

# Multicultural Health



An Assessment of Health and Personal Social Service Needs relating to Ethnic Minority Groups within the Mid-West Area (Limerick, Clare, North Tipperary)



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Culturally and linguistically proofed for equality purposes by  
representatives of the Eastern European, Western European,  
African and Islamic Community of Ireland.

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# Multicultural Health

Research project by Culturewise Ireland

Author/researcher:

Dr.Alvina GROSU,

Contributors:

Dr.Wilberforce Owusu-Ansah, Ina TRIBOI

Editing team:

Susan LONG, Lisa MAURO BRACKEN, Bedelia COLLINS, Daura CARBALLO

Field research assistants:

Magdalena JANOWIAK (Poland),

Mark MANTEY (Ghana),

Aminah KYAKOONYE (Uganda),

Daura CARBALLO (Spain).

Design and layout: Nicolae SUSANU

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# Abbreviations and Acronyms

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<b>A&amp;E</b>	Accident and Emergency
<b>CDP</b>	Community Development Project
<b>CHC</b>	Community Health Centres
<b>Co</b>	County
<b>CSO</b>	Central Statistics Office
<b>CWO</b>	Community Welfare Officer
<b>DETE</b>	Department of Enterprise, Trade and Employment
<b>DJELR</b>	Department of Justice, Equality and Law Reform
<b>DSFA</b>	Department of Social and Family Affairs
<b>EEA</b>	European Economic Area
<b>EHO</b>	Environmental Health Officer
<b>EMC</b>	Ethnic Minority Community
<b>EM</b>	Ethnic minorities
<b>EMO</b>	Ethnic Minority Organizations
<b>EU</b>	European Union
<b>GP</b>	General Practitioner
<b>HSE</b>	Health Service Executive
<b>HIP</b>	Health Information Program
<b>IBC</b>	Irish Born Child
<b>IRC</b>	Irish Refugee Council
<b>LHO</b>	Local Health Officer
<b>LTR</b>	Leave to Remain
<b>MRCI</b>	Migrant Rights Centre Ireland
<b>MEC</b>	Minority Ethnic Communities
<b>NAPAR</b>	National Action Plan Against Racism
<b>NAPS</b>	National Anti Poverty Strategy
<b>NCCRI</b>	National Consultative Committee on Racism and Interculturalism
<b>NMS</b>	New Member States
<b>ORAC</b>	Office of the Refugee Applications Commissioner
<b>PHN</b>	Public Health Nurse
<b>PPS</b>	Personal Public Service (numbers)
<b>RIA</b>	Reception and Integration Agency
<b>RIS</b>	Refugee Information Service
<b>RLS</b>	Refugee Legal Service
<b>SASP</b>	Small Area Population Statistics
<b>SWA</b>	Supplementary Welfare Allowance
<b>SVP</b>	Society of Saint Vincent de Paul
<b>UN</b>	United Nations
<b>VEC</b>	Vocational Educational Committee

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# 1. Introduction

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We are living in the 'age of migration'. Cities and towns throughout Ireland are becoming increasingly multicultural. In response to changing population dynamics based on immigration and the impact that this change will have on the demands and the needs of the health service, its providers and its users, the HSE West has commissioned this research. The aim is to develop a profile of ethnic minority communities living in the Mid-West Area and conduct a high level assessment of the health and personal social service needs of ethnic minority communities across the Mid-West Area. While the Traveller community constitutes one of Ireland's largest ethnic minority groups it was decided not to include them as part of the needs assessment as their needs have already been assessed and are being catered for in the separate Traveller Health Programme.

This research will provide the basis for the development of an Ethnic Minority Health Strategy and Action Plan arising from the findings/ recommendations of the assessment.

The key objectives in addressing the aim of the study were:

- To identify the demographics of the ethnic minority communities living within the HSE Mid West Area (Limerick, Clare and Tipperary North).
- To ascertain the experiences of and challenges identified by ethnic minority communities in accessing health and personal social services.
- To determine the level and range of health and personal social services that are essential in meeting the specific needs of ethnic minority communities within the area.
- To identify any innovative initiatives that have been developed to overcome barriers to care and improve access to health and personal social services for ethnic minority service users.
- To make recommendations based on the research findings and develop a health care strategy and action plan that will facilitate the process of meeting the health and personal social service needs of these groups.

This report was prepared by Culturewise Ireland in close collaboration with the Ethnic Minority Working Group of the HSE West, Mid West Region, ethnic minority groups, health service providers and key Statutory and Voluntary Agencies in the region.

In preparing this report a review of research and policy documents on health needs of ethnic minorities was conducted. This involved identifying barriers to current provision and examples of good practice. Sources of information for this review have included research studies, service evaluations, organizational policies and strategies from a variety of statutory and voluntary organizations. A review of statistical information available from different government authorities assisted in the development of a profile of the ethnic minority population in the Mid-West Area. In the process of consultation with members of the ethnic minority community, ethnic organizations, community organizations and some employers the issues and needs of the "new" health service users were explored. To identify and evaluate the needs from a service provider's and user's perspective a combined approach of consultation, interview and questionnaires for health services staff and the ethnic minority community in the Mid-West Region was applied.



## 2. Context

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### 2.1 Background to the research

In the relatively recent past Ireland changed from being a state with strong traditions of emigration to being a receiving society, experiencing substantial, diverse and ongoing inward migration. It is estimated that there are 160 nationalities living in Ireland (Department of Social and Family Affairs 2002). The heterogeneity of this group is reflected in the estimate that approximately 80 to 100 languages are spoken by the ethnic minority population in Ireland.

The growing number of persons from different ethnic minorities contributes to a rich mix of diversity. While this is welcomed, it should also be acknowledged that persons from ethnic minority communities may present with unique needs for healthcare and associated support, which are often quite different from the needs of the indigenous community.

In 2001 the Government published *Quality and Fairness "A Health System for You"* which strongly advocated the principles of people centeredness, user friendliness and equitable access to health services for all.

To further the goals and recommendations of the strategy and in response to the ever increasing numbers of foreign nationals entering Ireland, the Health Service Executive has commenced work on developing an Intercultural Strategy for health services. This Intercultural Strategy will be in line with the recommendations of the National Health Strategy and the recently published *Planning for Diversity: The National Action Plan against Racism*.

The HSE West fully supports the principles of these reports and seeks to develop a person centred service of the highest quality which will assist ethnic minority persons to have equitable access to appropriate health care as required.

In response to the changing population dynamics and the impact this change is having on the demands and needs of the health service, its providers and its users, the HSE West established an Ethnic Minority Working Group. The Group's main aim is to develop a Health Care Strategy and Action Plan for ethnic minority communities living in the Mid-West Area based on the assessment of their needs. A key consideration for the research is the lack of baseline data on service users from an ethnic minority background in the Mid-West Area. Therefore, to ensure an inclusive approach is taken in any initiatives supporting the work implemented with ethnic minority communities, the Working Group has committed resources to carrying out this assessment of the target groups personal and social support needs. This health needs assessment will inform the development of a Health Strategy and Action Plan for Ethnic Minorities.

The EMWG worked with Culturewise Ireland to map out the study and oversaw the implementation of the research, emphasizing the importance of consultation and partnership with local authorities and voluntary bodies within the Mid-West Region. A particular focus of this approach was to involve a substantial number of voluntary groups and organizations working with ethnic minority communities in the Mid-West Region and also the relevant statutory bodies.

The comprehensive findings and recommendations of this most recent assessment of health and personal social needs of ethnic minority communities will assist the HSE West in the development of an inclusive health service that responds appropriately to their needs.

### 2.2 Literature review

This section reviews existing literature on health needs assessments. It provides a context for more specialised needs assessment and provides an overview and definition of health needs assessment. This is followed by a review of existing literature in relation to the research subject.

#### *Contextualizing health needs assessment*

Health needs assessment has been defined from various perspectives. *Stevens and Raftery (1994)* define health needs assessment as 'the assessment

*of a population or community's ability to benefit from health care*'. Although this definition is based on 'health care' it implies more than a narrow clinical focus. In this sense, 'health care' includes treatments but also prevention, diagnosis, continuing care, rehabilitation and palliative care. 'Benefit' may also include reassurance, supportive care and the relief of carers. Many individual health problems have a social impact with multiple knock-on effects and difficulties for families and carers; hence the loss of beneficiaries of care may extend beyond the patient.

*Mackintosh et al. (1998)* consider the assessment

*of health needs to be a strategic process, providing the background information required to make sound decisions. It informs, educates and supports service providers and consumers in developing or sustaining services. Health needs assessment should thus be considered as an on-going, cyclical process.* Unfortunately, health needs assessment are often hampered by a lack of existing research in this area, the absence of reliable or comparable data, and the lack of follow-up studies to help identify trends (Barnados, 2002).

*The purpose of a health needs assessment is to improve the health of a whole population and to target resources towards improving the health of those at specific risk or in under-served population subgroups.* The two essential determinants of a population's ability to benefit are the extent of the health problem (incidence/ prevalence), and the effectiveness of interventions to deal with it. *These interventions will not only be diagnosis, treatment and palliation but will include preventative measures and health promotion (LHA, 1999:8).* The key tasks have been to identify and define that population, to identify priority groups within it, and to gain an insight into the current state of affairs regarding their health and use of health services.

*The proper context of health needs assessment is the determinants of health. Existing literature defines health determinants as the personal, social, cultural, economic and environmental factors that influence the health status of individuals or populations.* People's health may thus be influenced by individual factors such as age, gender and family history; socio-economic factors such as ethnic background, education, employment, poverty and social exclusion; cultural factors such as diet, physical activity, sexual behaviour, drugs, smoking and alcohol intake; environmental factors such as housing, air and water quality, and working conditions; and also the services that are available locally, such as education, health services, social services, transport and leisure. These factors can vary from place to place and from person to person. *Health needs assessment require a broad definition of health and its determinants that include individual, social, economic, cultural, environmental and service factors (Barnados, 2002).*

#### *Use of primary health care services*

The National Health Survey for England and Wales provides some indication of the use of health services and prescribed medication by ethnic minorities. This data suggests that there is a wide variation in the use of GP services and evidence of widespread concern about the use of primary care services. All refugees, regardless of their status, are

entitled to NHS services free of charge (including the right to register with a GP, dentist or optician and to receive NHS prescriptions). However, under-registration is common and may be associated with a range of contributory factors (such as preoccupation with housing, employment and money, language problems, and the limited availability of translated information in uncommon minority languages among others). There may be cultural uncertainty about charges and about the means to obtain services, low expectations and concern regarding confidentiality between government departments and the NHS (Refugee Health Consortium, 1998).

A study in Cork, which explored the health needs of asylum seekers and refugees, found that the majority of the respondents had medical cards (Southern Health Board, 2003) compared to a study in the UK where 30% hadn't signed up with a GP and 35% were registered but not using GP services (Bernard-Jones, 1993). Studies in the UK have found that the use of primary care is generally greater among ethnic minority groups, that they experience difficulties in physically accessing their GP and tend to be less satisfied with the outcome (Ryan, 2000). Another finding from the Cork study was that 29% of the respondents had difficulty making appointments to see their GP and that language is a major barrier (Southern Health Board, 2003,). Interpretation services were seen as being problematic for both patients and health care professionals in the provision of healthcare to asylum seekers (Southern Health Board, 2003,) and migrant workers (MIA, 2006).

Research conducted by the NHS Trust at the University Hospital in Newham, one of the most diverse ethnic and cultural boroughs in London, showed that regardless of their ethnic background, patients' satisfaction depended on four key items: how patients perceived their care; their relationships with their doctor; being treated with dignity and respect; and their overall perception of the hospital (Dudhwala, 2006).

According to the research reviewed, some GPs remain confused about refugee entitlements and some continue to offer temporary rather than permanent registration, which prevents the acquisition of medical records by the practice and therefore hampers continuity of care. Many GPs find working with refugees time-consuming and stressful in the light of their overwhelming needs. A number of services have evolved specifically to address refugees' special needs, located within general practices or run by health authorities as outreach ventures in hostels or community centres. Pharmacists are often seen as a non-threatening source of advice about health problems, along with dentists and opticians are

therefore in a good position to provide information on accessing NHS services. Studies, however, have found that these practitioners are in need of good quality culturally appropriate materials for health advice, both visual and written (Refugee Health Consortium, 1998).

#### *Ethnic minorities experience of health services*

There is an expanding body of published research examining the health care experiences of people from ethnic minority communities, highlighting their differential experiences of service usage. For example, it has been widely reported in empirical studies that disabled people from ethnic minority communities, including children, may experience a double discrimination in both health and health care, along with an absence of culturally competent support systems. There is evidence of mistrust within some minority communities of the motives of health service providers (Brent CHC, 1981, Chamba et al., 1998) and a number of studies address the importance of thinking beyond cultural differences to include a consideration of institutional power and racism (Ahmad and Atkin 1996, Priestley 1995).

For users from different ethnic backgrounds, there is the additional issue of cultural competence in service provision. Training is certainly a prerequisite, but consultation with other community members is likely to be needed as well in order to explore the nature and implications of people's cultural heritage in doing so. It is also important to take account of the views of people of, for example, a similar age group to the potential service user as well as community elders. As with any person with learning difficulties, consultation with other family members is likely to be a prerequisite but, again, more so when roles within family and community networks are different from those of the professional's own community. In an Irish study involving ethnic minorities, the asylum seekers reported that mental health and well being as the biggest health problem, exacerbated by the difficulty in accessing mental health service (MIA, 2006).

#### *Communication*

In studies of health needs of ethnic communities, language and communication issues were universally identified as being of critical importance. Communication problems were identified at all stages of service delivery from accessing information about services (and health promotion) in the first place, to the first point of enquiry (for example reception) and at each subsequent stage of service provision. Many professionals reported the challenges to communicating information about health and healthcare services.

There were several examples given of communication problems between patients and healthcare practitioners. These can be compounded by the need to communicate medical terms, which can be difficult even with an interpreter. Some respondents also reported cultural differences in the way people communicate. The use of metaphor, for example, can lead to misunderstanding (Leeds Health Authority, 1999,). Several studies stated that good quality interpreting is hard to find when needed and it is hugely under-resourced, therefore inevitably, practitioners circumvent the process and use family members. The issue of using family members, particularly children, as interpreters generated considerable debate. Several respondents in the studies reviewed felt that the use of children as interpreters for their parents or other family members was unacceptable and examples were given of confusion and distress caused, particularly where the topic is sensitive. Less alarming examples were given of health staff using a child as an interpreter but being left in considerable doubt exactly what was being communicated.

Even where language is not a major barrier in consultation or diagnosis, due to the availability of interpreting and translation services, medical professionals from the majority community encounter cultural tensions in working with some ethnic minority families with disabled children. There is recognition of failure to understand fully the underlying cultural context (which leads to miscommunication).

For example, there may be an apparent conflict between the traditional health beliefs of older generations and a simultaneously high expectation that Western medicine will provide a 'cure' for all conditions (Leeds Health Authority, 1999,).

Similarly in an Irish study (MIA, 2006), the main problem which arose during the discussion related to language barriers and communication and culture in the wider health service, particularly when attending hospital. These issues were barriers to understanding how the system works, what the GP or the nurse is saying, and the feeling that they themselves are not fully understood (MIA, 2006).

#### *Access to services*

Communication difficulties can be compounded by practical barriers to accessing health care. There was a widely held view that ethnic minority families continue to receive a 'poorer' service than their white counterparts (Leeds Health Authority, 1999,). There was a view that ethnic minority parents are less likely to know about services, even when those services are specifically targeted. Other access problems include opening times and practicalities such as

location and availability of transport. Another finding was that respondents felt that those who needed the service the most frequently failed to benefit from them because there may be a lack of knowledge of existing services and routes of access.

For some services, such as immunization, rates of access are very good but less so for more complex or specialist services. It is not uncommon for children with complex difficulties to be overseen until they are identified at school or nursery. In addition to practical barriers to access, other barriers may be attitudinal. Although the attitudes and behaviours of staff have changed positively in the last few years, some respondents felt that there were still a need for a change in attitude and culture in services (Leeds Health Authority, 1999,).

While special health provision has been made for asylum seekers and refugees in Ireland, this is not the case for migrant workers (MIA, 2006). For instance, the migrant workers who were in lower paid jobs and whose English was poor said that they did not understand the Irish health system and had no knowledge of their health rights and entitlement (MIA, 2006). Another study also found that access to health care is less clear for women on work permits or working visas, who are students and women living in Ireland undocumented (Cairde, 2006).

The long wait in the A&E reception room in the hospital was mentioned as a problem, so too were waiting lists within the health service in general (MIA, 2006). In addition to language and lack of communication serving as barriers to engagement with the health services, many other factors also inhibit immigrants from using them effectively. Some of these factors include front line staff, which ranged from a lack of understanding of the health services and the lack of previous medical histories, to poor facilities and take-up and to cultural differences (MIA, 2006). In a study that examined the experiences of ethnic minority women living with HIV it was found that their complex needs require very specialized care and medication (Cairde, 2006). Their needs also relate to their broader social and economic experiences in Ireland which affect their ability to access services, which in turn impact on their health (Cairde, 2006).

#### *Poverty and social exclusion*

Many respondents highlighted poverty and social exclusion as factors affecting health needs of ethnic minority children. Issues that were highlighted included poor housing and overcrowding. In addition to ill effects on physical health, many people pointed to the impact on children's emotional well being (Leeds Health Authority, 1999,). Racism on council estates coupled with bullying and harassment were

cited as persistent concerns with the potential to undermine the confidence of the whole family and in particular, children. It was observed that parents often feel ill equipped to challenge racism for fear of making a bad situation worse.

Many young people saw lack of money as a reason for being unable to stay healthy. (Leeds Health Authority, 1999) Some felt that they couldn't go to the doctors because they could not afford to take the time off work and others wanted to have health checks but felt unable to because of the cost. The issues concerning young people from ethnic minority groups were similar to those concerning young people generally. If they perceived discrimination it was just as likely to be on the grounds of them being young than on them being from an ethnic minority group. It is important to point out that it is impossible to draw more than tentative conclusions from such a small sample and that a different composition of groups may have generated different findings for example young people who are less confident in the use of English or young people who are regular users of health services. Nevertheless, it is an interesting (and possibly quite heartening) observation that racism is not widely perceived by young people to be a major issue in health services.

A finding in a needs analysis study undertaken in County Mayo involving immigrants was that the system of direct provision and the increased vulnerability to poverty associated with it undermines the physical health and the social well-being of asylum seekers (Mayo Intercultural Action, 2006).

The wider social determinants of health, such as enforced poverty and poor housing, characteristics of direct provision and hostel accommodation, contribute to increased health risks. Culture shock and language barriers make accessing health services extremely difficult, resulting in unmet physical and mental health needs (MIA, 2006).

Another finding was that children and families living in already overcrowded conditions have to buy extra food to supplement the diet provided in the accommodation centres (MIA, 2006).

The migrant workers also experience social isolation, due to loss and separation from normal family and community support and this contributes to mental stress (MIA, 2006). One study found that 69% of women interviewed had experienced some form of racism in Ireland, which has resulted in significant levels of distress and feelings of powerlessness (Cairde, 2006).

#### *Access to health information and education*

The majority of young people felt that there needed to be better access to health information (Leeds

Health Authority, 1999,). Ideas included more leaflets available in surgeries, schools and community centres. The problem with leaflets is they frequently don't get read and this was acknowledged but it was agreed that there should be the opportunity to be able to access this information. Some people said that it would enable them to make more choices about how they were treated, or would give them information to seek alternative therapies. Direct contact between health professionals and young people in schools was seen to be a positive method of informing young people. A study reported that many were unaware of the different support organizations that exist in that they did not have information about the range of organizations for ethnic minority women, or the range of organizations for those living with HIV (Cairde, 2006). Similarly, in another study, 50% of those interviewed did not know where to find information (MIA, 2006).

#### *Health issues of asylum seekers*

An Irish study involving asylum seekers and refugees reported that two-thirds of respondents shared bedrooms with three to four people, the majority of those who shared with people from their own countries. Service providers and asylum seekers themselves expressed dissatisfaction with this situation and it was seen as a source of frustration (Better World, 2003). This finding has also been supported by earlier studies where detention facilities were found to have the capacity to aggravate tensions (Leanings, 2001). Irish studies have highlighted boredom, unemployment, overcrowding, welfare dependency and a general lack of suitable accommodation particularly for children of asylum seekers living in these areas (Begley et al, 1999; Fanning et al, 2000; Collins, 2001). In a Cork study, the main problems for those living in centres were similar: lack of space, dissatisfaction with food, a lack of privacy and the mixing of different ethnic groupings. Many also had difficulties regarding the rural location of the centre, which led to feelings of isolation and discrimination. They felt that living in designated centres prevents them from socializing because of travel costs and limits imposed by their small weekly allowance (€19 per week). There were also food complaints in terms of quality and choice in the Cork study (Southern Health Board, 2003,) and other studies have found that children's diet was a particular concern to parents (Fanning et al., 2001). Another finding from the Cork study was the difficulty in finding any type of accommodation and often the housing that is available is unsuitable in terms of location or living standards (Southern Health Board, 2003,). Similar difficulties have been identified in studies in the UK (Acheson, 1998) and in the Ireland (Begley et al, 1999; Fanning et al, 2000; Collins, 2001). Families are

often unprepared to move out of the centres because of feeling of isolation and inability to cope.

#### *The health of ethnic minority women*

Numerous studies show that women that belong to ethnic minorities often experience considerable ill health due to a variety of reasons mainly linked to the negative aspects of migration, such as language barriers and isolation, compounded by negative stereotypes and racism (ERHA, 2004; Australian Government, 2005; UNFPA, 2006).

Factors which affect the experience of health care among ethnic minority women were mentioned in Australian and Irish studies and include:

- Family responsibilities – for many women, family obligations have to be met before undertaking other activities such as health-promoting activities (for example recreation and physically active initiatives).
- Cultural restrictions regarding movement in public spaces (e.g. needing a chaperone, not being allowed to drive, being financially dependent on the family).
- Cultural restrictions on education and employment for women, which puts them in a highly dependent position when living in a culture where they do not know the language, the legal system or their rights, may have limited family and social networks and do not know how to access appropriate health services; and
- Cultural imperatives for women to see female health workers (where necessary with the involvement of a female interpreter) (Australian Government; 2005).
- Access to services – Ethnic minority women often do not have the information they require in order to access services. Many of them are reluctant to do so for fear of contact with official services or because they are afraid they will face negative repercussions at work for any health related absences. The cost of services for many of them is also prohibitive. Many women self-medicate using medication from their own countries or travel home to receive treatment.
- Mental health - Many ethnic minority women find themselves in situations of isolation, poverty and exploitation. This leads them to experience high levels of stress, anxiety and depression.
- Cancer – Some ethnic minority women do not understand the concept of screening and are reluctant to attend for prevention and treatment services.
- Practical supports - There is no practical support

for women parenting alone or experiencing health problems. This weighs particularly heavily on women with HIV, as this illness carries particular stigma.

- Migrant women as healthcare workers – Much of the work subcontracted by the HSE is done by ethnic minority women, for example as nurses in nursing homes and home helps. It is vital that the HSE as an employer and contractor respects national employment and equality legislation (WHC, 2006).

Violence against women in its many forms:

- Support for victims of gender-based violence is needed. The level of support currently available is vastly under-resourced and under-funded. Domestic Violence – this problem is widespread and needs to be documented. Women who have spouse-dependent visa cannot work and are often isolated in the home. Moreover, if they leave the relationship they lose the legal right to remain in the state and become undocumented. This situation leads to underreporting and creates many barriers to accessing services.
- Female Genital Mutilation (FGM) – there are women living in Ireland who have undergone FGM and more information needs to be given to health care professionals on how to address their needs. Information also needs to be provided in order to prevent this form of violence taking place in Ireland.

#### *Maternity services*

In addition to family doctors, dentists and hospitals, several mothers mentioned their encounters with health visitors, especially after the birth of their first child. These accounts were, on the whole, very positive and were not characterized by the same sorts of cultural or language concerns often expressed in relation to doctors. Few of the parents talked about using specialist child health services, although those who did often had real concerns that these operated in a culturally insensitive and predominantly white environment (Leeds Health Authority, 1999, 2002). Another study reported language as a major barrier to accessing maternity services (MIA, 2006). A further study on maternity care and reproductive health reveals that women have very little information on how to access services; often encounter racist attitudes amongst health professionals, including being used as scapegoats for the strained resources of the maternity services and feel disempowered in their own health choices (WHC, 2006). For instance, some women might have never heard of 'induction' and need more information and assistance in their

decision-making process. The research stressed a lack of support for women who are alone and who have traumatic experiences, e.g. miscarriage, stillbirth, etc. Anecdotal evidence also points to migrant women accessing unsafe ('backstreet') abortions due to the legislative ban on abortion in Ireland and the fact that because of their precarious residence status, many women are afraid to travel in order to procure an abortion (WHC, 2006).

#### *Staff composition and competence*

In the Leeds Health Authority, 1999 study, a number of respondents expressed the view that health services need to review its policy on recruitment and selection to attract more staff from ethnic minority groups and to better reflect the diversity within the population. The argument was that greater diversity would be a major step forward in reducing access barriers. Several respondents felt that the staffing ratio in an organization should better reflect the community they serve, for example, by actively recruiting people from ethnic minority groups. It was felt that this might be a way of encouraging ethnic minority groups to access health services (Leeds Health Authority, 1999,). A similar study conducted by the HSE Eastern Region recommended that diversity and cultural competence training for HSE staff (HSE, 2005)

Research undertaken by the HSE in the Eastern Region (HSE, 2005) suggests that some health care professionals lack a sufficient level of awareness and understanding in dealing with service users from ethnic minority backgrounds. It reports that ethnic minority communities cited negative experiences of interactions with health services. In some cases the experiences relayed were described as 'racism' (HSE, 2005). Understanding the life experiences of refugees and sensitivity to their human as well as health needs is a basic requisite of interactions within the health services.

