Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin’s North Inner City

A Case Study of a Community Development Approach to Health Needs Assessment

Community Development and Health Programme
Cáirde – July 2006

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Section One: Introduction

Summary

This assessment was part of a wider Community Development and Health Programme which aims to develop a model of community participation in primary care among minority ethnic groups.

This publication has two main parts — one part sets out in detail the community development process adopted in conducting a health needs assessment among minority ethnic groups in Dublin's North Inner City; and the second part sets out some preliminary findings emerging from the health needs assessment at this stage.

More detailed analysis of the findings will be published in Autumn 2006.

1.1 Introduction

Over the coming years, as the Primary Care Strategy is rolled out, various health authorities, primary care teams and communities will be conducting assessments of the health and related needs of their communities. This publication is a case study description of conducting a health needs assessment through a community development approach in order to ensure community participation. This publication serves to promote this as an approach at community level.

The health needs assessment conducted by Cáirde is the second phase of a wider Community Development and Health Programme (CD&H) currently being implemented by Cáirde. The CD&H Programme is a Cáirde initiative funded by the HSE Northern Area under the Eastern Regional Health Strategy for Ethnic Minorities. For Cáirde, the process adopted is as important as the findings of the assessment. The process adopted increases capacity to effect change at community level.

This publication has two main parts — one part focuses primarily on the approach in conducting a health needs assessment, and the second part sets out some preliminary findings from the health needs assessment. Work is still progressing on analyzing the results of the assessment, and a more detailed analysis of the findings will be published in the autumn in a series of short publications along the following themes:

- Immigration and Health
- Accommodation and Health
- Racism, Discrimination and Health
- Employment, Education and Health
- Access to, and Experience of, Health Services
1.2 Background - Community Development and Health Programme (CD&H)

The practice of community development approaches to health is taking root in Ireland; an approach that recognises that health and well-being are linked to social determinants such as poverty, psychosocial factors, education, unemployment/employment, housing, transport, and gender discrimination. A number of government health strategies have prioritised community development approaches, acknowledging that such an approach is ‘critical to the successful delivery’ of health strategies, and a series of other government funded initiatives have demonstrated the value of such an approach. There is little data available in Ireland which analyses health outcomes for minority ethnic communities, but research from the UK and other jurisdictions shows poorer health outcomes for ethnic minority community members being determined by income, racism and discrimination, poor housing, low educational attainment and higher unemployment. The CD&H Programme works to combine a community development approach with determining health and related needs of minority ethnic groups, while supporting ethnic minority community participation in the process.

In late 2004, Cáirde initiated a pilot programme to demonstrate a community development model which would support the participation of minority ethnic communities in primary care. The pilot was funded by the HSE Northern Area. The aim of the Community Development and Health (CD&H) programme is to build the participation of ethnic minority communities in primary care at a local, regional and national level, in particular supporting the participation of ethnic minorities in the process of determining health and primary care needs through community development.

The objectives of the CD&H programme are:

- To deliver an accredited training programme for up to 20 participants from ethnic minority communities to build skills to participate in health and primary care, covering community development, population health, facilitation and outreach skills, group work, communications and information technology;
- To establish a model of community participation in primary care which best meets the needs of disadvantaged ethnic minority communities, and which builds the capacity of disadvantaged ethnic minority communities to engage in primary care planning at local level;
- To assist in creating dialogue between disadvantaged ethnic minority communities and health service providers and work towards the elimination of barriers to accessing health services at primary care level;
- To develop recommendations and models of best practice for the delivery of primary care services at a local level appropriate to the needs of disadvantaged ethnic minority communities, and impact on health policy development at local, regional and national level, particularly the implementation of Primary Care – A New Direction.
In implementation, the CD&H programme has four phases:

**Phase One: Capacity Building Phase (Jan 05 – Sept 05)**
This phase focused on delivering training to 16 participants from disadvantaged minority ethnic communities to build the capacity within minority ethnic groups to understand and analyse health inequalities, and to build capacity for involvement in designing, developing and implementing responses to issues affecting the health of their communities. This phase was the subject of an earlier case study report published in April 2006 – “Community Development and Health Programme – An Intervention for Social Change: A Case Study of the Capacity Building Phase of the Programme”

**Phase Two: Health Needs Assessment Phase (Oct 05 – March 06)**
Following completion of the capacity building phase, participants became voluntary interns within Cáirde as Assistant Community Health Workers; and conducted a health needs assessment of minority ethnic communities in the North Inner City. This phase explores the health needs of minority ethnic groups, and is the subject of this case study report.

**Phase Three: Actions Phase (March 06 – Dec 07)**
The actions phase will respond to the needs identified in two ways. Firstly, it will create a dialogue between marginalised ethnic minority communities and health service providers to address the barriers for these communities in accessing health services. Secondly, it will develop a model for community participation in primary health care. In this phase, a pilot Community Health Action Team is proposed comprised of a project co-ordinator and some of the participants in the role of Community Health Worker. It is proposed that a number of priority actions will be selected, and the Community Health Action Team will work in partnership with primary care health service providers, minority ethnic groups and relevant bodies to facilitate participation of ethnic minority communities in the agreed actions. Funding has not yet been secured for this phase of the Programme.

**Phase Four: Mainstreaming Learning (March 06 – Dec 07)**
Throughout this process, the Community Health Action Team will prepare documents, submissions and presentations and meet key stakeholders and relevant bodies to highlight elements of best practice. Learning will be fed into various policy levels Health Service Executive Primary Continuing and Community Care, Dept Health and Children Primary Care Steering Group and Task Force, and NAPS and Health Working Group to ensure that learning is shared. Funding has not yet been secured for this phase of the Programme.

The rest of this case study report focuses on sharing our experiences of implementing Phase 2 of the Community Development and Health Programme - the Health Needs Assessment Phase (Oct 05 – March 06).
### Section Two: Health Needs Assessment

#### the Approach

**Summary**
Cáirde adopted a community development approach in conducting the health needs assessment in order to develop strong community participation in developing primary care, by:

- Operating from a social determinants of health model;
- Implementing the principles of community development;
- Facilitating community participation; and
- Incorporating a rights based approach to health, challenging health inequalities.

**This meant…**

- Adopting a collective approach by facilitating ethnic minority participation in designing and conducting the research, and by facilitating ethnic minority participation in the research itself;
- Targeting those excluded and marginalised and selecting assistant community health workers from within disadvantaged minority ethnic groups;
- Developing capacity for participation by providing training to the assistant community health workers regarding community development, health and research;
- Developing capacity for participation by facilitating the emergence of wider community infrastructure, such as the Ethnic Minority Health Forum and its member groups, and providing ongoing training and supports to these groups;
- Linking the research and the assistant community health workers as a resource to the wider community, and community infrastructure;
- Investing in both the process of conducting the health needs assessment as well as the task of identifying need; and
- Underpinning the assessment with a commitment to equality and diversity.
2.1 Introduction
This section gives an account of the community development approach adopted by Cáirde in conducting the health needs assessment. It firstly sets out the rationale for developing community participation in health and gives an overview of the current policy context within which this can take place. It then sets out, from Cáirde's perspective, what adopting a community development approach to health means, and shows how Cáirde applied this approach to a health needs assessment. The section ends by setting out the specific methodology used in the research process itself.

Section Three focuses on the preliminary findings of the assessment.

2.2 Why community participation in health?
Fostering community participation in health makes sense. A recent assessment of community involvement in local government identifies a range of benefits which are directly applicable to a health planning context. Benefits include:

- It results in more appropriate and relevant services being delivered
- It ensures that policy makers and providers are in tune with needs and issues within communities
- It ensures that local people are well informed about what is happening
- It ensures that local development and decisions about development reflect the needs and wishes of the local community
- It provides a mechanism for the resolution of conflict
- It gives a sense of ownership in policy development and initiatives within an area because people have an opportunity to voice their opinions
- It develops a culture of participation that has relevance beyond the local level
- It allows individuals to have some control over what happens in their community
- For those groups in society that are socially excluded it provides an opportunity for their voices to be heard and for the development of ways to address the marginalisation they experience
- **It is the right of every citizen to be able to participate in decision making about his/her community**

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2.3 What is the context for community participation in health?

Cáirde’s work with minority ethnic groups is focused on promoting a community development approach to health, which seeks to build the capacity of excluded groups to participate in addressing factors which impact on their health. This approach is about supporting communities to participate more effectively in health service planning and development. This is in line with a recent trend in government policy seeking to promote community participation in health.

- **National Health Strategy - Quality and Fairness - A Health System for You.** The national health strategy has as its vision the development of a health system that supports and empowers people and communities to achieve their full health potential and that encourages people and communities to have a say and ensures that their views are taken into account. It embraces wider determinants of health model which identifies social, economic, environmental and cultural factors which influence health; and acknowledges that inequalities exist in health status across different groups. It sets out four primary goals which seek to improve access to services leading to better health outcomes for all. Action 52 of the strategy provides for the participation of the community in decisions about the delivery of health and personal social services.

- **Primary Care – A New Direction** The strategy identifies that primary care will have a strong emphasis on working with communities and individuals to improve health and social well-being. Under the strategy, new inter-disciplinary primary care teams will be established and health needs assessments will be prepared. Under Action 19, the strategy states that mechanisms for active community involvement in primary care teams will be established, and that community participation in primary care will be strengthened by facilitating the involvement of local community groups in the planning and delivery of primary care services.

- **Community Participation Guidelines** published by the former Health Boards Executive set out community development principles to underpin community participation in health policy planning, development and evaluation.

- **Guidelines for Involvement in Health – Position Paper of the National Primary Care Steering Group.** These guidelines build on earlier definitions of community involvement and set out a range of practical examples of how community participation can benefit health service planning and how this can be achieved. These guidelines place particular emphasis on empowerment and the role of the community development in addressing health inequalities.

- **Regional Health Strategy for Ethnic Minorities** developed by the former Eastern Regional Health Authority in 2004 sets out a range of proposed actions promoting participation of minority ethnic groups. It specifically values a community development approach in targeting groups traditionally excluded from mainstream services.
and includes a pilot initiative to build participation of minority ethnic groups in the primary care strategy through community development (Cáirde initiative set out in this document).

- **Health Service Reform Programme** In addition to specific government policy, the reform of the health services presents a new context in addressing the health and related needs of minority ethnic groups. Under the establishment of the new Health Services Executive, a new Primary, Community and Continuing Care Directorate has been established. This new model has identified primary care as a key arena for responding to the needs of excluded groups, and the emerging structure of the HSE identifies social inclusion as a specific pillar to respond to the needs of disadvantaged groups.

