

**Food, Nutrition and Poverty Among
Asylum-Seekers in North-West Ireland**

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FOOD, NUTRITION AND POVERTY AMONG ASYLUM-SEEKERS IN NORTH-WEST IRELAND

**A collaborative study by the Health Service Executive – North Western Area
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Abstract

In response to concerns expressed by asylum seekers in the North West of Ireland, this research aimed to document dietary intake and food choices and behaviour among asylum seekers in counties Sligo, Leitrim and Donegal, and to explore the social and economic context. A total of 86 asylum seekers living in Direct Provision and in rented accommodation in the community participated in the study. Quantitative and qualitative methods were used to assess daily nutrient intake and food patterns and underlying economic and social factors.

Study results highlighted issues of concern for nutritional status and health and well-being, particularly weight gain, high calorie intake from protein and fats, limited food choice, food poverty, and social exclusion. Recommendations are outlined for policy, community and individual actions, for the Direct Provision system, and for health service planning and delivery in order to promote, protect and improve health and well-being for asylum seekers and reduce their food poverty.

Key words:

food poverty, diet and nutrition, asylum seekers, poverty of choice and connection, social exclusion, North West Ireland

Disclaimer

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Executive Summary

This research study documents the realities of the food and nutrition experience of asylum seekers living in the North West of Ireland, in counties Sligo, Leitrim and Donegal. The research represents a collaborative partnership between the Health Service Executive, North Western Area¹ (HSE-NW) and the Centre for Health Promotion Studies, National University of Ireland in Galway (NUI Galway). A multi-disciplinary team with expertise in nutrition, anthropology, public health, health promotion, community health and service planning designed and implemented the study, and authored the report. The research was funded by Combat Poverty Agency.

Objectives

The research was conducted in direct response to concerns expressed by asylum seekers themselves over their food and nutrition situation and their poverty. Some concerns were also mirrored by service providers. The research objectives were:

- To conduct a quantitative assessment of the diet, nutrient intake and food-related behaviours of asylum seekers living across the region
- To conduct a qualitative investigation of the broader determinants of dietary habits among a small sample of asylum seekers
- To conduct interviews with a range of service providers and community workers dealing closely with asylum seekers, to elicit their perspectives.

Methodology

The study consisted of two parts:

1. **Quantitative** data on food intake, dietary patterns and nutrition were collected using a food frequency questionnaire with 76 asylum seekers, selected through a stratified random sampling technique. The sample was drawn from all² adult asylum seekers across the region living in both Direct Provision centres and in private rented accommodation in the community. Daily intakes

¹ Formerly known as North Western Health Board; now incorporated into the HSE Western Area

² Totalling 347 at the time of the study

of nutrients were computed using a specially written computer programme and standard Food Tables, and then analysed at NUI Galway using SPSS™ version 11.0. Three former asylum seekers granted refugee status, an East European former migrant worker, and a volunteer support worker collected the data, with training and supervision from the HSE-NW and NUI Galway research team.

2. The **qualitative** component consisted of 10 asylum seekers, recruited by purposive sampling, interviewed in-depth by two researchers who analysed the transcript data using N5 software. Interviews were also conducted with service providers. A focus group was held with a support group.

Attention was paid to ethical conduct by providing clear information to participants, obtaining consent, stating research benefits, and dealing with people with respect and cultural sensitivity. Fieldwork took place from August 2003 to March 2004.

Findings

Four main areas can be identified from the research findings:

1. Dietary intake and nutrition-related behaviours

- Asylum seekers in this sample obtain a high percentage of their total energy intake from protein and from saturated fats, and a low percentage from carbohydrate, compared to recommended levels.
- Nearly half (45 per cent) of the participants reported unintentional weight gain since arriving in Ireland.
- There is a higher intake of red meat and saturated fats among asylum seekers in Direct Provision, and a higher intake of pulses in the community.
- While the intake of fruit and vegetables in Direct Provision is adequate relative to recommendations, it is still perceived to be low by asylum seekers compared to their previous diets.
- The Direct Provision environment impacts negatively on breastfeeding and infant-feeding by reducing women's ability to eat and feed on-demand, with a tendency to overuse processed products.

2. Food poverty

- Asylum seekers in both accommodation types experience food poverty.

- Many asylum seekers, including those in Direct Provision, spend money sourcing preferred, but expensive, ethnic foods.
- Transport difficulties incur extra food shopping costs for asylum seekers.
- Lack of close family and friends limits social networks that can ease costs of transport and shopping.
- Children's needs and debt avoidance are often prioritised over food purchases.

3. Poverty of choice

- Asylum seekers want to determine their own food choices and they adopt different strategies, depending on accommodation type.
- In the community, asylum seekers often live in 'food deserts': low-rental peripheral areas which have limited physical access to shops stocking preferred ethnic foods and affordable healthy food options.
- Direct Provision imposes control over food choices which, together with other factors, impacts negatively on appetite and food-related behaviours.
- There is a lack of variety of fresh fruits and vegetables, and a repetitive weekly menu in Direct Provision.

4. Poverty of connection

- Direct Provision impacts negatively on the social context of eating.
- In the community, asylum seekers experience social exclusion and do not have wide social support networks.
- Asylum seekers are not well-integrated into community life and have few opportunities for social interaction.
- Lack of money is a key factor but so are lack of child care, language difficulties, cultural distance and mental health.

Much of the quantifiable evidence for the food and dietary experience of asylum seekers was confirmed by the qualitative evidence which helps us understand more deeply the factors underlying eating patterns and food behaviours that contribute to dietary intake and ultimately nutritional and health status.

Recommendations

The report concludes with a series of recommendations for action at different levels: the individual, the community, the health system, the Direct Provision system and for national policy. These are outlined in the Table below. This study has provided an in-depth documentation of the lived experience of food poverty for asylum seekers, the social and cultural context of their food behaviours, choices and preferences, and the central importance of food in their lives as a component of their physical, emotional and social well-being.

Key elements in achieving good nutrition are ensuring the accessibility and availability of affordable healthy food. However, choice, preference, familiarity, the social context of eating, emotional well-being and appetite, physical activity, and having control over the whole process are also important. Each of these components needs to be fully recognised and addressed at different levels, from policy to programming, in order to address inequities affecting dietary behaviour and a reduction in food poverty among socially disadvantaged people in Ireland.

Level	Recommendation
National Policy	<ol style="list-style-type: none"> 1 Review and increase allowances/ welfare payments for asylum seekers 2 Develop rights-based, pro-poor, socially inclusive public policy for health 3 Appoint a Junior Minister of State for Food in Department of Health and Children to tackle food poverty as a factor in health inequalities
Direct Provision	<ol style="list-style-type: none"> 1 Increase the choice and availability of ethnic foods and promote healthy diet options that incorporate ethnic and fresh foods 2 Work in multi-sectoral partnerships to promote and protect the health and well-being of asylum seekers 3 Provide more self-catering units and limit the time in Direct Provision to 6 months by speeding up the whole application process. After 6 months, people should live in the community and be able to work
Health System	<ol style="list-style-type: none"> 1 Ensure partnership with Reception and Integration Agency to plan and monitor food in Direct Provision 2 Participate in, or create, broad multi-sectoral partnerships to promote availability of, and access to, a wide variety of affordable ethnic foods as part of promotion of asylum seeker health and well-being 3 Be more culturally aware and competent, embed cultural and ethnic diversity and anti-racism training, and avoid ethnocentricity

- 4 Prioritise the nutritional needs of children and breastfeeding and pregnant women, and support their health-promoting behaviours
 - 5 Promote opportunities for asylum seekers to be more physically active
 - 6 Ensure the social inclusion and participation of asylum seekers
- Community**
- 1 Foster community development approaches aimed at creating supportive environments for asylum seekers to access affordable food of their choice
 - 2 Form partnerships with retail sector to increase local availability of ethnic foods
 - 3 Support asylum seeker participation in community nutrition projects
 - 4 Advocate for equal access of asylum seekers to all services
 - 5 Stimulate interest around ethnic differences in food, food habits and cooking to develop understanding and exchange
- Individuals**
- 1 Build cultural competency by participating in anti-racism/diversity training
 - 2 Acknowledge the importance of food in daily life for asylum seekers
 - 3 Adopt health-promoting behaviours and develop own nutritional knowledge
-

Chapter One: Introduction

Everyone has the right to seek and enjoy,
in other countries, asylum from persecution.

*Article 14: Universal Declaration of Human Rights*³

In the last decade, Ireland has changed considerably from a mono-cultural to a multi-cultural society. This creates both opportunities and challenges for all aspects of public policy and service provision (Quinn et al, 1999). The assumptions of sameness and homogeneity in the population, which have been a feature of service delivery in Ireland, are no longer appropriate. Policies and practices must increasingly be responsive to the emerging situation.

The research described in this report is a response to these emerging needs in the context of the growing population of asylum seekers⁴ in counties Sligo, Leitrim and Donegal (in the area of the former North Western Health Board, NWHB, now Health Service Executive, HSE). Through both quantitative and qualitative research, this report documents the diet and nutrition of asylum seekers and relates these to the social exclusion and poverty experienced by this group. The results are used to develop recommendations for policy and service delivery in order to promote, protect and improve health and social well-being for asylum seekers in the region.

The study was designed and implemented by a collaboration of people from the NWHB and the National University of Ireland in Galway (NUI Galway). The multidisciplinary nature of the team, composed of expertise in nutrition, anthropology, public health, health promotion, coordination of service delivery, nursing and community health enabled a number of perspectives to inform the process, influence the interpretation of results and shape recommendations. The research process involved the participation of local former asylum seekers granted refugee status and people working closely with asylum seekers as part of their community-based work.

³ Universal Declaration of Human Rights, adopted and proclaimed by the United Nations General Assembly resolution 217A(III) on December 10, 1948

⁴ It is important to distinguish between different categories of people: refugee, asylum seeker, programme refugee, and those with Humanitarian Leave to Remain. Definitions of these

1.1 Rationale and aims of the research

The research takes as its starting point the requirement to understand the realities of the lives of asylum seekers by listening to their voices and responding to their needs – as they define them – in order to design and deliver appropriate and quality services that can cater for this marginalised, but diverse, group of people on an equitable basis.

This research explores how issues of poverty and social exclusion interact with dietary choices, dietary intake and the nutritional status of asylum seekers living in the North West of Ireland. The overall aim of the study was to determine the dietary behaviour, nutritional status, food choices and their related structural, environmental and social determinants for asylum seekers. Specific objectives were to:

- Conduct a quantitative dietary assessment of asylum seekers living in Direct Provision and rented accommodation across the North West region
- Conduct a qualitative investigation of the broader determinants of dietary habits among a small sample of asylum seekers
- Conduct interviews with a range of service providers to elicit their perspectives on the diet, health and related determinants for asylum seekers with whom they come into contact.

It is important to stress at the outset that this research was not initiated by the health service, nor is it an evaluation or review of how the health system plans and delivers its services to asylum seekers. Rather it developed in response to concerns expressed by asylum seekers themselves over their food and nutrition situation, their poverty, their social exclusion and their difficulties in integrating with the host Irish society. These concerns were also articulated to the people working closely with asylum seekers both within the health services and within civil society.

1.2 Who are asylum seekers?

Asylum seekers are people who have arrived in the State without the required entry documentation and who, at the time of entry, apply for 'asylum'. This means asking to be recognised as a 'refugee' under the Geneva Convention of 1951.

categories are provided in the Glossary of Terms. Each definition confers a different status

A refugee is someone who:

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

For an asylum seeker, the path to becoming a refugee is to have his/her plight officially recognised through processes that have been set up by the United Nations, and dealt with in countries that offer temporary or permanent refuge. Once these processes are completed, and a case for asylum approved, an applicant's status is changed from 'asylum seeker' to 'refugee' (Allotey 2003; see also Glossary of Terms). The United Nations High Commission for Refugees (UNHCR) argues that even if many asylum seekers ultimately fail to qualify as refugees we should understand that they think of themselves as refugees, given the state of their countries, the basic suppression of human rights by failing democratic regimes, and the effects of sanctions and campaigns against those regimes.

Although human mobility is an integral part of the biological and cultural evolution of human settlement (Zwi and Alvarez-Castillo 2003), asylum seekers and refugees constitute a population group that arguably presents one of the most significant current public health challenges (Dualeh and Paul 2002). Often lost in the complexity of situations that create refugees are the specific needs of this group whose vulnerabilities are created by a combination of the outcomes of conflict, displacement and family dislocation, poverty, environmental and social risk factors for poor health, weak or only partially functioning health systems in their countries of origin, natural disasters and/or violations of human rights (Allotey 2003).

Also lost is the heterogeneity of this population. Asylum seekers are not all the same, and there are dangers in treating them as a 'single amorphous group of non-citizens' (Kneebone and Allotey, 2003). Asylum seekers come from all parts of the globe, all walks of life, and every strata of society, with significant differences created by

upon those to whom it refers, especially in legal terms.

gender, culture, socio-economic status and circumstances. Asylum seekers' experiences differ greatly depending on where they come from, on what they have experienced prior to leaving their homes, and on their personal and family circumstances. Many asylum seekers and refugees may also have experienced great trauma in the events leading up to fleeing their country of origin, including the sudden, often violent, loss or bereavement of close family members. Thus, it is clearly unwise to simplify and stereotype their experiences. However, what they all have in common is an unwanted experience of upheaval and having to uproot from their country of origin, and then having to make their way in a different culture and an unfamiliar political and social environment.

Beyond a predominant discourse on statistics about numbers of applicants and deportations, and arguments over the levels of welfare payments, it is important not to lose sight of the reality of asylum seekers' lives. A guide to General Practitioners in the UK can help set the scene. This report highlighted a wide range of factors influencing the health of asylum seekers (Levenson and Coker 1999). The main factors mentioned were:

- Poverty, cashless system of assistance, linked with poor diet
- Homelessness, or poor quality, temporary, overcrowded living conditions
- Vulnerability to experiences of racism and discrimination
- Loss of status,⁵ depression
- Bereavement and loss of loved ones
- Experience of torture and traumatic events.

1.3 Asylum seekers: their right to health and health care

Health is a fundamental human right, indispensable for the exercise of other human rights. As shown in Table 1.1, a number of articles in international covenants and declarations are explicit about the connection between health status and access to health care, and human rights.

As a member of the United Nations and signatory to these human rights instruments, the Irish government is responsible for affording protection to asylum seekers and

⁵ Many asylum seekers held influential positions in their own professions or in public life prior to leaving their country of origin

ensuring their health and well-being while undergoing the asylum process. Specifically, the government assumes the responsibility and obligation to:

- Respect, and not directly violate, the rights of an individual which includes making arbitrary decisions to withhold care
- Protect rights and prevent violations by non-state actors and provide redress for when violations occur
- Fulfil rights by taking all appropriate measures to incrementally allocate sufficient resources to meet the public health needs of communities within its borders.

Table 1.1: The international framework of health and human rights

‘Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, widowhood, old age or other lack of livelihood in circumstances beyond his/her control.’	Article 25:1 Universal Declaration of Human Rights, 1948
‘The State Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.’	Article 12:1 International Covenant on Economic, Social and Cultural Rights, 2000
‘States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy.’	Paragraph 34 General Comment on the International Covenant on Economic, Social and Cultural Rights, 2000

Clearly, limiting equal access to health and social care services for asylum seekers, as for any other population group, would constitute an infringement of their rights. The World Declaration on Nutrition also acknowledges that access to nutritionally adequate and safe food is a right of each individual (FAO 1992).

1.4 Asylum seekers in Ireland

The increasing global movement of massive numbers of refugees and asylum seekers represents one of the major moral, political and social issues facing the world today. All nations must plan for, and meet, the special and essential health and social needs of this vulnerable group of people. Recent political and conflict events in the Balkans, west and central Africa, Afghanistan, and the Middle East have led to

millions of people moving out of their countries of origin. Added to these are even more millions internally displaced within their own national borders. There are currently about 17.1 million asylum seekers and refugees worldwide (UNHCR 2004a). The vast majority of these come from countries of the developing world. Only a quarter of them ever make it to Europe. In terms of Ireland's share, out of all asylum claims submitted in Europe between 1990 and 2003 only 1 per cent have been made in this state (UNHCR 2004b).

European Union Directive 2003/9/EC of 27 January 2003 lays down minimum standards for the reception of asylum seekers in member states. This includes a section on material reception conditions and health care (EU Journal 2003). The law governing refugees and the processing of claims for refugee status in Ireland is set out in the Refugee Act, 1996 as amended by section 11(1) of the Immigration Act, 1999, by section 9 of the Illegal Immigrants (Trafficking) Act, 2000, by section 7 of the Immigration Act, 2003 and in the Orders, Regulations and Directions made under that Act (Department of Justice, Equality and Law Reform, Reception and Integration Agency).⁶ Much documentation is available on the asylum process and its legislative framework (Fanning and McEinri 1999, Collins 2002, Fanning 2002), and will not be covered further here.

The total number of asylum seekers in Ireland is constantly changing as people continue to arrive, while others leave. Generally, in the first few years of this new century, there was an accelerated growth in the number of applicants for asylum in Ireland. Recent figures show a downturn in applications for asylum in Ireland, a trend repeated across the European Union with the numbers of asylum seeker applications overall falling by about 20 per cent (UNHCR 2004b). In November 2004, applications for asylum in Ireland had reached a 5-year low. Only a small proportion of asylum seeker applicants arriving in Ireland are granted refugee status: of these 6 per cent are made at first hearing, and a further 11 per cent on appeal (Irish Refugee Council 2005).

In 2004, the top 5 countries of origin of new asylum applicants were: Nigeria (1,776), Romania (286), Somalia (198), China (152) and Sudan (145).⁷ The top 10 countries of origin of refugees recognised were: Somalia (82), Iraq (34), Sudan (34), China

⁶ www.ria.gov.ie/the_asylum_process (accessed on March 4th 2005)

⁷ statistics from the Irish Refugee Council website accessed on www.ria.gov.ie/statistics (March 4th 2005)

(23), Iran (20), Zimbabwe (18), Nigeria (18), Afghanistan (16), Ukraine (14) and Russia (14). At appeal, the top 10 countries of origin of refugees recognised were: Nigeria (87), Croatia (62), DR Congo (47), Romania (44), Albania (35), Moldova (34), Ukraine (34), Kosovo (24), Russia (23), and Zimbabwe (23).

From April 2000, the Irish state's response was a policy of dispersal to ease pressure on centres and services in Dublin. Asylum seekers were dispersed throughout the country into shared, hostel-type, full-board accommodation, known as Direct Provision. There are currently 63 Direct Provision centres across the country, housing over 6,100 people. Up until 2003, families with children or special circumstances had been allowed to move from Direct Provision into private rented accommodation in the community. Since 2003, all asylum seekers already in Direct Provision, as well as new arrivals, can only live under the Direct Provision system. By the end of 2004, nearly 15 per cent of asylum seekers in the state have been living in Direct Provision for more than two years (see footnote 7).

Table 1.2: State welfare allowances and payments for asylum seekers

Place of residence for asylum seeker	Autumn 2003 (data collection)	December 2004	Current From 3 Jan 2005
In Direct Provision	€ 19.10 week / adult	€ 19.10 week / adult	€ 19.10 week / adult
	€ 9.50 week / child	€ 9.50 week / child	€ 9.50 week / child
In the community	€ 134.80 week / single adult	€ 134.80 weekly / single adult	€ 148.50 week / single adult
	€ 224.20 week / couple	€ 224.20 week / couple	€ 247.50 week / couple
	€ 16.80 week / child	€ 16.80 week / child	€ 16.80 week / child
	€ 151.60 week / single parent	€ 151.60 week / single parent	€ 165.60 week / single parent

Table 1.2 summarises the social welfare payments and allowances made to different categories of asylum seekers living in different accommodation settings. Allowances for asylum seekers in Direct Provision were decided in April 2000, after deducting the costs of food and accommodation, and have not been reviewed since. State welfare payments to asylum seekers living in private rented accommodation in the community have increased as shown in the table in line with inflation and consistent with welfare payment increases to all other recipients.

Since 1 May 2004, when the new accession countries joined the European Union, legal changes around 'habitual residence' led to the withdrawal of Child Benefit for asylum seekers. All asylum seekers are eligible for additional Exceptional Needs Payments made at the discretion of the Community Welfare Officer for costs of travel related to medical treatment and childbirth.

In 2003, the total number of asylum seekers arriving in the European Union was only a little over half of what it was ten years ago (UNHCR 2004b). In line with this trend, the number of asylum seekers arriving in Ireland is also decreasing. Given this changing scenario and decreasing burden on European host countries, there is now an increased moral argument to make sure that the situation for those asylum seekers who are here in the state already, and those we can expect to arrive in the near future, receive the best care and services.

1.5 Asylum seekers in the North Western region

At the time of the drafting of this report (March 2005), the number of asylum seekers in the North West was 858, as shown in Table 1.3. This is more than double the number than at the time of the data collection phase of the study when the total was 347. The largest numbers of asylum seekers in the region now come from Nigeria, followed by Ghana, a nearly equal mix from other sub-Saharan African and Eastern European countries, and a small number from the Middle East.

Table 1.3: Current (March 2005) numbers of asylum seekers living in the North West region by accommodation type

	Direct Provision			Private rent in the community			Total
	Adults	Child	All	Adults	Child	All	
Sligo	206	77	283	34	18	52	335
Leitrim	75	25	100	13	7	20	120
Donegal	62	2	64	162	177	339	403
Total	343	104	447	209	202	411	858

The HSE-NW is responsible for ensuring appropriate health and personal social service delivery for asylum seekers. Table 1.4 summarises these services.

Table 1.4: HSE – North Western Area service provision for asylum seekers

Service	Main activities related to asylum seekers	Area covered
Regional Coordinator	<ul style="list-style-type: none"> • Coordinate service inputs from community services for asylum seekers • Represent the Board on National Fora for asylum seeker issues • Organise and deliver training in cultural diversity for Board staff and partner agencies • Work with support groups to promote non-statutory care • Provide information on relevant issues to Board and partner agencies 	Regional
Community Health Adviser	<ul style="list-style-type: none"> • Follow up communicable disease screening • Organise TB screening • Advise asylum seekers on health issues • Keep asylum seekers updated on immigration issues • Interact with GPs and other service providers 	1 in Donegal 1 recently appointed in Sligo/Leitrim
Public Health Nursing	<ul style="list-style-type: none"> • Carry out newborn baby checks • Promote and organise immunisation • Do developmental checks on under-5s • Provide advice to mothers and babies 	Several at sub-county level in all 3 counties
Community Welfare	<ul style="list-style-type: none"> • Deal with all income maintenance and medical card entitlements • Advise and refer on an individual basis • Maintain local database, feed into national system • Liaise with other sectors • Facilitate social events and sporting activities 	Several at sub-county level in all 3 counties 1 Coordinator for Sligo/Leitrim
Social work	<ul style="list-style-type: none"> • Readiness to support in child protection issues • Provide temporary fostering if mother hospitalised • Other routine support as needed 	Several at sub-county level in all 3 counties
Mental health	<ul style="list-style-type: none"> • Routine response to GP referrals 	All areas

Within the health system, there are specialist staff dedicated to working with asylum seekers locally as well as a multidisciplinary Asylum Seeker and Refugee Forum that meets to share information and integrate service provision for asylum seekers. Other

related responses include the development and launch of an Anti-Racist Code of Practice and development and implementation of ethnic diversity and anti-racism training modules as part of an overall equality and diversity training programme for all staff. Although the North Western region hosts the smallest number of asylum seekers in the country, its historical and geographical peripherality and the continuing strength of traditional social structures present specific challenges for service planning and delivery to this population group.

