

Review of Current Research on the Health of Refugees and Asylum-Seekers in Ireland

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**REVIEW OF CURRENT RESEARCH ON THE
HEALTH OF REFUGEES AND ASYLUM-SEEKERS
IN IRELAND**



**Conducted by the
Health Services Research Centre
Royal College of Surgeons in Ireland
on behalf of the
Northern Area Health Board**

December, 2001



**REVIEW OF CURRENT RESEARCH ON THE
HEALTH OF REFUGEES AND ASYLUM-SEEKERS
IN IRELAND**

Sarah Delaney and Hannah M. McGee

**Health Services Research Centre
Department of Psychology
Royal College of Surgeons in Ireland**

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PREFACE

This review of current research on refugees and asylum-seekers in Ireland was commissioned by the Northern Area Health Board (NAHB). The Health Services Research Centre at the Department of Psychology, Royal College of Surgeons in Ireland conducted the study. The study team comprised Ms. Sarah Delaney, (anthropologist and research officer) and Professor Hannah McGee (psychologist and Centre Director). The study aimed to provide a national review of recent and current health-related research on refugees and asylum-seekers in Ireland. The study also identified priority areas for future research, and made recommendations as to the most effective methods of addressing these priorities.

We acknowledge the support and assistance of many individuals in completing the report. We acknowledge the advice of Mr James Stapleton at the Irish Refugee Council; Mr Frank Edwards of the Reception and Integration Centre, Department of Justice, Equality and Law Reform; Dr Ciarán Browne of the Eastern Regional Health Authority; Ms Alice Griffin of the South-West Inner City Network; and the generosity and support of Access Ireland. We also thank all those who supplied us with information and documentation during the course of the review: Mr Dermot Ryan (Department of Psychology, University College Dublin); Ms Jennifer Ryland (Psychological Service for Refugees and Asylum-seekers, Eastern Regional Health Authority); Dr Treasa Galvin (Department of Sociology, Trinity College Dublin); Dr David Evans (Department of Public Health, Western Health Board); Ms Aoife Collins (NASC – The Irish Immigrant Support Centre); Ms Eimear Doyle (Monaghan Partnership); Ms Suzanne Lyons (Department of Public Health Medicine and Epidemiology, University College Dublin); Mr Dermot Folan (Director,

Management in Practice Programme, Irish College of General Practitioners); Dr Pauline Faughnan (Social Science Research Centre, University College Dublin); Mr Piaras Mac Einri (Irish Centre for Migration Studies, University College Cork); Dr Angela Veale (Department of Applied Psychology, University College Cork); Ms Dearbhla King (Centre for Social and Educational Research, Dublin Institute of Technology); Ms Brigit Quirke (Pavee Point); Fr Mike Begley (SPIRASI); Dr Alastair Christie (Department of Applied Social Studies, University College Cork); Ms Patricia McCarthy (ICON); Professor Mac MacLachlan (Department of Psychology, Trinity College Dublin); Ms Finola Malone (Eastern Regional Health Authority) and Dr Jo Murphy-Lawless (Centre for Gender and Women's Studies, Trinity College Dublin).

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EXECUTIVE SUMMARY

Study Background

In recent years, Ireland has experienced an increase in the numbers of people applying for refugee status. This has focused health service planners and providers on the specific needs of refugees and asylum-seekers.

Although individual research projects have been undertaken, little or no consolidation of resulting findings has been carried out in order to inform future policy and practice with regard to refugees and asylum-seekers, and, indeed, people with different ethnic identities in general.

The health and well-being of refugees and asylum-seekers

The physical and mental health of refugees and asylum-seekers is a complex issue.

Mental distress can often be the single biggest issue for refugees and asylum-seekers due to the effects of 'cultural bereavement' to post-traumatic stress following torture or war. With regard to physical health, some refugees and asylum-seekers arrive with long-standing illnesses and disabilities, others with newly-acquired problems. There is a strong link between mental distress and physical problems, and refugees often experience continuous low-grade illness such as coughs or colds as a result of stress or debilitation.

What is important for service providers to remember is that refugees' physical and mental distress results from both pre-asylum experience and the consequences of flight. Their responses to physical and mental distress and their expectations of doctors or other health professionals are rooted in their culture and previous expectations of health care. In considering how to provide service provision that is effective, sensitive and responsive to the needs of refugees, it is essential to view health and health care as socially and culturally constructed.

Aim of review

To provide a national review of recent and current health-related research on refugees and asylum-seekers in Ireland, and to identify priority areas for future research and make recommendations as to the most effective methods for future endeavour.

Methods

Key individuals and departments were contacted in research centres and in academic, health board and community and voluntary settings in the area of social, anthropological and health services research. Information on relevant current or recent research being carried out by them or others likely to be overlooked was sought. A comprehensive literature review of research carried out in both Ireland and the UK was undertaken.

Well-researched issues

Those aspects of the refugee and asylum-seeking experience which have been focused on by researchers include:

Needs analyses – a number of needs analyses are being or have been conducted in Ireland. Consolidation of these should provide a detailed picture of the health and social care needs of refugees and asylum-seekers in Ireland.

Women refugees and asylum-seekers – many projects have focused on women's issues, ranging from maternity care needs, to social support systems, to surviving gender-based torture. In terms of priorities, it may be more useful now to work with the information gained from existing projects to plan service initiatives rather than initiate new research projects. However, the topics of contraception and reproductive health are still relatively under-researched and would benefit from focused research.

Mental health – many of the research projects identified during this review incorporated a psychological component. Emphasis should now be placed on consolidation of relevant findings.

Housing – the housing of refugees in Dublin have now been relatively well identified and researched. The impact of dispersal on the accommodation services in locations outside Dublin should be monitored in future work.

Under-researched issues

Refugee men – virtually no research in published material or in projects in Ireland focused on the health needs of male refugees and asylum-seekers. This parallels the pattern in the broader health system until recently. It is now timely to investigate health-related aspects of the refugee experience that are specific to men.

Female Genital Mutilation (FGM) – FGM is not believed to be widely practised in Ireland. However, given its widespread use among some groups seeking refuge here, the complex ethical and moral issues surrounding it need to be more fully understood.

Racism – several recent studies in the United Kingdom (UK) have clearly identified the existence of widespread institutional racism within the National Health Service (NHS). This should alert Irish service providers to the possibility of racist practices within the health service. Ongoing monitoring of health services for potential racism should be introduced.

Cultural Competence – cultural competence refers to awareness and understanding of the nature of cultural difference, combined with the ability to put this awareness and understanding into practice in day-to-day life. Most of what is in this review on cultural competence is by definition unpublished. Further development of this approach to research and practice should be encouraged.

The context of future developments in research on the health of refugees and asylum-seekers in Ireland.

If research is to empower refugees and asylum-seekers to specify their own priorities for health and social care, they must be placed at the heart of the decision-making process. One methodology that has been used in this situation is that of Participatory Research or Participatory Learning and Action (PLA). This approach to research presents a process through which the lay knowledge and culture of research participants can be respected.

Recommendations

Specific research topics

- Research topics that have already been the focus of sustained attention by the research community in Ireland, in particular work on women refugees and asylum-seekers, on mental health and on housing should now be consolidated and used to inform policy and practice.

- Research has only recently focused on refugee children. It is expected that further work will commence in the coming year. Concerns have been raised about the danger of over-researching this vulnerable population. Caution should therefore be exercised in planning new projects.
- Issues specific to male refugees have been under-researched and should be prioritised in future studies
- There are no reports of difficulties concerning the practice of female genital mutilation (FGM) in Ireland to date. However, given the estimated high incidence in certain countries that are well represented among refugee and asylum-seeking community in this country, it is important to raise awareness of the practice by researching attitudes towards and practice of FGM among refugee communities in Ireland in a sensitive and collaborative manner.

Research and Development Issues

Mechanisms for information sharing should be set up to facilitate communication among researchers in the fields of ethnicity, refugees and asylum-seekers. These could include:

- funding a resource library for Irish or other relevant reports that are otherwise hard to obtain, such as reports with a limited distribution and post-graduate research projects
- setting up an internet site where research findings and progress reports can be posted
- setting up an e-mail discussion group open to all those with an interest in the area
- it is important to ensure that research findings are translated into action ‘on the ground’. One useful approach is the use of participatory research strategies which empower both service providers and refugee communities to implement change on a grassroots level

- cultural competence has the potential to provide a framework of health service provision that translates awareness of and sensitivity towards cultural difference into practical guidelines for service providers. Research in this area should be encouraged.

General Service Delivery Issues

the Irish health system endorses equity as a key principle underlying service delivery. Mechanisms for ensuring that services are equitably delivered, including being made regardless of race, socio-economic status or refugee/asylum-seeker status are needed in an accountable system

CHAPTER ONE

INTRODUCTION

In recent years, Ireland has experienced an increase in the numbers of people claiming asylum as well as in immigration generally. Since this is a new experience for Irish people, and since Ireland has until now been a relatively culturally homogenous place (with the notable exception of the traveller community), there is a need to understand refugees and asylum-seekers both in terms of their transitional status and also in terms of the diverse cultures that they represent. This is necessary in the context of the rapid economic, social and cultural changes that have occurred since the mid-1990s. The social and health research communities have focussed their attention on the refugee and asylum-seeking community in order to facilitate knowledge and understanding of the issues refugees and asylum-seekers face; and document their needs as they must build their lives in a strange, new and rapidly changing country, a country that is in the process of reshaping its own identity.

Although a considerable body of research has been built up over the 1990s, little or no consolidation of resulting findings has been carried out in order to inform future policy and practice with regard to refugee and asylum-seekers, and, indeed, people with different ethnic identities in general. This review summarises current and recent research in order to date and identify priority areas for future endeavour, and to form the basis for a single forum in which researchers can communicate with each other.

In order to do this, it is necessary to provide some background from research in the United Kingdom (UK), which has a much longer history of dealing with both different ethnicities and refugees and asylum-seekers. Lessons learned from the experience of the UK can help us to avoid making some of the same mistakes, and to adopt (and contextualise to an Irish setting) some of the most useful approaches undertaken in working with all those who are seen as 'ethnically different'.

The health and well-being of refugees and asylum-seekers is a consequence of both pre-asylum experiences and the process and consequences of exile. This chapter provides a brief introduction to the health and well-being challenges facing this group as a precursor to outlining the research questions being asked about health and well-being challenges of refugees and asylum-seekers. Chapter Two goes on to outline the history and current trends of seeking refuge in both Ireland and the UK. Chapter Three summarises the main methods utilised in this review. Chapter Four reviews key literature on refugees and asylum-seekers in Ireland, with an outline of research currently underway. Chapter Five reviews literature on ethnic minorities, refugees and asylum-seekers in the UK. Chapter Six focuses on the complex issue of female circumcision, or female genital mutilation (FGM). The international debate on this topic, legislative and research patterns in the UK, and lessons that can be learned for Irish health care workers and researchers are discussed. Chapter Seven summarises the key patterns emerging from the literature reviewed, and identifies priority areas for future research. Key recommendations for the consolidation and development of work with refugees and asylum-seekers are set out in Chapter Eight. Finally, Appendices A to C summarise, respectively, the legal situation facing asylum-seekers in Ireland, the statutory entitlements of refugees and asylum-seekers in Ireland, and key research projects identified during the course of the review.

1.1 HEALTH AND WELL-BEING OF REFUGEES AND ASYLUM-SEEKERS

Mental health

Lowdell (2001) has pointed out that the biggest issue for refugees and asylum-seekers is that of mental health, ranging from the effects of ‘cultural bereavement’, to post-traumatic stress disorder (PTSD) following war, torture and flight. Attempts to assess the mental health and well-being of asylum-seekers and refugees have so far been limited, however, some general findings are summarised in this section. A proportion of asylum-seekers and refugees do arrive in host countries in considerable ill-health and with mental health needs as a result of torture, conflict and war. In addition to signs of PTSD, some asylum-seekers have needs that cannot easily be met by GPs yet do not meet the established criteria for psychiatric intervention. These people often receive little in the way of adequate health care. Unofficial self-medication (i.e. through alcohol and drugs) often helps victims cope with these psychological effects. Occasionally, individuals who had received treatments in their home country find they are not available in the host country. This can create problems for people who find it difficult to control their stress and anxiety. Diagnosis of mental health can be inconsistent in its quality, for example, service providers can show poor understanding of cultural differences in the ways individuals describe and account for their ill health. This situation can be made worse by language difficulties. Finally, many refugees and asylum-seekers experience improvement in their health after arrival because the situations they find themselves in now are better than those they left. However, they often experience new types of problems such as low self-esteem and self-confidence in their new environment.

Definitions of what constitutes normal and abnormal behaviour vary widely from culture to culture, and within any given group, are dependent on demographic factors

such as age and sex, social class, and occupation. Behaviours that may be perceived as abnormal at one time may be regarded as normal at other times, such as during carnivals. Service practitioners often encounter behaviours that in other societies are acceptable, but that could be interpreted as signs of mental illness in host countries (Dein, 1997).

Physical health

The physical health of refugees and asylum-seekers is a complex issue. Although many arrive in good health, some asylum-seekers and refugees arrive with long-standing illnesses and physical disabilities, others with newly acquired problems. Some people become ill in the host country (e.g. tuberculosis (TB) may be contracted as a result of over-crowding and unsanitary conditions). However, it is important to emphasise the complex relationship between mental and physical well-being. Asylum-seekers and refugees who are fleeing for their safety often arrive with physical disabilities as a result of torture and/or conflict (e.g. with amputations, broken bones, and neurological damage). They often experience continuous low-grade illness as a result of debilitation, for example coughs and colds. Refugees and asylum-seekers struggle with maintaining acceptable levels of personal hygiene, especially those living in overcrowded hostels. The issue of HIV is one of considerable personal and political importance. Most asylum-seekers and refugees have not been tested and do not know their antibody status. Often it remains hidden, as they do not want to know their antibody status for fear it might hinder their asylum application.

Given the disruption that leaving one's country and settling in another country brings, there are difficulties in developing meaningful community-based preventative work. As a result, refugees and asylum-seekers are denied effective means to safeguard their health.

1.2 CLASHING MODELS OF HEALTH – HEALTH AS A CULTURAL CONSTRUCTION

'The chasm between lay and professional knowledge, characteristic of Western science, does not exist for the Yoruba of south-western Nigeria. Here, the range of acceptable medical evidence includes dreams, visions, intuition, and feelings, as well

as empirical signs. This allows room for non-professional contributions to medical knowledge and for choosing the type of knowledge to be used in particular situations.’

Lindenbaum and Locke, 1993

Refugees’ physical and mental distress results from both pre-asylum experiences and from the consequences and realities of exile. Refugees’ responses to physical and mental distress and their expectations of and responsiveness to a healer (doctor/therapist) are rooted in their culture, traditions and mores. The majority of refugees in the UK and Ireland are from non-Western communities whose culture and beliefs are predominantly holistic – the interrelationship between physical, mental, emotional, social and spiritual aspects are integral to well-being and, therefore, pivotal to the healing process (Baluchi, 1999). This can lead to a great deal of confusion and misunderstanding on the part of both refugees and asylum-seekers, and their service providers. In considering how to provide service provision that is effective, sensitive and responsive to the needs of refugees, it is essential to view health and health care as constructed socially and culturally, and therefore best dealt with through a negotiated dialogue with the targeted recipients of care.

1.3 THIS REPORT

The significant increase in the numbers of refugees and asylum-seekers arriving in Ireland has focused health service planners and providers on the specific needs of refugees and asylum-seekers *per se* and also on the possibly differing needs, customs and constructions of health, illness and healthcare of these groups. A range of research projects has already been undertaken in Ireland into all aspects of the refugee experience, including healthcare. As the health service region with the highest concentration of refugees and asylum-seekers, the Eastern Regional Health Authority aims to provide a suitably targeted, evidence-based response to the health needs of these groups. In doing so, it seeks to inform plans with pertinent evidence while avoiding the unnecessary duplication of relevant research that is either currently underway, or has already been completed. The aim of the current project is therefore

to identify current and recently completed research projects concerning refugee health in order to identify priority areas for future research and programme development.

CHAPTER TWO

PROFILE OF REFUGEES AND ASYLUM-SEEKERS IN IRELAND AND THE UNITED KINGDOM

2.1 DEFINITIONS OF REFUGEES AND ASYLUM-SEEKERS

The UNHCR defines a refugee as person:

‘...who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside [his or her] country of origin and is unable or, owing to such fear, is unwilling to avail [him or herself] of the protection of that country; or who not having a nationality and being outside the country of [his or her] former habitual residence as a result of such events, is unable, or, owing to such fear, is unwilling to return to it.’

(UNHCR, 1979)

A distinction can be made between two main groups within the refugee community in Ireland. The first group consists of what are termed ‘programme refugees’. These are refugees who have been invited by the Irish State to live here since 1956. Groups invited include Hungarian refugees who arrived in 1956, a group of refugees from Chile who arrived in 1973, and a Vietnamese group who arrived in 1979.

Between 1992 and 1999, various government decisions allowed for refugees and families to come to Ireland from the Balkan conflicts. In 1998/1999, approximately 1,000 Kosovars were invited to Ireland. The numbers thus invited are outlined in Table 2.1.

**Table 2.1: Numbers of programme refugees invited to
Ireland between 1956 and 1999.¹**

Nationality	Year of arrival	Numbers registering
Hungary	1956	530
Chile	1973	120
Vietnam	1979	212
Bosnia	1992-99	1,228
Kosovo	1998-99	1,053

¹ Source: National Consultative Committee on Racism and Interculturalism, 2000.

The second group of refugees that can be distinguished in Ireland are not invited by the State. Rather, on arrival in the country, they are required to go through a detailed application and assessment process to determine whether or not they will be granted refugee status. Hence, they are referred to as ‘asylum-seekers’.

A certain amount of controversy exists as to the use of this term. A legal distinction has been made between ‘asylum-seekers’ and refugees, in that asylum-seekers are seen as those who are in the process of applying for refugee status, and refugees are seen as those whose applications have been successful and have leave to stay permanently in Ireland. However, some have argued that the term ‘refugee’ encompasses the aforementioned distinction on account of the individual’s personal position as a refugee in the literal sense of the word (Sansani, 2001). Comhlámh (2001a) also point out that, in their view, ‘...an asylum-seeker is a *de facto* refugee whose application for refugee status is being processed’.

Both terms ‘refugees’ and ‘asylum-seekers’ will be used in this report in order to acknowledge the distinction between them in terms of their respective legal status, whilst recognising that the experiences, rights and needs of both groups of people have much in common.

