality and anonymity and what the study involved in relation to the participant (Bowling, 2002). Schmitt & Klimoski (1991) suggest that adequate information on the objectives and intended use of the research should be given to participants Webb et al , (1966) has also agreed with the points made above and has stated that individuals need protection m relation to their privacy and protection from manipulation by the research; also required is the protection of the aura of trust on which society and the research requires preservation

It was necessary to obtain informed consent from the research participants This was done by giving each participant a written letter conveying the purpose of the questionnaire. It also highlighted the fact that each respondent would be asked to reveal information which they may perceive as being personal, as a result a number of asylum seekers declined to participate in this study Barrett & Coleman, (2005 p 566) have argued that "social science students in health may be disadvantaged by the inflexible requirements for giving information and obtaining written consent"

Various other authors have described the difficulties associated with asking for signed consent, because vulnerable populations may be reluctant to provide such a record of their identity (Coomber, 2002, Kent et al., 2002, Truman, 2003)

All the international guidelines relating to health research now advocate ethical review (Polgar & Thomas,2005) and ethics committees are an almost worldwide phenomenon (Arda, 2000, Coker & Mc Kee 2001,Goodyear-Smith et al , 2002, Maio , 2002, Aksay & Aksay 2003, Kim et al , 2003,Hearnshaw, 2004, Hyder et al ,

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2004). Ethical approval for this study was sought and granted from the ethics committee at the Institute of Technology Sligo.

However, Glaszious & Chalmers (2004, p.121) argue that ethical review is itself an unevaluated intervention: "it is time that a more concerted effort be made to assess the likelihood of benefits, harms and costs of different approaches to ethics review for different types of evaluation".

In essence, this research methodology was designed not to cause injury to respondents. Each participant was assured his or her identity would not be disclosed and that confidentiality was assured.

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3.4 Sampling selection and methods.

Burns & Bush, (1998) define population as the set of all objects with common characteristics. Kinner & Taylor (1996) have argued that in any census it is unlikely that all members of the population will be surveyed and have stressed that a sample is generally adequate. The sample identified for this study was all asylum seekers over the age of 18 years of age who were residing either in direct provision centres or in self-catering units in the seven counties within the Health Service Executive west. Site sampling is based on the identifying groups of people and then sampling everyone in the site or group (Knight, 2002).

The advantages of sampling, as against complete coverage, have become obvious in recent years and need to be stated only briefly. In essence, sampling saves money, time and labour. Added to these practical advantages, sample coverage often permits a higher overall level of accuracy than a full enumeration (Moser & Kalton, 1971). Bowling (2002) has suggested that the size of the sample aimed for should be

calculated at the design stage of the study. Initially it was agreed that the research would only cover four counties (see section 3 1) in the north west area However it was later decided to include the west of Ireland as the number of asylum seekers residing in the north west area had decreased significantly in comparison to previous months

Two major principles underlie all sample design. The first is the desire to avoid bias in the selection procedure, the second is to achieve the maximum precision for a given outlay of resources (Moser & Kalton, 1971). Black (1999) states that it is difficult to produce a truly random sample, the researcher can only try to get the most representative sample possible by using the resources and knowledge of the population that is available.

A number of sampling methods were considered and it was agreed among the research team that the researcher would approach each and every adult asylum seeker in the centres and self-catering units and ask them to participate in the study The researcher devised a floor plan after deliberation with either the Family Support Worker or the centers Duty / General Manager; these were then used as a sampling frame The use of a sampling frame is very important A sampling frame is an objective list of the 'population' from which the researcher can make his / her selections (Bowling, 2005)

As each participant filled in a questionnaire their room number was ticked off, the same procedure was used for each room that contained more than one resident. Any asylum seekers who choose not to participate in the study were also ticked off. This procedure was repeated until all residents were accounted for

A snowballing technique was used to contact asylum seekers living independently in

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Co Donegal. Snowball techniques involves "identifying certain key individuals in a population, interviewing them and then asking them to suggest others who may also want to take part in the research" (McNeill & Chapman, 2005, p.50) With snowballing, the sample emerges through a process of reference from one person to the next, people can be asked to nominate others who meet certain criteria for choice, certain conditions related to the research project or certain characteristics (Carter & Henderson, 2006).

Unfortunately, as stated earlier this technique did not prove to be a success It was quite difficult to get in contact with the asylum seekers, the asylum seekers who were contacted were cautious about giving out their friends and families contact details The researcher also found that the necessity to give written consent acted as a deterrent to participants

The researcher was given permission to enter the direct provision centres on the basis that they were accompanied by a security person while visiting the private quarters (areas that are not accessible to the general public) of the direct provision centres Reluctantly, the researcher agreed, as otherwise access to the asylum seeking community would have been minimal. Every effort was made to preserve the privacy of the participants The security officer was asked to remain outside the interview room while the research was being conducted

3.5 Data Collection

Questionnaires were utilised to collect the data, these questionnaires were designed to gather information from each research participant in relation to five key health indicators, they were

1. Demographics

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2. Health status

3 Quality of life (QoL)

4 Use of health services

5 Health related behaviours

Only a small number of those living in self-catering units were contactable due to confidentiality reasons The Asylum Seeker and Refugee Services, based in the north west region, were not at liberty to disclose the private address of asylum seekers who reside in the general community The researcher did attempt to contact some of these asylum seekers through service providers and hoped that information would be obtained through a snowballing technique, however, this yielded little results

Due to the transient nature of asylum seeker's lifestyles and the high number of parents with Irish born children, the researcher found it difficult to estimate accurately which month would be the most productive in terms of maximum occupancy of the direct provision centres

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Table 3.1: Direct Provision Centres and Self-Catering Units in the HSE West area.

County	D. P. Centre	Location	Max cap.	Approx no of participants
Galway	Eglinton Hotel	Salthill	235	25
	Western Hotel	Eyre Square	180	60
Mayo	Railway Hotel	Kiltimagh	90	13
	Old Convent	Ballyhaunis	158	31
Roscommon	Apartment Bock	Ballaghadereen	86	13
Donegal	Cliff View	Donegal Town	45	25
	Private acc	Donegal County	-	0
Leitrim	Sliabh na Iarann	Ballinamore	24	7
Sligo	Globe House	Sligo City	250	70

Table 3 1 provides an overview of both the direct provision centres and the self-catering units that are located within the Health Service Executive west area. Also included in the table are the numbers that relate to the maximum capacity (including children) for each centre and an approximation of the total number of adult asylum

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seekers who participated in the study. The column 'maximum capacity' refers to the total number of asylum seekers that the centre is capable of providing accommodation to and not necessarily the number of asylum seekers who were present during the data collection phase

At the time the study was being conducted there was no direct provision centre in Co Roscommon, however there are approximately twenty four asylum seekers residing in self catering units m Ballaghadereen, Co Roscommon The researcher found these people the hardest to contact and arrange meetings with, fortunately contact was made through a snowballing approach These questionnaires were completed m the participant's homes and not m centres as previously conducted (n=13) Initially, it was hoped that questionnaires completed by asylum seekers in self-catering units would be analysed separately and compared to those from direct provision centres Unfortunately, the researcher felt that the sample size was not large enough to do so

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As mentioned previously there are a number of asylum seekers living independently in the general community in the Letterkenny area of Co Donegal, although attempts were made to contact these people, these attempts yielded no results. Most of the non-Irish nationals that the researcher made contact with were either eastern European workers, those with work permits or recognised refugees, all of whom were outside the remit of the research proposal

3.5.1 Pilot Study

According to Peterson (2000), the most sophisticated method of pre-testing a questionnaire is to conduct a pilot study. Piloting helps to detect any problems in the researchers questioning such as wording, types of questions used and general layout

(Burgess, 2001) "Questions can be first tested on members of the research team or colleagues, in order to make initial assessments of comprehension sense and so on and then prepiloted with a small group from the population of interest" (Bowling, 2005 p 402, b) Oppenheim (1992) has stated that in order to pilot the questionnaire correctly it is necessary to select a sample of participants as similar as possible to those who would be responding in the main study Face to face piloting continued with the new sample members until the researcher was confident that the questionnaire required no further changes

A number of authors have cited the importance of piloting a questionnaire to determine how long it takes recipients to complete them, to check that all questions and instructions are clear and to enable the researcher to remove any items which do not yield usable data (Bell, 1993, Tarling & Croft, 2005)

Before the actual research was conducted, it was agreed that a pilot study should be carried out The pilot study was then carried out on a small number of adult asylum seekers in Globe House, Sligo Thirteen asylum seekers (n=13) were chosen randomly from attendance records to participate in the pilot study These questionnaires were not included for analysis with the other 242 completed questionnaires as there were changes made to the questionnaire following the pilot study

The pilot study provided valuable information and insight into the appropriateness of the questionnaire, as a result of the pilot study a number of minor changes were made to the questionnaire A summary of these changes are as follows

- Certain words were exchanged for those of a clearer terminology, e g reside was exchanged for live
- Questions which the research participants felt were of little importance were removed from the questionnaire as some of the residents aired concerns that

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the questionnaire was too long and its length would deter other residents from taking part in the research

- A number of residents highlighted the fact that although they spoke English, they did not recognise the written form of some of the words used in the questionnaire

- It was recommended that a food table should be made available to those who were unfamiliar with portion sizes and food groups

- The participants also suggested that the questionnaire should be translated into French

When asked if they felt that the researcher should ask the questions verbally they all agreed as they felt that with thirty three questions on the questionnaire, the response rate may be quite low The researcher also checked the questionnaire for possible misinterpretations or for words / topics that may be considered too sensitive to use

3.6 Analysis of Data

All data collected was analysed using Statistical Package for Social Science (SPSS) During the design phase the questionnaire was laid out m a manner that would compliment ease of analysis The questionnaire was coded after the pilot study when the final draft was completed, in order to check for any problems that may arise at a later date All results were entered into Microsoft Excel, then checked for discrepancies When completed they were imported into SPSS and rechecked Both parametric and non-parametric tests were used to analyse the data from this study

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Parametric Tests

There are a wide range of tests that can be used to test for significant differences between groups, the independent samples t-test is one of these

An independent samples t-test is used when you want to compare the mean scores on some continuous variables, for two different groups of subjects (Pallant, 2001).

According to Pallant (2001); there are general assumptions that apply to parametric tests such as t-tests, these assumption include;

1 The dependent variable is measured at the interval or ratio level

2. Scores are obtained using a random sample from the population

3 Populations from which the samples are taken are normally distributed

4 Samples are obtained from populations of equal variance

5 The observations that make up your data must be independent of one another

According to Stevens (1996), violation of assumption number five is very serious.

The power of the test will depend on the difference between the sample size, population being compared and the level of significance. The power relates to the probability that a test will produce a significant difference at a given level of significance (Bland, 1995)

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The level of significance used in this was 0 05 Crichton (1993) acknowledges that it is important to ensure that the study is designed so that it has a good chance of detecting significant differences if they exist. The 0 05 level of significance is usually taken, and the power should be greater than 0 8

Pallant (2001) has noted that the power of a test is very dependent on the size of the sample used in the study, however, Stevens (1996) has noted that when the sample size is large (e g , 100 or more subjects), the 'power is not an issue'

The t-test was used in this study to determine whether or not there was a statistical association between two variables The most commonly used variable in the t-test was gender

Non-Parametric Tests

Non-parametric techniques are used with data that is measured on nominal and ordinal scales (Pallant, 2001). The chi-square test is a non-parametric test of statistical significance for bivariate tabular analysis. This type of test is useful when examining the relatedness or independence between categorical variables (Pallant, 2001). The chi-square was used in this study to examine the relationship between males and females on a number of variables, for example; health status, quality of life and so forth, allowing a determination regarding the statistical difference of the two groups to be made

Like parametric tests, non-parametric tests also have assumptions that should be fulfilled, these include

1 Random samples
2 Independent observations

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Chapter 4

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Chapter 4 – Profile of Research Participants

Both men and women participated in this study. 155 (64%) of the 242 asylum seekers that participated were male while 87(36%) were female. The male female ratio of 1.7:1 is similar to that found in other studies (Owen, 1994; Fanning et al., 2000; Acheson, 1998).

Recent Irish studies have found that refugees and asylum seekers are in general, a young population (Aldous et al., 1999). This feature is in keeping with International findings (Collins, 2002). The asylum seeking community in the west of Ireland is predominantly a young population ranging in age from 18-59 years. The following chart illustrates the number of participants in each of the age categories.

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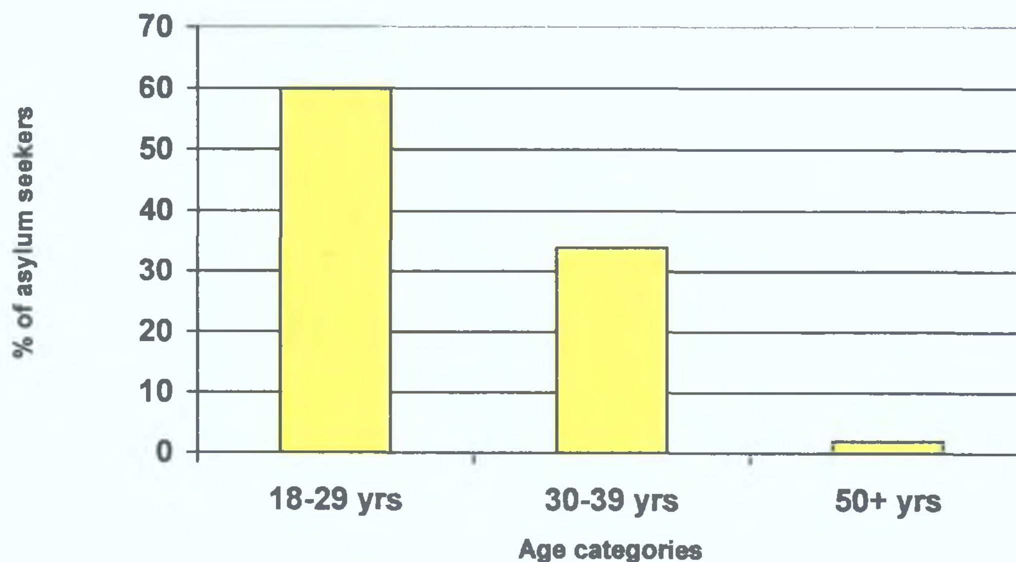
Fig 4.1: Age categories of research participants



The participants hailed from over 40 different countries. The majority of participants came from Africa (169 participants) followed by Asia (56 participants), 15 participants came from Eastern Europe and two came from the Caribbean.

The top five countries of origin are as follows, Nigeria (17.4%), Somalia (9.9%), Congo (8.7%), Sudan (7 9%), Afghanistan (5.4%), and Iran (5 4%) shared fifth place. These patterns are consistent with patterns of applications for asylum in recent years According to figures, released from the Irish Refugee Council (2006), the top five countries of origin of new applications in the first 6 months of 2006 have been as follows Nigeria, Somalia, Romania, Afghanistan, and Sudan.

At the time of data collection, 70 (28 9%) participants were resident in Co.Sligo, 5 (2.1%) in Co. Leitrim, 13 (5 4%) in Co Roscommon, 44 (18 2%) m Co Mayo, 85 (35 1%) in Co Galway and 25 (10 3%) were resident in Co Donegal 229 (94 6%) participants were residing in direct provision centres, while only 13 (5 4%) participants were living in self-catering units Both male and females participated in each county with the exception of Co Donegal All participants from Co Donegal were male

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The health of the migrant population in the west and North West of Ireland

Of the 242 participants, the majority felt that their health was good / very good, 49 (20 2%) stated that they felt that their health was excellent, 43 (17 8%) reported that their health is very good while 89 (36.8%) said that they felt their health was good, only 33 (13 6%) felt that their health was poor

Table 4.1: Health status of participants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	excellent	49	20 2	20 2	20 2
	very good	43	17 8	17 8	38 0
	good	89	36 8	36 8	74 8
	fair	28	11 6	11 6	86 4
	poor	33	13 6	13 6	100 0
	Total	242	100 0	100 0	

A chi-square test was carried out to determine if there was a significant statistical difference in the health status of males and females. In this instance;the pearson chi-square was used The value is 5 393 The associated significance level is 0 249 In conclusion there is not a significant difference in the health status of males and females

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Table 4.2: Quality of life (QoL) of participants

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very good	34	14 0	14 0	14 0
	good	81	33 5	33 5	47 5
	neither poor nor good	56	23 1	23 1	70 7
	poor	39	16 1	16 1	86 8
	very poor	32	13 2	13 2	100 0
	Total	242	100 0	100 0	

Only 34 (14%) respondents said that their quality of life was very good, 56 (23.1%) said that they felt that their quality of life was neither poor nor good, 71 (29.3%) rated their quality of life as being poor / very poor

The chi-square test was also carried out on this variable The associated significance value is higher than the alpha level of 0 05 There is not a significant difference in

the quality of life of males and females.

The participants were asked to choose from a list provided as to what they think would improve their health; they were also given the opportunity to provide their own answer. From the list provided the participants felt that if their lives were less stressful, if they had fewer changes in their lives and if they had the ability to partake in employment, all would have the greatest benefit to their heath.