Chapter Two: Background

Food is never 'just food' and its significance can never be purely nutritional ... it is intimately bound up with social relations, including those of power, of inclusion and exclusion, as well as with cultural ideas about classification, the human body and the meaning of health.

Caplan 1997

This chapter explores how food choice is largely determined by non-nutritional factors such as culture, social norms and behaviours. Having set the social and cultural context of food, the chapter then reviews the literature on food poverty (see section 2.2 below for definition) in general, and food poverty among asylum seekers in particular. We look at the evidence that illustrates how living on a low income with limited means, few social supports, and on the margins of mainstream society, can affect dietary patterns and the quantity and quality of the diet at both individual and household levels. These are major socio-economic factors that determine the short and long term nutritional status and health of individuals and this population group as a whole.

2.1 Food choice is a complex phenomenon

Food is an expression of who a person is, what they are worth and a measure of their ability to provide for their family's basic needs. Food is also a focus for social exchange and a major contributor to health and well-being.

Dowler *et al.*, 2001

Food is much more than nutrition, and food choice is more than just an important health-related behaviour (Fine *et al.* 1996, Murcott 1998). Moreover, while eating is obviously a universal and necessary feature of human existence and survival, it is almost infinitely variable in actual practice, varying both within and between societies (Gofton 1986). This makes food choice hard to predict and the analysis of food choice far from simple (Duran and Dolan 1997, de Garine 1997, Devine *et al.* 1999, Rozin 2000).

Evidence in the anthropological and sociological literature on nutrition, diet and food reveals that many of the qualities and attributes we link with particular foods are largely symbolic and embedded in our cultural and societal norms (Douglas 1975, Messer 1984, Murcott 1988, Martens and Warde 1998, Coveney 2000). Work with Chinese immigrants in London demonstrated that food selection is influenced far more by cultural factors than by knowledge of the nutrient content of food or other physiological qualities of food (Wheeler and Tan 1983, Wheeler 1992).

Worldwide, migrants are usually slower to discard their food habits than many other aspects of their cultural life (Shiels 2004). Because of the central place of food in cultural group identity, a change in place of residence does not mean that there is an automatic change in dietary preferences and choice (Storey and Harriss 1988, Harbottle 1997, Luke et al 2001). Food operates as a source of group, as well as national, identity. For example, there is evidence about strong culturally-determined food beliefs and practices relating to diet during pregnancy, childbirth and the weaning period that persist during residence outside Nigeria (Ojofeitimi and Tanimowo 1980, Odebiyi 1989, Orwell et al 1984). The Irish multicultural newspaper, *Metro Éireann*, has also reported on persistence of traditional food habits and food purchasing behaviours among asylum seekers and refugees, for example Romanians (Reilly 2005).

Ethnicity is kinship on a larger scale, and, like ethnicity itself, ethnic cuisine only becomes a self-conscious, subjective reality when ethnic boundaries are crossed (Van der Berghe 1994). With asylum seekers crossing ethnic and culinary boundaries, their different food tastes and preferences clearly mark them as alien to the host society and their own consciousness of that can become pronounced. The readiness of a migrant individual, or group, to adapt food habits to the norms of the new host culture is an indicator of cultural distance, which has been associated with psychological distress and ill health. A Glasgow study of South Asian refugees found that refugees occupied an economic niche with considerable cultural distance from the majority and concluded that this was injurious to their health (Williams 1993).

Humans share food. It is our central social ritual, and applies in the first instance to our immediate family as nearly all of us have been nurtured in small family groups. Anthropological literature cites evidence of food sharing as 'a metonym for the family' and marks family roles and relationships in a material form (Douglas 1975, Moisi et al 2004). Food made in the home for the family is charged with symbolism (Charles and

Kerr 1988, Petridou 2001, Bugge 2003), and promotes intergenerational care-giving, altruism and love as model characteristics (Moisi *et al* 2004). Anthropological literature provides many examples of how food mealtime rituals and practices contribute to family identity and domestic life (Douglas 1975, Charles and Kerr 1988, Valentine 1999, Tuomainen 1996). Mealtime rituals discipline and 'normalise' children (Grieshaber 1997), and family food consumption socialises moral values, duties and valued experiences (Gullestad 1995).

Food also acts as 'social glue' (Quandt *et al* 2001). The social environment in which food is prepared, distributed and consumed, the cooking together, eating out, eating together and food sharing, all serve to reinforce social relations and cultural norms. Therefore, it is useful to consider not only what traditional foods were consumed, but also traditional meal patterns (Goode *et al* 1984). Any enforced change in these components of meals and eating patterns can have implications for dietary intake and may be significant for asylum seekers, especially those living in Direct Provision.

In conclusion, while the title of this research refers to poverty, it does not imply that economics is the most important issue when considering the food and nutrition of asylum seekers. It is very important to realise that, beyond issues of accessibility or affordability, people's food choices are also governed by a number of other factors.

These include:

- Taste and smell differences and preferences
- Unfamiliarity and differences between new and other [own] foods
- Lack of knowledge of how to prepare/cook new foods
- Perceptions that certain food items are harmful
- Texture differences and preferences
- Culturally categorised qualities (many cultures add symbolic labels, such as 'hot-cold' or 'moist-dry' to be intrinsic properties of individual food categories that affect internal healthy balance)
- Perception of physiological/digestion effects (e.g. gas-producing foods, such as certain legumes, may be avoided)
- The nutrition and health beliefs of the local culture, which may deem certain foods good or bad for certain conditions (e.g. green leafy vegetables or salads may be judged good for the blood, for lowering blood pressure, for mitigating the debilitating effects of diabetes; salty and spicy meats may be considered bad for these same ailments or for the heart).

In considering why people eat what they eat, and what motivates this health-related behaviour, it is useful to bear in mind that nutrition knowledge (i.e. what foods are known to be good/bad for health and nutrition, and communicated through nutrition education and health promotion activities) is likely to play only a small part in determining the food choice of individuals. This is confirmed by the lack of systematic evidence that shows nutrition education interventions and measurements of nutrition 'knowledge' having a direct and beneficial impact on food choice and subsequent nutrition intake (Axelson et al 1985, Wheeler 1992, Tedstone et al 1998).

This should alert us to ensuring that health promotion approaches need to be mindful of not taking food and eating out of its social context (Mintz 1994, Rozin 1996). We must look at food choices of asylum seekers within their particular context, and consider a range of influencing factors likely to determine their food choices, only one of which will be income and poverty.

2.2 Nutritional status, diet and food poverty

Nutritional status is the extent to which an individual is experiencing undernutrition or overnutrition, or is in a state of nutrition balance. Nutritional status is a major determinant of current health status and future health outcomes for individuals and households throughout the life cycle and, in the case of pregnant women, a determinant of health for the foetus and the newborn (Gibson 1990). An individual's nutritional status is determined by a combination of factors including genetics, predisposition to certain conditions, patterns set down during foetal growth and development, past and current pattern of physical activity, and past and current food intake.

Diet plays a very prominent role in determining nutritional status and inequalities in health outcomes, such as premature death from a number of dietary-related chronic health conditions including cardiovascular disease, some cancers and diabetes (James et al 1997). The burden of disease attributable to habitual diet is greater than is often appreciated (WHO 2002a).

At its fifty-first session in 2001, the World Health Organisation Regional Committee for Europe considered inequalities, including the issue of food poverty (document EUR/RC51/S). It has recently produced a 5-year policy (WHO 2000) and associated action plan (WHO 2002b) to guide member states in developing inter-sectoral food and nutrition policies, and is documenting evidence of the impact of poor nutrition and lack of access to food across the European Union. However, there is still little policy recognition of food poverty and, as yet, no national social policies anywhere in Europe that explicitly acknowledge the need to address food poverty and food hunger (Riches 1997, Robertson 2000, WHO 2000a).

It is important to consider the meaning and scope of food poverty. Across ethnic groups, data worldwide show that diets progressively become more unbalanced, and less in line with nutritional requirements⁸ with decreasing socio-economic status (James et al 1997, Irala-Estevez et al 2000, Roos et al 2001). However, although lack of income is a central feature, and clearly has a constraining effect on the food choices people make, it is not the only determinant of the complex phenomenon of food poverty. Social inequalities are as important as income in understanding food poverty and its relationship with nutritional status and health (Dowler and Calvert 1995, Dowler and Dobson 1997, Dowler 1998).

There is growing evidence that the social context in which people live their lives can impact on nutritional status through influences on food choice and dietary intake. Inadequate or inappropriate nutritional intake is largely related to social inequalities and inequity, which operate partly through income poverty, but are not solely explained by it.

In 2001, food poverty in the UK was described as:

the inability to acquire or consume an adequate quality or sufficient quantity of [nutritious] food in socially acceptable ways, or the uncertainty that one will be able to do so.

Dowler et al 2001

This definition emphasises that food poverty is not just about money; it highlights the importance of the social context and how food is part of people's socio-cultural identity. Building on the increasing evidence-base in the UK, there has been a growth

⁸ Nutrition requirements for healthy growth, physical and mental development, pregnancy and breastfeeding, and activity

in advocacy, discussion and policy documents relating to food poverty and policy published over the last few years (Cole-Hamilton and Lang 1986, Department of Health UK 1996, National Food Alliance UK 1997, Webster 1998, Dowler 1998, Lang 2000, Lothian Anti-Poverty Alliance 2001, Watson 2001, Sustain 2002).

It is a cruel paradox that one of the most obvious symptoms of food poverty is fatness (Sharpe 2003). Though the caloric intake of poorer families may be high, their micronutrient levels are lower. Overall, the diets of poorer people are more likely to lead to poor health, including obesity, than the diets of the more affluent (Sharpe 2003, UK National Food Survey 1998). The foods we are supposed to be eating more of, such as fruit and vegetables and low-fat items, are more likely to be on the menu in high-income homes than low-income ones.

Conversely, poorer people are eating more sugar and whole-fat milk. The difficulties of preparing healthy food for a family on a low budget are increased by the fact that many processed foods provide better value per calorie than some healthier alternatives such as fruit and vegetables (Sustain 2002).

People on low incomes can have difficulties in accessing affordable and quality foods where they live. Lack of transport, cost of transport, and lack of quality affordable food nearby can lead to people living in 'food deserts' (Sustain 2002, Reising and Hobbiss 2000). The shift to out-of-town supermarket shopping, for all its convenience, has also left many low-income consumers at a disadvantage.

Shopping has become an overwhelmingly car-borne activity, but UK research on disadvantaged households shows that 68 per cent of households dependent on benefit lack access to a car. So either transport costs have to be added to the food bill, or shopping has to be done at local shops, often those linked to a petrol station or small general convenience stores which sell a limited range of mainly packaged foods at higher prices than supermarkets (Sharpe 2003).

In Ireland, food poverty is a relatively new area of investigation. The lack of national policy direction on food poverty and on nutrition has recently been addressed by the Combat Poverty Agency (Friel and Conlon 2004). This review highlights the important contributions of a number of advocacy and policy documents in bringing the issue to wider attention. While there is still little direct evidence, extrapolation from secondary data analysis suggests that social inequality in dietary behaviour

exists in Ireland and that socially disadvantaged people in Ireland are certainly at risk of food poverty.

With food poverty, there is no simple threshold of food deprivation below which people are hungry, but a social gradient in dietary habits.

Friel and Conlon 2004

Table 2.1 summarises studies on population groups that refer to food poverty both in Ireland and elsewhere.

Table 2.1: Studies referring to food poverty in disadvantaged groups

Population group	Ireland	In UK (and elsewhere)
Refugees/asylum seekers	Fanning et al 2001 Corbett 2002 Collins 2002 Kennedy & Murphy-Lawless 2001	Sellen et al 2000 Cole-Hamilton and Lang 1986 McLeish et al 2002 Dwyer and Brown 2004
Homeless people	Walsh 2002 MacNeela 1999 Hourigan and Evans, undated Hickey and Downey 2004	Derrickson et al 1994 (USA) Luder et al 1990 Stitt et al 1994 Evans and Dowler 1999
Older people	Layte et al 1999 Friel et al unpublished 2000 Quandt et al 2001	EURONUT-SENECA studies (across Europe)
Medical card holders	SLAN 1998	
Mothers parenting alone	McCaskin 1996 Moloney 2001 Graham 1994	Dowler and Calvert 1995 Graham 1992
Travellers	McNamara 1995	
Long-term unemployed	Lee and Gibney 1989	Hobbiss 1991
Low income families	Daly and Leonard 2002 Clarke 1993 Friel 2003 Gormley et al 1989 Vincentian Partnership 2002 PAUL partnership 1998 Murphy-Lawless 1992 Friel and Conlon 2004	Dobson et al 1994 Carragher et al 1998 Hulshof et al 1991 (Holland) Nelson 1997 Owens 1997 Coakley 2001 Wrieden et al 2002 Sustain 2002
Rural dwellers	Nolan et al 1998	
Children	NicGabhainn et al 2002	Watt et al 2001

Friel and Conlon's review (2004) highlighted the difficulties that people on low incomes, people who are homeless, people who live in temporary accommodation or who are just moving away from home for the first time, have in providing themselves with a healthy diet. People who experience social disadvantage:

- Eat less well compared to those from socially advantaged groups
- Spend relatively more money on food, even though the amount spent is less, than is the pattern among socially advantaged groups
- Have more difficulties accessing a variety of nutritionally balanced, good quality, and affordable foodstuffs than socially advantaged groups
- May know what is 'healthy' but are restricted, physically and mentally, by a lack of financial resources.

2.3 The social determinants of food poverty for asylum seekers

Food is a general marker of social exclusion, and those who are unable to eat in ways that are acceptable to society can also be said to experience food poverty.

Dowler *et al.*, 2001

Evidence across the developed world demonstrates that healthy eating costs more than eating unhealthily (Sharpe 2003, UK Food Commission 2004, Friel *et al.* 2004). For asylum seekers too, there is a clearly a link between poor health and food poverty and past and present economic deprivation. Some asylum seekers arrive, having experienced extreme poverty, from least developed countries or deprived areas of middle income countries; or they may have experienced upheaval in areas of war or displacement. Many also have inadequate nutritional status for health, related to the poor nutritional norms of their area of origin (King's Fund 2000).

Studies of the children of refugees and immigrants in Central America reveal that they suffer from high morbidity, with a higher incidence of diarrhoeal and respiratory illness and low weight-for-age than local counterpart children (Moss *et al.* 1992). The authors concluded that poverty is the main determinant of these adverse health outcomes, irrespective of their legal status, origin or length of time in the country.

Whatever their income, people make food purchases according to their financial resources but it is also important to remember that they do so in a social and cultural context. Although there is still debate about how this context interacts with health and nutrition, the social and cultural context is by no means the same for all people in Ireland (Salant and Lauderdale 2003). The social and cultural stresses of being an asylum seeker are markedly different from, and probably more complex than, the majority Irish population, for several reasons:

- **Social exclusion** is a broader concept than poverty because it encompasses not only low economic and material means but also the inability to participate effectively in economic, social, political and cultural life, and in some circumstances, alienation and distance from mainstream society (Baum 1999, Department of Social, Community and Family Affairs 2001-2003). Away from their families, friends and communities, asylum seekers live in a drastically curtailed social environment which can detrimentally affect their access to food as well as their enjoyment of the social context that food normally brings.
- People **living alone** may miss meals, snacks, or liquids, be less likely to go out in search of sociability, care, food, and health care, and may reduce their appetite for food, access to care and functional ability (Manandhar 1999, Pieterse et al 2002). This may be the experience for many asylum seekers finding themselves for the first time living alone without any family and friends for support. Most migrants report that the more contact there is with already established migrant ethnic communities as well as the host community the more people benefit from social support and 'stress-buffering' (McKay et al 2003).
- **Acculturation** can be broadly defined as culture change. It results when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both groups (Redfield 1936, quoted in Salant and Lauderdale 2003). For some people, migration may be beneficial to mental health as they leave the cause of the problem and arrive in a place where diagnostic and treatment opportunities are available to them, but for many others the reverse is true (Sundquist and Johansson 1996). The experiences of encountering a different society can be associated with violent uprooting and disruption of social and cultural connections with the home country, post-traumatic stress, not feeling secure in everyday life, conflict of values, loneliness and poor self-esteem, and perceived and

experienced discrimination and racism. Evidence from a UK review of migrant mental health reported more feelings of changed energy levels, changes to appetite and to dietary choice among immigrants compared to native groups (McKay et al 2003). Migrants also tended to exhibit disadvantaged nutrition risk factor profiles and suffered from more hypertension, chronic conditions and obesity. The authors concluded that the greater the degree of acculturation, the greater the risk of weight gain.

- **Fear** over a food supply that is controlled by (unknown) others can lead to alarming psychosocial issues for asylum seekers. Hunger strikes are common among asylum seekers in detention centres, protesting their lack of control and disempowerment, and general living conditions. In Australia, riots have taken place over the provision of food, with reports by asylum seekers of fear of eating detention-centre food, believing that, for example, sedatives are added to ingredients. Absurd though it may sound, it indicates the level of paranoia that can exist (Tyler 2003). In Ireland, tensions over food provision in Direct Provision have also been reported (Reilly 2004).

2.4 The food poverty of asylum seekers in Ireland

In Ireland, we still know very little about the social situation of asylum seekers, how this impacts on their health and social well-being. We have not yet explored how asylum seekers access healthy food choices that are acceptable to them and how they adopt coping strategies to escape food poverty. Recently, however, some Irish research has begun to highlight these issues (Kennedy and Murphy-Lawless 2001, Collins 2002, Corbett 2002, Nolan et al 2002).

The accommodation of asylum seekers in Direct Provision, and the provision of full board with a small weekly allowance (see Table 1.3), has effectively removed them from the mainstream welfare provision. The food provided for asylum seekers living in Direct Provision accommodation is determined by a contract between the Minister for Justice, Equality and Law Reform and the accommodation provider. Clause 5 of this contract stipulates the provider's obligations in the provision of catering services, and sub-clause 5.3 states: 'the menus offered shall reflect the reasonable needs of the different ethnic groups accommodated at the Centre' (RIA 2003). However, the

definition of this is unclear. The contract provides sample menus that include foods such as sauerkraut, Romanian chicken stew, *ogbuno* soup and pounded yam.

A report from the Western Health Board is critical of the 'blanket approaches to accommodating, feeding and supporting asylum seekers' in Direct Provision (Corbett 2002). Another study reported that Muslim asylum seekers within Direct Provision feel that food within centres is unsuited to their dietary needs (Nolan et al 2002). Catering staff in Direct Provision centres have also reported that trying to cater for different nationalities, religions and preferences is a major challenge, and asylum seekers in Cork have demanded that a much wider variety of foods of ethnic origin be made available (Collins 2002).

A document entitled *Direct Provision and Dispersal: 18 months on*, published by the Irish Refugee Council in 2001, acknowledged that there was wide variation in the food situation for asylum seekers within the Direct Provision system:

Some condemn asylum seekers to share a room with up to five others, with no access to services and to eat food that some dislike intensely, and at a time not of their choosing; whereas others have their own bedrooms and cook their own food at a time that is convenient to them.

Irish Refugee Council 2001a

The structured meal times and lack of access to cooking facilities in Direct Provision fail to meet the food needs of many people, and raise concerns about important links between health problems and long stays in communal accommodation (Fanning et al 2001). Inadequacies in food and nutrition have been highlighted particularly for pregnant and breastfeeding women (Kennedy and Murphy-Lawless 2001), which echoes similar work about women asylum seekers in the UK (McLeish 2002, McLeish et al 2002, Dwyer and Brown 2004). Women themselves have reported difficulties with breastfeeding and revert to artificial feeding (Fanning et al 2001).

There has been criticism of the limitations put on pregnant women and mothers of small children in Direct Provision accommodation. This criticism relates to the lack of choice and control over food, and not being able to cook for themselves and their infants despite the necessity to supplement their children's food (Collins 2002, Tunney 2002). African women in Direct Provision have complained that they are denied a fundamental part of their way of life: cooking food for their families.

The Fanning report (2001) referred to cases of malnutrition among pregnant and breastfeeding women, ill-health related to diet in babies, weight loss among children, and worries about the health of children and hunger among adults as a result of 'within household rationing' in order to prioritise the needs of children. It concluded that the current system of food provision in Direct Provision is inadequate, unsuitable for the needs of parents, and largely fails to meet the food requirements of asylum seeking children. This echoes similar work among asylum seekers in the UK (McLeish 2002, McLeish et al 2002, Dwyer and Brown 2004).

Extreme economic deprivation may also be experienced by asylum seekers in Direct Provision as a result of inadequate diet and the inability to afford sufficient, and appropriate, food alternatives of choice because of inadequate income. There is some evidence that the current Direct Provision system puts people seeking asylum at a high risk of poverty and that their food poverty becomes pronounced (Fanning et al 2001, Nolan et al 2002, Friel and Conlon 2004). The organisation of Free Legal Advice Centres (FLAC) considers that Direct Provision is a departure from existing social welfare legislation, describing it as discriminatory and without legal basis (FLAC 2003).

Lack of money among asylum seekers in Cork and Kerry was linked to difficulties of keeping in contact with family at home, with health care provision, with childcare and child education costs and with socialising outside the centres (Nolan et al 2002). In focus groups, food emerged as the most contentious issue and the one felt to be most in need of change. Many asylum seekers said that the food provided was culturally inappropriate and repetitive, and their experience of an imposed lifestyle centring on a lot of fried foods combined with physical inactivity was widely regarded as having a negative impact on health (Nolan et al 2002).

The Irish Refugee Council is critical of the Direct Provision system in relation to social exclusion and has highlighted its negative impacts:

Direct Provision reinforces social exclusion. Ireland is a cash economy: to participate one needs access to money for transport, for example, and to engage in social activities.

Irish Refugee Council, 2001a

The main recommendation of the Fanning report was that the policy of accommodating asylum seekers in Direct Provision should be limited to the first six months following their arrival in the country, after which the right to work should be granted, enabling more people to move into rented accommodation in the community (Fanning *et al* 2001). This is echoed in the recent policy and food poverty review (Friel and Conlon 2004) in which the authors call for the abolition of the system of Direct Provision, urging that asylum seekers be treated under the general social welfare schemes. The report also recommends that asylum seekers be granted the right to work after 6 months of residency in the state, with a policy approach ensuring a minimum income standard rather than a focus on Direct Provision.