Profile of asylum-seekers in Ireland 1990-2000

Although the cumulative number of asylum-seekers in Ireland between 1992 and 1997 still only represents 0.15% of Ireland’s population, the situation from the mid 1990s onwards has been characterised by a dramatic rise in the number of applications for asylum in Ireland; i.e. from 39 in 1992 to 7,019 in 2000 (see Table 2.2). It is estimated that the whole of Europe receives only 5% of the world’s asylum-seekers. In 1999, as a percentage of the population, Ireland was the second highest recipient of applications in the EU (Table 2.3). However, although numbers seeking asylum in Ireland have continued to increase between 1998 and 2000, the rate of increase has slowed from 67% between 1998 and 1999 to 42% between 1999 and 2000. For the first quarter of 2001 Irish figures show a sharper decrease (21%) than that recorded in Europe or the EU. The Irish share of European asylum applications declined slightly to 2.3% from 2.5% with its ranking also falling from eleventh to twelfth receiving country (Woods, 2001).

Table 2.2: Applications for asylum in Ireland 1992 – 2000²

Year	Number of applications	Successful on initial application	Granted temporary leave to remain on initial application	Successful on appeal	Granted temporary leave to remain on appeal	Total
1992	39	7	7	1	2	17
1993	91	9	5	1	14	29
1994	362	34	66	1	6	107
1995	424	90	21	11	10	132
1996	1,179	172	36	97	20	325
1997	3,883	141	0	354	19	514
1998	4,626	120	0	158	4	282
1999 ³	7,724	71	-	-	-	71
2000	7,019 ⁴	26	-	-	-	-
Total	25,347	670	135	523	75	1477

Table 2.3: Applications for asylum – comparative figures for Ireland and select European countries 1992 – 1997⁵

Year	Ireland	UK	Denmark	Germany
1992	39	32,300	13,991	438,191
1993	91	28,500	14,473	322,599
1994	362	42,200	6,700	127,517
1995	424	55,000	5,100	129,517
1996	1,179	37,000	5,900	151,300
1997	3,883	41,500	5,100	136,000
Total:	5,978	236,500	51,264	2,193,391

Statistics released by the Refugee Applications Commissioner of the Department of Justice, Equality and Law Reform in April 2001, indicate that there is a pattern emerging in the countries of origin of asylum applicants, with most applicants coming from Nigeria and Romania (see Table 2.4). The other nationalities who have come to Ireland in significant numbers over the last four years have been Congolese, Algerians, Poles and people from the ex USSR (Woods, 2001).

Table 2.4: Countries of origin of asylum applicants in Ireland 1991 – April, 2001⁶

Country	1999	2000	To April 2001
	%	%	%

² Source: Department of Justice, Equality and Law Reform, 2001.

³ Applications for 1999 and 1998 are still being processed. This is indicated in the table by the - symbol

⁴ Initial application figures for 2000 only available up to August 31.

⁵ National Consultative Committee on Racism and Interculturalism, 2000

⁶ Department of Justice, Equality and Law Reform, 2001

Nigeria	24.5	31.1	36.6
Romania	28.8	21.8	12.8
Poland	7.8	-	-
Moldova	3.6	3.5	3.4
Croatia	-	-	3.8
Czech Republic	-	3.7	-
Ukraine	-	-	3.6
Democratic Republic of Congo	-	3.3	-
Algeria	3.5	-	-
Other	31.8	36.6	38.8

Change this to a chart, based on UNHCR 2001. Asylum trends in Europe – part 2. geneva UNHCR.

Most of the refugees and asylum-seekers in Ireland are resident in the Eastern Regional Health Authority (ERHA) area. In 1999, it has been calculated that a total of 9,412 asylum-seekers were resident in the ERHA area, of which 2,280 were children (de Brún, 2001; Faughnan and Woods, 2000).

The historical background to refugees and asylum-seekers in Ireland Comhlámh (2001a), the development workers organisation based in Ireland, have identified three periods in the evolution of Ireland's refugee policies:

- A first phase of antipathy towards refugees and asylum-seekers, which lasted from the foundation of the State in 1922 until membership of the United Nations (UN) in 1956.
- A second where Ireland accepted 'programme refugees' as part of the refugee regime of UNHCR from 1956 until the late 1980's. These included the acceptance of 539 Hungarian refugees in 1956 following the Soviet invasion of Hungary. Although this initiative was welcomed at first, the programme was ultimately seen as a failure as only 60 of these refugees remained in the State after two years.
- The third phase, from the late 1980's to the present, saw the establishment of an official policy marking a change in attitude towards refugees, largely as a result of

European integration and harmonisation of policies across the EU. In 1996, the Refugee Act was developed, and was the first explicit piece of legislation to deal with refugees and asylum-seekers in Ireland.

Even though the numbers of refugees in Ireland still represent a tiny proportion of the population, this significant increase impacted on the political and socio-cultural landscape of Ireland in two main ways:

- Political impact: political recognition that asylum seeking by refugees was now an integral part of life in Ireland was slow to develop. The four-year delay in implementing the Refugee Act (from 1996 to 2000) led to a confusion of responsibilities and policy directives among the various Government departments. Public debate gave rise to some positive improvements both in policy and in clarity of provision for asylum-seekers. However, the major amendments to the 1996 Act in subsequent years, and the continued negative attitudes by some in authority towards the process of seeking asylum, have meant that the originally progressive legislation has been significantly ‘watered down’ in its ability to deal with the challenges of asylum-seeking in Ireland. In addition, most of the legislation contained in the Refugee Act applies only to refugees and not to asylum-seekers (de Brún, 2001).
- Socio-cultural impact: up until 1994, Ireland had had limited exposure to non-national ethnic groups or individuals. This, combined with a long tradition of portraying countries and peoples of the ‘Majority World’ in ways that emphasised their helplessness, encouraged the formation of stereotypical racialised representations of refugees (but especially those of African origin) (Dillon and Griesshaber, 1996). A profile of attitudes of Irish people towards helping third world countries (conducted as a survey by the Advisory Council on Development Co-operation in 1989) illustrates this view. In comparison with other European nations (bearing in mind the fact that many other European countries had had

much more exposure to refugees and asylum-seekers than Ireland which at the time had almost none apart from programme refugees), Irish people had less awareness of the structural causes of poverty (Dillon and Griesshaber, 1996).

With the increasing numbers of applications for asylum, and, perhaps more importantly, the increasing visibility of people from other ethnic backgrounds in public places, refugees and asylum-seekers are frequently blamed for the exacerbation of social problems such as housing shortages and social welfare. This situation has not been aided with the introduction of direct provision (Comhlámh, 2001a). Under direct provision (introduced in April, 2000) accommodation and meals, and a residual maintenance payment for personal needs are provided directly by the Government. By its very nature, direct provision creates a barrier to integration, as it restricts asylum-seekers' right to work and their ability to socialise. In addition, lack of work and money means that asylum-seekers find it difficult to participate in social activities and therefore to participate fully in the life of the community. The current Irish asylum-seeking process is summarised in Appendix 1. All asylum-seekers are entitled to apply for a 'Medical Card', i.e. free GP, out-patient and inpatient services (the entitlements of refugees and asylum-seekers in Ireland are discussed in Appendix 2).

Profile of refugees and asylum-seekers in the ERHA

Eastern Regional Health Authority (ERHA) figures for February 2001 showed that 4,855 non-nationals were claiming Supplementary Welfare Allowance (SWA) (see Table 2.4). When adult dependants and children are added, the total number of asylum seekers in the ERHA region for February was 8,769, a decrease on the November 1999 figure (9,412) of 7%. The decrease can be explained by the changeover to direct provision in April 2000 (Woods, 2001). Since April 2000 arrangements for asylum seekers are made by the Directorate for Asylum Support Services (DASS) now the Reception and Integration Agency (RIA) under the Department of Justice Equality and Law Reform.

Table 2.5 : Eastern Regional Health Authority non-national claimants for social welfare allowance, February, 2001⁷

	<i>All</i> n	Male n	Female n	Male %	Female %
Claimants	4855	3547	1308	73%	27%
Adult dependents	1548	356	1192	23%	77%
Child dependents	2366	1183	1183	50%	50%
Total	8769	5086	3683	58%	42%

⁷ Woods, 2001.

In February 2001 73% of ERHA claimants were male as against 79% in November 1999 (Faughnan and Woods, 1999). While a higher percentage of actual asylum seekers were female, where two people are married or cohabiting, the claimant tends to be the man (Woods, 2001). The percentage of asylum seeking women had increased from 37 to 42%. This may be related to the increased likelihood, even under direct provision, that a woman who has had/or who is expecting a child will be allowed to live in the Dublin area.

Sixty eight percent of claims were for one person while 32% had an adult dependant. This was related to marital status in that 54% of claimants were single, 37% were married and another 3% cohabiting. The difference in figures reflects the fact that not all those who were married have their spouse with them. Women claimants were more likely to be married than were men and were much more likely to have a child dependant (48% of female claimants as against 23% of male).

Seventy one percent of claimants had no children (compared to 77% in 1999). The total number of child dependants had risen slightly (by 4%). This may reflect the greater length of time 2001 claimants had spent in Ireland, or it could be related to a tendency to allow claimants who have Irish-born children to come off direct provision while their claim for residency is being processed. The majority of those with children had either one or two children. Only 2% of claimants had four or more children. Ten percent of lone claimants had child dependants – in most cases one child (Woods, 2001).

Overall, although more men than women registered as claimants, more women than men were supporting adult or child dependents. The numbers of child dependents identified, although relatively low, did show a slight increase. Recent research (Fanning et al, 2001) pointed out that precise figures for child asylum-seekers are not available. A pattern is emerging of disparities in claimant trends informed by gender and age. It is important that these differences are monitored and the reasons for them understood in order to avoid inequity in social welfare provision.

2.2 SEEKING ASYLUM IN THE UNITED KINGDOM

Asylum law in the United Kingdom (UK) is also based on the United Nations Convention on the Status of Refugees of 1951. Until 1993 however, no asylum legislation existed in the UK and it was not clear what status the UN Convention of 1951 had in British law.

As in the Republic of Ireland, various refugee resettlement programmes had been implemented before the UN Convention finally became law in 1993. In the 1950's the UK accepted over 21,000 Hungarians, during the 1970's and 1980's Ugandan, Asian, Vietnamese, Chilean and other Latin American refugees were accepted.

In 1993, the Asylum and Immigration Appeals Act incorporated the UK's obligation under the 1951 UN Convention on refugees into law. This Act also ensured that those who were refused asylum had the right to appeal negative decisions on their applications within strict time limits.

In 1996, the Asylum and Immigration Appeals Act introduced a 'white list' of countries that the Home Office did not consider posed any serious threat to its inhabitants. Time limits for appeal were also tightened considerably. Asylum applicants who had travelled through a 'safe' country en route to the UK (any EU member state, the USA, Canada, Switzerland and Norway) could only appeal against a refusal once they had left the UK. The Act also introduced restricted entitlements to housing and removed welfare benefit entitlement for all those who did not make a claim for asylum immediately on arrival in the UK.

The Immigration and Asylum Act 1999 became effective in the UK in April 2000. Under this legislation the principles of dispersal and direct provision were implemented, with asylum-seekers receiving £34.54 per week, of which £10 was provided in cash. This attracted much criticism from support agencies and some members of the medical community (Connelly and Schweiger, 2000) who pointed out that the health of refugee communities in the UK was already poor. These people were now facing an uncertain time trapped in poverty and dependency.

Commentators pointed to the strong links between poverty and ill-health (see Moore and Harrison, 1995; and Black, 1988).

Although asylum-seekers in the UK do have access to the National Health Service (NHS), access is restricted due to the lack of interpreters available⁸. This is exacerbated by the dispersal of refugees to areas where the appropriate services may not be fully developed.

Profile of refugees and asylum-seekers in the UK 1980-2000⁹

The UK received a relatively low number of applications for asylum between the years 1980 and 1988, with an average of 3,903 per year. However, in 1989 the number of applications for asylum jumped from 3,998 in 1988 to 11,640 in 1989. Since then applications for asylum have never dropped below 22,000 per annum, and rose to 76,040

in the year 2000. However, in comparison with Germany the UK receives an average of 42,397 per year, whilst Germany receives an average of 176,526 per year.¹⁰

Countries of origin (UK) 1999-2000

The most significant increase in the numbers of asylum applications was from the nationals of Iraq and Iran. Somalia and the Federal Republic of Yugoslavia registered significant decreases in the number of applications.

⁸ One exception is the language translation service run by the Essex Rivers Healthcare Trust. www.nhs.uk/nhsmagazine

⁹ The UK also accepted a total of 12,665 programme refugees between 1985 and 1995

¹⁰ Source: the British Refugee Council, 2000. <http://www.refugeecouncil.org.uk/infocentre/stats/>

Figure 2.2 : Top 15 countries of origin (UK), 1999-2000

Find figures for this from www.refugeecouncil.org.uk/infocentre/stats/

Conclusion

The figures for asylum applications in Ireland show a significant increase from the mid-1990's, placing the country as the second largest receiving nation in the EU. Most applicants come from Nigeria and Romania. In contrast, the UK has been receiving refugees and asylum-seekers for much longer, and experienced an increase in levels of applications in 1989. The top two countries of origin of asylum applications in the UK are the Republic of Yugoslavia and Somalia.

CHAPTER THREE

METHODS

3.1 DESIGN

The main research strategy in this review was a consultation exercise in the form of a letter sent out to key research centres, academics, health boards and community and voluntary agencies working in the area of social, anthropological, and health services research. The letter described the aim of the review, and requested information on relevant current or recent research being carried out in the relevant agency.

In addition, a comprehensive literature review was undertaken of research carried out in both Ireland and the UK. Both hard copy and internet searches were conducted.

3.2 SAMPLE

Letters were sent to 54 parties in total. In addition to this, contact was made with 12 other organisations working in the non-governmental sector. The breakdown of institutions and organisations contacted is as follows:

3.2.1. Higher education institutes

The University of Ulster

The Queen's University of Belfast

NUI Galway

The University of Limerick

University College, Cork

University College, Dublin

Trinity College Dublin

NUI Maynooth

Dublin City University

Dublin Institute of Technology

National College of Ireland

The Irish College of General Practitioners

The Royal College of Surgeons in Ireland

3.2.2 Research Centres

Irish Centre for Migration Studies, University College Cork

The Centre for Gender and Women's Studies, Trinity College of Dublin

The Centre for Social and Educational Research, Dublin Institute of Technology

The Equality Studies Centre, University College Dublin
The Health Research Board
The Institute for the Study of Social Change, University College Dublin
The Policy Research Centre, National College of Ireland
The Social Science Research Centre, University College Dublin

3.2.3 Community and voluntary organisations

The South-West Inner City Network (SWICN)
Amnesty Ireland
Comhlámh
Barnardo's
Access Ireland
SPIRASI
The Association of Refugees and Asylum-seekers in Ireland (ARASI)
Pavee Point
The Irish Refugee Council
Inner-city Organisations Network (ICON)
The African Refugee Network
NASC – The Irish Immigrant Support Centre

3.2.4 Health Boards

Department of Public Health, North-Western Health Board
Department of Public Health, Western Health Board
Department of Public Health, Mid-Western Health Board
Department of Public Health, Southern Health Board
Department of Public Health, South-Eastern Health Board
Department of Public Health, Midland Health Board
Department of Public Health, North-Eastern Health Board
Department of Public Health, Eastern Regional Health Authority

A total of 40 replies were received. Twenty-two new projects were identified during the course of the review. All new research identified as a result of the consultation was entered into a table under the following headings: title; theme; target group; methods; challenges; study dates; status; key contact.

CHAPTER FOUR

RESULTS: CURRENT RESEARCH ON REFUGEES AND ASYLUM-SEEKERS IN IRELAND

‘Cold, afraid, isolated, lonely, unable to understand anyone, unable to trust anyone, lost, unfamiliar with the food, worried about friends and family back home, always made to feel a foreigner’

Asylum-seeker on the experience of seeking asylum in Ireland (McCarthy, 1999)

4.1 SERVICES FOR REFUGEES AND ASYLUM-SEEKERS IN IRELAND

A number of support services, both statutory and voluntary, have been set up to help refugees and asylum-seekers cope with their experiences of arriving in a strange country. The Refugee Agency was established by the Government in 1991, and is responsible for the resettlement and integration of programme refugees. The agency provides a range of supports, including assistance with housing and resettlement and advice in accessing health, welfare and educational services.

Other support services have been provided by the Non-Governmental (NGO) sector. The Irish Refugee Council has a membership of over 50 organisations, and provides advice, information and referral services as well as seeking the development of proper policies and services for refugees and asylum-seekers. Access Ireland, a social integration project established by the Refugee Council, works to promote greater awareness of refugees and for their integration into Irish society.

A network of ‘refugee led’ initiatives has started to emerge in recent years. These include the Bosnian Community Development project, which acts as a resource to the Bosnian Community in Ireland, the Association of Refugees and Asylum-seekers in Ireland (ARASI) and the African Refugee Network.

Refugee Lives: The Failure of Direct Provision as a Social Response to the Needs of Asylum-Seekers in Ireland (Comhlámh, 2001a) was published earlier this year. The report aims to place the Dispersal and Direct Provision policy in an historical and

legal context, and to provide an illustration of the realities of the lives of asylum-seekers dependent on the system. It concludes that the hasty introduction in 2000 of Dispersal and Direct Provision was a crisis response to the chronic shortage of accommodation in Dublin for asylum applications. The initiation of this policy, while the principle of dispersal and de-ghettoisation of inner cities was welcomed by Comhlámh, was seen as a failure for 3 main reasons:

- While asylum-seekers were dispersed to regional centres, support services were not. Communication difficulties resulted, which have hampered the provision of full legal services and entitlements for asylum-seekers.
- There was a negative reaction to the programme in a small number of regional locations selected early in the process, perhaps because of poor prior consultation and information.
- The system of Direct Provision is described as ultimately discriminatory and promotes the marginalisation of asylum-seekers in rural towns and villages.

However, some positive outcomes of dispersal include benefits to ethnic minority communities and Irish people, with community initiatives and activities being introduced to encourage integration.

4.1.1 Current research

A directory of statutory and voluntary organisations delivering services to refugees and asylum-seekers (*REFWORLD Ireland Directory*) is being prepared for publication by the end of 2001. This is a joint initiative between SPIRASI and the ERHA.

Local Issues with Global Connections: The Relevance of Refugee and Asylum-Issues for Local Authorities in Kerry (Collins, forthcoming) is a study which explores the ways in which local government in Kerry can become more informed about refugee and asylum-seeking issues, particularly the global dimension. This was a qualitative study based on semi-structured interviews with key informants from the statutory and

non-statutory sector. The research has been completed, and is due to be published by December, 2001.

