

Irish Prison Service, Irish Red
Cross & Education & Training
Boards Ireland in Association with

Western University Ontario
Schulich Interfaculty Program in
Public Health

An Evaluation of the
Process of the
Community Based
Health & First Aid in
Prisons Programme
(2009-2014)

A Collaborative Study Using a
'Realist Approach'

April 2016

Table of Contents

Preface	4
1.0 Introduction	5
2.0 Executive Summary	6
3.0 Main Findings	7
4.0 Recommendations	8
5.0 The Background to Identifying the Public Health Problem in an Irish Prison	9
5.1 Looking Outside the Silo – The Steps to CBHFA in Prisons through a complex systems journey	11
5.2 The Red Cross Movement as the Builder of Communities	12
5.2.1 The Red Cross Movement Seven Fundamental Principles underpinning change for a healthier and safer environment of living for the present and the future	13
6.0 CBHFA in Action Methodology as a Complex Systems Solution	14
7.0 The Aim of the CBHFA in Prisons Programme	15
8.0 The Aim of the Evaluation	15
9.0 The Research Methodology Used - A ‘Realist Approach’ to Evaluation	15
9.1. The Theories Underpinning the Proposed Solution and the Programme Theories	19
9.1.2. WHO (2007) Whole prison Approach to Health	19
9.1.3 Peer Education and Motivation	19
10.0 The Methods of Investigation	20
10.1 The Prisons in Ireland	20
10.2 Sampled Prisons	20
11.0 The research Tools and Information Sources	21
11.1 Semi Structured Interviews	21
11.2 Interview Process	23
12.0 Analysis of the Primary Data	23
12.1 The Stages of Data Analysis	24

12.2 The Listening Stage	24
12.3 The Transcribing Stage	24
12.4 Creating Data Bits.....	24
12.4.1 Creating Validity and reliability in Data Reduction and Categories	25
12.5 The Main Themes identified	26
13.0 Key Emergent Themes as Findings	26
13.1 Main Findings Explored.....	27
13.1.1 Powerful Programme Taking Health Education to the Community	27
13. 2 Communication Issues	40
13.2.1 Local Communication Between the Parts of the Programme	40
13.2.2 Improved Relationships between Prisoners and Staff.....	40
13.2.3 Communication about the Purpose and Mission of CBHFA in Prisons	41
13 2.4 Community Based Project Management.....	42
13.2.5 Barriers to the Programme	42
13.3 CBHFA Prison Programme Management Structure	43
13.3.1 CBHFA Community Health Action Committees (CHAC)	43
13.3.2 Motivation of Staff and Volunteers.....	44
13.4 The Operational Role of Volunteers	47
13.5 Consolidation and creativity of Action in the community	47
13.6 Preparing for re-entry into society	47
13.7 Community Development, Empowerment and personal development	48
13.8 Women prisoners are different to male prisoners in CBHFA	49
13.9 Measuring health outcomes of volunteer activity.....	49
14.0 How the findings Influence the programme Theory as the end point of the Realist Cycle	50
14.1 WHO (2007) Whole Prison Approach to Health.....	50
14.1.1 How does the Whole Prison Approach Contribute to CBHFA in Prisons?	51
14.2. Peer to Peer Education	52

14.3 Creating Change	53
14.4 Volunteer Motivation.....	54
15.0 Discussion of the Findings in Relation to programme Theory.....	54
15.1 Taking Health Awareness down to communities – Whole Prison + Peer Education + Motivation of all	55
15.2 Having the right motivated Structure in place	55
15.3 Transitioning for Society – a goal for 2015-2019	55
15.4 Personal Development and Building Communities	56
15.5 Measuring Impact	57
16.0 Programme Theories Revisited.....	57
17.00 Ethical Considerations.....	58
18.00 Limitations.....	59
19.00 Conclusions.....	59
20.0 References	60
Annexe 1.....	64
Irish Red Cross Survey Post Rapid Voluntary HIV Testing.....	64
Annexe 2.....	72
Examples of the Guided Reflective Exercise undertaken with IRC volunteer inmates.....	72
Annexe 3.....	76
Community Based Health & First Aid Programme	76
Summary of Modules & Topics.....	76
Annexe 4.....	77
Interview Questions/Focus Group Guideline Developed by the Western University MPH Student and Collaborative group of Critical friends.....	77
Annexe 5.....	80
Secondary Data showing the lists of Types of Projects Implemented by Volunteers within each prison from their year of commencement	80

Preface

In late 2014, the Community Based Health & First Aid Programme partnership of the Irish Red Cross, Irish Prison Service and Education and Training Boards became affiliated with the Schulich Interfaculty Program in Public Health at Western University, Ontario Canada.

This came about as the result of an International visit of the Irish Programme to the Canadian Red Cross and Canadian Corrections Authority at which time the programme presented a paper at the International Health Conference in Ottawa. As a result, a representative of Western University negotiated with us to provide Master of Public Health (MPH) students with real life learning experiences through a 12 week Practicum placement each year.

Case Based Learning is used by Western University's MPH program as a penultimate learning experience where students have the opportunity to apply public health theory to practical areas of work within public health. The diverse areas where students work through their local, national or international practicums provides a wide range of real life subject matter for the University's collection of new teaching cases for use with subsequent classes.

The learning for the organizations (IPS, IRC & ETB) gathered through the work of the 2015 student has highlighted another area that needs to be addressed in 2016. Therefore, it is hoped that the 2016 practicum student will pick up from important work undertaken by the first practicum student and develop a specific finding further. In this way, the CBHFA programme is able to be improved by using independent academic/practice resources and the student him or herself has unique opportunities for learning through real life public health problems.

Whilst Nikki Abiobun MPH practicum student was applying her knowledge and skills in the context of public health in an Irish Prison community, she was also encouraged to think about the transferability of the CBHFA methodology to specific contexts in Canada such as Aboriginal health. The Case Based Learning approach appears uniquely placed to be able to explore complexity where given processes working in one context can be shaped to work in another context.

Western's definition of a public health case, based on the realities of public health problems and decisions is:

"A real-world situation that promotes independent thinking as well as group discussion which ultimately allows the learner an opportunity to explore complex public health issues and apply theory to practice by analyzing, integrating and synthesizing knowledge" (1)

2015 was the first year for the Programme to host a student and this report serves both as an Evaluation of the CBHFA in Prisons programme and a report identifying the student's experience.

Graham Betts-Symonds, CBHFA Programme Director, Irish Prison Service/Irish Red Cross

Off-site Practicum Student Supervisor for Western University Ontario

Community Based Health and First Aid in Prisons in Ireland

A Realist Evaluation

1.0 Introduction

Community Based Health and First Aid in Prisons (CBHFA) was introduced into Wheatfield Prison Dublin Ireland in 2009 as an Action Research approach to solving a public health management problem identified by a newly appointed Health Care and Nursing Manager.

It was developed as a partnership between the Irish Prison Service (IPS), the Irish Red Cross (IRC) and the Educational Training Boards of Ireland (ETB). The programme approach of CBHFA in Action was implemented over a 12 month period and then internally evaluated in 2010.

The successful outcomes lead the IPS Health Care Directorate to seek the expansion of the programme to other prisons in Ireland which occurred and by the end of 2014 the programme was introduced in all 14 prisons in Ireland.

Whilst internal evaluations were used in 2010, 2011 and 2013 to steer the progress of the model throughout the Prisons estate, it was thought to be advisable to include an external element to a review of the programme over the period 2009-2014 with particular reference to the *process* of how CBHFA in Prisons was implemented and perceived by stakeholders.

Nikki Abiodun was a Master of Public Health student from Western University's MPH Class of 2015 and is by profession a pharmacist holding a doctorate in that discipline. Her role was to be an independent evaluator with a brief to undertake interviews with key stakeholders about the CBHFA in Prisons Programme. The rationale behind this was that interviewees and prisoner focus groups would be more likely to give their real opinions to someone they perceived not to be directly involved either in the Programme or as part of IPS/IRC/ETB organizations.

Nikki's brief was to gather information about the inception of the programme and demonstrate how the approach was used based upon the theory conceived of behind the programme. She was also to convene a group of 'critical friends' in the planning period of her work in order to understand the realist approach and plan the questions to be used in the interviews.

2.0 Executive Summary

2.1 Community Based Health and First Aid in Prisons has delivered community based health awareness in all prisons in Ireland between 2009 and 2014.

2.2 The level of productivity in each prison has been relative to the existence of an effective well-motivated CBHFA management structure.

2.3 Peer to peer education as one on the bases of this programme has shown to be effective in promoting successful community based health awareness in Irish Prisons.

2.4 As a programme theory, the 'whole prison approach' to prison health has proven an effective approach but needs to be more widely expanded to be truly 'whole prison'.

2.5 Prison Community Based Health is a complex system which requires the flexibility shown in the CBHFA approach to provide ever changing needs in different prisons and circumstances of programme management.

2.6 Experiences in the Dochas Women's Prison have shown that the approach used in the male prisons is not suitable in the women's prison due to the differences between men and women prisoners.

2.7 CBHFA in prisons has had a significant contribution to the personal development of prisoners as well as in empowering them to be an active part of the local community.

2.8 Communication issues are the most important findings of this evaluation affecting both the management and development of the programme in all prisons.

2.9 The key to successful high output CBHFA in Prisons volunteering is a highly motivated and committed programme Governor.

3.0 Trained volunteers need to be given a clear direction by becoming attached to the Chief Nurse Officer in each prison to link them to operational health awareness needs.

3.1 The programme needs to develop effective systems and tools for the measurement of public health outcomes linked to the various CBHFA projects.

3.2 Every prison needs to have a CBHFA management structure in place with well-motivated staff to be effective in delivering community based project outputs.

3.3 Volunteer motivation is very much affected by the degree of engagement of CBHFA management structure staff in facilitating access for landing based projects.

3.4 Evidence from the data collected indicates that volunteers go through a change process in which they are personally developed, gain confidence and become empowered.

3.5 Consideration needs to be given to the future of volunteers after prison to utilize their skills and knowledge in the wider community.

3.6 There is a need to increase the level of understanding amongst staff about the role and function of CBHFA volunteers in the prison community.

3.7 The CBHFA in Prisons Programme needs to be more connected with the IRC at both headquarters and local branches to connect with the IRC nationwide CBHFA development initiative being developed in 2016.

3.0 Main Findings

The main findings from the emergent themes in this evaluation are described in some detail in the text.

1. Powerful programme in taking health awareness to the community level

There is overwhelming evidence from both primary and secondary data that in the period from 2009 to 2014, the CBHFA in prisons programme was implemented in all prisons and carried out a wide variety of landing based health and well-being awareness projects and there are ample examples shown.

2. Communication issues

In the primary data there was a clear and strong concentration on issues relating to the need for improved communication both between local partners and in terms of programme dissemination, improved relationships between staff and prisoners was also a significant finding.

3. Management structure and motivation

Data showed the importance of the programme management structure in each prison and that high output volunteering project work reflected good CBHFA management structures. A key finding linked motivation of volunteers with self worth and giving back to society. It also showed that staff motivation was an important factor and placed motivation theory as a programme theory central to both rather than just volunteers.

4. Operational role for volunteers

Volunteers, once their training has finished, need to continue to 'belong' or they are likely to become demotivated. A suggestion has been made to link them to operational health.

5. Consolidation and creativity of action in the community

Data from key informants suggest that there should be a greater profile for IRC inmate volunteers and their work. This is linked to access and is discussed in the findings.

6. Preparing for re-entry into society

Information gathered from both volunteers and key informants from all three programme partners suggested the need to prepare volunteers for a role beyond prison rather than just improving prison health. Moves have been made to address this and are discussed in the text.

7. Community development, empowerment and personal development

This was one of the most noticeable findings in the data from all sources. Personal development and empowerment appears to have occurred with most volunteers through their participation in the programme. In all prisons, volunteers talk of their community rather than prison.

8. Women prisoners are different to male prisoners in CBHFA

One of the 5 sample prisons was chosen to be the women's prison because it is the only prison that did not progress beyond the first cycle. This was ideal for a realist approach to looking at the unique context.

9. Measuring health outcomes of volunteer activity

Data from senior management indicated that they were convinced of the value for money and money saving achieved by the programme, but none were able to quantify it. Whilst there are a number of examples of project monitoring and evaluation, a system would be useful to be able to quantify public health outcomes.

4.0 Recommendations

- The considerable impact made by the programme in all prisons between 2009 and 2014 needs to be redeveloped in all prisons affected by the Industrial relations issues of 2015.
- In order to properly utilize volunteers who have completed training, they should become attached to the Chief Nursing Officer (CNO) in each prison who can organize relevant health awareness projects.
- Elderly care seems to be an important potential for volunteers in a number of prisons and a module of home care would be useful for Irish Prisons.
- Improve communication at the local level between the IRC, IPS (Healthcare and Discipline) and ETB
- Ensure that monthly Community Health Action Committee (CHAC) meetings occur on a regular basis with the Governor present.
- Healthcare needs to nominate one nurse from each side of the roster to link with the CBHFA programme.
 - Where staffing problems exist, CNOs need to find a creative answer to providing the input needed from healthcare which in the classroom only requires an hour a week.
 - It might be considered to engage an agency nurse to undertake the health subject classroom learning in a number of prisons where there are temporary staffing difficulties.
 - The further training of life sentence (long term) CBHFA facilitators to be able to fill this gap. However, the importance of having the direct links with healthcare must not be compromised.
- Sensitization workshops need to be conducted with all prison staff on a more regular basis and include a day for the training of all new staff (prisoner officers and nurses)
- Activities/strategies need to be organized that increase staff awareness about the role and function of inmate IRC volunteers within the prison community.
- In order to gain the buy-in and support of prisoners when introducing CBHFA to a prison, programme management need to encourage volunteers to undertake a quick 'win-win' project that shows action in the community.
- There needs to be special sensitization efforts to clarify the role of volunteers with nurses in all prisons.
- Greater visibility of the Red Cross project is needed in all prison communities with posters and the highlighting of action.
- Female prisoners are very different to male prisoners as noted in the data from all staff and volunteers of the Dochas Centre, requiring a very different design of the course. This should be a

shorter version that begins with community assessment to highlight areas of interest and need for female prisoners.