The Tallaght Intercultural Action Project reported incidents of inappropriate treatment of African and Eastern European women, particularly in interactions with the maternity services. Such incidents involved differences of cultural norms including understanding and approaches to pain and labour; food preferences among women who have just given birth; and visitors who bring food to a new mother arises from a communal sense of caring for a relative or friend rather than intending to offer any slur on the health care system or its providers. This advocacy group indicated that a need for Cultural Sensitivity stating that an equitable health care system would enable staff to respect these differences and accommodate cultural preferences.

## 2.3 Approach of the research

In meeting the aim of this study “*To develop a profile of ethnic minority communities living in the Mid-West Area and conduct a high level assessment of the health and personal social service needs of ethnic minority communities across the Mid-West Area*” it was decided to combine and adapt the following approaches, which come from Stepping Forward – A Guide to Local Health Needs Assessment.

### *Community Development approach*

The key elements of the research were the engagement of the EM communities living in Mid-West Area and Health Service Providers in the entire research process. Involvement of the EM communities in identifying the level and range of health and personal social services that are essential to meet their needs as well as the challenges in accessing these services was the first step towards working with EM communities to address its problems. The methodology of the research emphasises qualitative methods such as focus group sessions, structured and semi structured interviews, questionnaires (the process used to collect the data was as important as the data obtained). The instruments were designed to get service users and service providers to describe the problems and propose the solutions in their own terms. They were also used to identify innovative initiatives that have been developed to overcome barriers to care and improve access to health and personal social services for EM communities.

### *Advocacy approach*

This study investigates and advocates for health and personal social needs of ethnic groups within mainstream Irish Society. Therefore the research has a principal interest in assisting EM communities who find it difficult to make their own case for health and personal social services, to incorporate a rights based approach to health and challenge health inequalities. In the process available routine information was obtained and used through consultation with key stakeholders ranging from relevant personnel working with the service users and representatives of key target groups. More detailed information on interventions, which may be effective within the Mid-West Region, was also collected.

### *Healthy Alliances approach*

The key point for a ‘Healthy Alliances’ approach is to explore and act on wider determinants of health and encourage liaison with other agencies. It is widely recognized that the determinants of health are much wider than simply health services, and involves many diverse influences such as physical, social and economic environments, occupation and employment, and lifestyle patterns. In assessing the information relating to these influences in lives of ethnic minority groups other issues relating to health services were also explored along with the relationship between these factors and health. The development of a health strategy for ethnic minorities and an action plan arising from the findings/ recommendations of this assessment involves partnership with local authorities and voluntary bodies in the region, agencies outside the Health Service Executive such as Gardai, VEC, Sport Partnerships and local employers.

### **Guiding principles**

- This needs assessment is owned by the people who will implement the actions. This is essentially following the management principle that to make something happen, it is important that the people involved accept the need for change and that it reflects their priorities/ needs.
- The design of this needs assessment will allow for solutions to be implemented while problems are being addressed.
- Health needs assessment is not an end in itself. It is a means of using the research findings to plan the Health Strategy for ethnic minorities and a future Action Plan across Mid-West Region.

### 3. Methodology

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#### Research design

To build a picture of health and personal social needs of ethnic minorities the research combined both qualitative and quantitative methods. This combination highlighted the scale of demand for health services, the additional resources needed and challenges to service delivery in the HSE Mid-West Region.

The use of qualitative and quantitative methods provided complementary information (Better World Healthwise, 2003). Qualitative techniques (focus group discussions combined with structured and semi-structured interviews) provided personal experiences and insights, while quantitative methods (written questionnaires for ethnic minorities and health services personnel) were used to measure particular demographic and health status characteristics as well as aspects of health service design and delivery. The emphasis on consultation with health service providers as well as ethnic health service users is two fold:

- It gives an opportunity for both service users and providers to identify their needs.
- It enables the participants to take ownership over future actions.

#### Research Sample

The research sample was determined according to key elements of this study.

- Consultation with members from ethnic minority communities /EM organizations and other organizations working with EM communities in Limerick, Clare and North Tipperary.
- Consultation with HSE service providers in Limerick, Clare and North Tipperary including management and staff.
- Consultation with other key statutory and voluntary agencies.

#### *Community consultation*

A central component of this needs assessment has been the collection of the views and experiences of ethnic minority communities as users of health and personal social services. There are no recommended sample sizes for this type of study. Due to the rapidly changing nature of ethnic minority communities and absence of HSE data collection systems, it was not possible to construct a sampling frame, which could be used for random sampling. This is also confirmed by other studies, which found that use of random sampling is unrealistic in health service research of "hard to reach" groups. The use of key informants and "snowballing technique" has been shown to be invaluable to inform this type of research and was employed in this research (*Strategies for sampling black and ethnic minorities populations, Journal of Public Health Medicine, UK 1995*)

#### *Professional consultation*

A significant strength of this health needs assessment has been the presentation of views and experiences of health service providers, statutory and voluntary sector organizations involved in delivering services to ethnic minorities in the Mid-West. The sample was identified via contact with the HSE, statutory and voluntary organizations in Limerick, Clare and North Tipperary and was drawn up to ensure representation by:

- Different professional groups within the HSE;
- Statutory and voluntary organizations;
- Managers within organizations and front-line staff;
- Organizations working with ethnic minorities in the Mid-West.

All areas of the Mid-West HSE were well represented in the sample. There were 29 statutory and voluntary organizations in the sample. Of them, 11 provide services only to ethnic minorities and 18 provide services to all segments of the population including ethnic minorities. This was important in terms of a representative sample. In total 24 interviewees mentioned that their organizations provided services to all categories of immigrants and 5 indicated that their organization provided services on a smaller scale to particular categories. Organizations included in the sample have regular contact with ethnic minority communities and include: the Irish Refugee Council, The Irish Polish Business Association, The Community Development Project in Ennis and West Limerick, The Migrants Forum in West Limerick, Doras Luimni, Cairde, The VEC, An Garda Siochana, Paul Partnership, Sports Partnerships, Social Services Centres, County Childcare Committees, and The Reception and Integration Agency (RIA).



In The HSE Mid region there were 3 focus group discussions and 16 phone interviews with a range of professionals from different sections within HSE. There were 168 questionnaires sent by post and via email to health service providers of which 38 were returned.

Research is based on information provided by volunteer participants. Confidentiality was very important to the process and all respondents were informed about how the information was to be utilized.

Some respondents were invited to the consultation day for the Health Strategy and Action Plan within Mid-West. Table 1. provides a summary of those targeted in the study and the data collection methods that were employed to access the information from them. The terms used in Table 1. to describe each target group will continue to be used throughout the study.

Table 1. Target population and methods of data collection used.

Numbers of the target population / Data collection method used	EM	HSE Professionals	Key Stakeholders
Questionnaires	87 Ethnic minority questionnaire respondents	38 HSE professional questionnaire respondents	0
Focus group discussions	48 EM focus group participants	40 HSE professional focus group participants	0
Interviewees	15 EM interviewees	15 HSE professional interviewees (mainly management)	29 Key stakeholder interviewees

### Qualitative study

#### Focus groups

Focus groups were used to gather views and opinions from different representative groups of ethnic minorities living in the region. There were 12 focus group discussions organized in this study. See Table 1 Appendix 3. Two of these groups were exclusively women and the last three mixed gender groups were attendees at the Intercultural Strategy Consultation Day. Geographical coverage was included as a factor in organizing the focus groups.

Focus groups were held at different meeting venues and at times that maximized participation. One researcher facilitated each focus group session, while another recorded the participants' comments. Each focus group lasted approximately one hour.

The focus group topics used to illicit the information were the same for ethnic minorities and health service providers. Four questions were used in these discussions. The same questions were used with focus groups at the Intercultural Health Strategy Consultation Day. The questions were:

- What are the main problems/ barriers experienced by ethnic minority communities in accessing the health services?
- How can HSE improve the design and delivery of its services so that they can improve the health and well-being of ethnic minority groups?
- What support can be given to ethnic minority groups and organizations to enhance access to health services?
- What do you think are the three most important things that the HSE should consider/address?

#### Interviews

Interviews were used in this study to obtain quantifiable and comparable information relevant to health and personal social needs of ethnic minorities within the HSE West, Mid West region. The design of structured and semi-structured interviews facilitated the identification of solutions to problems mentioned by respondents throughout the assessment process. The aim was to:

- Capture and describe the experiences of and challenges identified by ethnic minority communities in accessing health and personal social services.

- Determine the level and range of health and personal social services that are essential in meeting the specific needs of ethnic minority communities within the area.

Sixteen interviews were conducted with different professionals from front line staff in primary care and acute settings as well as management in the HSE. The interviews were conducted face to face and by telephone. Participants were identified from ethnic minority communities /EM Organizations and other organizations working with EM communities in Limerick, Clare and North Tipperary.

Other interviewees were HSE service providers in Limerick, Clare and North Tipperary including management and front line staff. During the fieldwork, representatives of other statutory, voluntary and employment organizations were interviewed.

Their selection was based on the criteria of social determinants of health with their work focusing on the following areas: integration, education, employment, accommodation and / or childcare.

#### *Content analysis of the focus group sessions and interviews*

A general theme structure was adopted in reporting on the focus groups discussions and interviews. Emerging issues are highlighted, outlining the context within each developed theme. As the objectives of this study are centred on the health and personal social needs of ethnic minorities, the structure of the results section encompasses these issues individually.

#### *Source of bias*

There is potential for bias in any qualitative study. *Selection* bias was addressed by inviting all individuals on the day of the focus groups to participate. *Interviewer* bias was minimized by keeping to the format of the questions agreed at the outset, allowing participants to talk without prompting and assuring them that it was anonymous. Confidentiality was paramount to the process and all participants were informed about how the information obtained was to be used.

## **Quantitative Study**

#### *Questionnaire for ethnic minorities*

A questionnaire was developed to carry out the collection of quantitative data. The aim of the questionnaire was to capture the knowledge and experiences that ethnic minority groups have in accessing health services and subsequently inform future design and delivery of these services. The questionnaire has 80 questions and was structured in three parts: general information, health and personal social needs and strategy to improve design and delivery of the health services. The design of the questionnaire was based on the following structure:

1. General information
  - demography
  - area and length of residence
  - languages spoken and level of English language
  - education
  - employment status
  - accommodation
  - family situation
2. Health and personal social needs
  - use of health services (primary care and acute settings) and level of satisfaction
  - rights and entitlements
  - general health status
  - health behaviour
3. Strategy to improve the design and delivery of health services
  - suggestions to improve the health services design and delivery

This questionnaire was designed based on one used in a health needs assessment of asylum seekers in Cork 2003 (Better World Healthwise). The sections were adjusted to apply the questions to all categories of ethnic minorities living in the Mid-West Region. The questionnaire was translated into three languages: French, Polish and Russian to assist those who had difficulties communicating in English. All ethnic minorities surveyed spoke one of these languages. The researcher also spoke English, Russian and Romanian and did not use an interpreter.

The questionnaire was designed to be self-administered by participants. An initial pilot was undertaken to ensure that all questions were clear and understood by all respondents. The Ethnic Minority Working Group HSE Mid- West oversaw the design and development of this questionnaire. A copy of the questionnaire is included in Appendix 1.

The field researcher outlined the aim of the research to all with no pressure placed on individuals to participate. Confidentiality was assured and the researcher was available to provide assistance in completing the questionnaires. A total of 87 ethnic minorities completed this questionnaire. They ranged in age from 18 to 65 and were of 34 nationalities. The fieldwork was carried out over a period of 2 months.

#### *Scoring of the questionnaire*

The questionnaire responses were coded numerically for analysis in the Statistical Package for Social Science (SPSS 14.0).

#### *Sources of bias*

The questionnaires were self administered although assistance was provided by the researcher when requested, the questionnaire was explained in a standardized format. Non-response bias was eliminated by asking participants individually to participate and there were very few refusals. Selection bias was addressed by using a presenting sample.

#### *Questionnaire for health service providers*

The second questionnaire was designed for health service personnel acknowledging that professionals from the HSE have different knowledge and experiences of delivering the health services to ethnic minorities and may feel they have some influence over the design and delivery of health services in the future. For these reasons the information was gathered from the front line HSE staff including managers across health professions and sectors. The HSE Ethnic Minority Working Group Mid West Region oversaw the design and development of this questionnaire. Administering and collection of the questionnaire was also facilitated by the EMWG Mid-West.

The following factors were included in the questionnaire:

- involvement in delivering health services to EM,
- identification of gaps in the existing provision of health services to EM,
- possible ways to overcome the barriers (gaps),
- prioritizing the areas that the health services should address,
- identifying the assistance and support that are required by health professionals,
- exploring models of good practice.

The questionnaire was designed to be self-administered by participants and anonymity was ensured.

A copy of the questionnaire is included in Appendix 2.

There were 168 of questionnaires sent via post and email. A total number of 38 respondents completed and returned the questionnaires ranging from health professions such as: GPs, public health staff, nursing and medical staff from acute services, midwives, social workers, community welfare officers, dieticians, an environmental health officer, an area health officer, social care workers, and an ophthalmologist. The fieldwork was carried out over a period of two months by the researcher.

#### *Content analysis of the questionnaire*

A general theme structure was adopted in reporting on questionnaires for health services personnel. Emerging issues are highlighted, outlining the context within each developed theme:

- language and communication;
- information and outreach;
- health services staff composition and cultural competence;
- design and delivery of health services.

#### *Limitations of the study*

The main limitations of this study were the low response rates from HSE professional questionnaire respondents. In order to overcome this limitation, the results of the three target groups studied will be examined cohesively in the Findings section. Three methods of data collection were used to produce all the quantitative and qualitative findings (Chapter 5). Three different populations were targeted to get a multiplicity of perspectives.

The combination of community development, healthy alliances and advocacy approaches directed the targeting of respondents and ultimately the methods of data collection. The use of multiple data collection methods and the target groups provides comprehensive findings based on quantitative facts and qualitative opinion making this research unique in its complementarity of results.

## 4. Profiling Ethnic Minority Communities

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The first objective for the study was to report on the nature of the overall population of ethnic minority communities in the Mid-West Region, and to determine the availability of demographic data relating to this population. Looking at the national picture, there is evidence of considerable variation between different regions and localities across the country, and between different ethnic minority groups. Some groups are growing faster than others, and local circumstances are important. The demographic picture is therefore complex, and considerable caution should be exercised in applying national trends to local planning.

For this reason, it has become increasingly apparent that planners and providers within health services require accurate and up-to-date information about local communities and community needs. However, the indicative research carried out for this study suggests that such information is frequently unavailable, unreliable, or difficult to access. In order to target the most appropriate services and resources, it is important to understand how the population of ethnic minority communities in the Mid-West compares with the national picture, and how the local distribution varies between localities within the region. Thus, the accurate identification of health needs and health inequalities involves a number of complex tasks. The following sections draw on both national and local data in order to highlight the most readily available sources of information, and to provide estimates of the current ethnic minority population in Mid-West.

### The national situation

Census 2006 Principal Demographic Results indicated that the population enumerated on census night, 23 April 2006, was 4,239,848 persons compared with 3,917,203 in April 2002, representing an increase of 322,645 persons or 8.2 % over the four-year period.

The number of non-Irish nationals who were resident in the State increased from 224,000 to 420,000 (+87%) over the same period. The most recent, and the fastest growing, immigration flow comes from EU New Member States (NMS), apart from Irish or UK nationals, along with Africans and Asians. Polish nationals numbered 63,300 while the number of Lithuanian nationals was 24,600. In overall terms non-Irish nationals made up 10 % of the usually resident population that indicated a nationality in April 2006.

The number of persons who migrated into the State in the twelve months before census day increased by 60% compared with four years previously. Approximately three quarters of them were from EU countries. Poland (33,400) was the single largest category, followed by the UK (22,600) and Lithuania (7,400). The remaining EU countries accounted for nearly 22 % of the one-year inflow. (*Census 2006, Principal Demographic Results, CSO, July 2007*)

This demographic trend of increasing migration is expected to continue, which estimates that the proportion of foreign born people in Ireland in 2036 may reach 18% of the total population. ([www.cso.ie](http://www.cso.ie))

National data from the Quarterly National Household Survey suggests that most immigrants are employed; 73% of those aged fifteen and over are in the labour force. Of the immigrants who came from NMS almost 90% are employed. (*Migration Policy, Nr.15, National Economic and Social Council, September 2006*)

### **Nationality, age and gender profile**

Over 610,000 usual non-Irish residents, representing 14.7 % of the total, were born outside the State, with EU 25 (excluding Ireland) accounting for nearly 440,000 (10.5%) of the total. The largest category was those born in Britain (221,600) while persons born in Poland (63,100) are now the second largest group amongst the foreign-born. Table 2 gives a detailed country breakdown classified by broad age group. This shows that 84.4 % of persons from the ten new countries which acceded to membership of the EU on 1 May 2004 and who were permanently living in the State at the time of the census were aged 15-44 years with almost equal distribution of gender. (*Census 2006, Principal Demographic Results, CSO, July 2007*).

Table 2: Persons usually resident and present in the State on Census Night, classified by place of birth and age group. Source: Census 2006, Principal Demographic Results

Nationality	Total	Age group				
		0-14 years	15-24 years	25-44 years	45-64 years	65 years and over
Ireland (Republic)	3,559,384	777,059	519,243	1,017,257	813,837	431,988
Outside Ireland (Republic)	612,629	83,437	99,222	303,294	98,464	28,212
EU	438,489	52,900	70,857	210,133	80,473	24,126
Other European Countries	27,517	4,298	3,996	16,403	2,533	287
Africa	42,764	7,854	5,778	24,864	3,750	518
Asia	55,628	6,936	11,106	31,488	5,298	800
America	38,301	9,506	5,910	15,223	5,425	2,237
Australia	6,624	1,505	1,218	3,205	539	157
New Zealand	2,393	289	245	1,474	325	60
Other countries	913	149	112	504	121	27
<b>Total</b>	<b>4,172,013</b>	<b>860,496</b>	<b>618,465</b>	<b>1,320,551</b>	<b>912,301</b>	<b>460,200</b>

Table 3: Persons, males and females, usually resident and present in the State on census night, classified by place of birth. Source: Census 2006, Principal Demographic Results

Birthplace	Persons	Males	Females
Ireland (Republic)	3,559,384	1,766,860	1,792,524
Outside Ireland (Republic)	612,629	318,332	294,297
EU	438,489	229,751	208,738
Other European Countries	27,517	14,706	12,811
Africa	42,764	21,647	21,117
Asia	55,628	29,073	26,555
America	38,301	18,161	20,140
Australia	6,624	3,238	3,386
New Zealand	2,393	1,286	1,107
Other countries	913	470	443
<b>Total</b>	<b>4,172,013</b>	<b>2,085,192</b>	<b>2,086,821</b>

**Ethnic or cultural background profile**

A new question on ethnic or cultural background was included in the 2006 census. The CSO consulted various representative agencies who suggested the tick box categories chosen and the wording used to describe these categories. Based on the results of the Census test it was decided to include the question in the 2006 Census. Table 4 summarises the headline figures for usual residents.

Table 4: Ethnic and cultural background of persons usually resident in the State on Census night, classified by ethnic or cultural background. Source: CSO, Census 2006, Principal Demographic Results.

Category	Thousands	%
<u>White</u>		
Irish	3,645.2	87.4
Irish Traveller	22.4	0.5
Any other White background	289.0	6.9
<u>Black or Black Irish</u>		
African	40.5	1.0
Any other Black background	3.8	0.1
<u>Asian or Asian Irish</u>		
Chinese	16.5	0.4
Any other Asian background	35.8	0.9
<u>Other including mixed background</u>		
Not Stated	46.4	1.7
	72.3	
<b>Total</b>	<b>4,172.0</b>	<b>100.0</b>

White was the predominant category accounting for nearly 95 % of the usually resident population. Persons of Asian or Asian Irish background accounted for a further 1.3 %, while those who ticked the African box in the Black or Black Irish section made up 1 % of usual residents.

### Religious profile

Changes in the number of adherents of the various religious groupings over recent censuses have been influenced by trends in migration. Table 5 classifies usual residents by religion and nationality. The table shows that 92 % of Irish nationals were Roman Catholic compared with 50.8 % for non-Irish nationals.

The religious grouping with the highest proportion of non-Irish national adherents was Orthodox (84.2%) with its members coming mainly from Eastern Europe outside the European Union. Muslims, with 68 % of their adherents being non-Irish nationals, are mainly of African and Asian extraction.

Table 5: Persons usually resident and present in the State on Census Night, classified by religion and nationality. Source: Census 2006, Principal Demographic Results

Nationality	Total	Religion								No religion	Not Sated
		Catholic	Church of Ireland (incl. Protestant)	Other Christian religion, n.e.s	Presbyterian	Muslim (Islamic)	Orthodox	Methodist	Other stated religion		
Irish	3,706,683	3,409,381	86,990	16,327	13,628	9,620	2,881	5,077	22,497	105,356	34,785
UK	112,548	54,214	22,511	1,667	3,621	761	117	2,053	4,167	21,851	1,727
Rest of EU	163,227	112,806	3,388	1,551	990	777	3,666	293	7,284	27,529	4,943
Rest of Europe	24,425	4,002	412	412	1,082	1,924	11,776	52	1,824	2,101	989
Africa	35,326	8,530	2,467	4,553	1,649	6,909	196	2,330	6,337	917	1,438
Asia	46,952	12,443	648	1,482	259	10,649	731	407	8,792	10,187	1,354
America	21,124	13,229	722	738	549	128	64	281	1,866	2,661	886
Other nationalities	16,131	8,188	1,049	411	410	606	295	196	848	3,198	930
Not stated, incl. no Nationality	45,597	22,172	761	217	127	405	268	79	418	1,452	19,698
<b>Total</b>	<b>4,172,013</b>	<b>3,644,965</b>	<b>118,948</b>	<b>28,028</b>	<b>21,496</b>	<b>31,779</b>	<b>19,994</b>	<b>10,768</b>	<b>54,033</b>	<b>175,252</b>	<b>66,750</b>

**Economic status profile**

Table 6: Persons aged 15 years and over, usually resident and present in the State on Census Night, classified by ethnic or cultural background and principal economic status. Source: Census 2006 report, vol. 5 Ethnic or cultural background.

Principal economic status	Total	Ethnic or Cultural Group								
		White			Black or Black Irish		Asian or Asian Irish		Other including mixed back-ground	Not stated
		Irish	Irish Travellers	Any other White Back-ground	African	Any other Black Back-ground	Chinese	Any other Asian Back-ground		
<u>In labour force</u>	1,892,787	1,627,713	1,806	182,207	9,187	1,480	6,924	17,639	20,464	25,367
At work										
Unemployed	27,791	16,429	800	6,239	2,067	71	339	533	855	458
Looking for first regular job lost or given up previous job	147,761	117,603	4,594	13,010	4,622	208	576	1,649	2,600	2,899
<u>Total in labour force</u>	2,068,339	1,761,745	7,200	201,456	15,876	1,759	7,839	19,821	23,919	28,724
<u>Not in labour force</u>										
Student	341,625	303,673	1,215	14,267	4,092	274	5,368	4,552	4,076	4,108
Looking after home/family	383,108	342,149	2,915	20,292	2,564	214	975	2,974	3,443	7,582
Retired	368,692	347,700	379	12,139	77	33	175	260	1,382	6,547
Unable to work due to permanent sickness or disability	137,776	129,483	1,164	4,307	258	35	67	174	886	1,402
Other	11,977	8,678	225	1,158	968	27	50	260	326	285
<u>Total not in labour force</u>	1,243,178	1,131,683	5,898	52,163	7,959	583	6,635	8,220	10,113	19,924
<u>Total aged 15 years and over</u>	3,311,517	2,893,428	13,098	253,619	23,835	2,342	14,474	28,041	34,032	48,648

**Immigration status profile**

Immigrant workers

Migrant workers are currently an important category of ethnic minorities, given their numbers and the fairly recent increases in the population. NGOs report that migrant workers tend to be in highly vulnerable and isolated situations; sometimes working in poorly regulated sectors and that they are least likely to have access to health services and clear information about what to do when they experience problems.

In terms of nationalities of the migrant workers in Ireland the data comes from the Department of Social and Family Affairs ([www.dsfa.ie](http://www.dsfa.ie)). These figures indicate the number of immigrants applying for PPS numbers. Anyone coming into the State who is documented can apply for a PPS number as long as they have permission to work and proof of identity. So, DSFA figures provide a snapshot of people registering for PPS numbers with a breakdown of their nationality, age and gender. It should be noted that these figures indicate “flows” and not “stocks”. They do not take into account the movement of people within the country or movement in and out of the State.

