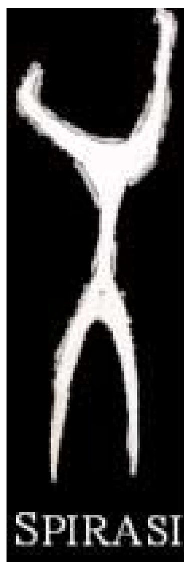
# An Evaluation of the HEALTH INFORMATION PROGRAMME 2002 – 2003

**A Pilot Programme between:**

**The Spiritan Asylum Services Initiative,**

**The Northern Area Health Board and**

**The Reception and Integration Agency**

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## Abbreviations

| | |
|---|---|
| **A&E** | Accident and Emergency (Hospitals) |
| **AMO** | Area Medical Officer (Public Health Doctor) |
| **ANC** | Ante Natal Care |
| **AS** | Asylum Seeker |
| **CWO** | Community Welfare Officer |
| **CCST** | Centre for the Care of Survivors of Torture |
| **GP** | General Practitioner |
| **HB** | Health Board |
| **HIP** | Health Information Programme |
| **IBC** | Irish Born Child |
| **NAHB** | Northern Area Health Board |
| **NCs** | New Communities |
| **NGO/s** | Non-Government Organisation/s |
| **RIA** | Reception and Integration Agency |
| **RIS** | Refugee Information Service |
| **RLS** | Refugee Legal Services |
| **Spirasi** | Spiritan Asylum Seekers Initiative |

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# Executive Summary

## 1. The Health Information Programme

The Health Information Programme (HIP) is a one year pilot project between three partners:

The Spiritan Asylum Services Initiative (SPIRASI)
The Northern Area Health Board (NAHB) and
The Reception and Integration Agency (RIA).

The Centre for the Care of Survivors of Torture (CCST), a specialist service operated under the auspices of SPIRASI, also served as a stakeholder.

Arising from discussions held by a multi-agency group, established by the Northern Area Health Board to examine health promotion issues for asylum seekers and refugees, one of the principle needs identified was the lack of accurate and comprehensive information on health services for newly arrived asylum seekers. This was impacting negatively on asylum seekers who, in many cases, were not availing of appropriate health services, and on service providers who found they were spending a great deal of time explaining the system to asylum seekers.

In order to tackle this need a Steering Committee, comprising the stakeholders listed above, was formed to oversee the establishment and management of a peer led health information programme located at SPIRASI. It was felt the programme would be most effective if delivered by suitably qualified personnel who, ideally, had first hand experience of the asylum and refugee process, hence the peer led nature.

Based at SPIRASI, the HIP Team, comprising three HIP Workers & a Co-ordinator, commenced delivery of the programme in early 2003 to newly arrived asylum seekers at the three main Reception Centres in Dublin: Parnell West Hotel, Kilmacud House and Balseskin Centre.

At this time the Northern Area Health Board were the sole funders of the Programme. From the outset, in order to assess the success and effectiveness, it was agreed external evaluation of the Programme was imperative. As a result an evaluator began working with the Programme early in 2003.This Report is the result of that evaluation.

## 2. Aims and Objectives

While the main aim, justification and methodology of the HIP were drawn up before the commencement of the Programme, specific objectives were not. Part of the evaluation process involved in this Report included working with the Programme Co-ordinator to agree key objectives. These are summarised as follows:

### Overall Goal

**To contribute to the positive integration and the full participation of asylum seekers in Irish Society, improving their quality of life and welfare, by facilitating improved access to health services and entitlements.**

### Main Aim

**To increase the capacity of asylum seekers to make more informed decisions about their health care by facilitating the improved understanding, access and interaction with statutory health services during the reception phase of the asylum process**

## Objectives of the Programme

- To disseminate information about the Irish health services to asylum seekers at the point of entry into the Irish State
- To facilitate asylum seekers to use the Irish Health services more appropriately
- To model a peer led health information programme and to identify the lessons from this approach for health promotion purposes.

## 3. Commencement of the Programme

The operational work of HIP began on January 13th 2003: information on Irish Health Services was delivered to newly arrived asylum seekers at the three main Reception Centres once a week.

During the course of the pilot, changes in Government policy and other factors impacted the delivery of the programme. The most significant of these were:

- Newly arrived asylum seekers no longer had the option of moving into the private rented sector.
- The Supreme Court issued its judgement in relation to the non-national parents of Irish born children.
- The strike by Public Health Doctors meant no health screening was carried out for ten weeks in 2003.
- An outbreak of chicken pox in the largest reception centre restricting delivery of the programme.

During the course of the programme in 2003, the HIP Team and Steering Committee considered it a priority to further develop culturally and linguistically appropriate materials for use during the sessions. The new materials assist with demonstrating the different roles and functions of various health service providers e.g. general practitioners, health screening doctors, CWO's, Public Health Nurses etc. The materials were formally launched at the SPIRASI premises by Mr. Ivor Calelly T.D., Minister for State at the Department of Health and Children, on World Refugee Day 20th June 2003.

## 4. Structure of the Report

The Report consists of five sections with two appendices.
**Section 1** sets out the Background, Context and Aims and Objectives of the HIP Programme.
**Section 2** sets out the Evaluation Methodology which includes the development of a plan to evaluate (a) the establishment phase, (b) the implementation phase and (c) the final evaluation phase. The evaluation objectives were agreed in the terms of reference and were:

- To assess the dissemination of health information to asylum seekers in a manner that has increased their capacity to make informed decisions about their health care.
- To assess the programmes effectiveness in increasing asylum seekers understanding, access and interaction with key Irish health services.

- To assess the transferability nationally of a peer led programme vis-à-vis the needs of both asylum seekers and service providers.

Detailed descriptions of the evaluation methodology are contained in Appendix 1.

The evaluation framework used in HIP is the Five Nations Model (used in the community development sector in Ireland) with six key evaluation components as follows: It explores (i) the Story of the programme, (ii) the Successes and Disappointments, (iii) establishes overall Learning and Critical issues, (iv) evaluates progress against Aims and Objectives, (v) identifies Impact of the project at individual, organisational, community and policy levels and (vi) evaluates Quality.

**Section 3** deals with quantitative data. In all, 868 persons attended the sessions (594 female or 68% of total; 257 males or 30% and 19 unknown or 2% of total). Those attending were predominantly in the 20 to 39 year age group and the vast majority indicated they could communicate through English but this does not mean they could comprehend what was said. **Section 4** deals in detail with the qualitative data under the six components of the evaluation model outlined under Section 2 above. In informing its analysis of the impact of the HIP, the author compared the effect on those asylum seekers who attended the Programme (study group) and those who did not (control group) as regards their relative understanding of the various roles of health service providers and the delivery mechanisms for health services in Ireland. This section states, inter alia, that **the main aim of the programme and its three objectives were substantively met** (see aims and objectives above). The section also deals with the transferability of the model pointing out that it should not be transferred en bloc and some elements require further research.

**Section 5** deals with the learning and critical issues for the future under three main headings Organisational, Operational and Strategic.

## 5. The Reports Conclusions and Recommendations

***Conclusions***

The programme has met all its key objectives:

- It successfully disseminated information about Irish health services to asylum seekers at the point of entry into the Irish State.
- It facilitated asylum seekers to use the Irish health services more appropriately.
- It successfully modelled a peer-led information programme and identified lessons from the approach for health promotion purposes.

The Programme proved the need for, and effectiveness of, a peer led and person centred approach to the health information needs of asylum seekers. It also proved the importance of an independent model. There was unanimous support by the two key stakeholders, asylum seekers and health service providers, for the continuation of the programme.

Asylum seekers at point of entry have broader needs than assessing base information about Irish health services; there is a need for a holistic approach to health promotion with asylum seekers. A modular approach which incorporates a focus on two main areas would meet the broader needs of the group: (a) Information on Irish health services and how they operate and (b) a focus on broader health promotion. The model should also incorporate a mediation role.

There is an ongoing need for health information and health promotion for asylum seekers at Accommodation Centres and at other points of dispersal.

Core elements of the model - peer and person centre, the employment of staff, the material and the adult education methodology are transferable to Reception and/or Accommodation Centres throughout the country. However the model should not be transferred en bloc as a number of key elements need redesigning and development. For the Transferability of the model see Appendix 3. A key evaluation objective was to assess the transferability of the model.

The partnership approach between the statutory and voluntary sectors has been a key element in the success of the programme.

## Recommendations

*Overall Recommendation:*
As the Programme has clearly demonstrated its value it should continue as a model of peer-led health information. When considering the continuation of the programme, the following specific recommendations might be of use:

### 1. Expansion:

1.1. In any development of this programme or in new programmes the key elements which contributed to its success should be retained i.e.
The partnership approach
The peer-led approach.
The methodology.
Full-time paid staff

1.2. The existing programme should be expanded in the following manner:
Its content should be broadened beyond the dissemination of health information to include a broader health promotion role and mediation role.
The culturally and linguistically appropriate materials developed as part of the pilot should be further refined and expanded.
The programme should be made available to asylum seekers who were unable to attend while in the reception centres, possibly at centres where asylum seekers go to avail of other services and supports such as non governmental agencies and support groups.

1.3. Consideration should be given to the provision of similar peer-led programmes in other health board regions of the country to supplement the information provided in the Dublin centres. Such programmes should be adapted to the needs of the asylum seekers residing in the region.

1.4. Prior to the expansion of the existing programme or the development of similar programmes elsewhere, an assessment of the health information and health promotion needs of asylum seekers should be conducted.

1.5. In expanding the existing programme or in developing new programmes consideration should be given to expanding the range of languages available to the programmes.

## 2. Staff Support & Development:

2.1. Support for the health information workers needs to be properly assessed and addressed in the continuation of this programme and in any new programmes.

2.2. The role of the existing HIP team should be addressed in the context of the contribution they can make to the development of similar programmes in other areas. This needs to be done in a way that does not detrimentally affect the continuation of the existing programme.

2.3. Ongoing training is essential for the HIP health information workers and in particular timely information on any changes in health board or Government policy in relation to asylum seekers.

## 3. Inter-agency Communication and Partnership:

3.1. Communication between health information programmes and health service providers should commence before the start of any new programmes and should be an ongoing integral part of the programme.

3.2. In promoting the existing and any new programmes there is a need to mobilise key people and resources to ensure newly arrived asylum seekers are aware both of the existence and the value of the information sessions e.g. managers and staff in reception centres, staff and information booklets of RIA etc.