- **Building Healthy Communities Programme – Combat Poverty Agency** Combat Poverty Agency has been to the forefront of promoting innovative ways to address health inequalities, and has been involved in supporting a number of projects around the country piloting community development approaches to addressing health inequalities, of which Cáirde has been one. Through this programme, Combat Poverty Agency and the supported projects have highlighted how community development has an important role to play in involving people who experience poverty and social exclusion in contributing to anti-poverty and health improving policies and practice.

Other policies and legislation which also relevant to the health of minority ethnic groups in a broader sense, are:

- National Anti-Poverty Strategy (NAPS)
- National Action Plan Against Poverty and Social Exclusion (NAPS/inclusion)
- National Action Plan Against Racism
- Housing Policy Framework – Building Sustainable Communities
- The Residential Tenancies Act 2004
- Housing (Miscellaneous Provisions) Act, 2004
- Prohibition of Incitement to Hatred Act 1989
- Equal Status Act 2000
2.4 What does community participation in health mean & how did Cáirde do it?
Cáirde adopts a community development approach. This means...
1. Operating from a social determinants of health model;
2. Implementing the principles of community development;
3. Facilitating community participation; and
4. Incorporating a rights based approach to health, challenging health inequalities.

2.4.1 Operating from a Social Determinants of Health Model
This model identifies that social, economic, environmental and cultural factors influence health, and health outcomes; depicted as “layers of influence” in Dahlgren and Whitehead’s diagram below. For minority ethnic groups, these factors include accommodation, education & training, employment, childcare, financial security, residency status, racism and discrimination and other asylum/immigration issues; as well as access to, and experience of health services.

In applying this model to the health needs assessment, Cáirde assessed a wide range of factors in the lives of minority ethnic groups, as well as issues relating to health services, and explored the relationship between these factors and health. It meant posing the question “What factors impact on the health of minority ethnic groups in the North inner city?”, rather than the narrower focus of “What health services do minority ethnic groups need in the North inner city?.” In this assessment, Cáirde explored personal circumstances; immigration situation; housing and accommodation; education; training; employment; environment; health and health services; as well as the interconnected relationship between all of these factors on people’s experiences of and views about health and related matters. In this assessment, the findings indicate a wide range of factors which have an impact on the health outcomes for minority ethnic groups, rather than a narrow focus of only indicating what health services minority ethnic groups need.

2.4.2 Implementing the Principles of Community Development

Community development principles and processes can be used as a means of strengthening and building healthy communities. A community development approach broadens our perspective of health by acknowledging and building on the role of people as social beings. In working to improve health through community development, people are not viewed as individuals in isolation of one another. People’s connections to one another and to organizations in the community, the context they live in (e.g. social, political), all inform community development processes in health. Community development is essential to creating health in a community.

Using a community development approach means working in a particular way which is...

- **collective** – supporting groups of people to develop knowledge, skills and confidence to engage in collective action. Through their involvement in community activities, people learn about skills and resources which they either have or realise they can acquire – that is why the provision of training and support for members of community groups is an important aspect of community development.

- **participatory** – actively engaging people in both defining, planning and taking initiatives to respond to health, socio-economic and political problems, with a particular focus on those who are currently most marginalised and excluded from the decision making process.

- **empowering** – aiming to effect a sharing of power to create structures which provide genuine participation and involvement.

- **task- and process-focused** – attention paid to both task and process, promoting an inclusive collective process.

- **innovative and creative** – it adopts dynamic, innovative and creative approaches to address health, social and economic problems thereby ensuring the participation of local communities.

- **focused on quality of life improvements** – it gains concrete improvements in the quality of life of people by reflecting the real needs as identified by local communities.

- **builds community sector infrastructure** – it recognises the importance of formal and informal support networks in bringing about social change, by actively supporting and resourcing the development of such structures.

- **committed to equality and ethnic diversity** – it involves strategies which confront prejudice and discrimination on the basis of gender, ethnicity, class, religion, socio-economic status, age, sexuality, skin colour or disability.

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7. In 2002, this approach was recognised by the health authorities in the production of Community Participation Guidelines by the former Health Boards Executive, and further endorsed by the National Primary Care Steering Group in December 2004 in their Guidelines for Community Involvement in Health.
In applying this approach to the health needs assessment, Cáirde...

- Adopted a collective approach by facilitating ethnic minority participation in designing and conducting the research, and by facilitating ethnic minority participation in the research itself. A collective approach was also adopted by looking at the needs of people in the context of their communities, rather than as isolated individuals.
- Developed capacity\(^8\) for, and facilitated participation by using creative and innovative methods.
- Targeted those excluded and marginalised by focusing on disadvantaged groups and linked the assessment to community infrastructure, such as the Ethnic Minority Health Forum.
- Invested in both task and process, and
- Underpinned the assessment with a commitment to equality and ethnic diversity.

### 2.4.3 Facilitating Community Participation

Cáirde adopts an approach of enabling communities to become genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change\(^9\). This approach encompasses a full range of activities from sharing information, to actively developing community activity regarding health at a grassroots level. Community participation is a key in the process of supporting communities to develop the skills they need to take responsibility for and make decisions about their own health.

#### 2.4.3.1 Training

Before conducting the assessment, Cáirde implemented a significant capacity building\(^10\) phase with 16 participants from disadvantaged minority ethnic groups to ensure that those who are affected by poverty and health inequalities develop capacity to engage in strategies to respond to health inequalities. This included training in community development, health inequalities, Irish health policy development, social determinants of health etc. This extensive programme is detailed in a recent Cáirde publication\(^11\).

When conducting the research itself, Cáirde implemented further training in research skills to ensure that those who are affected by poverty and health inequalities were included in designing and implementing the research framework.

#### 2.4.3.2 Building Community Infrastructure

In addition, Cáirde invested in building wider community participation in the process. In the first instance, those who participated in the training described above were selected on the basis of being already involved in their communities as community activists. Furthermore, the research was linked to building the capacity and participation of the Ethnic Minority Health Forum (EMHF), a network of grassroots ethnic minority led community groups facilitated by Cáirde to impact on ethnic minority...
health. In parallel to the health needs assessment, Cáirde supported the ongoing development of the Forum and its member groups by building their capacity in community development theory and practice, knowledge of Irish policy system; by building their skill base (facilitation, presentation, etc.). Cáirde facilitated these groups to meet to discuss experiences and difficulties regarding health services, and also supported them to participate in and contribute to the research process.

**Ethnic Minority Health Forum**
The EMHF is a framework where members of ethnic minority groups come together to:

- Identify and discuss issues and concerns affecting the health and wellbeing of their communities
- Decide, in a collective approach, the most appropriate actions to address these needs.

The Forum’s goal is to collectively impact in a positive way on the health and wellbeing of ethnic minority communities.

**EMHF Objectives:**
- To identify and discuss issues and concerns affecting the health and wellbeing of their communities
- To voice out ethnic minority health issues and concerns
- To determine the most appropriate actions to address these needs
- To advocate on behalf of ethnic minorities on issues related to their health and wellbeing
- To undertake, in a collective approach, such actions that would have a positive influence on the health and wellbeing of ethnic minority communities

### 2.4.4 Incorporating a rights based approach to health, challenging health inequalities

The right to health is “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupation and environmental conditions, and access to health-related education and information...A further important aspect is the participation of the population in all health-related decision-making at the community, national, and international levels” UN General Comment 14 related to the International Covenant on Economic, Social, and Cultural Rights (2000).

The process of challenging health inequalities builds on an understanding that the causes of ill health are rooted in inequalities prevalent in society. The right to health was established in 1946 in the constitution of the World Health Organization and reaffirmed in the Universal Declaration of Human Rights in 1948. The right to health is included in over 100 national constitutions.
In 2000, the UN established human rights standards to measure the level of progress towards fulfilling the right to health. Achieving these standards is the primary responsibility of government bodies. These standards are:

- **Availability:** public health care facilities, goods and services must exist and be available in sufficient quantity. At a minimum, this includes safe drinking water, adequate sanitation, hospitals and clinics, trained medical personnel receiving domestically competitive salaries, and essential drugs.

- **Accessibility:** health care must be physically and economically available and affordable. It must be provided to all on a non-discriminatory basis. Information on how to obtain services must be freely available.

- **Acceptability:** all health facilities must be respectful of medical ethics, and they must be culturally appropriate, sensitive to gender and life-cycle requirements, as well as respect confidentiality.

- **Quality:** health facilities, goods, and services must be scientifically and medically appropriate and of good quality. At a minimum, this requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe water and adequate nutrition within the facility.

Cáirde has incorporated this into the health needs assessment by stressing the importance of the social determinants of health where healthcare service and delivery is one of the factors considered rather than the solitary focus of health. Also, Cáirde stresses the changes required in the relationships between policy makers responsible for decisions which affect communities’ health and the communities themselves to impact on ethnic minority health. Cáirde also stresses the changes required in the policy responses in order to impact on the health status of disadvantaged minority ethnic groups.

### 2.5 Health Needs Assessment Methodology

The need for the ethnic minority community health needs assessment emerged from the work of Ethnic Minority Health Forum facilitated by Cáirde. The Forum found that there is a need to document the issues and experiences of ethnic minorities living in Ireland in order to develop appropriate actions to address these issues. This information would be an evidence-based guide, informing the work of the forum as a tool for negotiating change with policy makers regarding the direction of the health services.

Cáirde’s approach to the research placed participation at the centre of the design of the methodology, whereby ethnic minority communities were actively involved in all aspects of the research, starting from the process of identifying priority areas for the research, designing the research process, conducting the research itself, and finishing with analysing the results and planning responses. A critical goal in this participatory approach is for the community to build its own capacity by developing skills, applying research results to improve their lives, and planning for future health related needs.
2.5.1 Recruitment
13 people from disadvantaged minority ethnic groups were selected to participate in an internship programme, on a voluntary basis, as assistant community health workers. Their role was to conduct the health needs assessment, with the support of a project co-ordinator with Nexus Research Co-operative providing technical support.

2.5.2 Training
The 13 assistant community health workers were trained in research techniques. This involved being centrally involved in deciding every stage of the health needs assessment from designing the research framework through to conducting the fieldwork and analysing results.