*Table 7: Allocation of PPS numbers by nationality 2006. Source: DSFA*

POLAND	93787	ESTONIA	1407	BULGARIA	267
LITHUANIA	16039	CANADA	1161	EGYPT	260
UNITED KINGDOM	14336	SOUTH AFRICA	1126	IRAQ	222
SLOVAKIA	10687	NETHERLANDS	1104	ARGENTINA	212
LATVIA	7954	SWEDEN	1103	THAILAND	210
FRANCE	6879	NEW ZEALAND	1010	GREECE	207
INDIA	5580	PORTUGAL	935	CONGO	193
GERMANY	4605	AUSTRIA	769	NORWAY	192
CZECH REPUBLIC	4458	MALAYSIA	636	EL SALVADOR	190
SPAIN	4433	SCOTLAND	594	ZIMBABWE	187
HUNGARY	4330	FINLAND	508	GEORGIA	186
ENGLAND	4296	BELGIUM	506	CROATIA	176
ITALY	4222	REPUBLIC OF KOREA	491	SOMALIA	167
USA	4079	RUSSIA	464	TURKEY	165
OTHER	3887	BANGLADESH	456	ISRAEL	162
BRAZIL	3460	SUDAN	448	MEXICO	158
ROMANIA	3336	IRAN	436	GHANA	153
NORTHERN IRELAND	2907	UKRAINE	405	MALTA	143
AUSTRALIA	2105	MOLDOVA	294	WALES	120
MAURITUS	1938	SWITZERLAND	291	CAMEROON	117
PHILIPPINES	1884	DENMARK	286	MOROCCO	112
NIGERIA	1623	JAPAN	277	KENYA	101
PAKISTAN	1425	BULGARIA	267	SLOVENIA	101
CHINA	1418	EGYPT	260	SRI LANKA	101

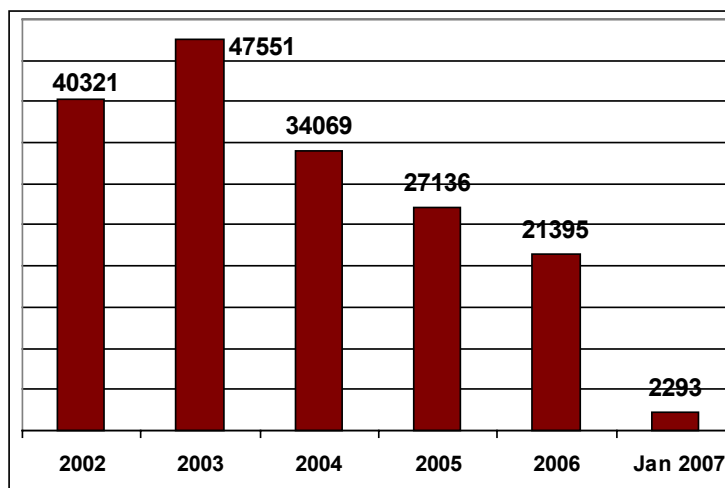
### Work Permit Holders

Work permits are the main legal route of entry to the Irish labour market of non-EEA nationals. While the overall number of immigrant workers increased, the number of work permits decreased significantly (Chart 1). The number of work permits issued by Department of Enterprise, Trade and Employment (DETE) peaked 47,551 in 2003 and since then the number has fallen to 2233 of work permits issued in Ireland by January 2007. This is partly due to a more restrictive work permit system being introduced after EU enlargement. Before this, accession state nationals were required to hold work permits. This is no longer necessary. Further, in August 2004, the DETE announced it would no longer consider applications for work permits for jobs in a number of occupations in the low-skilled, low waged sectors. In addition all work permit applications for eligible occupations received by the DETE are assessed to ensure that every effort has been made to source EEA nationals. It can be said that work permit system now plays a less significant role in the context of immigration. (MIA, 2006).

Work permit holders from as many as 86 countries were given permission to work in sectors such as the catering, service industry, agriculture and fisheries, industry, etc. ([www.enterprise.ie](http://www.enterprise.ie)). It should also be noted that some migrant workers are employed in highly skilled and comparatively well paid employment in sectors such as information technology and parts of the health service.



Chart 1: Work Permits issued Nationally 2002-06. Source DETE



The figures suggest a decrease in the number of work permits issued since mid 2004. These figures do not reflect the numbers of work permit holders who might have stayed in the State after their permit has expired.

Asylum seekers & refugees

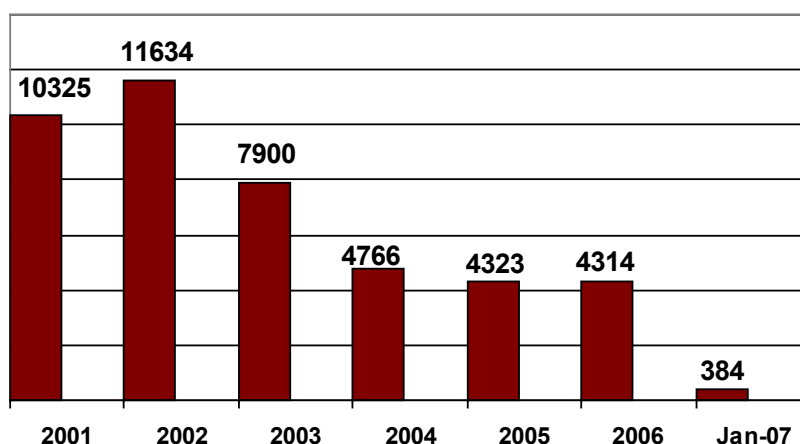
Many asylum seekers and refugees have experienced traumatizing situations and have had to overcome political persecution, detention, and war to reach a country where they are unlikely to have a wider family or support network and have to deal with a new language, culture and systems of Government. This is compounded where access to education, training, and employment during these lengthy periods is restricted. Asylum seekers in Ireland live in 'direct provision' – communal accommodation centres on full-board and with reduced social welfare payments. Criticisms of direct provision have included inconsistency in standards, choice of food and lack of cooking facilities, cultural appropriateness of services and the concern that the system isolates asylum seekers from the rest of society. (NCCRI, 2006).

In particular, asylum seekers and refugees may have specific physical and psychological health needs due to their previous experiences. In Ireland, asylum seekers are entitled to a medical card for free general practitioner services, and to exceptional needs payments through community welfare officers, and to a medical screening.

The number of asylum seekers and refugees who come to Ireland is a very small percentage of the whole immigration figure. The number of asylum seekers coming to Ireland increased dramatically from the mid 1990s up to 2002 when it peaked at 11,634 applications in one year. Since then, the number of applications has been reducing and in 2006 there were 4314 applications for asylum in Ireland (Chart 2). 384 applications were received by ORAC in January 2007 ([www.orac.ie](http://www.orac.ie)).

The top 5 countries of origin of the people coming to Ireland seeking protection are: Nigeria, Iraq, Sudan, DR Congo and Zimbabwe.

Chart 2: Number of Asylum applications in Ireland 2003- 2006. Source: ORAC

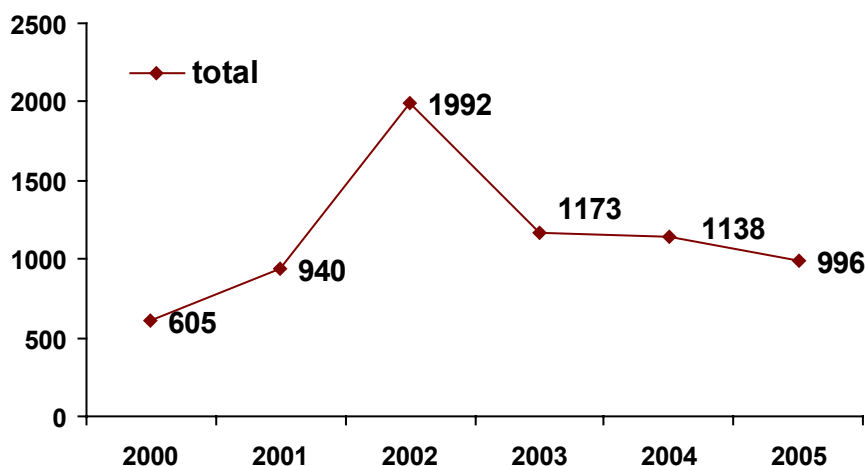


The cumulative number of applicants during the five years period (January 2000 to November 2005) came to 50793 people. Numbers of people refusing or missing from direct provision for the same period is 5660. (RIA Monthly Statistics Report, November 2006, [www.orac.ie](http://www.orac.ie))

Refugees are either asylum seekers whose claim for asylum has been granted by the Government in question, or people who have been invited by the government to come directly to the country as refugees through humanitarian programmes, sometimes referred to as 'programme refugees' or 'quota refugees'. Refugees are likely to experience many of the same issues as asylum seekers in terms of background; however the main difference is that they have for the most part the same entitlements as citizens, such as the right to work.

Recognition rates in Ireland are some of the lowest in Europe and have decreased steadily, from 1.992 in 2002 to 966 in 2005. In the period 2000-05 from a number of 53654 of people who sought asylum in Ireland a number of 6814 people have been recognized as refugees. Of this 4022 (59%) were refused in the first instance, but recognized after their appeal. A very small number of people 617 were granted leave to remain on humanitarian grounds.

Chart 3: Refugees' recognition rates 2000-05. Source DJELR



Leave to remain – Irish Born Child (LTR-IBC)

Another category of ethnic minorities is foreign-national parents of Irish born children granted leave to remain under the Irish Born Child Scheme in 2005 (IBC/05). Following the 2004 constitutional amendment on citizenship, the Minister of Justice, Equality and Law Reform introduced the Irish Born Child 2005 administrative scheme through which application to remain on the basis of having an Irish Born Child could be made. The scheme closed in March 2005.

The entry status of people granted LTR-IBC shows that students, workers and other migrants as well as asylum seekers were present. Although the scheme was aimed at regularising the large number of asylum seekers eligible under this system, in fact they make up around 60% of total number of persons granted this status. Under the IBC/05 Scheme, 17,917 applications were received from parents of children born in the State prior to 1 January 2005 when the provisions of the Citizenship Referendum came into effect. 16,693 applications for leave to remain were granted for an initial period of 2 years and permission is now due to be renewed for periods of up to three years at which stage those qualifying will be eligible to apply for full citizenship. ([www.justice.ie](http://www.justice.ie)).

Everybody with this status must be able to prove that they are financially self-sufficient within two years of obtaining the status and that they do not rely on social welfare or State funding for subsistence. There is no right to family reunification, or to permanent residence. They have restricted access to education and training, which places them at a disadvantage in entering the labour market. This is further exacerbated by the fact that a great many are one-parent families (MIA, 2006).

Students

Students are not usually regarded as "immigrants", but recent years have seen a dramatic growth in the numbers of international students in the Irish educational system. Despite the high number of international

students in Ireland, there is very little data available. The Census 2006 Report indicates a total of 341,625 students in Ireland of them 32,649 are non-Irish students. When classified by ethnic or cultural background, figures indicate that the largest student group of 14, 267 is of white background other than Irish and Irish Travellers. (*Census 2006, vol. 5 – Ethnic or Cultural Background*)

A survey by Education Ireland records a total of 22,947 non-Irish students registered in participating Higher Education Institutions in Ireland during the 2004-2005 academic year, 14,106 of whom were from non-EU countries. This figure does not include a much larger number of students enrolled in private language schools. International students have limited access to the labour market. (*NCCRI, 2006*).

To conclude this section it is important to mention that while some of the migrants from all the above categories will return home, many will remain seeking long-term residency and citizenship. It is estimated that there are 165 nationalities living in Ireland (*Department of Social and Family Affairs 2002, www.dsfa.ie*).

## The situation in Mid-West Area

The Health Service Executive West, Mid-Western Area comprises the counties of Limerick, Clare and Tipperary North Riding and provides health services in 2006 for a population of 360,651, which represented 8.5% of the population of the State. (*Census 2006 Preliminary Report, CSO*)

According to the Census 2006 the population in the Mid-West Region increased on average by 6.2 % during the period from 2002-2006, with Limerick County having a population increase of +8.4%. Developments in the suburban areas adjacent to Limerick city were major contributors to this growth. For example, Ballycummin electoral division (ED) in the outskirts of Limerick City increased its population by 2,844 or 21.2 % between 2002 and 2006.

### **Nationality profile**

The most recent, and the fastest growing, immigration flow into the Mid-West Region comes from EU New Member States (NMS) with 11,931 persons, apart from Irish or UK nationals, along with Rest of the World nationalities that account for 8,769 persons. Polish nationals represent 5,348 while the number of Lithuanian nationals was 1,282. In overall terms non-Irish nationals in the Mid-West made up around 9% of the usually resident population that indicated a nationality in April 2006.

*Table 8: Nationalities of persons usually resident in Mid-West. Source: CSO, 2006 Small Area Population Statistics (SASP).*

Nationality	Total	Limerick City	Limerick Co.	Clare Co.	North Tipperary
Irish	321,701	46,038	119,451	96,302	59,910
UK	9,437	713	2,997	3,738	1,989
Polish	5,348	1,538	1,742	1,365	793
Lithuanian	1,282	241	435	285	321
Other EU 25	5,301	1,190	1,376	1,969	766
Rest of the world	8,769	1,746	2,603	3,481	939
Not stated	3,255	420	1,111	1,171	553
<b>Total</b>	<b>355,203</b>	<b>51,886</b>	<b>129,715</b>	<b>108,331</b>	<b>65,271</b>

### **Ethnic or cultural background profile**

Census 2006 data indicate estimated figures for people from different ethnic and cultural background in Clare, Limerick Co. & City and Tipperary. There were 26,808 White people from any other cultural background than Irish and Irish Travellers. The total number of Blacks or Black Irish would be 2,879 persons. Asians or

Irish Asians would represent 3,289 persons. Other ethnic groups, including mixed background are 3,839 people. There were 6,145 persons that didn't state their ethnicity. (Census 2006 Report, vol. 5, SCO)

*Table 9: Ethnic and cultural background of persons usually resident in Clare, Limerick and Tipperary.*  
Source: Census 2006 Report, vol. 5, CSO

Province County or City	Total	Ethnic or Cultural Group								
		White			Black or Black Irish		Asian or Asian Irish		Other including mixed back-ground	Not stated
		Irish	Irish Travellers	Any other White Back-ground	African	Any other Black Back-ground	Chinese	Any other Asian Back-ground		
Clare	108,760	95,308	665	7,520	1,124	75	211	523	1,274	2,060
Ennis	23,101	18,576	409	2,065	835	49	76	184	494	413
Co. & City	180,314	161,718	1,411	10,353	1,197	109	566	1,226	1,506	2,228
Limerick										
Limerick City	84,729	72,933	386	6,645	1,129	81	499	997	984	1,075
Tipperary	147,944	134,066	890	8,935	307	67	238	525	1,059	1,857
Nenagh	7,330	6,095	22	898	29	4	21	54	82	125

**Religious profile**

Changes in the number of adherents of the various religious groupings over recent censuses have been influenced by trends in migration. Table 10 classifies usual residents by religion. The table shows that 90 % of people were Catholics compared with almost 5 % for other religions.

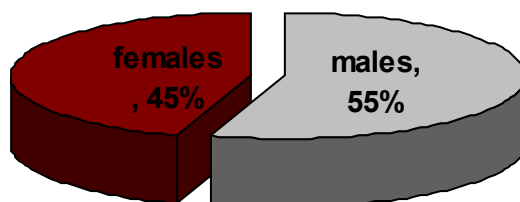
*Table 10: Religions of persons usually resident in Mid-West on Census night.*  
Source: CSO, 2006 Small Area Population Statistics (SASP)

Religions	Total	Limerick City	Limerick Co.	Clare Co.	North Tipperary
Catholic	326,562	47,069	120,903	98,189	60,401
Other Religions	17,775	2,613	5,691	6,067	3,404
No religion	11,902	2,169	3,538	4,680	1,515
Not stated	4,760	689	1,384	1,984	703
Total	361,028	52,539	131,516	110,950	66,023

**Gender profile**

The gender composition of the ethnic minority population in Clare, Limerick Co.& City, Tipperary area is quite similar to the national one. Census 2006 figures indicate that there were 20,151 males (55%) and 16,664 females (45%) during April 2006 living in this region. There were 3295 males and 2850 females that did not state their ethnicity.

Chart 4: Gender composition of ethnic minorities in the Mid-West Region.  
Source: 2006 Census Preliminary Report, CSO



*Immigration status profile*

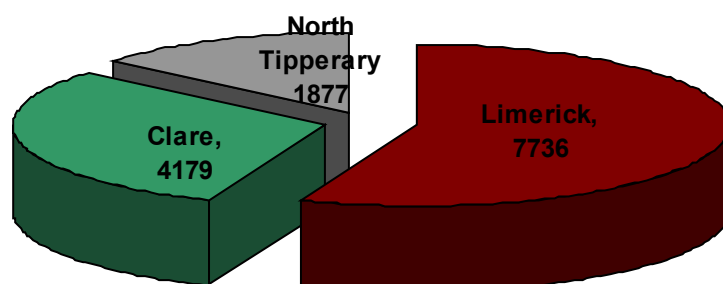
Migrant workers

The Department of Social and Family Affairs (DSFA) keeps a register of Personal Public Service (PPS) numbers issued at all local offices throughout the State. This provided limited information, such as the number of people who have registered in a given local office of the DSFA, their nationality, age and gender. Accessing the information proved to be an onerous task as it had to be extracted manually for the three selected areas of the Mid-West Region: Limerick, Clare and North Tipperary. The figures illustrated in this exercise do not provide details of those who have not applied for PPS numbers, those who have come to Mid-West for reasons other than employment or those who have left the area or returned home.

Table 11: Top 20 nationalities of those that applied for PPS numbers in the Mid-West Region 2006  
Source: DSFA

Limerick		Clare		North Tipperary	
Nationality	Number	Nationality	Number	Nationality	Number
POLAND	4,927	POLAND	2,466	POLAND	1,195
SLOVAKIA	623	SLOVAKIA	308	UK	200
U K	226	GERMANY	151	SLOVAKIA	88
CZECH REPUBLIC	195	ENGLAND	130	INDIA	68
ENGLAND	171	CZECH REPUBLIC	128	ENGLAND	47
INDIA	160	FRANCE	120	SOUTH AFRICA	26
PAKISTAN	157	LATVIA	117	CZECH REPUBLIC	23
FRANCE	142	USA	81	USA	22
HUNGARY	113	INDIA	64	GERMANY	19
GERMANY	110	HUNGARY	42	AUSTRIA	16
SPAIN	108	SWEDEN	37	OTHER	15
CHINA	96	SOUTH AFRICA	34	ESTONIA	14
USA	69	PHILIPPINES	32	SPAIN	12
ITALY	45	NETHERLANDS	32	FRANCE	10
BANGLADESH	41	CHINA	31	NEW ZEALAND	10
ESTONIA	39	PAKISTAN	26	ITALY	9
PHILIPPINES	39	MOROCCO	23	PAKISTAN	9
OTHER	31	ITALY	21	AUSTRALIA	8
CANADA	29	AUSTRIA	21	EGYPT	7
AUSTRIA	28	SPAIN	21	UKRAINE	7
Total	7,736	Total	4,179	Total	1,877

Chart 5: PPS numbers allocated in the Mid-West Region 2006. Source DSFA



National data from the Quarterly National Household Survey suggests that most immigrants are employed with 73% of those aged fifteen and over in the labour force. Of the immigrants who came from new member states almost 90% are employed. (Migration Policy, Nr.15, National Economic and Social Council, September 2006) This is reflected in the Mid-West Region, where the highest numbers of immigrants who have registered for PPS numbers come from NMS. In line with national trends, Polish people are the largest national group in all three areas: Limerick, Clare and North Tipperary, followed by British, Lithuanians and Slovaks.

The DSFA keeps a register of claims such as unemployment and one parent family payments issued at all local offices throughout the region. This data provided information such as the number of people who are in receipt of these payments in specific local offices of the DSFA. It also incorporates their nationality and gender. This information had to be extracted manually for three selected areas in the Mid-West Region: Limerick, Clare and North Tipperary.

Table 12: Summary of all DSFA claims in the Mid-West Region. Source: DSFA Mid-West

Scheme Type	Limerick	Clare	North Tipperary	Total
One parent Family Allowance	117	78	41	<b>236</b>
Unemployment Benefit	259	239	95	<b>563</b>
Unemployment Assistance	434	406	153	<b>993</b>
Total	810	723	289	1822
Adult dependants	413	166	49	628
Children dependants	224	499	172	895
Total	1447	1388	510	3345

Table 13: Non Irish nationals with highest levels of claims in special schemes of the DSFA in the Mid-West Region. Source: DSFA Clare, Limerick and North Tipperary.

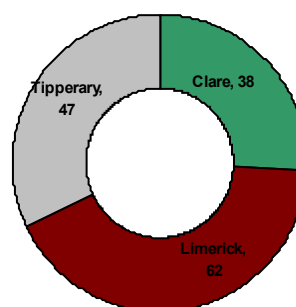
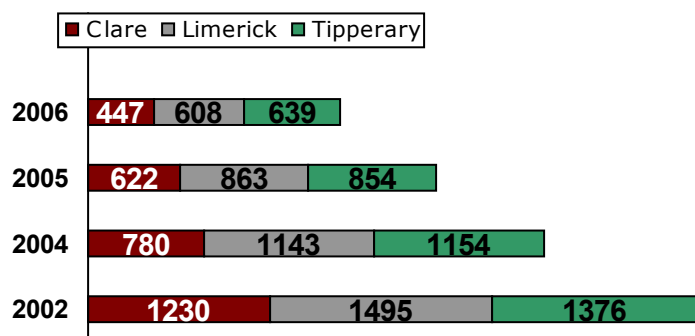
Limerick		Clare		North Tipperary	
Country of origin	Number	Country of origin	Number	Country of origin	Number
UK	262	UK	337	UK	175
POLAND	110	POLAND	59	LATVIA	24
LITHUANIA	59	NIGERIA	44	POLAND	21
NIGERIA	59	GERMANY	27	LITHUANIA	19
SUDAN	35	CZECH REPUBLIC	26	ROMANIA	5
GUINEA	27	SLOVAKIA	21	SLOVAKIA	4
SOMALIA	15	LITHUANIA	20	RUSSIA	3
ALGERIA	10	LATVIA	19	HUNGARY	3
CZECH REPUBLIC	10	USA	17	GERMANY	3
LATVIA	10	FRANCE	11	USA	2

**Work Permits in the Mid-West Region**

The national trends in declining numbers of work permit holders is reflected in the Mid-West Region, with a peak number of 4,101 in 2002, which decreased to 1,694 in 2006, and to 147 work permits issued by January 2007. The same pattern of decline in migration via the work permit system is seen in all three counties: Clare, Limerick and Tipperary. Data on the number of work permits issued by county are available from the Department of Enterprise, Trade and Employment (DETE) website.

Chart 6: Work permits in Counties Clare, Limerick and Tipperary, Source: DETE

Chart 7: Work permits issued in January 2007 in Clare, Limerick and Tipperary; Source: DETE



It should also be noted that some migrant workers are employed both in low paid and in highly skilled and comparatively well paid employment in sectors such as information technology and in sectors of the health service.

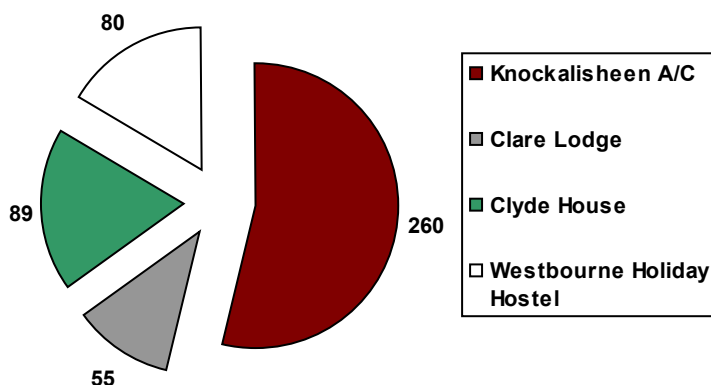
**Asylum seekers in the Mid-West Region**

In the Mid-West Region, there are 4 direct provision centres, operated by RIA, which provide hostel accommodation for people waiting for the assessment of their asylum claims. The centres in Limerick are Clyde House and Westbourne Hostel and in Ennis are Clare Lodge and Knockalisheen Accommodation Centre. These hostels are owned and managed by private individuals or companies, but paid for by the State.

The total number of asylum seekers in direct provision centres in the Mid-West is 504 persons (RIA Monthly Statistics Report, November 2006) with 324 accommodated by RIA in Clare and 180 in Limerick. There are no centres in Tipperary North.

A snapshot of residents of direct provision centres during the last week of January 2007 gives a total figure of 484 asylum seekers. The break down by centres is as follows: Knockalisheen Accommodation Centre, Clare has 260 residents including families, single males and single females; the Clare lodge in Ennis has 55 single males; Clyde House in Limerick has 89 single residents and in Westbourne Holiday Hostel also in Limerick there are 80 single residents. (HSE West-January 2007)

Chart 8: Composition of asylum seekers in direct provision centres January 2007 in the Mid-West Region.



The following table presents more detailed information regarding residents of the four direct provision centres with a break-down of heads of households which indicates single persons from Clare Lodge, Clyde House and Westbourne Holiday Hostel, while adult and child dependants and single parent families all reside in Knockalisheen Accommodation Centre.

Table 14: Residents in direct provision centres in Mid-West by last week of January 2007. Source: HSE West.