- Ensure that strong personalities in potential volunteers do not get in a position of dominance with other volunteers.
- In order to accommodate Phase II Prison to Community of the CBHFA Programme, all suitable volunteers should be prepared as facilitators of Overdose Prevention and Violence Prevention in close cooperation with Probation Services.
- In order to provide ex-prisoner IRC CBHFA volunteer facilitators for phase II in the community Probation projects, the CBHFA in prisons programme must be institutionalized and strengthened.
- The programme needs to be aware of other programmes and content to ensure there is no duplication. In line with Geneva thinking about CBHFA+ revision in 2016, opportunities to partner with other programmes that provide the gaps should be encouraged.
- Ensure that the health components of the course in all prisons can be facilitated either by health department staff or a dedicated agency nurse for this purpose.
- The prison authorities should ensure that the Governor for CBHFA in each prison is totally committed to supporting the project.
- An ACO on each side of the roster is imperative to the success of the programme in each prison.
- The 'Whole Prison approach' should be further consolidated by improved communication with all staff and the inclusion of other relevant disciplines such as probation and psychology.
- Volunteer recruitment and ongoing management needs to be monitored with prison intelligence contributing to the process to ensure that there is swift action where the Emblem may be compromised.
- The CBHFA in prisons Programme should be better linked with the IRC Headquarters and the Branch level so that phase II (Prison to Community) connects up with the national IRC CBHFA initiative being developed in 2016.

5.0 The Background to Identifying the Public Health Problem in an Irish Prison

Before going into the evaluation specifically, it is important for the reader to understand the background and history of why the programme was devised and where the thinking behind the programme evolved. This will provide the reader with an important message about recognising the value of transferring processes from one public health context to another and that in complex systems, everything is connected (Bateson 1986) and that changes in one part of a system can lead to changes in other parts of the system (Dilts 1991).

For a health care manager, it was important to assess the extent to which the current activities at the time were addressing given standards identified in the prison being managed. The Irish Prison Service Health

Directorate produced the IPS Health Care Standards in 2004 and updated them in 2007. These standards were used by the health care manager in 2008.

There are nine standards defined of which standard 5 deals with all elements of prisoner/patient health awareness and education relating to disease prevention and the maintenance of healthy lifestyles and well-being.

Audit of this standard, from a prison *community based* perspective, scored poorly because the dissemination of specific health issues was not undertaken *within the community* setting. Nurses would provide advice/information about a specific health issue on a one to one basis but usually when and if the prisoner interfaced with nursing staff in the health centre.

Whilst one solution would be to begin doing awareness-raising campaigns and education sessions within the prison landings, nursing resources were not available to undertake this work. Experience has also shown that prisoners often relate nurses (as nurse-officers) as part of the prison management structure rather than independent practitioners outside of the prison discipline. As such, interviews with prisoners have shown that inmates may have less regard for the advice of health care professionals than might be expected.

Therefore, it was apparent that even if the gap between the health centre and the prison landings could be bridged by nurses working at that level, the value of the awareness in terms of its uptake might be limited.

The manager used Evans *et al* (1986) quality assurance process in relation to standard 5 relating to health awareness and education.

- Identifying and reviewing key areas
- Setting standards
- Selecting measurement criteria
- Constructing an audit tool
- Comparing practice with standards
- Identifying reasons for failing to meet standards
- Making an action plan
- Reviewing progress

Audit identified that standard 5 was not being met in terms of community based public health education and awareness.

The standard set was the implementation of a peer-led community public health awareness function within the prison through the CBHFA in Prisons programme in 2009.

In terms of selecting measurement criteria, it was understood that if a system was put in place that would ensure community based health awareness was being carried out, the standard would be met. However,

information gathered in the interviews from key informants and the Programme Director indicated that not enough specific measurable criteria were set. Recommendations for future practice will include this.

1. The audit tool was the internal evaluations of 2010, 2012, 2013 and this evaluation covering the period from 2009-2014 (see Irish Red Cross website for reports www.redcross.ie/cbhfa).
2. Comparing practice with standards can be measured at the basic level in terms of whether or not community based education is being carried out in prisons. However, there needed to be more specific measurements of how each subject/project within the programme was impacting prison health.

The last three stages, 6, 7 & 8 of this quality assurance process includes identifying reasons for failure to meet the standards, making an action plan and reviewing progress, which will be examined through this process evaluation study.

Four key issues were identified as strategically important factors impeding more effective primary health care in the prison.

1. Whilst well qualified/experienced nursing and medical staff were available within the prison health centre, there was no direct health education and awareness within the prison community between the surgery and the prison landings and households (cells).
2. The prison health culture was reactive rather than preventive/proactive in terms of disease prevention and health promotion. In other words, healthcare staff remained at the health centre level and prisoners visited the centre when they were sick. Nurses had a central role in responding to emergencies at the prison community level and encouraging proactive preventive health centrally.
3. Health was perceived by prison staff and inmates as the sole responsibility of the doctor and the nurse operating within the health centre 'space'.
4. There was a sense of prisoners being at 'effect' rather than at 'cause' in taking responsibility for their personal development and health

5.1 Looking Outside the Silo – The Steps to CBHFA in Prisons through a complex systems journey.

Exploration of the role of other departments relating to health education was an important part of finding a solution to the healthcare management problem. Every prison in Ireland has, in addition to a dedicated health centre, a dedicated prison school whose role it is to provide education to prisoners.

The prison schools run by the ETB offer a wide range of subjects. Areas of education provided by the school teachers relating to health are fitness education, healthy lifestyles and First Aid training. Until it was discovered by the healthcare manager researching this problem, no one in healthcare was aware that prisoners were being given accredited FETAC level 5 First Aid courses as well as health and fitness education. At the same time, the education department in the same prison had no idea of the shortcomings of operational health awareness at the community (landing) level.

From an educational perspective, both students and teaching staff were frustrated by the fact that they could teach prisoners first aid in the school but they couldn't practice it in their community because of the

taboo on prisoners holding first aid equipment that could be used as weapons or for self-harm purposes. The health awareness they received in class was perceived as being for themselves rather than for their community.

The First Aid Teacher and the Health Care Manager each had something that could contribute to better community health if they integrated their work. The teacher had the educational resources and the Health Care Manager controlled the operational health within the community.

5.2 The Red Cross Movement as the Builder of Communities

At this stage there was a need to create the ‘community’ sense rather than the ‘self’ sense relating to ‘community health’. The Health Care Manager had worked with the International Red Cross in different rural and urban communities around the world. He had recently, as a consultant to the International Federation of the Red Cross and Red Crescent Societies Health Department in Geneva, redesigned Community Based Health and First Aid content and methodology (Action Learning) for global use. The purpose of the CBHFA approach was to build community capacities in self help relating to public health and emergencies, including First Aid.

The thinking behind the new CBHFA methodology of ‘learning and doing’ had emerged from ‘learning by doing’ methodologies in Vulnerability and Capacity Assessment for Community Disaster Preparedness and Risk Reduction (IFRC 2006: 2008). That approach, in turn, had been developed from a ‘learning and doing’ approach to combat medical services in the Middle East.

In each of these contexts, a systems model was used – a *process* model (Figure 1). This is because all three contexts were complex systems and some would suggest complex systems problems need complex systems solutions (Checkland 1986). Public health is complex as are all individuals within a community and the world itself is chaotic. Bolstad and Hamblett (1999) maintain that in chaotic systems, the only predictable outcome is that there is unpredictability.

Related to this, Davis & Sumara (2006) suggest that educators need to apply complexity theory; chaos and fractals in their design of learning and these were the premises on which the CBHFA in Prisons Programme developed.

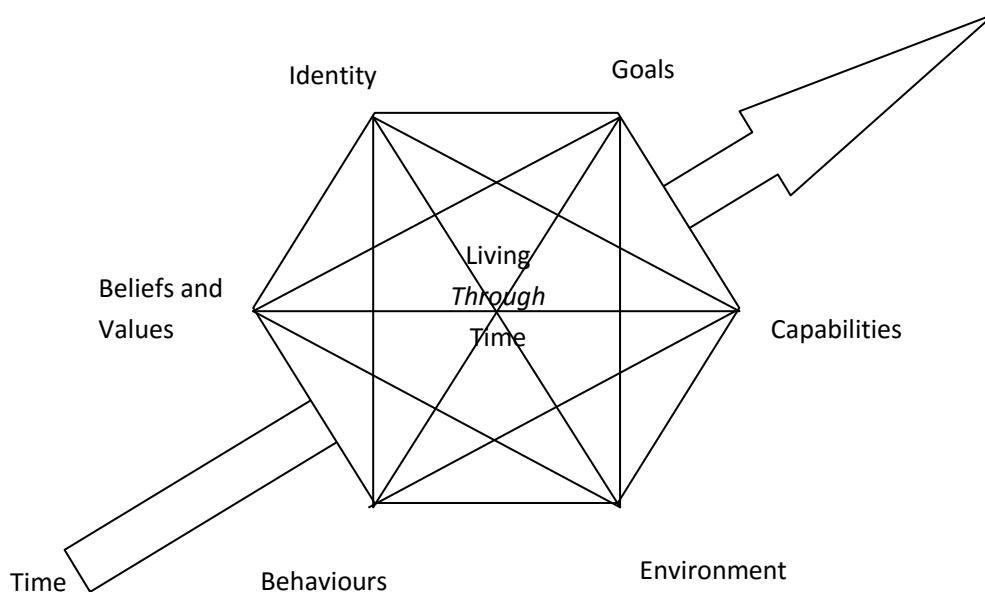


Figure 1

Living *Through* Time (IFRC 2006; IFRC 2008, IFRC 2009)

The essence of this change model according to the CBHFA in Prisons designer, (derived from a linear model by Robert Dilts (1991)) is that changes in one part of the system may lead to changes in the others. Changes in thinking about prison health and hygiene may lead to changed behaviours and a changed environment. Equally, changes in behaviour through volunteer advocacy may provide an experience of cleaner and safer environments leading to changes in beliefs about 'community' rather than 'prison'. This was the model for local change used in this programme. Evidence of such changes in thinking have been seen through primary prisoner volunteer interview data collected in this study as well as data collected in previous evaluations (see annexe 2)

5.2.1 The Red Cross Movement Seven Fundamental Principles underpinning change for a healthier and safer environment of living for the present and the future

The Heads of the three partners involved in the development and maintenance of the CBHFA in Prisons programme recognized that the Fundamental Principles were ideal tenets on which to base both prison life and the rehabilitation needed to reduce recidivism.

Data from prisoners identified that these Principles were important to them in terms of changing their thinking about themselves and how they aspired to be. This is important because giving prisoners the opportunity to enter into a period of renewal - irrespective of their past wrong doings, allows them to recognize that they can still do good and 'give back' to society through *living* the Red Cross Principles within their 'community' (prison) and in the wider community to which they will return to with their families.

An important step forward with this programme in prisons, is to ask volunteers to interpret the 'official' global definitions of each Fundamental Principle into language and content that will be easily recognized by the local prisoner population in each prison. Thus, the Principle of Impartiality includes the fact that impartiality means not only religion, culture and colour. It also includes the type of crime committed by individual prisoners.

This is a huge shift in thinking as there is always a potential for conflict between what is thought of as 'ordinary prisoners' and 'sex offenders'. This is almost a code of *honour amongst thieves* which differentiates between what is recognized amongst prisoners as acceptable and non-acceptable crimes.

An inmate volunteer joining the local prison Red Cross community means that they have to be prepared to undertake their work as advocates for safer and healthier living even with communities of prisoners that are thought of as unacceptable within criminal circles.

In order to promote knowledge and understanding of the Fundamental Principles, volunteers put up posters showing the Principles around the landings. This provoked interest such that volunteers were asked to clarify what each of them meant and to demonstrate how following them would lead to a safer environment and better understanding between each other and prison staff.

The most successful dissemination of the Fundamental Principles was when they were linked to projects in the landings which had a practical application of theory to practice. For example, in the weapons amnesty the volunteers used the strategy of 'intrigue'. In this there was a seven day countdown to the giving up of cutting weapons in the prison. Each of the seven days was noted on all landings by a new poster each day that would highlight one of the principles and being one day closer to the end of the amnesty period:

Day 7

Seven Days to Give up your Weapons

HUMANITY

It was reported by volunteers that the poster placed in a visible area of the landing (Street) invoked prisoners talking to each other and the volunteers about "*what does humanity mean?*" Volunteers then took the opportunity not only to encourage prisoners to give up their weapons but to help them understand what Humanity might mean to them within the prison community and how it was related to reducing violence in their community. This strategy was used for the remaining 6 days prior to the ending of the amnesty period, using a different Humanitarian Principle each day.

5.2.1.1 Re-Thinking a Community

Communities are built up of individuals, within households, within streets, within neighbourhoods. Only a little imagination is needed to think about prisoners as individuals or community members, prison cells as households, landings as streets and Prison Blocks or divisions as neighbourhoods.

The missing partner was the Red Cross Red Crescent Movement. With the Irish Red Cross being involved, the three representatives of the partnership were the Irish Red Cross, Irish Prison Service and the Education and Training Board (formerly VEC).

6.0 CBHFA in Action Methodology as a Complex Systems Solution

The CBHFA in Action approach was designed as a complex systems approach to improving public health in the real and complex world. It was a break away from the historical 'content' linear approaches to Red Cross programming where you begin at the beginning of the manual and end at the last page. Traditional course learning required the volunteer to complete the course first and then take some action.

In CBHFA in Action, the course starts where the current problem is – which might be half way through the course, according to the manual. Then, after the lesson on the current emergency (i.e. TB outbreak), volunteers are encouraged to go out into their community and disseminate simple prevention messages on that subject.