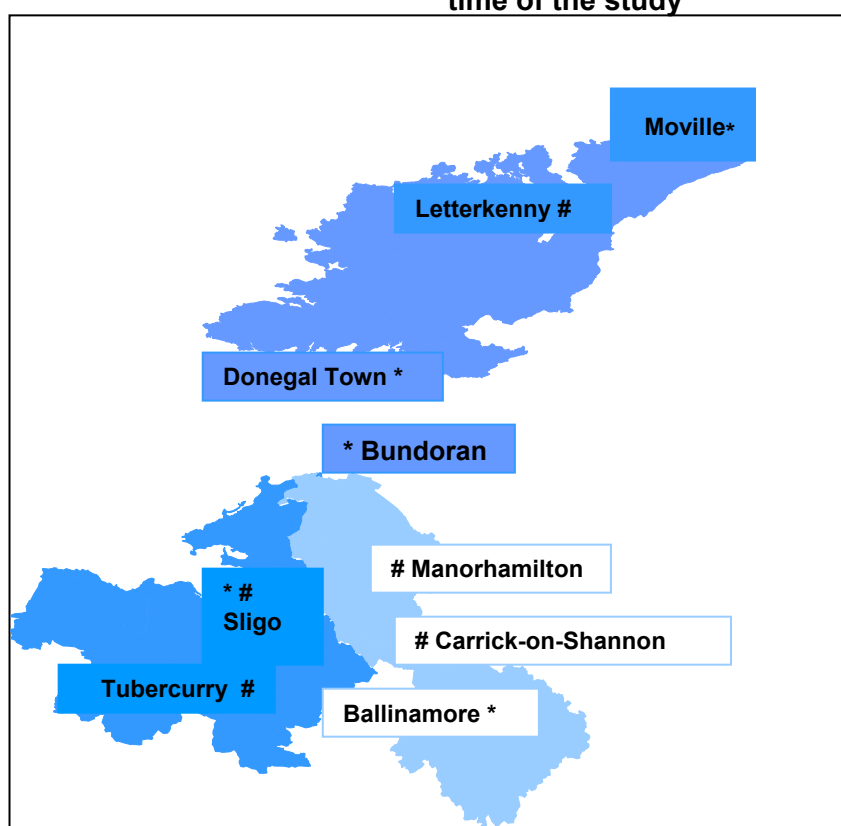
Unfortunately, compared to asylum seekers living in Direct Provision, we know much less about food, nutrition and poverty issues for asylum seekers living in the community. A needs analysis of asylum seekers and refugees in Cork showed different experiences in relation to food and nutrition for those in Direct Provision and those in private rented accommodation (Collins 2002). Asylum seekers in private rented accommodation reported more satisfaction with their food because they had a degree of control over cooking what they liked. Although in receipt of social welfare entitlements, asylum seekers, unlike other welfare recipients, also experience:

- lack of access to transport, while often being located on town periphery
- a very limited social network in the community
- extreme marginalisation due to racism
- lack of access to training.

Chapter Three: Methodology

This chapter outlines the quantitative and qualitative data methodologies used in the research study. Triangulation of research methods facilitated the quantification of dietary practices along with a qualitative investigation into the reasons why asylum seekers eat the food they do. Important issues of ethics and culturally-competent communication were taken very seriously throughout the research.

Fig 3.1: Map of North West Ireland showing where asylum seekers lived at the time of the study



Key: * denotes Direct Provision centre # denotes asylum seekers in rented accommodation

3.1 Assessing food intake and choice: methodological considerations

There are a number of validated and robust methodologies for assessing dietary intake in community-based settings as part of nutritional status assessment (Messer 1989, Kohlmeir et al 1994, Nelson and Bingham 1997). The two types of observational survey methodology available are quantitative dietary intake instruments known as 'food recall' and 'dietary record' (Haraldsdottir 1991,

Livingstone 1995).⁹ Special attention needs to be paid when using these among ethnically diverse groups or among groups very different ethnically and culturally from the dominant group.¹⁰ Although food and nutrition studies on asylum seekers across the European Union are few (WHO Regional Office for Europe 2004)¹¹, a growing literature on diet, nutrition and ethnicity points to the importance of understanding the cultural system of unfamiliar ethnic groups.

There are also warnings about the dangers of applying research instruments designed for use in the dominant, white culture (Al-Mokhalalati 1982, Lockie and Dickerson 1991, Tuomainen 1996, Kassam-Khamis et al 2000). The importance of using qualitative approaches for the study of diet and nutrition among asylum seekers is obvious when we consider that food is a cultural item and that the cultural context of food is an important factor influencing food choice (as discussed in section 2.4. above).

Taking all these factors into consideration, the research team selected a combination of quantitative and qualitative data collection tools as outlined in Table 3.1.

Table 3.1: Dietary intake and food choice methodology adopted in the study

Data type	Method	Variables
Quantitative		
Demographic and social profile	Some data available from NWHB databases Missing variables added to a structured questionnaire	Age, marital status, years of schooling, immigration status, period of residency in the North West, ethnicity, national origin, religion, children, accommodation type
Dietary and nutritional assessment	Food Frequency Questionnaire (based on instrument already developed by CHPS)	Food consumption: nutritional adequacy, quality and quantity. Food basket: elements of cost, availability, retail, and exchange
Qualitative		
	Semi-structured interviews with asylum seekers, service providers and key informants with some written submissions. Focus group with support group	Poverty and social exclusion issues Perceptions of diet adequacy, well-being Differences between current and previous/habitual diet Food preference and choice Social networks, community life Cooking and preparation Consumption, social context of meals

⁹ For more details, see Gibson 1990

¹⁰ Considerable cross-cultural work has been done on improving the methodology for assessing patterns of food intake among different ethnic groups worldwide by the International Union of Nutritional Sciences (IUNS)

¹¹ Personal communication with Aileen Robertson

3.2 Quantitative study: assessing diet, nutrient intake, behaviour and food choice

A Food Frequency Questionnaire instrument was developed from a modified version of one used in the national health and lifestyle survey (SLAN) of the general Irish adult population (Friel et al 1999), as well as a questionnaire previously validated by the Centre for Health Promotion Studies, NUI Galway and Focus Ireland in studies of food and nutrient intake among homeless people in Galway and Dublin (Walsh 2002, Hickey and Downey 2004).

The piloting of the Food Frequency Questionnaire provided valuable insight into the appropriateness of the instrument and led to a number of changes, including additions and deletions from the list of foods, changes to wording in the context of cultural appropriateness and ease of comprehension, adding food portion photographs, and re-ordering questions. The final instrument was designed to cover the whole diet and included 152 food items arranged into the main food groups (see Appendix A).

Seven sections, involving mainly closed questions, focused on the following areas: socio-demographic details; food and nutritional status (Food Frequency Questionnaire); nutritional knowledge; eating patterns; access to cooking and storage facilities; food purchasing patterns; and general health. Frequency of consumption was determined by asking participants to indicate their average use of each food item over the previous 30 days by ticking one of nine possible frequency categories. For each food an amount depicting a medium serving or common household unit (e.g. slice, teaspoon) was included to help estimate portion size.

Due to national policy restricting the paid employment of asylum seekers, the recruitment and training of local asylum seekers to act as interviewers in the research study was not possible. Instead field interviewers were recruited through local networks in the community and voluntary sector.

Five people (3 men, 2 women) were recruited as interviewers for the Food Frequency Questionnaire:

- three former asylum seekers (2 African, 1 Middle Eastern) who had been granted refugee status and thus could be employed

- one Irish national involved with a local asylum seeker support group
- one East European migrant, now a local resident, who had contact with asylum seekers in a work capacity and was married to an Irish national.

These interviewers were selected according to their experience and understanding of asylum seeker issues, good English, cultural sensitivity, and communication skills. Field interviewers were trained over two days on the aims, objectives and methodology of the project. An information pack was given to each interviewer which included the above information, an individual photo identity badge, food portion size pictures, and photos of unfamiliar foods identified in the pilot.

The sample frame constituted the complete up-to-date list of asylum seekers living in Direct Provision and in rented accommodation in the community across the three counties. A total of 347 asylum seekers were resident in the region at the time of the study design. Sample size calculations were based on detection of a number of point estimates identified in relevant literature. After excluding people known to be experiencing significant personal trauma, the selection criteria for recruitment into the study were: asylum seekers who had applied for refugee status in Ireland and were resident in counties Sligo, Leitrim and Donegal; were aged 18 years or older; and spoke some English.

With the aid of key informants from the Health Board and from the community and voluntary sector, names and contact details of a total of 83 asylum seekers living both in Direct Provision centres and in privately rented accommodation in the area that matched the above criteria were available. Letters were sent directly to asylum seekers living in privately rented accommodation explaining the nature of the study and asking for their participation (Appendix B). Similar letters were sent to the managers of the Direct Provision centres explaining the nature of the study and asking permission to visit and interview the occupants (see Appendix C).

The quantitative data collection took place in the autumn of 2003. Administration of the questionnaires took place either in the participant's home (in the case of those living in privately rented accommodation) or in a private space in the Direct Provision hostel. A number of asylum seekers living in the centre that did not give the field workers permission to visit were interviewed outside the hostel with the help of an asylum seeker support group in the area. Quality of data collection was assured by

regular inspection of completed questionnaires and rapid follow-up on any gaps or inconsistencies.

In the food frequency section of the questionnaire, foods were converted into quantities using standard portion sizes. The daily intakes of energy and nutrients were first computed from the food frequency data using a specially written computer programme¹² which linked the frequency options with the cooked food equivalents in McCance and Widowson Food Tables 5th edition (1997). All quantitative data were analysed using SPSSTM version 11.0.

3.3 Qualitative study: hearing what asylum seekers and others have to say

The second component of the research used qualitative methods to investigate issues relating to food in the lives of asylum seekers in the region. This involved documenting the perspectives of asylum seekers, as well as the perspectives of key service providers and members of support groups coming into regular contact with asylum seekers. Each interview set out to capture the meaning of food and its cultural and sociological significance in asylum seekers' lives.

Individual semi-structured interviews (see Appendix D), each lasting between 1-1.5 hours, were conducted with 10 asylum seekers during the autumn and winter of 2003. Of these 10 interviews, 4 were men living in Direct Provision. Of the 6 women interviewed, 4 lived in private rented accommodation and 1 lived in Direct Provision. Participants were recruited through the managers of Direct Provision centres and the Community Health Adviser and Community Welfare Officers. Attempts were made to interview individuals from a variety of cultural backgrounds and those who could speak and understand English. Two interviews required some assistance from a family member who acted as a translator. In all cases, participants agreed to the tape-recording of the interview.

Interviews were audio-taped and transcribed. The interview transcripts were thematically analysed through reading and re-reading the transcripts and listening to the tapes. For the next stage of the analysis each transcript was indexed and managed using N5 qualitative data analysis software to assign the text of the

¹² Written by B. Kanagaratnam, Dept. Experimental Medicine, NUI, Galway

transcripts to content category codes, providing a broad framework for analysis. The second stage allowed for the further assignment of text to other emerging category codes. The first phase of the coding was completed by two researchers independently reading the transcripts and allocating categories. For the second stage both researchers discussed the content of the finer grained results and revisions were made until a high degree of inter-rater reliability was obtained.

A total of 10 service providers who were in close and regular contact with asylum seekers were interviewed for this part of the study, as shown in Table 3.2. A female trainee General Practitioner conducted individual private interviews with 4 General Practitioners who had considerable numbers of asylum seekers as patients. All the service providers had been seeing asylum seekers for at least one year, and some for as many as 4 years. A member of the research team conducted a focus group with a support group for asylum seekers in Sligo. Appendix F contains the list of questions posed to service providers and support groups.

Table 3.2: Breakdown of service providers interviewed for the research

Health Providers / supports	Sligo/Leitrim	Donegal	NW region
General Practitioners	2 interviews	2 interviews	
Community Welfare Officers	1 interview	1 interview	
Public Health Nurses	1 interview	1 interview	
Regional Services Coordinator			1 written submission
Community Health Advisor			1 written submission
Local support group	1 focus group (8 participants)		

3.4 Ethical considerations

The research team adhered to four principles of good ethical practice outlined in key international documents (Medical Research Council UK 1992, CIOMS 2002, World Medical Association 2000, Nuffield Council on Bioethics 2002), namely:

- Providing clear information, prior to, and at the time of, interview and during dissemination, including right to withdraw

- Obtaining consent and allowing time for reflection, questions and refusals
- Stating the benefits of the research for various parties involved
- Dealing with people respectfully and with cultural sensitivity.

The study purposely selected only those asylum seekers that had some command of English. Interviews for both parts of the study took between 45–90 minutes and efforts were made to conduct them at a time and venue comfortable for the participant. It was stressed that participation or non-participation in the study was not related in any way to the asylum seeking process and would have no influence on it.

Each participant was given a €10 telephone card as a token of appreciation for his/her time and contribution, and an information pack containing background to the research, its expected benefits and use,¹³ a contact list for nutrition-related queries, and general healthy eating leaflets published by the Department of Health. All women participants were interviewed privately by a woman interviewer. The involvement of former asylum seekers in the development of the research instrument and data collection greatly assisted the ethical process.

3.5 Study limitations

The asylum seekers in this study were recruited through contact with Direct Provision centres and community workers who work with asylum seekers in the region. A possible selection bias may have occurred with this sample enjoying a stronger network of support, with subsequent influences on dietary behaviour. Most asylum seekers unable to speak any English are excluded in this research, but this group may well be less nutritionally stable and more isolated than those participants who had some command of English.

These results relate only to the sample of asylum seekers surveyed in the North West region of Ireland and are not necessarily representative of the asylum seeker population in the country. Although children do make up a large proportion of the sample frame for asylum seekers in the North West, no children were involved in the study and their specific dietary needs and nutritional situation were not investigated.

¹³ Published national report with recommendations for policy and practice

Chapter Four: Results

This chapter presents the results of the quantitative and qualitative components of the research. The demographic characteristics of the sample are described, followed by health and nutritional status, and daily nutrient intakes derived from Food Frequency Questionnaire data compared with nutritional recommendations. The dietary behaviours and structural barriers of food choice are described.

4.1 Quantitative study

This section presents the results of the Food Frequency Questionnaire and details on nutrient intake and dietary patterns.

A total of 76 asylum seekers were interviewed, representing a response rate of 76 per cent. This figure represents 21 per cent of all adult asylum seekers living in the three counties (n=347) at the time of interviews. Out of these 76, 37 (21 men, 16 women) lived in Direct Provision and 39 (16 men, 23 women) lived in the community.

Table 4.1: Nationalities of the quantitative study sample (n=76)

Eastern Europe Baltic States		Central Asia		Middle East		North Africa		Sub-Saharan Africa		
<i>country</i>	<i>n</i>	<i>Country</i>	<i>n</i>	<i>country</i>	<i>n</i>	<i>country</i>	<i>n</i>	<i>country</i>	<i>n</i>	
Albania	2	Azerbaijan	1	Iran	2	Algeria	1	Angola	2	
Belarus	1	Uzbekistan	1	Iraq	2			Cameroon	1	
Chechnya	2			Syria	1			Congo	4	
Croatia	1							Ghana	22	
Czech Rep	2							Ivory Coast	1	
Estonia	2							Liberia	3	
Kosovo	1							Nigeria	18	
Russia	3							Sierra Leone	1	
								South Africa	1	
								Togo	1	
Sub-totals	14		2		5		1		54	
									Total	76

As shown in Table 4.1, study participants came from a wide range of countries, the two largest groups represented being from Ghana and Nigeria. Some demographic characteristics of the asylum seekers studied are shown in Table 4.2.

Table 4.2: Demographic characteristics of the quantitative study sample

Characteristic	Variable	Results
Gender	female	39 (51%)
	male	37 (49%)
Age	age range	18–46 years
	mean age	31 years
Education	completed third level	44%
	completed secondary	22%
	average age leaving education	19 years
Marital status	married/living with partner	60%
	Single/never married	38%
Accommodation	In Direct Provision	37 (49%)
	in private rental in community	39 (51%)
Living with relative	Overall	71%
	Of these, in Direct Provision	32%
	Of these, in private rental	68%
Women pregnant	At time of interview	5 out of 39 (12%)
	in the preceding year	24 out of 39 (61%)

Nearly half the sample (44 per cent) had been in Ireland for less than a year, and 12 per cent had been in the country for over two years. The mean number of months spent in Ireland was 13 months. Of the 39 females who participated in the study, 24 women had given birth in the previous year. The vast majority (21/24) had breastfed their children and the average reported length of time of breastfeeding was 5 months. All but three of the 24 women (11 in Direct Provision, 10 in the community) who had given birth in the previous year breastfed their children, and for an average of 5 months.

(a) Health and nutritional status

Participants were asked to self-rate their health, their quality of life and their level of satisfaction with their health. While 78 per cent of the sample reported having very good, or good, health, 51

per cent reported visiting a doctor or medical professional in the month prior to being interviewed.

Body Mass Index¹⁴ (BMI) is a measure of nutritional status in adults. Although more than a quarter of the sample (28 per cent) did not know their weight and height, BMI was estimated on 72 per cent (n=55) of the sample who were able to report their current height and weight. The mean BMI for this group was 26 (in the overweight category), and the range for the group was 19-44 kg/m². Healthy BMIs were found in 40 per cent of the sample, but 44 per cent were overweight and 16 per cent fell into the obese BMI category. These results are not surprising as nearly half (45 per cent) of all participants reported putting on weight in the preceding year.

(b) Daily nutrient intake

The human diet is composed of two different types of nutrients: macronutrients and micronutrients. Macronutrients (carbohydrate, fat, protein and alcohol) are the main sources of energy in the diet. Micronutrients are the vitamins, minerals and trace elements that the human body requires for optimal metabolic functioning. The daily requirement of macronutrients is dependent on a person's age, sex, level of physical activity and health status.

In order to determine how the asylum seekers participating in this study compare to the Irish Recommended Daily Allowances (RDAs), the choice of RDA used is based on a mean weight of 73.4kg for community-living participants and 73.7kg for Direct Provision centre participants, a moderately active physical activity level and age group of 18-64 years.

In this study, the daily nutrient intake was derived from the food frequency information through the estimated food quantity data converted to nutrient availability using the McCance and Widowson food tables. Whilst no statistically significant differences are observed between participants living in the community and those living in Direct Provision centres in terms of their intake of either macronutrients or micronutrients,

¹⁴ Body mass index (BMI) is measure of body fat based on height and weight that applies to both adult men and women. It is calculated by dividing the weight of an individual (in kgs) by their height squared (m²). A BMI below 20 is considered to be underweight whereas a BMI of 20 to 25 is in the healthy range. A BMI of 25 to 30 is considered overweight and a BMI over 30 is obese

there are a number of instances where the levels vary substantially from that recommended according to the different accommodation types.

Macronutrients

Overall, the median daily energy intake for Direct Provision centre participants is 12.2MJ (2918 Kcals) per day. The figure is higher, 13.8MJ (3305 Kcals) per day, for community-living participants. However, a person's daily energy requirement is dependent on sex, age, weight and physical activity. For males the daily energy requirement ranges from 12.1 to 13.4MJ per day, and for females ranges from 9.2 to 9.6MJ per day. As shown in Table 4.3, the median for women in both accommodation types exceeds these requirements, as does the median for men living in the community.

Table 4.3: Median energy intake levels by gender and accommodation type

	Median MJ		Median kcals	
	Community	Direct Provision	Community	Direct Provision
Men	16.8	12.1	3987	2854
Women	13.6	12.5	3216	3000

Table 4.4 shows that asylum seekers in Direct Provision are consuming less than the recommended proportion of energy derived from intake of carbohydrate and fat, but much more than is recommended for protein. For community-living asylum seekers, the pattern was similar but closer to recommended levels. Direct Provision centre participants consume more protein on a daily basis than community dwellers.

The mean total fat intake contributes to 33 per cent of the total energy intake of Direct Provision participants and 34 per cent for community-living participants. However, when type of fat is taken into consideration, we find that saturated fat accounts for 13 per cent of the total energy intake among participants living in Direct Provision and 12 per cent of total energy for community-based participants. This is greater than the recommended level of 10 per cent.

Table 4.4: Percent contribution of macronutrients to energy intake compared with recommended level

	Macronutrient		
	Protein	Fat	Carbohydrate
% intake recommended	10	35	55
Direct Provision: overall %	22 ++	33 -	48 --
Community: overall %	19 ++	34 -	50 --

++ well above recommended level + slightly above recommended level
 - slightly below recommended level -- well below recommended level

The mean polyunsaturated fatty acid intake contributes to 5 per cent of daily energy intake for Direct Provision centre participants and 5 per cent for community-living participants, again much greater than the recommended level of 2.5 per cent. The alcohol intake is small in both locations.

Micronutrients (vitamins, minerals and trace elements)

Study results show that asylum seekers in both accommodation types are consuming levels of food-based vitamin B (Thiamin), Vitamin B₂ (Riboflavin) Vitamin B₆ (Pyridoxine), folate, Vitamin C, Vitamin A, calcium, zinc, phosphorus, selenium and fibre in excess of recommendations. However, intake of iron is only just adequate, particularly for asylum seekers living in Direct Provision, and intakes of Vitamin E, Vitamin B₁₂ (Cyanocobalamin) and Vitamin D are well below the recommended levels in both accommodation types.

(c) Dietary behaviour and knowledge

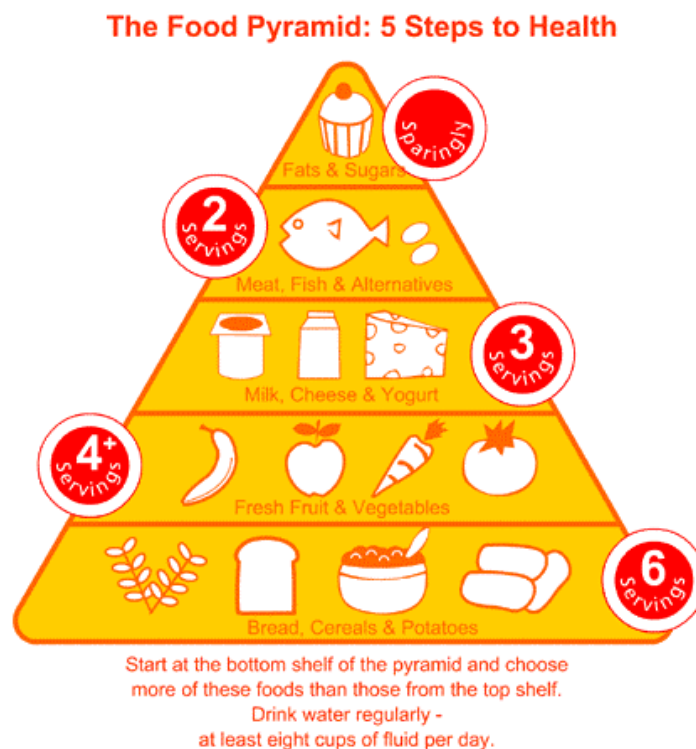
The vast majority (95 per cent) of those living in the community, and two thirds (68 per cent) of those living in Direct Provision, reported eating foods commonly consumed in their home country in the month prior to being interviewed. In one hostel, African asylum seekers reported that they were pleased that a visiting chef cooked African dishes two or three times a week. Nearly a quarter (23 per cent) of participants avoided some foods and drinks as part of their religion. More people living in the community made meals from basic ingredients, ate fast-food takeaways,

bought ready-made meals, and ate meals at friends' houses (friends mostly from their own country or region) than did those living in Direct Provision.

Most people (90 per cent) thought that their diet could be 'healthier', mostly by eating more vegetables (76 per cent) and fruit (57 per cent), more meat (40 per cent) and fewer fried foods (24 per cent). African participants thought their diet could be improved with more variety of African foods. A quarter of all participants were on a weight-reducing diet, a behaviour which was significantly more likely among women (33 per cent) than men (14 per cent). One man said he was vegetarian but could not follow a vegetarian diet in the hostel because they have to eat whatever they are given.