A number of research projects are currently underway. A feasibility study in all EU Member States seeks to provide loans to refugees to start their own business, access to further/higher education or to requalify for employment. This is being carried out by the World University Service, with SPIRASI as the Irish partner organisation, and it is funded by the EU EQUAL fund. It is planned to run from December 2001 to the end of November 2003 and is currently in the initial planning stage. Another study is a needs, service and policy analysis of the role of NGOs in the reception and integration of asylum-seekers, refugees and immigrants in Ireland. This study is being carried out by the Irish Centre for Migration Studies at University College Cork (UCC), and is funded by the Royal Irish Academy. It is due to begin in November, 2001.

Two studies are being carried out under the auspices of the Social Science Research Centre, University College Dublin. These examine service provision for refugees and asylum-seekers. The first examines perceptions of reception services for asylum-seekers as perceived by workers in the statutory sector and community welfare officers (Faughnan, in progress). The main research strategy is an analysis of statistical data on asylum-seekers in Ireland within a European and global context, and analysis of data from the Eastern Regional Health Authority on asylum-seekers within the region. This study is due for completion by the end of 2001. The second study focuses on the role of voluntary and community organisations in promoting a multi-cultural society (Faughnan, in progress). There are two phases to the study, the first being a survey of voluntary and community organisation staff, and the second is a planned action research component. The survey is due for completion by the end of 2001, and it is planned that the action research component will be completed in the early months of 2002.

4.2 GENERAL OVERVIEW STUDIES

Report of a Survey of the Vietnamese and Bosnian Refugee Communities Living in Ireland (O'Regan, 1998).

O'Regan (1998) carried out a detailed survey of Vietnamese and Bosnian refugee communities in Ireland, under the auspices of the Refugee Resettlement Research

Project. This project was a collaborative initiative between the Refugee Agency and the Department of Psychology in the Eastern Regional Health Authority. The primary aim of the proposal was to examine the resettlement patterns of Vietnamese and Bosnian programme refugees and their families in Ireland. The research aimed to inform policy-makers and service providers, thereby facilitating the continuing development of services to the refugee communities (O'Regan, 1998).

The project consisted of a survey of 105 adults and 31 children from the Vietnamese and Bosnian programme refugee communities. The adult population from which the sample was drawn included:

- those who arrived in Ireland as adults under the primary admissions category
- those who arrived in Ireland as children under the Family Reunification Scheme and who have now reached adulthood
- those who arrived in Ireland as adults under the Family Reunification Scheme.

The primary research instrument was a semi-structured interview schedule, which was developed and piloted over several months. The schedule examined a comprehensive range of topics regarded as important to the resettlement process. The schedule was developed to give information on the following broad categories:

- **background information about the research participants in their countries of origin**
- their circumstances and experiences of becoming a refugee
- their experience of arriving and resettling in Ireland
- their present economic, social and personal circumstances
- their hopes and plans for the future.

Also included was the General Health Questionnaire (GHQ-28) (Goldberg and Williams, 1998). This was used as a measure of the incidence of psychological distress among the programme refugee groups.

O'Regan found that the majority of refugees have suffered significant losses. Their experiences prior to arriving in Ireland included significant levels of trauma due to

events such as war, injury, bereavement, separation from loved ones and substantial loss of personal possessions (O'Regan, 1998). At the time the survey was carried out, a high proportion of Bosnian and Vietnamese participants were in receipt of unemployment payments from the Department of Social, Community and Family affairs. However, since then there has been evidence of an improved employment rate among that community. Results of the survey indicated that for those refugees in employment, many benefits were apparent, improved income and lifestyle, better mental health and an increased sense of belonging to the community.

One issue that emerged was the stressful nature of resettlement. A lot of this stress was found to be due to the demands placed on the individual in adjusting a new environment. However, O'Regan argues that the very fact of becoming a refugee implies a considerable level of physical and/or emotional trauma. The health needs of refugees were therefore seen as dependent on the experiences they had before arriving in Ireland and based on the situations in which they find themselves.

O'Regan found that while the Eastern Health Board put in place a designated psychological service for Bosnian refugees in 1992, there was evidence that not all those experiencing mental health difficulties were accessing psychological services. There seemed to be a level of dependence on medical interventions, as evidenced by the high frequency of prescriptions being issued to those with mental health problems. The low level of psychological service uptake (both State-provided and private) was felt to be likely to be due to a combination of cultural factors and language barriers.

The results from the O'Regan survey indicated that, on the whole, the children were doing well. Overall, children demonstrated high levels of integration within the educational system. Academic performances were very good, although particular individuals with low achievement rates scored within the clinical range. It would appear that one of the factors influencing academic performance is the presence of English language difficulties. O'Regan recommended that future research into refugee children take this issue into account.

4.2.1 Current research

A general screening of the dental health of refugee and asylum-seeking children was carried out from January to June, 2001. Analysis of the data is ongoing and is due to be completed by the end of November, 2001.

4.3 RACISM

Torode, Walsh and Woods (2001) have pointed out that asylum-seekers respond at different levels and in different ways to the period of prolonged waiting for a determination of their cases. For many asylum-seekers a State benefit system is new, as they come from societies where no such benefits exist. Over time, asylum-seekers and refugees become conscious of, and sensitive to, hostility toward them as the recipients of state benefits. The loss of the breadwinner role and perceived decrease in social status are more difficult when the host society emphasises social welfare payments as pull factors in refugee movements, to the exclusion of push factors such as war and human rights abuses (Torode et al, 2001).

However, it is not just in the realm of interpersonal interactions that racism exists. Tracy (2000) has argued for the recognition that Irish immigration policy is inherently racist, and that '...the levels of discretion in refugee and asylum...policy, undocumented immigration and naturalisation are an area of concern since the negatively ascribed discourse allows discretion to perpetuate racist attitudes' within immigration policy. Therefore, even before someone has completed the initial application process (to say nothing of later appeals, etc.) he or she has encountered institutional racism.

Other aspects of dealing with statutory and institutional services can pose significant problems as well. Racism and discrimination on the basis of skin colour are major barriers to social integration. In a survey carried out by Loyal and Mulcahy (2001), 78% of a sample of 622 black and/or ethnic minority people living in Ireland had experienced some form of racism, either direct or institutional racism. 16.1% of the sample reported that they had experienced at least one incident of racism in a medical or health care setting. While this figure is relatively low compared to the 44.5% of respondents who had experienced racist incidents on the street, it still should be a source of concern for all those working in health care settings. A needs analysis carried out by the African Refugee Network (McCarthy, 1999) found that while participants' experience of the Irish health service was generally positive, specific areas of concern did arise such as the high cost of dental care, the depression and anxiety caused by the social isolation of their asylum status, and cultural issues to do with maternity care. These ranged from racist comments from nurses and doctors, to cultural misunderstandings about visiting patterns. An example of how such

confusion can occur is provided by Kennedy and Murphy-Lawless (forthcoming), who describe how many of the women interviewed in their study felt that there was a definite lack of privacy in the wards. In their own countries, it was more usual for new mothers to labour without a partner and to spend the immediate postnatal period resting in hospital and without visitors on the ward.

A survey of 146 adults and children (33% adult and 67% children) by Casey and O'Connell (2000) found that 28% of the sample felt that they had been discriminated against when dealing with doctors due to their colour or race at some time. Half of respondents classed as 'Asian' for the purposes of this survey felt that they had experienced discrimination when dealing with doctors. Casey and O'Connell found that 'ethnic minority individuals are discriminated against in personal and institutional settings and that the experience of racism in general correlates highly with levels of psychological stress.

An interesting study that focused on how secondary school pupils construct their opinions of refugees and asylum-seekers (Keogh, 2000), indicated that many different factors contributed to negative opinions. For example, the term 'asylum-seeker' was often associated with 'asylum' as it pertains to being 'insane'. Keogh points out that 'asylum-seeker' itself has negative connotations, which bring to mind concepts of insanity or deviance. Another factor cited was a fear of Ireland losing its identity, in other words that aspects of Irish culture will become diluted if members of other ethnic groups come to the country. Pupils also expressed the fear that Ireland is too small to accommodate refugees and asylum-seekers. The pupils appeared to have difficulty in understanding the motivations behind people leaving their home countries to come to Ireland, and felt that the main motivation was for financial gain in a more affluent host country.

4.3.1 Current initiatives

The Inner-City Organising Network (ICON) is preparing an anti-racist pack for inner city local people and community groups. Local people and community groups are being consulted, and the most frequently occurring myths about people from other ethnic backgrounds, along with most frequently asked questions, will be identified. The pack will be tailored to answer these specific points (see Appendix C).

Further research on racism in the health services is essential in order to ensure that the potential for institutional racism within the health services is to be kept at a minimum.

4.4 NEEDS ANALYSES

Needs analyses seek to identify in a formal manner the needs of specific target groups. A number of needs analyses have been carried out to identify the needs of refugees and asylum-seekers in Ireland. Many of these cover a range of aspects of the experience of being a refugee or asylum-seeker such as social integration, education and training, accommodation, and health issues.

African Refugee Needs Analysis (McCarthy, 1999)

One example of a needs analysis is that carried out by McCarthy on behalf of the African Refugee Network. This study used a range of techniques to identify the key needs of African refugees living in Ireland (specifically the Dublin area) including:

- discussions with African refugees and asylum-seekers
- carrying out a survey of African refugees and asylum-seekers to gather demographic and background information (n=40)
- training members of the African Refugee Network in basic interviewing methods and social research
- reviewing the relevant literature
- interviewing a number of service providers
- hosting a round table discussion for refugees and asylum-seekers
- carrying out four case studies of African refugees and asylum-seekers.

This study found that the legal bar on the right to work and study for asylum seekers is the major barrier to social integration. This meant that participants could not develop a network of work and/or student friends and colleagues. The majority of African people in Ireland are from professional or skilled backgrounds that are used to working and earning relatively high salaries. Welfare dependency is unfamiliar and is felt to be very personally demeaning. Aside from racism (discussed above), cultural issues were also highlighted as being potential barriers to integration.

Most of the participants appeared to be satisfied with service provision. However, some racist incidents were mentioned (see above), and it was pointed out that the needs of refugees who have been tortured or severely traumatised prior to their arrival

in Ireland was not felt to be adequately addressed by current statutory service provision, although some voluntary services do exist.

On a more general level, the area of cultural difficulties and misunderstandings arose in relation to the Eastern Health Board. It was pointed out by participants that cultural issues may not be understood by staff in health services, as well as by those working for the Department of Justice, Equality and Law Reform. This can be the cause of a considerable degree of tension and conflict.

4.4.2 Current research

A number of analyses of the needs of refugees and asylum-seekers are either currently underway, or have recently been completed in Ireland. Most of these are outside the Greater Dublin Area, and are being carried out in response to changing population profiles as a response to Dispersal and Direct Provision. Those recently completed include a study of refugees and asylum-seekers in County Monaghan that aims to profile the local population and conduct a needs analysis (Doyle, forthcoming). This study, conducted from a qualitative perspective, entailed focus groups with service providers, convention refugees and asylum-seekers. It was completed in September, 2001 and was planned to be published in November, 2001.

Meeting the Needs of Asylum Seekers in Tralee (Collins, forthcoming) was completed this year and awaits publication. This study used a combination of qualitative and quantitative methods with asylum seekers (excluding convention or programme refugees) and local service providers. This study also included a population profile. Two research projects currently underway are *Meeting Refugee Health Needs – Demands and Challenges (Galvin, forthcoming)* and *The Needs of Asylum-Seekers in Cork*¹¹ (Collins, forthcoming). *Meeting Refugee Health Needs* is being carried out by the Department of Sociology, Trinity College Dublin on behalf of the Western Health Board. It will utilise a combination of quantitative and case study techniques to identify key health needs of refugees and asylum-seekers, and to identify the key barriers to accessing health care from the point of view of refugees, asylum-seekers, general practitioners, and other health professionals. *The Needs of Asylum-Seekers in*

¹¹ Working title.

Cork is similar to that carried out in Tralee, with a population profile and a general needs analysis forming the main components of the study. A combination of quantitative and qualitative methods will be used.

4.5 MENTAL HEALTH AND WELL-BEING

It has previously been stated that mental distress is one of the greatest difficulties facing refugees and asylum-seekers who arrive in a strange country. This is no different for those who arrive in Ireland. In the context of resettlement in a new country, and particularly in the context of enforced displacement experienced by more and more refugees, the incidence of psychological distress is one of primary concern.

Several population studies have found positive associations between perceived discrimination and anxiety (Dion and Earn, 1975), lower levels of life satisfaction (Broman, 1997), high blood pressure (Krieger, 1990; Krieger and Sidney, 1996), lower levels of self-esteem (Pak, Dion and Dion, 1991; Gil and Vega, 1996) and higher levels of psychological symptoms (Furnham and Shiekh, 1993). Studies particularly focusing on refugee and asylum-seeker populations have found similar negative effects of discrimination on psychological well-being (Sundquist and Johnson, 1996; Gorst-Unworth and Goldenberg, 1998). One explanation of this observed relationship between perceived discrimination and poor psychological health is the sense of loss and helplessness that discrimination incurs in victims of racial discrimination (Fernando, 1984).

4.5.1 Seeking Refuge in Ireland: Acculturation Stress and Perceived Discrimination (Horgan, 2000).

This study aimed to examine the effect that prejudice has on refugees, asylum-seekers and international students in Ireland. Its objectives were to:

- examine the effect of perceived discrimination on acculturation levels
- examine the effect of both perceived discrimination and acculturation level on psychological well-being.
- in addition, the study examined individual factors such as employment, level of trauma experienced prior to arriving in Ireland, satisfaction with social support in Ireland, length of time in Ireland, age and gender.

The sample included 18 refugees and 15 asylum-seekers living in Ireland. Of these, 20 were male and 13 were female. Respondents ranged in age from 16 to 42 years; length of residence in Ireland ranged from two months to 78 months.

Levels of acculturation stress in the sample were high, with 48 per cent of the forced migrants and 41 per cent of the voluntary migrants showing a possible clinical disorder. These findings are consistent with the bulk of the literature that has found a relationship between psychological health and refugee and asylum-seeker status (Lavik et al, 1996, Felsman et al, 1990). Satisfaction with social support was also related to refugees' and asylum-seekers' levels of acculturation stress and employment status.

The observed relationship between social support and acculturation has been demonstrated previously in numerous studies involving both forced and voluntary migrants (Berry et al, 1987; Beiser et al, 1989). One explanation for this relationship is that social support acts as a buffer against stressors in the environment (Cohen and Wills, 1985), another is that perceived availability of social support helps the person to maintain a sense of control in the event of stressful situations occurring in his or her environment (Schwarzer and Leppin, 1991).

Horgan (2000) identified a number of implications arising from this research: the high levels of discrimination perceived by refugees and asylum-seekers is consistent with previous research carried out in Ireland (Gray et al, 1999; McVeigh and Binchy, 1998; Collins, 1995; Boucher, 1998) and indicates that procedures are necessary to counteract this growing development in Irish society. In addition, many asylum-seekers have reported the asylum-seeking process to be stressful (Collins, 1995; McVeigh and Binchy, 1996). Among recent asylum-seekers, these stressors are likely to persist, as they are still subject to the employment restrictions that no longer apply to those individuals who have been seeking asylum for more than one year.

4.5.2 Current research

Two research studies have recently been completed that investigate mental health and well-being with refugees and asylum-seekers. Baneham completed an M.Litt

dissertation on family separation in the Vietnamese Community in Ireland in 1999. *Asylum in Ireland – a Public Health Perspective* (Begley, et al, 1999) investigated public health issues and the experience of refugees and asylum-seekers with a focus on psychological stressors. The study used a mixture of quantitative and qualitative methods. A questionnaire was administered (n=80), and focus groups were held with asylum-seekers. The report was a joint initiative between SPIRASI, the Mid-Western Health Board, the ERHA, and the Department of Public Health Medicine and Epidemiology, UCD.

One study is currently under way entitled Psychological Distress Among Refugees and Asylum-Seekers in Ireland (Ryan, in progress). This is an M.Litt thesis being carried out in the Department of Psychology, UCD. It aims to investigate sources of stress, manifestations of psychological distress and social support among asylum-seekers in Ireland. Research strategies will include a sociodemographic questionnaire, the SCL-90R Checklist (Symptom Checklist 90 Revised), a perceived social support measure, a perceived discrimination scale, and semi-structured interviews. This study is due for completion by October 2002.

4.6 ETHNICALLY APPROPRIATE HEALTH CARE

Despite the discourse promoting sensitivity and cultural competence in dealing with culturally diverse clients, the concept of ‘culture’ has largely been excluded from theoretical conception and research methodology in health services research (Young-Hong, 2001).

Ethnically appropriate health care is based on the premise that there are many subtle yet distinct processes that affect the quality of health encounters, for example differences in the way that medical and non-medical people construct concepts of health, illness and well-being (and appropriate treatments), and, for people from ethnic minority backgrounds, differences in language, expectations, and religion (along with discrimination) (de Brún, 2001). De Brún argues that health care services should be aware of the potential for misunderstanding in such a complex situation, and adapt to meet the needs of consumers.

A survey conducted in 2001 of 144 Romanian asylum-seekers in the ERHA area aimed to appraise the ethnic appropriateness of services in the ERHA region from the perspective of these asylum-seekers (de Brún, 2001). The main areas for investigation were:

- an assessment of the role played by language barriers in hindering medical/non-medical communication
- an exploration of the sensitivity of the health professionals in dealing with issues relating to different religious beliefs
- the appropriateness of health professionals in dealing with cultural and ethnic diversity and perceived differences in treatment by health professionals because of race or ethnic differences.

A number of aspects of the health service were investigated including:

- health service utilisation
- use of translation services
- the ethnic appropriateness of GP services
- the ethnic appropriateness of hospital services
- the ethnic appropriateness of Community Welfare Officer services.

The study found that there was a high degree of satisfaction by asylum seekers with health services. The most vulnerable groups identified were those with poor language skills. This group tended to find it more difficult to make an appointment, explain their symptoms or situation and understand the treatment and directions of the health professional. Some services made more effort to inform asylum-seekers of the availability of a translator service (such as Community Welfare Officers). Information on conditions and situations was found to be generally not available in multi-lingual format. There was moderate agreement by respondents that religious beliefs were respected by health professionals and the treatments and directions given were appropriate to the cultural and ethnic backgrounds of asylum-seekers. There was also a moderate level of agreement by respondents that they were not treated differently by health professionals because of their race or ethnic background.

4.6.1 Cultural competence in health care.

However, only one study was identified in the course of this review which focussed specifically on the concept of cultural competence, as opposed to cultural knowledge, awareness or sensitivity, in health care. This study, carried out as a post-graduate thesis, investigated the cultural competence of nurses in caring for ethnic minorities in hospitals in Ireland (Boyle, 2001). Boyle argues that the concept of 'interculturalism' (that is, behavioural interactions between people of different cultures) must be considered in order to inform nurses' attitudes, opinions and knowledge of people from diverse ethnic and cultural backgrounds (Boyle, 2001).