Fig 4.3: **I think that my own health would be better if I had.....**

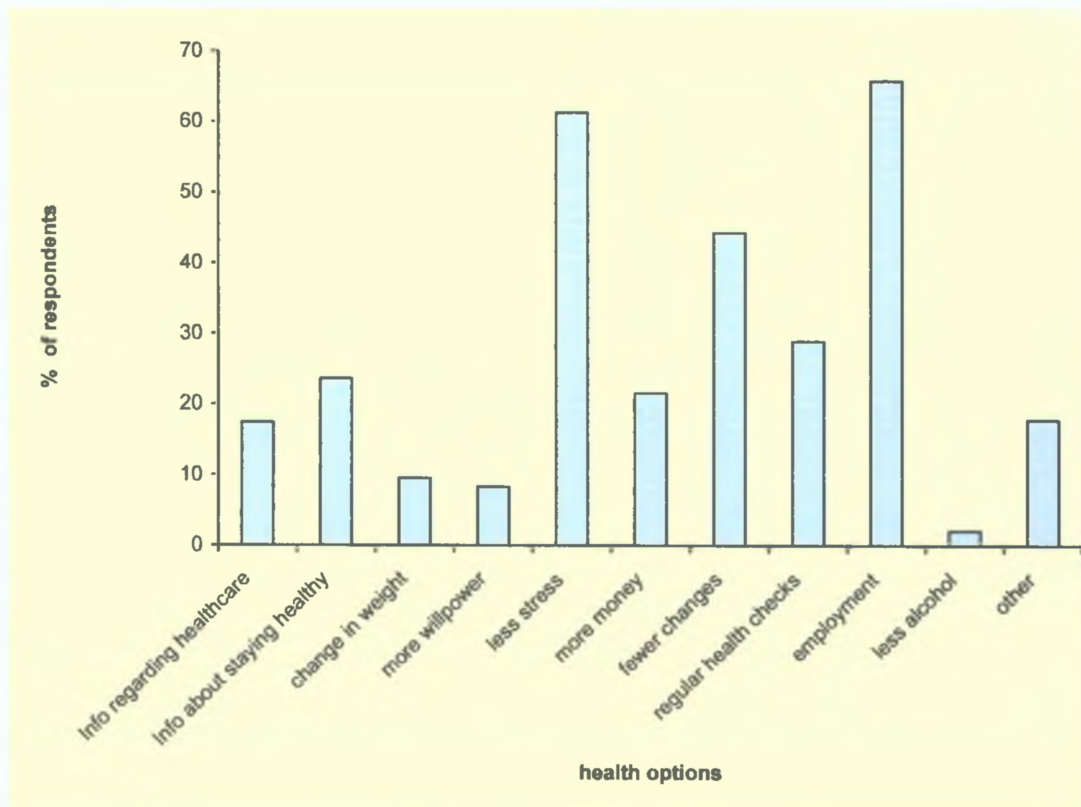

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Table 4.3 : **Other optıons**

		Frequency	Percent	Valıd Percent	Cumulatıve Percent
Valıd	educatıon	21	8 7	47 7	47 7
	better qualıty of lıfe	1	4	2 3	50 0
	indıvıdual prıvate accomodatıon	5	2 1	11 4	61 4
	less personal sıckness / tests	1	4	2 3	63 6
	tradıtıonal food	1	4	2 3	65 9
	refugee status	12	5 0	27 3	93 2
	balanced dıet	1	4	2 3	95 5
	better medıcıne	2	8	4 5	100 0
	Total	44	18 2	100 0	
Mıssıng	Not Relevant	198	81 8		
Total		242	100 0		

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40 (16 5%) partıcıpants opted to gıve theır own answer to the above questıon 21(8.7%) partıcıpants saıd that a better educatıon would ımprove their health, 12 (5%) saıd that ıf they were granted refugee status theır health would be better, compared to only 3 (1 2%) who suggested that theır health would be better ıf they had theır own prıvately rented accommodation

It ıs recognısed that the health and well beıng of people ıs ınfluenced by a range of factors, both wıthın and outsıde the ındıvıdual's control (Lalonde, 1974) this has lead to a number of models that attempt to ıdentıfy the determınants of health and the pathways through whıch they operate (Davıes & Mc Dowall, 2006)

Authors such as Sımons-Morton et al , (1995) argue that the determinants of health have tended to be dıvıded ınto a general framework that consısts of four broad categorıes, namely genetıcs, envıronment, healthcare and personal behavıour. However the environmental category can also be dıvıded ınto two the physıcal and socıal envıronment (Ryan et al , 2005)

Whıle there are many more ınfluences on health and health status, the prımacy of ındıvıdual responsıbılıty for health remaıns popular A number of authors and reports have documented the growıng recognıtıon of the ımportance of assocıated,

multiple and or interrelated factors influencing health "This recognition is welcome for a number of reasons. Firstly, it acknowledges and understands health as both a complex and multifaceted phenomena Secondly, it values the understanding and input of multiple disciplines and mterest groups and thirdly it is an approach that also makes sense" (Ryan et al , 2005 p 6)

Different people are likely to hold different views of health Naidoo & Wills (2000) have acknowledged that social status, gender and ethnic origin, will affect their concept of health (Naidoo & Wills, 2000) People from the same ethnic collectivity share a bond that includes common origins, a sense of identity and a shared standard for behaviour, which are perceived to be cultural norms (Harwood, 1981, Saunders, 1954) "Complex systems of health beliefs and practices exist across and within cultural groups In addition, variations, whether extreme or modest, to cultural beliefs and practices are found across ethnic and social class boundaries and even within family groups" (Davidhizar & Giger, 2004, p 122)

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On arrival, health concerns seldom top the agenda for refugees and asylum seekers (Ryan, 2000). Asylum seekers attitudes to health are based on immediate needs, such as housing, asylum, employment, and finances (Clinton- Davis & Fassil, 1992, Kemp, 1993, Hargreaves et al , 2001, Papadopoulos et al , 2004, Woodhead, 2000) rather than on prevention and the influence of lifestyle on health (Murphy, 2001)

Displacement is difficult for all refugees, but women are often the most seriously affected (Burnett & Peel, 2001) They are vulnerable to physical assault, sexual harassment and rape (Wallace, 1990). The needs of women may not be identified, especially in cultures where the male is traditionally the spokesperson (Gammell et al , 1993) As the structure of the African family is male dominated women can be placed m an inferior status, creating a situation of inequality with respect to rights covering most facets of life (El Safty, 2001)

There are also gender inequalities in health for example; higher mortality rates are observed in men and generally women self report poorer mental health (Ministry of Health New Zealand, 1999). Biological factors provide part of the explanation for this difference (Ministry of Health New Zealand, 2002) However, Ostlin (2002) argues that much of it relates to the gender roles that define men and women according to the positions they occupy in society. The different roles they perform and the variety of social and cultural expectations and constraints placed upon them.

The researcher carried out a number of cross tabulations on the data, with respect to gender In order to determine if there was significant differences in health behaviours / health status of male and female participants. The majority of tests showed that their was not a significantly statistical difference between genders Variables that showed a significant difference are documented throughout this chapter

The majority of respondents felt that both their health and quality of life was between good/excellent (74.8%), however 25 2% of respondents had concerns regarding their health and stated that they felt it was only fair/ poor The research participants identified a number of options that would improve their health, as a result, three major themes emerged, these are as follows. employment, less stress and fewer changes in their lives

The vast majority (65 7%) of participants felt that the ability to partake in paid employment would have the most beneficial impact on their health. According to Brehony & Clancy, (2006) asylum seekers coming to Ireland can find themselves trapped in a web of exceptions, one of which is the denial of the right to work These authors have suggested that this onerous denial is responsible for many ills and is reinforced by severe restrictions on the asylum seeking community's access to social services It is recognised that unemployed people have worse health than those in employment (Harkin& Stead, 2002, Townsend et al , 1992) "In the case of asylum seekers, denial of the right to work and to earn a living, coupled with their weekly

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allowance which is considerably lower than other welfare payments to Irish citizens, increases the social and economic gap between asylum seekers and virtually all others" (Brehony & Clancy, 2006, p 26)

Employment is also a key issue in resettlement (Block, 1999, Brent & Harrow, 1995, Carey – Wood et al , 1995, Haringly Council, 1997, Gammell et al , 1993) Carey – Wood et al , (1995) found that the unemployment rate among refugees was above that for minority ethnic groups in general The biggest impact of unemployment is growing poverty for many families and individuals (Brehony & Clancy, 2006)

In total, 148 (61.2%) participants felt that if their lives were less stressful, their health would be better. According to Ahern (2000), there is no doubt that refugees and asylum seekers are susceptible to psychological problems following their varied and extraordinary experiences pre-flight, during flight and post flight in their host countries

Decisions to flee may be as a result of the direct effects of conflicts on health (Agar, 1999), political unrest and economic difficulties (Grove & Zwi, 2005). Social disruption can become so widespread that food supplies are interrupted and schools and health facilities may cease to function (Ager, 1999, Coker, 2001, Kalipeni & Oppong, 1998, Rutter, 1994).

The whole process of flight can be traumatic as often family members are left behind The experience of passage can also be dangerous (Muecke, 1992) What forced migrants have in common is the limited choices available to them. Particularly vulnerable members are women and children (Coker, 2001, Kalipeni & Oppong, 1998)

Papadopoulos (2006) has also identified that material deprivation, discrimination and language difficulties may all play a part in the attribution of the diagnosis of

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mental illness to members of minority ethnic groups. Mental health professionals working with refugees have commented that, despite the traumatic stress associated with fleeing from violent conflict, what people need most is practical help with rebuilding their lives in a new country as post migration stress can often be as great as pre-migration stress (Brehony & Clancy, 2006).

Not only is physical health a concern in regards to asylum seekers but so too is the psychological well-being of such individuals (Hall, 2004). There is a general feeling of disempowerment among the asylum seeking community. Feelings of depression and boredom are common (Dibelius, 2001) as many of the asylum seekers daily decisions are made for them.

The Dutch Refugee Council (1997) found that higher levels of frustration and aggression and poor mental health arose as a result of long stays in overcrowded reception centres. High levels of dependency and boredom were also found to contribute to increased incidences of both family and relationship – related problems.

Nearly half of respondents; 107 (44.2%) said that there health would be better if they had fewer changes in their lives. The Free Legal Advice Centre (2003) have acknowledged that as a consequence of seeking asylum, asylum seekers may have experienced long periods of constantly moving from place to place, of living in hiding, or of being in transit on their way to a safe country of asylum. The Dutch Refugee Council has also acknowledged that the process dealing with experiences and adjusting to new situations may stagnate as a result of continuous exposure to stress and tension. This may be due to lack of privacy and independence or due to frequent relocations between reception centres or flats (Dutch Refugee Council, 1997).

Some participants opted to give their own answer to the above question. 40 (16.5%), three distinct patterns also emerged here, these are as follows: better education,

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refugee status and private accommodation.

Twenty one (8.7%) respondents said that if felt that if their education was better, this would have a beneficial effect on their health. Unlike refugees who have the same

r or third

level education, they are however entitled to attend VEC – adult literacy classes. Taking into account the number of asylum seekers applying for these course, sufficient classes may not always be available to cope with demand.

While working in a local direct provision centre the researcher experienced first hand the difficulties that some asylum seekers endured in relation to this. Some residents had to wait a significant period to gain a place in one of the classes, for those who were lucky enough to gain a place, childcare for some became an issue. Parents were often forced to bring their children with them to the class as there was no crèche in operation in the direct provision centre. If a class occurred at the same time as some of their children were due to return from school, the parent was forced to cancel the class to look after their child. For some fortunate residents of this particular direct provision centre, a number of primary school teachers provided voluntary classes during the summer period.

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A small number of respondents also identified private accommodation. 3 (1.2%) said that they felt having private (self-catering unit) accommodation would have a beneficial effect on their health. The issue of accommodation dissatisfaction is no surprise!. All asylum seekers entering Ireland are accommodated in direct provision centres, where they receive food, lodgings, and a small monetary allowance.

Brehony & Clancy, (2006) noted that living with such an international community was not some thing people expected before fleeing their own countries, a study conducted in Co. Mayo found that respondents found that their accommodation was very cramped and had no facilities for children, some women had to share a bed with one or two young children and some had to share a room with other women and

children.

Giger & Davidhizar (2004) highlighted the importance of having adequate inner and outer personal space as this is linked to an individuals comfort zone. The authors suggest that once personal space is invaded, discomfort is experienced. Although personal space is an individual matter and varies with the situation, dimensions of personal space comfort zone also vary from culture to culture (Shearer et al., 2002). The need for territoriality cannot be fully met unless individuals can defend their space against invasion or misuse by others (Roberts, 1978).

According to Murray & Huelskoetter (1991), physical distancing from others varies with setting and is culturally learned. People by nature are territorial. "Territoriality refers to a state characterised by possessiveness, control and authority over an area of physical space". In order for territoriality is to be met, the individual must be in control of some space and must be able to establish rules for that space (Davidhizar & Giger, 2004, p52).

It is essential to remember that having personal space promotes self-identity by affording opportunities for self-expression and that personal wellbeing is often related to the critical distance a person keeps from others (Giger & Davidhizar, 2001; Giger et al., 1997; Reaches, 1997; Wilson & Kneisl, 1995).

Only 12 (5%) participants said that if they were granted refugee status, their health would be better. For asylum seekers there is an overwhelming concern with immigration status (Directorate of Public Health; Croydon Health Authority, 1999; Papadopoulos & Gebrehiwot, 2002). Those who have been granted refugee status express enormous relief (Papadopoulos, 2006). Taking into consideration that if an asylum seeker is granted refugee status, they will have the opportunity to reside in their own private accommodation. Recognised refugees will also be permitted to take up paid employment and they will have access to further education, all of which are not available to them currently. It is no wonder that they feel being granted refugee status would be beneficial for their health.

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Direct Provision

Sleeping, eating, thinking,
sleeping, eating, thinking,
fifteen pounds a week – what else but
sleeping, eating, thinking.

You're in your rainy centre
lookin out the door
on your seventh cup of too-weak tea
at the people passing by
cars and bikes and
mammies with buggies and grannies with sticks
and you think
how you would like
to have somewhere to go
but you're consigned to
sleeping, eating, thinking
sleeping, eating, thinking,
and fifteen pounds a week – what else but
sleeping – eating – thinking.

What the present influx needs
in a cage with invisible bars - what?
a complex mesh of razor wire
nobody can see - sorry!?
a holding chamber dark
walls not necessary - walls!?
the shackles are installed
in the mind, like a chip,
the incarcerator's dream
of inflicting maximum discomfort
and look:- no marks … look no marks …
- I see what you're getting at
nothing to complain about – look, no marks!

Just – sleeping, eating, thinking,
sleeping, eating, thinking …
Fifteen pounds a week, fifteen pounds a week …
sleeping, eating, thinking,
fifteen pounds a week.
But for crying out loud – officially you're free
how ungrateful can you be
you have free tv …

Poem by D. O Kelly , 2001

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Usage of Irish Health Services

The participants were provided with a comprehensive list of sources of information and asked to tick whichever was relevant to them. They were also given the opportunity to provide their own option For those who gave more than 1 answer their first source of information about health was their GP (78 9%), 29 (12%) get their information from the media while 12 (5%) use health organisations to obtain the information, 2 (0 8%) go to health professionals other than their doctor to obtain information about health while only 1 (0 .4%) contact the Dept of Health and Children for information about health

Table 4.4: Main sources of information

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	gp	191	78 9	79 3	79 3
	health organisation	12	5 0	5 0	84 2
	media	29	12 0	12 0	96 3
	DOHC	1	4	4	96 7
	other health professional	2	8	8	97 5
	other	6	2 5	2 5	100 0
	Total	241	99 6	100 0	
Missing	missing	1	4		
Total		242	100 0		

18 (7 4%) research participants opted to give their own answer. Of these 18 people; 5 (2 1%) get it from their hospital, 3 (2 1%) from the Refugee Information Centre, 1 (0.4%) from their own self-knowledge, 4 (1.7%) from the PHN, 2 (0 8%) get their information from leaflets and magazines, 1 (0 4%) person from the library, 1 (0 4%) from their accommodation centre and 1 (0 4%) person from the Citizens Information Centre.

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Table 4.5: Sources of information – other options

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Hospital	5	2 1	27 8	27 8
	Refugee Information Centre	3	1 2	16 7	44 4
	Self Knowledge	1	4	5 6	50 0
	PHN	4	1 7	22 2	72 2
	Leaflets and mags	2	8	11 1	83 3
	Library	1	4	5 6	88 9
	Aaccomodation centre	1	4	5 6	94 4
	Citizens Information Centre	1	4	5 6	100 0
	Total	18	7 4	100 0	
	missing	224	92 6		
Total		242	100 0		

The majority of participants are registered with a G.P in Ireland (93% of responses) A chi-square test was also carried out to determine if there was a statistical difference in the percentage of males and females who are registered with a G P In this instance, the Continuity Correction value was used to analyse results, as the test produced a 2 by 2 table The corresponding significance value is 0.016, there is a significant difference in the number of males and females who are registered with a G.P (89 7% of males are compared to 98 9% of females)

The author feels that this may be due to the fact that 53 (60%) women had given birth to a baby since arriving in Ireland and so would have needed regular G.P check ups to monitor their pregnancy The majority of respondents also identified their G P as their main source for obtaining information (78 9% of responses) Davidhizar & Giger have acknowledged that "some cultures are primarily oral and do not rely on a written form of communication In such a society, the spoken word holds greater meaning and power" (Davidhizar & Giger, 2004, p36) Hmong are considered an oral cultural group For these individuals, the formation of and acceptance in a social group is primarily dependent on the spoken word (Shadick, 1993).

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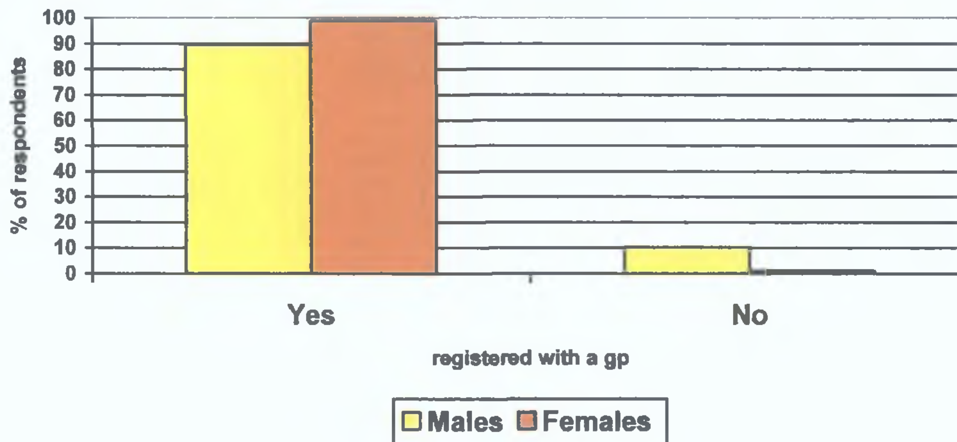
Fig 4.4: Gender & percentage of participants who are registered with a G.P. in Ireland



"Effective communication of healthcare information motivates individuals to work with their health care providers to manage their health" (Davidhizar & Giger, 2004, p21).Giogianni (2000) notes that individuals are more confident in pursuing health care if they have received effective healthcare communication and are better informed. In todays society communication is the core of most nursing curricula.