Responses revealed generally low levels of knowledge about the nutritional values of meat, fish and poultry, with only 37 per cent of responses correctly identifying these as good sources of iron. Generally there was a higher level of knowledge about dairy products and fruit and vegetables, with 71 per cent of responses correctly identifying these as good sources of vitamins and minerals.

Figure 4.1: Food Pyramid used in Ireland



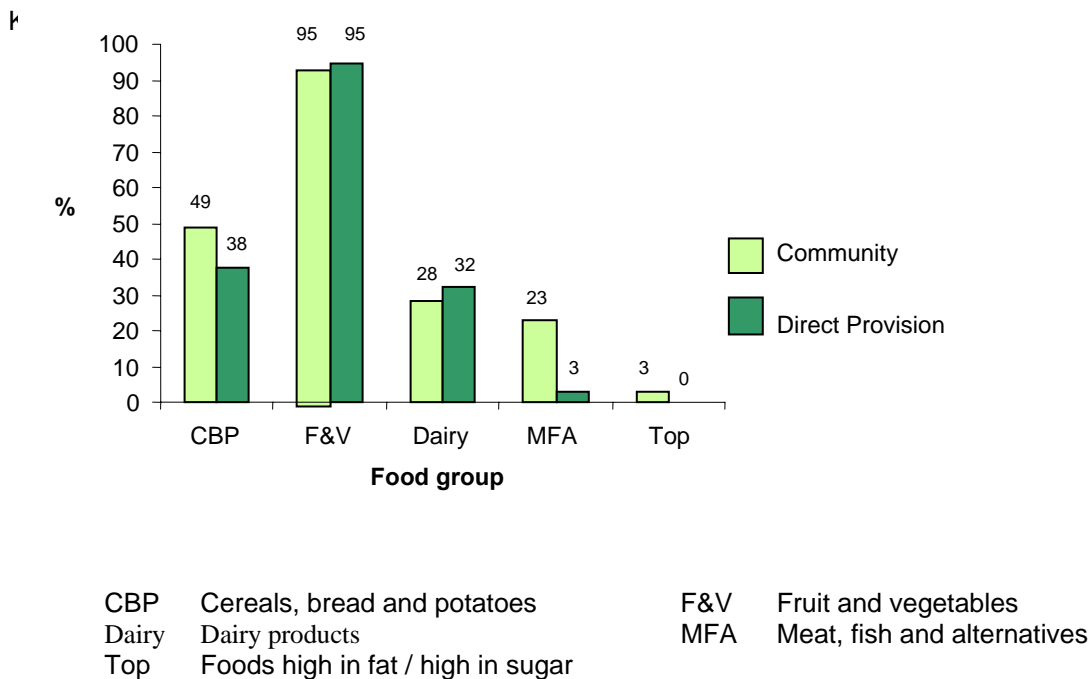
Source: www.irishpride.ie/products/pyramid.htm
 (accessed on 4 March 2005)

(d) Comparison with recommendations

Nutrition health education and promotion is based on RDAs of nutrients that are derived from recommended daily consumption of a number of food groups, and are often visually represented by food pyramids, plates or circles. A Food Pyramid (Figure 4.1) is used in Ireland. This presents five shelves which depict the recommended number of daily servings of each food group (Nutrition Advisory Group 1995). However, the foods represented are based on majority consumption patterns of the general Irish adult population and do not currently reflect ethnic diversity in dietary practices across the country and among different groups.

For public health nutrition policy and intervention purposes, identified groups at nutritional risk can be targeted more easily through dietary practice than nutrient level. It is therefore useful to compare the dietary behaviour of this group of asylum seekers with that recommended for healthy living in Ireland. The percentage of participants living in Direct Provision and the community who meet the recommended daily number of servings from each shelf of the food pyramid is shown in Figure 4.2.

Figure 4.2: Percentage of participants consuming the recommended number of servings from each shelf of the Food Pyramid



Only 38 per cent of participants living in Direct Provision centres and almost half of community-living participants fulfil the recommendations on daily intake of cereals, bread and potatoes (six servings). With the Food Pyramid recommending three servings of dairy produce daily, only 32 per cent of Direct Provision participants, and 28 per cent of community-living participants, are following recommended dietary practices. Moreover, 16 per cent of people living in Direct Provision centres, and 46 per cent of those in the community, consume more than three servings of dairy produce per day, and may be at risk of excess saturated fat intake, especially community-living participants.

Two daily servings of meat, fish and alternatives are recommended for healthy living. The majority of participants (86 per cent in Direct Provision centres and 69 per cent of those in the community) consume more than two servings per day, compared to 38 per cent of the SLAN survey population. An excess consumption of animal proteins which are high in saturated fat may cause an increase in unhealthy blood cholesterol levels and put strain on the kidneys.

Almost all participants in this study report fruit and vegetable intake in line with the recommended four portions daily. Overall the pattern of consumption of fruit and vegetables has the highest agreement with recommendations, a finding also observed in the SLAN survey. Foodstuffs in the top shelf of the food pyramid are high in sugar and fat and it is recommended that these are eaten only sparingly. However, 97 per cent of Direct Provision centre participants and all of the community-living participants report consuming three or more servings daily from the top shelf of the food pyramid. Excess intake of these types of foods is likely to lead to consumption of too much saturated fat and sodium, which carry increased risk for heart disease.

In a typical week, overall, participants reported that fruit and vegetables were the food items purchased most regularly (by 68 per cent of participants), followed closely by dairy products (67 per cent) and fresh meat and poultry (58 per cent). Microwaveable foods were the least frequently purchased, at 18 per cent. Individuals living in Direct Provision centres consume significantly less high fibre cereals and more butter, white rice, fried potatoes and pasta dishes than those located in the community. The amount of dairy produce consumed also varies significantly between the two locations. Individuals living in the community consume significantly more eggs and more full-fat dairy products, whereas individuals living in Direct Provision centres consume significantly more low-fat dairy products.

More people living in the community consume processed meat and more oily fish than Direct Provision centre participants. The daily median intake of pulses is similar in both locations.

(e) Structural barriers affecting dietary choice

Structural barriers relate mainly to cost, physical access to shops via transport, and availability of cooking equipment and kitchen facilities. The range of the weekly amount spent on food was reportedly € 0-240, with an average of €70. Considerable differences in food expenditure were revealed between those living in the community and in Direct Provision. This is expected as three daily meals are provided in Direct Provision and hostel residents have less weekly disposable income to spend on food than do community-living asylum seekers.

When participants were given a list of possible choices relating to what influenced their food choices, 70 per cent reported that cost was the most important factor. Cost was followed closely by taste (mentioned by 67 per cent of participants), foods for health (66 per cent), and the ability to store food (47 per cent).

Nearly half (48 per cent) of participants used paid transport, mostly taxis, for shopping. The other half either walked or cycled to the shops. The average weekly amount spent on transport for food shopping was €15. Lidl was the most popular retail outlet shop used by the asylum seeker participants for all food items, except for meat and poultry. The highest proportion of participants who bought meat, fish and poultry used butchers, followed by Tesco. However, a relatively high percentage (21 per cent) reported buying their meat, fish and poultry from 'other shops'. This refers to shops that stock products from Africa and elsewhere, most of which are outside the region.

Almost all (97 per cent) of the study participants living in the community reported they had access to a kitchen or food preparation area in their accommodation. Of these, two thirds had access to a private kitchen and the remaining third could use a communal kitchen. In Direct Provision, although the number of people with access to a kitchen was still fairly high (81 per cent), there were reports from several participants that access was restricted to certain times, and required prior permission from the manager or chef (which was not always forthcoming).

4.2 Qualitative study

The qualitative component of the study looked in depth at the food experiences of asylum seekers living in both Direct Provision and private rented accommodation in the community. A total of 10 asylum seekers (4 men, 6 women) participated in one-to-one in-depth interviews about their experiences of diet and food, and their feelings about this aspect of their lives.

Some of the characteristics of the 10 asylum seekers interviewed are presented in Table 4.5. Half of the participants lived in Direct Provision and the other half lived in private rented accommodation in the community. Of the 10, 9 lived in Donegal, with 1 living in Sligo. Of the 6 women, all had children with them, and 3 of the women had children below 5 years of age.

Table 4.5: Characteristics of asylum seekers in the qualitative study sample

Sex	country of origin	Direct Provision		
		marital status	time in Ireland	children
M	Syria (Kurdish)	Single	3 months	0
M	Congo	Married	11 months	4 (all in Congo)
M	Nigeria	Single	8 months	0
M	Iran	Married	4 months	0
F	Nigeria	Married	11 months	1 (10 months); 1 in Nigeria
Sex	country of origin	Community		
		marital status	time in Ireland	children
F	Ghana	married	24 months	1 (20 months)
F	Nigeria	single	11 months	1 (7 months)
F	Nigeria	married	12 months	2 (6 years; 9 months)
F	Romania	cohabiting	4 months	2 (in primary school)
F	Romania	widowed	41 months	1 (14 years)

(a) Perspectives of asylum seekers

In this section, details of the relationship that asylum seekers have with food are revealed. Participants' views are organised thematically according to the most frequently raised issues, which were:

- Food poverty
- Cultural aspects of food
- Coping with dietary change
- Coping with social exclusion
- Direct Provision: the food experience
- Direct Provision: coping with loss of control
- Direct Provision: feeding babies and children.

Table 4.6: Current priority issues for asylum seekers in the qualitative sample

Sex	from	Here	Asylum seekers in Direct Provision				
			1 st top rank	2nd	3rd	4th	5th
M	Syria	3 mths	freedom	seeing family	being allowed to work	having a passport	-
M	Congo	11 mths	leaving the hostel soon	being allowed to work	length of asylum process	lack of control including over food	-
M	Nigeria	8 mths	furthering education	being allowed to work	listening to music	having good food	access to computer
M	Iran	4 mths	having work to do	being joined by family	better facilities including transport	stress from asylum application process	more availability of own food
F	Nigeria	11 mths	asylum application	being joined by daughter	being allowed to work	better accommodation	getting African food

Sex	from	Here	Asylum seekers living in the community				
			1 st top rank	2nd	3 rd	4th	5 th
F	Ghana	24 mths	being joined by husband	asylum application	being allowed to work	education	enough money for African food
F	Nigeria	11 mths	being joined by fiancé	asylum application	having more money	-	-
F	Nigeria	12 mths	incomplete ¹⁵	-	-	-	-
F	Romania	35 mths	not going back to Romania	good education for children	health care	-	-
F	Romania	41 mths	welfare of children	asylum application	being happy	having more money	food

As the interview came to a close, participants were asked to prioritise what they felt were the current most important issues in their lives. This was done to gain an

¹⁵ This respondent withdrew from this exercise as she found it too emotionally difficult

understanding of the relative importance of food to asylum seekers as well as to confirm, or otherwise, other content in the interview data. The results of this ranking exercise are shown in Table 4.6 and reveal that the refugee status seeking process and reuniting with family members were the top concerns.

Lack of work and money, and the uncertainty and lack of autonomy of their situation as asylum seekers, emerged as the highest priorities:

To know that your life depends on other persons and it's not a priority for this person, it leaves you feeling – even everybody is a human being, and if you are an asylum seeker you can't plan your life. Even someone who is in prison they know after ten years they will go free. But now we don't know how long we are here. I feel to lose my patience, my hope. I need some money to do something. They help us ... to become bad ...

Man in Direct Provision [8]

However, food also emerged as an issue for more than half of this sample of asylum seekers. People are acutely aware of how their current situation can have a negative impact on their health via their diet:

Sometimes I would be just quiet and thinking and you know when you are thinking you don't feel like eating. It would make you reduce weight ... I am not happy. I am sad ... I did not plan to come here and stay here not with my husband so when you don't get what you want to eat, you be thinking your husband is not here, you don't get what you want to eat, you don't have enough money to buy the African food you want, so when I am very unhappy I just lost appetite.

Woman in private rented accommodation (3)

Food poverty

Having sufficient money for food, and other access issues related to food of choice, emerge from the transcripts as key concerns. The realities of food poverty emerge strongly as participants reported insufficient money to meet all their needs, including food, and talked of difficulties managing on a low income. They spoke of fear of running out of food, accepting help from friends, buying on credit, paying the bills first then not having much left over for food, and missing meals to make food last.

For some, their diet is closely related to their poverty:

I would love to work and go out. If I am working and earn the money, the food, my diet, would be more balanced. Oh I don't like the way I am I told you. But it is because of money, like I said if work I will be able to earn money. To do my own thing, if I have enough money, I would be OK.

Woman in Direct Provision [7]

For community-living asylum seekers in private rented accommodation, the rental tops-ups and costs related to sending children to school were also frequently mentioned. These clearly compete with food in the household budget:

I pay top up [*referring to rent*]. Then because the money they are giving us, I use them to buy food. And I have a baby, he has to eat too. I pay light bill and my telephone bill, you understand ... I'm telling you, like I'm here now, maybe every week ... maybe I have €18 left for me.

Woman in private rented accommodation [1]

In Direct Provision, even though theoretically all food and board requirements are fully provided for, asylum seekers feel their lack of spending power from their €19.10 weekly allowance and expressed their desire to be able to pay for additional or alternative food:

Today it was chicken in pancake [*hostel lunch*] and I cannot eat that but I cannot buy something different. No money. I have no choice.

Man in Direct Provision [7]

Sourcing cheap foods, buying on credit, accepting food gifts and relying on charitable organisations emerged as strategies to cope with food poverty. Poverty also leads some asylum seekers to borrow, pool or share with others, usually their own nationality, to make ends meet:

You know, OK, I give you one story. So I ran out of cash. I have €2 and I don't have milk for my baby. I say, my god, what is all this? So I have to call my friend [*same nationality*]. My friend say 'come, come, I still have money left, come, don't worry.'

Woman in private rented accommodation [1]

For those in the community, most asylum seekers reported missing meals and cutting portions from necessity as a strategy for making food and money stretch:

Today I not have any food.

Interviewer: Does that happen sometimes?

Yea sometimes. Pay rent, electric, pay oil, he [*child*] goes to school, school books, food. No money. The social pay €150 week. This no money. My husband is dead ... sometimes you know I is going to sleep ... instead of eating. Sometimes you have nothing. Drink tea all day.

Woman in private rented accommodation [4]

A similar situation was revealed for another women, as told through an interpreter:

She [the mother] said, three weeks ago they say 'the teacher says I need to buy school book.' She had just photocopy you know. So today she stop one dinner and buy the book.

Woman in private rented accommodation [5]

Related to food poverty are access and transport costs necessary to obtain food. Those in rented accommodation spoke of the hardships of paying transport costs on a low budget:

It is 40 minutes walk as I have a son at school now. So I use to pay out of my supplement. I pay €16 every week for the cab.

Woman in private rented accommodation [1]

Those in Direct Provision, who receive a basic weekly allowance of €19.10, also report that they often spend more than half that amount on taxis for shopping. Although many do share trips and thus the cost, this does not always happen.

When asked about eating out, all asylum seekers reported that this was a luxury none of them could afford.

Cultural aspects of food

Asylum seekers are frequently using strategies to access their own familiar foods. This appears to be largely driven by the emotional and cultural determinants of food choice rather than any nutritional aspects and knowledge. Asylum seekers particularly from African countries expressed a strong desire to source and eat their own ethnic foods:

You know there is sometimes you understand maybe when you eat Irish food. Sometimes you be thirsty to eat African stuff. You feel like eating African stuff. In the African shop [in Sligo] I buy yams, plantains, bananas and okra, you know grits?¹⁶ Beans. African oil, palm oil, African fish, gari.¹⁷ My favourite food is potato, yam, plantain, fufu.¹⁸ I have one made from rice, we call it Motu. We mash rice with soup. Just like you, just for instance you go to Africa, you feel like eating Irish food, you understand me, just like that.

Woman in private rented accommodation (2)

There are only a few outlets selling African and Asian foods in the North West: one shop in Sligo, and one in Letterkenny.¹⁹ Women described with enthusiasm their dependence on such shops for the supply of familiar foods from home. Most African people in both types of accommodation also talked of travelling to Galway or to Dublin to buy food supplies and carry them back, involving transport and other additional costs. Many spoke of the considerable financial implications of sourcing and buying African foods:

I buy cray fish, red beans, yam. Yam is very expensive ... €10, €12 for one. Yes, and gari. Gari is expensive. So maybe we buy coconut, also expensive ... Any time we go to Galway we used to buy food because it's cheaper. Even in Dublin it is cheaper ... When I have money, I buy yams, yam flour from Nigeria, meat, some fish, banga,²⁰ cow's tail in town.

Woman in Direct Provision [7]

¹⁶ Grits is soaked dried corn kernels, then ground

¹⁷ Gari is flour made from yam

¹⁸ Fufu is flour made from either pounded plantain, cassava or yam, and often formed into dumplings and used in stews and soups

¹⁹ Closed since the study was conducted

²⁰ Banga is a soup made from palm fruit and beans, usually eaten with fish or prawns

Although most commonly reported among the Africans, many other ethnic groups, such as the Romanians, also talked of going to Dublin to source their own foods, and that these were expensive. Despite the additional expenses and inconvenience involved in acquiring their own foods, everyone considered that eating their own food is an important issue for them.

Coping with dietary change

Following on from the questions about food preference, asylum seekers were asked how they felt they were coping with dietary change and how their current diet here compared with their diet back home. Some asylum seekers revealed how adaptations to their changing living circumstances, including food, were being made; some positive and others negative.

The adjustment to dietary change appears much harder for Africans than for the East Europeans. A Romanian woman talked of how her food situation in Ireland is better than it was in Romania because here there are no shortages or long queues to buy food, and Romanian people have few problems adjusting to new Irish foods from which ingredients and tastes can easily be adapted.

There were comments made about problems adjusting to unfamiliar foods and lack of knowledge about how to prepare and cook them:

Sometimes I go to shop. I don't know food, you know. I would just be looking at it, but to cook it? You understand, I can't. When I see them [unfamiliar foods], I would not even look at them because I don't know how to cook it. But now I'm learning a bit. You know, sometimes I go to the library and I pick up those books ... I am trying!

Woman in private rented accommodation [2]

There appears to be a balancing act for many people between Irish and African food. One woman talked of how she was trying to bring up her child on the same foods as Irish children to help them integrate better whilst also ensuring that sometimes traditional African foods are incorporated into her diet.

In the transcripts of both Direct Provision and community-living asylum seekers, mothers are allocating money and food preferentially to their children, whilst sometimes going without themselves:

I make sure that I feed my baby properly. For me I want more African food but I don't get more because of the money so I make sure because of the baby I feed the baby very well ... But I eat less.

Women in private rented accommodation [3]

Coping with social exclusion

The transcripts are full of references to asylum seekers feeling like strangers in an alien environment, and having very limited social networks compared to local people. The lack of opportunities to socialise normally and, as part of that, eat socially is felt to be largely due to lack of money:

Interviewer: Has anyone ever asked you to the pub for a drink?

If I have money that time I say 'yea OK, we go back'. But if I don't have it I say 'no, I have to go somewhere else', like that. But I watch TV.

Man in Direct Provision [9]

This is also felt by children:

I go to school, you know. Go to school and probably friends go to McDonalds. 'It's OK', I tell them, 'my mother wants me come home.' I lie to do that.

Interviewer: Alright and how does that make you feel?

Not exactly normal sometimes you know.

School age son²¹ of woman in private rented accommodation [4]

Many asylum seekers spoke of their feelings of isolation and loneliness, and social and cultural distance between themselves and the local population. The lack of opportunities to eat out was highlighted as an important social need that contributed to feelings of social exclusion and isolation:

²¹ This child was not recruited for interviewed but he wanted to add his own comments when hearing about the study and being present at the interview with a relative in his house

Interviewer: Do you ever eat meals outside of the house? Like in a café?

Sometimes I go to McDonalds

Interviewer: McDonalds, OK.

Maybe sometimes when I'm lonely ... Sometimes I see Irish people there, talking to each other, you know.

Woman in private rented accommodation (2)

With food and meal times identified in the Literature Review in Chapter 2 as a key aspect of people's social lives, asylum seekers talked of how their experiences of a lack of eating meals socially reinforces their social exclusion and emphasises cultural distance as it would not be their experience back home:

Interviewer: Have you ever had an invitation to anybody's home?

No.

Interviewer: In two years, you have never been in an Irish person's home?

No ... you don't know anyone and some of the whites, the Irish, are very difficult to meeting with. I don't have any friends. I am alone with my baby here all the time.

Woman in private rented accommodation [3]

Churches appear prominently as an important supportive source of social interaction for many asylum seekers, particularly the Pentecostal and 'African' churches. However, the social interactions, friendships and supports are largely confined to the church-related setting and very rarely spread into the local domestic setting.

Lack of English is a factor for the social exclusion of many asylum seekers. Even when asylum seekers have some English, there are still communication barriers from local accents and fast talking which have implications when shopping for food.

Lack of transport is also a key constraint to social inclusion:

The transport is the big problem for you. So you stay in and you go to the library sometimes and shopping once, twice a week.

Woman in private rented accommodation [1]

The lack of work and activity, and generally 'things to do' is contributing to feelings of apathy and reinforcing social exclusion among asylum seekers:

Here we eat at – breakfast is served at 7.30 till 10 and the lunch it's at 1 to 2 and dinner is at 6 to 7. So past those times you can't eat. So you can see the short time between 1 till 6 and we are not allowed to work, you don't work. You don't work and you don't spend the energy. So you know all those things – you have no interest to the food.

Male in Direct Provision [8]

Direct Provision

There were overwhelmingly negative opinions on both the type and the variety of food provided in the Direct Provision centres, as well as the general environment for meals. However, there was also appreciation of the difficulties that authorities must face in catering for so many different nationalities and food preferences. In this sense, the general feeling was that the Direct Provision situation was tolerable for a short time but was not conducive to health and well-being in the longer term.

The food experience

Much of the difficulty with making the weekly allowance last, and feelings of insufficiency, has to do with wanting to buy preferred ethnic foods:

It is not my food

Man in Direct Provision [6]

Unhappiness with a lack of familiar ethnic foods in the Direct Provision centres emerges as the most common complaint, especially among the non-Europeans. Many asylum seekers regularly buy their own food out of their weekly €19.10 so that they can eat what they prefer. While this unhappiness with the food results in people buying their own alternatives as substitutes, it also results in wastage:

When I no happy with the food just I used to eat the sardines with bread. And if you wanted to notice that more of us are not happy about the food, you have to go to see the rubbish, the bin rubbish. It's full of food. Sometimes we

try to joke between us if we see the woman who cook for us coming, we say, 'oh, she is cooking the things that we will see put in the rubbish!'

Man in Direct Provision [8]

One African woman describes the difficulties of adjusting to the unfamiliar canteen food when she first arrived:

I am fed up with the food here. Very quickly after I got to this place I got fed up, after a month ...When we first came here you know I was thinking that I could cope with it but I couldn't, sometimes it make me sick, I vomit. So in view of that I stopped eating ... Sometimes smelling it you know I would not be able to eat it up, be sick from it.

Woman in Direct Provision [7]

People are skipping meals because of their dislike of the food offered:

I do miss meals sometimes if I don't like to eat.

Interviewer: Why is that?

Maybe I'm not hungry, like if they cook what I don't eat. Maybe then I eat bread or I take tea.