Boyle set out to investigate the level Irish nurses' perceptions of their own practice and their ability to provide care for people of ethnic minority. Access was gained to 5 clinical/ward areas of a general hospital:

- adult medical and surgical
- paediatric medical and surgical
- paediatric casualty area.

Fifty nurses were randomly selected to take part in the study. Thirty-eight took part, giving a response rate of 76%. Boyle found that 95% of the respondents had cared for people of ethnic minority. Most (66%) said that they had nursed people from the African continent. Interestingly, none of the nurses referred to Travellers, indicating that they did not view Travellers as a minority ethnic group. With regard to nurses' experience of caring for people of ethnic minority, 11% said their experience was very good, 55% said it was good and 32% felt it to be poor.

4.6.2 Other research

A project to train general practitioners in dealing with refugees, asylum-seekers and migrant workers is being developed by the Irish College of General Practitioners. This project is currently awaiting final funding approval from the Department of Health and Children and the Department of Justice, Equality and Law Reform.

Access Ireland is developing a project to train refugees and asylum-seekers to act as 'cultural advocates' in the community in order to improve the links between refugee and asylum-seeking communities and statutory services, including health services.

SPIRASI and the Department of Tropical Medicine and International Health at the Royal College of Surgeons in Ireland are collaborating in a study exploring the

knowledge, experience and practice attitudes of general practitioners to all immigrants (with a focus on refugees and asylum seekers in the ERHA region (n=100)). The data collection phase has been completed, and the report should be completed by the end of 2001. The project was designed as a pilot study, and it is intended to conduct a larger study comparing findings in Ireland and UK.

The Department of Applied Social Studies in University College, Cork are collaborating with the University of Münster (Germany) on a research project investigating the work of social workers and their perceptions of refugees and asylum-seekers. It is planned to carry out semi-structured interviews over the next year, with a planned completion date for the end of 2002.

4.7 WOMEN REFUGEES AND ASYLUM-SEEKERS

The establishment of gender-sensitive health, accommodation and social welfare services are deemed to be essential for refugee women. However, the situation of refugee women in Ireland has only recently begun to receive attention, promoted by the publication of the Zena report on the needs of Bosnian women (Sultan-Prnjavorac, 1999), the launch of guidelines on best practice concerning refugee women (Irish Council for Civil Liberties, 2000) and by the UNHCR conference held on refugee women in 1999 (UNHCR, 1999). Women refugees, however, have specific health and welfare needs that are not adequately catered for within a 'gender-blind' approach.

4.7.1 The maternity care needs of women refugees

At a conference run by Access Ireland in December, 1998, Lavinia Okoro discussed the many aspects of giving birth that are radically different between Ireland and Africa (Okoro, 1998). For instance, when some African women have a baby they are tired and often wish to sleep. This can lead to confusion among professionals who may believe that they do not love their babies. However, Okoro pointed out that resting after childbirth relates to a culturally-specific form of ante-natal care in many parts of Africa. Often pregnant women begin to prepare for child birth at about seven months' gestation. Special food is prepared, and from the seventh month to delivery, friends and family will bring hot food to the pregnant woman every day. After delivery women are allowed to rest. Female friends and family look after the baby. Newly-delivered women are not allowed in the kitchen for six months. This can

cause problems for refugee and asylum-seeking women and their families, who are living in sub-standard and cramped accommodation. These significant differences must be understood and respected if health and welfare professionals are to ensure that service provision and practices do not reinforce misunderstandings and racial stereotyping (Okoro, 1998).

Women refugees and asylum-seekers – their maternity care needs (Kennedy and Murphy-Lawless, forthcoming)

Kennedy and Murphy-Lawless' recently completed study (forthcoming) on the maternity care needs of women refugees and asylum-seekers aimed to elicit their perspectives on their maternity needs and their views of Irish current service provision.

Kennedy and Murphy-Lawless argued that the Irish health care system is dominated by consultant-led maternity care alongside high levels of interventions. Interventions, ranging from the insistence on routine amniotomy to electronic foetal heart monitoring, to an inappropriate supine position during labour, to routine epidural pain relief to inappropriate episiotomy, make it more difficult for women to give birth and often require a further intervention to overcome the effects of the previous interventions. Such an approach, which poses difficulties for Irish women, can be detrimental to women from different social and cultural backgrounds, where social support is a strong feature of maternity care and where women's expectations of birth have been shaped by a 'woman-centred social model' (Kennedy and Murphy-Lawless, 1999).

In addition, the experience of loss and suffering creates extra needs for pregnant refugee women. This experience of loss creates special dimensions of need for pregnant refugee women, with consequent impacts on their physiological, psychological and social profiles during pregnancy. Kennedy and Murphy-Lawless believe that if Irish maternity care services are to be responsive to women in this very special situation, they need to know in the first instance what specific difficulties women are encountering in giving birth in a foreign culture.

Therapists working in the Medical Foundation in London with victims of political violence and torture emphasise that for a woman refugee, the time of pregnancy and the period afterwards is very often marked by profound depression and trauma which go well beyond conventional categories of post-natal depression. Indeed, in their experience, health care staff consistently misdiagnose PTSD as post-natal depression resulting in women not receiving the specialised care that they need (Kennedy and Murphy-Lawless, 1999).

The recent study was based on a two-pronged research strategy:

- a quantitative survey of asylum-seeking women in the greater Dublin area who were either pregnant or who had already given birth in the area
- a small number of detailed qualitative case studies.

Women were interviewed in a range of care settings including: health centres; hostels; Bed and Breakfasts; flats rented out to the Department of Justice, Equality and Law Reform for refugee families; and flats and houses in the private rented sector arranged by families themselves.

The final sample size was 61 extended interviews. The women interviewed came from countries such as Nigeria, Romania, Kosovo, Cameroon, Ghana, Ukraine, Algeria, Bosnia, Iraq, Poland, Russia, and Sierra Leone and ranged in age from 15 to over 40.

Key concerns identified by the respondents included basic problems in accessing information on rights, entitlements and services; dealing with institutional racism resulting from a tendency in Irish health care to treat all people the same (attempting to be equitable) while not acknowledging diversity; an inadequate information flow for care workers in the community sector or between the hospital and community sector to effectively respond to the difficult dynamics and realities of refugee women's lives; major difficulties for both women and service providers with regard to language; and tremendous difficulty in accessing suitable accommodation.

A PhD study of the needs of refugee and asylum-seeking women and their existing children is at the planning stage in the Department of Public Health Medicine and Epidemiology, UCD. This study will focus on health needs, pregnancy outcomes and satisfaction of women and their children attending at three Dublin hospitals. The

study will be a mix of quantitative and qualitative methods and its expected conclusion data is 2003 (Lyons, forthcoming).

4.7.2 Social support and refugee women

Christine Dibelius (2001) conducted Irish research with lone mothers from different African countries from the point of view of their social networks. She defines social networks as those networks which:

‘...embed and support a person’s social identities (Hirsch, 1981). The establishment of a person’s social identities and social roles depend significantly on the recognition and feedback received in the social network.’

The role of social networks in determining access to social and psychological support, and access to state services has been emphasised in literature. Dibelius points out that networks play an important role in determining access to information, resources and support. In addition, networks have been described as the infrastructure or social matrix in which support occurs (Badura and Waltz, 1982; Pierce et al, 1990). According to Dibelius, obtaining concrete instances of helping from one’s social network constitutes actually received support, while the psychological affirmation of belong to a network of reliable social relationships is necessary for perceived support.

Dibelius argues that given that migrants and refugees have suffered significant losses in their previous social networks, the emergence of a new network and the prevalence of low levels of loneliness can be seen as indicators of quality of life in the new host country.

The research involved a small-scale qualitative study based on semi-structured interviews with nine refugee women from three African countries. Dibelius found that the networks of the lone parents she spoke to were shaped and constructed through the interaction of many different factors, from such pragmatic concerns as money, transport and language skills, to more complex factors such as experience of inclusion and exclusion, solidarity and mistrust of Irish people, other refugees and different sections of their own community.

4.7.3 Sexual Violence against Women Refugees

Although research on the prevalence of torture survivors in Ireland has not yet been published, international research reveals that 30% to 60% of all refugees in Europe have experienced torture and other forms of serious violence (Begley et al, 1999). In Ireland, Begley, et al (1999) point out that one Dublin general practitioner found that 44% of asylum-seeking patients have survived torture, and a study by Hughes (1997) suggests that approximately 5 to 20% of refugees in Ireland are survivors of torture. McCarthy (1999) has stated that there are a number of factors which prevent a woman refugee or asylum-seeker from coming forward to look for medical help or counselling on arrival in Ireland. One major factor is that many women are bringing with them the internalised cultural attitudes of their country of origin. For example, sexual attacks of any sort may be seen as shameful and the victims may be stigmatised within their own country.

Two forms of gender-related harm frequently arise as an issue in claims by asylum-seeking women. The first is where women have been the targets of sexual violence. Women in such cases have often faced difficulties in showing that they are victims of persecution rather than targets of random violence despite the fact that it is widely accepted that rape and sexual violence are commonly used as weapons of war. The difficulties are exacerbated by the trauma resulting from such experiences and the cultural factors that may inhibit women from speaking freely about their experience.

Another form of gender-related harm arises when women face penalties for transgressing social morés in their country of origin, e.g. where they disobey laws on adultery, child-bearing, dress code and so on. Penalties in such cases can be disproportionately severe, and can even amount to death (Irish Refugee Council, 2001). Other threats women face can include:

- being singled out for persecution due to the fact that they are political activists or campaign for human rights for themselves, friends or family
- being related to other men or women who are targeted by the State or other protagonists (NNCRI, 2000).

4.7.3.1 The provision of health services to refugee women who have survived gender-based torture (Sansani, 2001)

Sansani carried out a qualitative study investigating the provision of health services to refugee women who have survived gender-based torture. This study focused on the views of service providers who address different refugee needs, in order to obtain a comprehensive view of the services available for these women. Service providers included representatives from various government-funded and independent programmes as well as academics whose work focused on ethnic and racial issues as they pertain to the development of social policy. Semi-structured or unstructured interviews were carried out with participants¹².

Some of the key issues identified as affecting the ability of refugee women who have survived gender-based torture to access a range of services and supports include:

- lack of language training
- childcare
- social isolation
- inappropriate accommodation.

Sansani also found that the lack of willingness among survivors of gender-based violence to broach their experiences, particularly with strangers, highlighted the complexities involved in dealing with the issues of gender-based torture. According to one of the participants interviewed:

‘It is not easy [for women] to have their trauma acknowledged...Another problem with sexual abuse is that it’s not easy to talk about these sort of things’

In general, Sansani found that the implementation of specialist services for torture survivors may better serve Ireland’s refugee community than the services provided by the then Eastern Health Board, because ‘...as torture is ultimately world-destroying, its effects may not be sufficiently combated by the generalised services available to the majority population in Ireland’ (2000).

Cunningham and Silove (1993) have described two main approaches to service provision to those who have survived torture. The first are those services which

¹² The number of participants interviewed was not specified in the study.

address ‘...the broad range of welfare and medical needs faced by refugees’. The second approach is to provide services that ‘specifically focus on the psychological needs of people who have been tortured.’ Because the relationship between the two is reciprocal, ‘the capacity for specialised services to focus on the specific needs of torture survivors in countries of resettlement depends on the strength and coherence of the wider service(s)’.

Sansani therefore argues that an integrated network of services that addresses primary needs such as housing and language training allows torture rehabilitation services to specifically focus on the needs of survivors. Well-co-ordinated general services may assist refugees in establishing a semblance to their lives that will in turn enable them to approach trauma rehabilitation effectively.

Tomkin (1999) has argued that in dealing with refugees, the official approach of the then Eastern Health Board is that of ‘integration’ and ‘normalisation’. That is, refugees are expected to adapt to the same services as the domestic population. This can lead to the danger that traumatic migratory experiences are often unaccounted for. On the other hand, however, Tomkin argues that isolating refugees as special cases requiring urgent psychological attention is also problematic and therefore service providers are hesitant to isolate refugees with ‘socially-loaded terminology’ (1999).

Another issue that was highlighted in Sansani’s study was the lack of integration among services. This has led to considerable service duplication in terms of the services available to refugees. Sansani argued that a greater coherence among services could allow refugees to tackle immediate needs upon arrival and then address needs that are more specific.

The issue of social stigma was also pointed to, in that refugees and asylum-seekers may be reluctant to avail of psychological services, and that although there is a great deal of trauma among refugees, only 2% access health board psychological services (Sansani, 1999). The location of health board psychological services in a psychiatric hospital may be perceived as threatening. Participants in Sansani’s study advocated the development of a ‘support centre’ elsewhere which would be less threatening and stigmatising.

4.8 CHILDREN

Although the increasing numbers of asylum-seekers arriving in Ireland has given rise to much debate and significant research, little attention has been paid to the particular needs of children. Whether or not children arrive in Ireland with their families, or unaccompanied, all face particular difficulties and challenges in coping with the loss of their homeland and friends, in adjusting to a new culture, learning a new language and integrating into a new school (Barnardos, 2000).

The main service available to children is primary and post-primary schooling. In addition the community and voluntary sector have developed various recreational and educational support services. Children can also avail of the clinical psychology services in the ERHA area.

4.8.1 Unaccompanied Minors

‘Separated children and young people’ are defined as children under 18 years of age who are outside their country of origin and separated from both parents, or their legal/customary primary caregiver (Separated Children in Europe (SCE), 1999). These children are among the most vulnerable groups of refugees and asylum-seekers and have particular needs and requirements, which need to be met in an organised and child-centred manner. At the end of 2000, there were 1,106 applications for refugee status from separated children being processed.

A report published by the Irish Refugee Council (1999) analyses in detail the practice and policies in Ireland in respect of separated children, and compares these with *The Separated Children in Europe Programme Statement of Good Practice* (SCE, 1999). The study highlighted the following areas of concern:

- there is no specific legislation in place to guarantee that separated children will not be refused entry
- there is no specific requirement for an independent *Guardian ad Litem* to be appointed by the courts to represent the needs of separated children
- in many situations separated children are placed in hostel accommodation without any adult caregivers

- there is no specific system in place to assist in tracing their families or in fast-tracking family reunification. Nor are there any measures in place to assist young people in reuniting with their families while their application is being determined.

As part of the study, a workshop was held with 10 children. In this the children stated that they did not think the Irish Government or people had a positive attitude towards refugees. Some said they had experienced verbal racial abuse. The young people also pointed out that they had to share rooms with adult strangers, and that access to education was difficult, with little or no guidance about how to enrol in a school. All agreed that a suitable person should be appointed to advise and support them through the asylum process.

4.8.2 Current research

A study has been recently completed on asylum-seeking children and their families, investigating poverty, social exclusion, the impact of direct provision and psychosocial impact of the asylum-seeking experience (Veale, forthcoming). This study used a mixture of quantitative and qualitative techniques to record child poverty and assess psychosocial status. This study has been completed and will be launched in November, 2001 under the auspices of the Department of Applied Psychology, UCC and the Combat Poverty Agency.

A post-graduate thesis was completed in June, 2001 which explored the psychological needs of unaccompanied minors in order to inform service planning and provision in the psychological services of the ERHA (Rea, 2001). Both qualitative and quantitative methods were used with 28 unaccompanied minors. Semi-structured interviews were carried out with the participants, along with formal measures such as a child behaviour checklist and a post-migration living problem checklist. However, it was pointed out by the clinical supervisor of this thesis (Ryland, 2001, personal communication) that there is a danger that this vulnerable group may be over-researched, with consequent exploitation in the process.

A project is currently underway to compile an information leaflet for service providers in the community on dealing with unaccompanied minors seeking asylum in Ireland. The booklet will contain information on entitlements and rights. This is due

for completion in December 2001 and is being carried out by the Centre for Social and Educational Research at the Dublin Institute of Technology.

4.9 TRAVELLING PEOPLE – IRISH TRAVELLERS AND THE ROMA COMMUNITY

In a recent study of Traveller mothers, Heron et al (2000) found an extremely high rate of psychological distress – 32% of the women were taking antidepressant medication at the time of the research. Other studies have also found high levels of psychological distress (Pahl and Vaille, 1986; Noonan, 1994). Heron et al made the point that other groups such as the Aborigines in Australia and the First Nation people in Canada have also had higher rates of mental health problems than their respective national populations (see McCarthy, 1995). In Australia, the Aboriginal Medical Service Co-operative has found that mental health problems are the most clinical problem presented to doctors in the specialist Aboriginal health service. Similarly, research has shown that the First Nation People in Canada have high rates of depression, with almost double the rate of suicide compared to the national population (Health and Welfare Canada, 1991).

The Roma originated in North India and left around the tenth century, arriving in Europe around the fourteenth century. Although they are often seen as a single entity, they do not constitute one ethnic group, but rather have many distinct ethnic identities, for example, the Quinquis of Spain, the Jenisch of Germany and the Vlachs of the Balkans. Diversity among these groups causes a great disparity in the data available on the differing groups of the ‘Roma’. Even the size of the Roma population in Europe is not certain, with estimates ranging from 6 to 10 million people (McCaughey, 1998).

A high degree of mutual distrust exists between the Roma and service providers in Ireland (Keating, 1998). Often, service providers have assumed that applicants are obviously fraudulent, which Keating describes as an ‘unfair and unprofessional’ assumption (1998). Smith (1997) has pointed out that Roma people are often, as with Irish Travellers, perceived as ‘outsiders’ whose moves towards self-determination are regarded as undermining the control of the dominant group (Jayasuriya, 1991:95). Institutional racism and poverty are major barriers preventing Roma people from accessing employment, health, welfare, shelter and essential services.

In addition, historical events such as the Holocaust (large numbers of Roma were incarcerated in camps and subjected to torture, rape and death along with Jewish people), enforced sterilisation, and the forced removal of children by health and welfare authorities have played a major part in the opinions that Roma people have formed about government-run health services (Smith, 1997). For example, a Roma woman using government health services, might bring memories and expectations of being judged and treated by staff according to her level of education, the number of children she has, where she lives and her assumed degree of poverty.

A study of Traveller and Roma women living on or using sites in Avon, England found that women frequently complained of encountering 'hostility' and 'unwelcoming behaviour' from receptionists and members of the public in hospital waiting rooms (Hawes and Perez, 1995). Many Roma women in this study encountered difficulties in using health services due to the inflexibility and antipathy of service providers towards women who did not have a permanent address, were illiterate or were unfamiliar with bureaucratic processes which required precise knowledge of times and dates, and so on.