Within the CBHFA methodology, volunteers and their facilitators decide what topics are to be learned about and take action on, based on their understanding of their community. This is done through carrying out a community assessment (module 3 of CBHFA) that uses various investigatory tools. These include mapping the community to identify hazards, risks and resources.

It includes undertaking interviews with prisoners, prison staff and key informants such as doctors and nurses, to find out what the professionals say the health problems are. Volunteers create a seasonal calendar that identifies specific health risks at different times of the year. They can also identify specific

national and international promotion days such as World AIDS Day, Cancer days and other events. These are then used by community volunteers to promote specific awareness of issues linked in with external campaigns and other agencies.

Once the community assessment has been undertaken, the volunteers and their facilitators carry out a simple analysis of the information called 'funnelling'.

Two key issues can then be addressed:

1. Selecting the topics to be learned about during the course and their priority.
2. Identify at least ONE public health project to start immediately.

In CBHFA in Action, working on a community health project happens concurrently with classroom learning thus creating immediate change within the community.

7.0 The Aim of the CBHFA in Prisons Programme

The original aim of the programme was to find a way of bringing community based proactive/preventive health awareness within the prison community in Wheatfield prison. Following the success of this pilot project, the aim was to implement the same programme in all prisons in Ireland over the period from 2009 to 2014.

8.0 The Aim of the Evaluation

During the process of the country-wide implementation of CBHFA in Prisons there had been a number of internal evaluations which were used as a means of directing the continued programme development in other prisons.

Following the implementation of the programme in all prisons by 2014, it was decided to have an evaluation that included an independent component. This was provided by an MPH student on Practicum for 10 weeks from Western University, Ontario.

Due to the short duration of her placement, it was decided to use a collaborative inquiry approach in which the student from Western University would act as an independent team member and conduct all interviews to ensure honest responses to the questions posed.

The purpose of the evaluation was to identify the extent to which the original aim was achieved and to use a 'realist approach' to identify within the process of the programme, how and why certain approaches based on programme theories were more or less effective and how they might be adjusted to improve the programme.

9.0 The Research Methodology Used - A 'Realist Approach' to Evaluation

The goal of the study was to identify how and why certain effects occurred in the prison programme, the understanding of which might lead to an improved programme in the future. It may also identify a set of *Characteristics of a Well-Functioning CBHFA in prisons Programme* that can be used to assist other jurisdictions to introduce similar programmes.

The Realist Approach is a theory driven methodology where theory is the starting point and the end point of the investigation (see figure 2). The programme development was based on a set of assumptions that supported the theories underpinning the CBHFA in Prisons programme. Then through a series of interventions, theory is able to be tested and then refined based upon the findings of the study. The process of the approach is shown in Table 1.

The realist approach assumes that nothing works everywhere or for everyone, and that context really does make a difference to programme outcomes. Consequently, it argues that in order to be useful for decision makers, evaluations need to identify *'what works in which circumstances and for whom?'*, rather than merely *'does it work?'* (IFRC 2015).

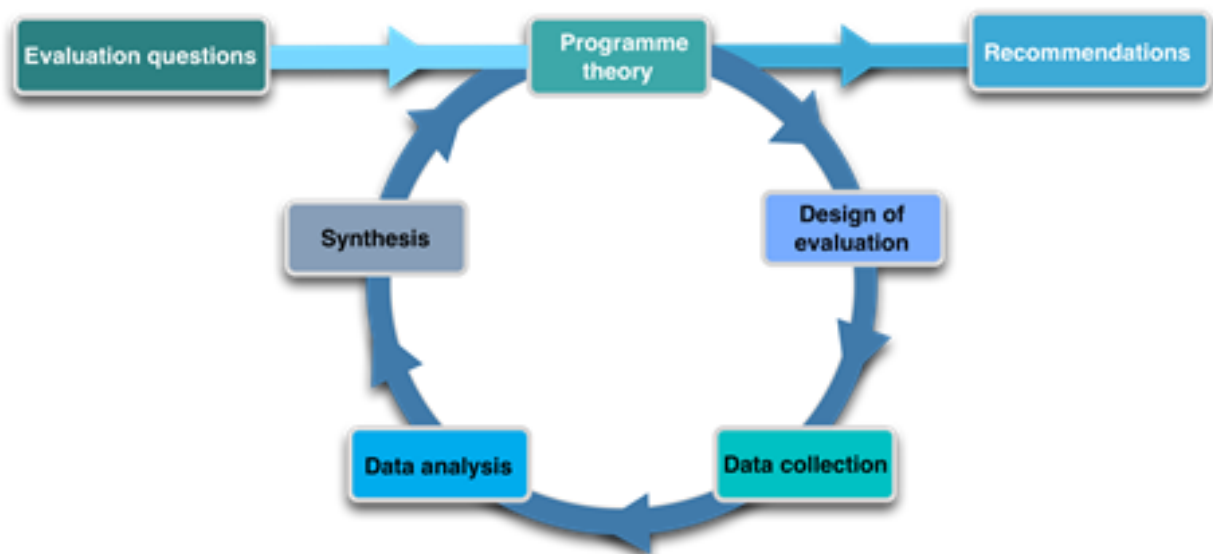


Figure 2

The Realist Approach Cycle

The following checklist summarizes steps for setting up and implementing a realist evaluation (Taken from the IFRC Guide to Realist Evaluations 2015). This process was broadly followed by the Evaluation Team.

Checklist for setting up and doing a realist evaluation

1. Identify the purpose of the evaluation and the evaluation questions

- Clarify the purpose for which the evaluation will be used.

Understanding the purposes will help to refine and prioritise the evaluation questions.

For what will the answer be used? Understand the policy or practices issues that commissioners need to address. Is the aim to refine this programme in this setting - to increase its effectiveness, expand the range of target groups for which it is effective - or inform the choice of the range of programmes required in a policy

domain? Is it to enable the programme to be adapted for scaling out to other settings?

Develop and prioritize the evaluation questions according to the purpose for the evaluation and in order to reflect the principles of realist evaluation.

For whom does the intervention work and not work and why (for which sub-groups is it more effective?) To what extent does it work for different groups (or not)? How and why? What matters in order for it to work?

2. Develop the initial programme theory: 'make your assumption explicit'

Collect information through the programme documents, plans and logical framework.

What are the interventions and their objectives? What is the explanation underlying the logical framework? What are the assumptions related to the influence of context, the underlying mechanisms of change, the motivation of the key actors and the role of other programmes?

Consult and conduct interviews with the key stakeholders (designers, funders and/or implementers of the programme).

Who designed this programme? Who funds it? Who is implementing the programme? What is their analysis of the problem? How did/do they think the programme will contribute to solving the problem? What are the conditions of success they identified?

Review past experience, findings of previous evaluations or research studies. Assess the evidences, including grey publications of previous evaluations and implementation studies.

Draft the initial programme theory based on this three source of information (programme documents, past experience or/and previous evaluation, interviews with key stakeholders).

Ideally it explains how the programme will generate the outcomes by showing which mechanisms will be triggered among different groups of actors, as well as the necessary conditions needed for the programme to work.

3. Choose the method of the evaluation

Design the evaluation in order to assess the results, explore the programme implementation, the processes of change and context.

Often, the case study design is used, in which the case selection is purposive: the cases should enable 'testing' of the initial programme theory in all its dimensions. It is often interesting to choose contrastive cases that present differences in contexts, intervention modalities or outcomes.

Include a broad range of respondents.

This will allow to obtain the optimal range of perspectives on the programme.

Choose your data collection methods according to the types of data that are needed to answer the evaluation questions, or more specifically, to test the initial programme theory in all its dimension.

Realist evaluation is method-neutral: both quantitative and qualitative data collection methods can be used. Assessing outcomes usually requires quantitative methods, assessing the causal process of change needs qualitative methods.

Develop and test the data collection tools.

Evaluation staff may be trained on their use.

<p><input type="checkbox"/> Adhere to the relevant ethical guidelines</p>
<p>4. Collect the data</p> <p><input type="checkbox"/> Identify and adhere to the usual quality standards of qualitative data and quantitative research.</p> <p><input type="checkbox"/> Record the interviews (if the respondent agrees) and make sure the interviews are verbatim transcribed.</p> <p><input type="checkbox"/> Keep contact and field notes, a research journal and maintain all data in a safe place.</p> <p><input type="checkbox"/> Adhere to the relevant ethical guidelines and ensure the anonymity of respondents.</p>
<p>5. Use a realist data analysis approach</p> <p><input type="checkbox"/> Organise data in relation to the initial programme theory.</p> <p>See whether the data relates to what was done (the intervention activities) or to context, mechanisms, outcome and (groups of) actors. What are the observed results or outcomes? What is the actually implemented programme? How was it carried out (duration, intensity)? Who are the actors involved in this programme? How did the intervention reach them and to which degree (coverage)?</p> <p><i>The analysis of qualitative data from interview transcripts and documents is based on coding in terms of 'description of the actual intervention', 'observed outcomes', 'context conditions' and 'underlying mechanisms'.</i></p> <p><input type="checkbox"/> Refine the analysis by assessing the contribution of the actual intervention to the observed outcomes.</p> <p>Can the results be linked to the actual programme? How can the link between the actual programme and the actual outcomes be explained? Which context conditions facilitated the uptake of the programme by the actors? Which conditions constrained the actors in taking up the programme? Are there alternative explanations (i.e. other interventions that took place and which may have contributed to the observed outcomes)?</p> <p><i>Quantitative data are analysed with the aim of assessing the effectiveness of the intervention and to substantiate or de-validate the explanation that emerge</i></p> <p><input type="checkbox"/> Identify the most robust and plausible explanation of the observed outcomes.</p> <p><input type="checkbox"/> Compare the findings of the analysis with the initial programme theory.</p>
<p>6. Use the findings from realist evaluation</p> <p><input type="checkbox"/> Adapt and refine the initial programme theory to reflect the results of the evaluation.</p> <p>Refinement ideally includes better understanding of what mechanisms are or how they actually work, and the identification of new mechanisms; better understanding of how factors in the context affect whether and which mechanisms operate; or a more refined understanding of the patterns of outcomes resulting from the interaction of contexts and mechanism.</p> <p><input type="checkbox"/> Communicate the findings and its implications for policy and programme.</p> <p>This should link directly to the purposes for which the evaluation was commissioned.</p>

Table 1

Taken from: Guide to 'Realist Approach' Evaluation (IFRC 2015)

9.1. The Theories Underpinning the Proposed Solution and the Programme Theories

- WHO (2007) Whole Prison Approach to Health
- Peer to Peer Education and Motivation

9.1.2. WHO (2007) Whole prison Approach to Health

This assumption is a central tenet of the Programme Theory for the CBHFA in Prisons programme. WHO recognizes that effective health in prisons must involve different disciplines rather than simply doctors and nurses. It recognizes the important contribution of paramedical professions as well as the role of prison management and prison officers in helping to accommodate access and coordination so that prisoners can access the care they need. In Irish Prisons with the CBHFA programme, this also includes the role of prison staff in facilitating the change to proactive thinking about health and well-being.

In CBHFA in prisons, experience has shown that the most important role is played by prison management and staff as well as health disciplines. The programme in Ireland is very action-orientated, with volunteers learning in the classroom and then doing in the prison. Only prison management and staff can make this happen – which is the most important part of the CBHFA in Action methodology.

In this study, data collected supports this with problems encountered mostly relating to problems in this area. Closely connected to the ‘whole prison approach’ is the need for ‘whole prison’ communication and sensitization and data shows that this has been a shortcoming.

9.1.3 Peer Education and Motivation

The central element of the programme that seems to be important is that it is based upon a model of peer to peer learning. This is supported by the literature on adult learning and will be explored in the findings.

Secondary data collected through interviews during an HIV campaign promoting rapid voluntary HIV testing indicated that prisoners listened and complied because it was presented and supported by their own peers who have undergone health awareness training (annexe 1). They also stated that they would not have presented themselves for voluntary HIV testing if it had been promoted by doctors and nurses.

In addition to advocating for ‘knowing your HIV status’, the campaign was accompanied by anti-stigma messages from inmate IRC volunteers. These encouraged prisoners to talk about HIV and the stigma attached to it in prisons. The opportunity was taken to dispel myths and incorrect information about how the disease is spread. Secondary Data from the post-testing interviews with prisoners showed that prisoners had changed the way that they thought about HIV and people with HIV (Annexe 1).

Healthcare management and prison management realised that the volunteers were an important asset for getting relevant messages to prisoners. An example of this was the role that volunteers played in preparing prisoners to manage their own medications with ‘in-possession’ packs of certain medications. As a result, key messages about the rules of in-possession medicines were successfully accepted by prisoners.

A further example of the power of peer education in this programme was shown in a project undertaken in the remand prison known as the ‘Benzo Project’. This was an example of a prison doctor and health care staff noticing that prescriptions of Epilim to prevent seizures in Benzodiazepine users were not being taken by prisoners.

The doctor and nurses provided the classroom learning about the risks of 'Benzo fits' to the volunteers and the volunteers designed the campaign material and delivered landing based awareness. This included demonstrating how to position someone in the recovery position should they come across a friend or inmate unconscious following a fit.

Prior to undertaking the campaign, the volunteers designed and then undertook a survey amongst prisoners to assess their pre-campaign knowledge. Following the campaign, the survey was given again. The data collected in this project showed that there originally was poor understanding of the rationale behind Epilim therapy and an increased understanding afterwards. In addition, it was striking that so many prisoners changed their view about completing Epilim treatment in the future. This change in behaviour arose from the power of peer to peer learning affecting what prisoners chose to believe and value (see figure 1).

10.0 The Methods of Investigation

- Semi-structured Interviews
- Data analysis – following Patton's (2002) Comparative Pattern Analysis method
- Review of Secondary Data including internal evaluations
- Case Study Development in order to understand findings with collaborative group analysis process
- Discussions with programme designers and staff

10.1 The Prisons in Ireland

Ireland has fourteen prisons in which there is:

- 1 women's prison in Dublin and in one section of a male Prison
- 2 open male prisons
- 1 dedicated remand prison
- 10 male sentenced prisons some with remand components of their work (medium-high security).