Man in Direct Provision [7]

However, there is also evidence that people are skipping meals intentionally in order to control their weight gain. This confirms the quantitative study result that nearly half of the 76 people interviewed reported weight gain since arriving in Ireland. There is widespread awareness and concern among Direct Provision asylum seekers in the sample that the food provided in the centres is fattening:

The food here is too fattening. I wasn't like this before [points to stomach and laughs]. I increase 15 kilos. I don't know here you speak about stone. It is difficult for me to put my shoes, big belly. You know we eat many things that are oil and grease.

Man in Direct Provision [8]

With many asylum seekers living in the same facility for several years, it is not surprising that a repetitive weekly menu in the long-term is criticised:

They are boring like everyday the same. Our menu is not changing, like every week is the same ... There is chips and burger 4 times a week.

Man in Direct Provision [6]

You go there and it's the same chicken waiting for you.

Male in Direct Provision [9]

The social context of eating back home is also missed and is hard to adjust to:

It's just eating on time, completely different. It is too routine here.

Man in Direct Provision [10]

Some participants were unhappy with the dining environment. As a result it is common practice for people to take their food away to their own rooms, to eat either by themselves or with one or two close friends, usually people from their own country.

Comments were made about cooking styles in the Direct Provision centres, the heavy use of sugar and colourings, poorly prepared rice, and a lack of fresh vegetables and fruit relative to their home diet. This confirms data from the quantitative study which found that consumption of food items from the meat, fish and poultry shelf of the Food Pyramid is high in Direct Provision. The quantitative study also found that the consumption of fruit and vegetables was high. It would appear that the difference in the findings from the qualitative study are more to do with perceptions of a lack of these relative to habitual diet prior to arrival in Ireland.

The diets of low and middle income people from Africa and from the Middle East particularly are generally characterised by high intakes of a large variety of plentiful seasonal and cheap fruits and vegetables, with meat being more an occasional food because of its higher price.

Many in the sample did recognise that there have been attempts to improve the food situation in Direct Provision and there was an acceptance of the considerable challenges that Centre Managers face providing for so many different cultures in one place.

We are about 54 persons in one place. We come from about 17 different countries. So this is difficult to cook something that person wants. It is difficult but they try.

Man in Direct Provision [8]

Coping with loss of control

For people in Direct Provision, one of the main issues that emerged was the lack of control, including over food, and the resultant eroding of dignity and self-worth:

The kitchen is locked up so nobody having access after half past six until day break. So you can't just go into the kitchen. The chef will lock it and will leave. So we don't have access to the kitchen. Maybe if you are hungry in the middle of the night that is your problem. But you want to be a person.

Woman in Direct Provision [7]

Some hostels are clearly making efforts to deal with the preference of many asylum seekers to be able to cook their own food.

They allow us to cook and I told you at the beginning that the boss of this hostel is doing best to make us happy. Two days a week there is a Nigerian woman who come and cooks African food. Well, not exactly African food, it's Nigerian food! It depends, the possibility of 1 time a week, maybe more, we can use if we don't like the food.

Man in Direct Provision [8]

However, the situation does seem to vary by facility and depends largely on the goodwill of individual staff. While in some places people seem to be allowed to enter the kitchen and cook at will, in other places this is not so:

There is no way you can just get up and say I feel like cooking this, I want to go into the kitchen.

Woman in Direct Provision [7]

Missing meals as a form of taking back some control in their lives is also behaviour reported by participants. Some admitted that complaints about food occur so that they can assert their voice and thereby recover some sense of control and self-

determination. The lack of control is also felt in other aspects of their lives in Direct Provision, such as watching their own choice of TV channels. Many asylum seekers talked of their overall sense of helplessness, uncertainty, lack of activity, not having anything meaningful to do and general lack of control over their own lives. There were also comments about how this situation and stress generally affected their appetite for food and had an impact on weight change for some:

Sometimes I feel there is stress, you know makes them [*some others in the hostel*] eat. You know when they think they might lose the food, they eat whatever there is, they eat it till it's gone.

Man in Direct Provision [6]

The transcripts are dotted with excerpts which refer to the feelings people have about how the rigid institutional system of food provision in the hostels imposes control over a very basic aspect of human life. The provision of repetitive meals to a strict daily timetable for many months, sometimes several years, is a constant reminder to people that they are not in control of a very central part of their lives.

Feeding babies and children

In Direct Provision centres, the lack of open access to a fridge and food preparation area appears particularly frustrating for breastfeeding mothers who often need to eat on demand, as well as for those with small children who want to prepare their foods fresh when needed. The problems experienced by breastfeeding mothers and mothers preparing fresh food on-demand for their young children centre on time, and other restrictions around access to the kitchen and food preparation, storage and cooking areas, are confirmed by service providers. One woman reported giving up breastfeeding because this would cause her to miss mealtimes (she usually fell asleep in between breastfeeds) and she was unable to access food and drink on demand as necessary.

It appears that some elements of food provision in the Direct Provision centres impede successful exclusive breastfeeding as well as self-preparation of weaning and follow-on foods. One woman spoke of the erosion of her dignity as a mother and the sharp contrast to normal child care practices at home:

You know children, if you are cooking for them you have to cook fresh things for them. That is the way I was brought up. I go into the kitchen and make the food fresh for her and she eat it. I prefer it to be fresh than 3 days, 4 days in the fridge I want them to know their food, you understand?

Woman with baby in Direct Provision [7]

(b) Perspectives of service providers

There is not enough money for food of choice, no money for treats, not enough money for normal hygiene items, no money to use for social use and so reduced opportunities for integration.

Services Coordinator

A variety of service providers who have regular contact with asylum seekers through their work were interviewed, either individually, by telephone or asked for written submissions (see Table 3.2. and Appendix F). Questions posed to General Practitioners, Public Health Nurses, Community Welfare Officers, the Community Health Adviser and the Regional Coordinator for Services for Asylum Seekers and Refugees highlighted a number of issues known to impact negatively on dietary patterns and nutritional status. Results are summarised in Table 4.7.

In this next section, excerpts from the service provider transcripts and submissions will be drawn on to explore each of these issues according to accommodation type. Many of the findings are consistent with the experiences that asylum seekers reported. Service providers highlighted five main issues that they believed were connected to the nutritional well being of asylum seekers and their children. These five main issues are now described in descending order of frequency of appearance in the transcripts. They are: food choice and preference, feeding and caring for children, money constraints and food poverty, mental health, social exclusion.

Table 4.7: Health and nutrition issues for asylum seekers in the HSE-North West region as reported by service providers

General area	Health issue	Possible link with diet and nutrition
Physical health	Ante-natal care	Meeting nutritional requirements during pregnancy; food avoidances
	Childhood illnesses, immunisation	Respiratory infections and diarrhoea can lead to weight loss, dehydration, and failure to thrive
	Muscular-skeletal injuries (especially among males)	Restricts physical activity and energy expenditure
	Skin problems	Some may be related to food allergies?
	Physical sequelae of FGM ²²	
	Multiple pregnancies	Anaemia
	Constipation (noted among some post-natal mothers)	Medication incompatible with continued breastfeeding
	Transient lactose intolerance	Impaired nutrient absorption
	A few cases of HIV/AIDS, Hepatitis B and diabetes	Nutrition links specific
Mental health	Psychotic and personality problems	
	Depression, including post-natal	Appetite suppression (temporary)
	Post Traumatic Stress Disorder	
	Separation anxiety, e.g. children	
	Mental sequelae of FGM	
Infant care, feeding	Discarding of colostrum (normal practice in some cultures)	Loss of immunity benefits to infant
	Early start to bottle feeding and reliance on commercial products, faulty infant feeding practices	Lower rates of breastfeeding, growth faltering
	Encouraging early Child Development (play, speech)	Stimulation, appetite, healthy growth
	Incorrect feeding patterns	Failure to thrive, growth faltering
Physical activity	Sedentary compared to home Limited access to sporting and leisure facilities mainly due to money and child care constraints	Low energy expenditure levels leading to weight gain

²² FGM refers to Female Genital Mutilation

Food choice and preference

In Direct Provision

Service providers generally did not feel that there was a problem with the quantity of food, rather that the food available was not the preferred food of choice for asylum seekers and that this affected their enjoyment of it, and sometimes even whether or not meals were consumed at all. Almost everyone interviewed commented that Direct Provision asylum seekers had complained about the restricted variety of the food. Africans and people from the Middle East and Central Asia in particular had expressed the desire to have access to more familiar ethnic foods.

Terms like 'lack of freedom', 'powerlessness' and 'dependency' were frequently used when describing the situation for asylum seekers in Direct Provision. Service providers reported that most friction has occurred in relation to:

- predominance of frying as a cooking technique, and too many chips
- heavy use of European staples such as potatoes and pasta and relative lack of African staples such as maize meal; lack of other ethnic foods
- general lack of variation in the weekly menu
- lack of fresh fruit.

In the early days especially, there was an over-emphasis on carbohydrate staples in the meals at Direct Provision centres:

I remember one day, in the early days, that is not with the present staff, and I don't think it was with a 'couldn't care less' attitude, it was just that they didn't know – like. I saw the meal was chips. It was as if they thought, 'well we'll provide the staple [*PHN's emphasis*] food so potatoes, chips. But we also need foreign food so we'll throw in some pasta' and I think there was rice as well. I was quite shocked because I remember just various shades of creamy colour. I thought my god, ugghh!!

Public Health Nurse

The lack of fruit in the Direct Provision diet was associated with constipation experienced by some asylum seekers, especially post-partum breastfeeding women. The tendency to miss meals, particularly breakfast, was also commented on by service providers, and is consistent with the qualitative interviews with asylum

seekers which had revealed that many stayed in bed till mid-day and then got up for lunch.

The Public Health Nurse and the Community Welfare Officer emerge as important gate-keepers who, in addition to their technical service provision roles, also negotiate with hostel management and staff, and support groups. Some service providers have written to the Health Board requesting more consideration of the constraints on people living in Direct Provision, and the limited opportunities to prepare preferred foods. Several service providers said they had received a few complaints by Muslim asylum seekers that meat is not *halal*²³ although this has not been substantiated.

The combination of the food provided, lack of activity generally and having very little to do, are seen as contributory factors in weight gain for some. Another reported common point of tension has been around mothers feeding babies and small children.

In the community

Service providers talked of how asylum seekers had commented on how much they appreciated having more privacy and freedom when living in the community, and how they were happier about their food situation.

Everyone's ideal is to be out living on their own, and be in control of their food. Many would have said that to me, they are very happy with being able to get to supermarkets, to Lidl and to Tesco. They can source out their own food.

Community Welfare Officer

It was noted that once in the community people tended to buy more fruit. However, the cost of buying fruit was raised as a concern:

For people in the community, African asylum seekers in particular talk of how they miss the huge variation of fresh fruit and vegetables they were used to

²³ Halal is an Arabic word meaning lawful or permitted, for Muslims. Eating halal refers to meat ritually slaughtered and prepared as prescribed by Islamic Sharia law. The opposite of Halal is Haram, which means prohibited. The terms Halal and Haram will be used strictly to describe food products, meat products, cosmetics, personal care products, food ingredients, and food contact materials.

at home and that when they want to buy them here, if they can find them at all, they are extremely expensive and unfortunately in most cases 'exotic' and unaffordable.

Community Health Adviser

Many service providers confirmed the creative strategies that some asylum seekers were taking to source preferred ethnic foods. Differences were noted between asylum seekers from Eastern Europe and from Africa in the extent to which food choice was an issue and efforts were made to source ethnic preferred food:

The East Europeans buy local. They don't seem to travel for food. Probably their food uses more the same ingredients as we do, they just prepare it differently. They seem to have adapted to our diet and lifestyle much easier than some of the Africans where the cultures are so different.

Community Welfare Officer

The Community Health Adviser considered that in general the asylum seekers in the community fare much better than those in hostels for sourcing the foods they want, but that a lack of familiarity with local foods was leading some to a high consumption of fast convenience foods (e.g. McDonalds).

Some service providers commented on the need to develop more culturally competent resources for health improvement purposes, including nutrition information in different languages, not just English.

Feeding and caring for children

They are tending to pick up our bad habits.

General Practitioner

All health-professional service providers expressed concerns over low rates of breastfeeding. They also expressed concerns over some weaning and young child feeding practices among a number of East Europeans in particular that would not be recommended under current Irish guidelines. Service providers highlighted the cultural mismatch between health, nutrition and parenting knowledge, and health beliefs and practices in different countries and ethnic groups, and how there were currently few best practice guidelines to help service providers deal with these issues.

There was concern that constipation had led to problems for some women and that these problems had a negative impact on breastfeeding:

Ladies who were breastfeeding were constipated and they went off to the GP who put them on medication, and then they are told, well you'll have to stop breastfeeding if you are taking these. It was very sad. At least five ladies. And the sad thing is that these were mostly women who were determined to breastfeed, had grown up with breastfeeding, overcame all the problems

Public Health Nurse

Service providers noted the rigidity of meal times in Direct Provision and felt that this system was often incompatible with how breastfeeding mothers of demand-fed small babies need to behave. The early timing of the evening meals, and limited opportunities to access suitable food out of meal hours, sometimes left mothers hungry during the night, and it was noted that this will negatively affect the feeding of their children:

People will say, look I was up all night breast feeding or the baby wouldn't sleep, so how can I get down to the dining room at those times? You fall asleep between 8 and 11 and the meal's gone. And you're very hungry!

Public Health Nurse

Service providers reported that the general lack of control over when and what could be fed to the babies was being expressed to them by the women, many of whom are experienced mothers.

Money constraints and food poverty

Compared to being in Direct Provision, the positive impact of living in the community on general well being was acknowledged, but money still emerged as a key issue:

In the community, I suppose they are eating what they like, buying it, maybe not as much, maybe not as much quantity, they are more active, they are out and about, rearing their children, going to the shops, coming and going, running their houses. And they have more control. It is an important change. You have your own privacy in your own home in your own family unit. I'd say

it is picking them up emotionally, but then the money becomes the main thing. I suppose the main thing is budgeting; whether they have enough money.

Community Welfare Officer

All service providers were aware that asylum seekers found it hard to cope with their low income, and noted that the early stages of the move out to the community proved particularly difficult as people struggled with managing budgets, bills, and shopping practicalities after months living in Direct Provision. Although hard to pinpoint, there is also a feeling that there is a tendency for adults to prioritise food and money generally in favour of children. Some service providers have the impression that money constraints do appear to impact negatively on food availability in the household.

Well it goes without saying that they are all below the poverty line. They will always be rationing and thinking what they are going to buy. There's one African family I know. They wouldn't actually say that food wasn't a priority but they have said to me 'oh well by the time you've paid this and this and this' ... and at one point someone actually handed out a few coins in the palm and said 'this is what I'm left with' and yet they hadn't mentioned food.

[Interviewer asks: And how much was it?]

About €16 for the week for a family of three.

Public Health Nurse

This very closely mirrors what asylum seekers themselves were saying. Whether or not the actual financial amount is insufficient for food, or whether any shortfall for food is due to poor budgetary control, or whether it is a combination of both is hard to define. More attention needed to be paid to helping asylum seekers improve their budgeting and organisation skills and how to manage on a low income. A few service providers commented on the poor living conditions of some asylum seekers living in the community, and how that affected nutrition.

Mental health

All service providers talked about the mental health of asylum seekers and the effect that their past experiences and present situation were having on their general well-being. Stress among asylum seekers is common, both from preceding life events and from not knowing what will happen next. One General Practitioner commented that a

lot of depression was 'situational'. Many women and men have left children, partners and parents behind at home, and ...

for many there is a real sense of loss.

Services Coordinator

While there was acknowledgement among service providers that mental health, depression and loneliness are common issues for asylum seekers, the pathways linking emotional state to food are not always clear. It is difficult to know to what extent any emotional and psychological states such as depression and boredom associated with being an asylum seeker impact directly on dietary patterns, appetite and motivation to over- or under-eat:

I have observed appetite reduction linked to depression. One person locked himself in his room for two days and refused to eat during that time.

Community Health Adviser

In Direct Provision, I think when they are depressed then they actually eat more because there is nothing else for them to do.

Public Health Nurse

Experiences of post-natal depression among asylum seeker women were described, and related to nutrition. A variety of other issues affecting mental health and well-being were also raised by service providers such as the loss of dignity from being dependent on welfare and the lack of privacy in Direct Provision:

They don't tend to eat all together. They go their rooms. I guess that's your space, that's your only space. And even then you may not be alone.

Public Health Nurse

Service providers associate the length of time people take to go through the asylum process as a cause of stress. The state of uncertainty over Irish-born children was also seen as a factor in the mental state of some asylum seekers. However, it is difficult to judge how all of this directly impacts on food intake and nutritional status.

Social exclusion

All service providers feel that many asylum seekers remain isolated from the wider society and are not well integrated into local community life. Even for those asylum seekers living in the community, most know very few people, including their neighbours, and rely generally on people from their own countries nearby, or elsewhere in Ireland, for social support.

It varies by family. But there aren't many social supports for them when they are out in the community. Very little. They don't know other people to ask for little bits of help. They do tend to manage on their own.

Community Welfare Officer

From the Direct Provision evidence, clearly living in close proximity in a physical 'community' with other asylum seekers does not automatically confer protection from feelings of exclusion or isolation.

It is not clear how far all these issues are understood by the RIA in its role as the main state department responsible for dealing with asylum seekers as they arrive and are dispersed across the country, often for years. In a letter to the research team, the RIA reported that the results of their food inspections of hostels were 'not nutritionally important'. This suggests a general lack of understanding about the importance of diet on nutritional status and health and well-being for asylum seekers. It also suggests an underestimation of the social context of food for a socially excluded population group feeling alienated and estranged from the mainstream community.

(c) Support group views

The members of Diversity Sligo, a support group for asylum seekers and refugees in the town, were asked to reflect on what they had observed about any food, diet and nutritional issues experienced by asylum seekers as well as their poverty situation. This focus group consisted of 10 people from different sectors of the local community including social services, non-governmental organisations working with poor and disadvantaged groups (e.g. St. Vincent de Paul), Garda (police), churches, Rape Crisis Centre, and interested volunteers.

During discussions, a range of concerns were identified, many of them consistent with those raised by asylum seekers themselves as well as health service providers:

- Limited local availability of familiar ethnic foods
- People spending what little money they had on preferred ethnic foods in place of Direct Provision meals, as well as on extra snacks and food and other items for their children
- Limited variety and opportunities for healthy food choices in the Direct Provision weekly menu
- Lack of opportunities for exercise, because of transport issues, childcare requirements and lack of cash
- Lack of opportunities for socialising; social inclusion due to the lack of transport, childcare difficulties and lack of cash
- Tendency to snack on high-fat foods; other unhealthy food choices
- Skipping meals
- Boredom and depression, thought to be affecting food intake for some people
- The infiltration of 'bad practices' such as over-reliance on manufactured baby foods, because of the practical limitations that women felt around on-demand preparation of fresh weaning and infant foods. These lead to changes to familiar child feeding practices as well as the feeling of pressure to conform to the dominant host culture.

However, on a positive note, the group did stress the many positive changes that have occurred in food provision at the Direct Provision centre in Sligo over the past year. They felt that management had been very responsive to the requests and preferences of the resident asylum seekers and that this should be acknowledged.

(d) Summary

From the quantitative data, both macronutrient and micronutrient levels in this sample of asylum seekers show some areas for concern in terms of nutritional status risk. The relatively high overall calorie intakes for women, and for men living in the community, are of note, and may be associated with increased nutritional status risk related to over-nutrition, particularly where there are low levels of energy expenditure. Excess calories from protein are also a cause for concern. The majority of the

micronutrients studied are consumed at or above the RDA level and are similar to results from the SLAN 2003 survey.

The qualitative data show that the current living and financial arrangements for asylum seekers in the North West affect diet and food intake in multi-dimensional ways. Asylum seekers undoubtedly experience degrees of food poverty in both types of accommodation settings, but more so when they are living in the community. The food poverty experienced by asylum seekers is also exacerbated by socio-cultural issues. Most non-Europeans talked about their preference for their own familiar ethnic foods and meals, the availability and consumption of which tended to enhance their feelings of general appetite, level of food intake as well as emotional well-being.

The relationship with food for these asylum seekers is closely linked with their income and material poverty as well as what we can describe as their 'poverty of choice' and 'poverty of connection' with others. These issues are confirmed by the views of service providers and other key informants interviewed for the study. The qualitative results overall confirm that food and nutrition are central to the lives of asylum seekers in both accommodation types.

Moreover, with food a central preoccupation in everyday life, wider economic, social and cultural issues reinforce aspects of exclusion experienced by this group of asylum seekers, compounding their vulnerability to poor nutrition, physical and mental health, and social well-being.

The key food-related issues for asylum seekers in rented accommodation are:

- food poverty
- juggling family food needs with other financial burdens such as rent top-up
- cultural preferences and accessing familiar ethnic foods locally and at low cost
- transport and access costs.

The key food-related issues for asylum seekers in Direct Provision are:

- own cultural preferences, unfamiliar foods served, lack of familiar foods and of access to familiar ethnic foods locally and at low cost
- the disproportionate volume of meat and high-fat foods
- the rigid timing and institutional setting of meals
- the lack of variety and the repetitive weekly menu

- lack of control over, and access to, facilities for the preparation, storage and cooking of preferred foods on demand, especially for weaning foods and food for young children.

In summary, from the asylum seekers as well as the service providers who come into regular contact with them, a consistent picture has emerged of frugal, cost-conscious strategies and a general lack of money for asylum seekers to access and obtain food. However, as well as issues of food poverty, there are issues of poverty of choice and poverty of connection. Social exclusion, and emotional stress related to the considerable length of time waiting in the asylum process and acculturation, can all affect the diet, nutrition and social well-being of this vulnerable population group.