	Head of Household	Adult Dependants	Child Dependants	TOTAL
Clare Lodge	55			55
Clyde House	89			89
Knockalisheen	159	14	87	260
Westbourne	80			80
	383	14	87	484

**Other categories of immigrants**

There is no source containing a complete record of all categories of immigrants living in the region. Apart from national figures on recognition rates there is no central or local database providing information on those granted refugee status, residency based on "Irish born children" and other categories of EM living in the community. Records of persons in receipt of Supplementary Welfare Allowance in the last week of January 2007 in the Mid-West gives a total of 805 non Irish Nationals. The categories are as follows: asylum seekers living in the community, refugees, residents based on IBC, adult dependants and child dependants, which is the biggest group on the database.

Chart 9: Categories of immigrants in receipt of SWA by the last week of January 2007. Source: HSE West.

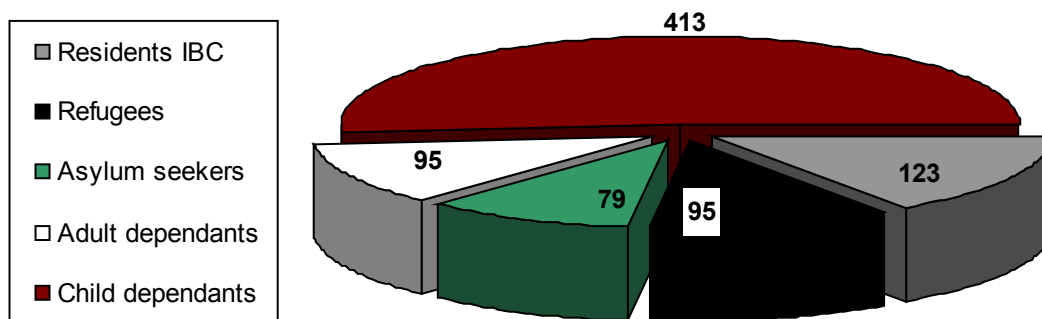
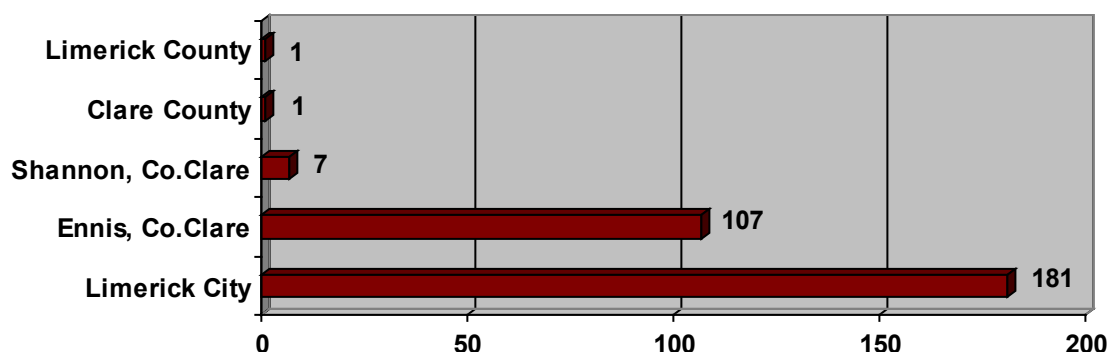


Chart 10: Area of residence for immigrants in receipt of SWA by the last week of January 2007. Source: HSE West.

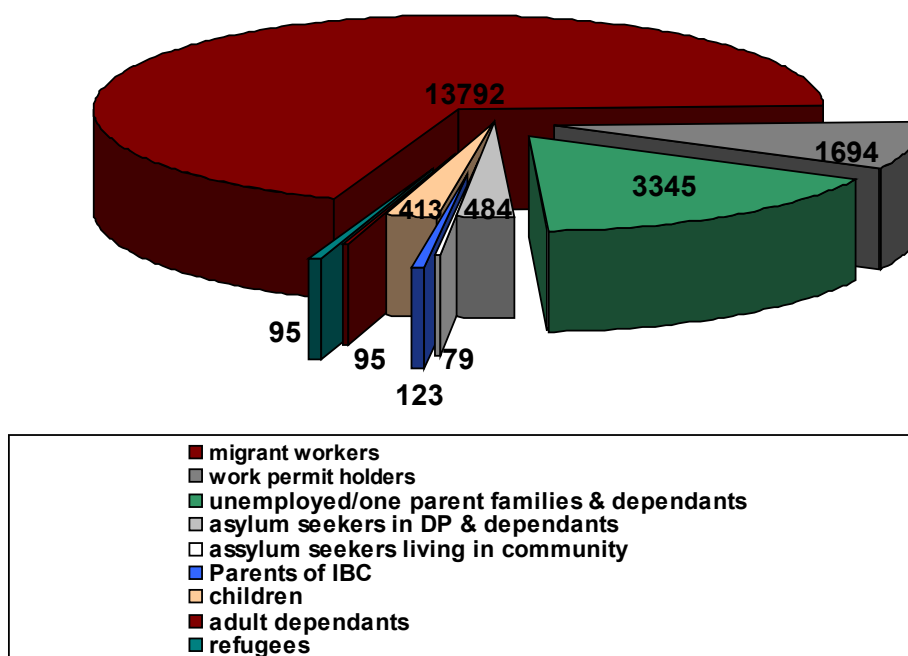




**The overall profile of ethnic minorities in the Mid-West Region by immigration status**

- In an attempt to create the overall profile of ethnic minorities residing in the in Mid-West Region by the period of 2006 – 2007 (last week of January), a combination of information from all the sources regarding numbers of immigrant with different immigration status was used.
- The fundamental assumption made for this profiling exercise is that all EM applicants for PPS numbers could be migrant workers.
- It should be noted that the figure of 13,792 people (source DSFA) indicates “flow” and not “stock”. It doesn’t take into account the movement of people within county or movement in and out of the State.
- The second largest group is that of work permit holders of 1,694 people (source DETE). The two categories are kept separately because there are significant differences in rights and entitlements, which make the second group more vulnerable.
- The third group represents asylum seekers in direct provision, 484 persons, followed by a special category of Children (some of them Irish Born) of 413 in number (Source HSE West).

Chart 11: The overall profile of ethnic minorities in the Mid-West Region by immigration status.  
Source: DSFA.



Overall the profile provides only an approximation based on relative information of the EM community living in the Mid-West Region. The lack of available, reliable and easy to access data means that planning for change and diversity in the community becomes very difficult. The picture, therefore, is not complete as there are categories like students, multi-ethnic family members, and undocumented people unaccounted for due to the lack of information.

## 5. Findings

This chapter presents the qualitative and quantitative results of the research. The aim of the research is to develop a profile of ethnic minority communities living in the Mid-West Area and conduct a high level assessment of the health and personal social service needs of ethnic minority communities across the Mid-West Area.

The findings are structured into three sections. Section I covers the demographic profile and social determinants of health of ethnic minority communities in Mid-West. Section II examines the health and personal social services needs of EMs that participated in the study and section III presents findings on developing a strategy for the improvement of the design and delivery of health services in the Mid-West Region.

The findings were generated from data collected using three methods and from three different target populations thus they are comprehensive and encompass three perspectives. Table 1 below provides a description of each target population studied and the method of data collection used with each.

*Table 1. Target population and methods of data collection used.*

Method of data collection	Number of respondents from those targeted		
Questionnaires	87 Ethnic minority questionnaire respondents	38 HSE professional questionnaire respondents	0
Focus group discussions	48 EM focus group participants	40 HSE professional focus group participants	0
Interviewees	15 EM interviewees	15 HSE professional interviewees (mainly management)	29 Key stakeholder interviewees EMOs (9) Others (20)

The three target populations for this research were 1. Ethnic Minorities (EMs), 2. HSE professionals and 3. Key stakeholders.

Collecting the information for this research from EMs involved holding 12 focus group discussions with 48 people; interviewing 15 individuals and analysing 87 questionnaires completed by EM respondents.

Accessing data from HSE professionals involved 3 focus group discussions with 40 representatives including HSE management and staff; collating 37 questionnaires from the front line staff in primary care and hospitals and interviewing 15 HSE professionals including the following (Management from the Social inclusion Unit, Family Support Services, Adult Counselling Services, Public Health Nursing, Community Welfare, Community Development, Mental Health, Clinical Nurse Managers and Patients Service Manager in the Regional Hospital sector.

Accessing information from key stakeholders involved 9 interviews with representatives from organizations working specifically with EM (these are referred to as EMOs) and 20 interviews with representatives of statutory and voluntary organizations and agencies. Appendix 3 provides details of all focus group participants and interviewees for this study.

Each of the three sections is divided into subsections, which have the following structure:

- Main quantitative findings from EM questionnaires;
- Associated themes from findings from focus groups and/or interviews with one or more of the target populations;
- Examples of good practice from sources such as HSE West and participants (where relevant and available);
- Case studies sourced from participants (where relevant and available).

## 5.1 Demographic profile and social determinants of health of Ethnic Minorities communities in Mid-West

The following demographic findings are derived from the 87 questionnaires completed by EM questionnaire respondents living in the Mid-West Region. This group exhibit demographic characteristics that are similar to those of EM nationally and in relation to the EM profile of the Mid-West Region (see Chapter 4 Profiling Ethnic Minority Community).

### • Gender and age

There were 42 males and 45 females in the study group. The majority of respondents - 77% were aged between 25 and 44; 16% were aged between 16 and 24; 7% were aged between 45 and 65. These findings demonstrate that the EM population of the Mid-West Region are largely of labour force age. This corresponds with national and regional demographics regarding the age ranges of EM in Ireland.

#### Qualitative findings on age and gender

Many EM focus group participants stated that they didn't have any particular health needs, explaining that they were young and their health was "OK". Some stated that they had general health check ups for preventative purposes when they went on vacation to their country of origin. As one EM respondent put it "It's much easier and faster to see the doctors at home".

HSE professional interviewees stated that in their opinion that EM women tended to use more Irish health services than EM men.

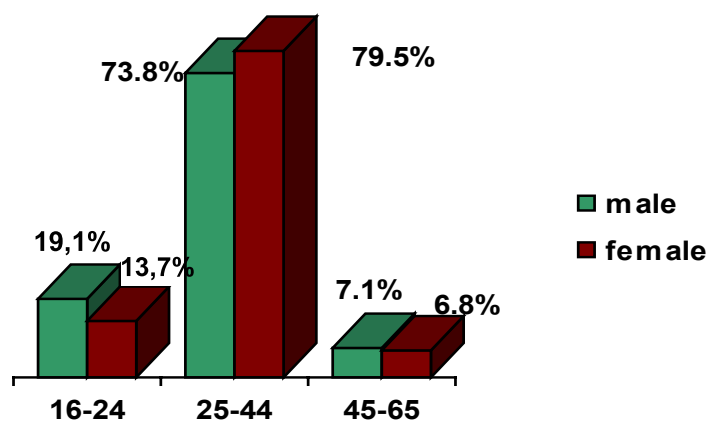
### • Country of origin

EM questionnaire respondents were from 34 different countries as outlined in table 5 with the two largest groups being from Poland (15%) and the Latvia (15%). This concurs with the national and regional EM population.

Table 15: Country of origin of questionnaire respondents.

Country of origin	Number	Country of origin	Number
Afghanistan	1	Latvia	10
Albania	1	Lithuania	4
Algeria	1	Mexico	1
Angola	2	Moldova	1
Benin Republic	1	Nigeria	3
Cameroon	3	Pakistan	2
Congo	3	Philippines	1
Croatia	1	Poland	12
Cuba	2	Russia	1
Estonia	4	Sierra Leone	2
Ethiopia	1	Somalia	2
Germany	1	South Africa	1
Ghana	2	Spain	8
India	3	Togo	1
Iraq	1	Ukraine	3
Italy	2	UK	1
Kenya	1	Zimbabwe	3
		Total	87

Chart 12: Age and gender group distribution.



*World region of origin*

When EM questionnaire respondents were grouped into EU countries, Africans, Asians, East Europeans and the Rest of the World group the world region of origin was recorded as follows.

*Qualitative findings on cultural origins.*

EM focus group participants and interviewees stated that they felt that Irish society has become multicultural very rapidly and now Ireland has "people from all over the world". It was also mentioned that EM tend to gravitate towards their compatriots as their comfort zone. Ethnic organisations and groups have started to emerge like the Irish Polish Business Association and Ghanaian Group\*.

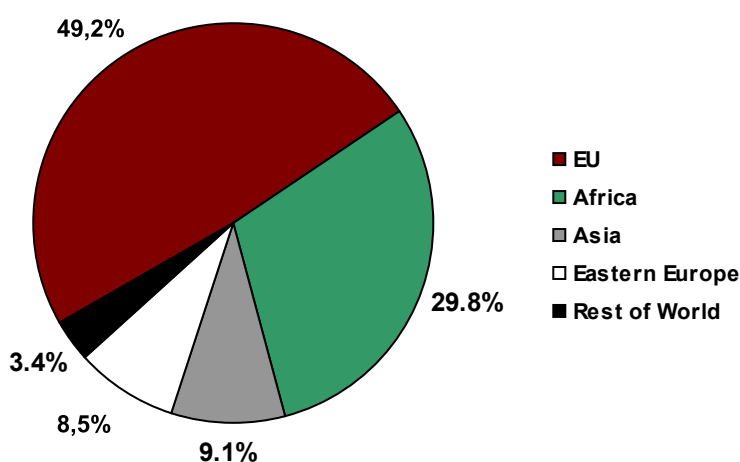
HSE professional focus group participants indicated that community groups are invaluable in assisting the HSE as they can reach isolated members of the EM communities and provide information in appropriate languages as the cultural background of EM communities living in Mid-West is so diverse.

Key stakeholder interviewees suggested to concentrating on community based advisory groups and peer educators, as these are very efficient ways for information dissemination to EM. These organisations felt that the HSE could assist in the provision of resources to such organisations including financial, human, transport and education. It was also recommended that the HSE continue to build on and foster existing partnerships with organisations working on intercultural initiatives in the Mid-West Region.

Good practice: An example of organising EM communities to participate in Irish social life and also promote their cultural values and lifestyle is the International Barbeque Competition which is organised in Limerick during the first weekend of May. Teams from over 60 countries participated in the festival by cooking their traditional food and wearing their national costume. Organisers of the event engaged local pubs and restaurants to be "Ambassadors" and sponsors for country teams. Organisers mentioned that HSE support and participation in promoting and maintaining the festival would be welcomed.

\* Representatives from these groups actively contributed to this research by assisting in the field work and facilitating outreach of EM participants.

Chart 13: World region of origin of respondents.

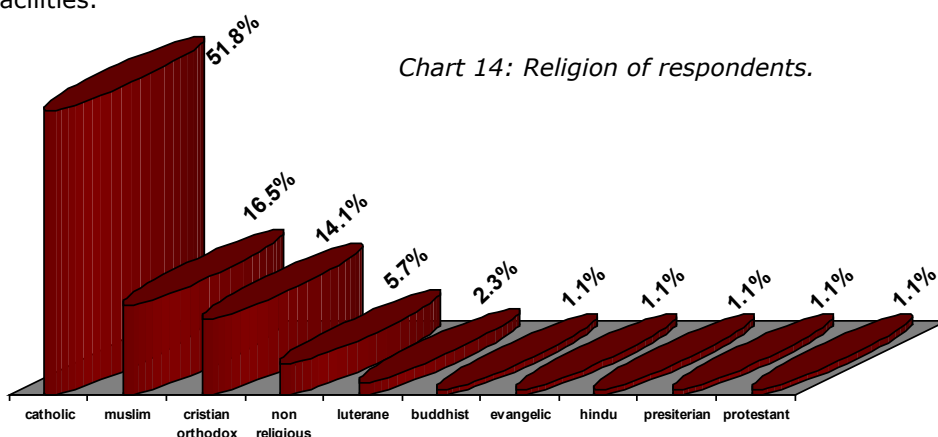


• **Religion**

The majority of EM respondents – 90% stated that they practiced one of the 10 religions listed below. Circa 6% stated that they practiced no religion, while 4% chose not to answer this question.

The top three religions are as follows: Catholic – 52%, Muslim – 16% and Christian Orthodox -14%. The census 2006 shows that the third largest religious group living in Ireland are Muslims. This is significant for the HSE as the Muslim community has very specific health service needs in relation to gender issues, circumcision, diet and praying facilities.

Chart 14: Religion of respondents.



*Qualitative findings on religious and gender differences.*

EM focus group participants and interviewees were asked about the importance of having health service staff that was of a similar ethnic background to them. The majority stated that this was an important issue. For one Muslim woman, the gender of her doctor was also a significant issue.

*"It was so difficult for me to get a GP female. There are just a few of them and they don't take new patients".*

Some HSE professionals, particularly in the hospital sector, are coming from different cultural and religious background. In doctors residence in Mid-Western General Hospital in Nenagh there is a facility provided for Islamic prayers. Also St Johns hospital, Limerick has a multi denomination prayer room.

**Good practice:** The booklet "Catering for people of different religions in St. John's Hospital" which is an ongoing project with new information being added consistently provides information on the healthcare needs of those with different religious beliefs. The foreword to this booklet reads:

*"As healthcare staff in St. John's Hospital go about providing care for patients, they are increasingly coming into contact with patients from different countries and cultures. It is important that we respect the religious wishes of these patients. We should not make assumptions about their religion or its importance to them. To avoid misunderstandings the patient should be asked about the importance of religion and rite to him or herself".*

• **Area of residence**

Geographical distribution of the sample for the Mid-West Region was as follows:

Circa 61% of respondents were residing in Co. Limerick, 22% in Co. Clare and 17% in North Tipperary. In Co. Tipperary there are no direct provision centres and some categories of immigrants such as asylum seekers, refugees and students existed only in very small numbers.

*Duration of living in Ireland*

The majority of respondents - 51% had been living in Ireland for 2 to 4 years; 34% had been in Ireland for up to 1 year; and a further 15% were long term residents of between 5 and 7 years in Ireland.

*Future plans to reside in Ireland*

Regarding future plans to live in Ireland, 56% indicated their intention for permanent residence.

Nearly 12% stated that they planned to stay for 6 to 8 years; 8% stated that they intended to stay for 4 to 6 years; with 24% claiming that they planned to stay up to 3 years.

Those with families who planned to live permanently in Ireland generally had their family members living with them and were mainly asylum seekers, refugees, residents and EU migrant workers. Significantly more Africans and EU citizens stated that they intended to live permanently in Ireland than those originating from other world regions.

Of those that stated their intention to reside permanently in Ireland, their English language knowledge is described as follows: 4% were beginners, 15% had basic English, 38% were at intermediary level, 21% were at an advanced level and 19% were proficient.

Chart 15: Geographical representation of respondents.

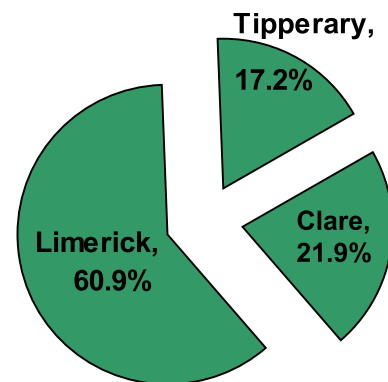
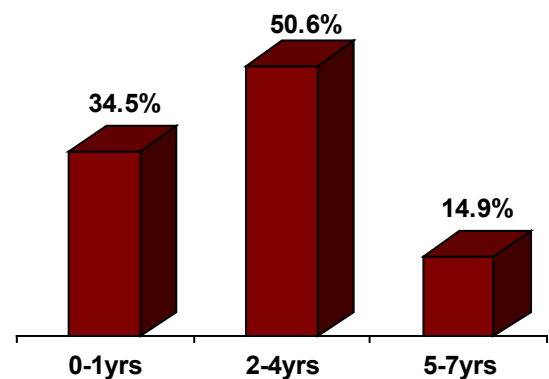


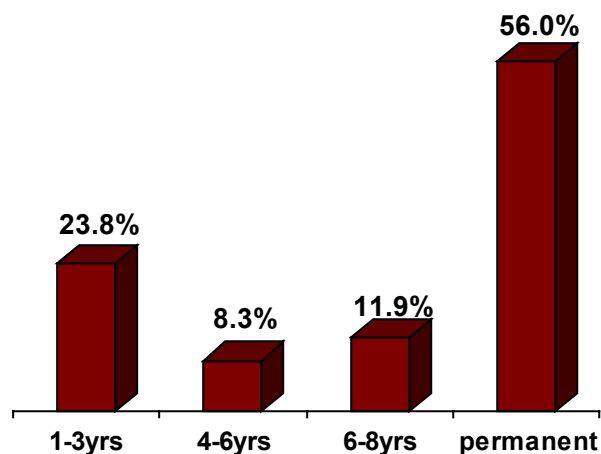
Chart 16: Duration of living in Ireland.



*Qualitative findings on supporting awareness of services in Ireland*

It was recommended by key stakeholder interviewees and HSE professional interviewees that information be provided to EM regarding the Irish health system and other aspects of Irish society in the initial stages of residency. It was suggested that this could be provided in the form of a welcome pack/ easy guide to HSE or could be dispensed by special information kiosks in key areas. It was felt that audio visual information would have more of an impact than printed leaflets. It was also recommended that a directory of services for immigrants be collated which would include HSE services and all voluntary and statutory services printed in basic English and a number of relevant languages. Other recommendations included the employment of liaison officers to work with the EM community and the HSE.

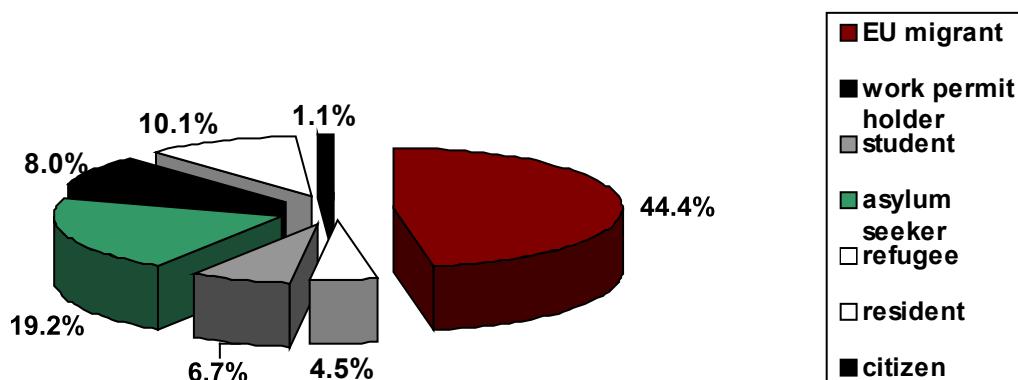
Chart 17: Intention of duration to continue to live in Ireland.



**• Immigration status**

The immigration status of the respondents was significantly important for this study, as it determines the rights and entitlements of those studied to health services and other state services. They response rate for this question was 94%. Almost all categories of immigrants are represented in this sample with the majority of respondents - 44% being EU migrant workers, 19% being asylum seekers, 10% were residents, 8% were work permit holders, 7% were students, 5% were refugees and 1% citizens. The sample composition correlates directly with the profile of the ethnic minority communities living in Mid-West Region and in Ireland as a whole.

Chart 18: Immigration status of respondents.



*Qualitative findings on immigration status*

EM focus group participants (migrant workers including work permits holders) had a general feeling that they were happy to get work and the wages they earned were better than those at home. They identified good pay, work conditions and a "good boss" as contributing factors for their health and also mentioned the ability to communicate, access to information about rights and entitlements "what to do and where to go when you have a problem" as essential elements of their adaptation.

Key stakeholder interviewees EMOs generally stated that migrant workers that they provided services to, tended to be in highly vulnerable and isolated situations; sometimes working in poorly regulated sectors and that they are least likely to have access to health services and clear information about the health system and its procedures.

**Case study:** During EM focus group discussion in Glin and on a mushroom farm in North Tipperary, migrant workers described their circumstances as isolated due to the following two reasons: 1. poor English language command and 2. the geographical location of their residence. The mushroom farm residences had no access to public transport and the only contacts with the Irish community were through food shops and employers.

Participants felt that more support is necessary in setting up good practice in employment of migrant workers. For example: arranging registration with a GP in the process of applying for work permit/visa. It was also suggested that more collaboration between government departments was required in providing accessible information in different languages about rights and entitlements of different immigrants groups in Ireland.

Asylum seekers represent another vulnerable category – this was the view shared by key stakeholder interviewees EMOs. It was felt that the nature of rules and regulations applicable to this category will create health problems in the long term. Many health workers spoke about the difficulty for immigrant workers, asylum seekers and refugees, who do not know how the system works. Their lack of knowledge and the transient nature of asylum seekers' lives also make it difficult and frustrating for health workers. While service providers, mainly HSE, expressed their frustration at their clients' failure to understand the system, many also highlighted their own need to be more aware of the situation of asylum seekers.

**Good practice:** Key stakeholder interviewees EMOs pointed to an example of good practice. The College Certificate course on the Social Inclusion of Asylum Seekers, Refugees and Migrants was established in Mary Immaculate College in Limerick. *It is the ideal course for those who frequently interact with people from different countries, be it their work colleagues or their clients. It is particularly useful to those with a remit in service provision to asylum seekers, refugees or migrant workers in both public and private sectors. With such rapid changes to Irish society, this course endeavours to empower all to adapt to these changes in a humanistic way. It was indicated that this course is ideally suited for staff and management of direct provision centres and suggested that a closer collaboration between course organisers and the Reception and Integration Agency in the Department of JELR is needed.*

## • Languages

### Spoken languages

Respondents were asked to list the languages they spoke. The total number of languages was 32 and the top most frequently mentioned were English, Polish, Spanish, Russian and French.