3.3. The placement of this programme within an NGO has proved successful. However, in any further developments consideration should also be given to other options including its placement within mainstream health services.

## 4. Sustainability:

4.1. Realistic co-funding should be identified and secured from other relevant statutory agencies that could benefit from the provision of Health and Welfare Information to asylum seekers on arrival in Ireland. This would be important both for the existing programme and for expansion of this programme and the development of similar programmes.

# 1. Introduction and Background

## 1.1 Introduction and Background

The Health Information Programme (HIP) is a pilot project between three partners:

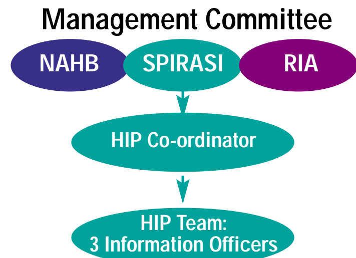



**Figure 1.** HIP ORGANOGRAM

- The Spiritan Asylum Services Initiative (SPIRASI) which is a response of the Spiritans Holy Ghost Congregation to the situation of asylum seekers in Ireland.
- The Northern Area Health Board (NAHB) which is responsible for health services and funded the initiative.
- The Reception and Integration Agency (RIA) which manages the accommodation needs of asylum seekers at reception centres.

The Centre for the Care of Survivors of Torture (CCST), a specialist service operated under the auspices of SPIRASI, also served as a stakeholder.

The idea for the programme arose from discussions at a multi-agency group established by the Northern Area Health Board to examine health promotion issues for asylum seekers and refugees. One of the issues identified by this group was the lack of accurate and comprehensive information on health services for newly arrived asylum seekers. This impacted both on asylum seekers as in many cases they were not availing of appropriate health services and also on service providers who found they were spending a great deal of time explaining the system to asylum seekers. The first response of the health board was to commission an information video in four languages. A multi-agency advisory group, comprising health service providers and members of various ethnic minorities was established and the video was produced early in 2001.

It soon became obvious that the video in itself was not sufficient to meet the need. As a result, SPIRASI submitted a proposal to develop a peer-led information project. A management group was established to examine this proposal and to oversee its implementation. As indicated above, this group consisted of representatives from SPIRASI, the NAHB and the RIA. The Northern Area Health Board agreed to provide the funding for a pilot programme for a one year period. It was also agreed that external evaluation of the programme should commence at an early stage in the programme.

## 1.2 Context

During the course of the pilot a number of changes occurred in Government policy that impacted on the people delivering the programme. Also, a number of unforeseen events occurred that also had an impact on the programme. These are important to note as it is likely that in the context of providing services to asylum seekers or refugees there will always be changes that will impact on a programme and that will require a significant degree of flexibility in its planning and implementation. The most significant changes that occurred during the course of the pilot programme were:

- Government policy in relation to direct provision changed. Newly arrived asylum seekers would no longer have the option of moving into the private rented sector. Their ongoing

accommodation would be met solely by the Reception and Integration Agency. This resulted in a lot of questions to the Health Information Team on this issue.

- Government The Supreme Court issued its judgement in relation to the non-national parents of Irish born children. The effect of this judgement is that non-national parents of Irish born children may now be deported following a review of their case. This also led to many questions to the Health Information Team.
- Government For ten weeks of the pilot programme there was no health screening carried out in the reception centres due to an industrial dispute by public health doctors. This made it very difficult to measure the impact of the programme on the take-up of health screening.
- Government There was an outbreak of chicken pox in the largest reception centre that disrupted the delivery of the programme for a period.

## 1.3 The Health Information Programme

While HIP is a joint initiative and managed by a management committee with representatives from each of the partners, it is housed and administered by SPIRASI from its premises on the North Circular Road, Dublin. The HIP initiative was delivered by a team which included a Coordinator and three Health Information Officers under the direction of the HIP management committee.[1]

The operational phase of the Health Information Programme commenced on 1st September 2002 with the appointment of the full time Programme Co-ordinator, and following this, on 1st November 2002 with the appointment of the three full time Health Information Project Officers. From September to December 2002, HIP was involved in the organisational development of the Programme. This consisted of an orientation in Spirasi, development of an understanding of Irish health services, accessing of resources, development and building of the team, establishment of structures and administrative systems for the Programme, development of presentation material, development of the session design and the piloting of these sessions.

The HIP office is located in a newly installed and furnished portacabin in SPIRASI which houses the co-ordinator. It was initially envisaged that the HIP officers would spend the majority of their time in the reception centres as outreach workers and so no provision for dedicated office space for them at SPIRASI was made by the management committee. As this need became apparent, an interim solution for the pilot phase was made involving the allocation of a staff meeting room for the HIP officers.

### 1.3.1. The Aims and Objectives of HIP

While the main aim of HIP was drawn up before the commencement of the project, as was the justification for and methodology of the Programme, specific objectives were not. Part of the evaluation process was to work with HIP using the information from a logframe developed by the coordinator to agree its key objectives. These were agreed in the Evaluation Terms of Reference to be:

**Overall Goal**

**To contribute to the positive integration and full participation of asylum seekers in Irish Society, improving their quality of life and welfare, by facilitating improved access to health services and entitlements.**

[1] Members of the HIP Management Committee: Frank Mills(NAHB), Frank Edwards (RIA), Michael Begley (SPIRASI), Richard Tomkin (CCST), Pamela Howard (RIA), Mike Walker (CCST) and Lisa Mauro-Bracken (HIP).

## Main Aim

To increase the capacity of asylum seekers to make more informed decisions about their health care by facilitating the improved understanding, access to and interaction with statutory health services during the reception phase of the asylum process

## Objectives of the Programme

1. *To disseminate information about the Irish health services to asylum seekers at the point of entry into the Irish State*
2. *To facilitate asylum seekers to use the Irish Health services more appropriately,*
3. *To model a peer-led health information programme and to identify the lessons from this approach for health promotion purposes*

### 1.3.2. The Health Information Sessions

The operational work of HIP began on January 13th 2003. The information on Irish Health services was delivered once a week at the three main Reception centres in the greater Dublin area – Parnell West Hotel (Parnell Square), Kilmacud House (Stillorgan) and Balseskin (St. Margaret's, Finglas). In addition, there are two satellite centres for newly arrived asylum seekers at North Frederick St. and Gardiner Place. Voluntary health screening is available in each of the three main reception centres. Health screening is arranged for residents of Gardiner Place and Frederick Street in the Parnell West Hotel.

A maternity outreach clinic funded by the Northern Area Health Board with staff provided by the Rotunda Hospital operates in Balseskin Reception Centre. Initial ante natal blood tests and ultrasound scans are performed in the clinic with a decision on fitness for resettlement outside Dublin made by a consultant obstetrician.

The Health Information Programme consisted of the presentation of information on the Irish Health services in the three reception centres for a morning once a week at each centre. Although the original vision for the afternoons was to involve one to one sessions with residents, the reality has been a combination of one to one interactions, language-related information sessions and repeat group discussions with additional participants. Three team members worked collectively in each session due to both language and support needs. The two other days were allocated to the organisational and planning aspects of the programme and occurred at SPIRASI. The following schedule represents a sample weekly plan for the programme.

| Time | Monday | Tuesday | Wednesday | Thursday | Friday |
|---|---|---|---|---|---|
| AM | SPIRASI Planning 9:30 10:30 | PARNELL WEST Group Session: 10:30 | KILMACUD Group Session: 10:30 | BALSESKIN Group Session 10:30 | SPIRASI Debrief: 9:30 10:30 |
| PM | Prep for week; Report writing Research | 1 to 1/group 2:00 | 1/group 2:00 | 1 to 1/group 2:00 | Reporting Network |

# 2. Evaluation Methodology

## 2.1 The Evaluation Process

The Health Information Programme (HIP) sought the services of an external evaluator in late 2002. The evaluator began working with the Programme early in 2003. Developing an evaluation plan involved three phases. These were:

**Phase 1: Establishment Phase**

- ✓ Collection of project and other relevant documentation
- ✓ Agreeing the broad parameter of the evaluation
- ✓ Evaluation training for the HIP team
- ✓ Identifying the quality and quantitative data required for evaluation purposes
- ✓ Meeting with stakeholders including the HIP staff team for familiarisation purposes and to develop the measures of success for evaluating the programme
- ✓ Drawing up and agreeing detailed Terms of Reference

**Phase 2: Implementation Phase**

- ✓ Drawing up and agreeing a detailed methodology for the final evaluation
- ✓ Evaluating the early days of the Programme – September – December 2002.
- ✓ Observation of the HIP sessions in each of the three centres

**Phase 3: Final Evaluation Phase**

- ✓ A focus group meeting was held with all stakeholders composed of two groups of participants, the HIP Management Committee, Programme staff, health service providers and two control groups of non-participants
- ✓ Evaluation report writing
- ✓ Consultation on the report
- ✓ Final Report.

Detail descriptions of the evaluation methodology are contained in *Appendix 1.*

## 2.2 Evaluation Objectives

The evaluation objectives were agreed in the Terms of Reference and were:

- *To assess the dissemination of health information to asylum seekers in a manner that has increased their capacity to make informed decisions about their health care*
- *To assess the programmes' effectiveness in increasing asylum seekers' understanding of, access to and interaction with key Irish health services*

[3] Kilmarnock House replaced Balseskin during June 2003 because the Special Olympic Athletes were accommodated in Balseskin for three weeks.

- *To assess the transferability nationally of a peer-led programme vis-à-vis the needs of both asylum seekers and service providers.*

## 2.3 The Evaluation Framework

The evaluation framework used in HIP is one used in the community development sector in Ireland called the Five Nations Model (known also by different names). This is a particular model established by the Scottish Community Development Centre and further developed by the Voluntary Activity Unit in Northern Ireland. The Five Nations Model takes a broad evaluation framework, using six key evaluation components. These are:

***Component 1:*** This component explores the '***Story'*** [2] of the Programme from the different stakeholder viewpoints. It looks at the process of the project over the given period.

***Component 2*****:** This component identifies the ***Successes and Disappointments*** of the Programme

***Component 3****:* This component establishes the overall ***Learning & Critical Issues*** for the Programme's successful operation in the future. This is a crucial element of the evaluation.