2.5.3 Consultation
Community Consultation: Through outreach work and through the Ethnic Minority Health Forum, the assistant community health workers facilitated an informal consultation process in the community to determine the most pertinent issues for minority ethnic groups with regard to health. Priority areas which emerged were:
- Immigration and Health
- Accommodation and Health
- Employment, Education and Health
- Racism, Discrimination and Health
- Access to and Experience of Health Services

Service Providers Consultation: An Information and Consultation Day with health service providers was also facilitated, which took the format of a participative workshop discussion with local health service providers (GP’s, Public Health Nurses etc.) The aim of the Consultation Day was to hear their experiences of providing services to people from minority ethnic groups. This was an initial step towards building partnership with local health services.

2.5.4 Interview Questionnaire Design
Over a series of sessions with Nexus Research, the assistant community health workers designed a questionnaire based on the consultations with community members and service providers. The assistant community health workers received training in interview techniques in a particular style pioneered by Nexus. Emphasis was placed on giving interviewees full information about the research project and what it would lead to. Interviews were to be conducted allowing interviewees to tell their story without interruption. If required, those conducting the interviews were also prepared to take some immediate actions in relation to certain issues, for example in cases of crisis referring people to Cáirde staff. This built trust and relationships with interviewees for the future work together.

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12. The same participants who had completed the capacity building phase of the Community Development and Health Programme, and completed the FETAC Level 5 Community Development Award.
2.5.5 Designing a Sample
Due to the mobile and rapidly changing nature of ethnic minority communities, and the absence of relevant, up-to-date social and demographic data relating to such groups in Dublin’s North inner city, it was not possible to construct a meaningful sampling frame which could be used for random sampling. Instead, it was decided that priority would be given to the collection of data pertaining to people’s life experience in a way which would be representative of the diversity of life experience amongst ethnic minority communities. With the technical support of Nexus Research, the assistant community health workers designed a sample based on key indicators deemed to be of significance in influencing life experience. Commencing with their peer group, and working outward, the assistant community health workers constructed a sample based on gender, immigration status, country of origin, family status and locality (Dublin 1, 3 or 7).

2.5.6 Fieldwork
The assistant community health workers conducted 101 interviews with people living in the area. Building trust and establishing relationships were pivotal to the research process because of the type of questions being asked and the quality of information needed for the results to be valuable. The assistant community health workers started with their own peers and a “snowballing technique” was adopted thereafter, where the first interviewees were able to refer the research interns to their friends or family members. As a consequence of this approach a “hard-to-reach” sample has emerged, many of whom are at a remove from mainstream services. Confidentiality was paramount to the process, and all respondents were informed about where and how the information would be used. Furthermore, if the assistant community health workers came across people who needed specific support they were referred to either Cáirde or another relevant agency in order to access the support they needed.

2.5.7 Understanding the Results
After the fieldwork, the assistant community health workers were supported to code and enter the data into a database; and they analysed the findings. They presented preliminary findings to the Ethnic Minority Health Forum and facilitated a number of focus group discussions with ethnic minority community members to draw out themes, and analyse their meaning.

2.5.8 Prioritising Actions
Upon publication of the findings, the assistant community health workers will begin a process of facilitating the Ethnic Minority Health Forum to take a lead role in developing partnerships with relevant bodies, agencies and service providers in order to work together on priority actions to resolve some of the issues emerging from the assessment. This process will facilitate Ethnic Minority Health Forum members, community members and service providers to develop new relationships in agreeing strategic actions which they can work on together. This will begin in September 2006.

13. Six focus group discussions were facilitated in April 2006 along the following themes:
- Immigration and Health
- Employment, Education and Health
- Housing, Environment and Health
- Discrimination, Racism and Health
- Access to, and Experience of Health Services – Men only
- Access to, and Experience of Health Services – Women only

Discussions also took place in April 2006 with:
- Ethnic Minority Health Forum
- Ethnic Minority Women As Leaders Programme
Section Three: Health Needs Assessment
Preliminary Findings

Summary
101 interviews were conducted among a sample of people in Dublin's North inner city, with a relatively young age group of mid 20s to mid 40s. Most had children. They were generally either long term unemployed, in low income employment or not entitled to work. More than half were dependent on social welfare. The overwhelming majority were living in private rented accommodation. They had a generally high level of education, and nearly all felt they had a good level of English. Due to the sampling method adopted by the research team, the sample can be described as a “hard-to-reach” group.

In adopting the social determinants of health model, the most pertinent issues emerging as factors impacting on the health of minority ethnic groups at community level were immigration, accommodation, racism and discrimination, employment and education, and access to health services.

Immigration status emerged as a barrier to accessing secure employment and education opportunities; as a barrier in accessing health and social services; as a factor in the stage at which people link in with health and social services; and as a factor in people’s perception of their own health.

Minority ethnic communities are dependent on the private rented sector, are experiencing high levels of dissatisfaction with their accommodation and living conditions, and are not accessing public housing which means they are not receiving the benefits of security of tenure. There is a high level of movement with most moving every year and a half.

A significant number of people from minority ethnic groups do not feel accepted within the community, and a smaller number within that have a feeling of experiencing racism and discrimination, which has an impact on their sense of belonging, trust and wellbeing. This is a factor in how they learn about the availability of health and social services, how they access health and social services, and the stage at which they access health and social services.
Many disadvantaged minority ethnic groups are at risk of poverty in that they are employed in low paid insecure employment, unemployed or not entitled to work. There are institutional barriers preventing them from accessing employment and education opportunities. For some this means foregoing education or employment opportunities in order to protect their access to health and social services.

Ethnic minority community members themselves identify a wide range of issues in their lives which cause anxiety, stress and depression other than issues regarding a medical condition or their access to health services. There is poor take up of many of the health services provided at community level, despite good levels of English and high eligibility among the sample. Some challenges include:

- Lack of knowledge of services available, and / or lack of understanding of different roles
- Lack of entitlement, or restricted entitlement, due to immigration status
- Financial cost of health services
- Poor “out of hours” services for those in employment
- Late presentation to health services
- Good communication and interpersonal skills among service providers increases accessibility of a service.

3.1 Introduction
This section sets out the preliminary findings of the health needs assessment. It firstly sets out the profile of the respondents who participated in the research, and then goes on to set out the findings under the themes of immigration; accommodation; racism and discrimination; employment and education; and access to and experience of health services. Each subsection ends by relating the preliminary findings to the health agenda. Further analysis of the results is currently taking place and will be published in a series of shorter publications along these themes in Autumn 06.
3.2 Profile of Respondents

From December 2005 to February 2006, 101 in-depth interviews were conducted in the North Inner City with ethnic minority community members. The area of the research included Dublin 1, parts of Dublin 3 and 7. The profile of the people who participated in the survey can be summarised as follows:

- Nearly equal representation of men and women (46%/54%)
- 77% (78 people) are between the ages of late 20s to early 40s (78 people)
- 67% (68 people) have children either here or in home country
- 57% (58 people) are African and 23% (23 people) are Eastern European, and remainder from other parts of the world
- 72% (73 people) are Christian, 15% (15 people) are Muslim and the remainder are either not religious or are of other denominations
- 78% (79 people) have intermediate or good proficiency in English, and remaining 22% (22 people) have basic English
- The average length of time in Ireland is two and half years
- 74% (75 people) have residency status, 26% (26 people) do not have determined status- asylum seekers and undocumented workers
- 81% (82 people) are living in the private rented sector and only 3% (3 people) are in public housing
- 92% (93 people) have second level education or higher, and only 8% (8 people left school prior to completing second level
- 54% (55 people) are living on social welfare payments,
- 30% (31 people) are in employment, 30% (30) are unemployed, 22% (20 people) are not entitled to work, 14% (14 people) are unable to work and the remaining 4% (4 people) are in full time education.

Out of 101 respondents, 46% (46 people) were men and 54% (55 people) were women.

The age group of respondents is a young population, with over three quarters (77%, 78 people) being between the age of 26 years and 45 years – (45%, 46 people, aged 26 to 35 years, and 37%, 37 people between 36 and 45 years). 18% (18 people) were aged between 18 and 25 years.
Over half (54%, 54 people) of respondents were married, and more than two thirds (67%, 67 people) had children either in Ireland or in their country of origin, or both.

Respondents were mostly African or Eastern European. There were 23 countries represented in the research with the majority of people originating from African countries (Nigeria, Kenya, Zimbabwe, Congo, Cameroon, Angola, Liberia, and South Africa). North African countries included Algeria, Morocco and Libya. Eastern European countries included Romania, Ukraine, Moldova, Russia and Bulgaria. New EU countries included Poland, Lithuania and Estonia. Middle Eastern countries included Iran and Afghanistan. Other countries included China and Mauritius.
Nearly three quarters (71%, 72 people) of respondents indicated their religion as Christian, mainly Catholic, Protestant, Orthodox Christian. 15% (15 people) indicated their religion as Muslim. 13% (13 people) indicated that they were not religious.

The overall level of English among the sample was very high. Half of all respondents (50%, 51 people) identified themselves as having a very good or fluent level of English, and nearly a further third (28%, 28 people) identified their English as being at intermediate level. Just a fifth (22%, 22 people) felt their English was at a basic level, and there weren’t any respondents in the survey who had no English.

Nearly two thirds of respondents (59%, 60 people) have been living in Ireland for over 3 years. About a third (31%, 31 people) have been here between 1 and 3 years. Only a small number of people have been here less then 1 year (5%, 5 people).
Nearly three quarters of respondents (74%, 75 people) had their immigration status determined, in that they “have papers” as it is commonly known. Over a quarter (26%, 26 people), did not have their immigration status determined.

The respondents were living predominantly in the private rented sector (81%, 82 people); where they were either renting accommodation themselves (67%, 68 people) or staying with people who rent (14%, 14 people). 11% (11 people) were living under direct provision in hostels or self-contained units. Only 3% (3 people) were housed in local authority housing.

Respondents had a high level of educational attainment. Over a quarter had finished school with a second level certificate (26%, 26 people) and nearly two thirds (65%, 66 people) had some form of 3rd level education, with 9 people having completed postgraduate studies. Only 8% (8 people) had left school before completing second level.

Over half of respondents (54%, 55 people) were living on some type of social welfare payment.

Nearly three quarters of respondents (74%, 75 people) had their immigration status determined, in that they “have papers” as it is commonly known. Over a quarter (26%, 26 people), did not have their immigration status determined.