A number of authors have documented the relationship between communication and culture. According to Giger & Davidhizar (2004 p.22), communication and culture are closely intertwined. "Cultural variables such as the perception of time, bodily contact, and territorial rights influence communication". Communication is the means by which culture is transmitted and preserved (Delgado, 1983).

In total, 184 (76%) research participants have had their health checked in the last 3 years, while 58 (24%) did not have a health check in the last 3 years.

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Table 4.6 : Reasons for not having a health check/ screening in the last 3 years

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	poor/no access in home country	24	9 9	41 4	41 4
	didnt want a checkup	10	4 1	17 2	58 6
	long waiting lists	5	2 1	8 6	67 2
	language difficulties	9	3 7	15 5	82 8
	no transport	2	8	3 4	86 2
	new in Ireland	3	1 2	5 2	91 4
	dont know how to access services	2	8	3 4	94 8
	lack of opportunities	3	1 2	5 2	100 0
	Total	58	24 0	100 0	
Missing	missing	184	76 0		
Total		242	100 0		

Of the 58 (24%) asylum seekers who reported that they did not have a health check in the last three years; 24 (9 9%) cited reasons such as poor / or no access to health services in their home country as the reason that they did not have a health check, 10 (4 1%) stated that they didn't want to have a health check, 5 (2 1%) said that the long waiting lists to see health professionals was the reason that they haven't had their health checked. 9 (3.7%) respondents said that language difficulties was the reason that they haven't had their health checked 2 (0.8%) respondents said that lack of transport was the main reason while another 2 (0 8%) said that they were unsure about how to access services in order to get their health checked 3 (1.2%) respondents said that they were new in Ireland and they didn't have enough time to get their health checked. Another 3 (1.2%) respondents said that they didn't have a health check or health screening in the last three years because they felt that there was a lack of opportunities to do so.

The continuity correction value of the chi-square test is 0 544, the associated significance value is 0 461 As this figure is larger than the alpha level of 0.05, this indicates that the results are not significantly different This means that the proportion of males that have had a health check in the last 3 years, is not

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significantly different to the proportion of females that have had a health check in the last 3 years (72.4% of males compared to 79.3% of females have had a health check)

The majority of respondents had experience in making appointments with health professionals, however, of the 242 participants 47 (19 4%) asylum seekers said that they did not. Of the 195 (80.6%) of respondents who said that they had experience in making appointments, 60 (24.8%) acknowledged that they experienced difficulties in making these appointments The results show that there was no significant difference in the proportion of males and females who experience these difficulties

Exploration of the difficulties that respondents experience highlighted five areas Language difficulties was the most commonly cited difficulty (67.8% of responses), long waiting times to get appointments was the next significant difficulty (23 7% of responses), other difficulties that the respondents experienced were as follows, lack of transport (3 4%), unhelpful staff (3 4%) and uncertainty about how to access services (1.7%)

While in theory asylum seekers, convention refugees and people given leave to remain have the same entitlements to health care in Ireland as Irish citizens Brehony & Clancy 2006 acknowledged that the Irish health care system fails to take into account the linguistics, social and other differences in a largely diverse group of service users (Brehony & Clancy, 2006)

Language, or rather inability to communicate effectively in English, has emerged, as a major problem m many studies (Brent & Harrow, Carey-Wood et al , 1995, Gammell et al., 1993, Harmgly Council, 1997, Papadopoulos & Gebrehiwot, 2002) Language is basic to communication Words shape experiences and influence cultural perceptions (Davidhizar& Giger, 2004, p 26). Words convey interpretations and influence relationships (Pirandello, 1970, Talbot, 1996; Varcarolis, 2002) "The

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communication practices of persons in different cultural groups affect the expressions of ideas and feelings, decision making and communication strategies" (Giger & Davidhizar, 2004, p 23) A culture may be limited and moulded (Hedlund, 1993)

Davidhizar & Giger (2004) have also noted that althought the same language may be spoken by a particular group of people, establishing communication is often difficult because word meanings for both the sender and the receiver vary based on experiences and learning Husband & Hoffman (2003) proposed that all interpersonal communication contains the possibility of ambiguity and misunderstanding. The possibilities of misunderstanding and poor communication become much greater when cultural boundaries are crossed

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Although Davidhizar & Giger (2004) has acknowledged that barriers exist when people speak the same language, there are more profound barriers present when different languages are spoken Each language has a whole set of unconscious assumptions about the world and life Understanding differences in the meanings of words can provide insight into people of different cultures

Authors such as Tilki, (2003) and Giger & Davidhizar, (2004), suggest that the lack of cultural sensitivity prevents people seeking effective healthcare when they have problems According to Papadopoulos (2006), refugee experiences with the healthcare system in the host country will impact on their practices For example, a negative experience may deter them from seeking help from a particular source again. Negative experiences may be a result of problems with communication, poor provision of information or culturally inappropriate care. "Culturally inappropriate care is ethnocentric and does not acknowledge the individuals needs in terms of religion, diet, language, beliefs and family support which differ from those of the majority, usually white culture" (Papadopoulos, 2006, p143)

Access to healthcare may present a problem due to lack of knowledge, concerning how to access care and communication problems if access is achieved (Collins, 2002, Brehony & Clancy, 2006) A lack of information about services is also a real obstacle to uptake by people from minority ethnic or refugee groups (Papadopoulos, 2006)

In a recent study, carried out in Co Mayo with migrant workers, asylum seekers and refugees, the main problem with health services which arose related to language barriers, communication, and culture in the wider health services. These issues were described as barriers to understanding how the system works, what the G P or nurse is saying and the feeling that they themselves are not fully understood People who have arrived recently cannot find their way around the health system (Brehony & Clancy, 2006)

Davidhizar et al., (2002) acknowledged that a client who enters the health care system without being able to speak the dominant language of the caregivers, enters a frightening and frustrating world This may also be true for clients whose first language differs from that of the health professional The importance of English language skills as a means of communication has been emphasised by many authors (Begley et al , 1999, Collins, 2002, Fanning et al , 2001, Bernard Jones, 1993, Jones, 1999)

The respondents were asked to identify the services that they availed off since their arrival in Ireland.The most commonly used service was the G. P. (76.4%) followed by the dentist (25 6%) The service that had the least usage was family planning with only nine (3 9%) of participants availing of this service

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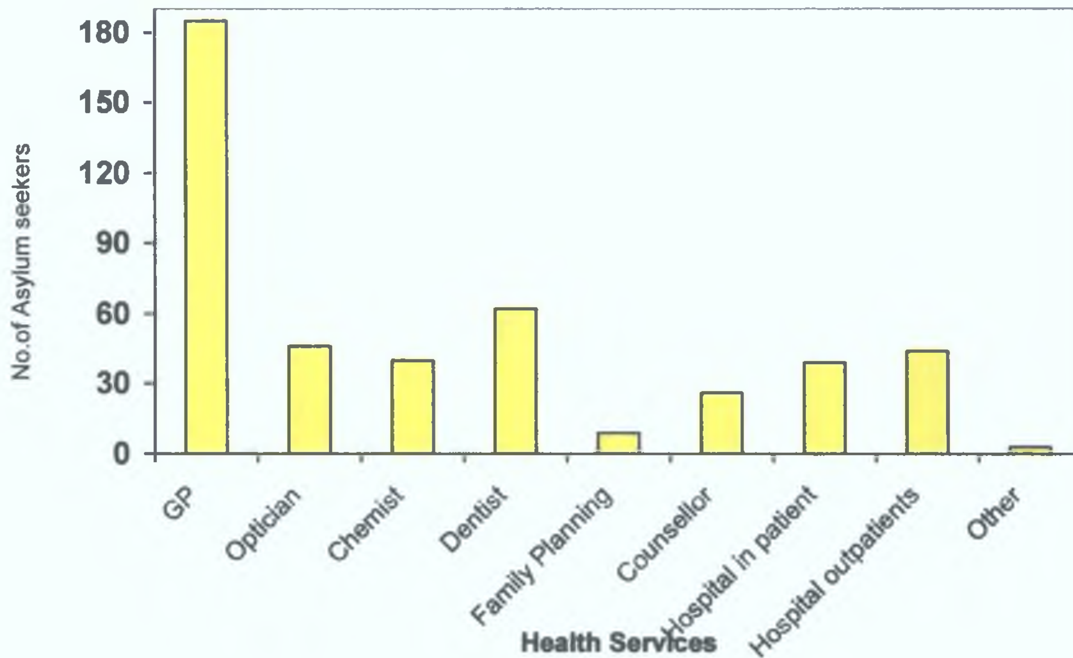
Fig 4.5: Health services that the participants have availed of since arrival in Ireland



The research participants were also given the opportunity to identify any other services that they availed of, that wasn't already on the list provided. Three people said that they availed of other health services, these were identified as being SPIRASI (33.3 %) and the Public Health Nurse (66.7%).

Campinha-Bacote (1997) has acknowledged that culture can have a profound effect on the expectations and perceptions of sickness that shape the labeling of sickness and on how, when and to whom communication of health problems occur.

The participants were provided with a list and asked to identify any medical condition which they may have been diagnosed with by a G.P. The following table illustrates that range of conditions that the participants could choose from. Of the 242 people who participated in the research, a total of 31 had ever been diagnosed with a medical condition by a G.P. From the list provided; hypertension (22.6% of

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responses) and angina (25 8% of responses) were the most frequently cited conditions. 12 of the research participants identified themselves as having medical conditions other than those outlined in the table

Only 8 (3 3%) respondents said they were told by a G.P that they had angina, a further 7(2 9%) respondents said that they suffered from hypertension (high blood pressure) According to Smaje (1995) diseases of ethnic minority populations do not differ fundamentally from those faced by majority populations. Cardiovascular disease is the leading cause of death in both developed and developing countries (Mc Kay et al , 2003) Papadopoulos (2006, p 55) cited that "migrants to western European countries may experience problems similar to those of people in low social classes and members of minority ethnic groups, however refugees and asylum seekers will have added problems relating to their refugee experience and their health will thus be placed in triple jeopardy"

Although the proportion of respondents who reported having being diagnosed with an illness seems quite small, it is imperative to take previous discussions into consideration. 47 respondents said that they do not have any experience in making appointments with any form of health professional In addition, 58 respondents have not had a health check in the last three years. Unlike Ireland, different populations may not hold the formal health system or its practitioners in priority. According to El Safty (2001), traditional healers are part of the culture in some countries in comparison to the formal health system which may represent an impersonal 'alien' approach to health care

The traditional healer interacts with the client through the channel of shared beliefs system, which is strongly rooted in their culture, and shapes the way of thinking of both healer and client. It is the same mentality This is not, however the situation vis-à-vis, the modern 'scientific' interpretation of the casual factors in illness (El Safty, 1983)

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According to El Safty (2001) the traditional patriarchal structure of the family places the elderly in an important role, vis- a-vis healthcare Their wisdom, expertise, and age are seen as qualifications for healing power

Table 4.7: Conditions that the participants have been diagnosed with

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	angina	8	3 3	25 8	25 8
	heart disease	1	4	3 2	29 0
	high blood pressure	7	2 9	22 6	51 6
	diabetes	2	8	6 5	58 1
	high cholesterol	1	4	3 2	61 3
	other	12	5 0	38 7	100 0
	Total	31	12 8	100 0	
Missing	missing	111	45 9		
	System	100	41 3		
	Total	211	87 2		
Total		242	100 0		

The 12 other conditions that was not provided in the table, are shown m the following chart, the most commonly cited condition was psychological attention (46% of responses)

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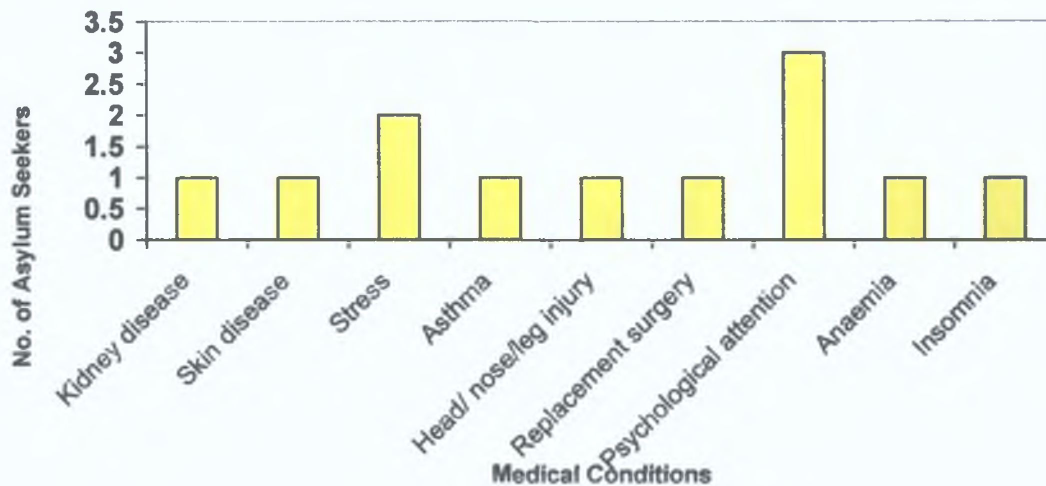
Table 4.6: Other Conditions Experienced



35.1% of respondents stated that they had received one or more serious injuries that interfered with their daily activities in the last two years. There is a statistical difference in the number of males (40.6%) who have received injuries in comparison to the proportion of females (25.3%). The majority of respondents said that they treated the injury themselves (48.4%), followed by 25.8% who received treatment by their G.P.. A report from the National Consultative Committee on Racism and Interculturalism (NCCRI) in 2006 states that, some G.P.s actively discourage patients from minority ethnic backgrounds in particular asylum seekers, from attending their surgeries (Donnellan, 2006).

Only 76% of respondents said that they had a health check in the last 3 years.
The respondents cited reasons such as little or no access in their home country (41.4% of responses), they did not want a health check (17.2%), and cited language difficulties as the reason for not having a health check.

Not having access to health services in a very 'real' and considerable barrier to health care for some populations. The researcher has chosen to detail the case in Africa, due to the large number of Africans seeking asylum in Ireland. 169 (70%) of

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the respondents in this study were of African origin. The following author has described the situation in Africa.

In Africa, the residential areas of target beneficiaries can be located a considerable distance from the health service facility, this is a factor relevant to the under utilisation of services "In the rural milieu, one medical centre may service a number of villages / hamlets that are spread around quite a vast area. It follows that seeking the service from this centre becomes a tedious task to the clients" (El Safty, 2001, p 6)

There are countless reasons why the respondents may not want to have their health checked, simply because they may perceive their health as being good, some may have suffered human abuses and may not feel comfortable disclosing this information to health practitioners Others may feel alienated from the health system in Ireland, depending on their culture and beliefs, going to a G P may be a bizarre occurrence as it was not the way of life for them previously According to El Safty (2001), the African family is both patriarchal and male dominated. Traditional the most favoured providers of health care are health barbers, herbalists, magic practitioners, and even priests from various religious backgrounds

"Cultural values and beliefs do influence and to a large extent, determine our health behaviours Knowledge is the prerequisite for developing cultural competence, the need to improve our understanding of different cultures other than our own is a moral as well as practical imperative" (Xu, 2004,p 435) The strong inter-relationship between cultures on one hand and the health status of the population on the other, creates an inseparable bond that it tightly intertwined and overlapping in such a way that it makes it impossible to understand one without the other (El Safty, 2001).

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Many people from ethnic communities have different cultural needs and belief systems than those of the indigenous population (Narayanasamy, 2002). Therefore health services in western society may not be appropriate for all cultures. Health care that is cognisant of their diverse cultural needs is a necessity in today's society (Cortis, 2003; Duffy, 2001; Holland & Hoggs, 2001, Price & Cortis, 2000, Fletcher, 1997) However, a number of authors some of whom are leaders in the field of transcultural health care have raised concerns that cultural healthcare needs of minority ethnic groups are not met adequately (Gerrish et al , 1996, Fletcher, 1997; Papadopoulos et al , 1998, Le Var , 1998, Gerrish & Papadopoulos, 1999, Foolchand, 2000, Price & Cortis, 2000, Duffy, 2001; Serrant-Green, 2001, Nairn et al , 2004) "There is the suggestion that further commitment to implement trans-cultural healthcare practice, based on research, will eradicate the existing anomalies in the healthcare provisions for people from the minority ethnic groups" (Narayanasamy, 2002, p 103)

Healthcare in the new millennium stresses teamwork. In order to improve client outcomes in today's multicultural society, it is imperative that all health professionals' work together to provide care that is culturally sensitive and competent "Cultural competence in today's borderless societies is not a luxury it is a necessity" (Purnell 2000, p 40)

"Valuing diversity in healthcare enhances the delivery and effectiveness of care, both physically and symbolically, health care providers need to address their personal views of traditional values, including biases and prejudices about other cultures and ethnic groups" (Zouch & Purnell, 2003,xxi) To achieve greater insight, health care professionals must strive to convey cultural knowledge and corresponding culturally understood attitudes and behaviours in their practices (Dogra & Karnik, 2003, Geiger, 2001; Klamath et al , 2003).

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Ensuring that services are accessible, and delivered in a way that is culturally sensitive to the diverse needs of immigrants, presents major challenges (Brehony & Clancy, 2006) Care for persons from other cultures must be consistent with the client's lifestyle and unique needs that have been communicated by the client (Geissler, 1991; Grossman, 1996), it is imperative that health professionals have an understanding of the subtleties and background of individuals (Collins, 2002).