### English language

The response rate for this question was 98% and all of the respondents spoke English at different levels: 16% were beginners, 15% had basic English, 29% were at an intermediary level, 20% were an advanced level and 18% were proficient. Younger people were more likely to have better English. The ability to speak English was most proficient among the African population who stated that English is often spoken in the home.

Slightly less than half (48%) of respondents were attending or had attended English language classes and 29% of those that had not attended said that they would like to do so. The main reasons given for non-attendance were family circumstances (particularly among those with children) and work commitments, as well as difficulties regarding availability of affordable and high quality English language classes to suit their needs and levels.

### *Qualitative findings on English Language classes.*

EM focus group participants and interviewees and key stakeholder interviewees EMOs expressed the view that people should be encouraged to learn English as it would be the best way to establish communication and in the long term integrate immigrants into Irish society.

*"It's easier to find a job and helps make contacts with locals..."*

In interviews with representatives from the VEC in Clare, Augustinian Church Language Classes and Irish Polish Business Association English Classes for Polish People, ideas about a closer collaboration with HSE were expressed. There were suggestions made regarding the development of a health information module for immigrants and its insertion into curricula of existing English language courses.

**Good practice:** An example of good practice in relation to an interagency approach to English language for ethnic minorities is the project in Knockalishen Accommodation Centre. English language classes are

provided by VEC Clare to asylum seekers residing in the accommodation centre. Childcare for the parents attending these classes is provided by the Clare Childcare Company. Attendees of these classes who participated in this research expressed the need and desire to extend their study beyond the beginners' level.

- **Education and Employment**

Estimation of educational standard was based on respondents reporting of their level of schooling. Of those who responded 73% claimed to have attained some third level education, 21% of the respondents stated that they had attended secondary schools and 6% stated that they had attended primary school only.

Regarding nationality and education, EU citizens and Eastern Europeans were more likely to have completed third level education than those from other world regions. In addition, those who had an incomplete second level education had lower levels of English proficiency. Circa 58% of respondents stated that they had been employed prior to coming to Ireland, 15% stated that they had been students, 8% had been unemployed, 5% had been self-employed and 2% had been undertaking household duties. The type of work undertaken prior to coming to Ireland varied.

Almost 8% of those that responded had been asylum seekers and refugees in other countries while 4% chose not to answer the question.

*Qualitative findings on cultural diversity of the HSE staff*

EM focus group participants and interviewees expressed the view that health services need to review its policy on recruitment and selection to attract more staff from ethnic minority groups and to better reflect the diversity of the population. Particularly, participants mentioned difficulties with recognition of medical professions and the length of time the "whole validation process" takes.

Greater staff diversity, it was argued, would be a major step forward in reducing access barriers. Several respondents ranging from management and front line staff in HSE felt that the staffing ratio in an organization should better reflect the community they serve. It was felt that actively recruiting staff from ethnic minority backgrounds would improve ethnic minority groups access to health services.

*"It's about recruiting staff from a diverse range of backgrounds, I mean that would hopefully address issues around language and interpreting and these sorts of things and also give different communities the confidence to come forward and actually use services facing people they can actually identify with"*

**Good practice:** An example of good practice in Mid-Western Region is the Health Information Programme (HIP is a peer-led initiative which was piloted in three asylum seeker accommodation centres. The main objective of the programme is to disseminate information about the health services to asylum seekers and in doing so increase their capacity to make informed decisions about their health. HIP delivers information through group discussions and on one to one basis for those who have personal questions. To assist the delivery of the information the team uses picture posters and picture cards in story book form and have found that this form of communication is useful in reducing language barriers.

*"The health information programme is an excellent programme and of great benefit to asylum seekers also it has been a wonderful experience for the group of asylum seekers that were trained to be peer educators, who sat exams and received certificates."*

- **Family**

The study did not record the marital status of respondents. However, 59% of the respondents left the questions regarding family composition blank. 41% of participants stated that they had their family members living with them. Of those who had families living with them 35% had between 1 and 4 children (17% had one child, 10% had two children, 6% had three children and 2% had four). Almost half of the families with children had children under the age of 5 years attending preschool, 41% attended primary school, 6% were in secondary school and 3% were in third level education. The majority of children attending preschool were born in Ireland. Almost 80% of children had parents in receipt of child benefit and 20% had parents not receiving



it. Some of these children were living in direct provision centres and therefore their parents were not entitled to claim child benefit.

#### *Qualitative findings on family issues*

EM focus group participants and interviewees felt that there is a greater need to be informed about the health services especially *"when you have children and if they are small..."*.

Having a baby in Ireland was a *"such an experience"* for a Polish woman and all her friends.

Families residing in direct provision mentioned lack of facilities for children. Women who are parenting alone have to take care of their children for twenty four hours a day in overcrowded accommodation. Diet was another issue raised by the majority of participants, with particular concern from pregnant and nursing women. If the food offered wasn't meeting their needs, they had to supplement their diet from their weekly allowance of €19.10. Women were increasingly dissatisfied because they were unable to prepare food for themselves and more importantly for their children. Parents expressed their sense of powerlessness and lack of choice and loss of control over their everyday lives and the lives of their children.

HSE professional interviewees described some of the issues of families with children in direct provision, such as *"perceived child protection issues, where nobody is designated to take responsibility for referrals and it tends to be left to the nurse; parenting issues and need for parenting craft classes"* as there are significant cultural differences in child rearing practices. There was also a suggestion for ongoing training for the frontline staff and the management of the centre on cultural diversity and *"working with asylum seekers"*, which was supported by the health professionals and organisations working with asylum seekers and refugees in the Mid-Western Area.

It was also suggested that *"nursing staff should have adequate and relevant communication with other staff members.....to deliver informed and comprehensive services"* and that communication should be improved with the Reception and Integration Agency regarding movement of the families within Direct Provision accommodation centers.

#### • **Accommodation**

There was a 98% response rate to this section. Of those, over two thirds 67% of participants lived in rented accommodation, 19% were residents in direct provision centres, 6% were owners of their dwelling unit, 4% had accommodation provided by their employer and 2% lived in student centres. Half of the respondents stated that they shared accommodation with non-family members. Significantly, 29% of them stated that they had problems with their accommodation, with lack of privacy and acceptable conditions as well as high costs for low quality accommodation, cited as the most common reasons.

#### *Qualitative findings on accommodation*

EM focus group participants felt that positive and negative experience in the private rental sector very much depended on the landlord. Most of them felt that the rent in Ireland was very high and that paying a deposit in advance in addition to their monthly bills was *"like mission impossible"*. All these payments added substantially to their cost of living.

#### Direct provision accommodation

Focus group discussions and interviews organised with asylum seekers in Knockalisheen Accommodation Centre showed that residents felt that they were compelled to live in ill-adapted, inadequately equipped institutional buildings in need of refurbishment. This group also felt that staff required better training in multicultural matters. Respondents gave examples of cultural clashes between residents and staff which they felt created misunderstandings and tension. During the field work for this research the situation in the centre escalated into a protest by residents. Some respondents felt challenged by living in such a multicultural environment. *"Living in the same room with three other people of different nationalities and cultures ... it's not easy to live that way"*.

A number of respondents that had spent time in African refugee camps prior to coming to Ireland felt that the standard of their accommodation in Ireland was not significantly better than what they had experienced in

Africa. Some respondents felt that as time passed while awaiting a decision on their application for asylum that their mental stress increased and that their mental well being deteriorated. HSE professional interviewees in the mental health area also recognised that living in direct provision centres has a major impact on the mental health of asylum seekers. They also mentioned that the main challenges of delivering mental health services to ethnic minorities are language and communication. They cited cultural belief systems of the etiology of illness and healing as well as attitudes toward seeking help from medical staff are some of the reasons for the need for cultural competence training.

## 5.2 Health and personal social needs of ethnic minorities communities in Mid-West.

### • General Practitioner Services

Circa 54% of EM questionnaire respondents stated that they were registered with a GP while 46% were not. Those who had not registered said that they did not know how to do so or that they had not needed a doctor to date. Almost 70% of those who were not registered with GP were migrant workers and 15% were students. One third of them were at beginners level in English language proficiency and a further one third were at intermediate level.

Significantly, half of those who were registered with a GP had had a general check up by a GP and the other half had not. Circa 50% of those who had children less than 16 years of age had not had a check up by their doctor. Almost 40% had seen their doctor in the previous month with significantly more women attending. Circa 10% of respondents stated that they had difficulties making appointments to see their GP. Of those having problems, the majority were asylum seekers in accommodation centres who cited "attitude" and the remainder blamed "the system". For the 54% of respondents who are registered with a GP, their level of satisfaction with GP services is presented in Chart 20. The response rate for this question was 82%. Very few of those dissatisfied with their GP have changed to another GP since coming to live in Ireland.

Chart 19: Registrations with GPs.

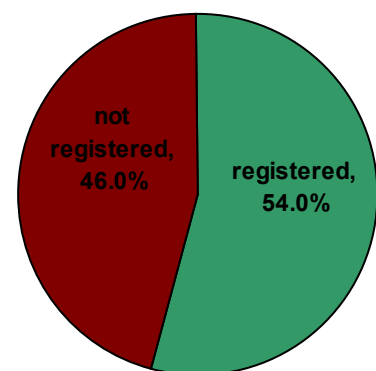
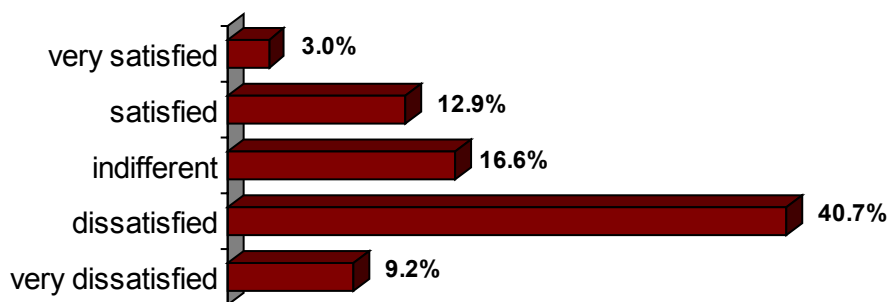


Chart 20: Level of satisfaction with GP among registered GP users.



Respondents were asked to mention the positive aspects of their experience in accessing General Practitioner services as well as the areas that might be improved. The vast majority found the atmosphere of openness and politeness very helpful, but that there was room for improvements in regards to communication to patients. This was seen as particularly important in terms of giving enough time to explain conditions and illnesses and treatment options as well as maintaining high levels of hygiene.

### *Vaccination status of children*

Almost 49% of respondents stated that their children had been vaccinated in Ireland. There was no information available on the vaccination status of the additional 51% of the group.

*Qualitative findings on ethnic minority experiences with general practitioners*

Some of the EM questionnaire respondents, interviewees and focus group participants had experience of hospital care, but the majority of contact that they had with Irish health services and staff was through GP surgeries. A number of concerns were expressed about the contact with GP's, the first of which was a feeling of not being listened to adequately. A number of EM respondents gave accounts of being dealt with too rapidly, or of having their own sense of what was wrong with them set aside.

*"My doctor's already got the prescription half written down before you've even told him what's wrong with you".*

Although all of the EM expressed concern over communication barriers due to a different language even if they spoke English as a first language, they did not feel confident using it.

*"...I spoke English all my life and they don't understand me..."*

Although people recognized that doctors are in high demand, being rushed through appointments was a concern to ethnic minority participants in this research. Use of medication by GPs was often perceived as a 'quick fix' to problems, and the view was expressed that there should be more choice of treatment. It was suggested that medication sometimes only provided a short-term solution and that longer-term problems needed a more individualized approach. Respondents expected GPs to give options and choices regarding their treatment.

*"I don't think it's healthy to take antibiotics all the time as my doctor prescribes. I wish he could say to me what the alternatives are".*

Linked to this was the concern that ethnic minorities rarely saw the same GP for long due to the transient nature of their residency and that familiarity between doctor and patient was lacking. Often, people felt they had to repeatedly explain their medical history as their medical records were not tracked. An outcome of the above concerns is that more trust needs to be built between ethnic minorities and their GP's. The majority of EMs appear to feel that health professionals are extremely busy and do not have adequate time for them (with their language difficulties) and believe that medication is used too frequently.

Three EM interviewees claimed to have had medical conditions that they felt would have been treated immediately in their home countries but were put on a waiting list for treatment here.

HSE professional questionnaire respondents, focus group participants and interviewees in primary care described the main gaps in provision of health services to EMs were communication problems. It was acknowledged that providing health services to ethnic minorities is challenging but stated that they were open to working with immigrant organisations in meeting the health expectations of immigrants. The HSE professionals felt that the expectations of immigrants are very high due to a misunderstanding of the Irish system. It was stated that EMs should be made aware of the Irish health system and its realities as this would reduce some of the tension and frustration caused to both service users and providers. HSE professionals stated they were interested in accessing resources for this purpose such as cultural competence training and informational support.

- **Interpretation**

Circa 22% of those who attended a GP stated that they needed an interpreter at the time. In most of the cases friends, acquaintances and adult relatives were used as interpreters. Just 2% had an opportunity to use the interpreting services. There were no cases when a child relative was used. Significantly more Eastern European participants required an interpreter when attending a doctor.

*Qualitative findings on the use of interpreters*

There was a range of views expressed by HSE professional interviewees about the use of interpreters. Although most were committed to the principle of using them, there were several difficulties highlighted. Resources were seen as a key issue here and affect the availability of appropriate interpreting. In addition, there was the problem of knowing when an interpreter would be needed:

*"Arranging interpretation services is a problem because you don't know when it will be required and what languages will be needed so it takes time to sort it out."*

Another issue was the fact that language skills alone were not always adequate and that within a specialist healthcare field it is important to have interpreters who have some grasp of the subject under discussion:

*"Interpreters must also have knowledge of the subject area they are working in. It is no good having someone who is fluent in Polish and English acting as an interpreter in the mental health field if he/she has no knowledge of this subject area."*

It was also acknowledged that some medical terms have no direct equivalent in other languages. Most respondents were uncertain about what qualifications interpreters should have, and would not readily know the difference between a qualified and unqualified one. Although accredited training for interpreters is required by health service providers.

**Good practice:** Interpretation services are provided in the Mid-Western Regional Hospital as part of patient services.

• **Medical cards**

Circa 40% of respondents were not aware if they had an entitlement to a medical card, while 57% knew their entitlements. Interestingly, the group lacking this knowledge was composed of EU migrant workers and work permit holders, as well as residents. The group represented by asylum seekers, refugees and students were aware of their entitlements. From those who were aware of their entitlements 60% had medical cards, 4% had GP cards, 17% had a European Health Insurance Card and 10% had private medical insurance. 9% had no type of health insurance or medical card.

Chart 21: Knowledge of entitlements to medical cards.

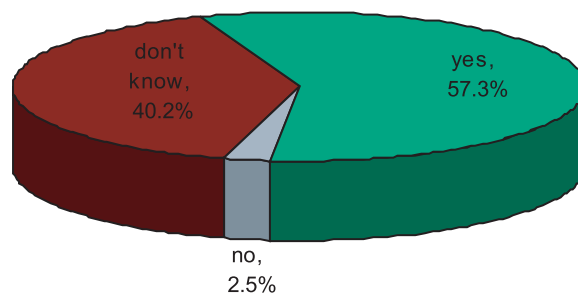
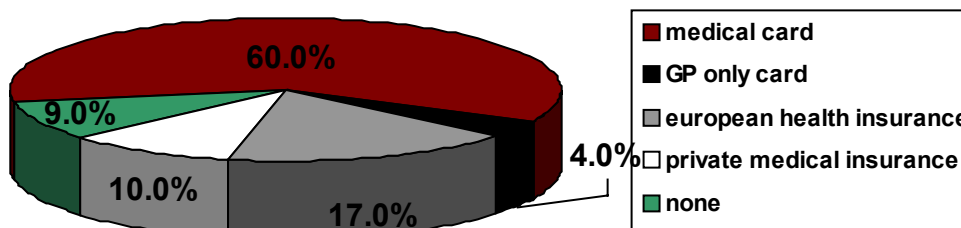


Chart 22: Types of health cover.



*Qualitative findings on knowledge about rights and entitlements*

EM focus group participants mentioned that information on rights and entitlements is very important to them, but that obtaining and understanding this information is a huge challenge. Some mentioned language difficulties, but almost all recognised that they did not understand the Irish Health system as it was different from the ones that they had in their countries of origin. Eastern European EM focus group participants (the majority being migrant workers) stated that they found it difficult to identify sources and types of information "I have no idea what I should look for, as I don't know what is there for me". For the majority of migrant workers that work full time and are on minimum wage, a visit to the community welfare officer was seen as a luxury because they had to take time off work and also had transportation difficulties and expenses which made accessing this service very costly.

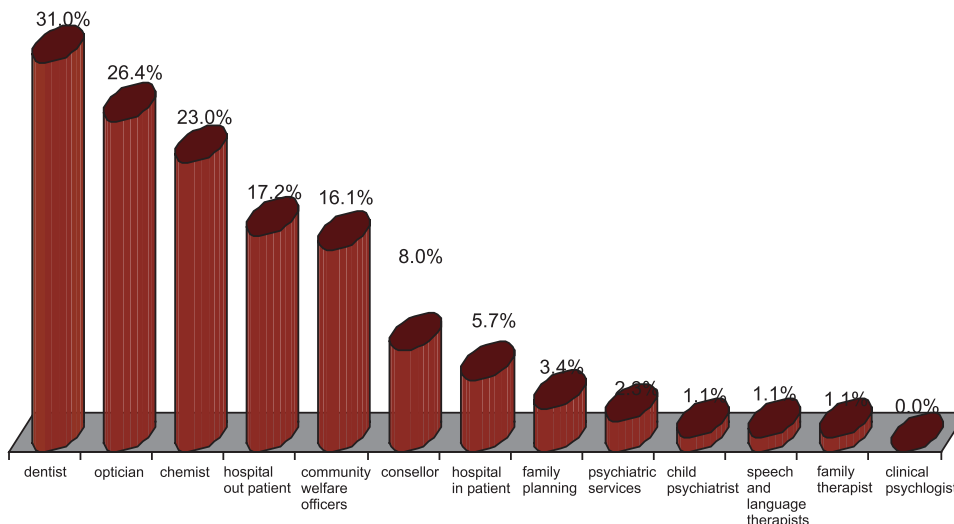
Key stakeholder interviewees EMOs brought up an equality issue in relation to migrant workers in Ireland. The point made was that if they pay tax in this country, they have an entitlement to equal access to information as well as to the rights and entitlements of Irish workers.

Appendix 4 describes the principles of quality customer service for customers and clients of the public service from the Department of Health and Children website. It claims that in their dealings with the public that government departments will adhere to particular quality standards such as equality of treatment and access to its services, proactive information provision and more customer friendly opening hours.

• **Use of health services**

The GP was the most commonly utilised health professional. Counselling and psychiatric services were among the least used. Chart 23 outlines the use of specific medical services. Interestingly, the longer an immigrant was resident in this country the more likely they were to use services such as dental and optical services.

Chart 23: Use of health services.



*Qualitative findings on use of health services*

The majority of ethnic minority interviewees and focus group participants felt that they needed better access to health information in order to access existing health services. Suggestions made to improve this included more leaflets available in GP surgeries, English language schools, ethnic food shops, churches and employers. They acknowledged that often even when leaflets are made available they frequently do not get read, but agreed that there should be the opportunity to be able to access this information. EM respondents stated that it would enable them to make more choices about how they were treated, or would give them information to seek alternative therapies.

Direct contact between health professionals and peer educators in Health Information Programmes was seen to be a positive and efficient method of informing ethnic minority communities about a range of health services. Very few EM interviewees and focus group participants were aware of services apart from GP's and A&E services. Many felt if they knew of other services they could seek alternative therapies rather than rely solely on the medication that GP's prescribed them. *"It's all about information and lots of people may not know how to find help when they need it..."*

HSE focus group respondents and questionnaire respondents felt that it was often the case that those who needed services most were the very ones that failed to benefit from them. They also felt that there may be a lack of knowledge about existing services and routes of access. For some services, such as screening and immunization, rates of access were high but lower for more complex or specialist services. HSE professionals representing paramedics and optical services that responded to questionnaires described inadequate service provision and confusion over access to existing services as gaps in current service provision to EM. It was suggested by these HSE professionals that these difficulties could be assisted through the development of a national and international database of patients' medical records and through the employment of coordination/ liaison persons to assist access to information and services for EMs. They also suggested that front line staff need to be trained to give out information on other health services and that all health services needed to work more closely with GPs.

**• Accident and emergency services**

Almost 22% of respondents stated that they, or a family member, had used the Accident and Emergency service since coming to Ireland. The majority of those accessing A&E services had Basic English language skills and 60% were satisfied with their own health at the time of the interview which would indicate that they attended A&E for emergency purposes.

Level of satisfaction by those who stated they had used the A & E services is reflected in the graph below. The main reason given for dissatisfaction related to the long waiting times.

Chart 24: Use of accident and emergency services.

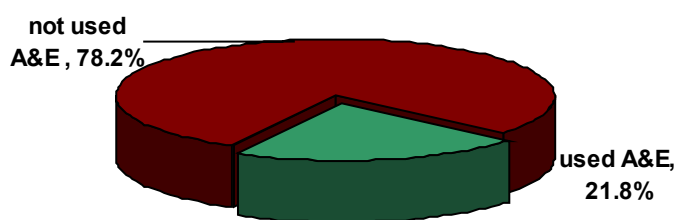
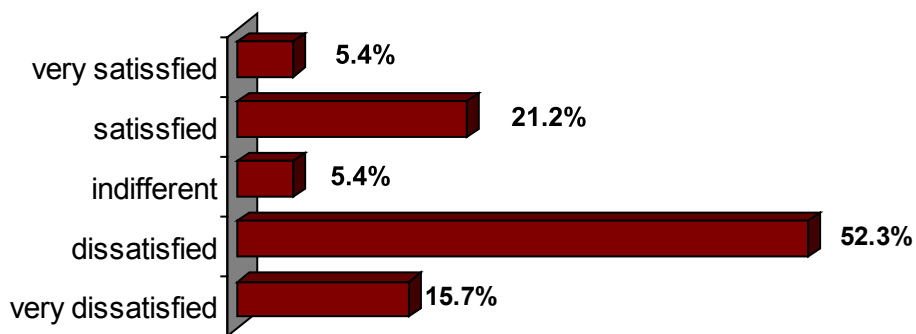


Chart 25: Level of satisfaction with A&E services among users.



Respondents were asked to mention the positive aspects of their experience in accessing A&E services as well as the areas that could be improved. Positive aspects included attitude of the staff (particularly nurses) and resources available. Suggested areas for improvements were reduction of the waiting time and costs, quality of the services and time efficiency of the staff along with generally better organization of the service.

*Qualitative findings on use of A&E and Hospitals*

Health professionals from acute settings spoke in focus groups discussions about the difficulties involved in not having the previous histories of their clients’ medical problems. This issue is exacerbated by the lack of communication between services. Hospital staff in HSE professional focus group discussions also expressed concerns about discharging and following up patients which are not registered with GPs.

HSE professionals that completed questionnaires mentioned that the gaps in the current provision of health services for EMs are language barriers and poor comprehension; a lack of interpretation services; a lack of awareness of EM on services available and how to access them; difficulties dealing with form filling.

They also mentioned that HSE have difficulty following up EMs with GPs due to the fact that not all EMs are registered with GPs.

HSE professional focus group participants and questionnaire respondents came up with the following strategies to overcome the difficulties experienced by EMs in accessing and making best use of A&E services. Provide a system that allows more simplified form filling. This would involve asking service users for relevant information that will enable them to access services and it would be available in different languages. It would involve developing patient information booklets/packs and patient feedback questionnaires to be made available also in different languages. Ensuring easier access to interpreters and ongoing monitoring of the quality of interpretation services would reduce language barriers as well as having HSE frontline staff trained in cultural awareness to ensure better understanding of EM service users. It would also involve more access to English classes for EMs and automatic registration with GPs on arrival in Ireland.

HSE professional questionnaire respondents from hospital settings suggested that priorities for health services to address were the need to develop literature in different languages; the provision of health education for patients to make them more aware of services, treatment and diagnosis; patient/family involvement in their plan of care; and support was required to assist EM in learning English.

In relation to hospital food, it was suggested that an improved menu selection was required to meet the dietary and custom needs of different cultures. It was also recommended that hospitals have access to religious leaders of other faiths for life and death situations. Another issue that arose for participants in focus groups, questionnaire respondents and interviewees was the need for a prayer room for all faiths.

HSE professional questionnaire respondents (particularly hospital staff) stated that they would like to receive support in terms of quality interpretation services that would be easy to access. They also suggested, that a system of follow up was required, especially in cases where patients were not registered with GPs. They suggested that action needs to be taken to ensure that all immigrants are registered with a GP. They felt that they required more time to deal with patients who have language problems. They suggested that signage needed to be improved around their hospital (make it multilingual or easier to understand, perhaps even pictorial). Respondents recommended that support was required in developing educational material in a visual form for those that did not read English. Existing visual information that has been developed for Travellers could be adapted to suit other EMs. It was also suggested that community services be increased namely HTN

clinics, including physiotherapy beds, home care services and better social services input to enable people to leave hospital and return home.