10.2 Sampled Prisons

1. Women's Prison in Dublin
2. 1 Open Prison
3. 3 Male Closed Prisons

The national prison population was approximately 3500 in 2014 which was lowered from 4,500 in 2009. The reduction in population was due, according to the prison and probation services, to the change in approach to include the greater use of community service orders and the introduction of a community return scheme.

This scheme allowed certain categories of prisoners sentenced between 1 and 8 years to be released at the midpoint of their sentences to continue their sentence through undertaking community service work for a prescribed number of days per week. However, in order to qualify for this scheme, prisoners had to demonstrate that they had engaged with all relevant services and had a good prison record.

The prisons sampled took 2 closed male well-functioning CBHFA prison programme prisons; one adequately functioning open prison; one male prison programme which was less well functioning and the female prison which experienced challenges in its CBHFA programme.

It was agreed with the evaluation team that such a purposeful sample would allow the study to have a good representation of the whole country-wide CBHFA in Prisons programme, sampling varying degrees of success and impediment. It was believed that this would provide a cross section of interview transcripts from typical to extreme cases as recommended by Dey (1993) which were likely to be information rich and a diverse cross-section of the sample prison groups.

In addition, given the short period of time that the independent researcher was available in Ireland to undertake the interviews with the sample group, it can also be said to be a convenience sample where the purposeful samples were suitably geographically placed within the country. Such convenience samples are supported by Graziano & Raulin (1997).

11.0 The research Tools and Information Sources

11.1 Semi Structured Interviews

Patton (2002) describes an interview guideline as a list of issues to be addressed during an interview, which yields enough information to analyse. This is useful because it gives guidelines for the categorization of different types of answers.

Prison level

In each prison sampled, interviews were undertaken by the Western University MPH student (independent interviewer) with representatives of the prison Governor, management staff at Chief or Assistant Chief Officer level, the teacher from the Education and Training Board working with the CBHFA prison programme and prison nursing staff working with the programme.

Bannister *et al* (1994) maintain that such semi-structured interviews may also produce perspectives not originally envisaged by the researchers. This is true of the important finding in this evaluation of the personal development and empowerment the prisoners encountered during CBHFA in Prisons.

This was recognized in the first couple of years of implementing the programme and so an interview tool was introduced in 2012 that indicated changes in outlook occurring in volunteers. This is now secondary data but is included in annexe 2. The tool was derived from Dilts' (1991) model of neurological levels.

The tool used facilitated inmate volunteers to make internal representations about six categories of living through time (as shown in the model of figure 1). These started at the environment level leading on to behaviours, capabilities, beliefs and values, identity and personal goals. The reader can easily recognize the impact from the language used by volunteers before involvement in the CBHFA in Prisons programme and afterwards. This has significance if we accept that language is the mirror of the mind.

National Level

Interviews were undertaken with senior management within the Irish Red Cross which included the Secretary General and the Head of National Services overseeing the CBHFA in Prisons Programme and the CBHFA Programme Manager involved in the programme from the IRCs perspective. Senior management in

the Irish Prison Service included the Director General and the Director of Health and Rehabilitation and the CBHFA Programme Coordinator for the City of Dublin Education & Training Board.

Interviews with the Programme Director of CBHFA in prisons was undertaken to gain an understanding of the inception and design of the approach in a prison context. This was important because the programme Director had a wide international Red Cross experience as well as being the designer of the CBHFA in Action programme methodology developed for global use for the International Federation of the Red Cross and Red Crescent Societies in Geneva.

In addition, he was an experienced Healthcare Manager and Change Management practitioner who adapted theories used in the design of the CBHFA in Action methodology in other contexts including military and community development for war and disaster. This led to the set of Federation Tool boxes on Community Assessment tools (Vulnerability and Capacity Assessment – Learning by Doing) where the methods used included the *Living Through Time model* – see figure 1). This methodology was subsequently the basis of the process element of the then new (2009) CBHFA in Action manuals used in the prison model now operating.

The Independent team member (Western University MPH student) used such information to build a picture of how health programme development processes that emerge in one context can be adapted to another in creative solution generation for public health in complex settings.

1. Focus Groups

Focus group meetings were held with inmate Irish Red Cross volunteers in each of the prisons sampled. A set of questions were created by the Western University MPH student and her critical friends group in the planning period of the evaluation. These questions were then used for guided semi-structured discussions. These discussions were audio-taped with the written consent of the group and transcribed after the focus group meetings.

Prior to use, the questions/guidelines were pilot tested for readability and comprehension outside of the sample areas. Adjustments were made where appropriate.

2. Secondary Data Review

The Western University MPH student used all relevant reports and data to provide information about the programme and its activities relating to health education and awareness linked to the work of inmate volunteers of the programme in the different prisons of Ireland. Documents also included reports on lessons learned workshops as well as staff training events and sensitization courses.

3. Case Studies

The information gathering process aimed to identify patterns through the analysis of interview data which would tell the story of individual prison samples as a case study and through connecting common patterns, identify at a national programme level the factors influencing both success and difficulty.

4. Field Diary

The Western University student and collaborative inquiry group kept field diaries to record emerging

thoughts and questions that may be useful during the analysis and reflective periods leading up to the writing of the evaluation report.

5. Evaluation Design Group

In order to be creative in this evaluation it was important to have a collaborative group involved in the design of the study especially as the Western University MPH student (as independent team member) was available in Ireland for a short period. This group was made up of well motivated representatives of each of the partners – a teacher, the ETB, a representative from prison management, Irish Red Cross and IPS Healthcare management and the independent researcher from Western University.

Critical friends as a supportive and questioning group are supported by Dey (1999), Binnie & Titchin (1999), McNiff (2003) and Whitehead & McNiff (2006). Dey (1993) maintains that collaborating with colleagues in research helps prevent bias since there is an opportunity for one analyst to replicate the results of another.

This critical friends group was involved in the design of the evaluation, question design and sample selection. Annexe 4 shows the interview questions/focus group guideline developed by the independent Western University student and her collaborative critical friends group.

For the purposes of validity, only the independent researcher from Western University was involved in the interviewing/data collection process and transcribing. Analysis of the data was undertaken as a collaborative process with the 'critical friends' collaborative group. Since the independent researcher lived in Canada, the collaborative group worked on the data analysis and shared outcomes with the independent researcher who reviewed the data remotely.

Tom and Sork (1984) and Jarvis (1999) suggest that collaborative research provides a means for different contributions to be brought together and quote the following:

"Findings that are the product of true collaborations between practitioners and academic researchers can and should be qualitatively different from the findings produced by either party working alone" (161)

11.2 Interview Process

Interviews were undertaken generally at the place of work of each key informant or in a chosen quiet place comfortable for the interviewee. Volunteer focus groups were held in the classroom of the prison school. All participants were again asked about their comfort with being on audiotape and none objected. It was again, reinforced that their participation and being recorded was voluntary at all times. Anonymity was guaranteed.

12.0 Analysis of the Primary Data

The method used to analyse qualitative data collected through interviews and focus group outputs followed Patton's (2002) Comparative Pattern Analysis method. Inductive analysis according to Patton (2002)

Involves discovering patterns, themes and categories in ones data, findings emerge out of the data...in contrast to deductive analysis where the data are analysed according to an existing framework (p.45)

12.1 The Stages of Data Analysis

This section describes the stages in making sense of the data so that information could be reduced into manageable themes and categories to arrive at some meaningful findings that would illuminate the theory upon which the programme was based in this evaluation. Pattons's *comparative pattern analysis* was used as well as using guidelines from Cresswell (1989), Huberman & Miles (1994), Bogdan & Biklen (1982) and Collaizi (1978).

12.2 The Listening Stage

Murrell (1998) urges the researcher to identify what is called

Significant statements or phrases (p.304)

The analysis began with 'listening' to taped recordings of all interviews.

During the listening stage the Independent team member collected a mass of conversational information. It included listening to the syntax which identifies information that may not be fully appreciated from reading transcripts alone. Some members of the collaborative group also chose to go through this important listening stage.

12.3 The Transcribing Stage

The transcription of interview audio tapes was completed in conjunction with the active listening, which helps the researcher understand the sense of the words and language used.

All interviews were undertaken solely by the Independent team member from Western University and were recorded with the written consent of all participants. Subsequently, they were transcribed by the researcher and used as the raw data from which to undertake collaborative analysis of the primary interview data.

The transcripts and recordings were studied a number of times at the beginning of the research process by some collaborative group members in order to fully appreciate the meaning of statements made, including the detail that can be of additional value whilst listening to tones and syntax of the written information. According to Bandler & Grinder (1975), listening to people's syntax sometimes provides information about a person's thinking patterns. The process of 'active listening' (Patton 2002) allows the collection of relevant parts of the dialogue represented in the transcripts.

Permission for follow-up visits was provided where clarification was required.

Following the initial readings of the interview and focus group texts, the researchers used field diaries to identify potential ideas and connections emerging at this stage, which was able to help identify developing patterns.

12.4 Creating Data Bits

A method used in this data analysis process of sorting data bits followed Appleton's (1995) document wallet method. This was a useful aid for helping to categorize the data. A filing wallet was constructed, which allowed the analyst to place responses to different questions and respondents into an appropriate section of the wallet. Each transcript was studied by the analysts and every sentence broken up into ideas that could be separated. Each idea was written onto a yellow 'post-it' and wall mounted according to question and respondent-type.

The *comparative pattern analysis* process was undertaken in a large room in the Irish Prison Service College over a week that had ample wall space to be able to hang large amounts of qualitative data bits. On the walls signs were put up to mark the type of respondent/focus group and the question numbers. This took all the wall space of the large room. Data bits on post-its were then wall-filed.

Once all of these 'data bits' were placed, the researcher began to sort them into groups by similarity of ideas or similarity of meaning. Eventually, the data bits began to take shape into clusters of data bits on the wall space as similar data bits were sorted and grouped. (See Figure 3)



Figure 3

An example of some of the wall mounted data bits. A hall was used with large wall space available to accommodate the masses of wall mounted data taken from the line by line review of the primary interview transcripts.

At this stage the researchers sorted to funnel the data into named categories, thus reducing the data into manageable categories of responses to questions of each respondent or focus groups.

This process was repeated for all interview scripts and focus group transcripts where each one occupied a separate space on the four walls of the room. This was so that once all data bits were erected and sorted from each individual source, they could be directly seen in relation to each other, aiding the visual process of comparing and contrasting as well as looking for common features in all sources.

At the point where all wall-mounted interview data were clustered, the researchers spent time looking at each cluster to find the higher logical level of explanation for the meaning of the cluster as a whole:

“What was the data saying to the researcher?”

“How could the essence of the meaning of each similar data bit be expressed as a cluster?”

And importantly –

“Would another researcher studying the same clusters gather a similar cluster meaning for that data?”

When the lead analyst's first sweep on the wall mounted data and clustering was completed, the meaning of each cluster in terms of a theme was identified and recorded. The categories were recorded in the field diary, thus reducing the data.

12.4.1 Creating Validity and Reliability in Data Reduction and Categories

For the purposes of reliability and consistency of interpretation of the data, a second analyst followed the same process of studying the raw data and the wall mounted data bits. The second researcher purposely did not discuss the first sweep process and interpretation of clusters with the first analyst.

The second analyst looked at all interview data bits, clusters and interpretation of clusters, making their own sense of what the data “seemed to be saying” and made independent notes in the second field diary.

Following completion of this, the two analysts compared their analysis of the data bits into clusters and the meaning assigned to each cluster as categories. Similarities of patterns were noted and where there was disagreement of data-bit sorting and clustering, discussions took place around the data on the walls in order to review meaning so that agreement could be arrived at that both analysts could agree upon. This process of clarification was very important to the validity of the sense-making that was part of the comparative pattern analysis methodology.

Following the clustering process and identification of main themes identified in each transcript, the analysts spent time ‘talking to the walls’ (Betts-Symonds in IFRC 2006) and each other to identify patterns across all interview/focus group data clusters to identify key themes across all interview data categories.

According to Heron’s (1996) cooperative/collaborative inquiry method, each researcher-participant acts from their own standpoint within agreed rules of design. The agreement sought and reached about the findings by co-researchers is not an agreement of identical representations. Heron states *‘it is about how the different experiences do and do not overlap and about how this mix of diversity and unity articulates more or less fully the inquirer’s subjective-objective reality’* (p.175).

12.5 The Main Themes identified

The collaborative group were given a copy of the content of the field diaries that indicated the main categories arrived at in the positioning on the walls and weightings noted.

Each co-analyst in Ireland and the Western University MPH student in Canada were asked to review the categories and produce their own key themes emerging from them.

Following this, the Ireland-based collaborative group met in an analysis workshop to present and then explain the rationale for their findings in terms of main themes emerging from the data. As critical friends they then challenged each other and required clarification to substantiate their outputs and this was done through case study example. The process was completed for all analysts and the commonalities noted. It is interesting that the wall charts completed by all four analysts contained the essence of similar key themes, even though the lists were generated separately.

Heron (1996) describes this as a valid process in stage 4 of his ‘stages of the Inquiry Cycle’ (p.73-103). He describes how a collaborative inquiry group present their reports to the group in a reflecting phase and then a final collation of individual accounts of what is significant. It is a means of identifying similarities and differences amongst inquirers leading to meaningful conclusions based on patterns.

13.0 Key Emergent Themes as Findings

Through the analysis of the data bits some key themes have emerged through the treatment of the data by the Collaborative group.

- Powerful programme in taking health awareness to community level
- Communication issues
- Management structure and motivation

- Operational Role for volunteers
- Consolidation and creativity of Action in the community
- Preparing for re-entry into society
- Community development, empowerment and personal development
- Women prisoners are different to male prisoners in CBHFA
- Measuring health outcomes of volunteer activity

13.1 Main Findings Explored

13.1.1 Powerful Programme Taking Health Education to the Community

Information gathered from primary data and secondary information about the programme in all Irish Prisons provides evidence that the aim of taking health education into prison communities has been achieved since prior to the programme there was no community based education. The information on community based projects conducted over the period from 2009 to 2014 is impressive for most prisons (see Annexe 5). What this evaluation has shown is that there are differing levels of health education productivity based upon the CBHFA commitment in each prison and how well functioning the CBHFA management structure is.