"When migrants, refugees, or minority ethnic groups do not access existing services it is easier to assume that they have chosen not to use them rather than examine the appropriateness of what is offered" (Papadopoulos, 2006, p 28). Cultural differences are evident in providing care for this population (Murphy, 2001), however it is essential that health care professionals are aware of their own cultural values, in an effort to avoid cultural impositioning Cultural differences must be addressed by those providing healthcare services to asylum seekers

Authors such as Purnell (2000), Papadopoulos, (2006) and Leininger (2002) have documented the importance of delivering culturally sensitive and culturally competent care to individuals. Cultural Competence is essential for illness and disease prevention and effective interventions (Purnell, 2000)

Providing appropriate trans-cultural healthcare not only has the capacity to address human rights but also provides the opportunity for more effective and acceptable care. In essence, it promotes health (Papadopoulos, 2006). It is therefore important that all health professionals embrace the concept of transcultural health care "Although not all health education professionals at first view themselves as 'working in minority health', we need to appreciate the inescapable connectedness that we have to the issues related to race, ethnicity, and health. Whether we are site based, health or disease issue based or population based we have a responsibility to understand that there are many complex issues surrounding race, ethnicity, and health" (Gambescia, 2002, p 29)

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According to Papadopoulos (2006) ethnocentricity is the underlying cause why some health professionals fail to provide culturally appropriate services. Ethnocentricity assumes that people from other cultures find mainstream provision acceptable and effective Camphina –Bacote, (2002) warns that if health professionals fail to take into account or are unaware of their own cultural or professional values, there is a risk that they may engage in cultural imposition whereby there may be a tendency of an individual to impose their beliefs and values on another individual

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Chapter 5

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Chapter 5 The Health Behaviours of Asylum Seekers

Health refers to a state of wellbeing that is culturally defined (Naidoo & Wills), valued, and practiced and which reflects the ability of individuals or groups to perform their daily activities in culturally expressed, beneficial, and patterned life ways (Leininger, 1991)

The term health care behaviour is defined as the social and biological activities of an individual that are based on maintaining an acceptable health status or manipulating and altering an unacceptable condition (Bauwens & Anderson, 1988) Elling (1997) noted that health care behaviours influences health status, which in turn influences health care behaviour, both of which can be affected by socio cultural forces such as economic (Naidoo & Wills, 2000), politics, environmental influences (Dahlgren & Whitehead, 1991), and the health care delivery system itself.

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"Life is dangerous. In fact we all die from it. Although life affects both animals and humans, only the latter are aware of the seriousness of the condition and understand that certain health related behaviours increase their odds of dying prematurely" (Weitkunat & Moretti, 2005 p 19)

There a two approaches to healthcare that can affect the health status of individuals Keinman et al , (1978) acknowledges that the biomedical approach to healthcare is culture specific, culture bound and value laden However the biomedical model represents only one end of a continuum (Giger & Davidhizar 2004)

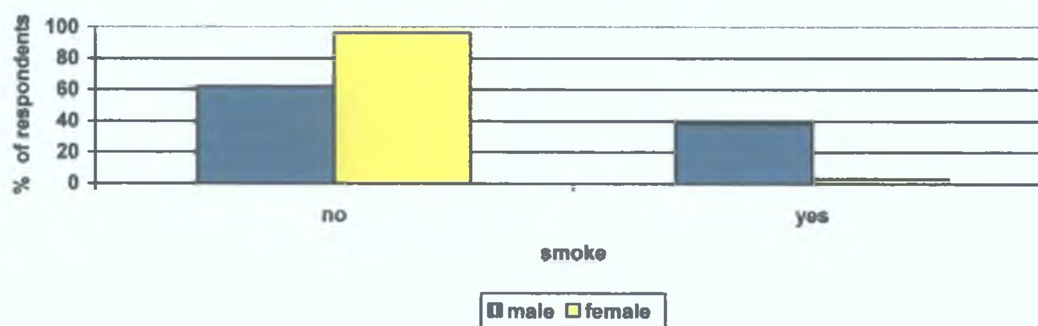
At the opposite end of the continuum is the traditional model. This model advocates popular beliefs and practices that diverge from medical science (El Safty, 2001). However, culture may also have an impact on their practices. Those who espouse to beliefs encompassed in the traditional model have varying health beliefs that are also shaped by culture (Specter 1996; Giger & Davishizar, 2002).

Some Muslim sects do not believe in prevention and thus are unwilling to perform the most basic health intervention and promotion activities. Taking active measures to prevent disease is thought to go against the wishes of Allah (Carneiro, 2000; Davidhizar & Giger, 2002).

Use of Tobacco

Authors such as Garner & White (2001) have identified that health related social habits show marked variations across ethnic groups. In relation to tobacco, 180 (74.4%) of the research participants said that they do not smoke compared to 62 (25.6%) who said that they do smoke. A chi-square test was performed. The Yates Correction for Continuity value is 33.247, the associated significance level is 0.000. This significance level is smaller than the alpha level of 0.05. This indicates that the proportion of males (38.1%) that smoke is significantly different to the proportion of females (3.4%) who smoke.

Fig 5.1: Proportion of males and females who smoke



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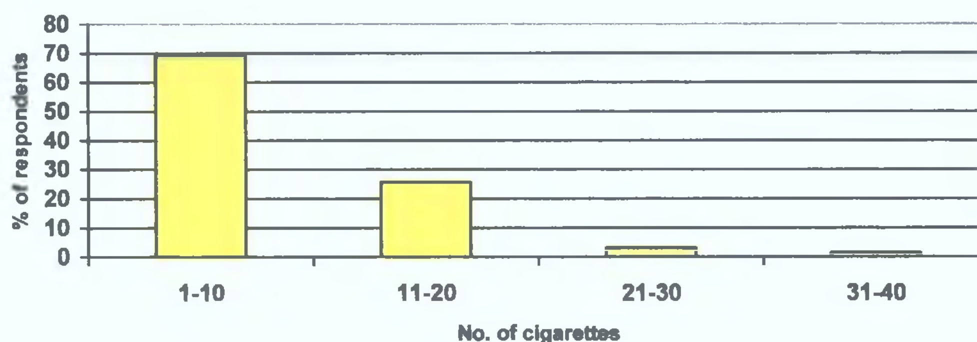
This figure is quite similar to the 27% of respondents in the SLAN survey who smoke cigarettes, however there is a significant difference in the percentage of males (38.1%) and females (3.4%) who smoke compared with (28%) of males and (26%) of females in the SLAN survey.

Fig 5.2; Average no. of cigarettes smoked per day



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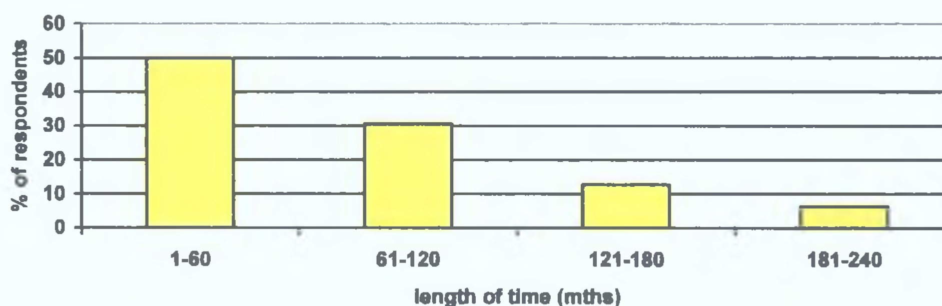
Of the 62 (25.6%) research participants who stated that they smoke cigarettes, the length of time that they have done so ranges from 2 months to 20 years, the majority have smoked for between 1-5 years. the average number of cigarettes smoked was 11.4. 19 participants smoke in excess of 10 per day.

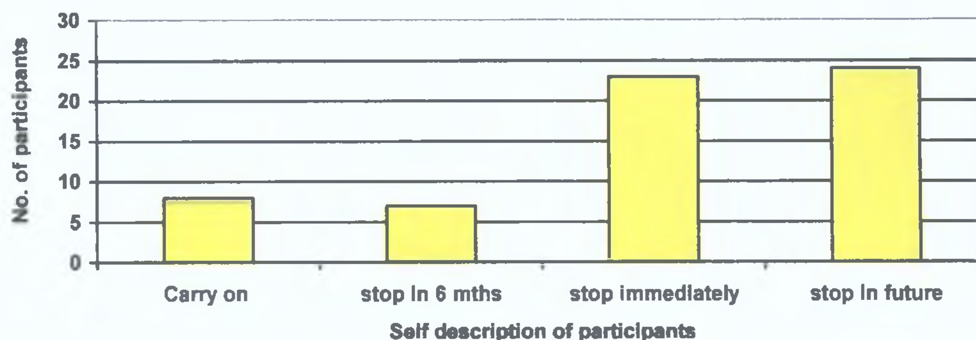
Fig 5.3: Length of time that the respondents have smoked



A predominant number (87.1% of responses) of asylum seekers expressed an interest in giving up smoking either immediately or in the near future. 23 (9.5%) participants

said that they would like to stop smoking immediately, a similar number 24 (9.9%) said that they would stop smoking at some stage in the future, only 8 (3.3%) participants said that they would like to carry on smoking.

Fig 5.4: Self description of participants



Alcohol Consumption

Garner & White (2001), in a study noted lower levels of alcohol consumption among members of ethnic minority groups. The majority of asylum seekers in this study stated that they have never consumed alcohol. 161 (66.5%) research participants said that they never drank alcohol beyond sips or tastes. Of those who do drink alcohol 38 (15.7%) said that they had their last alcoholic drink during the last week, while 8 (3.3%) said that they had their last alcoholic drink more than 12 months ago. Only 7% had consumed alcohol in the last month compared to 78% of respondents in the SLAN survey. 21.1% of asylum seekers drink alcohol on 1-2 occasions during the week compared to 57% of SLAN respondents. The average number of units consumed by asylum seekers is 10.

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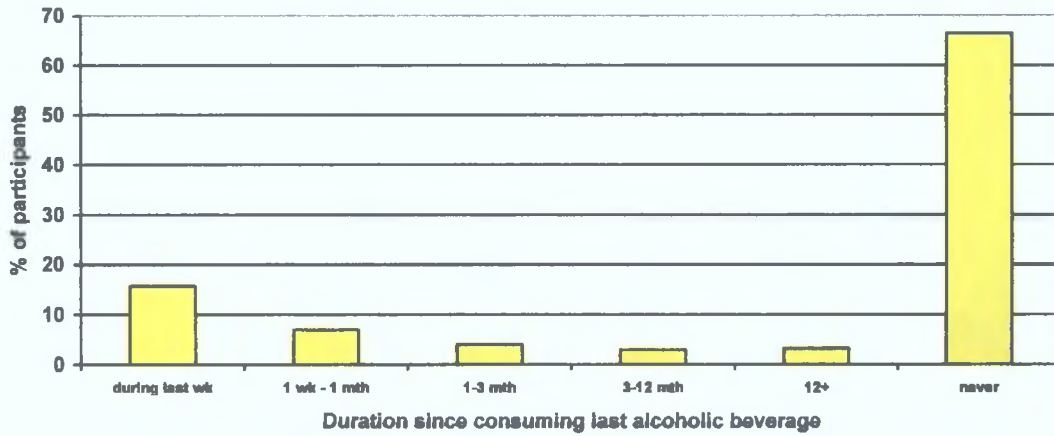
Fig 5.5: Length of time since consuming alcohol



The majority of those who consume alcohol, do so on 1-2 days of the week (21% of responses).

Fig 5.6: No. of days during the week that the respondents consume alcohol

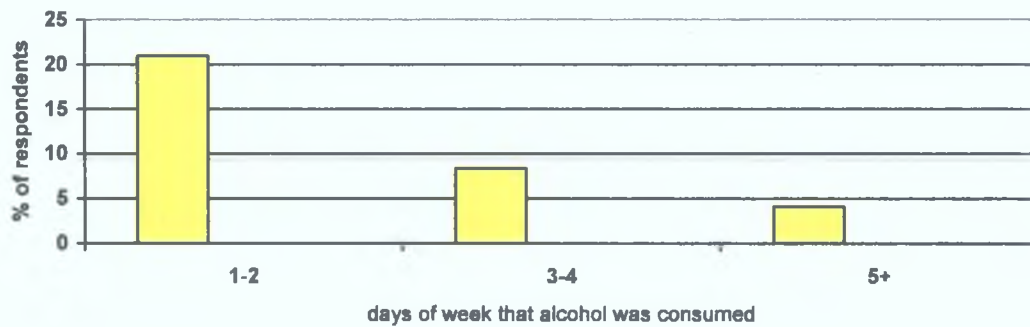
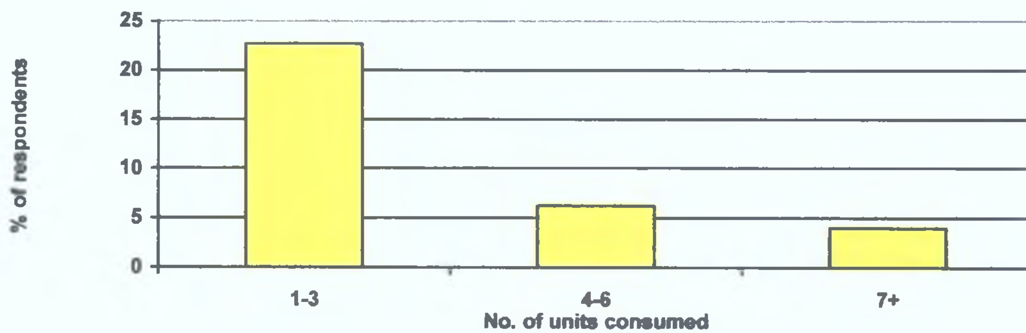


Fig 5.7: Average no. of units of alcohol consumed



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The average number of units consumed by participants was 3.4 units

It has been known for a long time that the lowest income groups are more likely to suffer negative effects of risky health behaviours than their less poor counterparts. "Maladaptive behaviours are not necessarily undertaken with a harmful intent, but may be regarded as coping behaviours to provide comfort or relief from stressful lives" (Murali & Oyebode, 2004, p.217). Maladaptive behaviours may also arise out of cultural beliefs Among Black people in South Africa, smoking is positively associated with socio economic status, whereas among white people the opposite is true (Marmot & Mustard, 1994).

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BMI of Participants

The participants ranged in weight from 50- 125kgs, and height from 1 22 -1 98 metres, the mean Body Mass Index (BMI) of the respondents was 26 This is a cause for concern , as a BMI of over 25 indicates that the individual is overweight, and this alone can give rise to an array of health concerns A raised BMI may be a result of the changes which have taken place in daily living for asylum seekers. Manandhar et al , (2006) noted that changes in the dietary behaviour of asylum seekers may impact on physical activity levels This in turn can exacerbating the problem of weight gain and rising body mass index

This table provides a summary of the height and weight of the research participants. The mean weight was 76.96 kgs The height of the participants ranged from 1 22 metres – 1 98 metres, the mean height was 1 72 metres

Table 5.1: Weight, Height & BMI of participants

	Weight in Kgs	Height in Metres	BMI
Mean	76 96	1 7212	26 1966
Median	75 50	1 7300	25 4314
Mode	70	1 78	24 80
Std Deviation	13 789	11345	5 59452
Range	75	76	48 86

An independent samples t-test was conducted to compare the weight of males and females There was no significant difference in results for males (M=78 24, SD =12 98), and females (M=74 88, SD=14 92), t=1.939 df= 240

The magnitude of the differences in the means was small (eta squared =0 015). This indicates that only 1.5% of the variance in the weight of participants is explained by gender

An independent samples t-test was conducted to compare the height of male and female participants The significance level for Levene's test is 0.041 The associated significance (2 tailed) value is 0 000. This suggests that there is a significant difference in the results for males (M=1 746, SD =0 1013), and females (M=1 6768, SD=0.1207); t =4 533, df= 154

The magnitude of the differences in the means was moderate (eta squared =0.07) This indicates that only 7% of the variance in the height of participants is explained by gender

"In general, the conclusions are that people vary in height because of race" (Giger & Davidhizar, 2004, p.137) According to Overfield (1995), individuals of higher socio economic status in all ethnic groups are taller Garn et al , (1989) noted that on

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average, obesity is more pronounced in the lower classes. Overall, the diets of poorer people are more likely to lead to poor health, including obesity, than the diets of the more affluent (Sharpe,2003, UK National Food Survey 1998; cited in Manandhar et al., 2006)

Physical Activity

An alarmingly high number of participants do not participate in physical activity. 105 (43.4%) respondents stated that they do not exercise at all, 14 (5.8%) exercise 4 times a week while 34(14.0%) exercise 7 times per week. However, even though the participants said that they do not participate in physical activity, the majority rated their daily lives as being fairly / very physically active (58.3% of responses).

Fig 5.8 : Percentage of participants who participate in P.A.

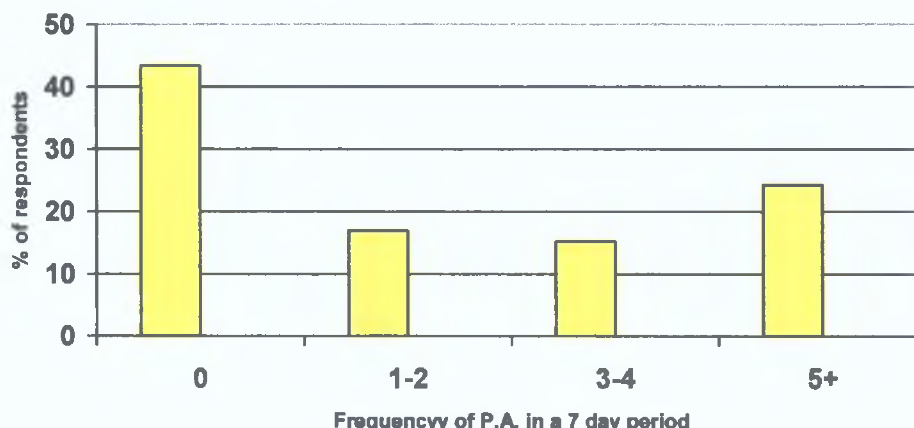

Table 5.2: Intensity of activities

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	very physically active	68	28.1	28.1	28.1
	fairly physically active	73	30.2	30.2	58.3
	not very physically active	60	24.8	24.8	83.1
	not at all physically active	41	16.9	16.9	100.0
	Total	242	100.0	100.0	

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The majority of research participants perceived themselves as being physically active, 68 (28.1%) respondents said that they were very physically active in their daily activities compared with 41 (16.9%) who said that they were not at all physically active

A chi-square test was conducted to determine if there was a significant statistical difference m the above variable for males and females. As this is not a 2 by 2 table, the pearson chi – square value was used to analyse the results. This value is 7 116, the associated significance value is 0 68 The significance value is larger than 0 05, indicating that there is not a significant difference in the results for males and females.