**Good practice:** *The National Intercultural Hospital Initiative, based on the European Migrant Friendly Hospital Project. The European project "Migrant-friendly hospitals" (MFH) brought together hospitals from 12 member states of the European Union, a scientific institution as co-ordinator, experts, international organisations and networks. These partners agreed to put migrant-friendly, culturally competent health care and health promotion higher on the European health policy agenda and to support other hospitals by compiling practical knowledge and instruments. The Mid- Western Regional Hospital, The Mid-Western Maternity Hospital and the Mid-Western Orthopaedic Hospital, St. Johns Hospital and the Mid-Western Regional Hospital, Nenagh also have committed to this initiative but would be at different stages of development of the initiative.*

• **Community health centres**

The response rate for this question was 95%. Circa 10% of the respondents and their families used the services at the community health centres with half of the cases being an adult relative and the remaining half had a child relative using the services. Of those who attended community health centres one third had done so within the previous three months and two thirds within the previous year. The level of satisfaction of respondents using the services at the community health centre is reflected in chart 27 below.

Chart 26: Use of community health centres services.

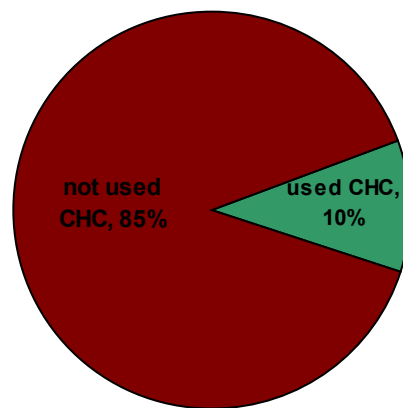
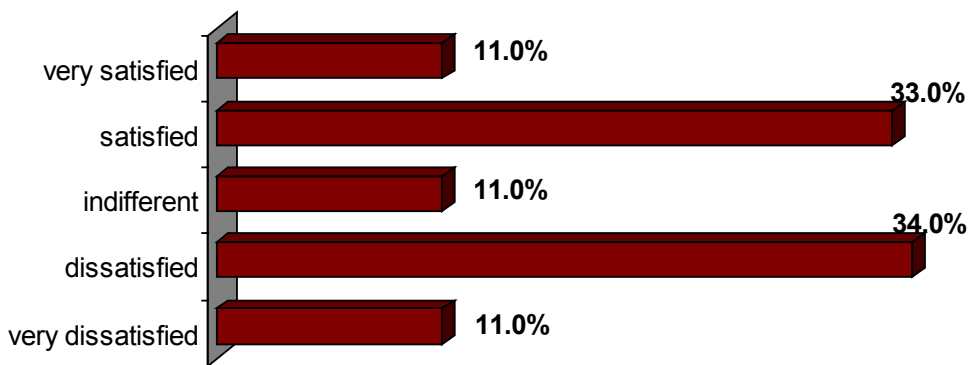


Chart 27: Level of satisfaction with community health centres services among users.



Respondents were asked to mention the positive aspects of their experience in accessing community health centre services as well as the areas that could be improved.

The majority found the atmosphere of friendliness very helpful but indicated that there was room for improvement with regards to signage at the centres (which were difficult to find). Customer service was also mentioned as an area requiring improvement with an emphasis on the need for staff training in cultural competence. Respondents also mentioned that high levels of hygiene in these centres would need to be maintained.

*Qualitative findings on use of community health centres services*

The majority of EM focus group participants and interviewees mentioned that they were unfamiliar with the concept of community health centres and the services provided there. Those few who had the experience of using the services in some of the centres pointed out how difficult it was to find the actual place.

*"The name "Community Health Centre" should at the entrance into the building".*

HSE professionals in the area of community welfare front line staff and management that completed the

questionnaires for HSE staff and participated in the interviews stated that the most significant difficulties for their current service provision were as follows: Language and communication difficulties; habitual residency conditions; delays in processing claims for residency for asylum seekers and time assigning. To improve the design and delivery of health services it was suggested to build “multi-ethnicity in the workplace through positive discrimination” by employing EM support workers who would advocate and liaise with their communities. It was also suggested that more health information programmes be developed and more sessions with peer lead groups should take place. The translation of forms, leaflets and websites were also cited along with more training in relation to various cultural backgrounds for staff working in this sector of the HSE.

• **Maternity services**

A total of 17% of the respondents had had at least one baby born in Ireland and had therefore used Irish maternity services. Circa 1% had had a home birth. Of those who had babies born in Ireland, almost two thirds used hospital antenatal clinics.

Chart 29 indicates the level of satisfaction of those respondents who stated they had a baby in Ireland using Irish maternity services. Respondents mentioned “staff friendliness and helpfulness”, good conditions and organization of the services. They suggested improvements in areas like lower patient staff ratio and increased cultural competence for maternity staff (particularly in birth and child rearing practices), travel distance and hygiene.

Chart 28: Use of maternity services.

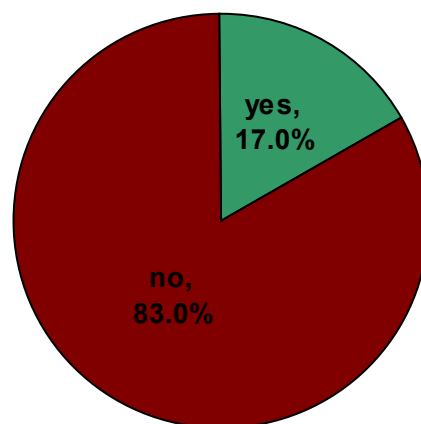
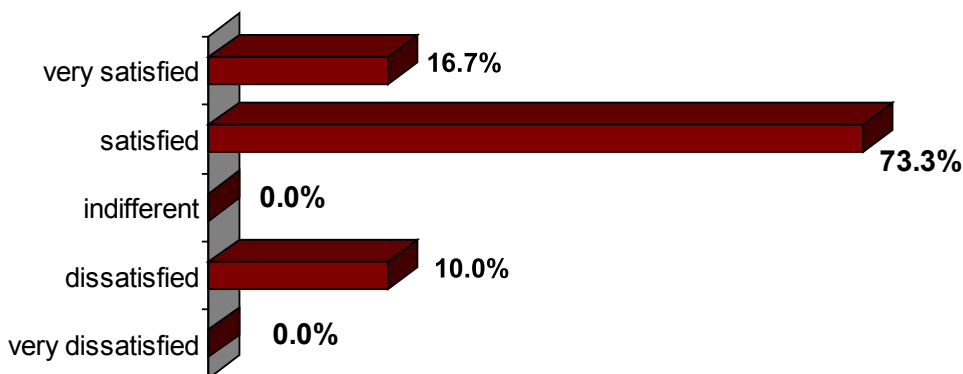


Chart 29: Level of satisfaction with maternity services among users.



Qualitative findings on use of maternity services

HSE midwives questionnaires respondents expressed their views regarding the provision of services to EM patients. Communication, lack of knowledge of cultures and availability of “multilingual material” were identified as gaps in current provision of maternity services to EMs. Respondents suggested that a “national approach should be taken in providing multilingual information and staff training” these would be the most effective ways, in their view, to overcome the identified gaps and to ensure that service users from these groups may effectively access and use the health services.

**Good practice:** The Mid-Western Maternity Hospital in Limerick is committed to a National Intercultural Hospital Initiative, based on the European Migrant Friendly Hospital Project. (See Best practice A&E).



• **Family support services**

Almost 22% of participants that have accessed family support services were more likely to be single parents. Of those who accessed the services, 80% had their families living with them in Ireland and were mainly asylum seekers, refugees and resident -IBCs.

Those respondents who accessed family support services in Ireland were asked to express their level of satisfaction with the service, which is reflected in the chart below.

Chart 31: Level of satisfaction with family support services among users.

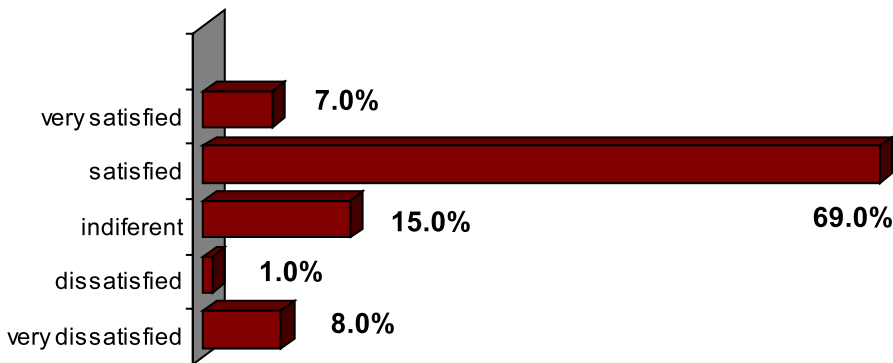
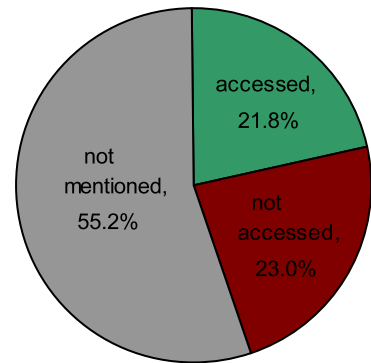


Chart 30: Access to family support services.



Qualitative findings on use of family support services

Family Support Staff that completed the questionnaire felt that the most pressing difficulties in current service provision to EMs were language barriers and lack of available interpreters. Other difficulties were the lack of circumcision clinics and different vaccination programs in other countries. When asked to describe how improvements in the design and delivery of health services could be made they suggested that a central HSE panel of interpreters be formed; that an Out Patient Department/surgical day ward for circumcision be developed; that extra time and resources supplied to staff working with EMs. HSE staff described the importance of being aware that the practice of family and friends interpreting for patients was not ideal and that CDs and DVDs in recognised languages could be developed to address: primary, 3 month, 9 month, 2 years, 3 ½ years check ups and vaccinations.

In the area of social work the following gaps in service provision to EMs were listed: a lack of understanding of cultural needs of clients, as well as a lack of understanding of cultural, social, emotional differences between various ethnic groups by HSE staff. They envisaged that improvements in design and delivery of health services should involve the provision of interpretation services, education/training for service users and providers to "raise awareness on differences – not judge by our standards".

Priorities for family support professionals included raising awareness on cultural needs, education for staff in developing cultural competence, clear policy and directions that encompass HSE ethics in service delivery to EM and consultation with minorities to determine their needs.

EM focus group participants and interviewees felt that it was not uncommon for children with complex difficulties to slip through the net until they were identified at school or nursery. Asylum seekers' children may also be of particular concern in this respect. For example, families in direct provision do not receive child benefit for their child, which makes them even more vulnerable.

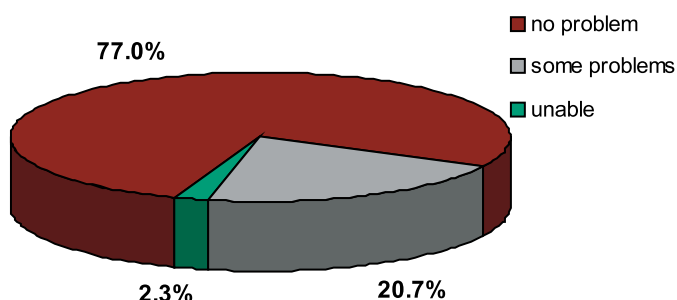
There was a general view expressed by key stakeholder interviewees that many services have to improve their quality of care towards ethnic minority families and that there is now a wider recognition that health services need to meet the needs of all diverse users. There was however, still a widely held view that ethnic minority families continue to receive a 'poorer' service than their Irish counterparts.

**Good practice:** Knockalisheen Accommodation Centre parent support programmes include the “Community Mothers Programme” and “Teen Parents Support Programme”. The Community Mothers Programme has trained two African mothers who provide support to EM parents living in the community. The programme is a home visiting service for parents with new babies and young children living in Limerick City and County. A trained “Community Mother” visits parents and shares information on many issues including child development and enjoying one’s children. The Teen Parents Support Programme is a confidential support service for young parents and pregnant teens in Limerick City and County.

**General health status**

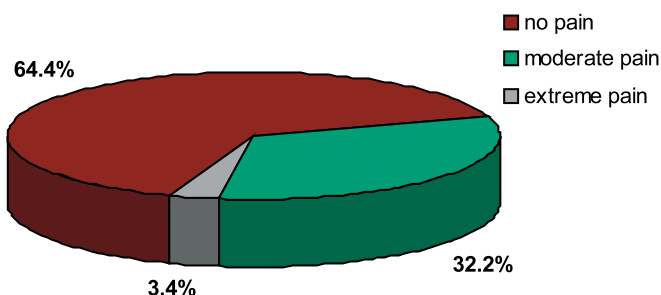
In response to a question on whether they had problems carrying out their usual daily activities - 77% stated that they had no problems. Seventy seven percent stated that they had no problems. Almost 21% had some problems and 2% were unable to perform their daily activities. (Chart 32). Interestingly, 77% of the respondents were aged between 25 to 44 and 55% were females. One third of them were asylum seekers, followed by migrant workers and residents.

Chart 32: Ability to perform usual daily activities.



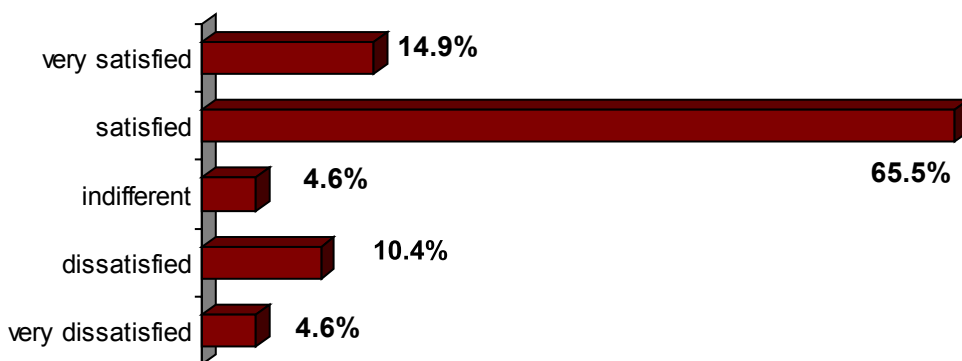
A slightly higher percentage (almost 32%) stated that they experienced some pain or extreme pain and physical discomfort. Therefore, those who experienced some problems performing daily activities were more likely to feel some or extreme pain and discomfort.

Chart 33: Level of discomfort in performing daily activities.



Circa 53% of respondents rated their quality of life as good and very good. More than 80% stated they were satisfied and very satisfied with their health (Chart 34). Those who stated that their quality of life was good or very good were significantly more likely to be satisfied or very satisfied with their health.

Chart 34: Level of satisfaction with own health.

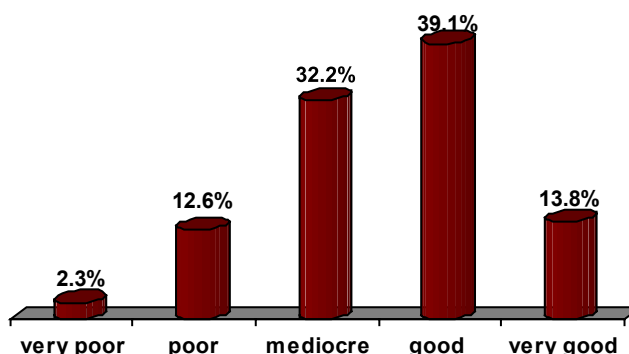


*Self-reported Medical Conditions*

Respondents reported that they suffered from a number of medical conditions, with the most frequently stated being allergies and bronchitis/respiratory illnesses (Table 16). Circa 10% of respondents indicated that they regularly took prescribed pills or medication.

Almost 70% of those not registered with a GP stated that they were satisfied with their health but half of them rated their quality of life as good while the other half rated theirs as mediocre.

*Chart 35: Quality of life rating.*



*Table 16: Reported medical conditions.*

Condition	%	Condition	%
Allergies	9	Heart attack	1
Angina	7	High blood pressure	6
Asthma	6	High cholesterol	1
Bronchitis/respiratory illnesses	7	Stroke	0
Depression	4	Skin diseases	2
Diabetes	2	Post traumatic stress	2
Epilepsy	1	Other	4

*Qualitative findings on general health status*

The majority of EM focus groups participants and interviewees felt that their health status was good and were satisfied with their lifestyle. Quality of life was thought to be higher in Ireland than in their countries of origin in terms of income, but many mentioned that they had to restrict themselves financially as the cost of living was very high. Some respondents that had medical conditions mentioned that medication and visiting the GP was very expensive in Ireland.

*"When I need the doctor advice, I call home and the medicine for me and my family are also sent to me from home".*

**• Health Behaviours**

*Smoking*

Almost 21% of respondents classified themselves as smokers, 15% described themselves as ex-smokers and 63% said that they had never smoked. Of those who smoked, 64% were male and almost 80% were from the EU and Eastern Europe.

*Alcohol Use*

Almost half of respondents stated that they drank alcohol. Reported weekly intakes show that 49% of those who drank alcohol consumed two or less units per week. Of those who drank, 91% were male. Just 3% of respondents used addiction services in Ireland.

*Nutrition*

Circa 71% of the group stated that they could buy the food they liked in nearby shops and 77% had cooking facilities. One third expressed that they had difficulties satisfying their dietary needs.

*Qualitative findings on health behaviours*

EM focus group participants in accommodation centres expressed their concerns about the nutrition provided to them and stated that their cultural dietary needs were not meet. They mentioned that the lack of halal products and kosher food as well as vegan and vegetarian choices available to them as being problematic. They objected to not being able to make decisions around their own diet. Some respondents mentioned that

it was necessary to purchase supplementary foodstuffs in order to meet their dietary needs and the needs of their families, but the majority could not afford to do so.

HSE questionnaire respondents in the area of environmental health and health promotion (including dieticians) stated that the gaps in current provision of health services were language barriers and awareness on different health practices. Examples of improvements in the design and delivery of health services included having more targeted education on food safety in different languages; training of existing staff in cultural diversity as well as recruitment of staff from different cultural backgrounds.

Dieticians and health promotion staff suggested that the use of a client centred approach would bring them a lot closer to identifying the needs of EMs clients and would also simplify their access to specific services. They also felt that it was central to promote specific services and staff training. They felt that the recruitment, selection and inclusion of EMs at all levels of the HSE was central to developing a strategy to increase EMs access to health services.

*"There needs to be an increased awareness and action by HSE that the services should adapt to the needs of communities and not restrict access because of cultural differences and language issues".*

Some key stakeholders interviewees EMOs indicated that there is a need for HSE support and healthy alliances approach in mainstreaming some of the integration initiatives that include promotion of healthy life-styles.

**Good practice:** Sporting activities were promoted through a healthy alliances approach. A group of women at Knockalisheen Accommodation Centre were assisted in their participation in the Limerick City Marathon in 2006. Joint efforts of the Health Information Programme (HIP) supported by the Health Promotion Dept, HSE West and Limerick Sports Partnership offered the opportunity for EM women to participate in the event and created unique and memorable experiences.

### 5.3 Strategy for improving design and delivery of health services for ethnic minorities in Mid-West

*Quantitative findings on Strategy for improving design and delivery of health services.*

*Experience accessing health services*

Respondents were asked about the problems they experienced in accessing the health services, which are reflected in the Chart 36. The top three problems recorded were: 1. access to information on services, 2. access to information on rights and 3. the quality of health services.

*Chart 36: Problems experienced in accessing the health services.*

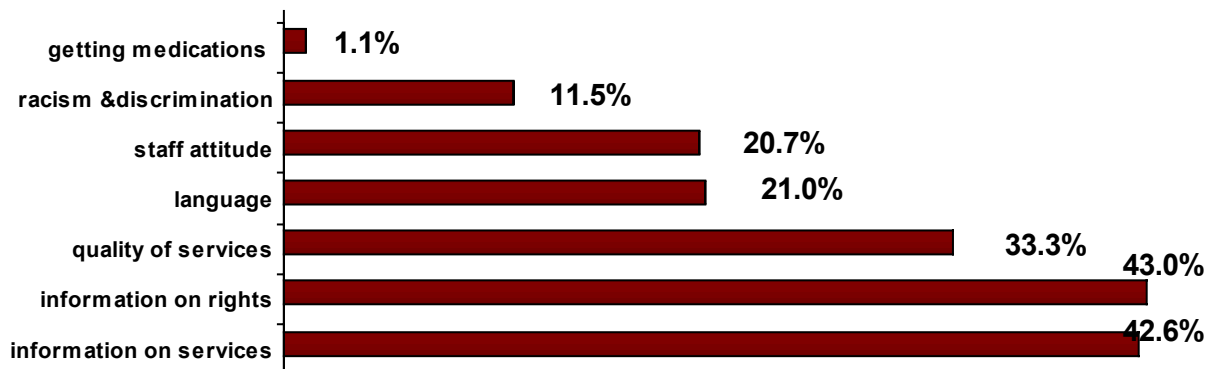
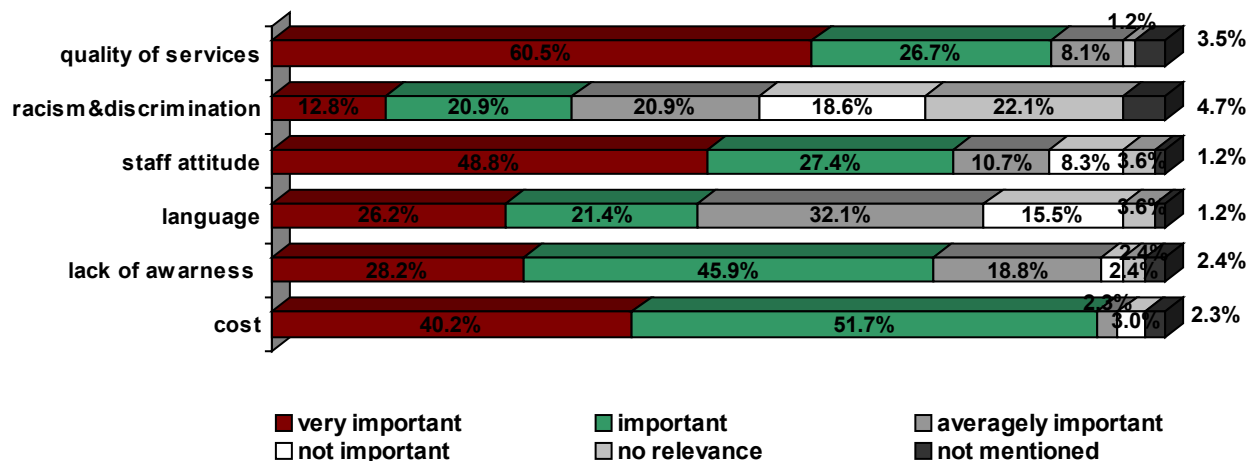


Chart 37: Rating of the problems in accessing health services.



Respondents prioritised the problems in accessing health services in order of importance as follows: 1. quality of services, 2. cost, 3. staff attitude, 4. lack of awareness about the services, 5. language and communication problems, 6. racism and discrimination.

Regarding solutions to these problems, EM questionnaire respondents made the following suggestions: Ensure equality in access to information about the health services along with information about their rights and entitlements for all categories of immigrants; Improve quality of the service, by training for existing health staff and employing multicultural staff; Deliver flexible services and speed up the change process.

EM questionnaire respondents expressed the need for English language classes, lower costs and more information available from the health services staff and from employers.

To the question: What are the three things HSE should do to make the services more suitable for your needs?, EM questionnaire respondents indicated: improved access to information about health services as the number one action; a second suggestion mentioned improving the quality of health services (affordable and flexible services) followed by cultural training for existing staff and employment of EM in to health services.

*Qualitative findings on barriers in accessing the health services.*

The process of consultation for this research highlighted many issues that were felt to pose problems for ethnic minority communities in the health care system. Some of the barriers were identified as:

- poor quality of health services in terms of delivery;
- lack of access to appropriate services;
- lack of culturally sensitive services in relation to religious and cultural needs;
- different health belief systems and procedures;
- language and communication difficulties;
- negative previous experiences of the health service;
- attitudes of some health staff;
- institutional racism.

Based on the analysis of the information provided by participants in the research, all the above listed barriers were classified into 2 main themes, which are as follows: 1. design and delivery of health services and 2. cultural competence of the healthcare staff.

**Design and delivery of health services**

Quality of health services was mentioned by EMs as the most important factor in delivery of these services followed by staff attitude and costs. The needs expressed by participants in this research fall into and are reflected in "Principles of Quality Customer Service for Customers and Clients of the Public Service" by the Department of Health and Children . A copy of the document is included in Appendix 4.

EM and Key stakeholders participants suggested that further attention needs to be paid to equality and diversity in the design and delivery of health services with particular attention to ensuring equal access to health services and accommodating diversity.

Some participants mentioned that the HSE is currently identifying and working to eliminate barriers of access to services for people experiencing poverty and social exclusion, and for those facing geographic barriers to services. It was felt that this work has to be extended with particular focus on EM giving the numbers of immigrants in Ireland. EM service users expressed the willingness to participate in meaningful consultation regarding development, delivery and review of the health services as well as meaningful evaluation of the existing services.

More specific issues in the area of design and delivery included the lack of accessible female GPs, prayer facilities, halal and kosher food choices on hospital food menus and a lack of circumcision clinics. The provision of choice, where feasible, in service delivery including payment methods, location of contact points, opening hours and delivery times, use of available and emerging technologies to ensure maximum access and choice of languages, and include intercultural element in quality of delivery were seen as the main solutions to these issues.