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Over half of respondents (54%, 55 people) were living on some type of social welfare payment.
3.3. Immigration

3.3.1 Introduction

This section sets out the immigration status of the respondents, and describes the situations in which people find themselves. It sets out the range entitlements according to legal status. This section also briefly explores respondents experiences of accessing immigration services and respondents own perceptions of their health.

3.3.2 Immigration Status and Access to Services

The immigration status of a person impacts on whether or not people have an entitlement to public services and employment. In the event of being entitled to a public service, people are subject to the same eligibility criteria as Irish citizens, such as income/means threshold for health and social welfare benefits, points system for housing etc.

- People with *refugee status* have same rights as Irish citizens and naturalized Irish citizens - they have the right to work, and are entitled to the whole range of social and public services - apart from the right to vote in general elections. They also have the right to family reunification to bring their family members to Ireland.

- People with *leave to remain* and *residency on the basis of an Irish born child* have similar rights to refugees, including the right to work and access to public services, but have limited access to 3rd level education and educational grants. They do not have the right to family reunification or the right to vote in general elections. Also, their status is “temporary” in that they have to renew their residency after a certain period and there are conditions to fulfil for this to happen.

- *Asylum seekers* are provided with the range of public services, including hostel accommodation dispersed outside Dublin, all meals, small monies (19.10 per adult) and access to health and social services while within the asylum system.

- *Nationals of new EU accession countries* have limited access to public services, particularly social benefits during their first 2 years of working in Ireland. They have to fulfil what is termed the “habitual residence” condition before accessing any state benefits.

- People with *work permits* are non-EU nationals coming to work in Ireland. Their work permit is issued to a particular employer, and they cannot freely change place of employment because there are specific employment sectors defined by the Department of Trade and Enterprise for which a work permit can be issued. Also it is the employer who applies for the permit and there is no guarantee of success even in the event of being offered employment. People with work permits have limited access to the state benefits. Spouses of migrant workers are entitled to join them in Ireland, but have no right to work or access state benefits.

- *Undocumented migrants* do not have the right to work or access to public services.

- Finally, people who are *waiting for a decision on leave to remain* applications do not have the right to work, and have no entitlement to public services, including health and social welfare benefits.
Nearly three quarters of respondents (74%, 75 people) had their immigration status determined, and the remaining quarter did not.

Of those who had their immigration status determined (74%, 75 people), over a third (35%, 26 people) were people who have been granted residency on the basis of Irish born child, over one fifth (23%, 17 people) were refugees and 15% (11 people) were nationals of new EU accession countries. Others comprised a range of different situations, as indicated in the table below. The average length of time spent by respondents in waiting for their status to be determined was 2 years 8 months.

Of those whose immigration status had yet to be determined (26% of all respondents, 26 people), nearly a third (31%, 8 people) were undocumented migrants, nearly a third (31%, 8 people) were people waiting for a decision on a leave to remain application, and 38% (10 people) were asylum seekers.
For all who participated in the research, immigration status represented a significant factor in whether or not they could improve their life circumstances, either in terms of employment or education. Over half (55%, 56 people) indicated that their legal status was a main barrier in accessing suitable employment. For asylum seekers, they were not entitled to work, and for migrant workers, being dependent on the work permit system presented them with a lack of choice of employment, leading to uncertainty and possible exploitation.

- “I came to Ireland years ago to visit my friend. I got a college place and my permission to stay run out. I continued with the college, they did not ask for my papers again. My fear is that they might find out any time or when I finish I may not get a job” (Undocumented migrant)
- “I am afraid because I am not legal here, I work with secret” (Undocumented migrant)
- “Immigration status and lack of rights for my husband (I can’t work legally here). I do not know if I can get a work permit, I heard it is difficult” (Spouse of migrant worker)
- “Work permit system is a barrier. Nowadays is very hard to find employer who will take on work permit application for non EU. Now everybody wants people from new EU states like Poland, because they don’t need work permits” (Migrant worker)
- “I came on student visa, it’s run out and now I don’t have any documents. I do not have a valid visa, so I have to take any work. I work 3 days per week and get 130 euro”. (Undocumented migrant)
- “My status in the country is not permitting me to work in Ireland” (Asylum seeker)

Nearly one third (28%, 28 people) stated that their immigration status was a barrier to pursuing education opportunities.

- “Because I have no status (no papers) none of the schools will accept my admission request…” (Asylum seeker)
- “My status does not entitle me to anything. I only got to do the gardening course because a voluntary organization interfered because of my health status.” (Person waiting on decision for Leave to Remain)
“I know the value of education, but being the asylum seeker doesn’t give me that opening. I have no legal entitlement - that is a barrier. I will be old before I get the opportunity to do what I want to do” (Asylum seeker)

“I have no papers. I am afraid to be deported. I am illegal in this country at the moment, because my working visa has expired 2 years ago” (Undocumented migrant)

Nearly one fifth (17%, 17 people) stated that their immigration status prevented them from making improvements in their lives due to being obliged to live in direct provision.

“Because there are six people in a single room, no privacy, no separate toilet, heater is not functioning properly, unhygienic condition, and leakage from the toilet upstairs to our room; the food is not nice, duvets are too old to my liking, compulsory time to eat...” (Asylum seeker)

“It’s like boarding school. I share a room with 4 others - someone needs their privacy - you end up arguing. Sometimes you are asleep and someone comes in - so you don’t really get proper sleep” (Asylum seeker)

“It’s like you are living in prison. All the conditions are similar to that of one in jail. Reminds me of my life in jail back at home and the memories are too bad to keep, yet still have to because I have no other option” (Asylum seeker)

“Living in accommodation centre was a big problem. It was like a concentration camp” (Person granted residency on the basis of Irish born child)

3.3.3 Experience of Immigration Services

People appeared to have mixed experiences of trying to access immigration services, with their views being influenced by whether or not a decision went in their favour.

Most contact with immigration services was in relation to applications for residency on the basis of an Irish born child and collecting their “green cards” in GNIB. They experienced a high level of satisfaction, as only 2 people among the respondents were refused.
The asylum process, the process of acquiring a visa and the process of family reunification presented particular difficulties among respondents.

- “Lack of understanding, preconceived knowledge about my case and no info about my country” (Asylum process)
- “Lengthy appeal and determination period, I am waiting for the decision for a very long time”. (Leave to Remain)
- “Waste of time, they only want to deport you” (Asylum process)
- “I would like to stay and work properly, but I can’t. I want to legalize myself but I have no choice. I can’t go home”. (Undocumented migrant about unsuccessful visa extension)
- “Department of Justice required a lot of documents; it is not easy to get them from my country. I provided my wife’s passport one year ago and the department did not return it. She can’t travel outside of Moldova. Now both of us are locked; I am in Ireland, my wife - in Moldova. It is not fair”. (Family reunification)
- “Takes years waiting, the process is too long. Every time they contact you, you are told to provide more documents” (Family Reunification)

### 3.3.4 Satisfaction with Health

#### Level of Satisfaction with own Health

<table>
<thead>
<tr>
<th>People without determined Immigration Status</th>
<th>Satisfied with their health</th>
<th>Not satisfied with their health</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>13</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>People with determined Immigration Status</th>
<th>Satisfied with their health</th>
<th>Not satisfied with their health</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>21</td>
<td></td>
</tr>
</tbody>
</table>

Two thirds (66%, 67 people) were generally satisfied with their health, and one third (34% 34 people) indicated their health status as poor. In general, respondents understood satisfaction with health as the presence or absence of illness at the moment of questioning.

Nearly three quarters (72%) of this group compared to 50% of the group whose status was undetermined were satisfied with their health.

Significantly, however, when this was compared with immigrations status, those respondents who had had their status determined were far more likely to report satisfaction than those who hadn’t. Of those with their immigration status determined nearly three quarters (72%, 54 people) were satisfied with their health. However, of those whose immigration status was not determined, only half (50%, 13 people) were satisfied with their health.
• “Not sleeping - my family situation is terrible. Can you imagine having a daughter and not seeing her? How can you sleep then? I don’t know how long it will take. They (my children) should be in school and right now they are not. You need money for everything. I am not employed. I can’t go to the solicitor because I need to pay him. Ireland wants you to be employed, because when your family comes, they don’t want you to bring them to social (welfare). How can you be happy with your health when all of this is happening? Even my children are being affected - staying without their mother and fearing deportation” (Family Reunification)
• “Stress (absence of other family members and husband)” (Family Reunification)
• “Stress about my IBC case (which was refused)” (Person waiting on residency on the basis of Irish born child)
• “I am not sick but I can’t do things I want to do - getting a job, going to school. I feel bored. You feel the society does not accept you” (Asylum seeker)

3.3.5 Implications of Immigration When Planning for Health

In addressing the wider determinants of health:
• Immigration status is a significant factor in people’s capacity to improve life circumstances, particularly in accessing secure employment and education opportunities which ultimately have an impact on poverty and social exclusion.

In planning the delivery of health and social services:
• Immigration status is a factor in whether or not people have an entitlement to health and social services; with some having no entitlement or restricted entitlement.
• Immigration status is a factor in the stage at which people will link in with health and social services; with those without entitlement presenting late.
• Immigration status is a factor in people’s perception of their own health, with those without status having a higher level of dissatisfaction with their health.
3.4 Accommodation
3.4.1 Introduction
This section describes the accommodation arrangements of respondents and explores whether or not people are satisfied with their housing.

The overwhelming majority of respondents were living in the private rented sector (81%, 82 people); where they were either renting accommodation themselves (67%, 68 people) or staying with people who rent (14%, 14 people). Only 3% (3 people) were housed in local authority housing.

Amongst other things, renting in the private sector is often characterised by short term leases and a lack of security of tenure both of which can prompt frequent changes of residence which in turn have important implications for health and access to services. The study showed that on average respondents had moved address at least once in the preceding two years, and that the average length of tenure was only 1 year 8 months. This indicates a high level of movement.

Only a third (36%, 36 people) were satisfied with their current living conditions, while over half (55%, 55 people) found that their accommodation was unsuitable. A small number (10%, 10 people) had both positive and negative comments about their living conditions.
### 3.4.2 Dissatisfied with Accommodation

**Most common reasons why people are not satisfied with their accommodation**

- Too small (40%)
- Poor standard (26%)
- Have to share with others: house, room or facilities (14%)
- Not value for money/ expensive (12%)
- Poor relationship with Landlord (8%)

From the chart above, it can be seen that of the respondents who were dissatisfied with their accommodation (55% of all respondents, 56 people), the most common complaint was size and overcrowding (40%, 22 people). A quarter (26%, 14 people) complained of a poor standard of housing. Dampness, problems with or no central heating were commonly mentioned. Lack of privacy was also an issue for some (14%, 8 people) in that having to share your house, room or facilities (such as kitchen and toilet) with others was an issue both for people living in direct provision hostel accommodation and also for migrant workers who could not afford to rent separate accommodation.