***Component 4*****:** Evaluates the Programme's progress against its specific ***Aims & Objectives*.**

***Component 5*****:** Identifies the ***Impact*** of the programme at four levels:

- at the level of the *individual* composed of participants, staff etc;
- at the *organisational* or *service* level e.g. changes in Spirasi due to the work of the pilot programme and developed services due to the work of the pilot programme;
- at the *community* level e.g. within the asylum seeker community; and
- at the *policy* level i.e. have there been any policy developments within e.g. the Health Board as a result of the work of the pilot.

***Component 6*****:** Evaluating the ***quality*** of the intervention. This is usually evaluated against the principles and values established by the organisation at its inception.

## 2.4 Evaluation Approach

The external evaluator worked with the staff in a team approach in all aspects of the evaluation.

The HIP Management Committee were involved in Phases 1 and 3. This involved commenting on and agreeing in depth on the Terms of Reference and the detailed evaluation methodology. The Programme Co-Ordinator was involved throughout in all aspects of the evaluation as well as taking full part in final evaluation focus groups. The logistics for the final evaluation took extensive time on her part, the collection and base analysis of quantitative data, the collection and delivery to the external evaluator of the qualitative data, and the logistical organisation of all the focus group meetings.

The staff team were involved in the final evaluation, in focus group meetings with some of the health service providers, in all the meetings with participants and control groups, and in drawing up the case studies.

[2] The underlined terms will be expanded on in Section 4.

The final evaluation commenced in June 2003 with a cut off point for data collection on June 30th; which represented a full six months of programme operational implementation. Quantitative data on participation and comparable data from the health screening service was complete by early July. Evaluation focus groups took place in June and July with all stakeholders.

## 2.5 Evaluation Limitations

SPIRASI allocated 31.5 external days for evaluating the pilot programme. Adequate time was therefore allocated for evaluation purposes.

The first limitation was the availability of the key stakeholders to the final evaluation. This was due to busy time schedules and illnesses affecting key personnel. One stakeholder (two people) attended the focus group for the morning, a second for part of the morning. Efforts were made to meet with the partner unable to attend, but continued illness made this impossible within the timeframe.

The second limitation related to accessing health service providers. While health screening nurses and CWO's were represented, other health service providers were not. Due to the strike of public health doctors (AMO's) screening data was not available from April to June 2003. The AMO's were, understandably, of the view they could not contribute meaningfully to the evaluation. The unexpected changes outlines in 1.2 also limited some aspects of the evaluation.

These limitations did not fundamentally affect any key element of the evaluation.

# 3. The Evaluation Findings – The Quantitative data

Substantive and regularised monitoring data was kept by the Co-Ordinator following initial discussion as to what would be required for evaluation purposes. Broadly the quantitative data indicates substantial numbers of asylum seekers in all three centres availed of the health information programme.

The quantitative data will be explored under the following headings:

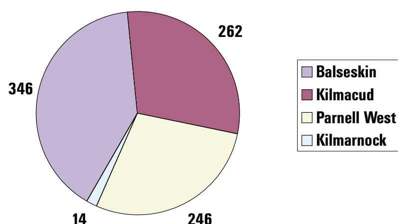
- Numbers attending
- Gender breakdown
- Number of sessions
- Age and gender breakdown
- Countries of origin
- Language requirements

## 3.1. The Health Information Sessions - Morning sessions

### *Numbers attending*

The total number of asylum seekers entering the direct provision system as of 30 June 2003 was 4,914; of these 3,577 were adults. The overall number of adults who attended the HIP session across the three Reception Centres was in excess of 868 people. However, due to the open and flexible nature of sessions it was not always possible to collect exact attendance data. Therefore, approximately 24% of asylum seekers residing in reception centres met with the HIP team. Figure 2 illustrates the number of asylum seekers HIP met at each centre during the six month implementation period. Sessions at the Kilmarnock centre were added in the late stages of the pilot due to closure of Balseskin Reception Centre.[3]

**Figure 2.**
**Number Participants Attending HIP at each Reception Centre**




### *Number of sessions*

In all, 57 sessions were held in the three centres. This was broken down as 19 sessions per centre. Each session provided information over a two to four hour period of time with informal discussions taking place during the meal periods in the morning and afternoon.

[3] Kilmarnock House replaced Balseskin during June 2003 because the Special Olympic Athletes were accommodated in Balseskin for three weeks.

## *Gender breakdown* [4]

The attendees at the sessions were overwhelmingly female with a male female ration of 1 Male to 2.31 Females. The total number of participants was 870 with the following gender breakdown:

- Female 594
- Male 257
- Unknown 19

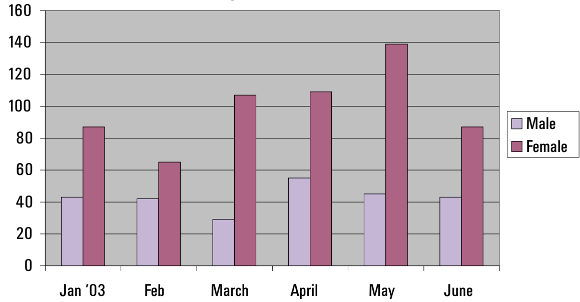
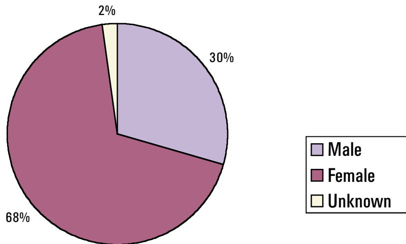



Figure 3 represents the distribution of male and female participants who attended HIP sessions over the six month period of the pilot phase. Women outnumbered men throughout this time with over 68% of the participants being female as shown in figure 4. In comparison to the Department of Justice and Equality data on male/female asylum seeker applications, the percentage of female's attending HIP was greater as fifty one percent of all applicants were female during the same time period. The higher proportion of female participants most likely represents a greater interest in health issues by females than males.

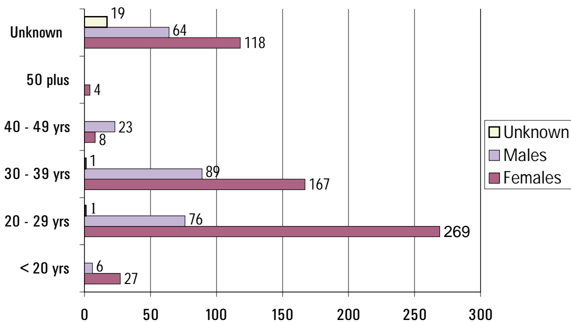
**Figure 4. Percentage of Male and Female Participants**




## *Age and gender breakdown*

The age breakdown of attendees is illustrated in Figure 5. Those attending HIP sessions were predominantly in the 20 – 39 year age bracket (69%) and the majority of these were women- 436 women compared with 165 men. Two hundred and one participants out of a total of 870 did not provide information on their age with 17 of these also not specifying their gender.

**Figure 5. Age Breakdown of HIP Attenders**




[4] Figures for gender information include two infants and total 870.

## *Countries of origin*

The country of origin of HIP participants had a similar breakdown to those applying for asylum with Nigerians being the largest community to attend.
Appendix 3 contains charts detailing the breakdown of country of origin for all participants.

**Figure 6. Country of Origin of Majority of Participants**

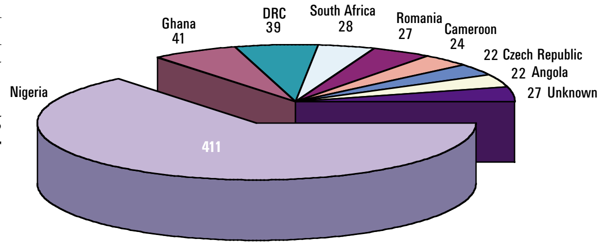
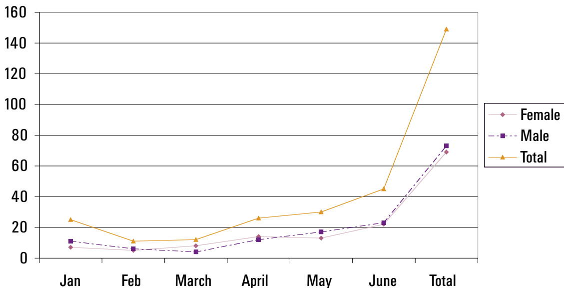



**Figure 7. Number of participants from Eastern Europe**




Although the number of participants from Eastern Europe was not high, Figure 7 demonstrates the gradual increase in HIP attendance over the six month period. It is believed this increase relates to the translation of materials into several Eastern European languages including an advertisement of the service.

## *Language requirements*

The vast majority, 540 or 61%, of the attendees to the HIP sessions identified that they could communicate through English. *This does not mean that they could fully comprehend what was being said.* Figure 8 illustrates the breakdown of the other languages mentioned by those who stated they could communicate in English. Of the 540 listing English, 132 conversed in it as a second or third language and may not be fluent. Information on fluency was not collected and cannot be inferred. Of the 540 English speakers where gender was known, 427 were women (80%) and 101 men (18%).

**Figure 8. Speakers of English only and English plus other languages**

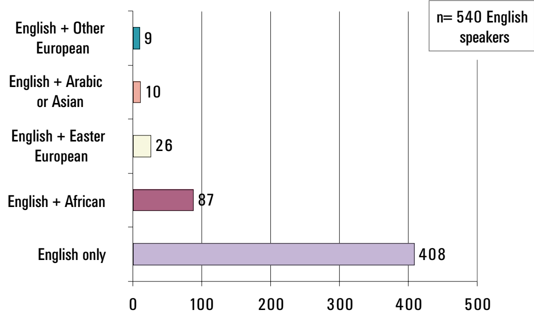
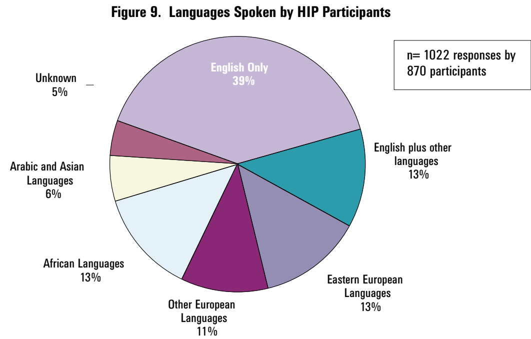


Figure 9 represents the language groups listed as being spoken by HIP participants.[5] The second largest language groups listed were by *Eastern European* and *African* language speakers each with 135 people (15.5%). These groups spread across a broad range of language needs. '*Other European languages'* which included French, Dutch and Portuguese speakers were listed by 112 people representing 13% of attendees. Arabic and Asian languages represented 58 participants (7%). There were 45 people who did not specify their language needs representing 5% of participants. A detailed breakdown of the languages spoken by participants is included in Appendix 3.