The samples in this data of five prisons were chosen where three represented the most relatively well-functioning of most prisons in Ireland and the two least well-functioning.

Data from all sources indicated the powerful nature of the programme in terms of motivating prisoner volunteers to become proactive in health education and as peer educators in their community depending on the level of CBHFA management support. The topics for projects emerged in each prison from undertaking the community assessment and interview of health care staff.

Secondary data shows the widespread extent of the types of projects conducted throughout prisons in Ireland and examples of these are shown in Annexe 5 for each prison as they came on board with the programme. In this section a selection of projects are shown and described below.

13.1.1.2 A Review of Secondary Data that supports the findings in the primary data – A Selection of Programme activities in the Evaluation Period from 2009 to 2014 from some prisons.

This section of the evaluation reviews the type of activities that inmate IRC Volunteers have undertaken during the evaluation period from 2009-2014 in different prisons. Each prison Volunteer group undertakes Module 3 which is the community assessment module in order to identify the key health issues to be addressed in their course and projects in their communities. Some of these projects are common to all prisons and others are relevant to specific types of prisons. For example, in open prisons where there is significant freedom, projects relating to adjusting to open prisons are relevant but not in closed prisons.



Figure 4
An Exhibition of Projects

13.1.1.3 General Hygiene and Cleanliness

A primary problem identified in all prisons was hygiene and cleanliness. In most prisons, at the landing and cell level, prisoners had access to a mop and bucket but the same implements were used for in-cell cleaning as well as toilets and shower areas. The volunteers came up with a solution by working with management to set up a colour coded mop and bucket system.



Figure 5
Colour coded mops and buckets and Improved Hygiene

13.1.1.4 Prevention of Disease Spreading through Cross Infection.

The prison environment is a breeding ground for infection sources because of communal living in small spaces. It was a factor identified by volunteers in the assessment of their community and in conjunction with information gathered from prison nurses. This was particularly important at the time of the first pilot in 2009 when the Swine Flu pandemic was at its height. The solution designed by the volunteers in partnership with healthcare and prison management was a hand washing campaign and cough/sneeze etiquette education with all inmates in the prison.

This was done through the use of a Glow Box to reinforce the message about the correct six stage hand washing technique. Once learned by the volunteers, they undertook awareness sessions on all the landings to improve hand washing and help to prevent swine flu amongst prison residents and staff.



Figure 6

Landings training with prisoners and staff about the six stage hand washing technique using the Glow box

Whilst it cannot be proven that this initiative was entirely responsible for the absence of any cases of swine flu, it is likely that it contributed to it. Interestingly, the prison next to Wheatfield at that time did not have the CBHFA programme in place and did have cases of swine flu. Throughout the 5 year history CBHFA in prisons, this type of awareness has been implemented in most prisons thus contributing to cleanliness and hygiene. Data collected from most key informants reported a significant improvement in the environment in the prisons.

Secondary data identified that in some prisons this cleanliness and hygiene work was augmented through volunteers undertaking bi-monthly audits of cleanliness and hygiene within the landings. They then worked with the supplies officer and were able to ensure that prisoners had sufficient cleaning materials to keep their cells and landings clean.

13.1.1.5 Bullying Project

One of the key problems in prison that increases individual prisoner vulnerability is the issue of bullying by other prisoners. Classically, prisoners are bullied into three areas:

1. Bullying to give up their prescribed medications.
2. Bullying for food.
3. Bullying to bring in contraband (including illicit drugs) from the outside when attending court or hospital appointment.

As part of their community assessment in module 3, volunteers in Cork Prisons recognized bullying as a significant problem for their community and the vulnerability of certain prisoners to the bullying tactics of other more aggressive and controlling prisoners.

The project they designed aimed to give every prisoner some tips about 'How to say no to Bullying' which became the title of the short films they helped to produce. Since they could not use prisoners as the actors in these films, collaboration with the ETB and some creative funding, the group was able to have actors portray the scenarios typical of prison life. The role of the volunteers was in advising the film crew and actors of the language, scenarios and situations that were common. In effect they acted as film directors.

The finished films were produced as a DVD which could be shown on the prison wide TV channel. In addition, it could be used throughout the prison estate in all prisons.

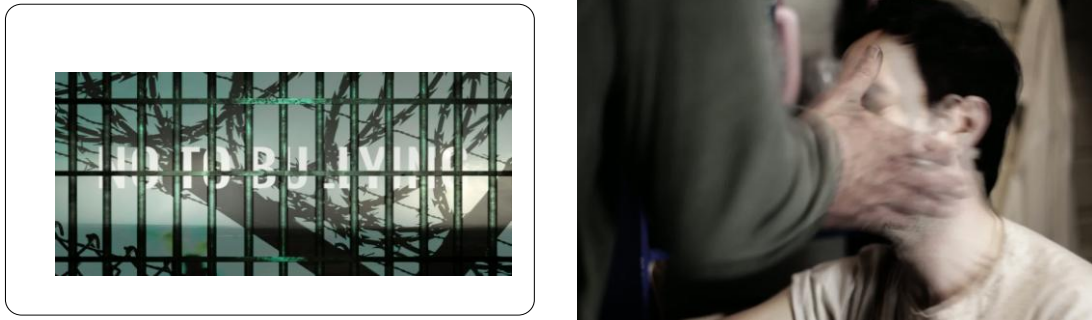


Figure 7
Anti-Bullying in Cork Prison

13.1.1.6 Packing Internal Orifices with Illicit Drugs

Leading on from the 'Say no to bullying' films, a serious issue was highlighted that placed prisoners at significant risk from massive drug overdose and physical damage to the bowels and anal sphincters by packing the rectum with drugs to evade detection on re-entering the prison after a visit outside for hospital and court attendances.

The risks with internal rectal packing include the bursting of the container used to transport the drugs and the massive drugs overdose that would ensue likely resulting in death. Even more graphic for the purposes of this project was information given about the permanent damage that can result from the repeated packing of the rectum and the weakening of the anal sphincter leading to incontinence.

Below are some of the graphic illustrations used in the poster campaigns that appear to have had a significant effect on prisoner's willingness to participate in such activities. Posters included some of the outcomes of the project where prisoners being bullied into this type of activity were able to say no – citing the pictures in the posters on the wall during the campaign. At a national CBHFA in Prisons Lessons learned workshop in 2013, other prisons were impressed with the project and sought to adopt it.

ARE YOU HAPPY TO USE YOUR BODY AS A SUITCASE?

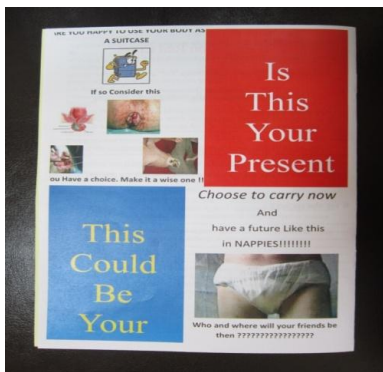


Figure 8
Graphic pictures used in the Packing Project Campaign in Cork.

13.1.1.7 Benzodiazepine Project

This project was cited in the section above on peer education. However, it is a good example of the emergence of relevant health topics related to specific prison populations through the Community Assessment of module 3. In addition, it demonstrates the power of a 'whole prison approach' to a health problem.

It came about because the doctor in a busy remand prison was auditing compliance with Epilim therapy used in the prophylactic prevention of seizures with prisoners with a history of abusing Benzodiazepines (sleeping tablets). Consultation with nurses confirmed that there was a serious non-compliance noticed from the administration of Epilim with large amounts of Epilim returned to pharmacy unused each week.



Figure 9
Picture relating to the Benzo project in Cloverhill

The CBHFA in Prisons Programme nurse and teacher identified that the topic in module 7 about drug abuse was ready to be taught. Therefore, the doctor was asked to participate in the class and raise the issue of Epilim non-compliance. She facilitated learning with the volunteers about the importance of taking a full course of Epilium and the problems that can occur if compliance is not adhered to.

As a result of the learning session, the group, the nurse, doctor and teacher decided to design a campaign to change this. Pre and post-project questionnaires were completed by the prisoner community and the outcome was a better compliance with Epilium therapy.

13.1.1.8 Non-Communicable Diseases

In 2012, Geneva IFRC CBHFA Programme launched an additional module to the CBHFA content called Healthy Lifestyles. In line with WHO, IFRC was promoting volunteer work with Non-Communicable diseases. These include Cardiovascular disease, Chronic lung diseases, Cancer and Diabetes recognizing that these were amongst the greatest killers.

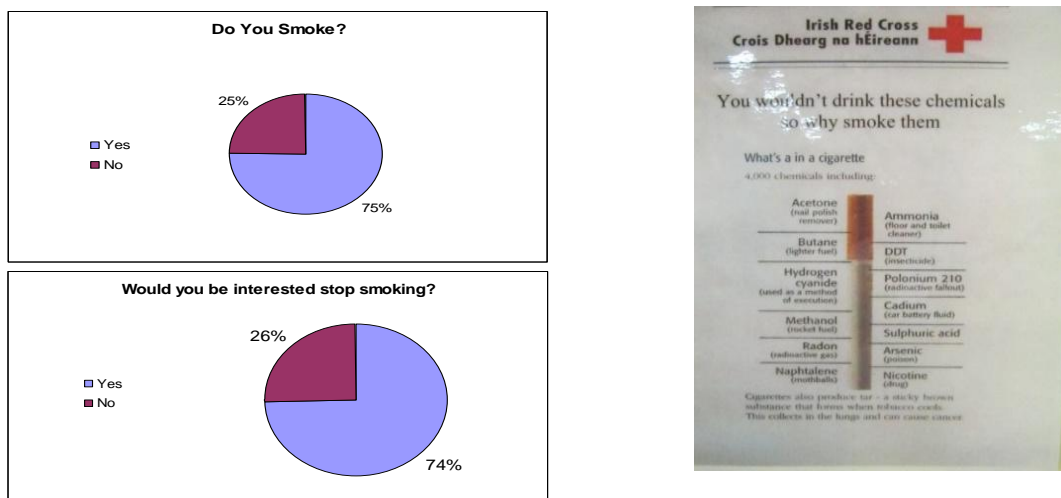


Figure 10
Representation of the outcome of the smoking survey, smoking project

At that stage the CBHFA in Prisons programme integrated it into the Irish programme as module 8. These modules lead to a number of important projects in all the prisons which included smoking cessation. The HSE provided trainers to train inmate IRC volunteers to take on the role of smoking cessation facilitators. For this, it was important for the volunteers to be connected with the various health centres so that there was coordination between the prescribing of smoking cessation aids and the volunteer support groups which provided peer support to prisoners. In some prisons there was a 30% success rate in stopping smoking and significant reductions in cigarette consumption.

Certain prisons focused on NCDs with their projects which included exercise and weight reduction campaigns and classes supported by volunteers and interfacing with professionals as required. One prison was able to demonstrate a number of overweight prisoners who significantly reduced their weight and improved their fitness with exercise and watching the size of meal portions and sugar reduction. The health centre reported that some of these diabetic prisoners were able to reduce or stop their diabetic medications.

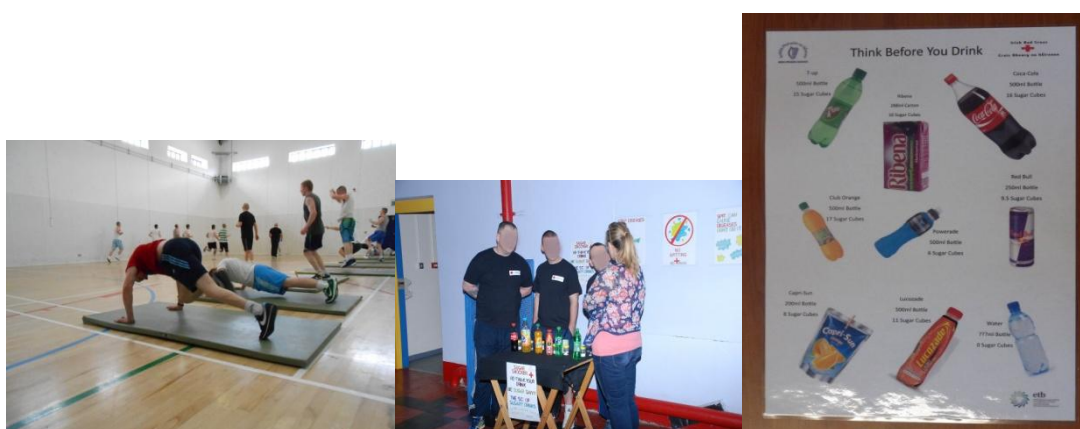


Figure 11
NCDs - Pictures showing exercise work and Reducing Sugar Drinks

Cancer awareness was supported in a number of prisons in partnership with the HSE in relation to skin cancer. Campaigns supported by materials provided by the Irish Cancer Society were organized and volunteers carried out sunshine audits identifying where adequate shade was not available and sought with management to change this where it could be done without too much cost. The proper use of sun creams was promoted and prison management were asked to provide sun cream dispensers in strategic positions so that prisoners would use it prior to going outside.



Figure 12
Sun Safe Campaign in association with Irish Cancer Society

Whilst this was achieved in some prisons, others were less motivated to invest in these initiatives to provide shade and dispensers. However, in 2016, an Irish Prison Service estate wide campaign has been organized through the IPS Health Care Directorate, IRC and Irish Cancer Society.

13.1.1.9 Stroke Awareness Campaign

In most prisons, volunteers promoted Stroke awareness through F.A.S.T poster campaigns and landing based talks.



Figure 13
Poster from F.A.S.T Campaign

13.1.1.10 HIV Mass Rapid Testing and Reduction of Stigma

This campaign was undertaken in a number of prisons in the Dublin area linked to in-reach HSE services from St James Hospital GUIDE Clinic. The consultant physician had visiting clinics weekly and undertook the management of all HIV and Sexually transmitted diseases cases.