A training programme is being planned for 16 Roma women in literacy, English and personal development by Pavee Point (the Irish Travellers' Representative Group). This is a pilot project that is due to start in November, 2001.

4.10 HOUSING

Health and well-being is fostered in the wider context of an acceptable living, working and social environment for people. Piaras McEinri (2000) has traced the accommodation and housing trends of refugees and asylum-seekers arriving in Ireland. Before 1999, there were relatively few asylum-seekers in Ireland, most of whom were living in Dublin. Social welfare and accommodation allowances for these people were administered to communities. By the end of 1999, the Department of Justice, Equality and Law Reform was faced with a serious difficulty in securing more accommodation for asylum-seekers in the Dublin area. The policy of Dispersal was therefore introduced in order to move asylum-seekers outside the capital.

However, McEinri pointed out that if this policy is to work, the necessary supports and services must be put in place as communities do not have the resources to cope with this situation alone. McEinri argues that 'new and imaginative' solutions are necessary if refugees and asylum-seekers are to be housed appropriately in Ireland, for example co-operating with voluntary or religious organisations (2000).

Bradley and Humphries (1999) studied the housing needs of Bosnian refugees (with a focus on programme refugees) in Ireland. They point out the difficulties facing these people, only 5% of whose households had succeeded in purchasing their own homes by December, 2000. This was found to be due to a number of factors: the rapid increase in house prices in the Dublin area since 1995; the fact that many refugee households may have arrived in the country in their forties and later, and found they were too old to purchase homes based on the then mortgage criteria set in Ireland; and the fact that the majority of households are welfare dependent and are therefore excluded from owner occupation.

Bosnian refugee households are therefore forced to depend either on social housing or on the private rented sector to supply housing. However, accessing both of these sectors can prove extremely problematic. The chances of being allocated social housing for the majority of refugees are low, according to Bradley and Humphries (1999), who found that ninety-two per cent of households on the social housing waiting list had never been offered a dwelling. The difficulties in either buying a property or availing of social housing have led to a reliance on the private rented sector to meet housing needs. However, increases in rent have meant that many households are forced to change accommodation, which can make integration into Irish society quite difficult.

In addition, the significant majority of households in private rented accommodation are households with children (75% according to Bradley and Humphries, 1999). The conditions of renting in Ireland mean that there is no security of tenure, and therefore this is not an appropriate long-term option for such families. Bradley and Humphries argue that the use of private rented accommodation to absorb social housing needs is a short-term solution to a long-term need and very costly to the State. Ninety per cent

of Bosnian households in private rented accommodation receive some form of rent allowance.

The problems facing the Bosnian refugee community, many of whom arrived as programme refugees and have a more secure outlook than those waiting for decisions on their applications for asylum, point out some of the difficulties that face refugee communities in general in finding suitable long-term housing. A comprehensive housing strategy tailored to meet the needs of these vulnerable and marginalised groups is necessary if they are to be able to plan successfully for the future and play an active role in Irish society and culture.

CHAPTER FIVE
**RESEARCH ON REFUGEES AND ASYLUM-SEEKERS IN THE
UNITED KINGDOM**

5.1 RACISM IN HEALTH CARE AND HEALTH RESEARCH

Although empirical evidence is scarce and hard to interpret, much public opinion and scholarly analysis in the United Kingdom places racism at the heart of ethnic and racial inequalities in health and health care (Smaje, 1995; La Veist, Wallace and Howard, 1995; Turshen, 1996).

Bhopal (1997) has described the bulk of past research into race, intelligence and health as racist, unethical and ineffective. Although concepts of race and ethnicity are complex and difficult to define, they continue to be applied to the study of the health of immigrant and ethnic minority groups in the hope of advancing understanding of causes of disease. He argues that by emphasising the negative aspects of the health of ethnic minority groups, such research may have damaged their social standing and deflected attention from their health priorities. Bhopal argued that scientists wish to uncover the causes and processes of disease, while health policy makers and planners want to meet the needs of ethnic minority groups (1997). However, much research into health and ethnicity is unsound. The definitions of ethnicity and race are vague, and the underlying concepts are poorly understood and hard to measure. There is inconsistent use of terminology, for example Asian, White, Caucasian, Hispanic – common terms in research but with inconsistent and non-specific meanings. There are difficulties in collecting comparable data across cultural groups: for example, do questions on stress or alcohol consumption have equivalence across cultures?

Bhopal points out some of the basic errors that are committed in health research:

- *Inventing ethnic groups* – for instance labelling a group as ‘Urdu’ on the basis of the language spoken, thus inventing an ethnic group (Melia, Chinn, and Rona, 1988).

- *Not comparing like with like* – for instance inner city populations are different from ethnic population samples, but studies of ethnicity and health continue to focus on them for convenience.
- *Lumping groups together* – for instance a paper on smoking and drinking habits in British residents born in the Indian subcontinent did not describe gender and regional variations, creating the impression that smoking and drinking were unimportant in the ‘Asian’ population (Balarajan and Yuen, 1986).
- *Not adjusting for confounding factors* – for instance inferences can change radically once interacting and confounding factors are taken into account. Lillie-Blanton et al challenged the observation that crack smoking was commoner in African Americans and Hispanic Americans and showed that once social and cultural factors were accounted for, there were no differences in prevalence (Lillie-Blanton, Anthony and Schuster, 1993).

The perception that the health of ethnic minority groups is poor can reinforce the belief that immigrants and ethnic minorities are a burden on the ‘healthier’ population. This perception is at least partially false for some ethnic groups (Marmot, Adelstein and Bulusu, 1984). Bhopal argued that the perception of poorer health arises from a focus on differences where the excess of disease is in the ethnic minority population (1997). A number of consequences detrimental to the health and well-being of ethnic minorities in the host country can arise from this:

- The focus on a few ‘ethnic’ problems is at the expense of major problems. Health education material for ethnic minority groups in the 1980s tackled issues such as contraception, lice, child care and spitting, but there was nothing on heart disease and little on smoking and alcohol (Bhopal and Donaldson, 1988).
- Most research into ethnicity and health is based on the comparative paradigm and presents data using the ‘white’ population as the standard. Inevitably, attention is focused on diseases that are commoner in ethnic minority groups than in the white population. This can lead to displacing problems like cancer and respiratory disease (which, while still very common, are less so than in the white population) from their rightful place as high priorities for ethnic minority groups.

- Finally, racial prejudice is fuelled by research portraying ethnic minorities as inferior to the majority. Infectious diseases, population growth and culture are common foci for publicity.

5.1.1 Racism and service providers

However issues of racism do not just affect service users. A study on institutional racism in the NHS published by the King's Fund (Coker, 2001) found that a smaller proportion of doctors from black and minority ethnic groups were likely to get promotion to consultant grade, and these doctors were more likely to be sidelined into unpopular specialities or inner-city general practice.

In response to ongoing and mounting criticism of racism affecting both service users and service providers, the NHS drew up a plan to take racial harassment in the NHS (1999) in order to provide guidance and support for NHS organisations in developing and implementing action to tackle racial harassment in line with the recommendations of the MacPherson report on the Stephen Lawrence Inquiry (MacPherson, 1999).

5.2 RESEARCH AND PROJECT WORK WITH ETHNIC MINORITIES AND REFUGEES AND ASYLUM-SEEKERS IN THE UNITED KINGDOM.

Baluchi (1999) has pointed to a dearth of comprehensive research on the health needs of refugees and asylum-seekers in the United Kingdom, in spite of the fact that refugee health, particularly mental health, has become a growing concern amongst primary and mental health providers and for health commissioners (1999). There is some relevant research in relation to children and young people including Yudkin and Turner (1992) who reported findings based on a survey of Kurdish and Somali community workers.

Details of clinical practice and methodologies for helping refugee children have also been published (Melzack, 199d73

However, research dealing with access to adequate health care services is more extensive, with a national study on refugee access to the NHS (Gammell et al, 1993). Many reports have also been instigated and undertaken by refugee community

organisations in the light of acute concerns about the well-being of their communities. The conclusions drawn in much of the research undertaken relate almost exclusively to improving accessibility and cultural sensitivity usually through the provision of interpreters, bi-cultural workers, or bi-lingual advocates (Baluchi, 1999). Whilst the role of bi-lingual advocates in meeting refugees' needs is invaluable, Baluchi suggests that the use of highly qualified and skilled interpreters or advocates is problematic, given cultural taboos which can inhibit people from talking about potentially sensitive problems.

5.3 THE HEALTH NEEDS OF REFUGEES

Karmi (1998) has argued for the development of a health care strategy that draws all the different strands of service provision together. A code of practice for health screening and a plan for the aftercare of refugees in primary and secondary care were fundamental tenets of his proposal. He warned that if the issue of refugee health care is not addressed in this way, refugees would continue to be seen as a burden and a problem for the health service. Initiatives would be duplicated in different parts of the country, which would be wasteful of effort and expense.

The need to identify precisely what the health needs of refugees and asylum-seekers are before instigating health programmes has therefore risen to the fore in recent times. In response to this need, the Kimia Health Clinic was founded in London in 1998.

5.3.1 The Kimia Health Clinic

The Kimia Health Clinic aimed to establish and develop a national specialist refugee health service, provided by refugee clinicians to promote the physical, mental, emotional and social well-being of refugee communities. The clinic carried out a survey of the health status and use of mental health services of 759 refugees in order to a) obtain quantitative data on refugees' physical and mental health status, both self-reported and verified by mental health clinicians and/or GPs, and on their use of and

views on mental health services, and b) establish the willingness of refugees with mental health needs to participate in research.

It was found that of the 759 respondents to the survey, 83% reported some form of physical illness (undifferentiated in the study). 71% of respondents also reported a range of mental health problems. The top seven listed in incidence were:

- Post-Traumatic Stress Disorder: 79%
- Mood Disorders: 74%
- Somatic Symptoms: 68%
- Sexual Dysfunction: 38%
- Personality Disorder: 15%
- Eating Disorder: 12%
- Schizophrenia¹³: 10%

Mental health difficulties were found to tend to last for a long time, with 68% of respondents reporting that their difficulties lasted for over one year.

One half of the 759 respondents who were patients of the Kimia Health Clinic and who had a confirmed mental diagnosis were asked to give their opinion of current service provision: 47% of these had used the community mental health services, with far more women than men attending (the male to female ratio was 1:12). It was felt that the considerably higher percentage of women patients seeking help from psychiatric nurses and mental health social workers was likely to result from women seeking help for the benefit of the entire family. Other sources used included Accident and Emergency services, voluntary admissions to mental health units, involuntary admissions ('sectioning'). It was found that often the asylum-seeking process could precipitate mental or emotional distress that could result in voluntary or involuntary psychiatric admissions (Baluchi, 1999).

¹³ It should be noted that the Kimia Health Clinic questions the reliability of western conceptual constructs associated with the diagnosis of schizophrenia, see Fernando, 1991 and Jenner et al, 1991.

A high percentage of all patients with severe mental health difficulties (97% of women and 80% of men), had tried and completed at least one course of therapy in another setting. Assistance from the Kimia health clinic had been sought in the hope that their culturally specific and refugee specific model of therapy might resolve or enable the patients to better manage their mental health difficulties. In conclusion, Baluchi came up with a number of recommendations towards building a sensitive health strategy for refugee health along 3 core issues:

- *Service Access and Needs Assessment for New Arrivals*

Service providers are often unsure of refugees' entitlements to NHS services from initial arrival. Information on this issue needs to be disseminated far more effectively, and be designed to target both service providers and refugees and asylum-seekers.

- *Physical health*

Refugee health needs are complex and multi-dimensional, often encompassing both mental and physical aspects. Information provided at primary care level alongside a specialist advisory and assessment service could prove clinically useful and cost-effective. The Kimia Health Clinic advocates the establishment of a lead Primary Care Centre (PCG) with appropriate funding in each District or PCG locality, depending on the size of the refugee population. Such Centres, GP-led with multi-disciplinary input including sessional refugee clinicians and bi-lingual advocates should provide:

- an initial health check which would provide an initial health record, including past medical history, which could be patient held
- ensure that any refugees with serious illnesses including tuberculosis identified post-entry, could have their needs appropriately met and be fully informed about essential medication requirements
- ensure, as necessary, a comprehensive needs assessment and links into independent living (community care) services and/or other health services
- facilitate permanent GP registration.

- *Mental health*

The study indicated that the Kimia Health Clinic's service model is clinically effective in addressing refugees' health needs, particularly mental health needs, and can also provide cost-benefits. It appears to provide an environment and model of care

which refugees consider to be safe and acceptable and is able to respond to appropriately to their physical, mental and emotional distress (Baluchi, 1999:47).

5.4 REFUGEE-SPECIFIC HEALTH INITIATIVES

In 1998, Karmi emphasised the need to develop health care strategies specifically tailored to refugees and asylum-seekers. At the time in Britain there was no comprehensive health and service strategy to care for this population, with refugees and asylum-seekers being randomly referred for health screening according to the judgement of the immigration officer. Those who had not been detained at the point of entry were to receive health care in the health district where they resided. A number of health initiatives targeted specifically at refugees and asylum-seekers have been initiated in the UK in response to the growing awareness of the special health concerns and needs of this group. Those initiatives that had been set up were done so as a result of uncoordinated interest in some health authorities, and there was a high level of duplication as a result of poor communication and co-ordination.

5.4.1 Meeting Refugees' Needs in Britain: The Role of Refugee-Specific Initiatives (Carey-Wood, 1997)

This study focused on four key policy issues: community development, employment and training, health and housing. Three main methods were adopted – analysis of published and unpublished information on a wide range of refugee agencies; interviews with key individuals in statutory, voluntary and community agencies; and case studies of selected initiatives specifically for refugees. The health-related aspects of the study will be focussed on for the purposes of this review.

In 1993, the Department of Health provided funding for four projects, all of which targeted the Somali community. They focused on HIV/AIDS counselling, education, support, mental health services and assessment of the health needs of men and women. In addition, the Health and Ethnicity Programme of the Northwest and Northeast Thames Regional Health Authorities has funded a number of projects on

refugees, including research on Somali and Eritrean women refugees in Haringey (Bernard-Jones, 1992), research on refugees and the NHS (Awiah, 1992) and part-funding of a refugee worker in Brent and Harrow. Many of these initiatives were partly prompted by the emphasis on health and ethnicity in the Secretary of State for Health's *The Health of the Nation* report published in 1992. Carey-Wood also identified two further specialist services developed by statutory and voluntary organisations that work with refugees, particularly in relation to psychological trauma. These are the Traumatic Stress Clinic at the Middlesex Hospital which receives referrals of refugees who have survived trauma and torture, and the Medical Foundation for the Care of Victims of Torture started in 1985 by Amnesty International's Medical Group to provide care and rehabilitation for victims of torture and their families.

The two services most commonly provided for refugees and asylum-seekers in the UK are translation and interpretation in medical situations and the use of health advocates. In view of this, four projects were studied which combined language with medical advocacy.

- The Refugee Support Centre, Stockwell
- The Somali Counselling Project
- The Haringey Refugee Development Project
- The Vietnamese Mental Health Project

Carey-Wood (1997) found that all these initiatives clearly demonstrated useful ways of working with refugee communities, such as joint initiatives, consultation processes, developing complementary services, community-based services, needs assessment and holistic approaches to mental health problems. The emphasis on and demand for counselling and mental health support in these initiatives highlighted the specialist knowledge and support required for practitioners and providers working with refugees. Services in which projects felt they were particularly successful and which would be easy to replicate included: befriending services and drop-in centres, training for professionals and community groups to recognise mental illness in refugees, preventative work on family disputes, and producing leaflets in a range of languages.

It was felt that there were clear advantages to developing refugee-specific initiatives (RSIs) in the health field because of the need to combine language skills, medical knowledge and knowledge of the refugee experience. The use of interpreters without specialist training in medical situations is not adequate in difficult and sensitive encounters. Another advantage of RSIs is the non-bureaucratic and relatively non-medical or non-psychiatric atmosphere of the RSI services, which may be more acceptable to refugees and more appropriate to their needs.

However, there were some disadvantages to using this model of health care: one of the projects (Haringey) experienced difficulties in communication and support between staff and management as it located outreach workers in the various community groups it served. Another difficulty encountered by outreach workers was the fact that they were often presented with non-health issues by their users. In the light of this situation, refugee-specific health initiatives should form strong links with other agencies, particularly social services.

Another difficulty that arose was low staffing levels and inadequate premises. The attitude of primary health care teams also caused some difficulty – for example one of the key roles of GPs in the initiatives was to refer refugee patients to specialist support services. This frequently did not happen as GPs did not have the time to listen and understand, nor were they aware of the services available.

The greatest limitation that arose was their ‘special project’ status. This status demands frequent and time-consuming fundraising and lobbying to ensure their continued existence. This status is the equivalent of pilot project status in the Republic of Ireland. Staff and management alike felt strongly that the time spent in raising money would be better spent in service provision.

5.4.2 E.M.B.R.A.C.E UK

E.M.B.R.A.C.E UK is a collaboration between the Ethiopian Refugee Association of Haringey and the Research Centre for Transcultural Studies in Health. It is a study which aims to describe and analyse the health and social care needs of Ethiopian refugees in the UK in the context of their ethnic and migration histories and the impact of these factors on their culture, values and beliefs. The research group hope

that this information will help policy makers and service providers to address the needs of Ethiopian Refugees.

A participatory approach using semi-structured group and individual interviews is being employed in this study, which is due to finish in November, 2001.

5.5 CULTURAL COMPETENCE INITIATIVES

Dein (1997) has pointed out that doctors in Britain 'increasingly encounter patients whose values and beliefs differ substantially from their own'. Without a knowledge of other cultural beliefs and practices, health service providers can easily fall prey to errors of diagnosis, resulting in inappropriate management and poor compliance. In response to this, a growing body of research in the area of 'cultural competence' has taken place in the UK in recent years.

Cultural competence is defined as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, and Isaacs, 1989). Cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of health care; thereby producing better health outcomes (Davis, 1997). Cultural competence emphasises the idea of effectively operating in different cultural contexts. It is this that differentiates cultural competence from concepts such as cultural knowledge (familiarisation with selected cultural characteristics, history, values, belief systems, and behaviours of the members of another ethnic group (Adams, 1995)), cultural awareness (developing sensitivity and understanding of another ethnic group). This usually involves internal changes in terms of attitudes and values. Awareness and sensitivity also refer to the qualities of openness and flexibility that people develop in relation to others. Cultural awareness must be supplemented with cultural knowledge (Adams, 1995), or cultural sensitivity (knowing that cultural differences as well as similarities exist, without assigning values, i.e., better or worse, right or wrong, to those cultural differences (National Maternal and Child Health Center on Cultural Competency, 1997)).