Chapter Five: Discussion

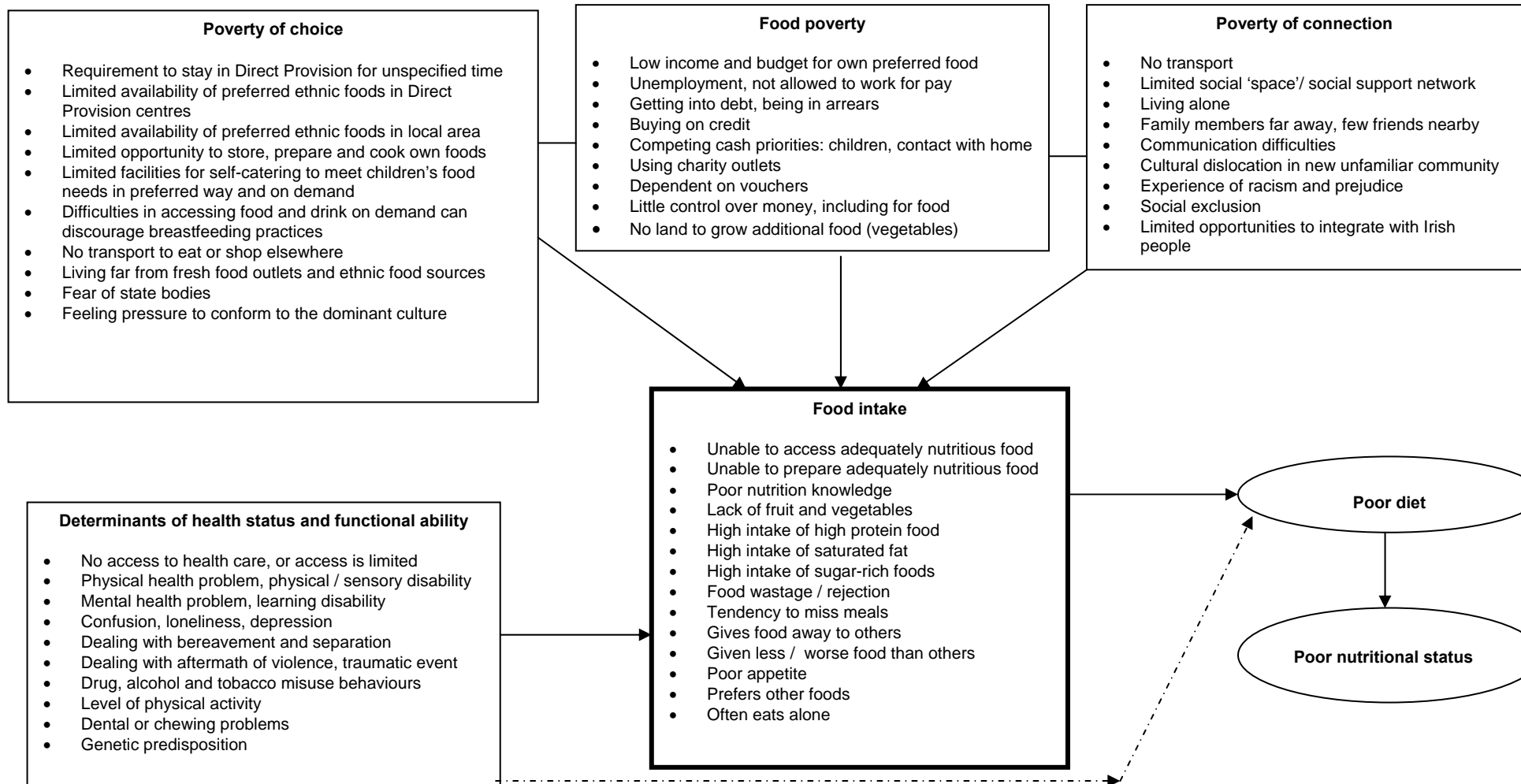
The findings described in the previous chapter provide a detailed dietary picture of asylum seekers as a population group. An in-depth documentation of the lived experiences of their food poverty, the social context of their food behaviours, food choices and preferences, and the central importance of food in their lives as a component of their physical, emotional and social well-being has also been presented.

What has emerged strongly in this research has been the extent to which the two types of data, the quantitative and the qualitative, are linked. The qualitative data complement and enhance aspects of the quantitative data. Information on food groups, meals and nutrient values comes alive when placed in the context of food in daily life and articulated using the voices of asylum seekers and those who work closely with them.

As a basis for further discussion, Figure 5.1 attempts to illustrate the broad categories of nutritional vulnerability affecting asylum seekers that have emerged in this study. The diagram summarises the various types of poverty (food poverty, and poverties of choice and connection²⁴) and how they impact on food intake and, ultimately, diet and nutritional status.

²⁴ categories coined for describing neighbourhoods in the USA (Katz 2004)

Figure 5.1: Risk factors for nutritional vulnerability of asylum seekers



Adapted from Ismail and Manandhar 1999

5.1 Food intake

While the research findings show that generally asylum seekers living in the North Western region have adequately nutritious diets, a number of issues require attention as some food intake patterns show sub-optimal achievement in terms of current daily dietary recommendations.

The high percentage of energy supplied from protein and from saturated fat, and the low percentage derived from carbohydrate, compared to recommended levels, is a cause for concern. This is mirrored by nearly half the sample reporting unintentional weight gain since arriving in Ireland. The excess in availability of intake of fat and protein is real in relation to RDAs, as well as to perceived comparisons with home diets. These findings mirror those of other studies among ethnic minority groups (James et al 1997, Sellen et al 2000, Nolan et al 2002).

Pulses account for a higher component of the protein dietary habit for asylum seekers living in the community than in Direct Provision. This difference may be related to asylum seekers being able to revert more to their own familiar dietary patterns once they are in control of their own food in the community. For many non-European cultures, pulses form a substantial part of the protein content of the diet, whereas meat is consumed less frequently because it is generally a higher cost and higher status dietary item.

In terms of carbohydrates, many asylum seekers are more familiar with maize and millet meal, flour derived from starchy tubers such as yam and plantain, sweet potatoes, couscous and rice, rather than the carbohydrate staples common in Ireland: wheat bread, wheat pasta and potatoes, and heavily part of the Direct Provision menu. The low-fibre intake in Direct Provision is not a surprising finding as it may be related to a pattern of missing meals, particularly the cereal-based breakfast, which is not a common dietary behaviour in non-European countries.

The high levels of consumption of sugar-rich foods must be addressed. It may reflect snacking on foods with hidden fats and sugars, which also tend to have high concentrations of food colourings and other additives and preservatives. This is often related to poverty as such foods tend to be cheaper than other alternatives (see Literature Review, e.g. Sustain 2002). The emphasis needs to be on avoiding this becoming an established pattern of food intake among children because long-term

consumption has been associated with hyperactivity, disruptive behaviours and allergies (Boris and Mandel 1994, Bateman et al 2004, Food and Behaviour Research 2004), and learned behaviour leading into adult life (Food and Behaviour Research 2004).

Many asylum seekers reported that their intake of fresh fruit and vegetables was far higher in their home countries than it now is in Ireland, and there is a perception that their current intakes of these foods is low, as reflected in the qualitative transcripts. The relative lack of variety of fruit and vegetables, and the unfamiliarity of some items which may not even be tried, compared to a far higher variety at home may also be contributing to this perception (Nolan et al 2002). 'Adequacy' should not merely be seen in terms of compliance with, or relativity to, current recommendations.

Consumption of dairy produce among asylum seekers in this study is generally in line with the recommended daily intake. Unfortunately the most common milk consumed by people living in the Direct Provision centres is full-fat milk, which, whilst good for the provision of calcium, is high in saturated fat, the intake of which has already been identified as higher than the recommended level of intake based on high meat consumption.

Alcohol consumption appears to be much less prevalent among asylum seekers, particularly women, in this study compared to the general population in Ireland. This is likely a combination of gender and religious restrictions, cultural background and lack of cash in the face of other priorities.

The range of food provided by Direct Provision centres to asylum seekers seems to be inadequate. Our sample was of asylum seekers from twenty-five different countries, all very different from one another in terms of ethnicity, culture, religion, and food preferences and practices. There is a tendency for those providing food to treat asylum seekers as if they are one homogeneous group (Corbett 2002). While this is true to some extent, this study found that there was variation between centres, and evidence that things had definitely improved over time.

Taking a health promotion approach indicates that there is some scope for nutritionists to stimulate discussion over diet with asylum seekers. Many of the asylum seekers in this study are unaware of the main food sources, the functions of the different food groups, and the cooking methods best suited to preserving

micronutrient content. Just over one third of participants know that meat is a good source of iron, a concerning finding given the number of women of child-bearing age in the study. Knowledge of dietary terms such as fibre, saturated fat and starch, and of the links between diet and cardiovascular disease and other specific diseases, was also poor across all ethnic groups in the health and lifestyles of black and ethnic minority groups in Britain (Health Education Authority 1999).

5.2 Determinants of nutritional status

A shiny face goes with a full belly.

West African saying

The prevalence of overweight and obesity is much higher in this asylum-seeker population than in the general population of Ireland (SLAN 2003). Changes which have taken place in daily living for asylum seekers also impact on physical activity levels as well as on their dietary behaviour, exacerbating the problem of weight gain and rising Body Mass Index. Risky health behaviours such as high protein and fat intake and changed child feeding practices, including early termination of breastfeeding, are also more prevalent among Direct Provision dwellers compared to those living in the community. Asylum seekers living in the community have better self-reported health, quality of life and satisfaction with their health compared to those living in Direct Provision.

Nutritional science contains evidence that, when exposed to a rapid and marked change towards a predominantly western-style diet, non-Caucasian ethnic groups from historically resource-poor settings put on weight faster, and are more prone to developing diabetes and obesity, than their Caucasian counterparts (James et al 1997). In this study, the evidence of unintentional weight gain, together with overall nutrient intake patterns revealing a high proportion of calories derived from protein, saturated fat and sugars, suggests a distinct nutritional risk profile and some potentially serious health implications for this population group.

In contrast to the very low prevalence of breastfeeding among Irish mothers generally, among this sample of asylum-seeker women breastfeeding is common. However, many asylum-seeker women in this study commented on the difficulties they encountered in maintaining breastfeeding in Direct Provision. Many had stopped

breastfeeding altogether, even though they had wanted to continue and had previously breastfed children without problems. Women themselves are concerned that they are forced by circumstances in Direct Provision to change previously good child-feeding practices. Instead of reinforcing and replicating good practice, the Direct Provision system serves instead to damage the traditional behaviours that were health promoting. The comments of asylum-seeker women are mirrored in the service provider interviews.

Another Irish study (Fanning et al 2001) also reported a tendency for women in Direct Provision Centres or hostel to give up breastfeeding within a few weeks of the birth of their baby. Although not specifically investigated in this study, we know that culturally determined food avoidances and food beliefs are common during breastfeeding in many ethnic groups, and that these may not be met in Direct Provision which may also cause some women to opt for bottle feeding.

The inadequate food provided in centres, and the institutional and restricted nature of food provision generally, appear to have adverse nutritional effects. They impact particularly on the optimal nutrition for a child below six months of age, exclusive breastfeeding, as well as breastfeeding with solids after that age. This may compromise the nutritional status of those children into later life, and it may also compromise the nutritional status of the women. As breastfeeding is a period of raised energy requirement for the mother, there should be more, not less, opportunities for women to access food and drink when necessary during this time. These conclusions are not new. In 2001, the Irish Refugee Council stressed that:

it must also be remembered that reception centres may be unsuitable, even on a short-term basis, to meet the needs of women with families, women expecting babies, and women who have experienced trauma.

Irish Refugee Council 2001b

We understand that the RIA is currently developing guidelines on infant feeding in Direct Provision based on the Food and Nutrition Guidelines for Pre-School Services produced by the Health Promotion Unit of the Department of Health and Children in 2004. It is hoped that these guidelines are developed in full consultation with a range of professionals, and prioritise the nutrition and health of infant and mother as well as their emotional and practical needs. Moreover, as 'culture matters', it is hoped that these, and any other guidelines for Direct Provision or matters related to asylum

seekers, avoid ethnocentricity by taking into full account the geographic, ethnic and religious diversity of this population group and how this is reflected in their food habits, beliefs and behaviours.

5.3 Income poverty

Study results show that asylum seekers experience various aspects of food poverty upon arrival in Ireland and during the often long period during which their asylum application is being processed. We have clearly identified that food poverty exists among asylum seekers in the North West and have described its effects. This situation existed at a time when Child Benefit was being paid to asylum seekers with children. However, since May 2004 such is no longer the case. It can be assumed, therefore, that the food poverty situation after completion of this study will have worsened as these cuts will represent a significant reduction in asylum seekers' income to meet their needs, including for food.

This study confirms a previous finding that it is common for asylum seekers living in Direct Provision centres to consider it necessary to purchase extra food and other items, to supplement the food and materials provided to them, but that many cannot afford to buy such food (Fanning et al 2001). Similar findings have been found among low-income groups in Ireland and elsewhere, as described in Chapter Two (Sustain 2002, Friel and Conlon 2004).

This study confirms the conclusion of Fanning's study (2001) that, although reporting a better quality of life and more control over food than when they lived in Direct Provision, asylum seekers living in the community are at increased risk of food poverty. Although shopping for food and eating meals returns as a normal feature of daily life, all of the community-living participants cited financial limitations as the main influence on their dietary choices. Buying cheap food items in cheap food outlets is the main strategy used. Whilst all food groups are purchased on a weekly basis, financial restrictions are reflected in the use of known cheaper retail outlets. Lidl is the main shop used by this sample of asylum seekers because of the low cost of foodstuffs and these retail outlets are frequently located on the outskirts of towns.

Many asylum seekers in the community live in 'food desert' areas, out of the town centre but too far to walk, reliant on either taxis to go to larger shops or using smaller shops with limited food variety, especially in terms of healthy food options such as

good quality fresh produce, and relatively higher prices. The data revealed how a considerable amount of weekly income, even for those receiving only €19.10 in Direct Provision, is spent on taxi fares for shopping.

Asylum seekers living in the community described cutting back on food purchases and missing meals themselves in order to be able to afford things for the children. Ensuring children were fed and could go to school, and avoiding debt and getting into arrears were main concerns. Unfamiliarity with the state welfare system, and fear of the state, contribute to these difficulties. Budgeting in a new and alien environment, and sometimes with only a rudimentary command of the language, is often difficult.

New work on inequalities in food choice is being undertaken by the UK's Food Standards Agency. This will identify barriers to food choice by those in minority and low-income groups, pilot interventions, and inform national policy. Lessons from this work may be useful in Ireland in the implementation of food poverty research appropriate to the Irish situation in different locations and among different population groups, and inform future nutrition, health, and poverty-related policy (Friel and Conlon 2004).

5.4 Poverty of choice

We eat first with our eyes!

Ghana saying

The search for ethnic foods, with their associated familiar tastes, smells and textures, is a deep-rooted universal human need. Regardless of accommodation type, asylum seekers frequently expressed their desire to consume their own foods, prepared and cooked in their own ways. Although this is a rational and understandable behaviour, it appears to exacerbate their food poverty as it requires the sourcing of ethnic foods, often at considerable distance, effort and expense, relative to local Irish foods. This study has highlighted the considerable lengths that asylum seekers, particularly from Africa, Asia and the Middle East, take to source their own preferred ethnic foods.

The evidence has revealed that many asylum seekers in Direct Provision attempt a balancing act between being controlled in an institutional setting and asserting their own preferences for foods of their choice and preparation. Most studies report that asylum seekers living in the community are more satisfied with their foods because

they have control over cooking more of what they like (Collins 2002) but this does not necessarily mean they are achieving a healthy diet. Whilst dietary practices are influenced by a concern for health and the taste of food, issues of access and availability of foodstuffs also feature very strongly in the responses.

Within the Direct Provision setting, people's normal behaviour of managing and caring for themselves and their families has been limited and this is evident in food practices. The social aspect of eating is also limited by the threat of theft of food and people resort instead to storing and eating food in their rooms. The corollary to the food experience in Direct Provision is that a proportion of asylum seekers end up eating out at an expense not readily affordable, or missing meals altogether.

For asylum seekers living in Direct Provision, living conditions strongly affect food intake, as well as other aspects of health and well-being. Most asylum seekers find the institutionalised nature of the whole food environment hard to live with, and missing meals is common in Direct Provision for a variety of reasons. Asylum seekers wish to make alternative food choices but are restricted in their choices. They opt for buying familiar ethnic food items of high cost and combine this with foodstuffs from the top shelf of the food pyramid which are cheap fillers compared to other more healthy alternatives.

In practice, the system of Direct Provision caters for asylum seekers as if they are a homogeneous group. Catering for groups as 'African' displays a lack of understanding of the extent of cultural diversity within the many cultures, religions, languages, ethnic and social groupings of the African continent and which will determine, in similarly diverse ways, the food choices and preferences of many asylum seekers.

As found in the Cork study (Nolan et al 2002), the majority of asylum seekers participating in this study believe that their diet could be healthier and that this would be best achieved by increasing consumption of fruit and vegetables and having a greater variety of foodstuffs. These two factors are mainly structurally determined and can be improved by providing greater food choice in the hostels and having a greater range of ethnic foods available in retail outlets at affordable prices.

There appear to be gender differences in the way that asylum seekers are coping with dietary change and restricted choice. Women with small children have been

more vocal than men in their complaints about food, especially around access to opportunities to prepare their own food for their babies. This is possibly because women are more often the carer, and have also been more accustomed to being in control of food purchase and preparation at home than have men, so for women there is more loss of autonomy.

5.5 Poverty of connection

He who eats alone, dies alone.

African proverb

The social exclusion of asylum seekers, their lack of opportunities to mix and integrate with mainstream Irish society, and to feel part of daily social life and networks, has been clearly illustrated by the research.

Putting a mixed and heterogeneous group of strangers together to live communally in an institutional setting will not ensure absence of loneliness and separation from each other, and social exclusion from the wider society. People living in Direct Provision have limited access to cooking facilities and more limited social networks than those living in the community because they have less contact with people other than asylum seekers living around them.

For many asylum seekers, the change to their normal social context of mealtimes and of preparing and enjoying food within their own cultural environment with people of their ethnic group, language, religion and locality accentuates the alien nature and separateness of their lived experience as asylum seekers and the loss of control they have over even the most basic part of human activity. Not surprisingly, therefore, this was a sensitive area to explore and it generated some strong emotions.

One former asylum-seeker woman from Africa, interviewed in the pilot study for the qualitative part of the research, recalled her early days in a Direct Provision centre and how much she missed both her home and food. She described the feeling of eating her own African food as 'like a baby getting its dummy': it acted as a comforter, brought her something familiar that would temporarily ease the pain of her alien situation and 'shaped her integrity'. Such enforced change of diet can contribute to what nutritional anthropologists have called 'cultural bereavement' (Williams 1993).

For all asylum seekers, poverty of connection is reflected in the lack of extended family and friends to help out with hand-me-downs and shared equipment, especially for children, and to share the costs of shopping trips. This poverty of connection also continues into the community setting. The majority of asylum seekers living in the community report using public transport for their weekly shopping and this in itself poses a problem, partly because of its cost which must be added to the food bill but also the difficulty in actually carrying the purchased goods. Such trips are a struggle for asylum-seeker women who have to take their small children with them as they have no family or social supports in the area and cannot afford childcare (even if it is locally available).

There may be a gender dimension to be considered. Women appear to be more socially isolated than men, especially those with small children, as physical and social activities and opportunities to mix socially with Irish people are more accessible to men (e.g. football games, the pub).

It is worth considering in detail income and expenditure realities for a single mother with a small child living in Direct Provision in the region at the time of the study as an example of the poverties of income, choice and connection. She receives €28.60 as a weekly state allowance. From this, in order to feel socially included in the host community, to receive psycho-social support through having a social network, and feel able to access her own preferred ethnic foods when she wants (which is important for her emotional well-being and sense of control over her life), she will face a number of expenses that cannot be covered by this payment. These expenses include the following:

- Find her own ethnic food available locally and not at high cost
- Pay for taxi transport to shops (buses are unavailable or inconvenient)
- Pay for everyday hygiene items such as sanitary towels, wipes and other hygiene items for the baby not covered by Exceptional Needs Payments
- Find out what is happening back home and keep in touch with family and friends (international calls and internet services cost money)
- Have a social life for increasing opportunities to meet and mix with Irish people
- Attend courses or participate in physical activity (but only ones that do not incur cost, as well as provide childcare facilities or reimburse childcare costs)

- Have a few 'treats' (have a party for her baby's christening party, go out with friends for coffee after church, go to hear a visiting band or go to the cinema).

As an asylum seeker living in Ireland, whether in the community or in Direct Provision, food choices and the context of eating are certainly very different to those of the home country. In addition to all the other changes in their lives, asylum seekers have to change and adapt to new challenges of understanding the local food base and food economy. Differential access to food choice is linked to relations of power, control, and exclusion (Burgess and Morrison 1998). Asylum seekers in both accommodation types have to cope with different foods and cooking styles, limited food choices, unfamiliar food items and the 'otherness of Irish food'. This has the potential to reinforce social exclusion in the longer term.

The results of this study also confirm the words of the Irish Refugee Council which has been widely critical of the system of Direct Provision:

This system of reception called Direct Provision is a discriminatory measure which socially excludes asylum seekers from the local community, both physically and financially. It flouts the principles of the National Anti-Poverty Strategy which guarantees the rights of minorities and encourages self-reliance through respect for human dignity and promotion of empowerment and equal access.

Irish Refugee Council, 2001a

5.6 Conclusion

This is the first report of food patterns and nutritional well-being of asylum seekers in the Republic of Ireland. It clearly shows that determination of population patterning of food and nutrient intake is useful for identifying groups at risk of diet-related disease and nutritional inadequacy. However, de-contextualising dietary behaviour from the real-world setting obscures the political, economic, cultural and social influence on dietary choices and a concentration on food and nutrient intake alone is insufficient for addressing the dietary needs of different population groups (Lynch et al 1997).

The findings from this study corroborate the above statement, highlighting the complex nature of dietary habits among this population group and exposing the realities of food poverty. The study illustrates how dietary choice is influenced by

inter-related population and individual-level matters, including factors that are structural, material and psychosocial in nature. It exposes the other 'poverties' experienced by this socially excluded population group: the poverty of choice, and the poverty of connection, which exacerbates their food poverty. In highlighting the significance of ethnic differences in people's food habits and practices, the research also shows how far culture really matters.

It is not clear how far all these issues are understood by the Reception and Integration Agency in its role as the main state department responsible for dealing with asylum seekers as they arrive and are dispersed across for the country, often for years. At an early stage of this study the research team wrote to the RIA requesting the results of hostel inspections that related to food provision, but the response was that the results were 'not nutritionally important'. This response suggested to us a general lack of understanding about the importance of diet on nutritional status and health and well-being for asylum seekers. It also suggested an underestimation of the social context of food for a socially excluded population group feeling alienated and estranged from the mainstream community.

All issues related to food for asylum seekers have so far been left to the Reception and Integration Agency and the Direct Provision centre managers and staff; and for those living in the community, to the general supports available for the Irish public. This approach is insufficient and needs review. The food choices, dietary intake and nutrition of this vulnerable population group, affected by food poverty and restricted in choices and in social connections, are health and social well-being issues, and as such clearly fall into the general remit of the health system, and to community nutrition services, multidisciplinary public health and health promotion in particular.

Current public health discourse emphasises strengthening the health system by paying more attention to the social inequalities and exclusion that negatively impact on health determinants and outcomes (Burke et al 2004). A key requirement of this is to understand the perspectives of those marginalised and vulnerable groups in order to design and monitor policies and interventions aimed at protecting and promoting their health and well-being.

This research contributes to such an understanding. It is hoped that the results will be used to debate current policy and service provision for asylum seekers, and stimulate the replication of good practice in policy, programming, interventions and

organisational ways of working, including better inter-sectoral planning and collaboration, and improved awareness and cultural competency among service providers. It is also hoped that this research can help address gaps and weaknesses in present policy and practice in terms of reducing food poverty, promoting and protecting all aspects of health and well-being, and for meeting the many diverse and complex needs and preferences of asylum seekers as they have expressed them.

Chapter Six: Recommendations

In order to deal with the issues raised in this research, and improve the food poverty situation for asylum seekers as well as their overall health and social and emotional well-being, a number of recommendations are now put forward. These recommendations are based on:

- what has emerged from the results of this research study
- the informed knowledge of the multi-disciplinary team which has worked together for many months during this collaborative research project
- the international literature.

As summarised in Table 6.1, the recommendations are presented according to different levels of intervention: national policy; the Direct Provision system; the health system, the community and individuals. From an equitable public health perspective, to really tackle this issue, intervention at all levels is necessary. Responses should be considered at the macro, sectoral, community and individual levels, drawing on the relevant available data pertaining to each. In addition, any successful health intervention, or intervention in any other sector, needs to be culturally sensitive, and a good understanding of health and social issues for ethnic minorities is required.