- “The landlord will not change carpet even if you keep insisting. It’s damp and it’s very cold. Heating is controlled by the landlord and it is on only for couple of hours. You should have your own heating”
- “The landlord comes into the flat at anytime without my concern, he asks me to vacate the flat at anytime he wants”
- “When the landlord comes to my brother’s house where I live as well to take rent, me and my wife have to go away, even in the late night. If the landlord wants to repair the house we also have to go away”. (Undocumented migrant)
- “Living in a bed-sitter is uncomfortable. Can’t receive any visitors; very bored. Also have to do everything in one space.”
- “Small, has not been renovated for many years, smelly”

### 3.4.3 Satisfied with Accommodation

**Most common reasons why people are satisfied with their accommodation**

- Location and Area (24%)
- Good standard (23%)
- Better than previous/ worse area to live (14%)
- Spacious (10%)
- Good landlord (10%)
- Living with friends or relatives (10%)
- Rent-free (6%)
- Other (5%)

Of those satisfied with their accommodation (36% of all respondents, 36 people), about a quarter (26%, 9 people) quoted location and area as the main reasons why they were satisfied with their accommodation. Closeness to the city centre and all amenities, and a quiet neighborhood were important considerations.
About a quarter (24%, 9 people) also cited a good standard of accommodation as the reason for their satisfaction. Good standards included a new house, a garden for children to play in and clean conditions.

14% of respondents (5 people) were happy with their living condition just because it was better than their previous one accommodation, possibly reflecting low expectations in relation to housing.

• “The location is okay, especially for my kids”
• “I’m living in good area and quiet environment, good house - large and everything in it”
• “The place is ok, compared with my previous experience. It has a garden and a parking space. Its older house but my children can go out to play in the garden safely - they don’t share it”
• “I have no choice. At least my friend is helping me”
• “Nice - much better then camp (accommodation centre) – freedom!”
• “It is better then previous accommodation - I have the whole house for myself and children”

3.4.4 Implications of Accommodation When Planning for Health

In addressing the wider determinants of health:

• Accommodation is a factor in addressing health inequalities. Minority ethnic communities are living in the private rented sector and are experiencing high levels of dissatisfaction with their accommodation and living conditions. There is also a high level of movement. For ethnic minority groups, it means that the quality of accommodation provided and security of tenure are currently the responsibility of private landlords, rather than public authorities. This situation is a factor when planning to address health inequalities and means health planners are to consider developing new relationships with private landlords, with a view to developing more stringent standards, improved monitoring of quality and better conditions for security of tenure.

• Disadvantaged minority ethnic groups are not living in public housing, which means they do not receive the benefits of security of tenure for those on low incomes. Health planners must explore why this is the case.

In planning the delivery of health and social services:

• There appears to be a high level of movement among minority ethnic groups, which has particular implications for ongoing access to health and social services. High levels of movement could lead to a high level of transfer between GPs, public health nursing service, supplementary welfare (rent) etc. and this presents particular challenges regarding the delivery of primary health care at community level – immunizations, child health records, registration of patients with GPs etc. High levels of movement will have an impact on how services are planned and delivered. All of these issues are relevant to the rolling out of the primary care strategy.
3.5 Racism and Discrimination

3.5.1 Introduction

This section explores whether or not people accepted in their local community, and briefly explores the extent to which people feel they experience racism and/or discrimination.

The research explored the extent to which respondents felt accepted within the local community. While assistant community health workers did not specify what “local community” meant, the majority of respondents understood it to mean the local Irish community.

From the chart, it can be seen that nearly half of respondents (49%, 50 people) felt that they were not accepted in the local community, and under half (41%, 41 people) stated that they feel accepted. A small number (5%, 5 people) had both positive and negative experiences of acceptance within the local community.

3.5.2 Not Accepted in the Community

Of those not feeling accepted in the community (49% of all respondents, 50 people), nearly half (45%, 22 people) cited racism and hostile attitudes from local people the reason for not feeling accepted. A further third (37%, 18 people) stated that they have no contact with their local community and that was the reason why they did not feel accepted. 10% (5 people) did not want to be involved with the local community for a combination of reasons, including insecurity of their immigration status, poor health, or their perception of local people as alcoholics and drug users. 8% (4 people) were involved only with their own community based on shared language or ethnicity, and often outside the area in which they lived.
• “Even when I am on the bus, the white person won’t sit beside you - so I am not accepted. I went to a resident’s meeting and they were saying that they have to fight so that their children do not marry foreigners. Accepted in the community? No.”
• “No contact with local community. I am trying not to be seen/noticed because of my status; also don’t want to get my friends in trouble (I rent a room from them)”
• “Have little contact with local people (living in apartment block, it is hard to see neighbors)”
• “I have nothing to do with these people, many are drunk or on drugs”
• “I do not know people within my local community. They are not friendly…”
• “I think I am invisible. I don’t think they care whether I am there or not”
• “We are called names, told to go back home by passers by, people show us finger…”
• “Don’t really feel connected - don’t have any contact with the local community. When people see you coming out of reception centre - they don’t want to do anything with you - that’s very hard. There is one council block near us and all I know about that is they are very racist. I like to go to the park - it reminds me of the park in my town”

3.5.3 Accepted in the Community

Of those who felt accepted in the community (41% of all respondents, 41 people), nearly two thirds (59%, 24 people) cited welcoming attitudes from neighbors and locals as the reason they felt accepted (saying “hello” and being friendly). Nearly one fifth (17%, 7 people) said a lack of conflict with local community members was an indication that they are accepted. A further 10% (4 people) of respondents mentioned that their sense of acceptance came from the fact that there are diverse communities living in the North inner city.

• “I live in an area with diverse nationalities. Great acceptance.”
• “There are very good; we had no problems - they say hello and neighbors are very nice”.
• “I don’t have problems with anybody; everybody is minding their own business”
• “Presently yes, I feel accepted. There are people who are finally saying yes and good morning. People who didn’t say hello for three years - now they say hello - you know you’ve been accepted.”
3.5.4 Discrimination

Racism, discrimination and hostile attitudes to ethnic minorities were mentioned across all the areas of the research. While it is difficult to distinguish between racist or discriminatory attitudes and what is perceived as racism, respondents indicated a real sense of experiencing racism and discrimination which impacted on their life experience in Ireland.

Nearly a quarter (24%, 24 people) of respondents have experienced racism in some way or form on the streets or locally:

- “Because I am black, I face a lot of racial abuse…”
- “Because I’m wearing a scarf I have a lot of problems…”
- “I always agree with them if they say some things - to avoid trouble. Now I take off my scarf before I go home because I was attacked once by children and I decided - not again”
- “I was attacked by a group of boys, also have been racially abused”
- “I experience racism every day”

8% (8 people) of respondents had been discriminated against or felt they could have been discriminated against in employment:

- “Other difficulties I have is to do with work; my Irish colleagues are very rude to me. Some Racists remarks swearing at me and being “SMART”. I have complained to the manager/supervisor. But nothing happened. I had to confront my supervisor and use words like discrimination & bullying, after that the situation improved, but it was very hard to because of my English”.
- “Some people are getting paid less than Irish workers. The other problem is how people are looking at you, when they hear your accent (especially on the phone when you are ringing about jobs). There was a vacancy a minute ago, but when you call with your accent - it is “gone”.
- “The problem of black to get a job here…”
- “People refuse me because I am Asian”
- “I’m not accepted wearing scarf at work”

A small number (5%, 5 people) indicated difficulties in accessing services, private and public:

- “When I moved, he (the landlord) didn’t trust foreigners. He had heard a lot of bad things about foreigners wrecking houses, so he used to check on me”
- “The landlord is not co-operative; he doesn’t want any good things for anyone. He is a racist and self-centered”.
- “She is not cooperative; the lady is a racist and she makes things difficult for people” (about CWO)
- “GP’s secretary is most times rude to foreigners”
3.5.5 Implications of Racism and Discrimination When Planning For Health

In addressing the wider determinants of health:

- A significant number of people from minority ethnic groups do not feel accepted within Irish society, and a smaller number within that have a feeling of experiencing racism and discrimination, which has an impact on their sense of belonging, trust and wellbeing. This is a factor for services providers in the wider range of public services, whereby if appropriate and accessible services are to be developed, then positive and trusting relationships must be developed with “hard-to-reach” groups.

In planning the delivery of health and social services:

- Isolated communities are distant from information networks, social networks and as a consequence distant from services - often perceived as a “hard to reach” group. This is a factor in how they learn about the availability of health and social services, how they access health and social services, and the stage at which they access health and social services.

3.6 Employment and Education

3.6.1 Introduction

This section explores the circumstances of respondents in terms of employment. It describes the circumstances of respondents in employment; on social welfare; and those unable/not entitled to work. It also briefly explores barriers to accessing employment.

From the table below, it can be seen that nearly three quarters (70%, 70 people) not active in the labour market. Nearly one third (30%, 31 people) of respondents are in employment. Nearly one third are unemployed (30%, 30 people) and seeking work, and just over one fifth (22%, 22 people) are not entitled to work in Ireland. A further 14% (14 people) are in receipt of a social welfare payment, but not seeking work, such as One Parent Family Payment or Disability Allowance. Only a small number (4%, 4 people) are in full time education. This profile suggests a group who may be at risk of poverty.

<table>
<thead>
<tr>
<th>Status</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>In employment</td>
<td>31</td>
<td>(30%)</td>
</tr>
<tr>
<td>Not entitled to work (undocumented or asylum seeker)</td>
<td>22</td>
<td>(22%)</td>
</tr>
<tr>
<td>Unemployed and seeking work</td>
<td>30</td>
<td>(30%)</td>
</tr>
<tr>
<td>In education</td>
<td>4</td>
<td>(4%)</td>
</tr>
<tr>
<td>Receiving social payment and/not seeking work (disability etc.)</td>
<td>14</td>
<td>(14%)</td>
</tr>
</tbody>
</table>

101 100%
3.6.2 Living on Social Welfare

Welfare benefits

Not receiving any benefits 46%

In receipt of some state benefits 54%

Over half of respondents (54%, 55 people) were living on some type of social welfare payment.