**Figure 9. Languages Spoken by HIP Participants**




Communication within the HIP team was possible in English, French, Arabic, Bulgarian and some African languages. The African languages included Ki-Kongo, Lingala, Ki-kamba, Ki-dando, Yoruba, Mende, Temne, West African Creole, and Pidgin. The major gap in language requirements, as identified by the HIP team, was the Eastern European languages. However, it is not likely that the full range of European languages would be available through any one person; Russian and Romanian were the largest single groupings where there were language gaps. With such high numbers of English language skills available among asylum seekers, alternative and sustainable ways of meeting the language needs of other groupings, particularly the smaller groupings will need to be considered.

## 3.2. Afternoon Sessions

The initial plan for the afternoon sessions, held also at the reception centres, was to meet with individuals, where specific needs would not have been met, for whatever reason, in the mornings. However, the format of these sessions varied from the original plan in order to accommodate the emerging needs of those attending in the afternoon. Generally, more group sessions based on language requirements occurred instead of one to one interactions. Also, one to one sessions tended to occur immediately after the morning session before breaking for lunch. These contacts were not recorded as participants would have completed the attendance sheet at the start of the morning. Information about group and one to one sessions was not recorded consistently and therefore, the data does not reflect a true picture of the afternoon sessions with only 51 people recorded as having had discussions. This represents just 6% of the people the team met in the mornings. In general the team identified several activities that interfered with attendance of both morning and afternoon sessions. Travel to town, bus schedules and appointments with service providers caused the greatest competition for the time of potential HIP participants. The afternoon sessions could have been more effectively used and the format of the afternoon sessions, therefore, requires reviewing and redesigning.

[5] Several participants are listed two or three times as many spoke several languages within the language groups listed. For Example, some Africans spoke, English, Portuguese and their Native languages.

# 4. Evaluation Findings – The Qualitative data

Extensive qualitative data was gathered for evaluation purposes and will be explored under the following headings:

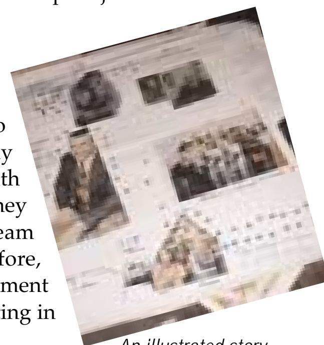
- The story of the programme
- Its successes
- Its impact
- Meeting its aims and objectives
- The quality of the intervention

Overall the qualitative data clearly indicated the substantive success of the programme.

## 4.1. The Story of the Programme

The 'story' aspect of any evaluation allows the organisation to explore what has happened for individuals and within the group during a specific time period. There is no 'formula' for writing the story of the group. The HIP team began its main story in November 2002, setting about their work with energy and enthusiasm. Some of the team had been through the asylum process themselves and all had a strong commitment to making positive changes in the lives of those newly arriving in Ireland. For all four this was their first full time paid job in Ireland so that all were both anxious and hopeful for their new positions.

Initial anxieties were quickly allayed and the team positively set about their own training as well as beginning to design the information module for delivery at Reception Centres. They began to realise the parameters of the data to be delivered and were keenly aware from the inception of the Programme of the multi-faceted health information needs of people at the point of entry. Organisationally, they identified their office needs within Spirasi as well as their team development needs. In this early stage, the team were, therefore, manifesting the normal range of components in initial group development – getting into roles, taking up positions, questioning, judging, conflicting in some areas, challenging leadership, and questioning the task.



*An illustrated story*

The team then quickly moved into the implementation phase in early January 2003. This period was a '*nail biting*' time; they worried that the information delivered might not be well received, wondered how people would react to the information, fearful '*no one would turn up*'. Fifteen participants attended the first session and 40 the second session. The result was '*a positive experience, good interaction with people, very inclusive*'. The sessions of the first week and the debriefing at the end of the week gave them confidence that what they were doing was worthwhile. They increasingly developed in confidence over the first two months until a chickenpox outbreak in one of the Centres broke the development flow. The limitations of the data delivered within the module continued to cause concern as the questions raised by participants affirmed the team's sense of broader health information needs.

The experience of the team therefore was one of growing confidence and motivation in the need for, and delivery of, information on Irish health services to asylum seekers.

## 4.2. The Programme's Successes

All stakeholders – participants, health service providers, programme partners and staff – were asked to identify the organisational, operational and strategic successes. Overall all stakeholders who took part in the evaluation were positive about the effectiveness, quality and outcomes of the programme.

### 4.2.1. Participants

The qualitative data from asylum seekers clearly indicated the substantive success and effectiveness of the health information programme**.**

Participant evaluations comprised of:

*a. Evaluating at the end of health information sessions*
*b. Evaluating at the end of the pilot period*

*This card (visual material) convinced me to be screened because when I heard that it was voluntary I decided not to go. But after seeing this and seeing this picture which shows a man with blood, I decided to go and be screened (Kilmacud June 2003).*

***a.*** Evaluations at the end of the health information sessions were recorded in 47% of sessions (27 sessions).

*The data from the daily sessions indicated:*

- **Unanimous support for a programme** which allowed asylum seekers access information about Irish health services
- **Unanimous support for the methodology of the programme** - they found the information and the manner of its presentation '*very educational*', clear, interesting and understandable.
- **Positive response about the access to a variety of languages** – '*I was surprised to hear information in my native language*' (Parnell West. May 2003).
- **High levels of learning about Irish health services** and how to access those services. The highest level of learning related to the medical card system as identified in the feedback from 89% of recorded sessions. The second highest related to the GP and AMO services and the differences between these - identified in 17 sessions (63%). The third highest related to the CWO role – identified in 11 sessions (41%).
- **Learning in a range of other areas** - developing a broader knowledge on accessing health services, the existence of the CCST, the importance of getting the information *before* accessing the service provider, how referrals work, and the importance of the Temporary Residence Certificate (TRC), child benefit, special needs and vaccinations.

> '*I now know not to get confused when they transfer me*' (Balseskin. June 2003)
>
> '*We learned where to go if we are sick*'. (Kilmacud. May 2003).

***b.*** At the end of the pilot period, focus group discussions took place in two accommodation centres where asylum seekers from the three Dublin centres had been dispersed - Kinsale Road in Cork and Mosney Accommodation Centre in Meath. Additionally, two focus group sessions were conducted with residents of these centres who had not attended HIP sessions; these, therefore acted as control groups. Nine people attended the non-control Mosney group and eleven in Cork; this represented just over 2% of the 868 adults who had attended the Dublin sessions. For the control group seven attended in Mosney and four in Cork.

*Data from participants who had attended Hip sessions indicated:*

Discussing the story card activity with a HIP officer.

- ***Strong retention of the learning***. Of the twenty people who took part in the two sessions, two had attended the session in February, five had attended in March, four had attended in April, and seven had attended in May and one in June.[6] There was therefore adequate time for most participants to either retain or forget the data. The participants as a whole showed a strong retention of knowledge of the service providers with whom they had continuing relationships and considerably lesser knowledge on those with whom they now had no contact. The knowledge retention therefore of the CWO, GP and Medical card services, requirements and usage was very high compared with their knowledge of the AMO service, which was very low. [7]
- ***Appropriateness of the peer-led approach-***(see section 4.2.4.)
- **The on going *effectiveness and usefulness of the methodology*** and particularly the visual handout material. Participants identified their constant referral to these handouts as they sought to make sense of services in their area of dispersal.
- **The *appropriateness of the programme at the point of entry*.**[8]
- ***Strong impact on participants*** – (see section 4.3.1.)
- ***The appropriateness of the programme's placement in the voluntary sector.***

CASE STUDY: Abla, not her real name, is a woman journalist from Cameroon. She attended the HIP session at Parnell West Hotel in March 2003. Before she attended the HIP session she had accepted the health screening invitation and was glad to know from HIP the benefits of the screening, especially its confidential nature. It also helped her understand better the reasons for the specific tests. Screening was most timely as she was experiencing a bout of unpleasant coughing. Her meeting with HIP enlightened her on how to access the psychological services available and she is at present a client of the CCST.

She noted the vast differences between health care provision in the Cameroon and in Ireland. 'We go to the local nurse at the health centre and the hospital for main operations. It is very popular to self medicate (go to the pharmacy) and there is no GP for follow up treatment'. She was very impressed by the poster shown of the CWO as she had mostly relied on word of mouth information from other residents at the hostel. She was very worried about her infant son's welfare and HIP's encouragement to approach the CWO was helpful.

Abla is grateful to the HIP team for informing her of services, including those she met when she came to CCST e.g. Metro Eireann. 'I can still exercise my brain while awaiting my asylum claim to be processed'.

[6] One was unknown

[7] The latter was likely to have been additionally affected by the industrial action of the AMO's during the asylum seekers residency at the reception centres.

[8] A small number, particularly those experiencing recent trauma, indicated a later point was more appropriate

### 4.2.2. Control Group

What was of equal interest was the comparison of knowledge of the control group with the participating group.

*Data from the control group indicated:*

- A stark difference in the overall clarity of what each health service offered and the way to access these services. While participants displayed *some* knowledge about each of the services, this was confused; they were confused about what services were offered by each of them and the differences between the services. For example the questions asked by the control group at the end of the session were markedly different to those asked by the participating group. The latter were asking more in depth questions: medical card for children, limits on health services, dental entitlements, etc. The control group were asking very basic questions concerning their medical care, GP services, CWO service.
- The lesser confidence of the control group to use the services effectively because of a lack of confidence that the information they had was correct.
- The limitations of the effectiveness of the written material distributed to asylum seekers at point of entry. All participants had received written material on health services when they arrived in Dublin. While they broadly found this useful the control group indicated most of their real knowledge about services was accessed through word of mouth. Unanimously they were of the view the information they had on arrival, or even since their dispersal, was inadequate.

*What is a medical Card? When do you apply for it? Can anyone who is a resident here get this? (Mosney).*

CASE STUDY: Nasfat (not his real name) is from Nigeria and did not come to any of the HIP sessions. He has been in Ireland a little over a year. He gets information on health care mostly from friends and the manager and receptionist at his hostel. While on direct provision he had a medical card and a GP. He has no idea who or what the AMO is about though 'we were screened by the doctors nurse..I know about the CWO but we call them 'the social.' What is the difference?'…I don't really have much to say about health care here because after I got married to an Irish lady the CWO stopped my welfare payments and my medical card. She said my wife has to support me. It is very embarrassing for me to have to depend on my wife. They refuse to give me a work permit so I can't even work. Health care at home in some parts is free of charge because of the World Health programme but here I am fed up. At the hostel it was ok but now I don't know what to do'. Nasfat regrets not having had the opportunity to attend a HIP session. He felt it would have helped him avoid 'all the confusion I am in now'.