National policy

The overriding determinant of food choice and food poverty among asylum seekers living both in the community and in Direct Provision is inadequate financial resources. A review of the level of payments made to asylum seekers is now overdue as these payments have not kept pace with other social welfare payments. All asylum seekers need higher social welfare payments and allowances to reduce their food poverty, and compensate for their poverty of choice, lack of material items, poverty of connection, and lack of social networks and transport. The recent decision to stop Child Benefit payments to asylum-seeker families with children represents a painful drop in their spending resources.

A Food Poverty Network should be established at national level to stimulate local nutrition and food poverty action plans (Press and Mwatsama 2004, Friel and Conlon 2004). More research on food poverty and 'food deserts' affecting ethnic minorities,

including detailing of 'food baskets' with ethnic food items, is urgently needed to inform such any policy initiatives.

Direct Provision

More attention needs to be paid to improving food in this institutional environment, ensuring it is of a high nutritional content, particularly for those with increased and special nutrient requirements, such as pregnant and breastfeeding women and young children. Much more flexibility and creativity is needed to increase the choice of ethnic foods and promote healthy diet options incorporating ethnic foods. Changes are needed to allow for asylum seekers to have more control over and choice of their food, and to better cater for their diverse food preferences.

The following are specific recommendations for increasing choice and improving opportunities for asylum seekers to follow healthier diets:

- Decrease the availability of saturated fat and high protein foods, and expand the weekly menus so that dishes are repeated less frequently
- Increase the availability of fresh fruit and vegetables, including tropical, non-dairy calcium-rich products and pulses, and more variety of carbohydrate staples (to include more rice, couscous, maize meal, dishes from African starch flours, sweet potatoes, and less wheat bread, pasta and potatoes).
- Train hostel chefs in culturally sensitive cooking skills and dietary knowledge (use multi-cultural cookbooks; see Shiels 2004, Regan 2004, Metro Éireann).
- Ensure that food items and the timing of meals are culturally appropriate (e.g. halal food; daytime fasting during Ramadan catered for).

The Direct Provision system and hostel management should develop multi-sectoral partnerships to promote and protect the health and well-being of asylum seekers. These should include alliances with dietitians to encourage health-promoting food environments and to monitor food provision in the centres, alongside Environmental Health Officers (concerned only with food safety and hygiene), and with local retailers to stock a wider variety of ethnic foods and fresh produce. Direct Provision centres should work more closely with their local Health Board, area partnership, community and voluntary sector, and sporting venues to increase opportunities for asylum seekers to participate in activities that would improve health, counter weight gain, relieve boredom and enhance integration.

Table 6.1: Summary of recommendations

Level	Recommendation
National Policy	1 Review and increase allowances/welfare payments for asylum seekers
	2 Develop rights-based, pro-poor, socially inclusive public policy for health
	3 Appoint a Junior Minister of State for Food in Department of Health and Children to tackle food poverty as a factor in health inequalities
	4 Establish a national Food Poverty Network to develop Action Plan
Direct Provision	1 Increase the choice and availability of ethnic foods and promote healthy diet options that incorporate ethnic and fresh foods
	2 Work in multi-sectoral partnerships to promote and protect the health and well-being of asylum seekers
	3 Provide more self-catering units and limit the time in Direct Provision to 6 months by speeding up the whole application process. After 6 months, people should live in the community and be able to work
Health System	1 Ensure partnership with Reception and Integration Agency to plan and monitor food in Direct Provision
	2 Participate in, or create, broad multi-sectoral partnerships to promote availability of, and access to, wide variety of affordable ethnic foods as part of promotion of asylum seeker health and well-being
	3 Be more culturally aware and competent, embed cultural and ethnic diversity and anti-racism training, and avoid ethnocentricity
	4 Prioritise the nutritional needs of children and breastfeeding and pregnant women, and support their health-promoting behaviours
	5 Promote opportunities for asylum seekers to be more physically active
	6 Ensure the social inclusion and participation of asylum seekers
Community	1 Foster community development approaches aimed at creating supportive environments for asylum seekers to access affordable food of their choice
	2 Partner with retail sector to increase local availability of ethnic foods
	3 Encourage asylum seeker participation in community nutrition projects
	4 Advocate for equal access of asylum seekers to all services
	5 Stimulate interest around ethnic differences in food, food habits and cooking to develop understanding and exchange
Individuals	1 Build cultural competency, participate in anti-racism/ethnic diversity training
	2 Acknowledge the importance of food in daily life for asylum seekers
	3 Adopt health-promoting behaviours and develop own nutritional knowledge

The current regimented system in Direct Provision and restriction on self-catering facilities outside Dublin should be reviewed and amended. The experience of other types of hostels providing self-catering or communal kitchens should be studied to overcome any potential health and safety concerns. Women with young children should have prioritised access to self-catering accommodation or communal units with self-catering, and a communal kitchen should be available in all Direct Provision hostels.

Time spent in Direct Provision centres should be limited to a maximum of six months, after which suitable rented accommodation in the community is facilitated to enable asylum seekers to be in control of their own food, and to experience food and mealtimes in a more normal and family-orientated setting.

Health system

With its health promotion and population health functions, the health system plays a crucial role in protecting and promoting the health and social well-being of asylum seekers. The health system must enhance its partnership with the RIA, including liaison over inspection visits to hostels in their areas to review arrangements to cater for food preferences, access to ethnic foods and self-cooking. Additionally, this effort should include the promotion of healthy diets, an assessment of the cultural, gender and age mix of asylum seekers and a review of their dietary needs and requirements.

A consultation process needs to be put in place for developing guidelines related to aspects of food provision and nutrition (e.g. for infant feeding in Direct Provision), for facilitating community dietician and nutritionist services, and for working with management and staff on issues of food choice and variety, food storage and preparation, and the eating environment. Similarly, the health system needs to participate in, or create, broad multi-sectoral partnerships for asylum-seeker health and well-being in order to raise awareness of what lies behind their special needs as a minority population group.

Internally, the Asylum Seeker/Refugee Health Forum operating in the NW should be replicated nationwide and include community dietician/nutritionists, and personnel with a brief on poverty and social exclusion. Funding and technical support should be increased for local support groups, women's groups and community organisations in any work aimed at improving social inclusion, recreational activities, childcare and

family support, and food poverty for the general population, and ensure that this also specifically refers to, and includes, asylum seekers. All health providers should become more culturally competent by taking part in ethnic and cultural diversity training, and be more aware of the culturally motivated choices that people make in their nutrition and health-related behaviours.

By seeking out international links on food, nutrition and health promotion from other cultures, more culturally competent health improvement resources should be developed and made available. This would include health messages (e.g. breastfeeding, hygiene, immunisation) in languages common among asylum seekers in the area, the use of growth charts providing growth centiles for children in non-Caucasian groups, and Food Tables and Food Pyramids incorporating commonly used ethnic foods.

All children have the right to optimal nutrition. Exclusive breastfeeding (up to 6 months) and correct weaning practices are essential elements to fulfil this right. The health system must ensure that the nutritional needs of children and breastfeeding and pregnant women are prioritised, and do everything possible to support their health-promoting behaviours. Mothers should be able to store, prepare and cook food for their babies and young children whenever necessary, and peer-support groups for informal learning and encouragement of breastfeeding should be facilitated.

Any actions to improve the food poverty, and other poverties of choice and connection experienced by asylum seekers, need to be underpinned by increased commitment to strengthen support around social needs and promote social inclusion for asylum seekers. The health system should acknowledge and focus on this at every opportunity, address the lack of recreational, sporting and physical activities for asylum seekers and promote opportunities for them to be more physically active, including practical steps to overcome difficulties related to cost, transport and childcare which currently deter participation.

Community

The paucity of multi-sectoral and multidisciplinary working between the food, health and community sectors in Ireland needs to be addressed in order to create an environment that would enable asylum seekers to access and afford food of their choice. Building on the movement towards inclusion of health in community

development,²⁵ programmes led by asylum seekers, in collaboration with food providers in Direct Provision settings, and with voluntary and statutory organisations, should be supported. Partnerships between communities and retailers,²⁶ for example, can address these issues.

Community nutrition and community garden projects should ensure that they seek to include asylum seekers as participants. In addition, peer-led community-based education programmes should be supported as they have been successful methods of imparting nutritional information and cooking skills to socially disadvantaged groups.

Individuals

Individual service providers, particularly important gatekeepers such as the Public Health Nurse and Community Welfare Officer, as well as support group members and staff in Direct Provision centres, should build their own cultural competency and work more closely with each other through specific sub-groups. They should also advocate for solutions to the health-care access difficulties experienced by asylum seekers, such as speedy registration onto a GP list²⁷ upon arrival.

There needs to be more acknowledgement that having a feeling of control over one's own food is extremely important to everyone, but even more so to asylum seekers who no longer have control over much else in their lives. For their part, asylum seekers themselves can develop their nutrition knowledge, including how to prepare unfamiliar foods available locally and cheaply, and enhance their skills, including managing on a low income.

In conclusion, the key components needed to improve the current situation can be summarised as follows:

- Develop interventions at all levels
- Treat food and nutrition as a fundamental part of health and well-being
- Develop strong partnerships and multi-sectoral working through a community development approach to build supportive and enabling environments

²⁵ Such as the Healthy Communities Programme launched by the Combat Poverty Agency

²⁶ Such as those interested in global issues through their promotion of Fair Trade

²⁷ Asylum seekers in Sligo and programme refugees in Carrick-on-Shannon encountered difficulties in gaining access to a GP and a medical card during 2004 and early 2005

- Increase payments for all asylum seekers to compensate for their food poverty and their 'poverties of choice and connection'
- Provide more flexibility and creativity around availability of ethnic foods in both settings
- Create an environment that supports health-promoting behaviours and practices
- Strengthen commitment to social inclusion and integration of asylum seekers
- Develop more cultural competency across all sectors
- Involve asylum seekers in the planning and delivery of services, interventions and facilities, and related research activities to ensure their voices are heard.

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Appendices

- A** Quantitative research protocol (Food Frequency Questionnaire)
- B** Letter of introduction to asylum seekers
- C** Letter to Direct Provision Centres
- D** Qualitative research protocol
- E** Questions for Regional Coordinator, Community Health Adviser
- F** Questions for other service providers and support groups
- G** Informed Consent Form

APPENDIX A

Qualitative research protocol (Food Frequency Questionnaire)

Food, nutritional status and access to food among asylum seekers in the North West of Ireland

July 2003

The Combat Poverty Agency recently commissioned the Centre for Health Promotion Studies, National University of Ireland, Galway and the North Western Health Board to carry out a survey on the food and nutritional status of asylum seekers living in the North West of Ireland.

The study aims to determine food and nutrition issues among asylum seekers who are often a socially excluded population group. It also aims to develop recommendations for policy and good practice to improve nutrition inequalities related to social exclusion. To do this there are a number of questions we need to ask you and would be most obliged if you could provide as much detail as possible.

Thank you very much for your time and help with the survey.



Food, nutritional status and access to food among asylum seekers in the North West of Ireland

Thank you for participating in our study. My name is _____

The following questionnaire covers a number of topics related to the kind of foods you eat, the food preparation and storage facilities available to you and a number of general questions about yourself.

All the issues that we talk about today are confidential; your name will not appear anywhere on this questionnaire and your details will not be given to anyone outside this study.

If you do not understand any of the questions please stop me and I will try to explain them more fully. If you feel uncomfortable with any of the questions, you do not have to answer them, and if you wish to stop the interview at any time you may do so.

Location (indicate if in a centre or in the community): _____

SECTION A: YOUR USUAL DIET

This section of the questionnaire asks about how often in the last month you have eaten different types of food. Please indicate, on average, how often in the last month (30 days) that you have eaten the foods listed below.

For each food there is an amount shown, either a "medium serving" or a common household unit such as a slice or teaspoon. Please put a tick in the box to indicate how often, **on average**, you have eaten the specified amount of each food, to the nearest whole number **during the past 30 days**.

Please estimate your average food use as best you can. Please answer every question, do not leave ANY lines blank.

Please check that you put a tick (✓) on EVERY line

MEAT, FISH AND POULTRY (MEDIUM SERVING)	AVERAGE USE IN THE LAST 30 DAYS								
	Never or less than once/ month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Beef : roast									
Beef : steak									
Beef : mince									
Beef : stew									
Beef burgers (1 burger)									
Pork : roast									
Pork : chops									
Pork : slices									
Lamb : roast									
Lamb : chops									
Lamb : stew									
Chicken portion or other poultry (e.g. turkey)									
Bacon									
Ham									
Corned beef, Spam, Luncheon meats									
Sausages, Frankfurters (1 sausage)									
Savoury pies (e.g. meat pie, pork pie, steak & kidney pie, sausage rolls)									
Liver, heart, kidney									
Liver pate									
Fried fish in batter, as in fish & chips									
Fish fried in breadcumbs									
Ovenbaked / grilled fish									
Fish fingers, fish cakes									
Other white fish, fresh or frozen (e.g. cod, haddock, plaice, sole, halibut)									
Oily fish, fresh or canned (e.g. mackerel, kippers, tuna, salmon, sardines, herring)									
Shellfish e.g. crab, prawns, mussels									
Fish roe, taramasalata									

A1. Meat, fish and poultry are good sources of which of the following?

- Iron []
- Fibre []
- Vitamin C []
- Calcium []
- Don't know []

Please check that you put a tick (✓) on EVERY line

AVERAGE USE LAST 30 DAYS	

BREAD AND SAVOURY BISCUITS (one slice or biscuit)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
White bread and rolls									
Brown/wholemeal bread and rolls									
Cream crackers, cheese biscuits									
Pitta bread									
Crisp bread, e.g. Ryvita									
Pancakes									
CEREALS (one bowl)									
Porridge, Readybrek									
All Bran, Weetabix, Shredded Wheat									
Branflakes, Bran Buds									
Cornflakes, Rice Krispies									
Muesli (e.g. Country Store, Alpen)									
Sugar Coated Cereals (e.g. Frosties)									
POTATOES, RICE AND PASTA (medium serving)									
Boiled, instant or jacket potatoes									
Mashed potatoes									
Chips									
Roast potatoes									
Potato salad									
White rice									
Brown rice									
White or green pasta e.g. spaghetti, macaroni, noodles									
Wholemeal pasta									
Lasagne									
Moussaka									
Pizza									
Macaroni Cheese									

A2. Bread, cereal, rice and pasta are good sources of which of the following?

- Carbohydrate []
 Vitamin C []
 Calcium []
 Vitamin D []
 Don't know []



Please check that you put a tick (✓) on EVERY line									
DAIRY PRODUCTS AND FATS	AVERAGE USE LAST 30 DAYS								
	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Cream (tablespoon)									
Full-fat yoghurt or Greek yoghurt (125g carton)									
Low fat yoghurt, fromage frais (125g carton)									
Dairy desserts (125g carton)									
Cheddar Cheese, (medium serving)									
Brie, Edam cheese (medium serving)									
Low-fat Cheddar Cheese, (medium serving)									
Cottage cheese, cream cheese, low fat soft cheese (medium serving)									
Eggs as boiled, fried, poached, scrambled (one)									
Quiche (medium serving)									
Light salad cream or light mayonnaise (tablespoon)									
Salad cream, mayonnaise (tablespoon)									
French dressing (tablespoon)									
Other salad dressing (tablespoon)									
The following on bread or vegetables									
Butter (teaspoon)									
Lite Butter e.g. Dawn Lite (teaspoon)									
Sunflower Margarine e.g. Flora (teaspoon)									
Low-fat margarine e.g. Low Low (teaspoon)									
Cream & Vegetable Oil Spread e.g. Golden Pasture, Kerrymaid (teaspoon)									
Olive Oil Spread e.g. Golden Olive (teaspoon)									

A3. Milk, cheese and yoghurt are important for which of the following?

- Strong bones []
 Teeth []
 Muscles []
 All of the above []
 Don't know []

Please check that you put a tick (✓) on EVERY line									
FRUIT (1 fruit or medium serving)	AVERAGE USE LAST 30 DAYS								
	Never / less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Apples									
Pears									
Oranges, satsumas, Mandarins									
Grapefruit									
Bananas									
Grapes									
Melon									
Peaches, Plums, Apricots									
Strawberries, Raspberries, Kiwi Fruit									
Cherries									
Tinned Fruit									
Dried fruit e.g. raisins									
VEGETABLES , Fresh, frozen or tinned (medium serving)									
Carrots									
Spinach									
Broccoli, Spring Greens, Kale									
Brussel Sprouts									
Cabbage									
Peas									
Green Beans, Broad Beans, Runner Beans									
Marrow, Courgettes									
Cauliflower									
Parsnips, Turnips									
Leeks									
Onions									
Garlic									
Mushrooms									
Sweet peppers									
Beansprouts									
Green salad, Lettuce									
Cucumber, Celery									
Watercress									
Tomatoes									
Sweetcorn									
Beetroot									
Coleslaw									
Avocado									
Baked Beans									
Dried Lentils, Beans, Peas									
Tofu, Soya Meat, TVP, Vegeburger									

A4. Fruit and vegetables are good source of which of the following?

Calcium

[]

Please check that you put a tick (✓) on EVERY line

DRINKS (medium serving)	Never or less than once/month	1-3 per month	Once a week	2-4 per week	5-6 per week	Once a day	2-3 per day	4-5 per day	6+ per day
Tea (cup)									
Coffee (cup)									
Coffee, decaffeinated (cup)									
Coffee whitener e.g. Coffee-mate (teaspoon)									
Cocoa, Hot Chocolate (cup)									
Horlicks, Ovaltine (cup)									
Wine (glass)									
Beer, Lager or Cider (half pint)									
Port, Sherry, Vermouth, Liqueurs (glass)									
Spirits e.g. Gin, Whiskey (single measure)									
Low Calorie or Diet Fizzy Soft Drinks (glass)									
Fizzy Soft Drinks e.g. Coca Cola (glass)									
Pure Fruit Juice e.g. orange juice (glass)									
Fruit squash (glass)									

If you have consumed foods/drinks/meals in the past 30 days that were not included in the lists above could you please record these in the space given below?

SECTION B: DETAILS ABOUT YOU AND YOUR CURRENT LIVING SITUATION

B1. Are you Male Female

B2. Do you speak English?

Well Adequately A little bit Not at all

B3. What age are you? _____years _____months

B4. Where are you from?

Nigeria	<input type="checkbox"/>	Iraq	<input type="checkbox"/>
Romania	<input type="checkbox"/>	Russia	<input type="checkbox"/>
Ghana	<input type="checkbox"/>	Other	<input type="checkbox"/>

If other, please specify _____

B5. How long have you been living in Ireland? _____years _____months

B6. How long has it been since you left your home country?

_____years _____months

B7. Are you living with people related to you? Yes No

If yes how many? _____

B8. What age were you when you left school? _____years

B9. What did your education include?

None/primary

Some secondary school

Completed secondary school

Technical college or university

B10. What is your marital status at the moment?

Married/Cohabiting Widowed

Separated/Divorced Single / Never married

Lone parent

B11. What did you work at in your home country?

SECTION C: EATING PATTERNS AND FOOD PREPARATION

C1. How long have you been staying in this type of accommodation? _____mths

C2. Can you use a kitchen or food preparation area in your accommodation? **Yes** **No**

If yes, what kind of kitchen/food preparation area is it?

Communal kitchen **Private kitchen**
Area in the bedroom **None**

C3. Do you have access to any of the following? (please tick all that apply)

Cooker with 2 or 4 rings	<input type="checkbox"/>	Stove kettle	<input type="checkbox"/>
Rice Cooker	<input type="checkbox"/>	Toaster/Grill	<input type="checkbox"/>
Oven	<input type="checkbox"/>	Refrigerator	<input type="checkbox"/>
Microwave	<input type="checkbox"/>	Freezer	<input type="checkbox"/>
Electric kettle	<input type="checkbox"/>	None of these	<input type="checkbox"/>

C4. On average, how much do you spend on food during a typical 7-day period (includes food bought for yourself and those who you live with)? **Remind participants to include money spent on snacks, tea and coffee, sweets/treats for themselves or their children, school lunches (if applicable) etc.**

€ _____

C5. Do you regularly (at least once per week) shop for any of the following? **(please tick all that apply)**

Milk/Tea/Coffee	<input type="checkbox"/>	Fresh vegetables/fruit	<input type="checkbox"/>
Bread	<input type="checkbox"/>	Frozen vegetables/fruit	<input type="checkbox"/>
Sweets/Cakes	<input type="checkbox"/>	Dried goods (e.g. pasta, rice etc)	<input type="checkbox"/>
Fresh meat/poultry	<input type="checkbox"/>	Dairy products (e.g. cheese, yoghurt)	<input type="checkbox"/>
Fresh fish	<input type="checkbox"/>	Canned foods (e.g. veg, fruit)	<input type="checkbox"/>
		Microwave foods (e.g. ready meals etc)	<input type="checkbox"/>

C6. If any of the above has been selected please tick where each type of food is usually purchased:

Shops	Fruit Veg	Bakery Goods	Meat / Fish	Milk	Other (tins)
Corner shop/newsagents					
Spar, Centra, Mace, Londis					
Tesco					
Dunnes Stores					
Supervalu					
Aldi					
Lidl					
Markets					
Butcher					
Fishmonger					
Baker					
Other					

C7. What influences your choice of foods? **(please tick all that apply)**

- Costs – foods I can afford
- Health – try to provide healthy diet
- Taste – foods I like eating
- Ability to store food
- Limited cooking facilities
- Ability to carry and transport foods
- Unfamiliarity with foods/brands in this country
- Lack of foods commonly consumed in home country
- Habit – what I usually have to eat
- Religion/cultural appropriateness

If other, please specify _____

C8. What type of transport do you use for food shopping?

Walk/cycle *Free transport*

Paid transport *None*

If paid transport please state amount spent in an average week _____

C9. In the last 7 days:

a) How many of your main meals (lunch or evening meal) were **eaten out**, for example, in a café, fast food restaurant, pub, restaurant? _____

b) How many of your main meals were **takeaways**? _____

c) How many of your main meals did you **prepare from basic ingredients**? _____

d) How many of your main meals were meals **bought ready-prepared**, for example, from a supermarket? _____

e) How many of your main meals (lunch or evening meals) were consumed at a **friend's house**? _____

SECTION D: DIETARY PRACTICES

D1. As part of your culture (or as part of your religion), are there foods/drinks that you cannot eat?

Yes [] No []

If yes could you explain what these restrictions are

D2. Do you normally follow any of the following diets? (Please tick all that apply)

Vegetarian	[]	Vegan	[]
Diabetic	[]	Gluten Free	[]
Weight Reducing	[]	Low Cholesterol	[]
Do not follow a special diet	[]	Lactose free	[]

If other, please specify _____

D3. What type of milk do you use most often? (Please tick one only)

Full fat	[]	Low fat	[]	Skimmed	[]	High-low	[]
Soya	[]	Buttermilk	[]	Dried	[]	Other	[]
None	[]						

If other please state what type _____

D4. If you drink milk how much do you drink each day (including milk in tea, coffee, cereals)?

None	[]	250 ml	[]	500ml	[]
One pint	[]	More than 1 litre	[]	1 litre	[]

D5. How often do you add salt to food while cooking?