Childbirth & Breastfeeding

112 (46.3%) respondents said that they had children while 130 (53 7%) said that they didn't have any children Of the 112 (46 3%) respondents who said that they children; 41 (16.9%) had one child at the time of date of data collection, 43 (17.8%) had 2 children, 17 (7%) had 3 children, 5 (2 1%) had four children while 4 (1 7%) had 5 children while only I (0.4%) had 6 children along with 1 (0 4%) other research participant who had 7 children This question was not relevant to 130 participants as the did not have children during the research period

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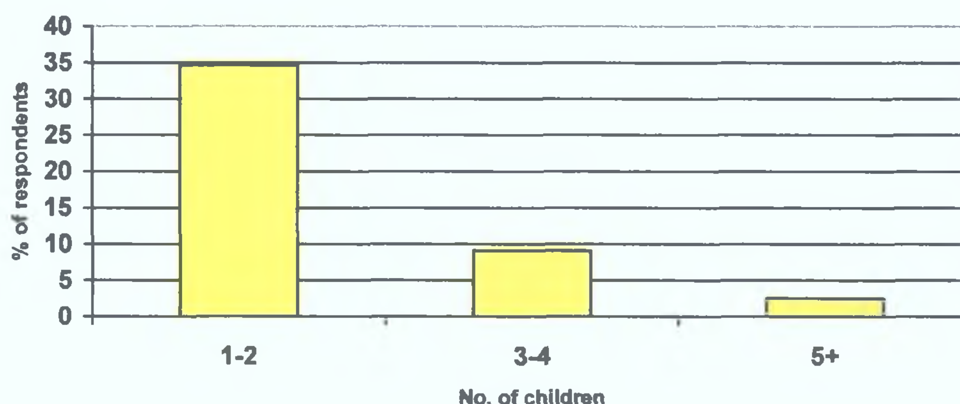
Fig.5.9: No. of Children



53 (21.9%) research participants had given birth to a baby since arriving in Ireland, while only 12 (5%) did not give birth to a baby since arriving in Ireland. This question was not relevant to 22 (9.1%) research participants as they do not have any children, 155 (64%) of the research participants were males and therefore this question was not relevant to them.

Table 5.3 : No. of respondents who have given birth to a baby since arriving in Ireland

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	53	21.9	81.5	81.5
	no	12	5.0	18.5	100.0
	Total	65	26.9	100.0	
Missing	Not Relevant - No Kids	22	9.1		
	Not Relevant - As Male	155	64.0		
	Total	177	73.1		
Total		242	100.0		

The asylum seeking community is a relatively young population, as a result considerable demands may be placed on paediatric, maternity and reproductive health services (Jones, 1999; Collins, 2002). In this study, 53(60.9%) respondents said that they had given birth to a baby since arriving in Ireland, all of these women

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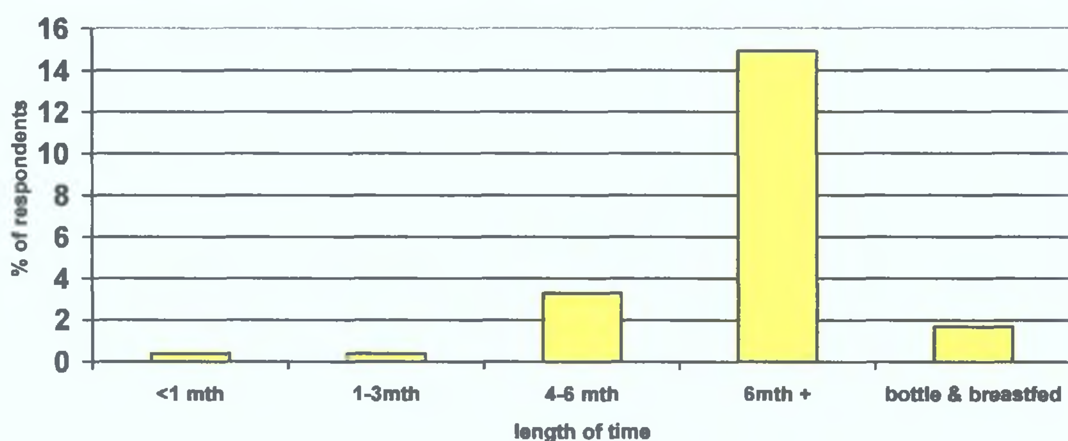
chose to give birth to their baby in hospital, none of the babies were born else where.12 (5%) women gave birth to babies that were born outside of Ireland, 22 (9.1%) participants in this study do not have any children.

Of the 53 (21.9%) research participants that gave birth to a baby since arriving in Ireland; 50 (94.3%) chose to breastfeed their baby compared to only 3 (5.7 %) who did not. The majority of mothers-36 who chose to breastfeed their last baby, chose to continue feeding for 6 months or more. Only 4 (1.7%) women both breast and bottle fed their child for the first 6 months.

Fig 5.10: Length of time that baby was breastfed only



Of the 53 women who breastfed their baby, only 25 (50%) continued to do so up until the baby was 12 months of age or older. 3 (1.2%) declined to disclose the age they stopped breastfeeding their baby at.

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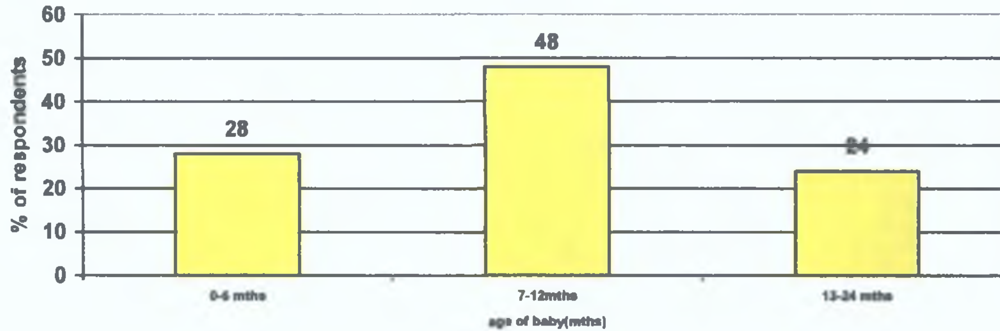
Fig 5.11: Age stopped breastfeeding baby



(Manandhar et al., 2006) in a recent study in the North West of Ireland found that breastfeeding is common among asylum seeking women in comparision to the very low prevalence of breastfeeding among Irish mothers . Victors et al., (2000) also noted that generally the prevalence of breastfeeding is often higher among lower socioeconomic groups. 94.3% of the fore mentioned breastfed their last baby, the majority, 36 (72%) breastfed their babies exclusively for six months or more. 13 (5.4%) of these women continued to do so for twelve months, only 4 (8%) mothers choose to bottle and breastfeed their babies for their first six months after birth.

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This figure is high in comparison to breastfeeding rates from a study conducted in the former North Western Health Board (N.W.H.B.) between 1998-2000, a total of 311 questionnaires were completed by women who were attending antenatal clinics in the N.W.H.B. region. Three separate questionnaires were used in the study; the first was completed by participants prior to the birth of their baby. Women who had successfully given birth were sent a second questionnaire approximately 6 weeks after the birth of their baby. Mothers who were still breastfeeding at this stage were invited to complete a third questionnaire when their baby was approximately four months old.

In the N.W.H.B. study the results of the second questionnaire show that only 17.9% (38) of females were still breastfeeding their baby, a further 6% were partially

breastfeedıng. This dropout rate is hıgh ın comparıson to the 4% of asylum seekıng women who chose to stop breastfeedıng theır babıes wıthın the first 3 months (2% - less than 1 month, 2% between 1-3 months).

Only 65 of the sample ın the N.W.H.B. breastfed their babies to stage 3 (baby was approxımately 4 months old), agaın thıs figure is low ın comparison to that of the asylum seekıng populatıon ın the north west (16% breastfed for between, 4-6 months, a further 72% contınued for 6 months or more).

The reason for the hıgh number of asylum seekers who breastfeed theır babıes may be due to cultural norms; formula milk may not be readıly available ın the respondents country of orıgın and as result breastfeedıng may have been the only method available Another possible reason ıs the cost of formula mılk ın Ireland Currently asylum seekers ın direct provısion are allocated a weekly allowance of baby food (formula and solıds) an allocatıon that is strıctly adhered to It is the responsıbılıty of each mother to ensure that thıs allowance lasts untıl the followıng week

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Chapter 6

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Chapter 6 Food choices of Asylum Seekers

The food choices and the context of eatıng for most new immigrants ın Ireland are quıte dıfferent to those of theır home country (Manandhar et al , 2006) Regardless of thıs dıfference 18.6% of the partıcıpants ın thıs study rated theır dıet as beın g excellent, a further 35 1% of respondents, rated their diet as beıng good, whıle only 1 12 respondents rated ıt as being faır / poor

"A category of dıfferences among cultural groups ıs nutritional preferences and deficıencıes. Nutrıtıonal preferences ınclude habits and patterns, when ıt comes to food choices people are creatures of habıt" (Zifferblatt et al , 1980, p 9).

A number of authors have suggested that ın some cultures food also has symbolic meanıng, that has nothıng to do wıth nutrıtıonal value In these cultures, eatıng becomes associated wıth sentıments and assumptıons about oneself and the world (Chang, 1974, Farb & Armelagos, 1980) Dıfferentıal access to food choıce ıs lınked to relatıons of power, control, and exclusıon (Burgess & Morrıson, 1998).

In most cultures food patterns develop ın early chıldhood as a result of cultural and family norms. These perceıved norms may ınclude cultural, socıal, relıgıous, economıc and psychologıcal components All of whıch may ınfluence an ındıvıduals feelıng about food Davıdhızar & Giger, (2004) noted that the paramount factors that seem to determıne food choıces are cultural and ethnıc ın nature

Accordıng to Wıllıams (1993) enforced change of dıet can contrıbute to what

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nutritional anthropologist have called 'cultural bereavement'. "Cultural bereavement and coping with 'deeply disruptive change' are widely shared experiences of migration, but refugees are distinguished from other migrants by their lack of choice" (Jones & Gill, 1998, p.142)

According to Manandhar et al , (2006, p 78) "the search for ethnic foods, with their associated familiar tastes, smells and textures, is a deep routed universal human need"

Giger & Davidhizar (2004) noted that established food habits can only be retained if the foods are available in the new location and are affordable (Davidhizar & Giger, 2004) In relation to asylum seekers, most studies report that asylum seekers living in the community are more satisfied with their foods because they have control over cooking more of what they like (Collins, 2002; Irish Refugee Council, 2001)

Under Direct Provision, three meals are provided daily, but many asylum seekers find it difficult to eat the food given to them. Food is generally prepared in advance by hostel staff and asylum seekers have little or no say as to what they prefer or are able to eat "The Irish diet, laden with meat and potatoes, often does not sit well with people accustomed to a range of foreign vegetables" (Hall, 2004, p.14) The result is that food has become a pressing issue for asylum seekers, some of whom are forced to use their weekly monetary allowance to purchase additional food (Free Legal Advice Centre, 2003). This can lead to a sense of powerlessness

In a study commissioned by the Irish Refugee Council, it was found that even though 92% of the asylum seekers who responded to the questionnaire maintained that it was necessary to purchase supplementary food stuffs in order to meet their dietary, and the needs of their families 62% of the respondents could not afford to do so (Fanning et al , 2001)

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Brehony & Clancy (2006) found that asylum seekers in the north west of Ireland were also forced to supplement their diets with their weekly income "The corollary to the food experiences in direct provision is that a proportion of asylum seekers end up eating out at an expense not readily affordable or missing meals altogether" (Manandhar et al , 2006, p 79)

Manandhar et al., (2006) suggested that the inadequate institutional and restrictive nature of food provision generally m direct provision centres, appear to have adverse nutritional effects of the residents Brehony & Clancy, (2006) also noted also that there is little in the way of fresh nutritious food and the lack of options is an issue If the food offered does not agree with them, they have no option but to supplement their diet using their own money

Only 67 (27 7%) respondents in this study reported taking vitamins, minerals or other food supplements in the last 12 months, compared to 175 (72 3%) who said that they did not consume any of the above. The results show that there was a significant difference in the proportion of males and females who consumed vitamins, minerals or other food supplements The results of the Yates Continuity Correction value is 9.720, the associated significance value is 0.02. The proportion of males (20.6%) that have taken vitamins, minerals or other food supplements during the last year is significantly different to the proportion of females (40 2%) who have consumed some It is the author's view that may also be a result of pregnancy and advice received from health professionals

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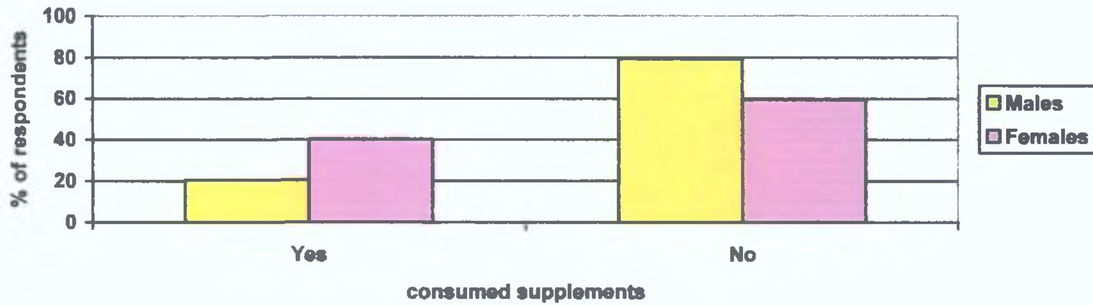
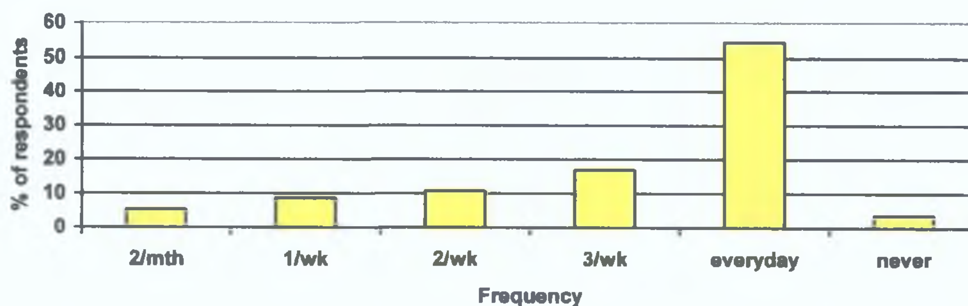
Fig 6.1: Percentage of males & females who consumed vitamins, minerals or other supplements in the last 12 months



The majority of respondents -132 (54.5%) stated that they consumed fried food on a daily basis, compared to 11% of SLAN respondents who reported consuming fried foods on 4+ times per week. 41 (16.9%) reported that they consumed fried food 3 times a week, followed by 26 (10.7%) who said that they consume fried food twice a week compared with only 9 (3.7%) respondents who said that they never consume fried food.

Fig 6.2: Frequency of fried food consumption



In relation to the food pyramid, there was significant deviation from the recommended daily serving guidelines in some of the food groups. It is recommended that individuals consume 5+ servings of fruit and vegetables per day

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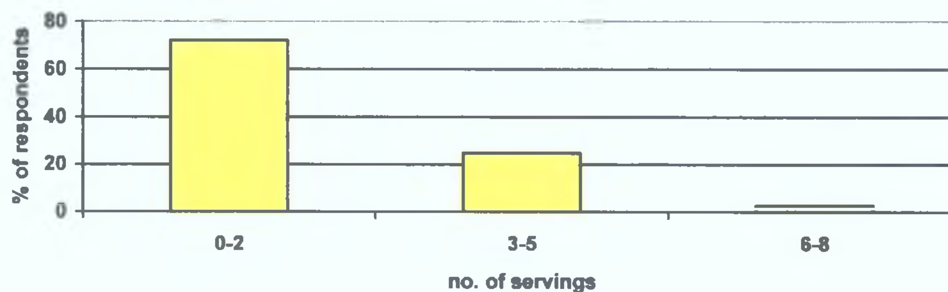
however only 15 (6.1%) research participants have stated that they follow these guidelines. Over 50% of the respondents consume 1-2 portions of fruit and vegetables on a daily basis. The average no of servings of fruit and vegetables consumed was 1.93. The number of respondents consuming the recommended portions of fruit and vegetables in SLAN was 69%. The recommended number of servings in 2002 was 4+ however, since then it has increased to 5+.

Fig 6.3: Servings of fruit and vegetables



The recommended consumption of dairy products on a daily basis is 3 servings. 93% of respondents consume within the recommended guidelines in relation to dairy products, comprising of 14.9% who consume the recommended 3 portions and 78.5% who consume less than 3. The average number of servings as shown above is 1.57. 61% of respondents in the SLAN survey consume within the recommended guidelines (29% consume 3 portions, 32% consume less than 3).