### 4.2.3. Health Service Providers

Two evaluation focus group meetings took place with two sets of health service providers working in the Reception Centres - nurses in the health screening units and Community Welfare Officers. Efforts were made to include the other health service providers but due to the industrial action of the AMO's during the pilot phase, they were of the view, understandably, they could add little to any evaluation; the GP who had agreed to meet with the evaluation team could not make the appointment. Four nurses attended the evaluation session and three CWO's. All three centres were represented in the session with nurses. One of the centres was

represented in the sessions with CWO's and a further CWO covered all centres on an emergency basis.

*Data from the health service providers indicated:*

- **Unanimous support for an on-going programme**
- **Positive and notable impacts**, particularity from health screening professionals. The programme had notably allowed more time for health service providers to prioritise health care with patients. (See section 4.3.2)
- **Asylum seekers were using health services more appropriately.** This was defined by the providers as less guarded and more relaxed when they attended health screening sessions following attendance at the HIP
- **The Programme's strengths** were assessed to be: its accessibility to asylum seekers, its independence, its non-official approach, its peer-led nature, the availability of different languages, its professionalism, its partnership approach.

### 4.2.4. Other stakeholders

The other stakeholders, primarily the programme partners and staff, also identified a range of the programme's successes. Overall the stakeholders were very positive about the implementation, quality and outcomes of the programme.

*Data from discussions indicated:*

- The overwhelming success of the peer-led and person centred approach. The peer-led component allowed for strong relationships of trust and openness to be established with newly arrived asylum seekers in very short time frames.
- The availability of a range of language skills
- The successful partnership
- The overall success of the placement of the pilot programme within the voluntary sector.
- The importance of the independence of the service, i.e. that the programme was seen not to be part of other statutory organisations with whom asylum seekers had contact
- The success and positive impact of the methodology used, in particular the visual material and the availability of handouts
- That the programme was established and delivered within such a short timeframe was a critical success
- The competence, professionalism, commitment, willingness to engage with the work, communication skills and personable abilities of the HIP team were crucial to the programme's success
- The critical importance of a paid, as opposed to a voluntary, service.
- The critical importance of effective consultation, communication and support from management in Reception Centres

**Three of the four key stakeholders were asked to rate the level of successes to disappointments within the programme as a whole; average rating across stakeholders was 74% successful; 26% was allocated to areas where stakeholders were disappointed with outcomes.**

## 4.3 The Impact of the Programme

Considering the limited timeframe in which the HIP was operational as a pilot programme - six months - there was a remarkable impact.

### 4.3.1. Participants

Evaluation data from participants indicated substantive immediate and longer term impacts.

***Evaluation data indicated:***

- The retention of information about health services and the specific functions and usage of the different services
- Changed usage of some services and particularly of health screening services. Screening staff identified that due to their access to more accurate information asylum seekers were more relaxed and open in their dealings with staff, had more clarity about the role and services offered, displayed increased awareness of services available and of screening tests. *'For those I know who have attended the HIP they are a lot better informed about the services'* (Balseskin). *'People have mentioned that they now know the service is confidential and independent and hence have raised issues they may not have done otherwise'* (Parnell West). The CWO's noted less aggressive behaviours, more awareness of the voluntary nature of the service, not as many health questions were asked, there was more awareness of how the system worked. *'There is a more relaxed working environment due to the clients having more information'* (CWO, July 2003).
- The development of more realistic expectations of the health services. *'I felt comfortable asking for things after HIP; you knew you could go to the doctor and ask for a prescription and then go to the chemist.'* (Mosney July 2003)
- Increased usage of health services, particularly screening services.[9] Comparative data for the same three months in 2002 and 2003 in Parnell West showed an increase of 91 people using the screening service. Over a four month comparable period in Kilmacud there was an increase of 136 people.[10] There was a decrease in usage in Balseskin of 445 people; as previously indicated this is likely to have been affected by industrial action.
- Increased usage of some other services, particularly the Medical Card service. [11]
- Strong learning in a range of other areas: child benefit, special needs, vaccinations, the existence of CCST, the importance of accessing information prior to using services, the importance of the TRC.
- High level of overall impact. Participants in Cork and Mosney were asked to rate the level of impact of the programme.

[9] Overall comparative data could not be accessed primarily due to the industrial action of AMO's, the advent of the Special Olympics which housed some of the athletes and a chicken pox outbreak during the pilot period

[10] Increases cannot be directly linked to the work of the HIP team but can act as an indicator of its impact.

[11] No quantitative data was available to assess overall increase in usage of general health services

The majority of participants rated the impact at the highest level:

| | |
|---|---|
| Not at all: | 0 |
| A reasonable amount: | 3 |
| A lot | 12 |
| Unknown | 5 |

From the key stakeholder viewpoints, therefore, the programme had substantial and positive impacts.

*Before I didn't know anything. After explaining I got to know how to do it'*

*'It was great when they came. It helped me as it gave me information on lawyers and filling in forms and registering with legal (RLS), advising me to go to the CWO. I was afraid what would happen with money but I did send it to legal and it did come back* (RLS request a €35 fee but returns €29). *They really helped us with that'.*

*'When you get the forms from here, they don't explain it to you, not the way HIP explained it. They were clear.* (Cork. July 2003.)

### 4.3.2 Other Stakeholders

Other stakeholders were asked to identify the impacts of the programme.

***The data indicates:***

- Major impacts in terms of health screening services. The latter indicated there was more time available for health and nursing itself, rather than in the past where considerable time was allocated to explaining how the health system works.
- The CWO service, as previously indicated, pointed to a more relaxed working environment between them and participants who had accessed the HIP
- Health Service providers became more aware of their own cultural education needs and their limited experience in an international context.
- Some health service providers rated high levels of impact while others rated it lower. Unanimously screening staff rated impact at the highest level ie '*A lot*'. The CWO's rated it at the lower levels either '*Not at all*' or '*A reasonable*' *amount.*
- HIP had made the working of the services easier. HSP's were asked also to rate if the impact of the HIP had made their work with asylum seekers easier, more difficult or had remained the same. Unanimously health screening and CWO staff indicated the HIP had made their work easier.
- Staff identified the impact of the visual material on health screening staff ie they became aware of alternative ways in which to convey messages about health services
- The building of new and positive relationships between statutory and voluntary sectors
- The development of an awareness of different approaches and responses, in particular the development of group versus individual responses. An impact of HIP on Spirasi was to

make the organisation aware of the impact and power of group responses.

- The intensity of the work had both positive and negative effects on the staff team. The positive impacts related to the development of skills, knowledge, confidence and new methodologies. The negatives related to the limitations of the programme of information dissemination, to the knowledge that their high level of skills was not fully used within the programme.
- In terms of policy impacts, it is unrealistic to expect short programmes to have major impacts on policy. However, one impact on policy was identified. The Programme was discussed as part of the consultative process initiated by the Eastern Regional Health Authority in relation to its strategy document on the health needs of ethnic minorities. The programme is mentioned in that strategy as a model of good practice.

### 4.3.3 Impact of HIP Methodology: Health Promotion Resource Material

The development of health promotion resource materials has been an extremely useful and successful component of the Health Information Programme. The HIP team's methodology focused on creating an informal interactive environment. Through the use of group discussions and activities, the HIP team gained active participation from their audiences. The visual resource materials aided this process.

During the training and design phase of the project (November and December 2002), the team identified key messages and conceptualised images which would assist them in explaining the important points. The team hired a graphic artist who turned their ideas into visual drawings. The posters and story cards developed went through several modifications before they were pre-tested with SPIRASI staff and students. In addition, before implementation began in January a session was held with the management committee and health board staff from the reception centres and Health Promotion Unit to ensure the messages reflected the needs identified by asylum seekers and health service providers.

*Minister Callely launching HIP Resource Materials.*

The initial two months of implementation were also a period of pre-testing to ensure the visual materials were understood and appropriate for use with newly arrived asylum seekers. The materials were modified based on comments provided by asylum seekers and others, but generally were well received.

The current format of the posters and story cards was such a success, that SPIRASI felt it was important to formally launch the materials. On 20 June 2003, World Refugee Day, the HIP team with the assistance of Ivor Callely, Minister of State at the Department of Health and Children launched the HIP Health Promotion Resource Materials. The materials were on view to the public and received a positive response particularly from Public Health Nurses and other Health Boards around Ireland.

The HIP team is constantly reviewing their messages and identifying other methods to present the information to a linguistically and culturally diverse population. The resource materials will continue to be a useful tool for presenting the HIP information and will be revised based on the needs of asylum seekers and any changes which occur in the health system.

## 4.4 Meeting the Programmes Objectives

The Health Information Programme substantively met it's main goal, aim and key objectives.

### 4.4.1 Meeting the Main Goal

***The main goal of the Programme was:***

*To contribute to the positive integration and the full participation of asylum seekers in Irish Society, improving their quality of life and welfare, by facilitating improved access to health services and entitlements.*

The main goal was met as far as it could be within the context of a one year pilot programme. Both qualitative and quantitative data outlined throughout this report, indicated that from both asylum seekers' and health service providers' viewpoints, the HIP had effectively promoted and contributed to the integration and participation of asylum seekers into Irish health services. Through the dissemination of information, evaluation data indicated asylum seekers access to health services was positively facilitated.

### 4.4.2 Meeting the main aim

***The main aim of the Programme was:***

*To increase the capacity of asylum seekers to make more informed decisions about their health care by facilitating the improved understanding of, access to and interaction with statutory health services during the reception phase of the asylum process*

The main aim of the programme was met. Both asylum seekers and health service providers clearly indicated that the HIP had increased their capacity to make more informed decisions and choices about health care. Data indicated improved understanding of, access to and interaction with statutory health service providers.

### 4.4.3 Meeting the Programme's Objectives

The three objectives of the programme were substantively met.