HSE professional interviewees, questionnaire respondents and focus group participants expressed their willingness to deliver quality health services with courtesy, sensitivity and the minimum delay, fostering a climate of mutual respect between provider and service user. They felt that to "*create in HSE a culture of inclusion*" there is a need to take a proactive approach in providing information that is clear, timely and accurate, is available at all points of contact, and meets the requirements of people with specific cultural and linguistic needs. It was suggested to continue the drive for simplification of rules, regulations, forms, information leaflets and procedures. It was also suggested that the HSE take up more opportunities for partnership and develop greater links between itself and organisations working specifically with EMs. It was felt that this could involve the HSE funding more community initiatives and programmes with a health element for EMs, or collaborating more with government agencies that work with EMs.

### ***Cultural competence of the healthcare staff***

All participants mentioned that the delivery of high-quality health care that is accessible and effective requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live.

*"Respect is when people are willing to teach and understand us."*

*"Despite similarities, fundamental differences among people arise from nationality, ethnicity and culture, as well as from family background and individual experience. These differences affect the health beliefs and behaviours of both patients and providers have of each other".*

*Critical factors in the provision of culturally competent health care services included understanding the*

- *beliefs, values, traditions and practices of a culture;*
- *culturally-defined, health-related needs of individuals, families and communities;*
- *culturally-based belief systems of the etiology of illness and disease and those related to health and healing;*
- *attitudes toward seeking help from health care providers.*

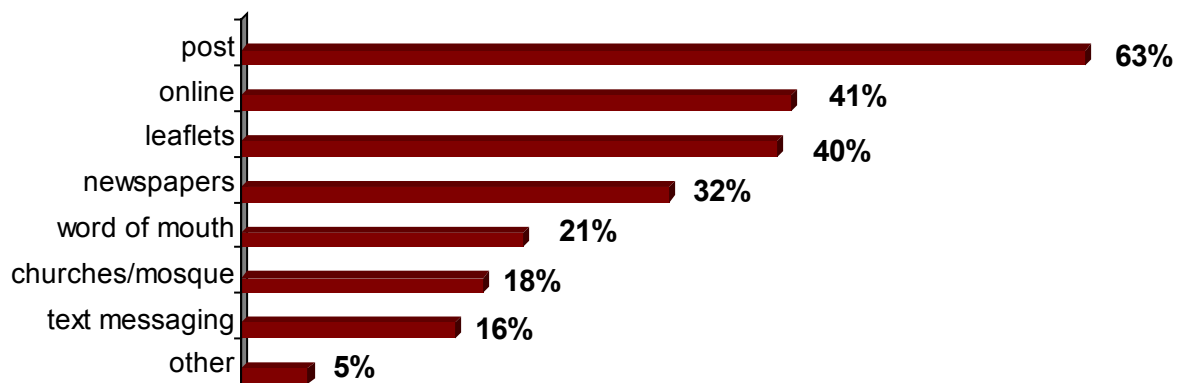
Some specific areas were raised where ethnic minorities felt that more culturally sensitive provision should be available around mental health services, Muslim patients' needs and sickle cell anaemia. Many involved in the discussion felt that the mental health needs of EM are not addressed. EM focus group participants and interviewees also expressed frustration at the lack of awareness and understanding of specific health needs of the Muslim community and specific illnesses for some EM groups.

*"In making a diagnosis, health care providers must understand the beliefs that shape a person's approach to health and illness. Knowledge of customs and healing traditions are indispensable to the design of treatment and interventions.... health care services must be received and accepted to be successful".*

### **Information and outreach**

Respondents were asked what would be the best methods for them to receive the information about health services available. Each respondent had the option to make one or more choices. The findings are described in chart 38. The top three preferred methods were: post 63%, on line 41% and leaflets 40%. In the option "other" methods participants mentioned HSE offices, emails and TV.

Chart 38: Preferred methods of receiving the information about health services



*Qualitative findings on information and outreach*

EM interviewees and focus group participants stated that the information about the health system, health services and rights and entitlements to these services is very important for them in the medium and long term. Those EM who had families and children living with them in Ireland felt that this need for information is essential for their families' well being. Some EM suggested that the websites could offer language choices; newspaper articles could raise awareness and promote better understanding of the health related issues of EM and that peer educators from different ethnic groups could reach out to their communities.

Key stakeholder interviewees, particularly from organisations working with EM, indicated that the challenges they felt were primarily in providing an informational package and in outreach.

Suggestions were made that a language appropriate information "welcome" pack/ easy guide to health (and other) services and health related entitlements in the form of a welcome booklet on arrival in Ireland be distributed through the DJELR (for asylum seekers and refugees) or through the DETE for those (EMs that come directly for the purpose of working in Ireland). It was felt that audio visual information would have more of an impact than printed leaflets.

It was also recommended that a directory of services for immigrants be collated which would include HSE services and all voluntary and statutory services printed in basic English and a number of other relevant languages. Other recommendations included the employment of liaison officers to work with the EM community and the HSE as well as engaging employers to outreach for migrant workers (including work permit holders).

HSE professional interviewees stated that in this challenge of reaching out to EM communities – HSE should join forces with Key stakeholders and EMOs. There was openness to collaboration expressed by all three groups. The best practice examples indicate that a healthy alliances approach is successful and should be promoted at all levels of service delivery.

There were 3 methods of data collection used to produce all the quantitative and qualitative findings. These findings were generated from 3 different target populations showing a multiplicity of perspectives. The demographic profile generated from the 87 EM questionnaire respondents demonstrated that a significant number of EM community intend to live in Ireland for the long-term and have a need for English language training, are generally of labour force age and may have specific needs in relation to accommodation and education. In relation to the range of currently existing health services EMs were shown to be often unaware of their existence and consequently did not have equality of access to these. Individuals identified the main barriers they encountered in accessing health services and rated these in order of importance. While research participants came from very different backgrounds with different perspectives, all agreed on the issues that emerged as most significant. These include 1. Language and communication; 2. Staff composition and cultural competence; 3. Information and outreach and 4. Design and delivery of health services. All these issues raised by respondents concur with those documented in the literature review. These issues will be further examined in the Discussion section in Chapter 6.

## 6. Discussion

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Due to the large influx of immigrants into Ireland in recent years in conjunction with concern for the health of all categories of immigrants, the HSE West, Mid West area (Limerick, Clare and Tipperary North) commissioned this research. The aim of the research was to develop a profile of ethnic minority communities living in the Mid-West region and conduct a high level assessment of their health and personal social service needs. This discussion section will recap on all sections of the research paying particular attention to the research findings.

### Literature review

The research commenced with an extensive review of literature pertaining to EM, their health needs and access to health services. Specific areas such as communication and language; access to health services; poverty & social exclusion; health issues affecting various groups of EMs and the composition and competence of health care staff were flagged as being very significant in research undertaken on similar topics in recent years. It was expected that the empirical evidence for this research would raise similar issues.

### Approach to the research

The three approaches used in conducting this research were

1. Community development approach - which centred on engaging those being studied in the process as the owners of the process as much as feasibly possible.
2. Advocacy approach – which sought to challenge and eliminate inequality and promote more equitable access to health services for EM.
3. Healthy alliances approach – which sought to explore and act on the wider determinants of health by extending the definition of health beyond traditionally narrow medical terms.

### Methodology

In order to present the most comprehensive findings the research gathered empirical evidence from three target groups (Ethnic Minorities living in the Mid-West Region, HSE Professionals working in the Mid-West Region and Representatives of key stakeholder organisations based in the Mid-West Region that have occasion to work with ethnic minority communities).

Three types of data collection were used in order to generate the qualitative and quantitative findings in this research. The aim of using more than one method of data collection was to maximise the complementarity and potentiality of the findings. Qualitative techniques (focus group discussions combined with structured and semi-structured interviews) provided personal experiences and insights into the research question, while quantitative methods (questionnaires) were used to measure particular demographic and health status characteristics as well as aspects of health service design and delivery.

For EM, confidential, pre-piloted, self-administered questionnaires in French, Polish and Russian obtained quantitative data from 87 individuals. In conjunction with this 48 EM individuals took part in focus group discussions while 15 undertook an interview.

For HSE personnel 37 confidential, self-administered questionnaires were returned, while 40 individuals participated in focus group discussions and 15 underwent interviews.

With regard to the third target group (key stakeholders), 29 of these undertook interviews with the researcher.

The combination of community development, healthy alliances and advocacy approaches directed the targeting of respondents and ultimately the methods of data collection. The use of multiple data collection methods and the target groups provides comprehensive findings based on quantitative facts and qualitative opinion making this research unique in its complementarity of results.

### Profiling

In order to contextualise the circumstances of EM living in the Mid-West Region, an extensive profile was conducted. It was found that the population of EMs living in the Mid-West Region were generally of working age. EMs living in the Mid-West Region originated from all over the world. EM males and females were in virtually equal proportions in the Mid-West Region. The profile will provide useful information reflecting specific needs for informing future planning and mainstreaming for health services in the Mid-West Region. The profile in the Mid-West Region reflects that of EMs nationally.



## Findings

Four themes are used to examine the research findings in this section. These themes were used for focus group discussions in the consultation day "**Bridging the Gap between Ethnic Minorities and the Health Service in the Mid-West Area**". The consultation day took place on March 28<sup>th</sup> 2007 in the South Court Hotel in Limerick, where the preliminary findings of the research were presented and reviewed by all target populations of the research. The summary of the consultation is attached in the Appendix 5. The purpose of this was to facilitate participants in the research to make recommendations for improving access to health services by EMs.

The focus was on the following themes:

1. Language and communication;
2. Information and outreach;
3. Staff composition and cultural competence;
4. Design and delivery of health services.

### 1. Language and communication

Language and communication barriers were found to be significant factors which hindered EM communities from accessing health services according to the findings. EMs respondents in this research were shown to speak 32 different languages, the most common of which were English, Polish, Spanish, Russian and French. While 98% of those studied spoke English to some level only 38% classed themselves as proficient or advanced in speaking it.

English speaking ability was most proficient among the African community. However there were instances where EMs with English as their first language had difficulty in making themselves understood to health service staff due to their accents. It was also indicated by some EMs that they felt that they were not adequately listened to or understood by health professionals.

Other language and communication barriers included the lack of professional interpreters for non-English speaking patients. While the lack of affordable and accessible English language courses was seen as a major barrier to those that wished to remain in Ireland for the long term.

It was felt by each target group studied in this research that language barriers could be addressed through the provision of affordable, accessible, appropriately pitched language classes for EMs. It was suggested that health could be tied into English language classes through the incorporation of a health module, which could potentially be developed with assistance from the HSE. In relation to interpretation services, it was felt that more interpreters with knowledge of medical terms were required to be employed by the HSE to translate for non English speaking HSE service users. Formal protocols and procedures for interpretation within a properly resourced service should be provided across the HSE.

### 2. Information and outreach

A key issue that arose in the findings section was the need for information and outreach. This issue ties in with language in that it was perceived by all target groups that there was not adequate health related literature available in languages other than English. This in itself excludes those that cannot read English. Particular groups of EMs such as migrant workers were often completely unaware of their entitlements and of services available to them. Simple multi-lingual promotional literature and information was seen by all three target groups as essential. It was recommended that such information be disseminated in written and audio visual forms and displayed in venues that reach EMs. The employment of liaison personnel to reach EMs that are most marginalised from health services particularly those who were unaware of their entitlements was also advocated. Pro-active recruitment and selection programmes that specifically target the EM community for jobs in the HSE West at all levels was envisaged as having the capacity to assist the dissemination of health services information among the EM community. In addition, peer education and outreach programmes should be considered as mechanisms for informing isolated EM communities about the health and other services along with migrants rights and entitlements. Another suggestion was that a language appropriate information pack on health (and other) services and health related entitlements in the form of a welcome booklet on arrival in Ireland be distributed through the DJELR (for asylum seekers and refugees) or through the DETE for EMs that come directly for the purpose of working in Ireland. It was also suggested that part of the process of obtaining a work permit should involve registration with a GP.

### **3. Staff composition and cultural competence**

This theme arose continuously from all three target groups in the findings section. EMs stated that their health practices and beliefs were often not understood or appreciated by health professionals, while health professionals acknowledged their need to better understand the cultural differences and needs of EMs in order to be able to more effectively meet their health needs. Lack of cultural sensitivity among health staff was also cited by EMs as a significant barrier to accessing health services. There was a feeling from all target groups that staff serving the EM population did not adequately understand the needs of these communities. Cultural competence training programmes for all frontline staff of the HSE were suggested to be developed so that all staff meeting EMs have a minimum level of skill in dealing with EMs. Specialised cultural competence training programmes were seen as essential for those with significant contact with EM service users. It was seen as important that a cultural competence programme of this kind would be cognoscente of the beliefs, values, traditions and practices of cultures that they work with; would understand culturally-defined, health-related needs of individuals, families and communities and would appreciate culturally-based belief systems of the etiology of illness and disease and those related to health and healing. The value of peer mentoring and education programmes was evident in the responses of all target groups who indicated the importance of having health service staff from the communities they served. The findings demonstrate that HSE West has a highly educated immigrant population at its disposal should it desire to increase its numbers of EM staff.

### **4. Design and delivery of health services**

Problems with physical access to health services such as opening hours, travelling distance and lack of knowledge about the specifics of Irish healthcare led to tensions between health service users and providers. The situation is getting more difficult because of the lack of accessible and available information on services, rights and entitlements, and generally the health system.

Lack of and co-ordination between HSE and community groups and government organisations that work specifically with EMs was also seen as problematic and a barrier to EM in accessing Irish health services.

Quality of health services was mentioned by EMs as the most important factor in delivery of these services followed by staff attitude and costs. The needs expressed by participants in this research fall into and are reflected in to "*Principles of Quality Customer Service for Customers and Clients of the Public Service*" presented on the website of the Department of Health and Children. A copy of the document is included in Appendix 4.

Other more specific issues in the area of design and delivery included the lack of accessible female GPs, prayer facilities, halal and kosher food choices on hospital food menus and a lack of circumcision clinics. It was suggested that the HSE take up more opportunities for partnership and develop greater links between itself and organisations working specifically with EMs. It was felt that this could involve the HSE funding more community initiatives and programmes with a health element for EMs, or collaborating more with government agencies that work with EMs. A recommendation from the consultation day Bridging the Gap, was the development of an Ethnic Minority Health Forum which should build on these partnerships and assist in implementing the recommended actions.

## 7. Conclusions

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This study aimed to establish the health needs of ethnic minorities living in the Mid-West Region. It sought to identify those aspects of their lives in Ireland that influence their health and well-being. It also sought to identify what EM and their service providers perceived as necessary to maintain and enhance their health and well-being. The study population consisted of EM who were living throughout Clare, Limerick and North Tipperary. In addition, the views of service providers and other stakeholders were documented to provide a more complete picture. The following conclusions were drawn from the findings of the study:

EM are predominantly a young population with almost equal numbers of males and females in the group. Currently, EM in Mid West are a heterogeneous group coming from 34 countries and speaking 32 languages. Thus, they come from a multitude of cultural backgrounds, which poses considerable challenges in the provision of healthcare. The majority of immigrants have been employed prior to coming to Ireland. They are generally well educated by their own and Irish standards, with those from the EU and Eastern Europe attaining higher educational standards than the rest of the group. More than 50% stated their intention to live permanently in Ireland. Most with this intention came from the EU and Africa. Interestingly, those who planned to live here permanently had their family members living with them and were mainly asylum seekers, refugees, resident IBCs and EU migrant workers. The majority of them had English as their first language, followed by Spanish, Russian, Polish and French. Despite the fact that studies have cited language as a major barrier to accessing health services, many of the study participants spoke English well and claimed to have had little difficulty communicating.

Many of the service providers consulted in this research stated that communication difficulties created problems in terms of lengthening consultations as well as the understanding of advice and instructions. The importance of basic information on health services for the EM community is crucial. There is a lack of understanding of the Irish health system and the roles of service providers and thus, a need for orientation and cultural training for both service providers and immigrants to cultivate mutual understanding and appreciation.

Access to existing health services by EM proved to be lower than their Irish counterparts. The highest use is for primary care services followed by A&E with a low level of satisfaction with both services. Language was not the only difficulty in attempting to provide health care for this population. Different cultural backgrounds and religious beliefs led to practices that are sometimes difficult for service providers to understand. There are differing birthing practices among some ethnic minorities, which have implications for Irish maternity services. Muslim women will not attend male doctors. There is a need for EM to be understood by Irish service providers but there is also a need for those providing services to understand the subtleties of the backgrounds and traditions of individual patients and groupings. Therefore, those providing healthcare service to EM must address cultural differences. Training and education is needed, in particular, when dealing with those who are diagnosed with mental health conditions, and in the provision of maternity services. An understanding of the nuances and backgrounds of individuals and groups is essential.

Problems with physical access to health services such as opening hours, travelling distance and lack of knowledge about the specifics of Irish healthcare lead to tensions between health service users and providers. The situation is getting more difficult because of the lack of accessible and available information on services, rights and entitlements, and generally the health system. A more proactive approach needs to be taken regarding the issue of information outreach for EM communities, particularly for those most isolated.

Quality of the services was indicated as very important for the EM communities, but there are also high expectations from the health system by EM communities. This often necessitates longer consultation times and explanations. Clarification of the role of GPs and other health professionals, as well as waiting lists and overcrowding of the hospitals is needed.

The physical health of EM in Mid-West is reported to be generally good but their long-term health status has not been studied. Despite apparent good health, one third of the respondents stated they feel some or severe pain and their self-reported ability to undertake daily tasks are poor. This may be a reflection of general unhappiness or poor emotional health. However, the majority of the group reported high satisfaction with their health and to a lesser extent their lives. Their quality of life is much poorer than that reported for the general Irish population in surveys.

Health related lifestyle factors were considered: one fifth of respondents were current smokers the majority of whom were from Eastern Europe and predominantly male. Alcohol consumption is present for half of the group with generally low amounts consumed per week. At present, there are differences in patterns to the Irish population and health promotion messages must be more targeted.

Staff working across a wide range of agencies identified communication and access to services as key issues of concern. Cultural competence was also identified and there was a strong view the ethnic composition of staff in health services should more closely reflect that of the communities they serve. The importance of sharing information across HSE departments and other agencies was highlighted. Social exclusion and poverty in general were identified as the prime determinants of ill-health. The contributors also explored the key aspects to addressing inequalities in health and achieving cultural competence. These are: Recognizing and valuing diversity; auditing systems and processes within HSE; creating a more inclusive organizational culture; and challenging individual attitudes and behaviour.

## 8. Recommendations

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### Language and Communication

- An audit of existing interpretation services needs to be considered with particular focus on effectiveness, quality and standards.
- Develop health materials and signage that are simple, using visuals in the most relevant languages to Mid-West EM communities.
- The development of health information materials for ethnic minorities needs to use simple English as identified by National Adult Literacy Association. Creativity needs to be exercised when working on health information reflecting the fact that leaflets alone have not been adequate.
- The HSE together with other NGO's and statutory agencies need to invest in the developing and improving access for ethnic minorities to English Classes. The HSE should contribute by providing a health component to these classes.

### Information and Outreach

- Further investment in the development of peer-led health information initiatives (for example the Health Information Programme by DORAS Luimní) as an aid to meet the health information and outreach needs of EM needs to be undertaken.
- In the development of health information material particular focus should be given to: Access to services, feedback systems, and rights and entitlements.
- Measures to encourage and facilitate active participation from ethnic community groups and community leaders are needed in the development of and in the rolling out of health initiatives. Guidelines for best practice need to be used where appropriate.
- The establishment of a Multicultural Health Forum within Limerick, Clare and Tipperary NR should assist the development and support of initiatives to meet the needs identified in this document. This Forum would require tri-partite representation from Ethnic communities, voluntary and statutory sectors.
- A directory of public services, NGO's, statutory and voluntary organisations serving Ethnic Minorities living in the Mid-West could be developed to facilitate information dissemination and networking in the area.

### Staff Composition and Cultural Competence

- In line with the National Intercultural Health Project deliver cultural competence training for all managers and frontline staff working in both community and hospital settings. The training would need to support capacity building of managers and staff to plan and deliver appropriate responsive, culturally competent services.
- A whole systems approach to a cultural competence would need to be used in order to ensure that the support and development of services meet the changing needs and demands of the service on an ongoing basis.
- Support the implementation of and ethnic minority identifier contained in data collection, in line with national initiatives.
- The use of cultural mediators/brokers or EM community health workers should be considered to support the work of HSE in promoting Interculturalism within the health service.

### Design and Delivery of Health Services

- Through the use of peer-led information programmes raise awareness on accessing health services in the Mid-West.
- The HSE need to continue efforts made to promote equal opportunities and diversity within the workforce and in relation to services delivered.
- Consideration at local level should be given to promote and celebrate diversity within the workforce by the recruitment and employment of staff from EM backgrounds where possible.

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[www.dsfa.ie](http://www.dsfa.ie)      [www.justice.ie](http://www.justice.ie)

# Appendix 1

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## Questionnaire for Ethnic Minorities

### HEALTH AND PERSONAL SOCIAL NEEDS OF ETHNIC MINORITIES IN MID-WEST OF IRELAND (Clare, Limerick, North Tipperary)

#### QUESTIONNAIRE

##### GENERAL INFORMATION

Please state your:

1. Country of origin
2. Nationality
3. Age       16-24               25-44               45-65               +65
4. Gender     Male               Female
5. Religion:     Catholic  
                   Christian Orthodox  
                   Jewish  
                   Muslim  
                  Other please state \_\_\_\_\_
6. Area of residence       Clare               Limerick               North Tipperary
7. Category you belong to       EU migrant worker  
   work permit worker  
   student  
   asylum seeker  
   refugee  
   resident  
  Other please state \_\_\_\_\_
8. How long have you been in Ireland?     0-1year     2-4years     5-7years
9. How long do you plan to live in Ireland?  0-3years     4-6years     6-8years     permanent
10. What languages do you speak?
11. what level of English do you have?     Beginner  
   Basic/Elementary  
   Intermediate  
   Advanced  
   Proficient
12. Have you or are you attending English language classes?       yes       no
13. If yes, what might prevent you from taking English Language classes?  
Please specify:
14. If no, would you like to attend English language classes?       yes       no
15. What might support or encourage you to take English Language classes?  
Please specify:

**EDUCATION/ EMPLOYMENT**

1. What is your educational background? (please tick one)

- No schooling
- Primary school education only
- Secondary education
- Some third level education at university / technological institute
- Complete third level education university / technological institute

2. What was your status before you arrived in Ireland?

- Student
- Employee
- Unemployed
- House duties only
- Other \_\_\_\_\_

If you have a spouse/partner please answer the following questions.

3. What is your status at present?

- student
- employee
- self employed
- unemployed
- Other please specify \_\_\_\_\_

4. What did your spouse/ partner do before coming to Ireland?

- Student
- Employee
- Unemployed
- House duties only
- Other \_\_\_\_\_

5. What is his/her status at present?

- student
- employee
- self employed
- unemployed
- Other please specify \_\_\_\_\_

**FAMILY**

1. Do you have family members living with you in Ireland?

- yes
- no

If no please go to next section.

2. How many adults and children live in the household with you?

Please state the number of: adults \_\_\_\_\_ children \_\_\_\_\_

3. Are the children attending:  pre-school  primary school  secondary school  third level institution

4. Do you receive child benefit on behalf of your children?

- yes
- no

5. Have you ever accessed family support services in Ireland?

- yes
- no

(Family support services are: area medical officers, clinical psychologists, community welfare officers, family therapists, child psychiatrists, public health nurses, social workers, speech and language therapists, etc.)