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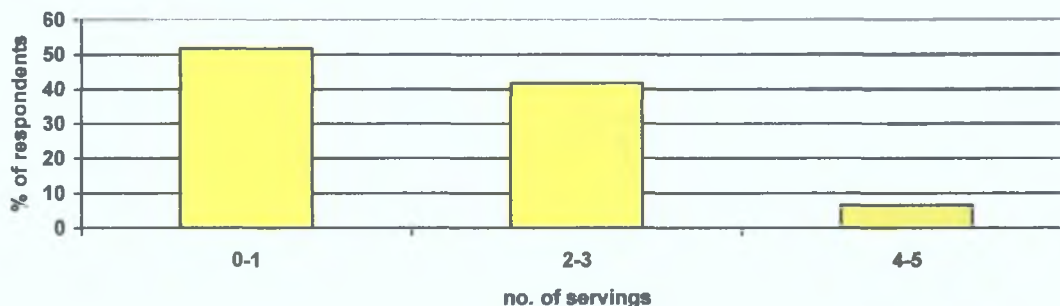
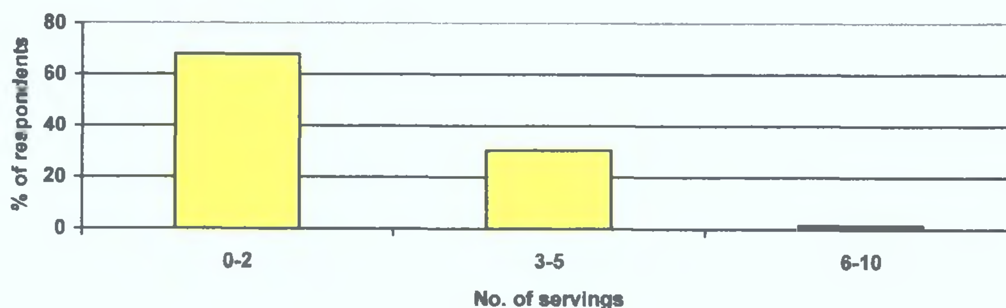
Fig 6.4: Servings of dairy products



The percentage of respondents consuming the recommended servings of meat and poultry on a daily basis is similar in both studies; 67.8% of asylum seekers (30.2% consume 1 portion, 33.1% consume 2 portions) compared with 61% of SLAN respondents (37% consume 2 portions, 23% consume less than 2 portions).

11 (4.5%) of the asylum seekers that participated in this study do not consume meat or poultry on a daily basis. However 67.8% of research participants report consuming within the recommended servings on a daily basis.73 (30.2%) consume 1 portion of the above on a daily basis, over one third- 80 (33.1%) of the respondents consume the recommended two servings of meat and poultry per day. The number consuming over the recommended number of portions starts to decrease going from 48 (19.8%) respondents eating 3 portions to only 1 (0.4%) consuming 10.

Fig 6.5: Servings of meat and poultry



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The average no. of servings consumed is 2.12

People in lower socio-economic groups tend to eat less fruit and vegetables and less food which is rich in dietary fibres, as a consequence they have lower intake of anti-oxidants and other vitamins and some minerals, than those in the higher socio-economic groups. (Colhoun et al., 1996; Ministry of Agriculture,1996; Department of Health,1989; Gregory et al., 1990; Gregory et al., 1995).

However, the majority of participants (75.6%) stay within the recommended guidelines, when consuming high fat/sugar foods, compared to only 17% of SLAN respondents. It is recommended that these foods are used sparingly. 55 (22.7%) respondents do not eat high fat or sugar foods on a daily basis, 69 (28.5%) eat 1 portion on a daily basis while 33 (13.6%) eat 2 portions, 26 (10.7%) of the research participants eat 3 portions of high fat food everyday, 28 (11.6%) eat 4 portions, this number starts to decrease for those eating 6+ portions of high fat or sugar foods with only 1 (0.4 %) person eating 10 or more portions on a daily basis.

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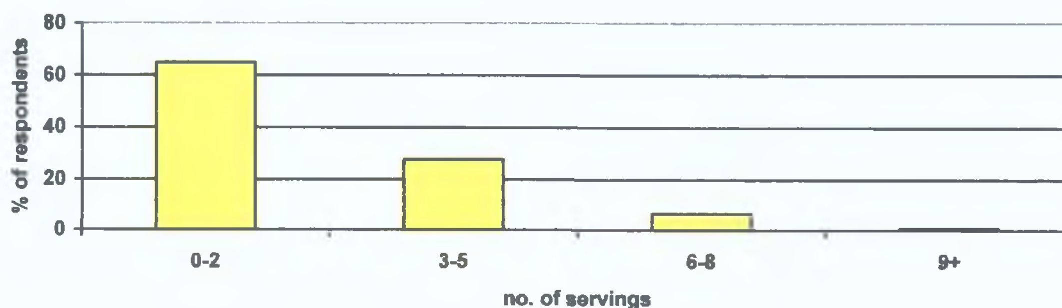
Fig 6.6: Servings of high fat / sugar foods



Criticism of the food choices of asylum seekers should not solely lie with this diverse group of people. Many authors have documented the lack of control that asylum seekers have over the food prepared in direct provision centres. The

researcher observed a token system in place in one direct provision system in the north west where each asylum seeker was presented with a token each week which entitled them to a couple of portions of fruit However the fruit portions allocated to each individual were well below daily consumption guidelines as outlined by the Dept. of Health and Children. The researcher feels that it is vitally important that all direct provision centres are monitored by Health Service Executive staff especially in the area of food provision as to date all issues related to food have so far being left to the Reception Integration Agency and the direct provision centre managers and staff.

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Chapter 7

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Chapter 7 Recommendations & Conclusion

7.1 Strengths of the Study

- This study is the first extensive grassroots study to provide a comprehensive profile of the health needs of asylum seekers in the HSE west and north west

- The questionnaire was translated into French, French was chosen as a result of the large number of west Africans seeking asylum in this country each year.

- All adult residents residing in each of the direct provision centres in the designated areas during the data collection phases were invited to apply, therefore reducing selection biases.

- Some of the asylum seekers who participated in this study were seeking asylum in Ireland for a considerable period, ranging from a couple of months to a couple of years and therefore had a substantial wealth of information and experience to disclose.

7.2 Limitations of the study

During the conductance of this piece of research, there were several factors which arose as possible limitations. These are outlined below:

- The main limitations of the study were language difficulties, the questionnaire was translated into French, but this was only a small step in

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overcoming this limitation as over 40 different nationalities participated in this research.

- There is a definite lack of published material in health care of asylum seekers. Although direct provision was introduced in 1999/2000 only a limited number of studies have been carried out to date both in Ireland and abroad. The author found it very difficult to access material that was specific to asylum seekers.

- The majority of questions were of a self-report nature and so the participants may have given what they perceive as socially acceptable responses.

- In hindsight, the researcher feels that as children make up a large percentage of the number of asylum seekers coming to Ireland, their views would have contributed significantly to the study.

- The researcher was given permission to enter the direct provision centres on the basis that they she would be accompanied by 'security' personnel, the researcher feels that the presence of whom may have deterred some asylum seekers from participating in the study.

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7.3 Reflection on Research

The author offers the following reflections:

- Direct provision centres were used to gain access to the asylum seeking community. These centres were used as they were the only source of contact available to the researcher. A snowballing technique was used for those residing in self-catering units, this didn't have a

successful outcome due to low response rates While the researcher holds strong opinions on the existence of direct provision centres, she was aware of these feelings from the start and did not let them interfere with the researcher Care was taken at all times to ensure that questions were asked in a standard format and to mask all of the researcher's feelings from the participants

- The author is also aware that the presence of security personnel may have had an impact on the research Every effort was made to minimize their presence The researcher explained the presence of the security personnel to the residents in a matter of fact way, so that their presence would not make the residents feel uneasy or impact on the research

- The researcher feels that the research was very worthwhile, the researcher got the opportunity to talk personally with all of the research participants The researcher is also very pleased with the high response rates from the direct provision centres

- The researcher is disappointed with the response from some of the managers of the direct provision centres Some of the managers did not put up posters in advance as requested, which may have resulted in some residents not knowing about the research

7.4 Recommendations

While the author would like to see the complete abolition of the direct provision system in Ireland, this is not likely to happen in the near future However in order to

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improve the health of asylum seekers who are currently in the system, it is imperative that a number of improvements are made immediately.

- All staff working with asylum seekers regardless of position should receive 'recognised'(HSE approved) training in the area of equality and anti racism. All training programs should be developed and run by Department of Health and Children staff and should be monitored closely by the Dept. of Justice Equality and Law Reform.

- The Health Service Executive should ensure that adequate and appropriate health care information, especially on how to access certain services should be translated into a range of languages and made available in direct provision centres.

- The Reception and Integration Agency (RIA) should implement standard guidelines in all direct provision centres in relation to the accommodation of asylum seekers. These guidelines should specify the appropriate number of occupants per room per square foot, and as a result avoid overcrowding. Where possible all residents who are not related to any other asylum seeker should receive private rooms.

- An independent complaint system should be set up to deal with any grievance that residents may have in relation to accommodation centres. Currently, if an asylum seeker feels the need to complain they must do so to the management of the centre. Some fear that if they do this, it will have a negative impact on their asylum application.

- All health care staff especially primary care staff should have the relevant training, experience, and confidence in providing culturally competent care.

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- Direct provision centres that provide accommodation to large numbers of asylum seekers, should have a full time G.P. on site, and childcare facilities.

- Kitchen Management staff in the direct provision centres should ensure that all food provided is culturally appropriate and provided at times that are convenient and suitable, taking into consideration the residents cultural beliefs, for example-periods of abstinence due to religious beliefs.

- All asylum seekers should receive adequate English classes that are culturally appropriate and accessible.

- More efforts should be made by the local community to involve asylum seekers in events, for example, parades and productions, as this may eliminate some of the social exclusion experienced by asylum seekers. All Irish citizens should make an effort to follow this recommendation. Especially those who are leaders of organisations for example; Sligo LEADER, Mayo Intercultural Action group (MIA) etc.

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7.5 Conclusion

There is no doubt that the demographic profile of Irish societies has changed considerably in recent years, what was considered primarily as a country of out migration, is now home to a diverse international community. While these changes have brought about many benefits, they also present challenges for our country, especially in terms of health care and service provision.

In the case of asylum seekers, migration is not just about moving from one country to another. Many have had to flee their homes in fear of their lives and that of their children, for reasons such as torture, violence and human rights abuses and in some

cases they have left loved ones behind This experience alone can give rise to an array of health issues

Asylum seekers are also faced with the challenge of resettling in a foreign country. For the majority of asylum seekers this transition is not an easy one. Not alone are they audibly and visibly different from the indigenous population, some also have the added disadvantage that they do not speak the language of their new country

Communication difficulties are a major barrier that not only affect the asylum seekers integrating into Irish society but also can have a detrimental impact on their health. Without the ability to access and interpret information concerning health care and service provision, asylum seekers may find themselves disadvantaged m relation to their health Sixty participants m this study said that they experienced difficulties m making appointments with Irish health professionals.

It is essential that health professionals embrace the concepts of cultural competent care A recurrent theme in recent research is the lack of awareness of asylum seekers in accessing health services and health information Every effort should be made by health agencies to develop multilingual health leaflets and information posters It is also essential that health care providers review their current health services regarding all immigrants, just because they provide a dedicated service to one particular group this does not necessarily mean that it is appropriate for multi-cultural use This alone can present major challenges for health providers

Regardless of the magnitude of this challenge, it is vital that all health workers embrace the concepts of cultural competence and cultural sensitivity in their practices Culture generic services are no longer acceptable, cultural competence must be seen as a moral requirement for all health care professionals

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Appendices

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Appendix 1 : Definition of terms

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Definition of common terms used throughout this Study

(As outlined by the Irish Refugee Council, 2002)

Temporary Residence Certificate

Once an individual has made an application for asylum, he / she will be issued with a Temporary Residency Certificate. The Temporary Residency Certificate will have the following on it;

- A photograph of the individual
- The nationality and gender of the person to whom it was given
- The date of issue and expiry
- A statement that the certificate is the property of the Minister for Justice, Equality, and Law Reform.

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Family Reunification

If an individual is recognised as a refugee, he/ she can apply for certain members of his/her family to enter and reside in Ireland, Section 18(1). A 'member of family' means:

- The spouse of a refugee
- The parents of a refugee who is under 18 years of age
- The unmarried children of a refugee who are under the age of 18 years

Refugees can also make an application for a 'dependent member of their family' to come and live with them in Ireland, under Section 18(4). A 'dependent member of the family' is defined as any 'grandparent, parent, brother, sister, child grandchild, ward or guardian of the refugee who is dependent on the refugee or who is suffering from a mental or physical disability to such an extent that it is not reasonable for him or her to maintain himself / herself fully'.

Separated Children

If an individual under the age of 18 years arrives in Ireland and is not in custody of any person, the immigration officer or an authorised officer (Refugee Applications Commissioner) will inform the local Health Service Executive where the child arrived, Section 8 (5) It is then up to the Health Service Executive to decide whether or not the child should make an application for asylum

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Voluntary Return

An asylum applicant can agree to voluntarily return to his/her country of origin at any stage during the asylum procedure The International Organisation for Migration (IOM) operates a voluntary return programme in which they pay individuals to travel back to their home country.

Deportation (as per the Immigration Act 1999)

If an individual receives a deportation letter, he /she have three options·

- An individual can make representation to the Minister for Justice Equality and Law Reform within 15 working days setting out why he or she should not be deported (Immigration Act 1999, Section 3(3) (b)).

- An individual can agree to voluntarily leave the country he /she must inform the Minister of his/her decision within 15 working days. The individual will then be given time to organise his/her travel If an individual voluntarily

agrees to leave the country, he/she will have to pay for his/her own travel back to their country of origin.

- An individual can agree to the making of a deportation order within 15 working days. If he or she agrees to the making of a deportation order, the Government will pay for his/her travel, but it will be marked on his her passport that he/she was deported from Ireland (Immigration Act 1999 Section 3 (4) (c))

If an individual consents to the making of a deportation order, and the order is not carried out by the State within 3 months, the deportation order will cease to have effect, although another order can be issued Immigration Act 1999 Section3 (8)

Asylum Questionnaire

Once an individual has made an application for recognition as a refugee, he / she will have to fill in an Asylum Questionnaire, and this must be returned to the Refugee Applications Commissioner within 14 working days (This document is a legal document and the information provided in it will be used as a major part of the decision made by the Refugee Applications Commissioner The Asylum Questionnaire is a complex document, and asylum applicants should always seek legal advice before completing the questionnaire)

Reception

Reception occurs in the first country of origin (Ager, 1999). This is often a neighboring country and the first 'safe haven' might be a refugee camp. Camps are often near the borders of the countries from which asylum seekers flee (Taylor, 2006)

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Poverty Proofing

Poverty- proofing was introduced, in July 1998 as part of the National Anti-Poverty Strategy (NAPs), it is a process whereby all government departments are required to systematically examine all policies and programmes in order to access their impact on poverty and inequality (Free Legal Advice Centre, 2003)

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Appendix 2: Support Services

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Access Ireland
Refugee Social Integration Project
Dominick Court
40/41 Dominick Street Lower
Dublin 1

Tel: 01 878 0589
Fax: 01 878 0591
Email: info@accessireland.ie
Website: www.accessireland.ie

Cairde
19 Belvedere Place *(off Mountjoy Square)*
Dublin 1

Tel: 01 855 2111
Fax: 01 855 2089
Email: info@cairde.ie
Website: www.cairde.ie

Free Legal Advice Centres (FLAC)
13 Lower Dorset Street
Dublin 1

Tel: 01 874 5690
Fax: 01 874 5320
Email: info@flac.ie
Website: www.flac.ie

Galway Refugee Support group
3 The Plaza
Headford Road
Galway

Tel: 091 779083
Email: refugee.galway@ireland.com

Immigrant Council of Ireland
2 St.Andrew Street
Dublin 2

Tel: 01 674 0200
Fax: 01 645 8031
Email: info@immigrantcouncil.ie
Website: www.immigrantcouncil.ie

Integrating Ireland
c/o Comhlámh
10 Upper Camden Street
Dublin 2

Tel: 01 478 3490
Fax: 01 478 3738
Email: info@integratingireland.ie
Website: www.integratingireland.ie

Irish Refugee Council (IRC)
88 Capel Street
Dublin 1

Tel: 01 873 0042
Fax: 01 873 0088
Email: refugee@iol.ie
Website: www.irishrefugeecouncil.ie

Mayo Intercultural Action (MIA)
c/o 60 Glenfort
Castlebar
Co. Mayo

Tel: 086 3483414
Email: miamayo@eircom.net

Migrant Rights Centre of Ireland (MRCI)
55 Parnell Square West
Dublin 1

Tel: 01 889 7570
Fax: 01 889 75 79
Email: info@mrci.ie
Website: www.mrci.ie

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Appendix 3: Black Report

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The Black Report

Concerns with inequalities in health reached national and international consciousness in the 1970. They were emphasised in the 1978 Alma – Ata and were the focus of the Black Report (Elliot et al , 2005)

The issue of socio economic inequalities in health came to international prominence in Britain in 1980 with the publication of the Black report, which outlined the growing divergence in health status between different socioeconomic groups (Burke, 2001) The Black Report found that in the United Kingdom people on low incomes had death rates two or three times higher than those of the better off classes and that the gap was widening (Black Report, 1980). The concept that deprivation and ill health were linked was not new but the black report produced convincing evidence that poverty and ill health were extricably linked and that material deprivation was a major determinant of ill health and death (Elliot et al , 2005)

Similar differences in death rates between the lowest and highest socioeconomic groups have been found in the 1990s in Ireland (Balanda et al., 1998) The Black Report made 37 recommendations for tackling inequalities among them that national health goals should be set, it also suggested that, measures should be put in place to tackle diet, smoking, alcohol and physical inactivity (Elliot et al., 2005). The social partnership agreement Sustaining Progress commits governments and the social partners to the building of a fair and inclusive society and to ensure that the people have the resources and opportunities to live life with dignity and have access to quality public services that underpin life chances and experiences (Sustaining Progress, 2003-2005)

The Black Report (Townsend, Davidson and Whitehead, 1988) identified four different strategies for examining class inequalities in health. These are commonly referred to as artefact, social selection, and materialist and cultural / behavioural theories They include, (Black Report, 1988)

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- Artefact theory asserts that the apparent relationship between class and health is spurious.

- Social Selection- these explanations are based on the assumption that people who enjoy good health are more likely to experience an upward social mobility than those who experience poor health are unlikely to hold down well paid employment and as a consequence are liable to move downwards in the class hierarchy.

- Materialist Explanations - Material differences between social classes such as housing, diet and working environment are the key determinants of inequalities of health. Links between low income and health are simple but can be devastating. Poverty affects the health of whole families and households (Benzeval et al., 1995). Unemployment, which is more prevalent among manual workers, contributes to class inequalities in health.

- Cultural / Behavioural Theories – these theorists focus on class differences in health beliefs and health behaviors (Taylor, 1997). It is believed that those in less skilled employment such as manual jobs perceive good health as the absence of disruptive symptoms, while in contrast professional people perceive health more positively on a broader scope.