***Objective 1:*** *To disseminate information about the Irish health services to asylum seekers at the point of entry into the Irish State*

This objective was fully met. Over eight hundred and sixty eight asylum seekers attended the 57 HIP sessions. Additionally the HIP team recorded meeting with 51 individuals to discuss their health information needs. These were undertaken at the point of entry in three Reception Centres in the greater Dublin area from the middle of January to the end of June 2003.

***Objective 2:*** *To facilitate asylum seekers in the use of the Irish Health services more appropriately*

As far as could be ascertained, this objective was met. Programme partners defined '*more appropriately*' as: using the right service for the right facility e.g. using a GP instead of the A&E, keeping to protocol e.g. visiting hours, queuing, making and keeping appointments, bringing medical cards to appointments, ambulance services not used for anything other than emergencies, acceptance of non-admission at maternity hospitals if childbirth was not imminent.

Time did not allow for evaluation with health service providers outside the three Reception centres, so that how asylum seekers were using these services is largely unknown. However, qualitative data from the health services within the centres, as previously outlined, indicated that asylum seekers were using the health service less aggressively, more openly and confidently. Final evaluations with participants strongly indicated a clearer understanding of how Irish health services operated and more satisfaction with the outcomes, in most instances, of their treatment by health service providers. That participants identified their satisfaction with the manner of their treatment by most service providers is an indication that they are using the services more appropriately, resulting in more satisfaction for themselves and for the providers.

***Objective 3:*** *To model a peer-led health information programme and to identify the lessons from this approach for health promotion purposes*

This objective was fully met. In terms of modelling a peer-led approach four non-Irish people were employed in the service, the three HIP officers and the co-ordinator of the Programme. Two of the four had been directly through the Irish asylum process.

## 4.5 The quality of the intervention

The quality of any intervention is usually evaluated against the agreed values and principles on which the intervention bases its work. In the case of HIP no principles or values were specifically documented, making difficulties in agreeing the criteria on which 'quality' was based. Evaluating the quality of the intervention was therefore the least developed aspect of the evaluation.

Two sets of stakeholders, programme partners and staff were asked to rate the quality of a variety of aspects of the programme on a scale from: Very bad; Poor: Average; Good; Excellent.

### *The programme partners*

Two stakeholders rated the quality of the intervention as follows:

***Poor:***
- The relationship of the HIP team to one of the Centres at the beginning of the project

***Average***
- Quality of the relationship between Spirasi and the HIP team

***Good***
- The quality of the partnership
- The quality of Spirasi's management
- The quality of the management of HIP
- The quality of the HIP team

***The two members differed on:***
- Quality of the HIP relationship to Parnell – Good to Excellent
- Quality of the relationship to Balseskin – Average (1) and Excellent (1)
- The overall quality of the intervention – Good to Excellent

### *Staff*

The staff team rated a broader range of aspects of the programme. Averages are therefore broadly taken across the team as a whole.

*Average*

- The quality of the management within SPARASI to the officer team
- The quality of the work in the afternoon
- The quality of the initial training

*Good*

- The quality of the management of Spirasi to the management of HIP

*Good*

- Quality of the material for participants (Unanimous)
- Quality of the presentations
- Quality of the relations with Parnell, Balseskin and Kilmacud
- Quality of the language skills

*Good to Excellent*

- Quality of HIP management
- Quality of the HIP team

**Excellent**

- Quality of the collective way of working (Unanimous)
- Quality of the relationship of HIP team to Spirasi staff
- Quality of relationship to participants (Unanimous)
- Quality of the work in the mornings

Data therefore suggests a broad satisfaction with the quality of the work of the intervention.

# 5. The Learning and Critical issues for the Future

## 5.1 The Learning

The learning from any programme is the most critical for future development of permanent programmes. The learning and changes recommended for the HIP are to be viewed in the context of the overall substantive success of the programme.

The learning is explored under the three headings:

- Organisational
- Operational
- Strategic

### 5.1.1 Organisational learning

***Evaluation data indicated:***

- The importance of extensive pre-planning with regard to all organisational components – budgets, accommodation, administration etc
- The importance of administrative and management supports including a recognition of the extensive administrative and supports needs within such a pilot programme
- The need for time allocation by partners to manage, support and guide the programme. There is also a need for formal clarity around the roles and responsibilities of all partners.
- The appropriateness of a group response to asylum seekers health information needs.
- The importance of understanding the intensity of implementing peer-led programmes:
- There are substantively different support needs required by peer-led models and these supports need to be in place prior to the implementation:

  -The experience can be both positive and potentially negative for any staff team, in particularly where staff are over qualified to deliver basic level information on a repetitive basis or in the context of staff working on issues which take them back to previously negative experiences. So the psychosocial needs of a peer-led model require specific supports. Time is required to research, understand and deliver these supports.

- The programme has also proved the importance of an independent model. Participants clearly indicated initial suspicion, fear and caution. '*We thought first they were spies from Justice, and wanted to get information from us. We were afraid when we first came. We asked others what it was about. We listened and read and then became open*'. (Mosney July 2003).

In summary, the organisational learning reflected the need to ensure that enough time, planning and support are provided to the peer-led programme. The critical issues, therefore, will have to focus on continuation and strengthening of the management committee by formalising the roles and responsibilities between partners. Substantive pre-planning with all stakeholders will be particularly essential prior to the expansion of the programme along with adequate administrative and management support funded and in place. In addition, the

psycho social support needs of the staff will require strengthening.

### 5.1.2 Operational learning

*Evaluation data indicated:*

- Language limitations within the programme particularly Russian and Roma.
- The critical importance of visual handout material
- The need to redesign the full-day module, in particular the usage of the afternoon session.
- The importance of a team approach, particularly during any pilot phase.

Operationally, the learning demonstrated the success of the programme especially in relation to the peer-led, people-centred approach. However, the continuation, strengthening and acceptance of the model will require the development and regularisation of formal communication systems between parties at implementation levels, in particular with health professional and management at Centres. Senior staff within key statutory partners should assist in the introduction of the programme into Centres fostering a strong relationship between the staff and service providers.

In conclusion, the methodology of the programme, the use of visual materials, the range of language skills, and personal commitment among the delivery team were of critical importance to its success. Continued access to a range of language skills within the programme as well as exploring a range of options to address language needs will help to strengthen this component. Identification of mechanisms where all asylum seekers can be offered the service prior to dispersal and prior to meeting with health service providers is also essential and may require a redesign of the present full day module. Further, identification of alternatives to the daily repetitiveness is required to address sustainability issues for delivery teams.

### 5.1.3 Strategic

*Evaluation data indicated:*

- There are sustainability issues in relation to the repetition of the same/similar data to different groups of people on a daily basis over long time periods.
- The importance of a partnership approach between the statutory and voluntary sectors.
- The appropriateness of the initiative at the point of entry

The partnership between the statutory and voluntary sectors was a key component to its success and will be essential to maintaining and expanding the programme. Identification of multi-annual budgets will also assist the sustainability of an expanded programme. While key elements of the programme are transferable, the model should not be transferred en bloc as an exploration of the different needs of new communities in Accommodation Centres as well as consideration of local characteristics will be required to ensure successful regional expansion.

# 6. Conclusions and Recommendations

## 6.1 Conclusions

***There are a number of key conclusions to the pilot Health Information Programme: These are:***

- The Programme has met all its key objectives:
  - ✓ It has successfully disseminated information about Irish health services to asylum seekers at the point of entry into the Irish State.
  - ✓ It has facilitated asylum seekers in the use of the Irish health services more appropriately.
  - ✓ It has successfully modelled a peer-led information programme and identified lessons from this approach for health promotion purposes.

- The Programme has proved the need for, and effectiveness of, a peer-led and person-centred approach to the health information needs of asylum seekers. It has also proved the importance of an independent model**.** There was unanimous support by the two key stakeholders, asylum seekers and health service providers, for the continuation of the programme.

- Asylum seekers at the point of entry have broader needs than assessing base information about Irish health services. There is a need for a holistic approach to health promotion with asylum seekers. A modular approach which incorporates a focus on two main areas would meet the broader needs of the group: (a) information on Irish health services and how they operate and (b) a focus on broader health promotion. The model should also incorporate a mediation role.

- There is an ongoing need for health information and health promotion for asylum seekers at Accommodation Centres and at other points of dispersal.

- Core elements of the model – both peer and person-centred, the employment of staff, the material used and the adult education methodology – are transferrable to Reception Centres throughout the country. However, the model should not be transferred en bloc as a number of key elements need redesigning and development. For the *Transferability of the model see Appendix 4.*[12]

- The partnership approach between the statutory and voluntary sectors has been a key element in the success of the programme.

[12] A key evaluation objective was to assess the transferability of the model.

## 6.2 Recommendations

### Overall Recommendation:

As the Programme has clearly demonstrated its value it should continue as a model of peer-led health information. When considering the continuation of the programme, the following specific recommendations might be of use:

### 1. Expansion:

**1.1** In any development of this programme or in new programmes the key elements that contributed to its success should be retained i.e.

- The partnership approach
- The peer-led approach.
- The methodology.
- Full-time paid staff

**1.2** The existing programme should be expanded in the following manner:
Its content should be broadened beyond the dissemination of health information to include a broader health promotion role and mediation role.
The culturally and linguistically appropriate materials developed as part of the pilot programme should be further refined and expanded.
The programme should be made available to asylum seekers who were unable to attend while in the reception centres, possibly at centres where asylum seekers go to avail of other services and supports such as non governmental agencies and support groups.

**1.3** Consideration should be given to the provision of similar peer-led programmes in other health board regions of the country to supplement the information provided in the Dublin centres. Such programmes should be adapted to the needs of the asylum seekers residing in the region.

**1.4** Prior to the expansion of the existing programme or the development of similar programmes elsewhere, an assessment of the health information and health promotion needs of asylum seekers should be conducted.

**1.5** In expanding the existing programme or in developing new programmes consideration should be given to expanding the range of languages available to the programmes.

### 2. Staff Support & Development:

**2.1** The support needs of the peer workers need to be properly assessed and addressed in the continuation of this programme and in any new programmes.

**2.2** The role of the existing HIP team should be addressed in the context of the contribution they can make to the development of similar programmes in other areas. This needs to be done in a way that does not detrimentally affect the continuation of the existing programme.

**2.3** Ongoing training is essential for the HIP health information workers and in particular timely information on any changes in health board or government policy in relation to asylum seekers.

## 3. Inter-agency Communication and Partnership:

**3.1** Communication between health information programmes and health service providers should commence before the start of any new programmes and should be an ongoing integral part of the programme.