5.5.1 Partnerships for Change

Partnerships for Change is an organisational development project that uses the methods of Participatory Action Research to change the way organisations work. The project operates in an iterative fashion, that is it reacts to findings and recommendations throughout its 'lifetime' by implementing changes continually. The project has the following aims:

- to identify why services are under or over used
- to give a voice to those experiencing the greatest inequalities in health
- to identify barriers hindering access to and progression through care pathways
- to inform and facilitate change in the appropriateness and cultural competence of services.

Partnership working has been key to the success of this project. At present, a total of 17 different stakeholder organisations are involved in the project with contributions and commitment at board level, as well as front line staff. At the beginning of the project a baseline exercise was carried out to explore the starting position of the stakeholder organisations in relation to cultural competence. The report of this exercise highlighted priorities that led to change. It also handed over ownership of any changes to the organisations themselves. Priority areas were identified as:

- strengthening the collection of ethnic data
- improving record keeping in relation to 'language spoken', 'language read' and 'religion'
- reducing 'Did not attend' rates for out-patient clinics
- training staff
- supporting the development of culturally competent organisations, services and care pathways.

The project has also developed and published an 'audit tool' for assessing culturally competent organisations, services, and care pathways which addresses the following seven aspects:

- Community profiling
- Ethnic monitoring

- Organisational responsibility
- Partnerships
- Public involvement in decision-making
- Multi-cultural awareness
- Human resources issues

5.5.2 Cultural Competence in Action Project (CCAP)

Various studies conducted in the last decade indicate that the provision of mental health services to people from ethnic minority groups has been problematic and is in need of improvement. Furthermore, a number of inquiries into homicides and serious incidents committed by mentally ill people have revealed inadequacies of provider organisations in dealing with the needs of minority ethnic users. Enfield & Haringey and Camden & Islington Health Authorities have identified the need for staff training as part of their strategies for improving the health of black and minority ethnic users.

The Cultural Competence in Action Project aims to:

- develop and deliver a team based, practice focused model of education and training promote cultural competence
- disseminate this model to other areas and NHS trusts through the development and use of open learning materials (Harries, 2001).

The project is designed to target health and social worker professionals and practitioners at selected day services in North Camden and North Islington, and the East Enfield Community Mental Health Team of the Enfield Community Care NHS Trust.

It is planned to carry out pre- and post-assessment of cultural competence at both individual and micro-organisational level, to negotiate strategies to capture existing strengths and remedy deficiencies, to develop and negotiate specific training activities and to develop materials to inform changes in other areas.

5.5.3 Tandem Advocacy Project – Greater Glasgow Primary Care NHS Trust

The Tandem Project is a Primary Care Community Initiative based in general practices across Glasgow. It was developed to empower black and minority ethnic groups to improve their access to health care. A bilingual advocacy service is provided according to principles of cultural sensitivity. Information is also provided regarding health issues in a variety of languages. The main ethnic groups served are Indian, Pakistani, Chinese and Arab.

5.5.4 Multicultural Health Development Programme

This project aims to help the Greater Glasgow Primary Health Care Trust to develop a service that addresses the health problems of the black and minority ethnic communities and facilitate the development of a culturally competent service. The project provides one-stop clinics, primary care programmes, training, policy and research activities and other related service provision programmes.

5.5.5 The Health Action Project (Greater Glasgow Primary Health Care NHS Trust)

The Health Action Project aims to ensure that health services are accessible to black and minority ethnic communities. 'Health advocates' are employed to accompany clients to appointments and to engage in community development and capacity-building. The project also provides placement opportunities for experience in a community setting and other health-related activities.

5.6 MENTAL HEALTH SERVICES

5.6.1 Breathing space – a mental well-being project for refugees and asylum-seekers

Breathing space is an initiative established to address the mental well-being needs of refugees and asylum-seekers, both within and outside London. It is a three-year joint development project between the Refugee Council and the Medical Foundation for the Care of Victims of Torture, in partnership with and funded by the Camelot Foundation.

The project has three main working areas:

- Advocacy and Training – informing and improving understanding of the mental well-being needs of refugees among target organisations in the voluntary and statutory sectors, and delivering effective training programmes to help target organisations provide high quality mental health services to refugees
- The Bicultural Team – taking referrals from the Refugee Council and the Medical Foundation for the Care of Victims of Torture to provide an effective casework service to support individual refugees who have mental well-being needs, and facilitating the capacity-building of refugee community organisations that provide mental health services to community members
- Research – investigating the impact on the mental well-being of refugees as a result of their settling in the UK. This is a new project which commenced in 2001 and is planned to run for three years.

5.6.2 Breaking ‘Circles of Fear’ (Keating, 2001)

This project involves a review of the treatment and care of African and Caribbean people with mental health problems. It is premised on the hypothesis that there are ‘circles of fear’ on the part of service users, families, carers and professionals that impact on the interaction between these groups which leads to poorer quality mental health services for black people.

The project aims to document the experiences and views of black communities on mental health services, to explore impediments to change, to document examples of innovative and good practice and to develop guidelines for practice, research, training and policy.

The project will use a qualitative methodology to explore the experiences of African and Caribbean communities of mental health services. It is planned to conduct the study in three sites, one in Birmingham, and two in London. Data is to be collected via focus groups interviews, site visits, and key informant interviews. The findings will be presented in a project report and will be used to inform policy and practice on a national and local basis (Keating, 2001).

5.6.3 The Somali Mental Health Project in Sheffield

This project was developed in response to the needs of the Somali population in Sheffield. Experience of war, torture and famine has left many Somalis in severe mental distress. This has been compounded by the process of migration and adjustment to a new culture. The Somali Mental Health Project has come to play an important role in the care and aftercare of the Somali population. The aim is to provide a service that will improve the quality of care as well as acting as a link between sufferers of mental distress and statutory services. Mental health workers in the project act as advisors, assessors, counsellors, co-ordinators and translators. They can either work independently or in conjunction with health care workers. Assessment of mental health is very often conducted in clients' homes, and with the consent of clients, necessary information is passed on to health care workers. In an advisory role, these workers provide information about services, facilities and opportunities in the community.

5.6.4 Mental Health Services for Asylum-Seekers (Greater Glasgow Primary Care NHS Trust)

This project consists of a small mental health team that has been set up to provide advice and consultation to primary and secondary care and voluntary organisations. The team provides a number of services including:

- advice and consultation to referrers
- information on referral options
- facilitation of entry into secondary mental health services
- training and information on asylum-seekers and services available to community mental health teams and other services
- translation of mental health information sheets for community mental health teams
- networking with external agencies such as the Scottish Refugee Council
- monitoring the use of current mental health services
- co-ordinating plans for mental health services.

5.7 WOMEN REFUGEES AND ASYLUM-SEEKERS

In any refugee population, approximately 50 percent of the uprooted people are women and girls. Stripped of the protection of their homes, their government and often their family structure, women are often particularly vulnerable. They face the

rigours of long journeys into exile, official harassment or indifference and frequent sexual abuse even after reaching an apparent place of safety (UNHCR, 2001).

The UNHCR policy on refugee women points out that becoming a refugee affects men and women differently and that these differences must be recognised when developing and implementing policy (1990). Emphasis should be placed on the participation of refugee women in planning and implementing initiatives. The policy goes on to point out that a programme that integrates refugee women should take into consideration factors influenced by the male/female roles in a society and include these in the planning activity with a view to benefiting the whole target population. This is essential if women's initiatives are to be included in mainstream activities, in order to avoid the danger that refugee women are not isolated or segregated (UNHCR, 2001).

Refugee women face many challenges. Their particular needs such as protection against sexual violence, access to resources and power need to be addressed.

5.7.1 Refugee women in the United Kingdom

When women claim asylum in the UK there is a lack of awareness by officials of how their gender has shaped their experience of persecution, and therefore their genuine claims are at risk of failing. In addition, women are particularly badly affected by recent changes in legislation affecting refugees such as dispersal and new support arrangements. Isolation, poverty and lack of support in the UK add to the pressures women are already experiencing (Refugee Women's Resource Project, 2001).

In response to the particular problems faced by refugee women, a number of projects have been set up to support refugee women's health and social care needs.

5.7.1.1 Black Women's Rape Action Project (BWRAP)

This project was founded in 1991 to offer counselling, support and advice to Black women and other women of colour, immigrant and refugee women, who have suffered rape, sexual assault or other violence. This project is based on the premise that immigrant and refugee women especially feel unable to tell officials or others in

authority the full story of the attack they have suffered, and to describe the effects this experience has had on their lives.

5.7.1.2 The Refugee Women's Resource Project

This project was set up in April 2000 by Asylum Aid, a registered charity which provides free legal representation and advice to asylum seekers and refugees. It aims to enable women fleeing serious human rights violations to gain protection in the UK. This project has recently completed research on two major areas of concern to both refugee women themselves, and those working with them.

The first project was entitled *Refugee Women and Domestic Violence: Country Studies* (RWRP/Asylum Aid, 2001a). This report gives some background information on the arguments for recognising domestic violence as grounds for protection under the Refugee Convention or the Human Rights Act and looks at the situation for women in five of the main countries of origin of asylum seekers to the UK – Albania, Bosnia and Herzegovina, China, Iran and Pakistan.

The research aims to enable legal practitioners representing women fleeing domestic violence to realistically assess the strength of a claim for protection under either the Refugee Convention or the Human Rights Act, as well as to raise awareness amongst decision-makers and others involved in the asylum process of the significance of domestic violence for refugee women. Fifteen countries were initially selected according to criteria such as numbers seeking asylum in the UK, origins and experiences of Asylum Aid's female clients, and geographical, religious and political spread. Each country report consists of sections on the political and human rights context, particularly in relation to women, international legal instruments, domestic violence and the law, the reality of seeking protection and the situation of separated or divorced women. Examples of relevant case law are quoted where possible.

A second report is entitled *Only Crooked Words* (RWRP/Asylum Aid, 2001b). This report focused on Kenyan women's experiences of seeking asylum in the UK. The research aimed to review and challenge Home Office decisions on the cases of Kenyan women asylum-seekers based on the research evidence, and to provide

recommendations and resources for use by Home Office representatives, legal practitioners and other advisers. The research was based upon analysis of written reports on women's rights in Kenya, analysis of 35 Home Office refusal letters provided by participating legal representatives in order to identify patterns for refusals of Kenyan women cases, and in-depth interviews with 6 Kenyan women asylum-seekers who had been refused asylum at first instance, and one interview with a Kenyan refugee.

The research found that the overwhelming majority of Kenyan women who claim asylum in the UK are refused and thus denied any form of protection. From the research it appears that Kenyan women's claim for asylum are rarely taken seriously. The reasons for this appear to be multi-faceted, including procedural factors that reflect a lack of consideration for gender issues, a lack of knowledge or recognition of the gravity of the human rights situation in Kenya, and a lack of understanding of the extent to which Kenyan women are even more deprived of fundamental human rights simply because of their gender (RWRP, 2001).

5.7.1.3 'Get down to earth and relate to all people': quality and standards in General Practice provided contraceptive services' (Newman, 2001)

This research study (completed in January, 2001) did not focus on refugees and asylum-seekers as such, but service user participants came from a range of different ethnic backgrounds. The aim of the study was to identify the factors that service users and providers consider important to the quality of contraception provision in a general practice setting. The study used a qualitative methodology. A purposeful sample was used to recruit service users and health professionals from General Practice in three London health authorities. The range of ethnic backgrounds represented included¹⁴: Turkish; Turkish Cypriot; 'Black African'; Afro-Caribbean; 'Black British'; 'White British'; Russian; and 'White English'.

Some of the key findings that emerged with regard to the needs of ethnic minority women attending GPs for contraceptive services included the need to provide

¹⁴ These ethnic classifications were based on self-reported ethnicity on the part of participants.

adequate translation services for women who do not speak English. It was not regarded as

satisfactory to rely on family or friends. In addition, where it was possible for a woman to attend a GP who spoke the same language, this was felt not to be desirable if the GP is from the same ethnic group. Women worried about confidentiality and that they might be 'judged' by the GP in these circumstances. In general, service users felt that those who did not speak English were discriminated against by service providers, for example, there was a perceived assumption that service providers assume that women from ethnic minority groups are ignorant about contraception.

5.7.2 Female genital mutilation (FGM)

One of the key foci of research on health issues relating to women refugees and asylum-seekers in the UK is the phenomenon of female genital mutilation (FGM). This is a highly complex area which poses ethical and moral dilemmas for refugee women, non-governmental organisations, and statutory service providers. In view of the difficult issues in dealing with FGM, a separate discussion is provided in Chapter 6.

5.8 UNACCOMPANIED MINORS

Unaccompanied minors are among the most vulnerable refugees and require special assistance and care. The policy of the UN for dealing with this group is their return to and reunification with their families (UN, 1995).

5.8.1 Health needs of unaccompanied minors

Malnutrition and post-traumatic stress disorder are two of the main conditions that young people can suffer from on arrival in the host country. Comprehensive health checks are therefore necessary but often do not take place (Children of the Storm, 2001), either because the children are too frightened to submit to a check, or because they are not aware of their entitlements or how to access them. Young unaccompanied minors may also lack the knowledge to keep themselves healthy in the absence of their parents or other relatives.

The UK receives a high number of applications for asylum from young people under the age of 17, and hundreds of these are not accompanied by any family members (Children of the Storm, 2001). A number of initiatives have been set up to target this group specifically.

Children of the Storm

This organisation was established in 1989 to cater for the emotional and material needs of the increasing number of young asylum-seekers entering Britain. The agency supports refugees under the age of 21 and aims to raise awareness of refugee issues in the community at large through producing information material, lobbying parliament and holding publicity events, providing financial assistance through a small grants scheme to provide emergency financial support to refugee children when funds are available; building schools' capacity through promoting peer support groups, and giving presentations and advice to schools and community groups on how to increase their capacity to integrate refugees and give them support, and creating opportunities through study support schemes which assist refugee youngsters with learning English and doing homework.

CHAPTER SIX

6. FEMALE GENITAL MUTILATION (FGM)

‘The *irua* marks the commencement of participation in various governing groups in the tribal administration, because the real age-groups begin from the day of the physical operation. The history and legends of the people are explained and remembered according to the names given to various age-groups at the time of the initiation ceremony. For example, if a devastating “famine” occurred at the time of the initiation, that particular *irua* group would be known as (*ng’aragu*). In the same way, the Gikuyu have been able to record the time when the European introduced a number of maladies such as syphilis into Gikuyu country, for those initiated at the time when this disease first showed itself are called *gatego*, i.e. syphilis. Historical events are recorded and remembered in the same manner. Without this custom a tribe which had not written records would not have been able to keep a record of important events and happenings in the life of the Gikuyu nation.’

(Kenyatta, 1965)

‘If I had known what I know now, I would have started ten years ago. I did not know the amount of suffering our women had gone through. I did not know that the women in our village who were sterile had infections after their operation. I did not know that the girls who had died had died because of this practice. We men never talked about it. We never asked and we just never knew.’

(Pa Demba Diawara. Imman Village Leader, Senegal in All-Party Parliamentary Group on Population, Development and Reproductive Health, 2000)

6.1 BACKGROUND

This review focuses on female genital mutilation as a cultural practice that is very unfamiliar in the Irish setting and one which has the potential for misunderstanding between Irish health professionals and refugees and asylum-seekers from other countries. The aim here is to provide some basic information about the nature of the practice and its relevance to particular ethnic groups in Ireland.

The two quotes at the start of this chapter illustrate the complexities and dilemmas facing all those who deal with the phenomenon of female genital mutilation (FGM). On the one hand, FGM is closely interlinked with the culture, identity and cosmology of those who practice it, while on the other it can be viewed as a dangerous and traumatic practice, symbolising the oppression of women and carrying a high mortality and morbidity risk.

Genital surgery can be performed for a variety of different reasons including medical, cosmetic, psychological, cultural and social. However, this discussion restricts itself solely to cutting rituals performed for cultural and traditional reasons on girls or young women.

FGM has acquired a religious dimension, although it actually predates both Christianity and Islam, and is not included in the formal teachings of the dominant religions. It is often thought of as a Muslim practice, but this is inaccurate as FGM is found in societies holding other beliefs including Christianity and Judaism, and there are many Islamic communities in the world who do not practice FGM (RCGP Patient's Liaison Group on Female Genital Mutilation, 2001).

6.1.1 Current WHO classification of Female Genital Mutilation¹⁵

A joint statement on FGM was issued by the WHO, UNICEF and UNFPA in April, 1997. In it, FGM was defined as follows:

¹⁵ Although the WHO uses the term FGM to refer to cutting rituals on girls, some authors have pointed out that FGM is regarded as a '...value-laden and offensive term to millions of women who do not regard themselves as mutilated...the insensitivity of this term has infuriated many who have dismissed it as yet another western imposed ideal' (Osman El-Tom, 1998; Abu Sahlieh, 1994).

'Female Genital Mutilation comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs whether for cultural or other non-therapeutic reasons' (WHO, 1997).

In addition, four types of FGM were identified:

Type 1: excision of the prepuce, with or without excision of part or all of the clitoris

Type 2: excision of all or part of the labia minora

Type 3: excision of all or part of the external genitalia and stitching or narrowing of the vaginal opening (infibulation)

Type 4: unclassified – this can include pricking, piercing or incising of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterisation of the clitoris and surrounding tissue; scraping of the tissue surrounding the vaginal orifice (angurya cuts); cutting of the vagina (gishiri cuts); introduction of corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow it; and any other procedure that falls under the definition of FGM given above.

FGM is usually performed by traditional practitioners, generally elderly women in the community specially designated for the task, or traditional birth attendants. In some countries, health professionals, trained midwives and physicians are increasingly performing genital mutilation (WHO, 1998).

6.1.2 The consequences of FGM

The immediate and long-term health consequences of FGM vary according to the type and severity of the procedure. Immediate complications can include severe pain, shock, haemorrhage, urine retention, ulceration of the genital region and injury to adjacent tissue. Haemorrhage and infection can cause death (WHO, 2000).

Long-term consequences include cysts and abscesses, keloid scar formation, damage to the urethra leading to urinary incontinence, dyspareunia (pain on sexual intercourse), sexual dysfunction and difficulties with childbirth. There are also psychosexual and psychological consequences such as feelings of incompleteness, anxiety and depression (WHO, 2000).

6.1.3 Justifications for performing FGM

This is a highly complex and controversial area. The justifications for performing the procedure are multiple and inter-related, and reflect the cultural and historical

situation of the societies in which it has developed. Some of the reasons given for performing FGM include:

- custom and tradition
- religion
- preservation of virginity
- social and cultural acceptance (especially regarding marriage)
- concepts of purity and cleanliness
- increasing sexual pleasure for men
- family honour
- a sense of belonging the cultural group and a consequent fear of exclusion
- improving fertility.