It was noted that in the three prisons targeted that less than 10% of the prison populations knew their HIV status. Arrangements were made to carry out mass voluntary HIV testing in these prisons. The role of IRC inmate volunteers was to advocate for testing and encourage discussion amongst inmates about HIV and AIDS.

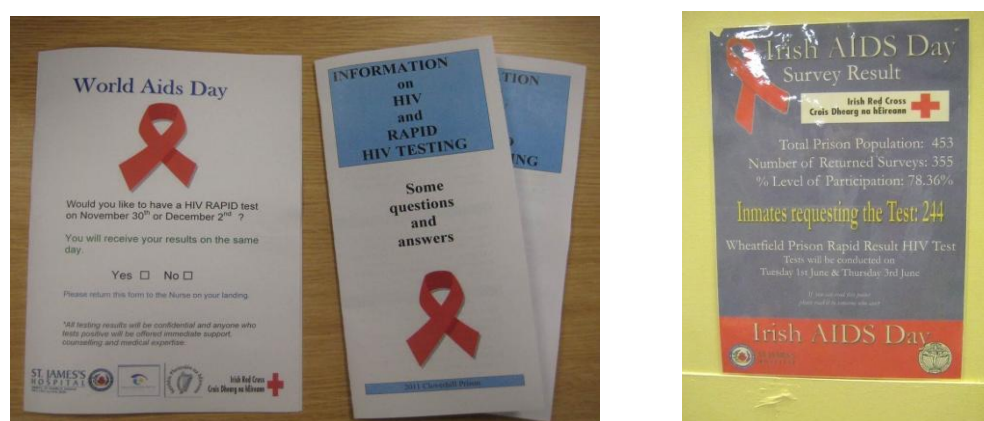


Figure 14
Pictures relating to the HIV Rapid testing – Wheatfield, Cloverhill and Mountjoy prisons

The result of the power of peer to peer education was significant where between 55% and 75% of all inmates in these prisons presented for voluntary testing. Data collected from interviews carried out at the

time of testing with inmates indicated that the main reason for availing of testing was the inmate IRC volunteer advocacy work (see appendix 1). The data also recognized that inmates had changed their opinion about mixing in close proximity with known HIV sufferers. Methods used by volunteers included landing based discussions lead by the volunteers and the presentation of videos on HIV/AIDS anti-stigma messages.

13.1.1.11 Sexually Transmitted Diseases

Sexually transmitted diseases were identified in module 3 by volunteers as very relevant to prisoners in all CBHFA courses. The controversial issue of condom availability in a confidential way was highlighted frequently. Gaol sex is a reality but is something prison authorities are reluctant to talk about as well as the prisoners themselves. In prisons it is generally accepted that the reality of living is that prisoners who are not homosexual may well engage in some form of 'gaol sex' which has significant implications for prison public health.

In one prison, healthcare and the volunteers undertook a survey amongst inmates to gather some idea of the scope of unprotected 'gaol sex. The findings were quite remarkable with a significant percentage admitting to have engaged in this type of activity even though they would be regarded as hetero-sexual. As a result of this, a limited access to condoms was agreed by prison authorities through the health care centre with one particular nurse involved in this confidential activity.

Whilst this is an important step forward, it still leaves many prisoners likely to continue unprotected gaol sex because of the embarrassment of having to approach a member of healthcare staff rather than having confidential and anonymous access to them.

13.1.1.12 Violence Prevention and Reduction

Linked to the assessment module of the CBHFA programme, inmate volunteers and their community recognized the serious problem of attacks on other prisoners using cutting weapons. Prison management were also concerned about this level of violence occurring in a specific prison. Through the community health action committee, it was agreed that prison management would work together with inmate IRC volunteers to address this problem through a weapons amnesty over the period of a designated week.

The role of IRC inmate volunteers was to advocate with prisoners to make their community safer by getting rid of cutting weapons held by inmates. The role of management was to guarantee to prisoners that giving up weapons during the amnesty period would not lead to any sanctions against them.

At the height of the cutting weapons crisis, 97% of all attacks on prisoners were with a cutting weapon. This resulted in 2 or 3 prisoners every week having to be escorted out to local hospitals for suturing of facial lacerations. This had implications for costs and manpower because if prison officers were tied up on escort duties, normal recreational activities had to be cancelled.

The results of the initiative were significant. Within three months the number of cutting weapons attacks was reduced from 97% to less than 6%.

Other prisons introduced what was called 'Safe Zones'. In this, prisoners agreed that certain areas would be safe from any violence such as the prison school.

Following on from this, some of the inmate IRC volunteers designed a peer led violence prevention course as one of the modules of CBHFA. This linked in to the IFRC Geneva call for CBHFA to have a Violence Prevention module within CBHFA. The CBHFA in Prisons programme created a version relevant to prison

communities. These courses have been incorporated into the Irish prison programme and undertaken in some prisons on a monthly basis.

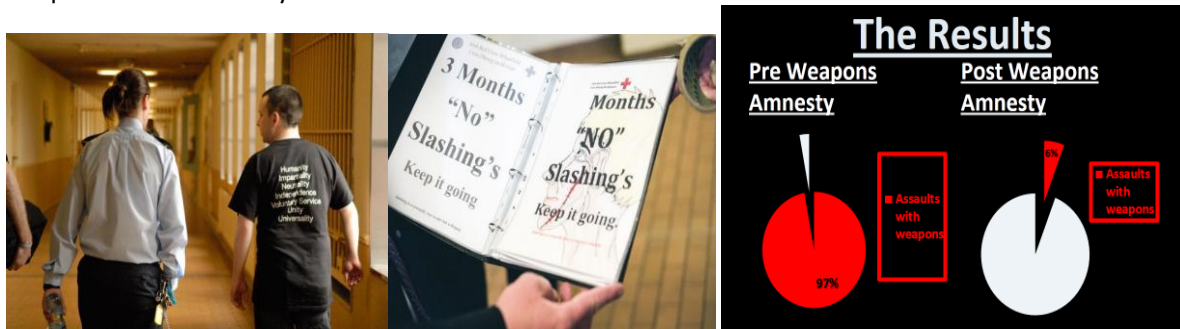


Figure 15
Weapons Amnesty in Wheatfield

13.1.1.13 Safe Zone Project

This project started in Castlerea where the school is a 'safe zone' area and inmates have signed a form (see figure 16) agreeing that they will not bully, intimidate or assault any other person while attending the school. This was a unique project that has made significant contributions to a safer community.

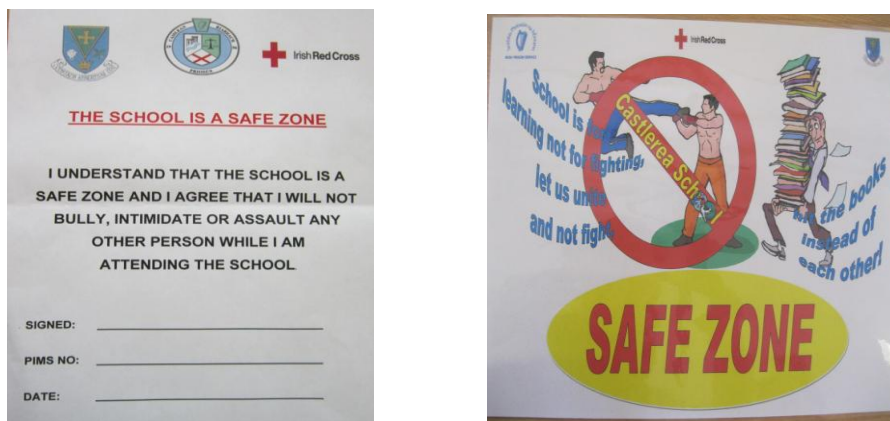


Figure 16
Safe Zone in Castlerea

13.1.1.14 Drug Awareness, Overdose Prevention

Also linked to recommendations from the Health Department of IFRC Geneva and findings of module 3 CBHFA, the IRC CBHFA programme has developed further the topic on substance misuse to be a module within CBHFA in Prisons. This is because in addition to violence, the biggest problem in Irish Prisons is drugs. Data in Ireland shows that a significant number of accidental overdoses of drugs occur in ex-prisoners who on leaving prison do not take into account their loss of drug tolerance.

As a result, IRC inmate volunteers have been trained to facilitate Overdose Prevention courses with their peers about keeping safe when taking drugs both in prison and on release. The emphasis is not on stopping taking drugs but on staying safe when taking drugs.

MQI Overdose Prevention

Partnership with Merchants Quay Ireland prison based Counselling Team



Risks of Overdose:

- Mixing Drugs
- Tolerance
- Using Alone
- Methadone
- Previous OD
- Health/Age
- Drug Quality



Figure 17

Overdose Prevention, Totally Committed to No Drugs

13.1.1.15 Helping New Prisoners to Settle in to Prison Life

Most prison CBHFA volunteer groups recognized the stress of being a new prison inmate and sought with management to provide some kind of support to new prisoners with the provision of basic information and friendship.

In some prisons this was a welcome pack, in others just a visit to offer friendship by IRC inmate volunteers. In one open prison, there was an open prison adaptation project in which IRC volunteers talked to newly transferred prisoners about adapting from a closed prison to an open prison. The trigger for this project was based on the fact that a number of prisoners coming from closed and restricted prisons could not cope with the freedom of an open prison and took the opportunity to escape.

Following the implementation of this project, statistics showed a significant reduction in prisoners fleeing open prisons.

In one of the prisons sampled in this study, volunteers were enthusiastic about what they termed the 'buddy project'. It was planned that IRC inmate volunteers would visit all new committals within the first 24 hours of committal. However, this did not materialise because of the lack of management support to make it happen through ensuring that volunteers had the access they needed. This reinforces the importance of ensuring that every CBHFA prison programme has the support needed from Chiefs and Assistant Chief Officers to ensure access to undertake their projects.



Figure 18

Information for prisoners/suggestion box

13.1.1.16 Caring for the Elderly

Volunteer work in relation to the care of the elderly has been described elsewhere in this report. However, this category of prisoner in Ireland is increasing with the prosecution of sex offenders offending years ago and only now coming into the criminal justice system. It is appropriate therefore that inmate IRC volunteers in these prisons are recognizing the vulnerability of the elderly and infirm.

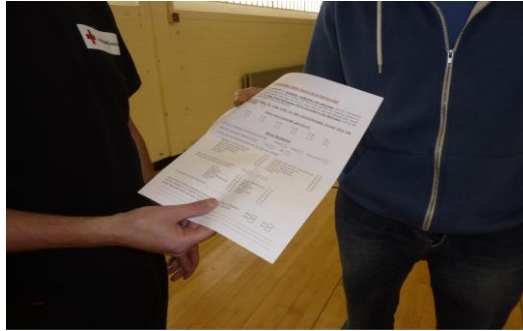


Figure 19
Survey in Arbour Hill

Nursing staff are already overworked with the running of health care activities at the surgery level and have less time for undertaking elderly community care. In certain prisons where these types of offenders are present, the role of the inmate IRC volunteer is important.

Data shows that nurses recognize the potential for IRC inmate volunteers to contribute to elderly care and this needs to develop further. However, data shows that whilst their potential is recognized, the role of IRC inmate volunteers in relation to nursing needs to be clarified.

13.1.1.17 Screening for Cardio-vascular diseases

In a number of prisons where there is good liaison with nursing and healthcare, volunteers have been taught how to check blood pressure with digital machines that do not require the skills of using a sphygmomanometer and stethoscope. The purpose of such campaigns is to encourage prisoners to come to a testing station manned by peer CBHFA educators (volunteers) to have their blood pressure checked.



Figure 20
Picture of volunteer taking blood pressure with digital sphygmomanometer

Volunteers record the readings and present them to the nurse responsible for the unit concerned. The nurse can then review the readings and decide who needs to be followed up. This type of ‘task shifting’ is in line with the work of volunteers in many community contexts throughout the world linked to local health centres.

13.1.1.18 Mental Health

Mental health issues are a significant problem in all prisons in Ireland and IRC volunteers are not qualified to deal with this. However, like most of the communities around the world, Red Cross volunteers can have a role in basic mental health well-being.

The CBHFA manual that supports the programme does not have a mental health topic within it and this is a shortcoming for prison community health. There is a need to develop a module for this area of health.

In CBHFA in Prisons, any work with this subject is undertaken linked to professional groups working with mental health awareness. In Castlerea prison there has been a number of initiatives lead by such organizations as Mental Health Ireland who spearheaded ‘Mind Your Head Week’.

The IRC CBHFA programme is working with an IPS planning group looking at a generic programme for prisoner mental health awareness that includes the Head of IPS Psychology. Once agreed, it will be adopted as an additional module of the Irish version of CBHFA.



Being a Dad in Prison

What **CAN** you do?



Stephen Burke

Wednesday 9.30 - 12.15



Figure 21

Mental Health Awareness in Castlerea & Portlaoise

13.1.1.19 Tuberculosis Awareness

Tuberculosis is a risk in any prison because of the close proximity in which prisoners live and the lack of ventilation in prison cells. It is a particular risk in committal prisons where there is a fast turnover of prisoners and where there is little known about the health of the numerous committals that happen on a daily basis.

The initial CBHFA programme implementation in Cloverhill Prison occurred at a time when there was an outbreak of TB. Based on the methodology of CBHFA, the starting point for the course was TB.



Figure 22

An example from the Remand prison of Pictures of posters in different languages about TB

13.1.1.20 Paracetamol project

An awareness campaign around the correct use of Paracetamol in two prisons has resulted in a significant increase in understanding amongst the prison community and the consumption of Paracetamol reduced by approximately 30% in certain prisons. Community surveys were carried out to identify the level of knowledge before and after community awareness raising with significant results in both cases.

In another Prison, there was a significant number of prisoners stating that they took Paracetamol because (a) they liked the taste of the elixir and (b) it gave them an opportunity to speak to the nurse. Few prisoners in either prison understood the dangers of consuming too much Paracetamol.