**3.2** In promoting the existing and any new programmes there is a need to mobilise key people and resources to ensure newly arrived asylum seekers are aware both of the existence and the value of the information sessions e.g. managers and staff in reception centres, staff and information booklets of RIA etc.

**3.3** The placement of this programme within an NGO has proved successful. However, in any further developments consideration should also be given to other options including its placement within mainstream health services.

## 4. Sustainability:

**4.1** Realistic co-funding should be identified and secured from other relevant statutory agencies that could benefit from the provision of Health and Welfare Information to asylum seekers on arrival in Ireland. This would be important both for the existing programme and for expansion of this programme and the development of similar programmes.

## APPENDIX 1: Evaluation Methodology

## APPENDIX 2: Charts: Details of Quantitive Results

## APPENDIX 3: Transferability of the Model

# Appendix 1: Evaluation Methodology

## HIP – Evaluation Methodology – Proposal. April 2003.

| | What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|---|
| 1. | To what extent asylum seekers who have accessed the programme have increased their usage of key health services | • Statistical data from the three centres which covers:<br>a. The usage of all the health services in the centres in the six months prior to the commencement of the programme July – Dec 2002<br>b. The usage of the service during the six months period from January – June 2003<br>c. Breakdown by gender if possible<br>d. If feasible comparative data in the control centre over the same 12 month period<br>• Usage data from CCST | • Agreement that this data can be made available and in the format required from the centres. RIA said they could access data.<br>• Data from the CCST which compares the numbers from the three centres over a period of 1 year, six months of which would be from the pilot period and six months before the pilot period.<br>• HIP team to collect data for case studies and follow up individuals stories | Are there any anomalies in the data, anything that might affect the data.[15] | That there are increases which can be directly or indirectly ascribed to the HIP programme | The 'key service providers' are currently defined by the HIP as:<br>• AMO's in all three centres<br>• Health Screening all three centres<br>• CWO's in all three centres16 |
| 2. | To what extent the asylum seekers are using the services 'more appropriately' | • Interviews or focus group discussions with the key health professions in all three centres | • A definition of 'more appropriately' defined by the HIP. | • Comparison of changes in use of service as noted or recorded by key | • Control group – asylum seekers and HP (Health professionals) | |

13 The data in this column will be added to in the final planning of interviews and focus group discussions.
14 The data in this column throughout is incomplete for three weeks.
15 It is noted that in April for example the Public Health doctors were on strike. This might affect the overall accuracy of the data if this affected the three centres
16 When documentation refers to 'health professionals', CWO's are included, and particularly in relation to their health role at reception centres.

| What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|
| | • Interviews with key health professionals in the control centre<br>• Focus group discussions with 10%[17] attendees from each centre at their new place of residence OR If focus group discussions appear to be running into difficulty in terms of organization a 'case study' approach could be taken with a number (e.g. 1/2 per centre) which would explore the health story of a number of different participants[18]. (Originally it had been hoped to meet with key health professional in the areas of dispersal; budgetary constraints will not now mean this is possible). Comparative data on the use of health services by the Romanian community – to be provided by Frank Mills | group meetings withall four sets of asylum seekers.<br>• Ditto for health professions in all 3 centres<br>• Data from Frank Mills on health service usages by the Romanian community | health professions in the 3 centres<br>• 'Appropriate/inappropriate' use of services in the control centre as noted by health professionals<br>• Impact of change of use/non change of use on health professional<br>• Specific exercises with asylum seekers within the focus group discussion to ascertain their changed usage of key health services<br>• Impact of changed usage on asylum seekers in a new area of residency as noted by asylum seekers themselves | demonstration of more frustration with the usage of service<br>• Asylum seekers and health professionals demonstrating less frustration and more satisfaction with the usage of services | |

[17] This % may alter dependent on the final number of attendees to the programme

[18] There may be some difficulty seperating out the health story from the whole story

| | What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|---|
| | | | | of people their improved / decreased frustration with satisfaction / non satisfaction with health services<br>• Decrease in missing of appointments – quantitative data if available<br>• Increase / decrease of complaints from health professionals – quantitative data if available. | | |
| 3. | What the contributory factors have been in enabling asylum seekers use health services more | • Focus group discussions with asylum seekers<br>• End of pilot evaluation with HIP team | • Organisation of focus group meetings with asylum seekers | • Contributory factors | | |
| 4. | To assess to what extent the data received through the programme has enabled | • Daily recorded evaluation from six months of the programme<br>• Focus group discussion with the 10% of asylum seekers at their new residencies | • Daily record sheets to be typed and analysed on a monthly basis from each (separately) of the centres.<br>• The full six months of evalua- | • Exploration of current usage of the local health services with both control and non- | • Asylum seekers demonstrating an understanding of key health services | • Specific exercises based on the HIP information session will be |

| | What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|---|
| | asylum seekers to take their first steps to using the health services more appropriately. | • Focus group discussion with the control group | tion sheets (Jan – June) from each of the centres | group<br>• What has helped asylum seekers understand and use health services more appropriately and more satisfactorily. | • Asylum seekers demonstrating they have used services and have been satisfied with the services | group discussions. |
| 5. | **Methodology** | | | | | |
| | • The extent to which the material resources and the delivery methods enabled asylum seekers to use the health services<br>• Ditto - on its accuracy, undersatanding and ability<br>• Adequacy<br>• Appropriateness<br>• Adult education methodology<br>• The timeframe for retention | • Weekly records of the HIP team<br>• Daily records od the HIP team on the accuracy, understanding ability, appropriateness of data<br>• Final evaluation sessions with HIP team<br>• Focus group discussion with the 10% participants – retention of data. Time permitting accessing data on general retention time for data retention.<br>• Observation of sessions – adult education methodology<br>• Information session plans and outlines<br>• Quantitative data from centres of the number of residents in the centre during the pilot period in order to compare attendance against the | • Weekly data to be recorded from each of the centres by the HIP team<br>• Daily participant evaluations to collated on a monthly basis from each of the centres<br>• Monthly observation of sessions in each of the centres by the HIP manager or the external evaluator<br>• Written outlines of the information sessions<br>• Collection of data on a monthly basis from each centre ion the number of residents per centres per week during the | • What has worked/not worked for the HIP team in terms of methodology<br>• Concepts and practices which have been delivered and those which require further methodological development<br>• Most effective methodologies (participants and educators) | • Asylum seekers demonstrating their correct knowledge of health service usage<br>• Increase in number s to sessions over the six month period<br>• Asylum seekers demonstration / not demonstrating continued understanding of the health date | |

| What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|
| | centres. | weeks of the pilot. | | | |
| **6. Peer-led Model** | | | | | |
| • How has it contributed to the success of the model<br>• Its strengths and weaknesses<br>• To what extent a paid versus a voluntary led model has impacted on the effectiveness of the | • Final evaluation sessions with HIP team<br>• Focus group discussions with 10% asylum seekers<br>• Monthly records of HIP team<br>• Comparison with one other voluntary led model<br>• Data on peer-led models from Spirasi | • Monthly data from HIP team to be collated<br>• Evaluation sessions with HIP team<br>• Access and usage of the 'A Part of Ireland Now' Voluntary Model of education<br>• Data to be collected from Mike Begley on peer-led models | | • Continued attendance of asylum seekers to sessions | |
| **7.** To assess the extent of the impact of the programme within staffing & timeframe limitations | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |
| **8.** Impact on key service providers | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |
| **9.** Asses the capacity building and skills development of the HIP tram | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |
| **10.** Assess Placement in SPIRAIs effect on | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |

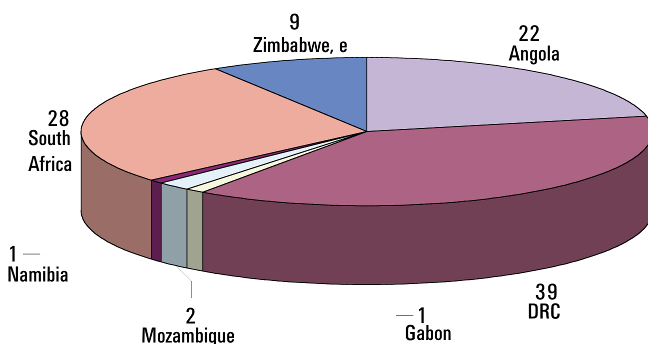
| | What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|---|
| 11. | Assess process and collective way of working within the organisation | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |
| 12. | Assess successes and failures of the programme in the context of dispersal language, confidentiality | • End of pilot evaluation with HIP team<br>• Daily evaluation sheets of participants | • Organisation & agreement of evaluation dates | | | |
| 13. | Evaluation of effectiveness, and equality within partnership, how/if priority interests affected the programmes outcome and the extent to which the partnership helped or hindered the programme | • End of pilot evaluation with HIP team<br>• Ditto with partners – focus group or individual interviews | • Organisation & agreement of evaluation dates | | | |
| 14. | Management impact and level of support. Availability of managements support for a longer term programme. | • End of pilot evaluation with HIP team<br>• Ditto with HIP Manager<br>• Ditto with partners – focus group or individual interviews | • Organisation & agreement of evaluation dates | | | |
| 15. | Assess effectiveness | • End of pilot evaluation with HIP team<br>• Weekly report from HIP team | • Organisation & agreement of evaluation dates | | | |

| | What is to be evaluated? | Methodology | What will be required & by whom | Areas for discussion[13] | Measures & Indicators of success[14] | Comment |
|---|---|---|---|---|---|---|
| **16.** | Assess the appropriateness of the number of staff for the size of the pilot programme | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |
| | **Strategic** | | | | | |
| **17.** | Asses the transferability of the model. Elements that need to be taken into account | • End of pilot evaluation with HIP team and partners<br>• Focus group discussion s with 10% asylum seekers<br>• Focus group discussions with health service providers | • Organisation & agreement of evaluation dates | | | |
| **18.** | Asses the transferability of the model. Elements that need to be taken into account | • Identify HB follow up programmes Focus group discussions with partners at end of pilot | • Partners to identify the follow up specific and planned programmes within key health provider areas. | | | |
| **19.** | Assess extent on the no follow-through component of the programme | • End of pilot evaluation with HIP team | • Organisation & agreement of evaluation dates | | | |
| **20.** | Learning outcomes, gaps, strengths, weaknesses, impacts, limitations, policy implications and critical issues for the future | • End of pilot evaluation with HIP team, partners, health service providers and asylum seekers. | • Organisation & agreement of evaluation dates | | | |