(Forward, 2001)

6.1.4 The distribution of FGM

It is estimated that 130 million girls have undergone FGM and that two million girls are at risk of undergoing some form of the procedure every year. The procedure is normally performed on girls between the ages of four and thirteen, but in some cases FGM is performed on babies or on young women prior to marriage or pregnancy (All-Party Parliamentary Group on Population, Development and Reproductive Health, 2000:5). Women and girls who have undergone or are at risk of undergoing FGM are increasingly found in Western Europe and other developed countries, primarily among immigrant and refugee communities.

Due to the sensitivity of the subject, and to neglect of the topic by the scientific community, systematic surveys of FGM have not been undertaken, and there are no comprehensive, country-by-country data available on FGM. On the basis of information available from a few small-scale studies, it is estimated that most women and girls who have undergone or are at risk of undergoing FGM live in 28 African countries. FGM is also found in parts of the Middle and Far East, in isolated communities in other parts of the world, and among African immigrants in Europe, Australia, New Zealand, the US and Canada.

Table 6.1: Estimated prevalence rates for FGM, updated May 2001¹⁶

Please note: Information about the prevalence of FGM comes from sources of variable quality. The data in the table below are organised according to the reliability of estimates.

Country	Estimated percentage (%)	Date information received
Burkina Faso	72	1998/99
Central African Republic	43	1994/95
Côte d'Ivoire	43	1994
Egypt	97	1995
Eritrea	95	1995
Guinea	99	1999
Kenya	38	1998
Mali	94	1995/96
Niger	5	1998
Nigeria	25	1999
Somalia	96-100	1982-93
Sudan	89	1989/90
Tanzania	18	1996
Togo	12	1996
Yemen	23	1997

6.2 FGM IN THE UK

6.2.1 Legislative background

In 1985, the Provision of Female Circumcision Act was passed by the UK Government. This act stated that 'it shall be an offence for any person - a) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia

¹⁶ Source for all above estimates, with the exception of Somalia and Togo: National Demographic and Health Surveys (DHS) from Macro International Inc. (<http://www.measuredhs.int>), Calverton, Maryland. Available on the FORWARD website (www.forward.dicon.co.uk).

minora or clitoris of another person; - or b) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.'

The penalties for a person found guilty of such an offence include a fine or imprisonment for a term not exceeding five years on conviction or indictment, or to six months imprisonment for a summary conviction. However, the All-Party Parliamentary Committee on Population, Development and Reproductive Health pointed out that although a specific Law on FGM does exist, in fact no prosecutions have taken place under this Act in the UK to date¹⁷. The report of the parliamentary hearings on Female Genital Mutilation (All-Party Committee on Population, Development and Reproductive Health, 2000) emphasised the vital role of education on FGM in the UK and abroad in empowering women and communities to implement change.

In 1999 the guide *Working Together to Safeguard Children* was issued jointly by the Department of Health, the Home Office and the Department for Education and Employment which included a clear commitment to education for the promotion of awareness of the harmful nature of FGM (December, 1999).

If on the policy level, FGM is universally condemned and treated as abhorrent, far more complex issues arise for frontline workers and service users who have to deal with the full complexity of the ethical, moral and health-related issues arising from the practice of FGM. One consequence of the unrelenting condemnation of government and health professionals towards FGM was to drive the practice underground, with a resulting increase in mortality and morbidity amongst girls and young women (Black and Debelle, 1995; Webb, 1995). The failure to understand the fundamental interaction of culture, identity and the psyche, and how FGM is intertwined with each resulted in misunderstanding and the perpetuation of dangerous practices within the UK and across Europe. This led to fierce debate amongst health professionals as to the most appropriate way forward in dealing with this emotive and distressing issue.

¹⁷ In 1993, a medical practitioner was struck off the register by the General Medical Council for performing female circumcisions while knowing the procedure was illegal.

Nonetheless, a consensus on future strategies for dealing with FGM is emerging in the UK, with an emphasis on sensitivity and understanding (Walder, 1993) for those who face the issue, alongside firm adherence to the law and the guidelines issued by both the British Medical Association (1996) and the WHO (1998). Although FGM is considered by many as a form of child abuse, some authors argue that it should not be described as such when discussing the issue with parents, as this perspective could be greatly resented (Black and Debelle, 1995). The need for education of parents and victims of FGM is also stressed (Momoh and Kaufman, 1998) as those who attend clinics have often had bad experiences with the authorities in the countries from which they fled. They may feel insecure, judged and mis-understood by what is to them an alien culture.

However, the medicalisation of FGM, i.e. the training of health professionals to carry out such procedures in a controlled environment is not condoned in any sense in the UK. Although this argument cannot be easily dismissed in light of the accounts of the alternative being mutilation by elderly women using crude tools in septic conditions (BMA), most international organisations and national medical associations, including the BMA, agree that health professionals should not carry out FGM and that to do so would constitute a clear breach of human rights.

According to the BMA, an effective approach to eradicating FGM in the UK should involve health care teams, counsellors, social services, educators and, most importantly, members and leaders of communities that practice FGM (BMA, 2001). Organisations such as FORWARD (an organisation set up to campaign for the eradication of FGM) emphasise research according to a participatory model involving the statutory sector, NGOs and community groups working together to develop practical and effective community programmes (FORWARD, 2001). Initiatives such as 'alternative rites of passage', where other activities and rituals replace those traditionally filled by FGM have been introduced, with initial success.

6.3 FGM IN IRELAND

No research dealing with FGM in Ireland was identified during the course of this review. Nor was there any information to indicate that this practice is ongoing in

Ireland. NGOs such as Comhlámh condemn the practice of FGM for three main reasons:

- it causes a universally unacceptable harm to women and girls
 - women suffer severe health consequences and indignity
 - it is an infringement on the physical and psychosexual integrity of women and girls
- and
- it is a form of violence against women.

However, Comhlámh do acknowledge that ‘...FGM is not done as a hateful act. Young girls are genitally mutilated because the parents believe it is in their child’s best interests. It is deeply inscribed in many African countries and is considered necessary for a girl’s progression to adulthood and marriage’ (2001b). The organisation believes that these practices should be changed through and with the communities involved in an open and participatory manner. Any future initiative to quantify the incidence of FGM and to deal with the problems it poses should link in with local communities, community groups and NGOs to ensure that the matter is dealt with in a culturally sensitive manner which is more likely to result in positive change.

7. DISCUSSION

It is clear from the literature available both in Ireland and the UK that the refugee and asylum-seeking experience is highly complex and diverse, and this has been reflected in the multiple research strands that have developed in this area. Given this situation, the risk of unnecessary duplication of research is high. It is therefore necessary to target specific areas that are under-researched or under-prioritised for future research and planning, in order to make the best possible use of available resources. Twenty-one new research or action projects were identified during the course of this review. This indicates a vibrant and dynamic research agenda, but also illustrates the need for consolidation of existing research findings to inform future endeavours.

7.1 WELL-RESEARCHED ISSUES

The information collected on recent and current research in Ireland indicates that research endeavours have concentrated on certain aspects of the refugee and asylum-seeking experience at the expense of other issues.

7.1.1 Needs Analyses

A number of needs analyses are being conducted or have recently been completed around the country. Consolidation of these should provide a detailed picture of the health and social care needs of refugees and asylum-seekers in Ireland, which should aid in service planning and provision in the future. The research being carried out in the Western Health Board area is focused exclusively on health needs and should provide a detailed and comprehensive picture of the health priorities for this group of people from the point of view both of service providers and refugees and asylum-seekers themselves.

7.1.2 Women refugees and asylum-seekers

Recognition has been finally given to the fact that women refugees and asylum-seekers have quite specific experiences and consequent needs on arrival in Ireland. An increasing number of researchers are devoting time to exploring a variety of aspects of women's experiences of seeking asylum and settling in a new country, ranging from maternity care needs, to social support systems, to surviving gender-

based torture. While this trend is encouraging, it may be more advisable to support and work from existing projects and initiatives than initiate new ones. One exception to this, however, is the area of contraception and reproductive health (excluding maternity care). This is a contested area that can be very difficult for women to talk about if they are unsure of themselves, their environment, and their service provider (Smith and Bury, 2000). It deserves specific attention in the culturally challenged context of refugees and asylum-seekers and has not been widely addressed to date. Following on this, there may be a need for health and social service and education agencies to consider the challenges to women and men of parenting young children in a strange host country. Work with Irish homeless women living and parenting in hostel or Bed and Breakfast accommodation has shown this to be a challenged without the addition of cultural issues (Smith, McGee, Shannon and Holohan, 2001).

7.1.3 Mental Health

It has been widely acknowledged throughout the literature that psychological and emotional concerns are of the highest priority in dealing with refugees and asylum-seekers, most of whom have experienced at least some degree of trauma before arriving in the host country. These issues are compounded by the stress of adjusting to a new culture and dealing with the complex and sometimes intimidating legal process of applying for asylum. Many of the research projects identified during the course of this review incorporated a psychological component, although their focus may have been on a particular group such as women or children, or a particular aspect of the refugee experience such as housing or service provision. Thus, although three projects were listed directly under the heading of mental distress, an awareness of the importance of psychological stress and distress is evident throughout the various research strands currently in place. Emphasis should now be placed on consolidation of relevant findings for the purposes of implementation and informing policy and planning.

7.1.4 Housing

The acute accommodation crisis in Dublin has meant that research attention was directed on housing for refugees and asylum-seekers at an early stage. The housing

needs of refugees in Dublin have now been comprehensively researched and identified. However, the introduction of dispersal has had consequences for many other locations within Ireland, and the impact of this on the accommodation services in smaller centres should be monitored in future work.

7.1.5 Children

Finally, refugee children as a discrete group with specific health and social care needs has only recently come to the fore as a priority for both research and action. Academic researchers and the voluntary and community sector responded to the recognition of the needs of refugee children quite rapidly, with the instigation of a number of studies investigating the experiences, psychological stress and needs of these children. However, there are ethical and practical difficulties involved in working with such a vulnerable group of people, especially with regard to unaccompanied minors. The numbers of unaccompanied or separated refugee children in Ireland are still very small, and the danger of over-researching this vulnerable group by directly interviewing them and thereby exposing them to unnecessary stress is high. Caution should be exercised in undertaking research in this area. Consolidation of research findings should be a priority in this area for the moment.

7.2 UNDER-RESEARCHED ISSUES

A number of aspects of the refugee experience have not received as much attention from the research community.

7.2.1. Refugee men

Although the distinct experience of women refugees is recognised and receiving attention, this was carried out in a context where refugees had traditionally been regarded as an undifferentiated group, and a gender-blind approach was undertaken. Now that it is understood that gender informs and underpins not only the experiences of refugees, but how people construct and understand their own refugee status, it is timely to investigate aspects of the refugee experience that are specific to men. A literature search of library, NGO and internet resources revealed almost no existing research on refugee or asylum-seeking men. However, some authors did point out how relationships within refugee families undergo radical transformation and role

reversals. Traditional relations of power can change radically, for example, children acquire new responsibilities (and perhaps rights) if their language skills improve faster than their parents, mothers may attain authority in the host society through roles in their children's schools and in the neighbourhood, and fathers may become more isolated if they lose their traditional position in the family, especially without the authority of the work status they had in their home country (Papadopoulos, 2001; 1999; Papadopoulos and Hildebrand, 1997).

7.2.2 FGM

Although the phenomenon of FGM is not believed to be common in Ireland, the extremely complex ethical and moral issues surrounding it mean that any initiative introduced in the future has to be backed up by a considerable body of research and planning. Current research suggests that the most effective approach to tackling FGM is based on participatory and community development backed up by legislation. If legislation is introduced in isolation, there is a considerable danger that children will be sent abroad to undergo the procedure, or, worse, be subjected to 'back-street' circumcision in Ireland.

7.2.2 Racism

Several recent studies in the UK have clearly identified the existence of widespread institutional racism within the NHS. This should alert Irish service providers to the possibility of racist practices within the health service. It should be pointed out here that some research findings appear to suggest a general level of satisfaction with the health services in Ireland, the only area of difficulty being maternity care. However, ongoing monitoring of health services for potential racism should be introduced in order to prevent the situation deteriorating.

7.2.3 Cultural competence

Unlike the UK, where the concept of cultural competence is increasing in popularity and has been implemented through a range of health projects, only one study that specifically looked at cultural competence has been completed in Ireland (Boyle unpublished). In addition, much of the work in the area of cultural competence or ethnically appropriate health care is either in the form of unpublished material (Boyle, 2001; de Brún, 2001) or is awaiting funding (for example, the project planned by the

Irish College of General Practitioners). Cultural competence as an approach to health care has the advantage of translating awareness and sensitivity to cultural difference into practical action in the health encounter, and any further development of this approach to research and praxis should be encouraged.

7.3 FUTURE DEVELOPMENTS IN RESEARCH STRATEGIES

Almost of all those who were contacted during the review expressed a strong interest in forming stronger links with other researchers in the field. There was a sense of isolation, and a lack of awareness of ongoing work on a national basis. Most of the participants requested a copy of the review or the development of some other mechanism by which information on current research can be exchanged effectively and efficiently. Given the wide range of published and forthcoming research on refugees and asylum-seekers identified through this review, two main steps are recommended.

1. Monitoring and tracking of ongoing research in order to consolidate findings. This would help to focus future research and build up a national picture of the situation of refugees and asylum-seekers in Ireland.
2. Translation of research into action, to implement the recommendations made to date, in future policy, planning, and service provision at the front line. One useful strategy that could be employed in this regard is use of action research methods to build the capacity of service providers and refugee communities to bring about lasting change in health care.

Cronin (unpublished) has argued that it is necessary when researching aspects of ethnicity and health to expand the current range of research methods, with increased emphasis on qualitative approaches. However, if research is to act to empower refugees and asylum-seekers to specify their own priorities for health and social care, they ‘...must be given a say regarding the kind of research to be carried out, the questions to be asked and the methods to be used’ (Cronin, 2000). One methodology which has been used in this situation is that of Participatory Action Research or Participatory Learning and Action. These techniques are capable of accessing both

qualitative and quantitative data, in addition to possessing the necessary flexibility to explore issues of a sensitive nature (O'Reilly-de Brún et al, 2001).

Cronin argues that this approach to research presents a process through which the lay knowledge and culture of the ethnic minority can be respected, while the knowledge and skills of health professionals and researchers can also be respected. Participatory research can provide a process through which all participants can make a relevant contribution. In order to illustrate the process of this type of research, a case study of a project carried out in Croydon is provided below. The technique of rapid participatory appraisal has been used in the UK to provide qualitative information about communities, especially by primary care staff working with deprived populations (Murray, 1999).

7.3.1 Using rapid appraisal to assess needs and identify priority areas for public health action (Valley, Scott and Hallums, 1999)

Due to the difficulties in obtaining accurate demographic information on Croydon's refugee community and concerns about the lack of knowledge of their health and social needs, a needs assessment study by rapid participatory appraisal was carried out by the Department of Public Health Medicine in the Croydon NHS Trust.

Valley, Scott and Hallums (1999) used this approach to assess the needs of refugees in the Croydon area. The research was carried out in two phases. The first phase consisted of identifying the composition and organisation of the local community. A list of local statutory and voluntary sector organisations was drawn up and preliminary discussions were held with key agencies. These meetings led to representatives being identified within each agency who would act as key informants. The second phase involved drawing together a multi-disciplinary team consisting of a senior public health specialist, a Statistics and Information Officer, one specialist registrar and two senior house officers in public health medicine. This team conducted interviews with key local informants, including health visitors, GPs, social workers, teachers, and police officers. In addition, wide-ranging consultation took place with community leaders, co-ordinators of voluntary sector agencies, and so on. Refugees and asylum-seekers were interviewed informally and several group interviews were carried out.

The appraisal succeeded in identifying and prioritising the key health needs of refugees in the area such as access to health care (cultural and language barriers); mental health (experiences of torture; loss of loved ones, home, cultural identity, and support networks); child health (psychological and behavioural problems related to past experiences; dental health; poor rates of immunisation and HIV infection); reproductive health (FGM); poor uptake of antenatal care; poor family planning coverage and poor attendance at cervical screening clinics); infectious diseases (TB and HIV/AIDS); nutrition (lack of access to culturally appropriate foods, compounded by the introduction of Direct Provision); and social factors (inadequate financial support; inadequate accommodation; and refugees' own priorities).

Priority areas for service development were also clearly identified through the rapid appraisal. These included developing interpreting services for refugees and asylum-seekers; improving access to primary health care; and developing a one-stop-shop refugee centre through which appropriate statutory and voluntary services could be delivered.

In conclusion, rapid appraisals provide a means of quickly assessing perceived need within a community. Although to a certain extent it can be described as a 'quick and dirty' approach, this strategy allows key issues to be rapidly identified and prioritised whilst ensuring community participation and ownership of emerging problems, and their solutions.

CHAPTER EIGHT

RECOMMENDATIONS

8.1 SPECIFIC RESEARCH TOPICS

- 8.1.1. Research topics that have already been the focus of sustained attention by the research community in Ireland, in particular work on women refugees and asylum-seekers, on mental health and on housing should now be consolidated and used to inform policy and practice.
- 8.1.2. Research has only recently focused on refugee children. It is expected that further work will commence in the coming year. Concerns have been raised about the danger of over-researching this vulnerable population. Caution should therefore be exercised in planning new projects.
- 8.1.3. Issues specific to male refugees have been under-researched and should be prioritised in future studies.
- 8.1.4. There are no reports of difficulties concerning the practice of female genital mutilation (FGM) in Ireland to date. However, given the estimated high incidence in certain countries which are well-represented among the refugee and asylum-seeking community in this country, it is important to raise awareness of the practice by researching attitudes towards and practice of FGM among refugee communities in Ireland in a sensitive and collaborative manner.

8.2 RESEARCH AND DEVELOPMENT ISSUES

- 8.2.1. Mechanisms for information sharing should be set up to facilitate communication among researchers in the field of ethnicity, refugees and asylum-seekers. These could include:

- funding a resource library for Irish or other relevant reports that are otherwise hard to obtain, such as reports with a limited distribution and post-graduate research projects
- setting up an internet site where research findings and progress reports can be posted
- setting up an e-mail discussion group open to all those with an interest in the area.

8.2.2. It is important to ensure that research findings are translated into action ‘on the ground’. One useful approach is the use of participatory research strategies that empower both service providers and refugee communities to implement change on a grassroots level.