Of those in receipt of social welfare benefits (54% of all respondents, 55 people), nearly a third (31%, 17 people) were receiving Unemployment Assistance or Benefit; a fifth (20%, 11 people) were receiving Supplementary Welfare Allowance (SWA) at the Direct Provision rate of €19.50 per adult per week., and a similar number (17%, 9 people) were receiving Supplementary Welfare Allowance at the full rate. Other types of schemes included were One Parent Family Payment, Disability Allowance, FAS/CE Scheme, Carer’s Allowance and Family Income Supplement (FIS) payment.

Significantly, of those unemployed (30% of all respondents, 31 people), three quarters (76%, 24 people) stated that it was over 2 years since their last employment, which is categorized as long term unemployed.

Of those not in receipt of social welfare benefits (46% of all respondents, 46 people), three quarters (67%, 31 people) derived their income from employment or self-employment. However, in this group, a quarter of respondents (24%, 11 people) indicated that they had no income of their own. These people were supported by and/or living with friends and relatives. People in this situation were:
• Spouses of migrant workers who were not entitled to work in the state and not entitled to any state benefits;
• Undocumented migrants who did not have any fixed place of employment and depending on their friends, relatives;
• EU nationals (accession countries) who were unemployed, but not entitled to state benefits (habitual residence condition not fulfilled) and dependant on others.

3.6.3 In Employment…

While nearly one third of respondents (30%, 31 people) were active in the labour market, closer examination of their situation indicated low incomes and insecure employment. Taking into account the high level of educational attainment referred to earlier - over a quarter had finished school with a second level certificate (26%, 26 people) and nearly two thirds (65%, 66 people) had some form of 3rd level education - this was not reflected in type of paid employment among respondents. For example, the people who stated their employment as cleaners here had worked in the following areas back home: assistant manager in a bank, primary school teacher, journalist, graphic designer, nurse and sales.

Of those in employment (30%, 31 people), nearly two thirds (66%, 21 people) were working in low paid, insecure jobs, often with irregular hours.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleaners</td>
<td>6</td>
<td>(19%)</td>
</tr>
<tr>
<td>General operatives/labourer/security in industry/factory</td>
<td>6</td>
<td>(19%)</td>
</tr>
<tr>
<td>Hotel, Catering &amp; Hospitality</td>
<td>3</td>
<td>(10%)</td>
</tr>
<tr>
<td>Shop Assistant</td>
<td>2</td>
<td>(6%)</td>
</tr>
<tr>
<td>Interpreter (ad hoc)</td>
<td>1</td>
<td>(3%)</td>
</tr>
<tr>
<td>Care worker</td>
<td>2</td>
<td>(6%)</td>
</tr>
<tr>
<td>Hair dresser</td>
<td>1</td>
<td>(3%)</td>
</tr>
<tr>
<td>Mechanic/Driver</td>
<td>2</td>
<td>(6%)</td>
</tr>
<tr>
<td>Self employed</td>
<td>2</td>
<td>(6%)</td>
</tr>
<tr>
<td>Services Sector</td>
<td>3</td>
<td>(10%)</td>
</tr>
<tr>
<td>Engineer</td>
<td>2</td>
<td>(6%)</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>(6%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>31</td>
<td>(100%)</td>
</tr>
</tbody>
</table>
3.6.4 Barriers to Employment

Many respondents indicated a range of difficulties which they felt acted as barriers to gaining employment.

Of those entitled to work (78%, 79 people), over one fifth (22%, 17 people) stated that they felt they couldn’t afford to take up an employment because of the financial impact of losing social welfare benefits. Lack of affordable and available childcare, expensive rent and lack of supports also contributed to this problem.

- “There were no jobs out there which can give me enough money to afford my day to day expenses…”
- “If I am in full time employment I will lose my medical and other benefits”
- “Minding children and expensive rent - can’t afford to work”
- “Having the children is a barrier. Also the problem is accommodation. If I work, I have to pay for my own accommodation myself and if I am low paid I will end up in the bad accommodation or worse”
- “Childcare is very expensive. My husband is looking for a job, myself too. But is very hard to pay the rent and crèche with very little money”

A further 14% (11 people) mentioned that qualifications recognition and a lack of work experience in Ireland posed a significant problem. People felt generally that their chances of finding employment, appropriate to their qualifications and experience, were very low.

- “I never tried seeking employment in the line of journalism because I feel the chances of getting one is very slim”
- “I don’t know why, but degrees from Africa are not accepted here”
- “My degree is not acceptable here. Or maybe nobody wants to hear about an engineer from another country with no experience here”
- “They cannot take you without experience. I have been looking all the time, but they need a big experience. They don’t recognize my experience from Kenya”
- “Not enough experience of working in Ireland. I worked in sales/customer support in and IT company, but it was a temporary contract. Now I am working in a newsagent until I find something better”

Other barriers to employment cited were poor a level of English (8%, 6 people), poor health and age (8%, 6 people), and racism / discrimination (6%, 5 people).
3.6.5 Implications of Employment and Education When Planning for Health

In addressing the wider determinants of health:
- The experience presented by this sample is one of a community at risk of poverty, and as a consequence at risk of health inequalities. They were, in general, either employed in low paid insecure employment, unemployed (often long term unemployed) or not entitled to work. Health inequalities are linked to poverty and social exclusion. Conditions which contribute to poverty and social exclusion are a significant factor in tackling intergenerational health inequalities. Institutional barriers to employment and education opportunities must be removed. Strategies to address underemployment, long term unemployment, and poor access to education and training must be developed to support people out of social welfare and into the labour market.

In planning the delivery of health and social services:
- Families and communities in this sample group have indicated access to health and social services as being important. In some case this has meant foregoing education or employment opportunities in order to protect their access to health and social services. In health service planning and delivery, creative initiatives must be explored to enable disadvantaged members of minority ethnic groups to access employment or education without the loss of health and social services benefits.

3.7 Access to and Experience of Health Services
3.7.1 Introduction
This section explores people’s perceptions of their health and explores their experiences of accessing a range of health services provided at community level.

Medical Card Entitlement

<table>
<thead>
<tr>
<th>Entitlement</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, entitled</td>
<td>54%</td>
</tr>
<tr>
<td>No, not entitled</td>
<td>32%</td>
</tr>
<tr>
<td>Don't know</td>
<td>14%</td>
</tr>
</tbody>
</table>

Half of respondents (54%, 55 people) stated that they were entitled to a medical card; and about a third (32%, 32 people) were not. The remaining 14% (14 people) were unsure of their entitlement.
3.7.2 Perceptions of Health Status

On the question about people’s satisfaction with their own health, nearly two thirds (64%, 65 people) answered that they were satisfied with their health, and nearly a third (32%, 32 people) were not happy with their health status.

When exploring why people were/were not satisfied with their health, answers revealed that most respondents understood their health in terms of presence or absence of illness at the time of questioning, rather than an assessment of a combination of factors affecting health and wellbeing or general quality of life.

### Why satisfied with health?

<table>
<thead>
<tr>
<th>Reason</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Not sick now”</td>
<td>51</td>
<td>(78%)</td>
</tr>
<tr>
<td>Don’t have time to think of health</td>
<td>2</td>
<td>(3%)</td>
</tr>
<tr>
<td>Good availability of healthcare in Ireland</td>
<td>4</td>
<td>(6%)</td>
</tr>
<tr>
<td>Look after myself</td>
<td>7</td>
<td>(11%)</td>
</tr>
<tr>
<td>Irish weather is good for me</td>
<td>1</td>
<td>(2%)</td>
</tr>
<tr>
<td></td>
<td>65</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Of those satisfied with their health (64% of respondents, 65 people), the overwhelming majority (78%, 51 people) stated that not being sick at the time of questioning was their main criterion for satisfactory health status.

- “I don’t have money to buy food that is bad for you (like meat). I eat healthily - porridge and vegetables from the market, make soups. Nothing that’s fried or full of fat. I don’t smoke or drink. The only thing I have a lot of worry and stress about is my children left back home. It affects my sleep”
- “I don’t feel I am sick - I only get flu, nothing else - no asthma or heart problems, I am healthy”
- “I am satisfied with my health because I am physically strong and have never been sick. Since I came here I have never been admitted to the hospital. I only sometimes feel depressed and stressed”
- “I work long hours and I don’t have time to think about my health”
“I am always happy to be alive. Strong black men do not get sick”
“\textit{I can attend my GP and the hospital when needed and get immediate treatment}”
“I think I am healthy, I have been well apart from getting tired (overload with work)”
“I don’t think much about my health (not as I probably should)”
“I believe medics here are better compared to my own country”

<table>
<thead>
<tr>
<th>Why dissatisfied with health?</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>13</td>
<td>(38%)</td>
</tr>
<tr>
<td>Particular health condition</td>
<td>15</td>
<td>(44%)</td>
</tr>
<tr>
<td>Financial constraints and lack of medical card</td>
<td>6</td>
<td>(18%)</td>
</tr>
<tr>
<td>Total</td>
<td>34</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Of those who weren’t happy with their health (34% of overall respondents, 34 people), nearly half (44%, 15 people) mentioned a particular health condition, which in their opinion contributed to their poor health status; including HIV, asthma etc.

• “I had a miscarriage earlier last year. I was afraid for this pregnancy as well so I did not tell even my mother until 4 months. So I was very worried.”
• “I also have asthma, which is aggravated here, because the house is quite damp and the central heating is not adequate. It is also worsens at work, where there is a lot of dust”
• “I’m waiting for an operation”

Just over a third (38%, 13 people) reported stress, tension, depression and anxiety as the main reasons for their dissatisfaction. The causes of such stress were identified by respondents as issues in relation to immigration, stressful living conditions, absence of family members, living with HIV, feelings of rejection and isolation.

• “I feel very depressed”
• “I am on depression medication. I am on lots of medications for my condition - HIV+. Even if I am unwell I have to push myself because no one can stand up for me. I have to do it myself”
• “I’m not well because I feel isolated from this society”
• “I didn’t feel well and GP could not explain why. Too much stress. I can’t understand (because of the language) what doctor said. The beatings from Moldova left damages on my body”

And of those dissatisfied, nearly one fifth (18%, 6 people) reported financial constraints and lack of medical card as a serious issue in their assessment of their health status.
“I have stomach pain and a handicap. Because I do not have medical insurance and enough money I can not get treatment and physiotherapy.”