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Appendix 4 : Research Packs

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INSTITUTE OF TECHNOLOGY, SLIGO

Institiúid Teicneolaíochta, Sligeach

Institute of Technology Sligo, Health Services Research

Re: Establishment of the Health Needs of Asylum Seekers in the Health Service Executive North West area.

Dear Respondent,

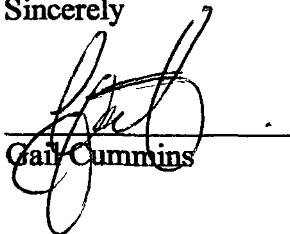
My name is Gail Cummins; I am a researcher in the Institute of Technology Sligo. I will be carrying out research with asylum seekers over the next 12months.I am inviting you participate in a research project to study the health related behaviours of asylum seekers in the HSE NW Please find enclosed a short questionnaire that asks a variety of questions about you, your health and your lifestyle.

The results of this questionnaire will be used to gain a greater understanding of the actual health and lifestyle needs of asylum seekers and in turn plan and develop health services and facilities which can cater for your needs.

I guarantee that your responses will not be identified with you personally as you will not have to fill in any personal details on this questionnaire, such as name and identity number I hope you will take the time to complete this questionnaire and return it Your participation is voluntary, you are under no obligation to take part in this research and you can withdraw consent to participate at any stage.

If you have any questions or concerns about completing the questionnaire or about being in this study, you may contact me at the following number 071-9155414. This project has been approved by the Health Services Review Board at The Institute of Technology Sligo.

Sincerely



Gail Cummins

IT Sligo An Institiúid Teicneolaíochta, Sligeach

Ballinode, Sligo, Ireland. Tel: +353 71 55222 Fax: +353 71 44096 E-mail: lastname.firstname@itsligo.ie

INSTITUTE OF TECHNOLOGY, SLIGO
Institiúid Teicneolaíochta, Sligeach
SLIGEAC

Establishment of the Health Needs of Asylum Seekers in the Health Services Executive North West and West area

---

I agree to participate in the research as outlined by Gail Cummins I am aware that I am under no obligation to participate and that I can withdraw consent to participate at any stage

I have read the attached form outlining the research and agree to participate in this study.

ITSligo An Institiúid Teicneolaíochta, Sligeach

Signed ______________________

Name ______________________

Ballinode, Sligo, Ireland Tel: +353-71-55222 Fax: +353-71-44096 E-mail: lastname.firstname@itsligo.ie

IDNO ......CNO . ...

Health Behaviour Questionnaire

Some Information about Yourself

- **Are you** Male ☐ or Female ☐
- **What is your country of birth?** ________________
- **What age are you?** ________________years
- **What county do you reside in?**
  Sligo ☐ Leitrim ☐ Donegal ☐ West Cavan ☐ Galway ☐
  Mayo ☐ Roscommon ☐
- **Do you live in?** (Please tick only one)
  Direct provision accommodation centre with other asylum seekers ☐
  Self catering accommodation ☐
  Other ☐ please specify________________________
- **How long have you been living in Ireland for?** _________ Years ________ months
- **Do you have experience in making appointments with health professionals?** Yes☐ No☐

  If yes do you have any difficulties /problems in making appointments with these health professionals? (doctors /nurses etc) Yes ☐ No ☐

  If yes, what is the problem? ______________________________

You and Your Health

1. **In general, would you say your health is?**
   Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor ☐

2. **How would you rate your quality of life?**
   Very good ☐ Good ☐ Neither poor nor good ☐ Poor ☐ Very poor☐

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3. **I think that my own health would be better if I had................**
(Please tick which 3 you think are the most important)

Better information about where to go for health care	
Better information about how to stay healthy	
Change in my weight	
More will power	
Less stress	
More money	
Fewer changes in my life	
Regular checks from my family doctor	
Employment	
Less alcohol	
Other please specify below	

Other..

4. **Where do you get your information about health?**
(Please tick all that apply)
GP /doctor☐ Health organisation ☐ Media – TV/Radio /Paper ☐
Department of Health and Children ☐ other health professional ☐
Other ☐ please specify ....
....

5. **Are you currently registered with a doctor in Ireland?**
Yes ☐ No☐

6. **Have you had a health check / health screening in the last three years?**
Yes ☐ No ☐
If no why was this?............................ ....
....

7. **Have you availed of any of the following health services since you arrived in Ireland?** (Please tick all that apply)

Doctor /GP practice		Optician	
Chemist for advice		Dentist	
Family Planning Services		Counsellor	
Hospital in-patient services		Hospital out-patient services	
Other, please specify below			

Other...................... ....

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8. Have you ever been told by a doctor that you have any of the following?

Angina /chest pain		Heart disease	
High blood pressure		Diabetes	
High cholesterol		Other please specify below	

Other..

9. What is your weight without clothes .... stone......... pounds / Kg.........

10. What is your height without shoes............ feet ....inches / Mtr............

11. When was the last time that you had your blood pressure checked?

Up to 3 months ago	
Up to 6 months ago	
Up to 1 year ago	
Up to 3 years ago	
Never	

12. What is your level of blood pressure?
High☐ Normal☐ Low☐ Don't know☐

13. Do you have any children? *(If you answer No, please skip to question 18)*
Yes☐ No ☐ Number of children_____

14. Did you give birth to a baby since arriving in Ireland?
Yes ☐ No☐

15. Where was your baby born?
In hospital ☐ In your home☐ Other please specify.................

Was this your choice? Yes☐ No☐

16. Did you breastfeed your last child? Yes ☐ No☐

If yes how long did you breastfeed only for? (Please tick only one box)

Less than 1 month	
1-3 months	
4-6 months	
6 months or more	
I breast and bottle fed my last child for the first six months	

17. At what age did you stop breastfeeding your last child at?............. months

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Lifestyle choices

18. How often do you participate in physical activity/exercise in a 7 day period?

....

19. With regard to your average daily activities, would you say that you are....

Very physically active ☐
Fairly physically active ☐
Not very physically active ☐
Not at all physically active ☐

20. Do you smoke cigarettes now? No☐ Yes☐
(If no please skip to question 24)

21. How many cigarettes would you smoke on average per day? .. .. .

22. How many years have you smoked for?.. ....years

23. Which describes you? I want to......

Carry on smoking		Stop smoking immediately	
Stop smoking in the next 6 months		Stop smoking at some stage in the future	

24. How long ago did you last have an alcoholic drink?

During the last week	
1 week to 1 month ago	
1 month to 3 months ago	
3 months to 12 months ago	
More than 12 months ago	
Never drank alcohol beyond sips or tastes	

25. On how many days during the week do you usually drink alcohol ?.. .... .days

26. On the days that you drank alcohol, how many units did you have on average?

If 1 unit is =

- A half pint / glass of beer, larger, stout or cider
- 1 measure of spirit –whiskey , rum, vodka
- 1 glass of wine, sherry port

No. of units. ......

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27. How would you rate your diet?
Excellent ☐ Very Good☐ Good ☐ Fair☐ Poor☐

28. Have you taken any vitamins, minerals or other food supplements during the last year? Yes☐ No☐

29. How often do you eat fried foods?

Never	
Twice a month	
Once a week	
Twice a week	
Three times a week	
Everyday	

30. Do you eat the recommended daily intake of the following foods?

How many pieces of fruit and vegetables do you eat on a daily basis?
. ... pieces
How many servings of dairy products do you eat on a daily basis?
....................servings
How many servings of meat and poultry do you eat on a daily basis?
....servings
How many servings of high fat / sugar foods do you eat on a daily basis?
....................servings

31. In the last two years have you had one or more injuries serious enough to interfere with your daily activities? Yes ☐ No ☐
The injury was treated by....

Myself	
GP service	
Family /Friends	
Hospital accident and emergency	
Hospital Outpatients	
Other please specify below	

Other.......................... ....

Thank you for taking the time to fill out this questionnaire, all information supplied will remain confidential.

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Health Behaviours of Asylum Seekers

A study on the health behaviours of asylum seekers is currently being undertaken, all asylum seekers who are resident in this centre are invited to participate.

Information sheets are available at reception, from the Family Support worker or by contacting Gail Cummins on 071-9155414

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Establishment of the Health Behaviours of Asylum Seekers in the Health Service Executive West & North West area

---

Dear Sir/Madam

My name is Gail Cummins. I am a postgraduate in the Institute of Technology Sligo. I am currently conducting research on the health behaviours of asylum seekers .This study will explore health behaviours in relation to diet and nutrition, alcohol consumption, tobacco use, physical activity.

The study also aims to compile a profile of the asylum seeking community in the Health Service Executive west and north west area and to identify the key barriers that asylum seekers face in accessing Irish health services.

As you are probably aware, your centre is located in the designated research area.I would be grateful if you would agree to allow me to enter your centre to meet with the asylum seeking community.

If you have any queries please do not hesitate to contact me at the following number 071-9155414

Sincerely

____

Gail Cummins

IT Sligo
An Institiúid Teicneolaíochta, Sligeach

IDNO CNO .... ..

Questionnaire sur le comportement envers la sante

Details Personnels

- **Vous etes** Homme ou Femme
- **Dans quel pays etes-vous ne?** ________________
- **Quel age avez-vous?** _______________ans
- **Dans quel comte vivez vous?**
  Sligo Leitrim Donegal West Cavan
- **Où vivez vous? (un seul choix)**
  Logement social pour demandeur d'asile
  Logement personnel indépendant
  Autres spécifiez_______________________
- **Depuis combien ?** _________ années ________ mois
- **Avez-vous deja contacte personnellement et pris rendez-vous avec un professionnel de la sante?** Oui Non

  Si oui, Avez-vous rencontre des difficultés? Oui Non

  Si oui, lesquels? _____________________________

Vous et votre Santé

1. **En général, vous considérer votre santé?**
   Excellente très bonne bonne normale mauvaise

2. **Comment est votre qualité de vie?**
   très bonne bonne ni bonne ni mauvaise mauvaise très mauvaise

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3. **Je pense que ma santé serait meilleure avec :… . . …….**
(Choisissez les 3 choix les plus importants)

Meilleure information pour savoir ou aller se faire soigner	
Meilleur information pour savoir comment rester en bonne santé	
Changement de poids	
Une plus grande motivation	
Moins de stress	
Plus d'argent	
Moins de changement important dans ma vie	
Des entretiens réguliers avec mon médecin de famille	
Un emploi	
Moins d'alcool	
Autre (spécifiez ci-dessous)	

Autre …. . . .. . . …… . . ..

4. **Ou vous informez vous sur la santé ?** (Choisissez tout les choix applicables)
Médecin/docteur Organisations de santé Media-TV/ radio/paper
Département de la Santé et des Enfants (ministère)
Autres profession de la santé Autres
spécifiez… ………. ……………. . .

5. **Etes-vous inscrit chez un médecin irlandais?**
Oui Non

6. **Avez vous été examine par un médecin durant les 3 dernières années ?**
Oui Non
Si non, pourquoi? ... .

7. **Etes-vous déjà allé dans un des organismes suivants?** (choisissez tout ceux qui s'appliquent)

Médecin/docteur		Opticien	
Pharmacien pour conseil		Dentiste	
Services pour conseil familial*		Assistant(e) social(e)	
Hôpital (lit, opération)		Hôpital (simple contrôle : radio)	
Autres, spécifiez ci-dessous			

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* *conseil pour contraception, avortement*
Autre. . . . .

8. Avez-vous été diagnostiqué pour les conditions suivantes?

Angine		Maladie du coeur	
Pression sanguine élevée		Diabète	
Cholestérol élevé		Autres, spécifiez ci dessous	

Autre ....

9. Quel est votre poids (sans vêtement) . .... . stone .... pounds /
Kg .. .

10. Quelle est votre taille (sans chaussure) . . pieds ... ..pouces
/Mètres . .

11. Quand vous etes vous fait prendre votre tension la dernière fois?

Moins de 3 mois	
Moins de 6 mois	
Moins de 1 an	
Moins de 3 ans	
Jamais	

12. Comment est votre pression sanguine?
Elevée Normale basse ne sait pas

13. Avez-vous des enfants, combien? *Si non, passez a la question 21*
Oui Non nombre d'enfants_____

14. Avez-vous donne naissance à un enfant depuis votre arrivée en Irlande?
Oui Non

15. Où est ne votre enfant?
A la maternité Dans votre maison autres, spécifiez .

Est-ce que cela était votre décision? Oui Non

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16. Est-ce que vous donnez le sein à votre dernier enfant? oui Non

Si oui depuis combien de temps? (Un seul choix possible)

Moins d'1 mois	
Entre 1-3 mois	
4-6 mois	
Plus de 6 mois	
J'ai donné le sein et le biberon pendant les 6 premiers mois	

17. Quel age avait votre enfant quand vous avez arrete de lui donner le sein?.............. months

---

Choix de Vie

18. Combien de fois par semaine faites vous de l'exercice?..

19. En considérant vos activités journalières, vous vous considérez :
Très actif physiquement
Plutôt actif physiquement
Pas très actif physiquement
Pas du tout actif physiquement

20. Est-ce que vous fumez des cigarettes (en ce moment) ? Non Oui
(si non, passez a la question 24)

21. Combien de cigarettes par jour fumez vous en moyenne?..........

22. Depuis combien d'années etes-vous fumeur?..........années

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23. Lequel choix vous correspond le mieux ? Je veux……

Continuer de fumer		M'arrêter tout de suite	
M'arrêter d'ici 6 mois		M'arrêter dans l 'avenir	

24. Quand était la dernière fois ou vous avez bu une boisson alcoolisee?

Dans la semaine passee	
Dans le mois passe	
Entre 1 mois et 3 mois	
Entre 3 mois et 1 an	
Il y a plus d'1 an	
Jamais bu d'alcool (a part pour goûter ..)	

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25. En moyenne combien de jour dans la semaine buvez vous ? .... .jours

26. Les jours ou vous buvez, en moyenne combien buvez vous (en unite d'alcool)?

Si 1 unite represente =

- ½ pinte / verre de biere : blonde , brune, stout ou cidre
- 1 mesure de spiritueux : whisky, vodka, rhum..
- 1 verre de vin ou de liqueur
- No of units

27. Comment considerer vous votre nutrition?

Excellente tres bonne bonne normale mauvaise

28. Avez-vous pris des vitamines, mineraux et autres supplements nutritifs?
Oui Non

29. Combien de fois manger vous des fritures ?

Jamais	
2 fois par mois	
1 fois par semaine	
2 fois par semaine	
3 fois par semaine	
Tout les jours	

30. Combien de ces produits consommez-vous chaque jours?

Fruits et légumes .... portions/jour
Produits laitiers....... . .. .portions/jour
Viande et volailles . . . . portions/jour
Produits a Haute teneur en graisse / sucre portions/jour

31. Dans les 2 dernières années, avez-vous eu 1 ou plusieurs blessures suffisamment sérieuses pour compromettre vos activités journalières? Oui
Non

La blessure a été soignée par....

Moi-meme	
Le medecin	
Famille/ami	
Urgences de l'hopital	
Les services de l'Hopital	
Autres, specifiez ci-dessous	

Other . . ..

Merci D'avoir répondu a ce questionnaire, toutes informations fournies sont et resteront confidentielles

IT Sligo An Institiúid Teicneolaíochta, Sligeach

Institute of Technology Sligo, Health Services Research

Re: L'établissement des besoins de santé des demandeurs d'asile dans les Services Exécutifs Sanitaire du Nord Ouest (HSENW)

Cher repondant,

Mon nom est Gail Cummins; J'entreprends mes recherches à l'Institut de Technology de Sligo. Je vais conduire mes recherches sur les demandeurs d'asile dans les 12 prochains mois Je vous invite à participer à ce projet de recherche afin de déterminer les comportements envers la santé des demandeurs d'asile dans le HSE NW Vous trouverez ci-joint un questionnaire vous concernant, ainsi que votre santé et votre style de vie

Les résultats de ce questionnaire seront utilises pour avoir une meilleure compréhension des besoins de santé actuels des demandeurs d'asile et nous permettra de planifier et développer un service de santé capable de répondre à ces besoins

Je me porte garante que vos réponses ne vous identifieront en aucuns cas puisque que aucune information personnelle ne sera retenue, comme votre nom et votre numéro d'identité ne sera demandé J'espère que vous prendrez le temps de remplir ce questionnaire et de me le renvoyer Votre participation est purement volontaire, sans obligations de prendre part a ce projet et vous pouvez retirer votre consentement n'importe quand

Si vous avez des questions ou des inquiétudes pour remplir ce questionnaire ou de prendre part a cette etude, vous pouvez joindre le numero suivant 071-9155414 Ce projet a ete approuve par : the Health Services Review Board at The Institute of Technology Sligo (Comité d'éthique sur les services de sante de l'Institute of Technology Sligo) .

Sincerely

____

Gail Cummins

IT Sligo
An Institiúid Teicneolaíochta, Sligeach

L'établissement des besoins de santé des demandeurs d'asile dans les Services Exécutifs Sanitaire du Nord Ouest (HSENW)

J'accepte de participer a l'etude proposee par Gail Cummins Je suis conscient de ne pas etre dans l'obligation de participer et que je peux retirer mon consentement a participer n'importe quand.