8.2.3. Cultural competence (an awareness and understanding of the nature of cultural difference, combined with the ability to put this awareness and understanding into practice in day-to-day life) has the potential to provide a framework of health service provision which translates awareness of and sensitivity towards cultural difference into practical guidelines for service providers. Research in this area should be encouraged.

8.3 GENERAL SERVICE DELIVERY ISSUES

8.3.1. The Irish health system endorses equity as a key principle underlying service delivery. Mechanisms for ensuring that services are equitably delivered, including being made available regardless of race, socio-economic status or refugee/asylum-seekers status are needed in an accountable system.

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APPENDIX I

THE ASYLUM-SEEKING PROCESS

The initial application for asylum is directed to the Refugee Applications Commissioner (RAC) who has overall responsibility for the asylum application process in Ireland. The offices of the RAC decide on the admissibility of a case, and co-ordinate the entire application process from the initial stages through to the final recommendation to the Minister for Justice, Equality and Law Reform. The offices of the RAC can deal with the application in one of three ways: a) decide that the application should be dealt with in another EU state under the Dublin Convention¹⁸; b) the application can be terminated if the RAC decide that the case is ‘manifestly unfounded’, i.e. those that do not show any grounds for the contention that the applicant is a refugee¹⁹; c) the RAC can consider the application in full. This process consists of an initial interview, questionnaire, possible second interview and recommendation.

Appeals against a recommendation made by the RAC can be submitted to the Refugee Appeals Tribunal (RAT). Appeals must be lodged within ten working days of receipt of the RAC recommendation. Decisions made by the RAT can be further appealed to the High Court. In certain cases High Court decisions can be further appealed to the Supreme Court.

The Legal Aid Board set up the Refugee Legal Service in 1999 to provide legal services throughout the asylum application process. However, the service is having difficulty in handling the volume of work, and asylum-seekers who have been dispersed outside Dublin are disadvantaged as the service is Dublin-based (Comhlámh, 2001a). As at April, 2000, the Department of Justice, Equality and Law Reform (2000a) estimated that ‘first stage’ applications were being processed within a four to thirteen month period, with appeals taking approximately twelve months to deal with (Barnardos, 2000).

¹⁸ The Dublin Convention came into force in 1997. If an applicant for asylum has entered the State through another Convention country, has lodged or applied for asylum in another Convention country, or has held a valid visa or residence permit for another Convention country, the Irish State can request that Convention country to accept responsibility for the application for asylum, in which case the applicant will be transferred back to that country (Department of Justice, Equality and Law Reform, 2000).

¹⁹ Full grounds for determining that a case is manifestly unfounded are set out in section twelve of the Refugee Act (1996).

APPENDIX II

ENTITLEMENTS OF REFUGEES AND ASYLUM-SEEKERS

Prior to April, 2000, asylum-seekers in Ireland were entitled to social welfare payments and rent allowances while their applications were being processed. However, the concentration of asylum-seekers in urban centres, especially the poorer inner city areas of Dublin, caused grievances in areas where there was already a significant degree of social exclusion and accommodation pressure. As a result, the Department of Justice, Equality and Law Reform introduced the Dispersal and Direct Provision Programme in April, 2000 (2000b).

Dispersal

Once an application for asylum is lodged with the Refugee Applications Commissioner (RAC), applicants are referred to the Reception and Integration Agency (RIA). Temporary accommodation is arranged in Dublin for up to ten days. Asylum-seekers are relocated from here to accommodation dispersed around the country. At the end of January 2001, the RIA was operating 63 such accommodation centres, located in 21 counties and hosting a total of 3,901 residents (Comhlámh, 2001a).

Direct Provision:

Asylum-seekers who are dispersed to accommodation centres are given accommodation on a full board basis. Three meals a day are provided. Adult asylum-seekers living in these accommodation centres are given a 'Residual Income Maintenance Payment' for personal needs of £15 per week. £7.50 is allocated per child. A number of non-governmental organisations such as Comhlámh, (2001a); The Irish Refugee Council, (2001); Barnardos, (2000); and Amnesty International, (FAQs Research/Loyal and Mulcahy, 2001) have criticised this payment as insufficient and discriminatory.

Other Entitlements

Asylum-seekers on direct provision are entitled to 'Exceptional Needs Payments' from the Department of Social, Community and Family Affairs for requirements such as school purchases, or the purchase of winter clothing. Asylum-seekers on direct provision who have children are entitled to full Child Benefit. However, recent

research (Comhlámh, 2001a) has indicated that many asylum-seekers are not aware of the full range of benefits and services to which they are entitled.

Health Care Entitlements for Asylum-Seekers

On arrival at a Reception and Integration Centre, asylum-seekers have access to a number of health and social services provided on-site. Medical screening services (covering tuberculosis, hepatitis B and C, diphtheria, polio and HIV) are offered to all applicants for asylum on a voluntary basis. Consultation with an in-house psychologist can be arranged if necessary or if requested by an asylum-seeker. All asylum-seekers are entitled to apply for a medical card. If their application is successful, they may register with a general practitioner. Asylum-seekers also have the right to access the health services on the same basis as an Irish citizen (de Brún, 2001).

APPENDIX III

Irish refugee and asylum seeker research projects (in progress) identified through the review

Title	Theme	Target group	Methods	Challenges	Study dates	Status	Agencies involved	Contact
<p>1) Psychological distress among refugees and asylum seekers in Ireland (M.Litt)</p>	Sources of stress, manifestations of psychological distress, and social support	All those who have been through the asylum-seeking process	<ol style="list-style-type: none"> 1) Sociodemographic questionnaire 2) SCL – 90-R (Symptom Checklist 90 Revised) 3) Perceived social support measure (emotional support) 4) Perceived discrimination scale 5) Post-migration stress checklist 6) Semi-structured interview 7) Incidents of perceived discrimination (semi-structured) 8) Concluding questions 9) Sample – purposeful sample using ngos as access point. Projected n=100 	<p>Access to population</p> <p>Access to interpreters/language barrier</p>	October, 2001 (to finish October, 2002)	Initial data collection phase	<p>Department of Psychology University College Dublin</p> <p>Government of Ireland grant</p>	<p>Mr Dermot Ryan Department of Psychology, UCD</p> <p>Tel: 01-7168368/8369</p>
<p>2) Psychosocial needs, social support and estimates of psychological distress among unaccompanied minors</p>	Exploration of psychological needs of unaccompanied minors, in order to inform policy, services and practices	Unaccompanied minors in the ERHA area (note: authors' concern about over-researching this group)	<p>Qualitative and quantitative data derived with 28 accompanied minors (randomly selected). Interview using semi-structured format and formal measures as follows:</p> <ol style="list-style-type: none"> (i) AZR (variation of Achenbach CB Checklist) (ii) Social network map (iii) post-migration living problem checklist <p>Interpreters used as necessary</p>	<ol style="list-style-type: none"> 1) Sometimes overwhelming emotional aspects in relation to material from participants 2) Logistics, e.g. random selection and meeting with participants throughout geographical area 3) Locating appropriate measures for the population 4) Ethical considerations such as protection of a vulnerable target group 	January to June, 2001	Submitted in partial fulfilment of research requirements for doctorate in Clinical Psychology, Queen's University of Belfast	<p>Psychology service for refugees and asylum-seekers, NAHB (Ms J. Ryland)/Doctoral programme in Clinical Psychology, Queen's University of Belfast (Professor N. Sheehy)</p> <p>Tel: 0044-28-90335445</p>	<p>Ms Avril Rea, Basic Grade Clinical Psychologist, North-Western Health Board, Sligo. After November 2001, Ms Jennifer Ryland, Psychology Service for Refugees and Asylum-seekers, NAHB, St Brendan's Hospital, Dublin.</p>

Title	Theme	Target group	Methods	Challenges	Study dates	Status	Agencies involved	Contact
3) Meeting refugee health needs – demands and challenges	Barriers to accessing health care from the perspective of both refugees and asylum-seekers and health practitioners	Refugees and asylum-seekers, general practitioners, public health nurses and acute hospital wards (obstetrics and gynaecology, paediatrics and A+E)	Phase one: questionnaire survey, demographic and knowledge of services full pop. refugees Phase two: survey of service utilisation Also – case studies – 5 reception centres, 3 refugees from each (male:female 2:1). Interviews with GPs and PHNs. Selected staff from hospitals.	Access	October, 2001 – February 2002	Negotiating access for data collection (09/10/01)	Department of Public Health, Western Health Board	Dr Treasa Galvin, Department of Sociology, TCD. Tel: 01-6082621 Dr David Evans, Department of Public Health, Western Health Board
4) Meeting the needs of asylum-seekers in Tralee	An analysis of the needs of asylum-seekers living in Tralee. Included population profile analysis of service provision in Kerry	Asylum-seekers living in Tralee town, County Kerry	Quantitative and qualitative methods: Questionnaires and interviews conducted with asylum-seekers (questionnaires in 6 languages) and local and national service providers.	Accessing asylum seekers	October 2000-April 2001	Completed Only Executive Summary available at present. Full version due to be published by Partnership Tra Li	Commissioned by Partnership Tra Li. Undertaken by Kerry Action for Development (KADE). Author: Aoife Collins.	Ms Barbara Eames, Partnership Tra Li Tralee, County Kerry. Tel: 066-7180190
5) Working title: 'The Needs of Asylum-seekers in Cork'	Similar analysis as Tralee needs analysis above: Population profile and analysis of wide variety of needs of asylum-seekers living in Cork city	Asylum-seekers living in Cork city. Including those in both direct provision and private rented accommodation	Quantitative and qualitative methods. Questionnaires (different languages) and interviews with asylum-seekers	Accessing asylum-seekers. Getting into direct provision centres and meeting those in private rented accommodation.	August 2001-end November 2001	In progress.	Undertaken by NASC and the Irish Centre for Migration Studies. Author: Aoife Collins. Funded by Cork City Partnership	Ms Aoife Collins, NASC, Cork Tel: 021-4317411
6) Refugees and asylum-seekers in County Monaghan – population profile and needs analysis	Health, education, training, employment, child care, accommodation, information, interpretation, legal, others	Refugees, asylum-seekers, and service providers	Qualitative focus groups held with service providers and refugees and asylum-seekers		August 2001-September 2001 (data collection and final report)	In preparation for publication, to be published in early November 2001	Monaghan Partnership/Monaghan County Council/Funded ADM – Peace and Reconciliation and Partnership	Ms Eimear Doyle Monaghan Partnership Tel: 047-71818

Title	Theme	Target group	Methods	Challenges	Study dates	Status	Agencies involved	Contact
7) Women asylum-seekers/refugees delivering in Dublin maternity hospitals and their children: health needs, pregnancy outcomes and satisfaction (PhD)	Maternity health needs and needs of existing children	Women and children refugees and asylum-seekers. Service providers	Three Dublin hospitals (Coombe, Holles St, Rotunda) = study sites. 75% quantitative questionnaire 25% qualitative		Early 2002 – Summer 2004	Awaiting ethical approval	Department of Public Health Medicine and Epidemiology, UCD Health Research Board funding	Ms Suzanne Lyons, Department of Public Health Medicine and Epidemiology, UCD. Tel: 01-7167345
8) Refugees/asylum-seekers/migrant workers as patients in general practice	Needs of GPs	Refugees/asylum-seekers/migrant workers/GPs	Not finalised	Funding	October, 2001	Awaiting funding November 2001	Irish College of General Practitioners Reception and Integration Centre, Department of Justice, Equality and Law Reform Department of Health and Children	Mr Dermot Folan, Irish College of General Practitioners Tel: 01-6763705
9) 'Seeking Asylum in Ireland'	Reception services for asylum-seekers as perceived by statutory sector and Community and Welfare Officers	Service providers, statutory sector and Community and Welfare Officers in particular	1) Analysis of statistical data on asylum-seekers in Ireland within wider European and global context 2) Analysis of data from ERHA on asylum-seekers within the region		To end 2001	Ongoing	The Social Science Research Centre, UCD	Dr Pauline Faughnan, Social Science Research Centre, UCD Tel: 7167009
10) 'Towards Inter-culturalism –	Analysis of the role of the voluntary and community organisations	Voluntary and community organisations and staff	Survey component Action Research component		Survey component to end 2001. Action research	Ongoing	The Social Science Research Centre, UCD	Dr Pauline Faughnan, Social Science Research Centre, UCD

The Role of the Voluntary and Community Sector'	nationally in promoting a multi-cultural society and the challenges				component from 2001, to early months of 2002			Tel: 7167009
11) 'Local Issues with Global Connections: The Relevance of Refugee and Asylum Issues for Local Authorities in Kerry'	Explored the ways in which local government in Kerry can become more informed about refugee and asylum issues	Statutory and non-statutory key informants (included survey of their views on the relevance of refugee issues to local authorities).	Semi-structured interviews with key informants		April 2001-July 2001	Completed but unpublished. Due to be published and launched over next couple of months	Commissioned by Kerry Action for Development Education. Author: Aoife Collins. Funded by the Combat Poverty Agency	Ms Mary MacGillicuddy, Kerry Action for Development Education, Tralee. Tel: 066-7181358
Title	Theme	Target group	Methods	Challenges	Study dates	Status	Agencies involved	Contact
12) Working title: 'The Role of NGOs in the Reception and Integration of Asylum-seekers, Refugees and Immigrants in Ireland'	Needs, service and policy analysis. Particular focus on international perspectives on integration and service provision.	Asylum-seekers, refugees and immigrants	Quantitative and qualitative methods		November/December 2001 – Open end date	Beginning November or December 2001	Irish Centre for Migration Studies, Funded by the Royal Irish Academy	Mr Piaras MacEinri, Irish Centre for Migration Studies, UCC. Tel: 021-4902889
13) No specific title	Dental screening of children aged 5 to 16 in Mosney	Refugee and asylum-seeking children	Used screening protocol for the forthcoming National Children's Dental Survey. Total population screened.		July – August 2001 Data Analysis to November, 2001.	Data analysis ongoing	The North-Eastern Health Board and the Oral Health Services Research Centre, UCC	Dr Mary O'Farrell Oral Health Services Research Centre, UCC Tel: 021-4901211

<p>14) Beyond the Pale – Asylum-seeking Children and Social Exclusion Ireland</p>	<p>Asylum-seeker children and families, poverty, social exclusion, direct provision, psychosocial impact</p>	<p>Asylum-seeker children and families in direct provision and in community settings</p>	<p>1) Quantitative – basic child poverty indicators recorded using a questionnaire 2) Qualitative – individual interviews with parents and children and workshop methodologies with adults and children</p>	<p>Workshops were difficult to implement. Asylum-seekers, especially those on direct provision, are separated from indigenous communities – no shared language or culture or experiences of community to set climate for group work. Hostel settings not conducive. Physical marginality and transport difficulties made participation in non-hostel settings difficult.</p>	<p>January – June 2001</p>	<p>Launched November 2001 (see bibliography for reference)</p>	<p>Department of Applied Psychology, UCC. The Combat Poverty Agency</p>	<p>Dr Angela Veale, Department of Applied Psychology, UCC Tel: 021-4904551</p>
<p>Title</p>	<p>Theme</p>	<p>Target group</p>	<p>Methods</p>	<p>Challenges</p>	<p>Study dates</p>	<p>Status</p>	<p>Agencies involved</p>	<p>Contact</p>
<p>15) Unaccompanied minors seeking asylum in Ireland (working title)</p>	<p>Information leaflet for service providers in the community</p>	<p>Voluntary organisations, schools, GPs, etc.</p>	<p>1) Data gathered from UNHCR, and other international organisations 2) Secondary statistical data gathered from Refugee Applications Commissioner 3) Interview (semi-structured) from social work team unaccompanied minors in Baggot Street 4) Informal consultations with representatives from</p>		<p>End September 2001 – mid December 2001</p>	<p>Compiling information and entitlements</p>	<p>Centre for Social and Educational Research/Barnardos</p>	<p>Ms Dearbhla King Centre for Social and Educational Research, Dublin Institute of Technology Tel: 01-4023491</p>

			UNHCR and the refugee project – Irish Commission for Justice and Peace. Also voluntary organisations and community welfare officers 5) Questionnaires to list of relevant organisations and groups working with refugees (n=40)					
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16) Training programme for Roma Women – Pilot Programme	Training in personal development, literacy, English for 16 Roma children	The Roma community	Evaluation methods not ascertained yet		November, 2001	Planning phase	Pavee Point	Ms Brigit Quirke Pavee Point Tel: 01-8780255
17) REFWORLD Ireland Directory	Directory of statutory and voluntary organisations delivering services to refugees and asylum-seekers in Ireland	Convention and Programme refugees and asylum-seekers	Standardised questionnaire distributed to all organisations, supplemented by documentary research		Early 2000-end 2001	Research completed. Now in final draft phase before publication end 2001	Spirasi/Eastern Regional Health Authority	Fr Mike Begley, Spirasi Tel: 01-8389664
Title	Theme	Target group	Methods	Challenges	Study dates	Status	Agencies involved	Contact
18) The Experiences of General Practitioners and Immigrant Health	Explore the knowledge and practice attitudes of GPs to all immigrants (focus on refugees, asylum-seekers and survivors of torture)	Convention and Programme refugees/asylum-seekers and survivors of torture	Postal questionnaire administered to random sample of GMS general practitioners in the ERHA region (n=100). Planned as pilot study. Intention to conduct larger study comparing findings from Ireland and UK		2000-2001 (projected)	Research completed. Now in write-up phase	Spirasi. Department of Tropical Medicine and International Health, RCSI	Fr Mike Begley, Spirasi Tel: 01-8389664
19) Responses of the Social Work Profession to Asylum-seekers	Perceptions of citizenship/the work of social workers/the profession of social work	Social workers/refugees and asylum-seekers	Semi-structured interviews to be carried out over the next year		2001-2002	Initial planning and literature review stage	Department of Applied Social Studies, UCC/Münster University/The Royal Irish Academy German Academic Exchange Service (DAAD)	Dr Alastair Christie, Department of Applied Social Studies, UCC.
20) Anti-racist	An information guide for local	Local people of the north-east inner city	Consultation with local people and community.		October, 2001 – end of	Initial project outline	Inner City Organisation Network	Ms Patricia McCarthy, Inner

pack for inner-city projects	people and groups tackling issues of racism	and community groups	Most frequently occurring questions and stereotypical views identified. Pack tailored to answer these questions		December, 2001.	completed. Awaiting funding from Department of Justice, Equality and Law Reform	Department of Justice, Equality and Law Reform	City Organisations Network Tel: 01-8366890
21) Health Advocates project (working title)	Training refugees and asylum-seekers to work as cultural health advocates in the community	Refugees and asylum-seekers	Still in planning stages		2001-2002 ongoing	Initial planning stage	Ms Ann Moroney, Access Ireland	Ms Ann Moroney Access Ireland Tel: 01-8780587