6. If yes, how satisfied are you with the service?

- very dissatisfied
- dissatisfied
- indifferent
- satisfied
- very satisfied



**ACCOMODATION**

1. Is your accommodation:       owned property  
     rented  
     B&B  
     special centre \_\_\_\_\_  
    Other, please specify \_\_\_\_\_
2. Do you share your accommodation with non family members?       yes       no
3. How many bedrooms are there for your household group? \_\_\_\_\_
4. Are there any problems with your accommodation?       yes       no

If yes, please state these problems:

**HEALTH & PERSONAL SOCIAL NEEDS**

**Section 1**

1. Are you or any of your household registered with a family doctor (GP)?       yes       no  
 If no, please state why not?  
 If no. please go to Q 13
2. Have you had a general health check-up by a family doctor (GP) since you came to Ireland?       yes       no
3. If there are children under 16 have they had a general health check-up by a family doctor (GP) in Ireland?       yes       no
4. In the last month did you attend a family doctor (GP)?       yes       no
5. Have you changed your family doctor (GP) since arriving in Ireland?       yes       no
6. Have any of the children in your household been vaccinated in Ireland?       yes       no
7. Do you have any problems making an appointment and seeing your (GP) family doctor?       yes       no
- If yes, please state what are the problems:
8. How satisfied are you with the services provided by your family doctor (GP)?  
 very dissatisfied       dissatisfied       indifferent       satisfied       very satisfied
9. What have you found helpful about your family doctor (GP) services?
10. What improvements could be made in GP services?
11. Have you or your household ever needed an interpreter when seeing a family doctor (GP) in Ireland?       yes       no
12. If yes, how was the interpreting need met?  
 An adult relative  
 A child relative  
 Interpreting services  
 A member of staff  
 Other \_\_\_\_\_

13. Do you have:  medical card  
 GP only card  
 European health insurance card  
 Private medical insurance  
 Don't have any

14. Are you entitled to any of the above mentioned?  yes  no  don't know

**Section 2**

1. Have you used any of the following health services since you are in Ireland? Please indicate:

- Optician
- Dentist
- Chemist
- Counsellor
- Psychiatric services
- Family planning services
- Hospital in patient
- Hospital out patient
- Community Welfare Officers
- Family therapists
- Clinical psychologists
- Speech and Language therapists
- Child psychiatrists

2. Has any of your family used the Accident & Emergency Department at a hospital in Ireland?  
 yes  no

If no, please go to Q 8

3. If yes, was that person:  an adult  a child

4. If yes, how many times in the last 3 months \_\_\_\_\_  
 In the last year \_\_\_\_\_

5. How satisfied are you with the service in the Accident & Emergency Department?  
 very dissatisfied  dissatisfied  indifferent  satisfied  very satisfied

6. What have you found helpful about the A & E services?

7. What improvements could be made in A & E services?

8. Has any of your family used Community Health Centres in Ireland?  yes  no

If no, please go to Q 12

If yes, was that person:  an adult  a child

If yes, how many times in the last 3 months \_\_\_\_\_  
 In the last year \_\_\_\_\_

9. How satisfied are you with the service in Community Health Centres?  
 very dissatisfied  dissatisfied  indifferent  satisfied  very satisfied

10. What have you found helpful about Community Health Centres?

11. What improvements could be made in Community Health Centres services?

12. Have you had a baby born in Ireland?  yes  no

If no, please go to section 3

11. If yes, where was the baby born?

In hospital  in your home  other \_\_\_\_\_

12. Did you use:  hospital antenatal clinics  ante natal classes  not applicable

13. How satisfied are you with maternity services in Ireland?

very dissatisfied  dissatisfied  indifferent  satisfied  very satisfied

14. What would be your specific needs regarding maternity services which weren't met if any)?

15. What have you found helpful maternity services?

16. What improvements could be made in maternity services?

### Section 3

1. How satisfied are you with your health? (Please tick one box only)

very dissatisfied  dissatisfied  indifferent  satisfied  very satisfied

2. How would you rate your quality of life?

very poor  poor  mediocre  good  very good

3. Have you ever been diagnosed by the doctor with any of the following?

- Allergies
- Angina
- Asthma
- Bronchitis / other respiratory illnesses
- Depression
- Diabetes
- Epilepsy
- Heart attack
- High blood pressure
- High cholesterol
- Stroke
- Skin diseases
- Post traumatic stress disorder

Other , please specify \_\_\_\_\_

4. Do you regularly take any prescribed pills or medications?

yes  no

Please indicate the statement which best describes your own state of health.

Usual activities (work, study, housework, family or leisure activities)

I have no problems with performing my usual activities

I have some problems with performing my usual activities

I am unable to perform my usual activities

Pain/ Discomfort

I have no pain/discomfort

I have moderate pain/ discomfort

I have extreme pain/discomfort

### Section 4

1. How would you describe your smoking status?

current smoker  ex-smoker  non-smoker

If an ex-smoker or non-smoker, please go to question 4

2. If you are a current smoker how many years have you been smoking?
3. If you are a current smoker, how many of the following do you smoke?  
 Branded cigarettes \_\_\_\_\_  
 Hand rolled cigarettes \_\_\_\_\_
4. Do you drink alcohol?  yes  no  
 If no, please go to question 7
5. If yes how many units (bottles/ cans) a week? \_\_\_\_\_
6. Have you ever accessed addiction services in Ireland?  yes  no
7. Can you buy the food you like to eat in nearby shops?  yes  no
8. Have you suitable cooking facilities where you live?  yes  no

**STRATEGY**

**Section 1**

1. What problems do you have accessing the Health Services?  
 Lack of information about services  
 Lack of information about your rights and entitlements  
 Language and interpretation  
 Staff attitude  
 Racism and discrimination  
 Quality of services  
 Other, please specify \_\_\_\_\_
2. Can you suggest a way or ways the problem mentioned in (Q1) can be solved?
3. In your opinion how important are any of the following issues in relation to why you have problems:

	Very important	Important	Averagely important	Not important	No elevance
Money					
Lack of awareness of your needs					
Language					
Staff attitude					
Racism & Discrimination					
Quality of services					
Others (please specify)					

4. Can you suggest how each of the above problems can be solved by the appropriate services?
5. Are there specific issues that affect your health/ well being that are not mentioned already?  
 yes  no
6. If yes (Q5), please explain.
7. Please tell us three things the Health Service Executive could do to make the services more suitable for your needs?  
 a)  
 b)  
 c)

8. In the space below, please describe what you would consider as an IDEAL health service?
9. What is the best method of getting to you the information about the health services available?
- Post
  - Online
  - Leaflets
  - Word of mouth
  - Churches/Mosque
  - Text messaging
  - Newspapers
  - Other, please specify \_\_\_\_\_
10. In the space below could you state any needs inside or outside the health care delivery system that affects your well being (makes you not happy)?
11. Is there anything that you found helpful in your contact with Health Services that you would like us to know about? Please inform us here of the things you found helpful.

## Appendix 2

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### **Questionnaire for Health Service Staff**

#### **An Assessment of Health and Personal Social Service Needs Relating to Ethnic Minority Groups with-in Mid-West**

Please indicate your occupation:

- Practice Nurse
- Staff Nurse
- Public Health Nurse
- Midwife
- GP
- Physiotherapists
- Community Welfare Officer
- Speech and language therapist
- Clinical psychologist
- Psychiatrist
- Child psychiatrist
- Family therapist
- Other, please state \_\_\_\_\_

1. Are you currently involved in providing services to people from different cultures and ethnic groups? Yes No  
If Yes, Please briefly describe:

2. Please briefly describe what you think are the main gaps that currently exist in the provision of health services to Ethnic minorities?

3. How do you think these gaps can be effectively overcome in the future to ensure that service users from these groups may effectively access and use the health services?

4. What do you think are the three most important things that the health services should consider / address in enhancing aspects of service provision to Ethnic Minorities?

1.
2.
3.

5. In your role around service delivery to persons from diverse cultures and groups, are there ways in which you would like to be supported in the future so that you can ensure improved access to health services for people from these groups?

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6. Are there models of good practice that can be used to exemplify how services can be developed in the future?

If so, please could you provide some brief information about specific projects or initiatives so that we could build on what works. (*Information around any projects in which you have been/ are involved would be especially helpful*).

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7. Please provide any further information/ comments.

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## Appendix 3

### Tables of Focus Group Participants and Interviewees

Table 17: EM focus group participants.

Focus group / hosting venue	Gender / nationality	Area(s) of residence
<i>Focus group 1</i> Migrant workers / Augustinian Church Centre	6 females & 2 males / Polish	Limerick City and County
<i>Focus group 2</i> Refugees / Doras Luimni	2 male / Somali 1 female & 1 male / Pakistani	Limerick City
<i>Focus group 3</i> Asylum seekers / Knockalisheen Accommodation Centre	2 female / Zimbabwean 1 female & 2 males / Somali	Clare County
<i>Focus group 4</i> Asylum seekers / Knockalisheen Accommodation Centre	1 female / Nigerian 2 female / Zimbabwean 1 female / Kenyan (all of them attended with children) 2 males / Somali	Clare County
<i>Focus group 5</i> Migrant workers / Mushroom Farm	2 female / Ukrainian 2 female / Latvian 1 female / Russian 1 male / Ukrainian 1 male / Latvian	North County Tipperary
<i>Focus group 6</i> Migrant workers / Mushroom Farm	2 female / Estonian 2 female / Latvian 1 male / Estonian 1 male / Latvia	North County Tipperary
<i>Focus group 7</i> Women's group / Irish Refugee Council	1 female / Somali 1 female / Ghanaian 1 female / Cuban 1 female / German	Ennis
<i>Focus group 8</i> Migrant workers / Glin	1 female / Polish 1 female / Philippine 3 male / Polish 2 male / Lithuanian	Limerick County
<i>Focus group 9</i> Writers for Ethnic Section of the Limerick Leader	/ Chinese / Spanish / Ukrainian / Nigerian / South African / Irish	Limerick City
<i>Intercultural Strategy Consultation Day</i>		
Focus group	Organizations represented	
Focus group 10 EM and organizations working with EM	Clare VEC Education services, Clyde House Accommodation Centre, Doras Luimni (2), Irish Refugee Council (2), Novas Initiatives, Ennis CDP.	Clare County Limerick County
Focus group 11 EM and organizations working with EM	Paul Partnership :Ethnic Minority Services, Ennis CDP, Knockalisheen Accommodation Centre, Centre, Doras Luimni (2), Irish Refugee Council (2)	Clare County Limerick County
Focus group 12 EM and organizations working with EM	Clare Care Family Support Services (2), Centre, Doras Luimni (2), Irish Refugee Council (2), Novas Initiatives, Red Ribbon Sexual Health Services.	Clare County Limerick County



Table 18: EM interviewees.

- Leader of Polish Community in Limerick (IPBA);
- Leader of Congo Community ;
- Leader of Ghana Community ;
- Imam of the Islamic Centre in Limerick;
- International Student attending UL from Africa;
- International Student from Eastern Europe;
- Refugee from Somalia;
- Refugee from Pakistan;
- Asylum seeker from Zimbabwe (HIP participant);
- Asylum seeker from Croatia (Augustinian Church Centre);
- Resident, parent of Irish born child from Eastern Europe;
- Work permit holder;
- Migrant worker from Poland;
- Muslim woman (Irish Refugee Council);
- Undocumented person from Eastern Europe.

Table 19: HSE professional focus group participants. Intercultural Strategy Consultation Day

<b>Title</b>	<b>County</b>	<b>Department Represented</b>
A/General Manager	Clare	GM's Dept.
A/Health Promotion Officer	Limerick	Health Promotion
A/Unit Manager	Limerick	Mental Health Services
Admin CWO	North Tipperary	Community Welfare Services
Admin CWO	Limerick	Community Welfare Services
Admin CWO	Regional	Ethnic Minority Services
Assistant Director of Public Health Nursing	Clare	Public Health Nursing
Catering Instructor	Clare	Elderly Services
Childcare Manager	Limerick	Childcare
Clerical Officer	Regional	Ethnic Minority Services
Clerical Officer	Clare	Mental Health Services
Clinical Nurse Manager II	Clare	Mental Health Services
Community Development Worker	Clare	Traveller Health Services
Community Physiotherapist	Limerick	Physiotherapy Services
Coordinator of Services	Limerick	Acute Hospital
Coordinator of Services	Regional	Ethnic Minority Services
CWO	North Tipperary	Community Welfare Services
CWO	Limerick	Community Welfare Services
Dietician Manager	Limerick	Acute Hospital
Director Adult Counselling	Limerick	Adult Counselling
Director of Nursing	Clare	Elderly Services
Director of Nursing	Limerick	Mental Health Services
Director Public Health Nursing	Clare	Public Health Nursing
EHO	Limerick	Environmental Health
Grade V	Limerick	Human Resources
Health Promoting Hospital Coordinator	North Tipperary	Health Promotion
Nurse	Regional	Medical Screening Unit
PHN	Limerick	Public Health Nursing
PHN	North Tipperary	Traveller Health Services
Primary Care Manager	Limerick	Primary Care
Principal Community Worker	Limerick	Community Development
Principal Dental Surgeon	Limerick	Dental Services
Project Leader	Clare	Childcare
Regional Manager Foster Care	Limerick	Childcare
Residential Unit Manager	Limerick	Childcare
Senior Area Med Officer	Limerick	Primary Care
Social Worker	Limerick	Mental Health Services
Staff Nurse-Male Medical	Clare	Acute Hospital
Superintendent CWO	Clare	Community Welfare Services
Training Officer	Limerick	Childcare

*Table 20: HSE professional interviewees.*

- Director of Social Inclusion Unit;
- Director of Childcare and Family Support Services;
- Director of Adult Counselling Services;
- Assistant Director Public Health Nursing;
- Social Work Team leader, Children Care Team;
- CWO Superintendent Tipperary North/East Limerick;
- CWO Superintendent Clare;
  - Principal Community Worker;
- Principal Community Worker Mental Health;
- Senior Clinical Psychologist;
- Clinical Nurse Manager II STI, Regional Hospital;
- Clinical Nurse Manager III, A & E Department, Regional Hospital;
- Patient Service Manager, Coordinator of Translation Services, Regional Hospital
- GP in a very busy medical centre in Limerick;
- Medical screening nurse, Coordinator of HIP.

*Table 21: Key stakeholder interviewees (EMOs).*

- Coordinator Doras Luimni (Limerick)
- Teacher of English Language Augustinian Church (Limerick);
- Cairde Liaison officer for New Communities in Limerick;
- SONAS project, PAUL Partnership, Limerick;
- Case worker, Irish Refugee Council, Ennis;
- Coordinator West Limerick CDP;
- Coordinator Ennis CPD;
- Migrants Forum, West Limerick Recourses;
- Chair of Glin Community Board.

*Table 22: Key stakeholder interviewees (other).*

- Health Services Coordinator, RIA;
- Deputy Manager Knockalisheen Accommodation Centre;
- Chair of "Social Inclusion Measures", Paul Partnership;
- Coordinator of a course, Paul Partnership;
- Liaison officer for EM, Garda Limerick;
- Garda Inspector for EM, Mid- West;
- Employer, developer and founder of Irish Polish Business Association;
- Owner of the Asian Food Market in Limerick;
- Adult Literacy Organizer, VEC, Clare;
- Director of Adult Education, VEC Limerick, Desmount College;
- Manager of Clare County Childcare Committee;
- Manager of Limerick County Childcare Committee;
- Manager of North Tipperary County Childcare Committee;
- Coordinator, Limerick Sports Partnership;
- Coordinator, Clare Sports Partnership;
- Manager Family Support Program, Limerick Social Services Council;
- Family Support Manager, Clarecare, Ennis;
- Community Development Support Worker, Clarecare, Shannon;
- Manager of Limerick Youth Services.

# Appendix 4

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## Principles of Quality Customer Service for Customers and Clients of the Public Service

In their dealings with the public, Civil Service Departments and Public Service offices will:

### *Quality Service Standards*

Publish a statement that outlines the nature and quality of service which customers can expect, and display it prominently at the point of service delivery.

### *Equality/Diversity*

Ensure the rights to equal treatment established by equality legislation, and accommodate diversity, so as to contribute to equality for the groups covered by the equality legislation (under the grounds of gender, marital status, family status, sexual orientation, religious belief, age, disability, race and membership of the Traveller Community).

Identify and work to eliminate barriers to access to services for people experiencing poverty and social exclusion, and for those facing geographic barriers to services.

### *Physical Access*

Provide clean, accessible public offices that ensure privacy, comply with occupational and safety standards and, as part of this, facilitate access for people with disabilities and others with specific needs.

### *Information*

Take a proactive approach in providing information that is clear, timely and accurate, is available at all points of contact, and meets the requirements of people with specific needs. Ensure that the potential offered by Information Technology is fully availed of and that the information available on public service websites follows the guidelines on web publication.

Continue the drive for simplification of rules, regulations, forms, information leaflets and procedures.

### *Timeliness and Courtesy*

Deliver quality services with courtesy, sensitivity and the minimum delay, fostering a climate of mutual respect between provider and customer.

Give contact names in all communications to ensure ease of ongoing transactions.

### *Complaints*

Maintain a well-publicized, accessible, transparent and simple-to-use system of dealing with complaints about the quality of service provided.

### *Appeals*

Similarly, maintain a formalized, well-publicized, accessible, transparent and simple-to-use system of appeal/review for customers who are dissatisfied with decisions in relation to services.

### *Consultation and Evaluation*

Provide a structured approach to meaningful consultation with, and participation by, the customer in relation to the development, delivery and review of services. Ensure meaningful evaluation of service delivery.

### *Choice*

Provide choice, where feasible, in service delivery including payment methods, location of contact points, opening hours and delivery times. Use available and emerging technologies to ensure maximum access and choice, and quality of delivery.

### *Official Languages Equality*

Provide quality services through Irish and/or bilingually and inform customers of their right to choose to be dealt with through one or other of the official languages.

### *Better Co-ordination*

Foster a more coordinated and integrated approach to delivery of public services.

### *Internal Customer*

Ensure staff are recognized as internal customers and that they are properly supported and consulted with regard to service delivery issues.

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## Appendix 5

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### Bridging the Gap between Ethnic Minorities and the Health Service in the Mid-West Area

#### Consultation Day Report

28 March 2007  
South Court Hotel, Limerick

#### Aim

The primary purpose of this day was to present the preliminary findings of the research "An Assessment of Health and Personal and Social Needs of Ethnic Minorities in Mid-West Region" to all who participated in the research with the view to facilitating them to make recommendations for improving access to health services by EMs.

*Objectives of this day were to:*

- create a sense of ownership of the research among all that participated in it;
- use the most appropriate expertise (those that participated in the research) as the most relevant source of information to proceed towards developing actions that the HSE could implement to improve access to health services by EMs;
- get attendees to choose the most urgent and important issues raised in the research that they felt needed to be addressed by the HSE;
- encourage networking among all participants for the future.

#### Attendees

Over 40 individuals took part in this consultation day. Participants included EMs living in the Mid-West Region, HSE professionals working in the Mid-West Region and representatives of key stakeholder organisations that work with EM communities operating in the Mid-West Region. The list of participants is attached in Appendix 6. All of those that attended the day had made contributions to the preliminary findings of the research. A representative from the Mid-West HSE Health Promotion Unit facilitated this consultation day.

#### Content of the day

The researcher presented the preliminary findings of the research to participants. The four main themes that arose from the preliminary qualitative findings were

5. Language and communication
6. Information and outreach
7. Staff composition and cultural competence
8. Design and delivery of health services.

These themes were used as focus group topics to generate recommendations from attendees. Participants were encouraged to self select the focus group topic of their choice and four focus groups were facilitated to develop recommendations on each topic. Focus groups were flexible and allowed participants to move from one to the other in order to be able to contribute to more than one topic.

When recommendations were generated and presented, each attendee was asked to choose what they felt were the most important and urgent 3 issues that required action. This was done using participative appraisal where each attendee placed a star next to the recommendation that was a priority for them. (Attendees were given 3 stars each). Under each focus group topic the order of recommendation is as follows

#### Language and Communication

1. Language Empowerment (long term) - supporting, promoting and empowering people to learn English  
\*Health component included in language classes **(18 stars)**
2. Develop communication skills of all health services workers – pre-registration / in-service **(9 stars)**
3. Develop interpretative services in both acute and non-acute health services to a standardised, quality, accredited service that takes account of cultural differences **(7 stars)**

4. Develop health materials and signage that are simple, using visuals and in many languages **(6 stars)**
5. Admission postcard in different languages, and story book format (visual)
6. Integrate health topics into language classes, in conjunction with adult classes and health services
  - language providers and voluntary groups
  - ❖ More communication between HSE and language providers
  - ❖ More simplification – more visuals
  - ❖ More visits and input from health services to language providers
  - ❖ Establish database, bank of people who can speak different languages in the health services
  - ❖ Further develop interpretive services
  - ❖ Increase the interpretive service to the non acute centres
  - ❖ Standardised interpretive service
  - ❖ Use of 3 way phones all the time
  - ❖ Accredited, quality service (medical terminology)
  - ❖ Different cultures taken in to account
  - ❖ Set of standard guidelines
  - ❖ Before the services are accessed, information on interpreters should be available
  - ❖ Improvement in signage
  - ❖ Language empowerment
  - ❖ Pre-registration training for all health care workers, in communication skills, in-service training on-going)
  - ❖ Anti-natal & post natal care
  - ❖ Maternity services (men & women)

#### **Information & Outreach**

1. Partnership / HSE / Gárdai / other agencies to employ people from ethnic minorities to provide education as peer educators (similar to primary health care approach) **(9 stars)**
2. Review Health lines Directory – be available / languages / should include ethnic minority groups **(6 stars)**
3. A health information model – to be part of the language schools VEV / private
4. e.g. An seo publication for teaching English as foreign language **(5 stars)**
5. Forum for service integration **(4 stars)**
  1. Information exchange
  2. Inclusive of all statutory agencies / service users
  3. Advocacy role **(2 stars)**
6. Developing of health information website with links to other sites of relevance – also in other languages (sports partnership / CDG / Gárdai) **(3 stars)**
7. Linking in with schools to provide information **(3 stars)**
8. Provide information to people working with ethnic minority groups & service users **(2 stars)**
9. Link in with other partnerships / agencies and they do the leg work **(1 star)**
  - (a) Increase the awareness of peer educators of culture specific illnesses **(1 star)**
  - (b) Increase the awareness of the medical profession and cultural specific illnesses
  - (c) Health profession need to be aware of vaccinations they many need
  - (d) Learn from Traveller Health Care Model (Primary Care)
10. Use events – to get information out e.g. international barbeque May Bank Holiday weekend
11. Link with Church groups – key spiritual leaders

#### **Staff Composition & Cultural Competencies**

1. Cultural Competence Training **(11 stars)**
  - (a) Mutual understanding and respect between client and service provider
  - (b) Including opportunities to explore prejudice **(1 star)**
  - (c) Evaluation of the practice and what impact it has had on service delivery post training
  - (d) Induction on-going development
  - (e) Understanding of human rights and it's implications for practice **(3 stars)**

2. Cultural Brokers / Patient Advocacy (possible programmes – staff within services from ethnic communities encouraged to contribute to mediating services / cultural awareness training **(7 stars)**)
3. Representation and participation of ethnic groups in developing, rolling out and evaluating cultural awareness programmes **(3 stars)**
  - a. on going development
  - b. in-service training **(1 star)**
  - c. Reflective practice
4. Use of community outreach / HIP / others to inform ethnic groups on HSE services / Irish culture **(1 star)**
5. Ethnic outreach programmes active partners with HSE Services
6. Standard time – allow time to reflect on attitudes

### **Design & Delivery of Health Services**

1. Develop an ethnic identifier to ensure proper data which will lead to better design of services **(11 stars)**
2. Ensure that registration with a GP is part of the processing of a work permit **(8 stars)**
3. Need diversity among HSE staff **(7 stars)**
4. Develop an Ethnic Minority Forum inclusive of all Ethnic Minority groups, to inform future planning **(5 stars)**
5. Ensure that strong links are maintained with Ethnic Minority groups – support must be provided in terms of funding, staff resources **(3 stars)**
6. Service specific assessments to see how service works and how it could be improved **(2 stars)**

## Appendix 6

**Table 23: List of participants attending the Consultation day: *Bridging the Gap between Ethnic Minorities and Health service providers in the Mid- West Region, 28 March 2007***

	<b>First Name</b>	<b>Surname</b>	<b>Title</b>	<b>Organisation</b>
1	Easter	Bolarin	Nigerian Writer	Limerick Leader
2	Susan	Bryson	Manager	Doras Luimni
3	Desiree	Buckley	Ethnic Minority Services	Health Services Executive
4	Daura	Carballo	Spanish Writer	Limerick Leader
5	Bedelia	Collins	Health Promotion Officer	Health Services Executive
6	Anne	Condon	HIP Coordinator	Health Services Executive
7	Kim	Coughlan	Health Promotion Officer	St John's Hospital
8	Tom	Crowe	Coordinator	Clare Sports Partnership
9	Mo	Foley	Project Worker	West Limerick Resources
10	Maria	Gibbons	Health Promotion	Regional Maternity Hospital, RHD
11	Margaret	Gleeson	Nurse	Nenagh General Hospital, HSE
12	Dr.Alvina	Grosu	Researcher	Culturewise Ireland
13	John	Heelan	Garda Inspector	Roxboro Garda Station
14	Maurice	Hoare	Coordinator Ethnic Minority Serv.	HSE
15	Martina	Hogan	Project Worker	Limerick Social Services
16	Teresa	Kearney	Project Worker, Unaccom. Minors	Health Services Executive
17	Mairead	Kelly	Health Promotion Officer	Health Services Executive
18	Joe	Kennedy	Volunteer	Glin Migrant Liason Committee
19	Mary	Kennedy	Health Promotion Officer	HSE
20	Mary	Killeen-McCarthy	Health Promotion Officer	Nenagh General Hospital
21	Aminah	Koyakoonye	HIP Team	Doras Luimni
22	Jacques	Lobe	Liason Officer for New Communities	Cairde
23	Anne	Loftus	Community Dev Worker	Clarecare, Shannon
24	Cecelia	Martinez Conway	Womens group	Irish Refugee Council
25	Patricia	Mathiasz	Community Welfare Officer	Health Services Executive
26	Lisa	Mauro Bracken	Consultant	HSE
27	Denise	McGrath	Health Promotion Administrator	Health Promotion
28	Mary	McMahon	PHN	Clare Health Promotion, HSE
29	Louise	Mullen	Sonas coordinator	Paul Partnership
30	Caroline	Murphy	Health Promotion Administrator	Health Services Executive
31	Orla	Ni Eille	Manager	Irish Refugee Council
32	Sr Ella	Noonan	Sonas	Doras Luimni
33	Irene	O'Callaghan	Project Worker	West Limerick Resources
34	Ed	O'Connor	Community Development Worker	West Limerick CDP
35	Comfort	Ofi	Project Worker	Irish Refugee Council
36	Marie	O'Flynn	Snr Comm. Welfare Officer	Ethnic Minority Services, HSE
37	Fr. Liam	Ryan	Priest	Augustinian Church
38	Dr Ronan	Ryder	GP	Old Mill Medical Centre
39	Clare	Sheehan	English Teacher	Clare VEC
40	Sam James	Tye	Chinese Writer	Limerick Leader
41	Andy	Walker	Health Promotion Officer	Health Services Executive
42	Maurice	Walsh	Youth Work Manager	Limerick Youth Service