This project was undertaken in partnership with the local pharmacist that provides pharmacy services to the prison as a community pharmacy initiative.

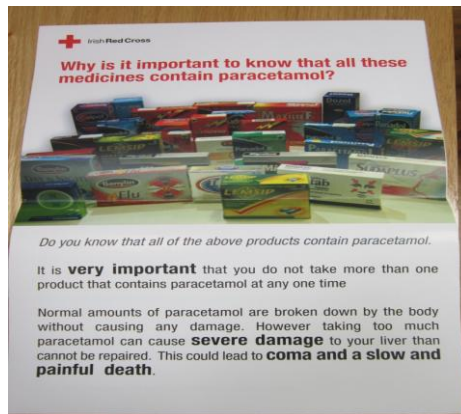


Figure 23

Paracetamol Awareness Project

13.1.1.21 Women's Health

In the Dochas Women's Prison, whilst they included many of the same types of projects that were run in the men's prisons, they also included awareness relating to women's health. Some projects were aimed at reducing the risk of pregnancy immediately on release from prison for obvious reason. Advocacy around methods of birth control was carried out by inmate IRC volunteers. It was also connected to the healthcare

department so that as women were coming to the end of their sentences, the most appropriate contraceptive methods could be started well in advance of release.



Figure 24
Posters advertising women's health

13.2 Communication Issues

The issue of communication was central to the findings of this evaluation in terms of local relationships in each prison and the notion of sensitization to the programme in general with all staff and stakeholders.

13.2.1 Local Communication Between the Parts of the Programme

In terms of the primary data, the teachers' interviews in particular indicated that in some of the sampled prisons, difficulties were caused by a lack of communication between local partner representatives in some prisons e.g. between the teacher and the nurse or discipline staff and Red Cross. Usually, this is because the CBHFA 'management system' as described in 13.2.3 and 13.3 below is not balanced or in place in a sustainable way. Local communication between the parts of the system is important in this programme since there are significant logistics involved in being able to accommodate inmate volunteers accessing various parts of the prison to undertake their health awareness and project work on the landings.

13.2.2 Improved Relationships between Prisoners and Staff

An important finding in this evaluation from key informants and volunteers is the positive change in relationships between prisoners and staff. It was noted by volunteer focus groups and key informants that there was a change in how staff and prisoner volunteers perceived each other and more direct communication between them.

In some prisons, prison officers interested and attached to the CBHFA prisons programme joined in some of the classes in the school and participated in project work. This is also true of senior staff such as some Assistant Chief Officers (ACO's) and Chiefs. These CBHFA prison programmes are usually stronger for this.

It was noted that such a change lead to a better understanding between prisoners and staff generally resulting in less tension within the landings. One ACO remarked that prior to the programme prisoners would be reluctant to talk to staff for fear of being regarded as an informant. Now, volunteers could freely discuss Red Cross project work in an open way.

Senior management recognized that the programme, through its communication strategy, has lead to community ownership and development. In addition it has been reported by a number of prison Governors

and senior management staff to actively reduce tension by providing access to the Governor through the Community Health Action Committee Structure.

13.2.3 Communication about the Purpose and Mission of CBHFA in Prisons

By far the commonest theme in the data from all informants of the five sampled prisons collected in this evaluation shows the importance of stakeholder 'buy in' of the programme. Based on the findings of this evaluation, the most important characteristic of creating a successful CBHFA in Prisons programme is information dissemination and working with key stakeholders.

In the start up of the programme in the first phase, this did indeed happen with representatives from each discipline but once the person returned to their station, they may not have passed on this information. After the first prison, the Programme began running Sensitization Workshops in order to give training to those staff members who had signed up to support it in their prison. This would include the Governor, Chief, ACO, a prison officer, the nurse and the teacher. Through this process four prisons at a time could be sensitized.

Despite the sensitization provided to each prison's CBHFA management group, data in this evaluation indicates that there is still not enough communication about it at each of the disciplinary levels of Nurses and Prison Officers.

The nature of the sensitization course is that it has to be participated in, to understand the way that CBHFA in Prisons works because of its action-learning nature. Therefore in order for the right level of communication to be achieved, it is recommended that Sensitization courses are ongoing and held at regular intervals for prison officers, nurses and relevant staff. In this way over time, more staff will understand and be able to give motivated support without interfering with good security.

The data from nurses shows that there could have been greater utilization of volunteers by healthcare if nurses had a better idea of the role and purpose of inmate volunteers complementary to their own. The greatest barrier appears to be coming from prison officers where data suggests that they were less accommodating to requests from volunteers to enter landings for health awareness work because they were not briefed.

Reflection on the processes used is illuminating in hindsight. It was an assumption of CBHFA in Prisons leaders that because management level were informed of impending activity, that this information would be passed on. Part of the complexity of the Irish Prison management system is the 'Roster'. In this, certain staff are on duty for one part of the week and others for the rest of the week. The system does not really cater for the handover of information since the two sides of the roster do not often meet.

There needs to be engagement with both sides of this roster in a way that allows prison officers to understand the methodology and purpose of the programme. It needs to particularly impress upon prison officers how the programme benefits staff as well as volunteers.

Data collected from focus groups of prisoners in some of the sample prisons identifies frustration amongst volunteers when their planned work in the landings is unable to happen where prison officers would not allow access due to a lack of communication. This is understandable given the basic security training of all prison officers.

Once programme management took these issues to the Community Health Action Committee, the difficulties were usually resolved. However, it demonstrates how important it is to promote communication about the programme at all levels of prison operation and management. This is consistent with similar dissemination needs in all contexts around the world for the integrity of Red Cross/Red Crescent Movement.

13 2.4 Community Based Project Management

Learning about relevant health issues and designing peer-led community projects and activities was relatively easy. The problem was in how to realise action at the landing and cell level. This is where the notion of a 'whole prison approach' to health becomes essential. Traditionally, prison officers are trained to be suspicious of all prisoner activity and to restrict their movement to pre-agreed parameters. In a sense, prisoner officer training is linear, black and white and does not accommodate complexity.

In order for inmate Irish Red Cross volunteers to undertake their community based public health awareness duties, prison officers who are the **key holders** need to be able to facilitate their movement in order to access other prisoners.

Traditionally, permitting prisoners from one area to enter into another is a risk because training has engrained upon prisoner officer the dangers of access in allowing the movement of contraband around the prison. This is not an intended barrier but the results of efficient prison officer security training. This CBHFA prison programme is to some extent revolutionary in any jurisdiction's prison system because theoretically it may be thought to challenge good security. Overall, in most prisons in Ireland facilitation of access for campaigns has been good and is based upon good communication between the partners at local level.

A clear recommendation of this evaluation is the need for more staff training relating to the Red Cross prisons programme and the International Red Cross/Red Crescent Fundamental Principles applied in a prison context. There is also the case that in any programme there will always be some who are negative and the important thing to do as mentioned by senior IPS management is to

'work with the 80% of motivated staff'.

13.2.5 Barriers to the Programme

The barriers to success of the programme were a question posed to most key informants and the volunteers through the focus groups. Such barriers included difficulties with other prisoners who may be jealous of the privileges perceived to have been granted to IRC inmate volunteers. This happened where certain prisoners were not successful in attaining a place in the course for whatever reasons. In the CBHFA in Prisons programme there was a sense of impartiality relating to the crime that inmate volunteers were in prison for. In one prison, a combined volunteer group of sex offenders and non-sex offenders was successfully run.

Other factors affecting the programme were the issue of visits from family members that often interrupted participation in programme classes. However, the most prominent was the sense amongst volunteers that staff did not support their role through a lack of staff training and awareness.

From a management perspective barriers were caused by the sheer workload of prison Governors and senior staff which took them away from CBHFA programme management. In addition, Governors noted that there was often a conflict between those prisoners that had graduated from CBHFA and those in

training. This was reflected in data from other sources that showed frustration amongst graduated volunteers about their lack of a clear role.

Another barrier to progression of CBHFA at the management level is the perceived risk involved in clearing known criminals for active service in the IRC. Experience shows that it is important for the Governor for CBHFA in Prisons to be comfortable with controlled risk taking when it comes to clearing specific individuals for IRC activity within the prison.

13.3 CBHFA Prison Programme Management Structure

A key element of the introduction of the CBHFA in prisons programme is the setting up of a management structure to allow classroom learning to be actioned within the prison community. To do this, every prison has a structure in place that includes the following attached to each CBHFA prison programme,

- Governor
- Chief Officer
- Assistant Chief Officer
- Prison Officers
- Teacher
- Nurse
- Representatives of the Volunteer Group

Having these people in place depends very much on staff motivation to participate and it was found to vary from prison to prison.

13.3.1 CBHFA Community Health Action Committees (CHAC)

Each of these has a role and the intention is that they meet together once per month along with two representatives of the inmate volunteer group. The purpose of such meetings is to progress community based activity that emerges from classroom learning. The Governor for the programme approves the project plans and instructs sub-ordinate officers to make it happen. The Chief and Assistant Chief Officers are responsible for ensuring the landing based action takes place as planned through creating the circumstances that allow inmate volunteers to access approved areas to carry out their work.

The role of the teacher is to provide the anchor to the programme within the school environment and ensure academic standards for the learning are achieved. The nurse's role is twofold – the first is in delivering the classroom learning on health and medical subjects. The second is to be the link between the activities of the volunteers and the priorities and standards of healthcare within the prison.

In terms of creating the desired action in the community, the role of the Governor and discipline staff cannot be underestimated. Experience has shown that where this structure is in place with well motivated staff, the programme is successful and community public health is delivered. Conversely, where this is weak, the programme outcome in the prison community is less effective. This is substantiated through the findings of this evaluation.

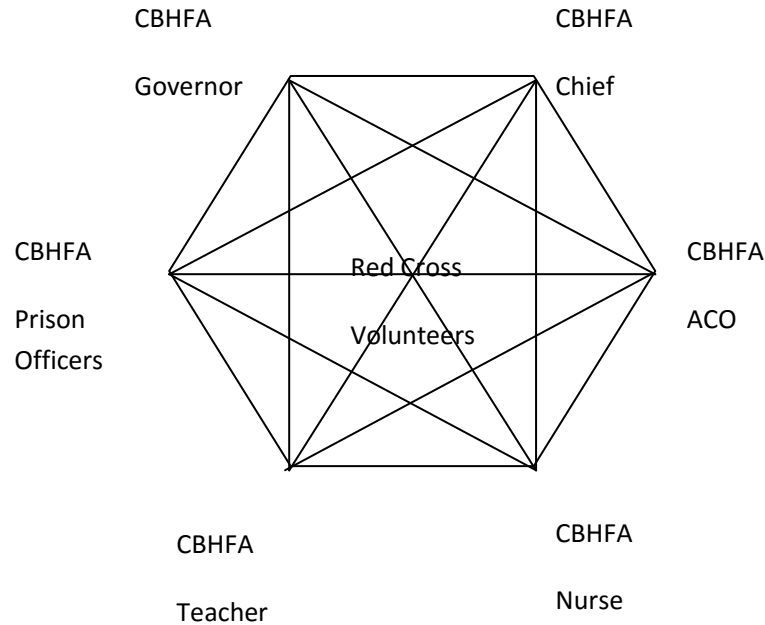


Figure 25

The Programme Structure for Successful CBHFA in Prisons Community Action

The importance of this structure is demonstrated in figure 25 above. A weakness in any one of the components of the systemic model results in less effective outcomes in the prison community.

The findings of this evaluation indicated that the above structure was instrumental in creating landing based activity and impact. The findings also showed that two elements of the structure were paramount – attendance and commitment to monthly ACTION Meetings by all parties and continuous support of project implementation through their operational roles in between meetings.

Of the samples used in this evaluation, interview data from all disciplines identified a lack of operational and meeting commitment as the reason for reduced community output in certain prisons. It must also be understood that this is not true of all prison groups in Ireland but of some of the sample group.

In all cases there was good Governor support and strong ACO support in *well-functioning* prisons. A key issue for many people in these roles was the level of work they are already involved in in their day to day work. None of the ACOs involved were dis-interested and all nurses were interested.

Conversely, data supported the model where real activity was the result of the dedicated support of each discipline in balance. Like the other systems models, weakness in one of the components leads to change in the others. The characteristics of a *well functioning prison CBHFA programme* were where all these components were well represented with well motivated staff.

13.3.2 Motivation of Staff and Volunteers

The data identified that delegating staff to these roles rather than their choice to participate affected the operation of community based activity. Motivation is an important factor not only for the inmate volunteers but for the staff that were supporting the programme through their operational roles. For example, one Assistant Chief Officer noted that:

“it adds to my work as I have still got to carry out my operational security duties as well as support the programme”.

However, this ACO also said she was motivated to support it because

“There’s a huge difference to the prisoners”.

“The environment is much better and more hygienic”

“The relationship between prisoners and staff has changed for the better”

Another officer is motivated because:

“You can see a huge change in the behaviour of prisoners. Some prisoners who were real problems have completely turned around”

The motivation to support CBHFA in Prisons from teachers comes from the satisfaction they see in the personal development of individual offenders as well as recognizing as educationalists the value of action learning. A key theme in transcripts included the idea that in educational terms the notion of learning in the classroom and doing in the community makes educational sense. The methodology used in CBHFA utilizes adult education theory very well and is linked to Brunner’s Discovery Learning through the community assessment module 3. In this, student’s motivation to learn about specific subjects is based upon their own discovery of the priorities within their community of living.

Prison Governors attached to the programme are acutely aware of the need to engage prisoners in rehabilitative work and to create safer prisons. Most of the data sources at senior management level recognized the programme’s ability to create change in individual prisoners. In addition, data showed the power of the programme in developing a *sense of community*. A senior prison service manager noted that:

“We don’t call them prisoners any more – we call them volunteers – they are on the journey to change and reform”

He recognized the value of the programme organizationally and his senior management team around all the prisons had a general acceptance of its relevance to the work and mission of the IPS.