J'ai lu la piece ci jointe presentant le projet de recherche et j'accepte de participer

Signature ______________________________

Nom ________________________________

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Appendix 5: Refugee Act Sections 13 Explained

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Section 13(4) (b): The Commissioner has made a recommendation that the applicant should not be granted refugee status (under the provisions of the Act applicable after September 15, 2003) An appeal to the Tribunal must be taken within 15 days

Section 13(2): The Commissioner has made a recommendation that the applicant should not be granted refugee status where an application has been withdrawn or deemed to be withdrawn(under the provisions of the Act applicable after September 15, 2003) No appeal to the Tribunal is possible

Section 13(5): The Commissioner has made a recommendation that the applicant should not be granted refugee status and has included in his report a finding under Section(6) (under the provisions of the Act applicable after September 15, 2003). An appeal to the Tribunal must be taken within 10 days

Section 13· The Commissioner has made a recommendation that the applicant should not be granted refugee status (under the provisions of the Act which existed prior to September 15, 2003)

Dublin II Regulatory/ DC Determination Where it is established that the applicants claim for refugee status should be determined in another Dublin regulatory/ Dublin Convention country

(Source· ORAC, 2006)

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Appendix 6 : Chi Square & T- Tests

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6.1 Cross tabulation – Gender & experience in making appointments with health professionals

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	1 741[b]	1	187		
Continuity Correction [a]	1 323	1	250		
Likelihood Ratio	1 797	1	180		
Fisher's Exact Test				236	124
Linear-by-Linear Association	1 734	1	188		
N of Valid Cases	242				

a. *Computed only for a 2x2 table*

b. 0 cells (0%) have expected count less than 5 The minimum expected count is 16 90

			Do you have any experience in making appointments with health professionals?		Total
			yes	no	
Gender	male	Count	121	34	155
		Expected Count	124 9	30 1	155 0
		% within Gender	78 1%	21 9%	100 0%
		% within Do you have any experience in making appointments with health professionals?	62 1%	72 3%	64 0%
		% of Total	50 0%	14 0%	64 0%
	female	Count	74	13	87
		Expected Count	70 1	16 9	87 0
		% within Gender	85 1%	14 9%	100 0%
		% within Do you have any experience in making appointments with health professionals?	37 9%	27 7%	36 0%
		% of Total	30 6%	5 4%	36 0%
Total		Count	195	47	242
		Expected Count	195 0	47 0	242 0
		% within Gender	80 6%	19 4%	100 0%
		% within Do you have any experience in making appointments with health professionals?	100 0%	100 0%	100 0%
		% of Total	80 6%	19 4%	100 0%

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6.2 Crosstabulation –No. males & females experiencing difficulty in making appointments with health professionals

			Do you have any difficulties in making appointments with these health professionals?		Total
			yes	no	
Gender	male	Count	37	84	121
		Expected Count	37 2	83 8	121 0
		% within Gender	30 6%	69 4%	100 0%
		% within Do you have any difficulties in making appointments with these health professionals?	61 7%	62 2%	62 1%
		% of Total	19 0%	43 1%	62 1%
	female	Count	23	51	74
		Expected Count	22 8	51 2	74 0
		% within Gender	31 1%	68 9%	100 0%
		% within Do you have any difficulties in making appointments with these health professionals?	38 3%	37 8%	37 9%
		% of Total	11 8%	26 2%	37 9%
Total		Count	60	135	195
		Expected Count	60 0	135 0	195 0
		% within Gender	30 8%	69 2%	100 0%
		% within Do you have any difficulties in making appointments with these health professionals?	100 0%	100 0%	100 0%
		% of Total	30 8%	69 2%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig. (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	005[b]	1	941		
Continuity Correction [a]	000	1	1 000		
Likelihood Ratio	005	1	941		
Fisher's Exact Test				1 000	532
Linear-by-Linear Association	005	1	941		
N of Valid Cases	195				

a Computed only for a 2x2 table

b 0 cells (0%) have expected count less than 5 The minimum expected count is 22 77

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6.3 Crosstabulation - Gender & health status

Gender * In general, how would you say your healthh is? Crosstabulation

			In general, how would you say your healthh is?					Total
			excellent	very good	good	fair	poor	
Gender	male	Count	31	23	58	17	26	155
		Expected Count	31 4	27 5	57 0	17 9	21 1	155 0
		% within Gender	20 0%	14 8%	37 4%	11 0%	16 8%	100 0%
		% within In general, how would you say your health is?	63 3%	53 5%	65 2%	60 7%	78 8%	64 0%
		% of Total	12 8%	9 5%	24 0%	7 0%	10 7%	64 0%
	female	Count	18	20	31	11	7	87
		Expected Count	17 6	15 5	32 0	10 1	11 9	87 0
		% within Gender	20 7%	23 0%	35 6%	12 6%	8 0%	100 0%
		% within In general, how would you say your health is?	36 7%	46 5%	34 8%	39 3%	21 2%	36 0%
		% of Total	7 4%	8 3%	12 8%	4 5%	2 9%	36 0%
Total		Count	49	43	89	28	33	242
		Expected Count	49 0	43 0	89 0	28 0	33 0	242 0
		% within Gender	20 2%	17 8%	36 8%	11 6%	13 6%	100 0%
		% within In general, how would you say your health is?	100 0%	100 0%	100 0%	100 0%	100 0%	100 0%
		% of Total	20 2%	17 8%	36 8%	11 6%	13 6%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)
Pearson Chi-Square	5 393[a]	4	249
Likelihood Ratio	5 592	4	232
Linear-by-Linear Association	2 206	1	137
N of Valid Cases	242		

a 0 cells (0%) have expected count less than 5 The minimum expected count is 10 07

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6.4 Cross tabulation Gender & Quality of life

Gender * How would you rate your quality of life? Crosstabulation

			How would you rate your quality of life?					
			very good	good	neither poor nor good	poor	very poor	Total
Gender	male	Count	17	54	38	22	24	155
		Expected Count	21 8	51 9	35 9	25 0	20 5	155 0
		% within Gender	11 0%	34 8%	24 5%	14 2%	15 5%	100 0%
		% within How would you rate your quality of life?	50 0%	66 7%	67 9%	56 4%	75 0%	64 0%
		% of Total	7 0%	22 3%	15 7%	9 1%	9 9%	64 0%
	female	Count	17	27	18	17	8	87
		Expected Count	12 2	29 1	20 1	14 0	11 5	87 0
		% within Gender	19 5%	31 0%	20 7%	19 5%	9 2%	100 0%
		% within How would you rate your quality of life?	50 0%	33 3%	32 1%	43 6%	25 0%	36 0%
		% of Total	7 0%	11 2%	7 4%	7 0%	3 3%	36 0%
Total		Count	34	81	56	39	32	242
		Expected Count	34 0	81 0	56 0	39 0	32 0	242 0
		% within Gender	14 0%	33 5%	23 1%	16 1%	13 2%	100 0%
		% within How would you rate your quality of life?	100 0%	100 0%	100 0%	100 0%	100 0%	100 0%
		% of Total	14 0%	33 5%	23 1%	16 1%	13 2%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)
Pearson Chi-Square	6 163[a]	4	187
Likelihood Ratio	6 125	4	190
Linear-by-Linear Association	1 514	1	218
N of Valid Cases	242		

a 0 cells (0%) have expected count less than 5 The minimum expected count is 11 50

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6.5 Crosstabulation – Gender & percentage of respondents who are currently registered with a G.P.

			Are you currently registered with a doctor in Ireland?		Total
			yes	no	
Gender	male	Count	139	16	155
		Expected Count	144 1	10 9	155 0
		% within Gender	89 7%	10 3%	100 0%
		% within Are you currently registered with a doctor in Ireland?	61 8%	94 1%	64 0%
		% of Total	57 4%	6 6%	64 0%
	female	Count	86	1	87
		Expected Count	80 9	6 1	87 0
		% within Gender	98 9%	1 1%	100 0%
		% within Are you currently registered with a doctor in Ireland?	38 2%	5 9%	36 0%
		% of Total	35 5%	4%	36 0%
Total		Count	225	17	242
		Expected Count	225 0	17 0	242 0
		% within Gender	93 0%	7 0%	100 0%
		% within Are you currently registered with a doctor in Ireland?	100 0%	100 0%	100 0%
		% of Total	93 0%	7 0%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	7 179[b]	1	007		
Continuity Correction [a]	5 843	1	016		
Likelihood Ratio	9 196	1	002		
Fisher's Exact Test				007	004
Linear-by-Linear Association	7 149	1	007		
N of Valid Cases	242				

a Computed only for a 2x2 table

b 0 cells (0%) have expected count less than 5 The minimum expected count is 6 11

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6.6 Crosstabulation – Gender & percentage of respondents who have had a health check in the last 3 years

Crosstabulation

			Have you had a health check / health screening in the last three years?		
			yes	no	Total
Gender	male	Count	115	40	155
		Expected Count	117 9	37 1	155 0
		% within Gender	74 2%	25 8%	100 0%
		% within Have you had a health check / health screening in the last three years?	62 5%	69 0%	64 0%
		% of Total	47 5%	16 5%	64 0%
	female	Count	69	18	87
		Expected Count	66 1	20 9	87 0
		% within Gender	79 3%	20 7%	100 0%
		% within Have you had a health check / health screening in the last three years?	37 5%	31 0%	36 0%
		% of Total	28 5%	7 4%	36 0%
Total		Count	184	58	242
		Expected Count	184 0	58 0	242 0
		% within Gender	76 0%	24 0%	100 0%
		% within Have you had a health check / health screening in the last three years?	100 0%	100 0%	100 0%
		% of Total	76 0%	24 0%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	801[b]	1	371		
Continuity Correction [a]	544	1	461		
Likelihood Ratio	813	1	367		
Fisher's Exact Test				434	231
Linear-by-Linear Association	797	1	372		
N of Valid Cases	242				

a Computed only for a 2x2 table

b 0 cells (0%) have expected count less than 5 The minimum expected count is 20 85

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6.7 T-Test Weight of participants in Kgs

Group Statistics

	Gender	N	Mean	Std Deviation	Std Error Mean
What is your weight in Kgs?	male	155	78 24	12 98	1 04
	female	87	74 68	14 92	1 60

Independent Samples Test

		ne's Test for Equal Variances		t-test for Equality of Means						
									Confidence Interv the Difference	
		F	Sig	t	df	g (2-taile	an Differer	Std Error Difference	Lower	Upper
What is your weig Kgs?	Equal variances as	1 242	266	1 939	240	054	3 56	1 84	5 75E-02	7 18
	Equal variances no assumed			1 864	158 598	064	3 56	1 91	- 21	7 33

6.8 T-Test Height of participants

Group Statistics

	Gender	N	Mean	Std Deviation	Std Error Mean
What is your height in metres?	male	155	1 7461	1013	8 138E-03
	female	87	1 6768	1207	1 294E-02

Independent Samples Test

		vene's Test for Equality Variances		t-test for Equality of Means						
									% Confidence Interval the Difference	
		F	Sig	t	df	Sig (2-tailed	ean Differenc	Std Error Difference	Lower	Upper
What is your height in metres?	Equal variances assum	4 210	041	4 760	240	000	6 930E-02	1 456E-02	4 062E-02	9 798E-02
	Equal variances not assumed			4 533	154 007	000	6 930E-02	1 529E-02	3 910E-02	9 950E-02

6.9 T-Test B.P. of participants

Group Statistics

	Gender	N	Mean	Std Deviation	Std Error Mean
What was the level of your blood pressure?	male	124	2 40	1 02	9 15E-02
	female	79	2 18	76	8 59E-02

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Independent Samples Test

		ene's Test for Equalit Variances		t-test for Equality of Means					% Confidence Interva the Difference	
		F	Sig	t	df	ig (2-taile	ean Differen	Std Error Difference	Lower	Upper
What was the le your blood press	Equal variances assu	18 368	000	1 631	201	104	22	13	-4 55E-02	48
	Equal variances not assumed			1 736	195 623	084	22	13	-2 96E-02	47

6.10 Crosstabulation - Gender & Rate of Intensity

Gender * How would you rate the intensity of your daily activities? Crosstabulation

			How would you rate the intensity of your daily activities?				Total
			very physically active	fairly physically active	not very physically active	not at all physically active	
Gender	male	Count	40	44	47	24	155
		Expected Count	43.6	46.8	38 4	26 3	155 0
		% within Gender	25.8%	28 4%	30 3%	15 5%	100 0%
		% within How would you rate the intensity of your daily activities?	58 8%	60 3%	78 3%	58 5%	64 0%
		% of Total	16 5%	18.2%	19 4%	9 9%	64 0%
	female	Count	28	29	13	17	87
		Expected Count	24 4	26.2	21 6	14 7	87 0
		% within Gender	32 2%	33.3%	14 9%	19 5%	100 0%
		% within How would you rate the intensity of your daily activities?	41 2%	39 7%	21 7%	41 5%	36 0%
		% of Total	11 6%	12 0%	5 4%	7 0%	36 0%
Total		Count	68	73	60	41	242
		Expected Count	68 0	73 0	60 0	41 0	242.0
		% within Gender	28 1%	30.2%	24 8%	16 9%	100 0%
		% within How would you rate the intensity of your daily activities?	100 0%	100 0%	100 0%	100 0%	100 0%
		% of Total	28 1%	30.2%	24 8%	16 9%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)
Pearson Chi-Square	7 116[a]	3	068
Likelihood Ratio	7 526	3	057
Linear-by-Linear Association	928	1	335
N of Valid Cases	242		

[a] 0 cells (0%) have expected count less than 5 The minimum expected count is 14 74

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6.11 Crosstabulation – Gender & No of respondents who smoke

			Do you smoke?		Total
			no	yes	
Gender	male	Count	96	59	155
		Expected Count	115 3	39 7	155 0
		% within Gender	61 9%	38 1%	100 0%
		% within Do you smoke?	53 3%	95 2%	64 0%
		% of Total	39 7%	24 4%	64 0%
	female	Count	84	3	87
		Expected Count	64 7	22 3	87 0
		% within Gender	96 6%	3 4%	100 0%
		% within Do you smoke?	46 7%	4 8%	36 0%
		% of Total	34 7%	1 2%	36 0%
Total		Count	180	62	242
		Expected Count	180 0	62 0	242 0
		% within Gender	74 4%	25 6%	100 0%
		% within Do you smoke?	100 0%	100 0%	100 0%
		% of Total	74 4%	25 6%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	35 040[b]	1	000		
Continuity Correction [a]	33 247	1	000		
Likelihood Ratio	43 360	1	000		
Fisher's Exact Test				000	000
Linear-by-Linear Association	34 895	1	000		
N of Valid Cases	242				

a Computed only for a 2x2 table

b 0 cells (0%) have expected count less than 5 The minimum expected count is 22 29

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6.12 Crosstabulation – Gender & Diet

Gender * ow would you rate your diet? Crosstabulation

			ow would you rate your diet?					Total
			excellent	very good	good	fair	poor	
Gender	male	Count	13	16	56	27	43	155
		Expected Count	12 8	16 0	54 4	35 2	36 5	155 0
		% within Gender	8 4%	10 3%	36 1%	17 4%	27 7%	100 0%
		% within ow would you rate your diet?	65 0%	64 0%	65 9%	49 1%	75 4%	64 0%
		% of Total	5 4%	6 6%	23 1%	11 2%	17 8%	64 0%
	female	Count	7	9	29	28	14	87
		Expected Count	7 2	9 0	30 6	19 8	20 5	87 0
		% within Gender	8 0%	10 3%	33 3%	32 2%	16 1%	100 0%
		% within ow would you rate your diet?	35 0%	36 0%	34 1%	50 9%	24 6%	36 0%
		% of Total	2 9%	3 7%	12 0%	11 6%	5 8%	36 0%
Total		Count	20	25	85	55	57	242
		Expected Count	20 0	25 0	85 0	55 0	57 0	242 0
		% within Gender	8 3%	10 3%	35 1%	22 7%	23 6%	100 0%
		% within ow would you rate your diet?	100 0%	100 0%	100 0%	100 0%	100 0%	100 0%
		% of Total	8 3%	10 3%	35 1%	22 7%	23 6%	100 0%

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)
Pearson Chi-Square	8 688[a]	4	069
Likelihood Ratio	8 660	4	070
Linear-by-Linear Association	243	1	622
N of Valid Cases	242		

a 0 cells (0%) have expected count less than 5 The minimum expected count is 7 19

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6.13 Crosstabulation - Percentage of males & females who consumed vitamins, minerals or other supplements in the last 12 months

Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	10 676[b]	1	001		
Continuity Correction [a]	9 720	1	002		
Likelihood Ratio	10 420	1	001		
Fisher's Exact Test				002	001
Linear-by-Linear Association	10 631	1	001		
N of Valid Cases	242				

a. Computed only for a 2x2 table

b 0 cells (0%) have expected count less than 5 The minimum expected count is 24 09

			Have you taken any vitamins, minerals or supplements during the last year?		
			yes	no	Total
Gender	male	Count	32	123	155
		Expected Count	42 9	112 1	155 0
		% within Gender	20 6%	79 4%	100 0%
		% within Have you taken any vitamins, minerals or supplements during the last year?	47 8%	70 3%	64 0%
		% of Total	13 2%	50 8%	64 0%
	female	Count	35	52	87
		Expected Count	24 1	62 9	87 0
		% within Gender	40 2%	59 8%	100 0%
		% within Have you taken any vitamins, minerals or supplements during the last year?	52 2%	29 7%	36 0%
		% of Total	14 5%	21 5%	36 0%
Total		Count	67	175	242
		Expected Count	67 0	175 0	242 0
		% within Gender	27 7%	72 3%	100 0%
		% within Have you taken any vitamins minerals or supplements during the last year?	100 0%	100 0%	100 0%
		% of Total	27 7%	72 3%	100 0%

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6.14 Crosstabulation - Gender & Injuries

			Have you injured yourself seriously in the last two years?		Total
			yes	no	
Gender	male	Count	63	92	155
		Expected Count	54 4	100 6	155 0
		% within Gender	40 6%	59 4%	100 0%
		% within Have you injured yourself seriously in the last two years?	74 1%	58 6%	64 0%
		% of Total	26 0%	38 0%	64 0%
	female	Count	22	65	87
		Expected Count	30 6	56 4	87 0
		% within Gender	25 3%	74 7%	100 0%
		% within Have you injured yourself seriously in the last two years?	25 9%	41 4%	36 0%
		% of Total	9 1%	26 9%	36 0%
Total		Count	85	157	242
		Expected Count	85 0	157 0	242 0
		% within Gender	35 1%	64 9%	100 0%
		% within Have you injured yourself seriously in the last two years?	100 0%	100 0%	100 0%
		% of Total	35 1%	64 9%	100 0%

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Chi-Square Tests

	Value	df	Asymp Sig (2-sided)	Exact Sig (2-sided)	Exact Sig (1-sided)
Pearson Chi-Square	5 768[b]	1	016		
Continuity Correction [a]	5 113	1	024		
Likelihood Ratio	5 924	1	015		
Fisher's Exact Test				017	011
Linear-by-Linear Association	5 744	1	017		
N of Valid Cases	242				

a Computed only for a 2x2 table

b 0 cells (0%) have expected count less than 5 The minimum expected count is 30 56

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