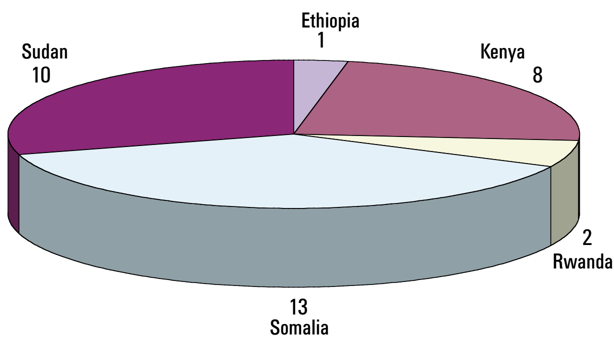
# Appendix 2: Charts: Details of Quantitative Results

## 2.1 Charts: Country of Origin Information

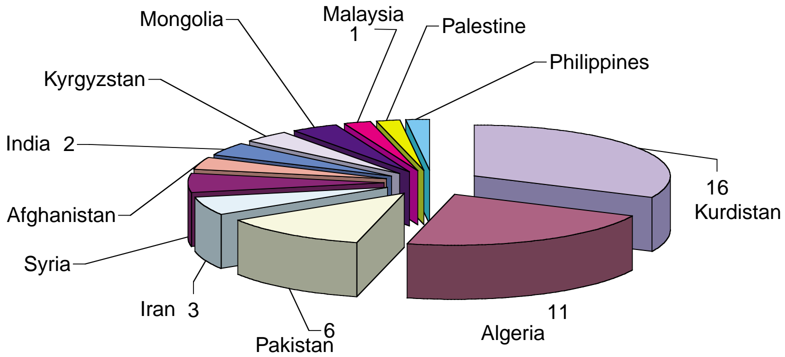
### Central and South African Participants



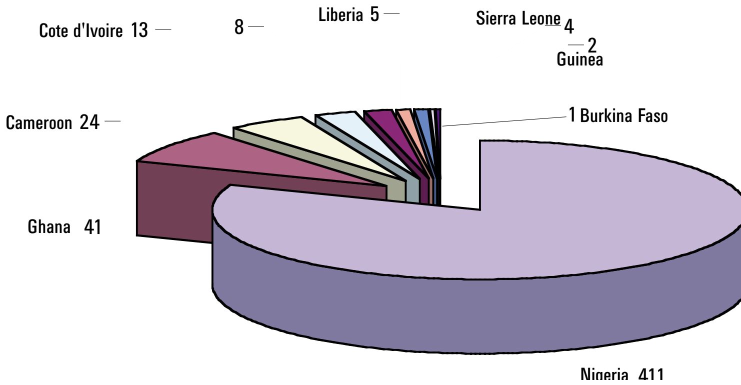

### Horn of Africa and East African Participants



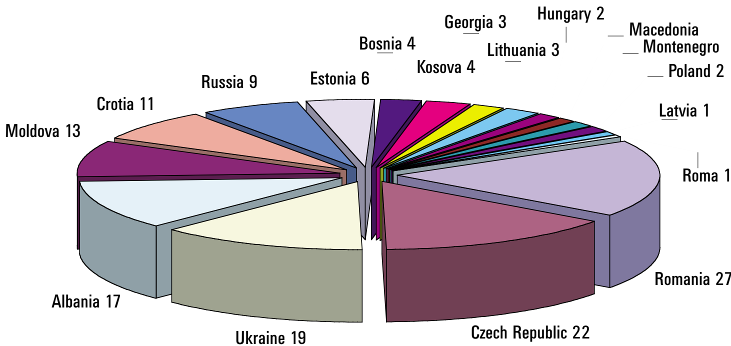
## N. African, Middle Eastern and Asian Participants




## West African Participants




## Eastern European/Russian Participants



| English and ESL | |
|---|---|
| Dari/Farsi (small English) | 1 |
| English | 408 |
| English/Africaans | 1 |
| English/Agbor | 1 |
| English/Albanian | 3 |
| English/Arabic | 2 |
| English/Benna | 2 |
| English/Bini/Yoruba | 1 |
| English/Bosnian | 1 |
| English/Croatian | 2 |
| English/Czech | 4 |
| English/Edo | 3 |
| English/Farsi | 1 |
| English/Filipino | 1 |
| English/French | 4 |
| English/Gala | 1 |
| English/Hausa | 4 |
| English/Igbo | 17 |
| English/Igbo/French | 1 |
| English/Igbo/Yoruba | 1 |
| English/Ijaw | 1 |
| English/Kosovo | 1 |
| English/Native Language | 2 |
| English/Panjabi | 1 |
| English/Pidgin | 1 |
| English/Polish/French | 1 |
| English/Romanian | 5 |
| English/Russian | 3 |
| English/Russian/French | 1 |
| English/Shona | 2 |
| English/Siswami | 1 |
| English/Somali | 1 |
| English/Somali/Swahili | 1 |
| English/Swahili | 2 |
| English/Urdu | 2 |
| English/Xhosa | 1 |
| English/Yoruba | 43 |
| Kurdish/Small English | 1 |
| Portuguese/English | 1 |
| Portuguese/English/Arabic | 1 |
| Russian Ukraine/small English | 1 |
| Russian/English/Georgian | 1 |
| Russian/small English | 3 |
| **Grand Total** | **536** |

| Eastern European Languages | |
|---|---|
| Albanian | 14 |
| Bosanki/Croatia | 3 |
| Croatian | 5 |
| Czech | 16 |
| English/Albanian | 3 |
| English/Bosnian | 1 |
| English/Croatian | 2 |
| English/Czech | 4 |
| English/Kosovo | 1 |
| English/Polish/French | 1 |
| English/Romanian | 5 |
| English/Russian | 3 |
| English/Russian/French | 1 |
| Georgian | 1 |
| Hungar | 2 |
| Lithuanian | 1 |
| Moldovan | 5 |
| Polish | 2 |
| Portuguese/Hungarian | 2 |
| Romania/Bosnian | 1 |
| Romanian | 20 |
| Romanian/French | 2 |
| Romanian/Russian | 4 |
| Russian | 20 |
| Russian Ukraine | 4 |
| Russian Ukraine/small English | 1 |
| Russian/English/Georgian | 1 |
| Russian/Estonia | 1 |
| Russian/Georgian | 1 |
| Russian/small English | 3 |
| Srbijan | 1 |
| Ukrainian | 2 |
| Yugoslavian | 2 |
| **Grand Total** | **135** |

| Arabic and Asian Languages | |
|---|---|
| Algerian | 1 |
| Amharic | 1 |
| Arabic | 13 |
| Arabic/F E | 1 |
| Arabic/French | 6 |
| Arabic/Somali | 1 |
| Dari/Farsi (small English) | 1 |
| English/Arabic | 2 |
| English/Filipino | 1 |
| English/Panjabi | 1 |
| English/Urdu | 2 |
| Farsi | 1 |
| Kurdish | 10 |
| Kurdish/Arabic | 5 |
| Kurdish/Small English | 1 |
| Mongol | 2 |
| Panjabi | 1 |
| Persian | 2 |
| Portuguese/English/Arabic | 1 |
| Urdu | 5 |
| **Grand Total** | **58** |

| Other European Languages | |
|---|---|
| Arabic/French | 6 |
| Dutch | 1 |
| English/French | 4 |
| English/Igbo/French | 1 |
| English/Polish/French | 1 |
| English/Russian/French | 1 |
| French | 64 |
| French/Dutch | 2 |
| French/Ewe | 1 |
| French/Lingala | 4 |
| French/Swahili | 1 |
| Portuguese | 11 |
| Portuguese/English | 1 |
| Portuguese/English/Arabic | 1 |
| Portuguese/French | 3 |
| Portuguese/Hungarian | 2 |
| Portuguese/Lingala | 4 |
| Romanian/French | 2 |
| **Grand Total** | **110** |

| African Languages | Total |
|---|---|
| Arabic/Somali | 1 |
| Edo | 1 |
| English/Africaans | 1 |
| English/Agbor | 1 |
| English/Benna | 2 |
| English/Bini/Yoruba | 1 |
| English/Edo | 3 |
| English/Gala | 1 |
| English/Hausa | 4 |
| English/Igbo | 17 |
| English/Igbo/French | 1 |
| English/Igbo/Yoruba | 1 |
| English/Ijaw | 1 |
| English/Native Language | 2 |
| English/Pidgin | 1 |
| English/Shona | 2 |
| English/Siswami | 1 |
| English/Somali | 1 |
| English/Somali/Swahili | 1 |
| English/Swahili | 2 |
| English/Xhosa | 1 |
| English/Yoruba | 43 |
| Ewe | 1 |
| French/Ewe | 1 |
| French/Lingala | 4 |
| French/Swahili | 1 |
| Igbo/Yoruba/Ishan | 1 |
| Lingala | 4 |
| Nigerian | 1 |
| Nkwani | 1 |
| Portuguese/Lingala | 4 |
| Somali | 8 |
| Twi | 7 |
| Urhubu | 1 |
| Yoruba | 11 |
| Zulu | 1 |
| **Grand Total** | **135** |

# Appendix 3: Transferability of the Model

### Transferability of the model

*The following elements of the model would appear to be transferable to the majority of situations:*

- Peer-led, person centred and employed approach
- The methodology
- The use of visual material
- The model used in morning sessions
- The supports for peer-led models
- The partnership approach
- The consultation and communication with local/on the ground professionals
- The support of management within Centres
- Administrative and budgetary supports

### *Areas requiring further research:*

Lesson from the pilot experience indicate further research is required in a number of areas prior to the extensive expansion of the programme. These include:

### Reception Centres

- The development of mechanism for communication and consultation between the programme and local staff
- Cultural awareness programmes for local staff
- The alternatives to a full day model
- The range of options to meet language needs
- The expansion of the role of the model to mediation, referral and broader health promotion in particular the parameters, skills and training required for an expanded role
- The long term placement of the initiative ie voluntary or statutory service
- Placement of the service in an out of Dublin context
- The development of a clearer understanding of the support needs of peer-led programmes

### Accommodation Centres [19]

If the HIP expands to Accommodation centres the need of asylum seekers will differ to those required at point of entry. Further broad research is therefore needed into the health promotion needs of people at the second stage of entry. In particular:

- The placement and sponsorship of the programme
- The identification of second level needs

[19] Asylum seekers are dispersed to Accommodation Centres placed throughout the country following their accommodation for a few days at reception Centres