“When I get sick I have no money to go to the doctor and the last time I had a chest infection my friend told me not to go near her children. She didn’t care about me.”

“I cannot go to the GP if I am sick because I do not have a medical card”

“I have been sick for the last while. I don’t have medical card to check with the doctor. I have seen him once. My partner is on welfare so we don’t have money. I have to travel back home for full assessment.”

### 3.7.3 Access to Health Services

The table below indicates the health services that respondents accessed in the previous 12 months. The table also indicates whether or not respondents felt satisfied with their experience of accessing a particular service. Column A represents how many people had contacted a service, rather than the overall number of times the service was contacted. Column B includes responses which indicated a high and medium level of satisfaction (when people described the contact as being “ok” or “fine this time”). Column C contains outright negative experiences.

From the table below, it can be noted that some services were accessed more than others.

- Nearly three quarters of respondents (70%, 71 people) had accessed their **general practitioner** in the previous year.
- Half (50%, 50 people) had accessed the **community welfare** service in the previous year.
- Just over a quarter (26%, 26 people) had accessed the **dentist**.
- Nearly one fifth (19%, 19 people) had accessed **accident and emergency** department at a hospital.
- 13% (13 people) had accessed the **public health nursing** service.

In general, however, there was a very low take up of the range of other services at community level, and nearly one fifth (17%, 17 people) had not accessed any services at all in the previous year.

During interviews, it emerged that many respondents did not have information about the services available to them, nor did they appear to understand the different roles of different services. In particular respondents confused the following disciplines:

- Public health nurse
- Community welfare officer
- Social worker
- Social welfare inspector.
## Most Accessed Health Services and Level of Satisfaction

<table>
<thead>
<tr>
<th>Health Service</th>
<th>(A) Accessed in the last year (No of people)</th>
<th>(B) Satisfied with the service (No of people)</th>
<th>(C) Not satisfied (No of People)</th>
<th>(D) Declined/Not answered</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP</td>
<td>71</td>
<td>46</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Community Welfare</td>
<td>51</td>
<td>29</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>13</td>
<td>10</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Dentist</td>
<td>26</td>
<td>12</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>19</td>
<td>8</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Family Support Service</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Community Mental Health</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Social Worker</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Maternity/Ante-natal</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Health/Family Planning</td>
<td>5</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Speech and Language</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dietician</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Addiction/Drugs Services</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Not accessing any of the services listed above</strong></td>
<td><strong>17</strong></td>
<td><strong>17</strong></td>
<td><strong>17</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

### Satisfaction with Services

In general, among those accessing services, many indicated high levels of satisfaction with the service. Respondents gave more than one reason for satisfaction/dissatisfaction.

#### General Practitioner

Of those who had accessed their GP (70% of all respondents, 71 people), two thirds (65%, 46 people) were generally satisfied with the service, 14% (10 people) were dissatisfied and the remaining fifth (20%, 15 people) did not comment.

Of those who had accessed the GP service (70%, 71 people), a third (37%, 26 people) indicated that the primary factors which contributed to a sense of satisfaction were good communication and being treated with respect by their GP. Communication was not understood as being able to speak English. Rather, good communication referred to the manner in which the service was delivered, as indicated opposite.
“GP was polite and listened to me”
“I feel equally treated to others, respected”
“Respect, understanding, good communicator”
“The doctor was understanding - took time with my English”
“GP was understanding and friendly. Took his time to explain”
“I was given a chance to express myself; he was nice to me”
“Knowing the doctor for some time contributed to success - easier to communicate”
“The GP speaks French, so he could understand me. He is welcoming”
“He listens to me and understood my situation”
“Friendly, good communications”
“He is very patient”

Of those who had accessed the GP service (70%, 71 people), the primary reason for complaint (14%, 10 people) was dissatisfaction with the quality of medical treatment or service offered. This related to prescriptions, poor follow-up and diagnosis, and the length of time spent with the patient.

“Only prescribed painkillers (treating the symptoms, not the cause)”
“Poor diagnosis, do not spend enough time with the patient”
“Very short time with GP because of too many patients”
“It is always prescription. They never do tests until very late”
“Medical system here is not effective. Nobody from medical professional wants to take responsibility or to make a decision; they do the safe thing - they are taking time with everything and it is all based on waiting. They look at you and probably think: his condition is going to improve or going to deteriorate then we will know what’s wrong with him.”
“I am not satisfied with the way that GP gives my kid treatment, all the time he prescribes antibiotics and it doesn’t matter what the problem is. He doesn’t listen or maybe he cannot understand everything I try to explain to him”
“She knows only about antibiotics. Only prescribing antibiotics”
“He doesn’t ask enough questions about my health. He just gives antibiotics…”
“What ever illness you have - you only get antibiotics…”
“I have seizures and headaches, but nothing that I was prescribed helped…”
“The slowness of the medical system here and response/ treatment is very traditional. The doctors do not offer any complimentary treatment or do not follow with full diagnostic. They treat one symptom at the time, mainly with medications. There are responsive methods rather then preventive.”
Secondary factors for dissatisfaction among respondents who had accessed a GP were:

- the cost of appointment or expensive treatment acted as a barrier (8%, 6 people)
- inadequate appointments systems and long waiting times for referral (7%, 5 people)
- unwelcoming environment and poor communication in GP clinic (6%, 4 people)
- difficulty with the administration of the medical card (limitations on the kind of prescription, difficulties in finding a GP who accepts medical card patients) (3%, 2 people)

Their views were as follows:

- “Very expensive (had to pay 40 euro), will not go there again, got a supply of antibiotics from home”
- “It was expensive, medication was also expensive”
- “I have no medical card as someone that is unemployed. My husband has to pay for everything, it is very frustrating. We are a young family; we are finding things very tough financially”
- “He (GP) said I need further tests which I can’t afford”
- “Not being able to see specialist straight away, waiting for results-stress, worry”
- “Bad appointment system. I was skipped once and I had to speak to the doctor about it. He didn’t deny it”
- “When I was referred to see a consultant I had to wait 6 months”.
- “Sometimes it is hard to get through to the clinic on the phone to make an appointment”

Community Welfare

Of those who accessed the community welfare service (50% of all respondents, 51 people), well over half (57%, 29 people) were satisfied with the service, one fifth (20%, 10 people) were dissatisfied with the service and the remaining fifth (21%, 11 people) did not comment.

It is important to note that many of the people interviewed were unclear of the difference between Community Welfare Officer and Social Welfare. Some people thought that Social workers are also responsible for welfare benefits.

Again, good communication emerged as being the primary reason for satisfaction among a quarter of respondents who accessed the community welfare service (24%, 12 people).

- “She listens to me, clarify things and very helpful”
- “He sympathises with my child”
- “He (CWO) speaks a little bit of French, he is a nice guy”

One fifth (20%, 10 people) of people who accessed community welfare indicated another reason for satisfaction, which was that they got the service they wanted (rent allowance, letter, filled the form etc.).
When asked to reflect on what contributed to dissatisfaction, over half (53%, 27 people) of respondents who had accessed the community welfare service, shared a negative experience from the past – even among those who rated their most recent contact with a CWO as a success. Some of these experiences are shared below.

- “Sometimes there are other CWOs and I am scared so I don’t go and wait till she (the one she is usually attends) is there”
- “Incompetence and wasting of my time, was waiting for the inspector for the whole day, sitting at the window. Nobody came. When I rang them again, they said that somebody came to the apartment, rang the doorbell and nobody was there. I know it is not true, because I was there. This happened three times. Only when I came to the CWO office and was crying from the nerves and humiliation, they said: it’s ok, go home, and just gave me my rent allowance without checking the apartment”
- “I had problems several times when I changed my address; CWO didn’t come to check my house; she claimed that she rang and nobody answered which is not true; I did not receive a letter about her visit either”
- “It is not possible to negotiate with them or argue an economical argument. It is either us getting benefits or if we work - not getting any support at all. There is no middle ground where we can meet”
- “We don’t get the full amount because my husband works. We still need to pay the landlord full amount in rent and it is difficult because my husband earns very little”

### Public Health Nurse
Of those who accessed the public health nurse service (13% of all respondents, 13 people), over three quarters (77%, 10 people) were satisfied with the service, 8% (1 person) were dissatisfied with the service and the remaining 15% (2 people) did not comment.

Many of the respondents were unsure as to what role the public health nurse has, and sometimes an explanation was required from the interviewer. The general satisfaction with the service was high, and again much of the satisfaction relates to the communication and interpersonal skills of the service provider.

- “She was very nice coming to see me”
- “She was nice. She came to my house”
- “She was making an effort to understand me”
- “She likes children”

### Dentist
Of those who accessed the dentist (26% of all respondents, 26 people), nearly half (46%, 12 people) were satisfied with the service, one fifth (19%, 5 people) were dissatisfied with the service and nearly one third (35%, 9 people) did not comment.
Accident & Emergency
Of those who accessed accident and emergency services (18% of all respondents, 19 people), under half (42%, 8 people) were satisfied with the service, one quarter (26%, 5 people) were dissatisfied with the service and under a third (32%, 6 people) did not comment.

Other Services
The general level of access to other primary care team disciplines was very low, ranging from no one in the sample accessing addiction/drugs services to only 5 people reporting contact with sexual health services. Some indicated that they were on waiting lists for services - 2 people waiting to access a dietician, and 3 people waiting for physiotherapy.

17% (17 people) of respondents did not access any health services, and the biggest group of people in this situation were people from the new EU accession countries. This is significant as it is this group which currently makes up the bulk of the ethnic minority population, and will continue to grow as the number of refugees and asylum seekers declines. This has implications for the development of appropriate health services for this target group.

The main reasons cited for not accessing services included:
• Insecure employment – therefore not able to access medical services during the day
• Financial cost of accessing medical services
• Lack of information about the availability of services
• Not wanting to get noticed due to undocumented status.