Always [] Usually [] Sometimes [] Rarely [] Never []

D6. How often do you add salt to food while eating?

Always [] Usually [] Sometimes [] Rarely [] Never []

SECTION E: GENERAL HEALTH

E1. In general, would you say your health is:

Excellent [] Very good [] Good [] Fair [] Poor []

E2. How would you rate your quality of life?

Very good []
Good []
Neither poor nor good []
Poor []
Very poor []

E3. How satisfied are you with your health?

Very satisfied [] Satisfied []
Neither satisfied nor dissatisfied [] Dissatisfied []
Very dissatisfied []

E4. Have you visited or been seen by a doctor/medical professional in the past month because of an illness or health problem?

Yes [] No []

E5. What is your height? _____feet _____inches (or nearest cm _____)
Don't know []E6. What is your weight? _____stones _____pounds (or nearest Kg _____)
Don't know []

E7. Has your weight changed since this time last year?

Yes, put on weight [] Yes, lost weight [] No []

E8. Which of the following do you think is better for your health

Weight gain [] Weight loss [] Don't know []

E9. Do you smoke cigarettes now?

Yes [] Yes, occasionally [] No []

E10. Do you drink alcohol? Yes [] No []

WOMEN ONLY

E11. Are you pregnant now? Yes [] No []

If yes do you intend to breastfeed your child? Yes []

No []

E12. Do you have a child under 12 months old?

Yes []

No []

If yes did you breastfeed? Yes []

No []

For how long_____

APPENDIX B**Letter of introduction to asylum seekers**

North Western Health Board
Bórd Sláinte and Iar-Thuaiscirt
Public Health Department
3rd Floor, Bridgewater House, Rockwood Parade, Sligo.

Tel: 071 - 74750
Fax: 071 - 38335

Food, nutritional status and access to food among asylum seekers in the North West of Ireland

Date

Person's name and address

Dear _____

In partnership with the North Western Health Board, the Centre for Health Promotion Studies, National University of Ireland, Galway is carrying out a study of food and nutritional status of asylum seekers living in the North West of Ireland. This study is funded by the Combat Poverty Agency. The study will explore food, nutrition and poverty issues among asylum seekers. It aims to develop recommendations for policy and good practice to improve food and nutritional access for asylum seekers.

We would like to ask for your help in this work and hope that you might agree to participate. This would involve a member of our research team calling to your home sometime in August to ask if you would be willing to answer questions about your eating and shopping habits and your food intake. If you do agree to participate, the researcher will call again at a time and place that suits you. Then he or she will ask you questions in a private interview which will take about an hour and a half of your time.

Your involvement is entirely voluntary and you do not have to participate. If you do agree to help in this study, all the information that you give will be treated in complete confidence. You will be given a €10 phone card at the end of the interview as a gesture of appreciation for your time and contribution.

If you have any queries regarding this study do not hesitate to contact me. Thank you very much for your time and help with the survey.

Yours sincerely,

Orla Walsh
Researcher, Centre for Health Promotion Studies,
12, Distillery Road,
National University of Ireland, Galway
091 524411 ext 2858

APPENDIX C

Letter to Direct Provision Centres



North Western Health Board
Bórd Sláinte and Iar-Thuaiscirt
Public Health Department
3rd Floor, Bridgewater House, Rockwood Parade, Sligo.

Tel: 071 - 74750
Fax: 071 - 38335

June XXXX, 2003

Mr/Mrs XXX
Name and address of hostel

HEALTH BOARD LOOKING FOR HELP TO DEVELOP RESEARCH QUESTIONNAIRE

Dearand all the asylum seekers in Slievaneeran Hostel,

I am a researcher with the Health Board. I am writing to invite asylum seekers living in your hostel to help us research into nutrition and food for asylum seekers in the region. This research is funded by the Combat Poverty Agency, and also involves the National University of Ireland in Galway. Please see the background information attached.

As part of our research, we will be doing interviews over the summer with a sample of asylum seekers living in private rented accommodation and in direct provision hostels in Counties Donegal, Sligo and Leitrim. XXX Hostel has been randomly selected to participate in the research.

We are looking for a number of asylum seekers in your hostel who have a good command of English to answer the questions on a questionnaire with one of our researchers who will come to the hostel to interview these people. If at all possible, XXXX would be the best date. If this is not possible, then either XXXX or XXXX. Each interview will last approximately one hour.

Please could you telephone me on 071 74758 or 087 9050777 to confirm whether or not I will be able to visit

Thank you for your cooperation, and I hope that it will be possible to meet you soon.

Yours sincerely,

Dr. Mary Manandhar
Senior Research Officer
Public Health Department

cc: Dr. Fiona Hardy, Regional Coordinator for Services to Asylum Seekers

APPENDIX D

Qualitative research protocol



Study on food, nutritional status and poverty

Opening note for interviewer:

Introduce self, study and go through informed consent

“This study is about food and your nutrition. It will look at what you are eating, what you feel about what you are eating, and how food fits into your life. I will just be asking you some general things to introduce a subject and then I hope that you will just tell me, in your own words, about that subject. I hope you will be able to tell me what your worries are, and how you feel about things. This might take about an hour. You can stop at any time though if you don't want to continue. Do you feel comfortable? Can we start?”

TOPIC GUIDE and probes

Tell me what do you think about your diet now, the food you get now
What's good and what's not so good about it?

What are your main worries/concerns about your food and diet generally?

IF COMMUNITY-LIVING:

Tell me a little about how you get your food. What do you have to do, where do you go?

- How far away is your nearest shop that sells food? How do you get there/back?
- Can you easily and quickly get to shops selling foods that you most like to have?
- How do manage carrying food bags home?
- What about the children? Do you take them or leave them with someone? Who? Do you have to pay for that?
- Do you ever get food from outside the area? What? From where? What does that involve? (travel, extra expense, other people)
- Do you have any problems with language when shopping for food?

Access to food - community

IF IN DIRECT PROVISION:

I know that your meals are provided for you by the hostel and that is where you mainly eat. How do you feel about that? (explain that no details identifying them will be passed about what they have said to the hostel owner, chef)

I know that sometimes people living in the hostels will miss meals, buy food themselves, or eat outside. Can you tell me a bit about that?

When you do get food for yourself, what do you do, where do you go?

Probe:

- How far away is your nearest shop that sells food? How do you get there/back?
- Can you easily and quickly get to shops selling foods that you most like to have?
- How do manage carrying food bags home?
- What about the children? Do you take them or leave them with someone? Who? Do you have to pay for that?
- Do you ever get food from outside the area? What? From where? What does that involve? (travel, extra expense, other people)
- Do you have any problems with language when shopping for food?

Food, nutrition and poverty among asylum seekers in NW Ireland

Tell me a little about the foods you like and the foods you don't like and whether or not you can get enough of what you do like

Access to food – Direct Provision

Probe:

- What are your favourite foods here? Same as your favourite foods at home?
- How often can you eat what you really like?
- Is the food you are given appropriate for you? Is it what you prefer to eat?
- What about the taste?
- Do you feel in control of what you eat?
- Do you feel dependent on others for your food?
- Do you feel that the food you get now is adequate?
- What about the quality?
- Are there any other issues for you?

Food choice and preference

Do you think you can afford to eat properly, the way you would like?

Is the money you have sufficient for what you want for food?

Probe:

- Do you worry whether the food will run out before you have money to buy more?
- Have you ever run out of money to buy food, or to prepare a meal and not had the money to buy more to make the meal?
- Do you think you can afford to eat properly?
- (IF CHILDREN) Do you think you can afford to have your children fed properly?
- Do you ever skip meals or cut meal sizes to save money?
- Do you ever skip meals so that your children have more to eat?
- Do you find you are relying on limited number of foods because of lack of money?
- Do you receive gifts of food? (Clothing, Medicines, Transport, Other) (stress that this information will not be passed on about them to anyone else). From whom?
- What money do you have coming in? From where? (allowances, casual labour)
- Thinking about how you live, would you say you had enough money or other help for food (have enough/just/more than enough). If no, explore for more detail

Food, nutrition and poverty among asylum seekers in NW Ireland

Describe to me the place in which you can prepare and/or cook food? And tell me what sort of things do you do to prepare and cook your food?

Probe:

- What about equipment?
- What about storage facilities?
- What about cooking methods?

Physical context of food

Tell me about who you eat with and what your main meal times are like?

Probe:

- How often do you eat with others? (daily, in a normal week). If with others, do they join you or you join them?
- If eats alone, is this from choice or circumstance? For how long like this?
- When you eat with others, how many people are present? (adults, children)
- Do you go to other people's places to eat sometimes, rarely? Why?
- Do you eat in restaurants, cafes with others, or alone? How often? Why?
- What are your table practices now? Who serves food, is there any sharing?
- Is that how you would normally eat back home? What's different? Is this different to the past, or what you are used to?

Social context of food

Tell me about the main people who are involved in your life and who help you with things like food?

Probe:

- Is there anyone in particular to whom you confide or talk to about your problems?
- Do you have friends/neighbours that would help you if you were sick for a while?
- Do you plan or work out with others how, when and where to shop/buy/exchange food?

Tell me what you think about your food and diet now in comparison with before in your life?

Probe:

Social networks

Food, nutrition and poverty among asylum seekers in NW Ireland

- What do you think about your diet in general now?
- What do you think about your present diet compared to that in your home country?
- (IF COMMUNITY) What do you think about your present diet compared to in hostel?
- What do you think about any change to your children's diets (if any with you here)?
- What do you think could be done to make your food situation better?
- What do you think could be done to make your health better?

Coping with dietary change

Tell me a little about how you have been feeling lately

Probe:

- Recently how have you been feeling generally?
- Have you recently had problems sleeping?
- Have you recently lost weight or gained weight unintentionally?
- Do you enjoy your food as much as you always did, used to? If not, why?
- How would you describe your appetite? (Poor, fair, good, very good)
- Have you been having poor appetite, not feeling like eating? Or increased appetite?
- Been feeling increasingly unhappy? Lonely? Losing confidence in yourself?

Emotional well-being

CARD EXERCISE

The aim of this exercise is to ask participants to list in order of priority what their important needs are now. Where food and diet sits in their lives relative to their other priorities and needs.

"Now we have nearly finished. Just one more thing. We have talked a lot about food today. But I wonder what else is important in your life at the moment. I am going to give you some cards. On these cards, I would like you to write down on each card what is important in your life..... anything at all...you can write it in your own language and then we can talk about it together.

If food isn't there, then write a card for food or mealtimes or whatever and ask where it ranks with the others.

Food, nutrition and poverty among asylum seekers in NW Ireland

Is this one (food) more important to you than this... or this ... where does it belong in your list of important things? Why have you put it there?

If you think about what life was like just a few years ago, when you were in your home, where did it belong then? Is there a big change? How does that make you feel?

Relative rank of food in daily life

Ending note for interviewer:

“That’s all the questions I have for you today. Thank you very much for talking to me about these things. It is important that we know better how everyone is coping with their food and how that helps their health and their sense of well-being. Is there anything you would like to ask me about the study?”

- Give phone card
- Give fact sheet about NWHB services to asylum seekers, contacts and supports
- Ensure informed consent form is signed and that participant keeps a copy

APPENDIX E

Questions for Regional Coordinator and Community Health Adviser

SERVICE PROVIDER QUESTIONS

1. Generally over the period that you have been dealing with asylum seekers in your work what have been the main physical and mental health issues you have seen?
2. Generally what have you observed about the diets of adults/babies/children asylum seekers living in (a) Direct Provision and (b) living in the community?
3. What, if any, issues about food and nutrition have been raised by asylum seekers themselves? Or to you by other health professionals? Or to you by support groups?
4. Without going into any personal details, have you ever had any issues of concern about asylum seekers' dietary practices or their nutritional status? If so, please explain a little further and give any possible explanations. What sorts of responses have been required? Have any required specific interventions? (we are thinking of anaemia, rapid weight change, eating disorders, diarrhoea or constipation that might be dietary related, food-related allergies, breastfeeding and weaning difficulties, worms, wasting due to TB and HIV/AIDS, lactose intolerance etc)
5. What about mental health and depression? Have you noticed any situations where mental health impacts upon nutritional intake and nutritional status?
6. Asylum seekers living in Direct Provision have all their meals provided for them in the hostel and usually eat communally and at set times. They also receive €19 a week to spend as they choose. What are your thoughts on the impact of these living, eating and income arrangements on their health and well-being?
7. Asylum seekers living in the community handle their own food out of their social welfare benefits. What are your thoughts on how these asylum seekers generally cope in terms of the quality and quantity of their diet, including for their children and babies?
8. Lastly, is there anything else you think you would like to raise in terms of government policy and the income, diet and nutritional status of asylum seekers?

APPENDIX F

Questions for service providers and support group

SERVICE PROVIDER QUESTIONS

GPs

Introduction:

How long have you been seeing asylum seekers in your practice?

Are they mainly in Direct Provision or living in rented accommodation in the community?

1. Generally over this period, what have been the main physical and mental health issues for those you have seen?
2. What have you observed about the diets of adults/babies/children? Which, if any, have been raised by asylum seekers themselves?
3. Without going into any personal details, have you ever had any issues of concern about asylum seekers' dietary practices or their nutritional status? If so, please explain a little further and give any possible explanations. What sort of responses has been required? (Prompt for anaemia, rapid weight change, eating disorders, diarrhoea or constipation that might be dietary related, food-related allergies, breastfeeding and weaning difficulties, worms, TB and HIV/AIDS, lactose intolerance)
4. (If not already mentioned above): What about mental health and depression, for example? Have you noticed any situations where mental health impacts upon nutritional intake and nutritional status?
5. Asylum seekers living in Direct Provision have all their meals provided for them in the hostel and usually eat communally and at set times. They also receive €19 a week to spend as they choose. What are your thoughts on the impact of these living, eating and income arrangements on their health and well-being?
6. Asylum seekers living in the community handle their own food out of their social welfare benefits. What are your thoughts on how these asylum seekers generally cope in terms of the quality and quantity of their diet, including for their children and babies?
7. Lastly, is there anything else you think you would like to raise or you think we should know about the diet and nutrition of asylum seekers?

SERVICE PROVIDER QUESTIONS

Community Welfare Officers

Introduction:

How long have you been seeing asylum seekers in your area?

Are they mainly in Direct Provision or living in rented accommodation in the community?

Can you briefly outline your main responsibilities in relation to asylum seekers?

1. In your experience, what do you think are the main social well-being issues for asylum seekers in your area of responsibility?
2. What have you observed about the diets of adults/babies/children? Which, if any, have been mentioned to you by asylum seekers themselves? Or by other health professionals? Or by support groups?
3. What are your thoughts on Direct Provision living and income arrangements on the health and social well-being of asylum seekers?
4. What are your thoughts on how asylum seekers living in the community generally cope in terms of the quality and quantity of their diet, including for their children and babies?
5. In your opinion, how does this compare with the Direct Provision situation in terms of coping with their food needs and choices?
6. In your opinion, how do asylum seekers in receipt of social welfare benefits living in the community compare with Irish recipients in terms of coping with their food needs and choices?
7. Lastly, is there anything else you think you would like to raise or you think we should know about the diet and nutrition of asylum seekers?

SERVICE PROVIDER QUESTIONS

Public Health Nurses

Introduction:

How long have you been seeing asylum seekers in your area?

Are they mainly in Direct Provision or living in rented accommodation in the community?

1. Generally over this period, what have been the main physical and mental health issues for those you have seen?
2. What have you observed about the diets of adults/babies/children? Which, if any, have been raised by asylum seekers themselves? Or by other health professionals? Or by support groups?
3. Without going into any personal details, have you ever had any issues of concern about asylum seekers' dietary practices or their nutritional status? If so, please explain a little further and give any possible explanations. What sorts of responses have been required? (Prompt for anaemia, rapid weight change, eating disorders, diarrhoea or constipation that might be dietary related, food-related allergies, breastfeeding and weaning difficulties, worms, TB and HIV/AIDS, lactose intolerance)
4. (If not already mentioned above): What about mental health and depression, for example? Have you noticed any situations where mental health impacts upon nutritional intake and nutritional status?
5. Asylum seekers living in Direct Provision have all their meals provided for them in the hostel and usually eat communally and at set times. They also receive €19 a week to spend as they choose. What are your thoughts on the impact of these living, eating and income arrangements on their health and well-being?
6. Asylum seekers living in the community handle their own food out of their social welfare benefits. What are your thoughts on how these asylum seekers generally cope in terms of the quality and quantity of their diet, including for their children and babies?
7. Lastly, is there anything else you think you would like to raise or you think we should know about the diet and nutrition of asylum seekers?

APPENDIX G

Informed Consent Form



Voluntary Informed Consent Form

Study on food, nutritional status and poverty

I, _____, consent to being interviewed by (name of interviewer) for a study into food, nutritional status and poverty among asylum seekers in Counties Donegal, Sligo and Leitrim. The purpose of the study is to find out how asylum seekers are coping with their food and nutrition needs in Direct Provision and in the community.

I agree to answer questions about the foods that I buy, cook and eat, and what I feel about my own food and my health. This information will be used to get a general picture of the diets of asylum seekers and what is affecting their nutrition. I understand that this information will be used to show what is working well in delivering services related to food and nutrition for asylum seekers, and what needs to be improved. The results of the study will be used to influence national policy as well as Health Board practices to improve the general situation for asylum seekers. All this has been fully explained to me orally either English that I can understand or through language interpretation.

I fully understand what my involvement means and have had the opportunity to ask questions. I understand that I will not directly benefit from participating in this study except to receive a €10 telephone card as a token of appreciation for my time. I understand that taking part in this study is not related in any way to my application for asylum.

Appendix G continued

I understand that the information from my interview will be used anonymously for collation into general themes for a report. The answers I give will not be used for any other purpose, and will be kept strictly confidential at all times. I have been assured that my name will never be used and anything I say will not be traced back to me. I have been assured that no private or confidential information relating to me will be included in the report.

I have the right to withdraw my participation at any point and do not need to give any reasons for my withdrawal. Now by signing this form, I give my informed consent to the interviewer to proceed with the interview.

Signed: Witnessed:
.....

Date:

Glossary of Terms

Asylum seeker	A person who seeks to be recognised as a refugee in accordance with the terms of the 1951 Convention relating to the Status of Refugees.
Body Mass Index (BMI)	Weight in kilograms divided by height squared in metres. This is a method of measuring how well nourished a person is.
Dietary Recall	A method of dietary assessment in which subjects are asked to recall their food consumption over a specific period of time.
Direct Provision	A support system for asylum-seekers whereby all accommodation costs together with the cost of three main meals and snacks, heat, light, laundry, maintenance, etc are paid directly by the state. In addition, asylum seekers in receipt of direct provision are paid €19.10 per adult and €9.60 per child per week. See also: www.justice.ie
Food Frequency Questionnaire	A method of dietary assessment in which subjects are asked to recall how frequently certain foods were consumed during a specified period of time.
Food insecurity	A situation that exists when people lack secure access to sufficient amounts of safe and nutritious food for normal growth and development and an active and healthy life. It may be caused by the unavailability of food, insufficient purchasing power, inappropriate distribution, or inadequate use of food at the household level, which may be chronic, seasonal or transitory
Food poverty	The inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation. Food poverty refers to the inability to access a nutritionally adequate diet through compromised behaviours and the social and economic environment in which people live. In food-poor situations, food cannot be eaten, shopped for, bought, provided or exchanged in the manner that has become the acceptable norm in society.
Humanitarian Leave to remain	Permission granted to a person to remain in the State. This is granted at the discretion of the Minister for Justice, Equality and Law Reform and may be granted, for example, to a person who does not fully meet the requirements of the definition of a refugee under the 1951 Convention, but whom the Minister decides should be allowed to remain in the State for humanitarian reasons.
Informed consent	Agreement to an action/participation based on knowledge of what the action involves and its likely consequences.
Macronutrient	Nutrients that the body uses in relatively large amounts – proteins, carbohydrates, and fats.
Malnutrition	A nutritional disorder or condition resulting from faulty or inadequate nutrition.
Mean	A measure of central tendency appropriate for interval and ratio variables. It is the arithmetic average of the values of a distribution, and is denoted by (sample mean) or μ (population mean). It is required along with the standard deviation or variance to summarise the distribution of a variable.

Median	A measure of central tendency, most appropriate for ordinal variables. It is the category or value that occurs in the middle of a ranked distribution. Also known as the 50 th percentile.
Micronutrient	Nutrients which the body requires in small amounts, such as vitamins and minerals.
Nutrient	Nourishing substance contained in the food and drink we consume.
Nutritional status	The physiological state of an individual that results from the relationship between nutrient intake and requirements and from the body's ability to digest, absorb and use these nutrients.
Nutritional vulnerability	Exposure to one or more risk factors leading to an increased chance of having poor nutritional status.
Poverty	People are said to be living in poverty if their income and resources are so inadequate as to preclude them from having a standard of living considered acceptable in Irish society. Because of their poverty they may experience multiple disadvantage through unemployment, low income, poor housing, inadequate health care and barriers to education. They are often excluded and marginalised from participating in activities that are the norm for other people.
Refugee	A person who fulfils the requirements of the definition of a refugee under the 1951 Convention and is granted refugee status. A refugee is defined as someone who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail him/herself of the protection of that country: or who, not having nationality and being outside the country of his/her former habitual residence, is unable, or owing to such fear, is unwilling to return to it. (Article 1 of the Geneva Convention of 1951 relating to the Status of Refugees, cited in Schedule 3 Refugee Act 1996: 30).
Programme refugee	A person who has been invited to Ireland on foot of a government decision in response to humanitarian requests from bodies such as the United Nations High Commission for Refugees (UNHCR).
Social exclusion	The process whereby certain groups are pushed to the margins of society and prevented from participating fully by virtue of their poverty, low education or inadequate lifeskills. This distances them from job, income and education opportunities as well as social and community networks. They have little access to power and decision-making bodies, little chance of influencing decisions or policies that affect them, and little chance of bettering their standard of living. Social exclusion is what can happen when people, or areas, suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, crime, bad health, and family breakdown. Social exclusion is a broader concept than poverty, encompassing not only low material means but also the ability to participate effectively in economic, social, political and cultural life, and in some circumstances, alienation and distance from mainstream society.
Standard Deviation	The square root of the deviance (a measure of dispersion which is calculated from the average of the sum of the squared difference of each value from the mean value) in a quantitative data set.

Acronyms

BMI	Body Mass Index
CPA	Combat Poverty Agency
CWO	Community Welfare Office/r
DALY	Disability-Adjusted Life Years
FAO	Food and Agriculture Organisation of the United Nations
GP	General Practitioner, family doctor
HSE-NW	Health Services Executive – North Western Area (previously North Western Health Board, NWHB)
IRC	Irish Refugee Council
IUNS	International Union of Nutritional Sciences
Kcal	Kilocalorie (measure of dietary energy)
MJ	Megajoule (measure of dietary energy)
NAPS	National Anti-Poverty Strategy
NUI Galway	National University of Ireland, Galway
PHN	Public Health Nurse
RDA	Recommended Daily Allowance
RIA	Reception and Integration Agency, Department of Justice, Equality and Law Reform
SLAN	Survey of Lifestyle, Attitudes and Nutrition (national survey)
SPSS	Statistical Package for Social Sciences
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organisation

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