Their experiences are as follows:
• “I have very little contact with any services, because the clinics mostly open during the day times. I am working till late and many weekends as well. I am working for myself (self-employed) so nobody will pay me a sick leave. I have my inhaling spray for my asthma from home (Poland). I do not attend any doctors here. It is too expensive, so I am trying to stay healthy apart form smoking. If something bad will happen to me or I feel very ill - I will go to the hospital in emergency. I don’t know the medical system here. But I heard about special insurance you could get if you are from the EU. At the moment I just do not have time, money or serious enough illness to deal with all that”
• “I don’t access any services. Since I moved from accommodation centre I was not in contact with them because of the money problems. I don’t want to be noticed because I am afraid that information about me and my case could be known to somebody. My friend found a job for me in hotel and I am happy not to deal with government any more”
• “Do not really have much time for services; apart when it is really need like renewal of the green card or the work permit. My wife
organises a lot of this. She and my youngest son joined me recently. She is not allowed to work, also she is expecting - so she does this sort of things - finding out information, etc. I do not have much time because of the working hours”

- I go to the shop to buy medicines - no contact with any of the services - fear” (undocumented)
- “I don’t have a medical card so I don’t go to any medical services. I don’t need anyway because I don’t get sick.”
- “No contact with any of the services. It is not a serious question for someone who came here for work. I have a son back home who is in college and I have to pay for that. What services? Who needs us here? These services only exist to get money out of working people like me”

3.7.4 Implications When Planning for Health
In addressing the wider determinants of health:

- Respondents themselves identified a wide range of issues in their lives which cause anxiety, stress and depression other than issues regarding a medical condition or their access to health services. In addressing these wider factors which impact on health, health authorities must engage in new relationships with service providers in other disciplines/sectors to increase understanding of the impact on health, and develop a new role in reducing the negative impact of other services on the health status of minority ethnic groups.

In planning the delivery of health and social services:

- There is poor take up of many of the services provided at community level, despite good levels of English and high eligibility among the sample. Health service providers must remove barriers preventing people from accessing services. Some issues for consideration in this context are:
  - Lack of knowledge of services available, and/or lack of understanding of different roles;
  - Lack of entitlement, or restricted entitlement, due to immigration status, including EU accession country nationals;
  - Financial cost of health services;
  - Poor “out of hours” services for those in employment;
  - Late presentation to health services;
  - Good communication and interpersonal skills among service providers increases accessibility of a service
Section Four: Conclusions and Next Steps

4.1 Conclusions

From the community development approach:

Adopting a community development approach to conducting a health needs assessment has had significant benefits. This approach has built capacity within minority ethnic groups in the North inner city to analyse factors which impact on their health, and has consequently built capacity to engage with health services to negotiate the nature of health responses required to improve their health of their communities. The approach adopted has enabled the research to access a “hard-to-reach” group, and as a result has gained insights into the experiences of minority ethnic community members often at a remove from mainstream services. The approach was linked to building capacity within wider community infrastructure (such as the Ethnic Minority Health Forum) and as a consequence a mechanism exists with which to facilitate dialogue, and implement actions arising from the research. This is an essential outcome if efforts to address health inequalities at community level are to be sustained, and creates conditions to ensure ongoing community participation in health. In essence, conducting the health needs assessment is the start of a process of engagement with health service planners and providers.

From the preliminary findings:

Addressing the wider determinants of health:

Overall, wider factors which impact on the health of minority ethnic groups include immigration, accommodation, racism and discrimination, employment and education. Further analysis in the coming months may present additional other factors. The preliminary findings indicate the following:

- Immigration status is a factor in people’s capacity to improve life circumstances, particularly in accessing secure employment and education opportunities which ultimately have an impact on poverty and social exclusion.
- Minority ethnic communities are living in the private rented sector and are experiencing high levels of dissatisfaction with their accommodation and living conditions. There is also a high level of movement. For ethnic minority groups, it means that the quality of accommodation provided and security of tenure are currently the responsibility of private landlords, rather than public authorities. This situation is a factor when planning to address health inequalities and means health planners are to consider developing new relationships with private landlords, with a view to developing more stringent standards, improved monitoring of quality and better conditions for security of tenure.
- Disadvantaged minority ethnic groups are not living in public housing, which means they do not receive the benefits of security of tenure for those on low incomes. Health planners must explore why this is the case.
A significant number of people from minority ethnic groups do not feel accepted within Irish society, and a smaller number within that have a feeling of experiencing racism and discrimination, which has an impact on their sense of belonging, trust and wellbeing. This is a factor for services providers in the wider range of public services, whereby if appropriate and accessible services are to be developed, then positive and trusting relationships must be developed with “hard-to-reach” groups.

The experience presented in this assessment is one of a community at risk of poverty, and as a consequence at risk of health inequalities. Health inequalities are linked to poverty and social exclusion. Conditions which contribute to poverty and social exclusion are a significant factor in tackling intergenerational health inequalities. Institutional barriers to employment and education opportunities must be removed. Strategies to address underemployment, long term unemployment, and poor access to education and training must be developed to support people out of social welfare and into the labour market.

In terms of the response required to address all of these issues and their impact on health, health authorities must engage in new relationships with policy makers and service providers in other disciplines/sectors to increase understanding of the impact on health, and develop a new role in reducing the negative impact of other policies and services on the health status of minority ethnic groups.

Planning the delivery of health and social services:

In designing appropriate and accessible health and social services, health authorities must consider the following:

- Immigration status is a factor in whether or not people have an entitlement to health and social services; influences the stage at which people link in with health and social services; and is a factor in people’s perception of their own health.
- There is a high level of movement among minority ethnic groups, which has particular implications for ongoing access to health and social services. High levels of movement could lead to a high level of transfer between GPs, public health nursing service, supplementary welfare (rent) etc. and this presents particular challenges regarding the delivery of primary health care at community level – immunizations, child health records, registration of patients with GPs etc. All of these issues are relevant to the rolling out of the primary care strategy.
- Isolated communities, like this sample, are distant from information networks, social networks and as a consequence distant from services - often perceived as a “hard to reach” group. This influences how they learn about the availability of health and social services, how they access health and social services, and the stage at which they access health and social services.
Some people are foregoing education or employment opportunities in order to protect their access to health and social services. In health service planning and delivery, creative initiatives must be explored to enable disadvantaged members of minority ethnic groups to access employment or education without the loss of health and social services benefits.

There is poor take up of many of the services provided at community level, despite good levels of English and high eligibility among the sample. Health service providers must remove barriers preventing people from accessing services. Some issues for consideration in this context are:

- Lack of knowledge of services available, and/or lack of understanding of different roles;
- Lack of entitlement, or restricted entitlement, due to immigration status, including EU accession country nationals;
- Financial cost of health services;
- Poor “out of hours” services for those in employment;
- Late presentation to health services;
- Good communication and interpersonal skills among service providers increases accessibility of a service.

In terms of the response required to address all of these issues, health authorities are invited to engage in new relationships with minority ethnic groups in order to gain the benefits of community participation in health. This is with a view to collaborative actions to implement real changes which impact on the lives of minority ethnic groups accessing services at community level.

4.2 Next Steps
The next Phase of the Community Development and Health Programme – Actions (March 06 – Dec 07) – will respond to the needs identified above in two ways. Firstly, it will create a dialogue between marginalised ethnic minority communities and health service providers to address the barriers in accessing health services. Secondly, it will develop a model for community participation in primary health care.

1. In the first instance, further analysis of the findings will take place through the Ethnic Minority Health Forum, resourced by the proposed Community Health Action Team which is comprised of the project co-ordinator and the assistant community health workers (funding yet to be secured). This further analysis will lead to a series of shorter publications in Autumn 06 along the themes of:

- Immigration and Health
- Accommodation and Health
- Racism, Discrimination and Health
- Employment, Education and Health
- Access to, and Experience of, Health Services.
2. Having identified the appropriate actions, the proposed Community Health Action Team will facilitate working partnerships among primary care health service providers, the Ethnic Minority Health Forum, minority ethnic community members and groups and other relevant bodies to implement agreed actions.

3. The proposed Community Health Action Team will conduct outreach work in the North inner city in order to raise awareness among minority ethnic groups and health service providers of health related issues experienced by ethnic minority community members, and will encourage engagement in the initiatives/actions to achieve changes.

4. The Health Services Executive is commencing a consultation process for the compilation of a national Intercultural Strategy in September 2006, and Cáirde will actively participate in that process to feed in issues raised in the health needs assessment. – both in terms of community participation in health, and in terms of health services planning and development. The proposed Community Health Action Team will facilitate the Ethnic Minority Health Forum and wider ethnic minority communities to engage in this process.

5. The fourth phase of the process – Mainstreaming the Learning – where the model of engagement of ethnic minority communities in primary care is documented, and learning from the process is fed into various policy levels\textsuperscript{16}, will happen simultaneously with the Actions Phase. This publication is seen as a first step in sharing the learning of implementing participative processes at a local level.

\textsuperscript{16} Health Service Executive Primary Continuing and Community Care, Dept Health and Children Primary Care Steering Group and Task Force, and NAPS and Health Working Group
About Cáirde…

Cáirde, a non-government organisation, works to reduce health inequalities amongst ethnic minority communities, using a community development approach. Cáirde works to support the participation of minority ethnic communities in strategies to enhance their own health.

Cáirde’s work is influenced by the following principles:

**Participation:** The achievement of health gain for ethnic minority communities will be determined by the extent to which minority ethnic communities are genuinely engaged in needs analysis, design and implementation of health strategies. In essence, this requires adopting a legitimate participative and community development approach to enhancing ethnic minority health.

**Holistic Approach:** Cáirde argues for an holistic approach to health based on the social determinants of health model; an understanding that health, both at individual and at community level, is affected by a wide range of factors including accommodation, education & training, employment, childcare, financial security, residency status, racism and discrimination and other asylum/immigration issues; as well as access to and experience of health services.

**Building Capacity:** Cáirde’s objective is to build the capacity of minority ethnic groups to identify their own needs and develop an awareness of the policy context within which services are planned and delivered; to build the capacity of ethnic minority groups to engage with statutory service providers and planners so that genuine processes of consultation and participation are initiated between minority ethnic communities and the policy system.

**Community Development:** Cáirde works through community development which is the pursuit of social change through collective action.

In the context of Cáirde’s work community development means:

- **Collective Action** – community organisations and individuals are encouraged to work collectively in identifying issues of concern and organising appropriate responses.
- **Participation** – Cáirde works to ensure that community members are full participants at all levels of planning, organisation and implementation of actions and programmes.
- **Equality** – Cáirde works for full equality for minority ethnic communities and individuals and in particular recognises the necessity for actions targeting gender inequality.
- **Social Analysis and Change** – Cáirde’ analysis is one that recognises the structural inequalities in Irish society which are maintained and sustained by government actions and inaction. Cáirde views change in how Irish society is structured as critical to the achievement of its goals.
- **Human Rights** – Cáirde views its work as being in pursuit of the full realisation of the social and economic rights of minority ethnic communities and individuals.
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