Others were motivated as CBHFA in prisons provides an area of health care that formerly could not access the actual community due to resource limits. It was also respected through its ability to lessen tension in prisons.

Other motivation was the high esteem that Ireland has globally and within EU countries for an innovative prison health strategy. Ireland was the first country to introduce the CBHFA approach in its prisons and has been helping to train Red Cross personnel and prison staff in a number of countries including the British Isles, Australia and Honduras as well as another ten countries through trainings in Ireland.

From a Red Cross perspective, the motivation to support this programme in Irish Prisons came from insightful senior management who recognized prisoners as a vulnerable part of Irish Society and that this is one part of the community where the Irish Red Cross should be.

Information collected from interviews with nurses showed a mixed response. Overall, nursing practitioners recognized that the programme was useful in that it helped deliver what healthcare was supposed to be doing but could not for resource reasons. A number of respondents identified specific areas such as HIV awareness, Hepatitis awareness, vaccinations, tuberculosis prevention and early warning to have been impact areas. Some nursing staff did not recognize any particular difference in health outcomes at surgery level and some were sceptical of the motivation of prisoners to be part of the programme.

In one of the prisons sampled, which specialised in sex offenders, nurses had some concerns about the potential for manipulation of prisoners by other prisoners who were Red Cross volunteers. Conversely, nurses in this same prison also recognised that without the Red Cross volunteer's important elements of elderly care and support would not have happened due to the lack of nursing resources at that level.

This included the work volunteers did in highlighting obesity as a problem and a project to help obese inmates lose weight. Data from their work identified that a significant number of prisoners lost weight with their support and indeed that some prisoners were able to come off their diabetic medications as a result of this activity in partnership with his doctor.

Activity supported by volunteers acknowledged by nursing was the smoking cessation programme and the information they were able to receive from volunteers about elderly patients during the volunteers meals on wheels service and home help cell cleaning activities. This is important to nursing who need to know whether elderly and often frail prisoners are eating properly and coping in their community.

Nurses in some of the prisons sampled acknowledged that the volunteers had even more potential but cited their own staffing resource problems in having sufficient time to work with them. Interviews in these prisons identified really dedicated and supportive nurses who were frustrated by not having the time to commit to the CBHFA programme.

Other nurses identified that they were not sufficiently aware of how the programme worked and its intentions. Others stated that there was some lack of clarity around the role of IRC inmate volunteers in relation to their own roles in relation to health.

Another valid point made by some nurses was that despite all the health awareness activity of inmate Red Cross volunteers, there was no quantifiable evidence that prisoners listened to it. This was an important theme in the evaluation because the programme lacked concrete evidence of health outcomes for all projects undertaken. This factor was also recognized by senior management at IPS who stated that despite the fact that almost certainly there have been significant savings and impact through the programme, we currently have no way of measuring this. This will be reflected in the recommendations of this report.

There were different levels of support for the programme in different prisons from prison officers. In some prisons, certain individuals were really supportive of the mission of the programme to (a) improve community prison health and (b) to create change in individual prisoners' outlook.

Analysis of the inmate Irish Red Cross volunteer's motivation to participate in the programme was varied. Initially, some volunteers admitted to extrinsic motivation but later admitted to being intrinsically motivated because they gained satisfaction from what they were doing in their community. There was a strong sense of being able to influence change in their community through the programme and interestingly it was important to them to be helping others.

Data strongly suggested that they were being empowered by a sense of *community* and of leading cleaner and better lives. There was a strong response about developing personally through participating in the programme and a sense of fulfilment.

13.4 The Operational Role of Volunteers

The data indicated that the role of inmate CBHFA volunteers was not always clear to everyone. Some data showed that volunteers once training was completed could feel isolated from new groups in training.

Changes were made based on this finding at the beginning of 2016 to attach all qualified volunteers to the Chief Nurse Officer in prison so that they become practice based. In this way, their health awareness volunteering becomes linked to operational need and relevance and gives the volunteers clear leadership.

13.5 Consolidation and creativity of Action in the community

Key informant interviews indicated that whilst landing based activity was evident, there needed to be a higher profile of the volunteers and their work. In addition, it was suggested that there be greater creativity in the types of projects that they undertake. Case study analysis shows a correlation between those prisons with a less effective CBHFA management structure in place to have the lower profile of landing activity. Conversely, those with more effective structures have greater volunteer and project profiles.

It is suggested that greater landing based activity will be achieved through correcting the difficulties in CBHFA management structure, particularly at Assistant Chief Officer level and improving general communication about the programme within prisons. In addition, the change to attaching qualified volunteers to the Chief Nurse Officer in each prison will also assist in dealing with this issue.

It is important to note, that the timing of the interviews of the evaluation was in the midst of an industrial relations issue in 2015 that had slowed down all voluntary work activities in the prisons and the high output period of 2014 was in contrast at that time.

13.6 Preparing for re-entry into society

The aim of phase I of the CBHFA in prisons programme was initially to create improved community based health in Wheatfield Prison and then subsequently up to the end of 2014, in all prisons in Ireland. It was not originally planned to include a specific programme of re-entry after prison, apart from the personal development that has become part of being a CBHFA in Prisons volunteer. It has become clear from the data that empowerment and change has occurred in many prisoners as a result of being involved with the programme. It was also hoped that it would contribute to recidivism.

Statistics showed in early 2015 that of the 680 volunteers trained in the period 2009-2014, half were now released and of that half 75% had not re-offended. Whilst it is early days to be measuring recidivism, it is an encouraging sign.

The data from both volunteer focus groups and key informants indicated that the programme should have some focus on preparing and supporting prisoners after they leave prison. In fact, phase II of CBHFA 2015-2019 is focusing on consolidating the CBHFA in prisons programme in all prisons as well as having a prison to community focus.

In this the current partnership of the IRC, ETB and the IPS has been expanded to include the Probation Service. Currently, inmate volunteers who are eligible for the Community Return Scheme (CRC), are being trained as facilitators in Overdose Prevention and Violence Prevention. In the Community Return Scheme prisoners in certain circumstances are released early and have to perform unpaid work for a set period of time for three days per week. These work days have traditionally been on labouring-type projects.

Ex-inmate CRS CBHFA volunteers are being used to facilitate workshops in agreed at risk communities as part of their CRS workdays. This utilizes their skills and training as volunteers/facilitators in prison when they leave. In addition, they play a preventive health role within local at risk communities and it provides some clear direction for the ex-inmate so that they stay usefully engaged rather than drift into old company.

It is envisaged that in the future, jobs will be created for such ex-prisoners in the coordination of this CRS CBHFA Health awareness work.

13.7 Community Development, Empowerment and personal development

The data collected from all sources indicated the importance of developing the sense of community in prisons. Significant data bits highlighted the importance attributed to working together and supporting each other as well as helping each other. A number of volunteers talk about the life changing experience of being part of the programme as well as a change in identity. Others talk about prison as a 'community' and the opportunity to influence change. In this way, they become more in charge of their own community and themselves.

The importance of the realization that prisoners are in control of their own lives is an important change for it also accepts that the responsibility for health is also personal rather than reactive. One Governor stated:

'Prisoners are very empowered and have new ways of bringing the issues to the table'

Information gathered from interviews of prison Governors indicates that some prisoners, as a result of the programme, have completely changed. This is evidenced from the lack of P19 sanctions. These sanctions are imposed by the prison Governor as a response to misbehaviour or contravening prison rules. Evidence has shown from primary interview data that positive changes have been seen in prisoners who have become IRC inmate volunteers. Governors and staff report changes in behaviour from difficult and troublesome management problems to active volunteers engaged in positive activities through Red Cross projects.

One teacher states:

'I like to see the personal development of the guys – confidence, communication, self esteem which leads to transforming their image of themselves and their mind-set of being productive members of their community'

A Governor remarks in his interview:

'Prisoners are empowered... they are not just prisoners anymore. They have a voice and don't see prison officers as their captors anymore'

13.8 Women prisoners are different to male prisoners in CBHFA

In all, one complete cycle of CBHFA in Prisons was run in the Dochas Women's Prison in Dublin and one cycle in the small women's section of Limerick Prison. Recruitment for the following cycle in the Dochas Prison was difficult due to the number of courses and activities open to female prisoners in the Dochas Centre. Subsequent discussions with all parties lead to the need to review how CBHFA is designed for the female inmates particularly in the Dochas Centre. The female course run in Limerick prison was more successful probably due to the fact that there is less available to women there than in the Dochas.

Data collected in this evaluation from the interviews of the nurses, Governor, teacher, Chief Officer and a Volunteer was enlightening. Because the female prison as one of the five samples in this evaluation is so different, the data is shown separately because the issues are so different to those in male prisons.

A common theme throughout was that female prisoners are very different to male prisoners as noted in the data of all staff and volunteers of the Dochas Centre requiring a very different design of the course. Information suggested that the female prisoner was less likely to go into the prison community to promote health messages for fear of peers and what they might say about or to them.

In addition, women prisoners do not have the support in prison that male prisoners have from visiting partners, parents and children etc. Data showed also that in the Dochas Women's Prison there is an exceptionally broad choice of courses and activities that are on offer to women in Dochas prison.

Another drawback to the course is that women typically are on short sentences and would not have the time in prison to engage with the programme over a four or five month period. It is also suggested in the data that their interests are family related and attention span is limited.

Plans have been made through planning meetings with the CBHFA team in the Dochas to redesign the programme into a shorter version that begins with community/personal assessment in order to home in on the real interests of female prisoners.

13.9 Measuring health outcomes of volunteer activity

Data from senior management and health acknowledge that whilst the impact of certain projects can be measured, there is not a system in place for measuring health outcomes or cost effectiveness of all projects in the community.

For example, before and after measurements of the numbers of cutting weapons attacks in the weapons amnesty was undertaken, it showed that the project changed the number of cutting weapons attacks from 97% to 6% in a matter of weeks. This was acknowledged by prison management to be saving the prison service huge manpower resources i.e. escorted trips to hospital and therefore financial savings. However, this was not calculated because it is not easy to do so.

The Rapid HIV voluntary testing project was carried out in three prisons. In each of these prisons, the prisoners knowing their HIV status was less than 10%. Following the campaign/project it could be measured that over 50% of all inmates were tested in two prisons and 75% in one prison.

The Paracetamol project in one prison aimed to warn prisoners of the dangers of taking too much paracetamol which is always popular amongst prisoners. Measurement in this project was based upon

measuring the reduction in the ordering of paracetamol over time following the campaign. There was a reported 30% reduction in ordering indicating a reduction in use.

Since 2014, teachers and volunteers have been encouraged to undertake baseline surveys of basic knowledge related to a specific campaign and then an end line survey to gain some indication of the effectiveness of the campaigns they do.

14.0 How the findings Influence the programme Theory as the end point of the Realist Cycle

The aim of the CBHFA in prisons programme when it started in Wheatfield prison was to enable community based health awareness at the landing level connected to formal health structures. Following its success in Wheatfield prison, it was gradually extended to all the prisons in Ireland by 2014.

The purpose of this evaluation was to test the theories on which the programme was set up, identify the extent to which the aim of the programme was being achieved and create opportunities to improve the programme in the future.

The findings have clearly indicated that the programme has introduced community level awareness to relevant health subjects. Evidence of that can be seen through the description of projects implemented in the different prisons.

The theories on which the programme is based include the following:

14.1 WHO (2007) Whole Prison Approach to Health¹

WHO acknowledged that public health for the last century ignored prison health, which resulted in increased spread of serious communicable disease such as tuberculosis and hepatitis in this population. The document was created to provide expert opinions on how to tackle different health issues and achieve good health within the prison (WHO, 2007).

WHO strongly recommended that prison and public health be closely aligned, this is because the prison population contains marginalized groups in society, who are from poor social economic backgrounds, drug users, lacking employment, suffering from homeless, engage in risky activity and suffer from poor health and untreated chronic diseases. In addition, living conditions in prisons were less favourable than home, living with overcrowding issues, violence, poor hygiene and risky behaviours among the inmates.

Prisoners released back into the community without proper healthcare contributed to a broader public health problem. In addition, prison officers and management who interacted with prisoners were also at risk of contracting untreated communicable diseases (e.g. Tuberculosis) (WHO, 2007).

WHO believed that many components were vital to good health in prison including political leadership, management leaders, staff leadership and prisoner community support. It highlighted the fact that the healthcare system within the prison community was complex and needed complex multi-level, cross-collaborative solutions. Health promotion and its sustainability were identified as a vital component to achieving good prison health. WHO promoted a whole-approach to prison health (WHO, 2007).

¹ This information section on the Whole Prison Approach to health was written by Nikki Abiodun (Western University MPH Student) as part of a case study presented as part of the requirements for her course.

The WHO whole prison approach also emphasized:

- ❖ Primary health care was the foundation of prison health services.
- ❖ Good health and well-being is achievable through health promotion and key to successful rehabilitation and resettlement.
- ❖ Healthcare delivered to prisoners must be ethical and professional. Health care staff must deal with prisoners as patients and not prisoners.
- ❖ The management of communicable disease must be effective to contain disease transmission.
- ❖ Assessment of respective prison community must be done and programs appropriately created to address identified issues.
- ❖ Drug use, mental health and dental services should be provided to prisoners.
- ❖ Effective identification of the needs in female prisons. Female prison population is generally smaller with different needs than male prison population.
- ❖ Health promotion and stress management techniques should be implemented for prison employees.

14.1.1 How does the Whole Prison Approach Contribute to CBHFA in Prisons?

It was our belief that in following this model, the whole of prison services and actors must in some way contribute to prisoner health through the global CBHFA approach adapted to a prison community.

The outcomes of this evaluation through the collection of primary data in 5 sample prisons and the secondary data reflecting all prisons confirmed that a multidisciplinary approach is the way to bring health awareness to the prison community linked to the second theory of peer education. It is clear from data from all sources that difficulties and successes in delivering local community health by prisoner volunteers was dependent upon that multi-disciplinary approach identified in a 'whole prison approach'.

This includes the integral part played by nurses, prison officers, governors and chief officers. Without their cooperation, neither the education nor the local access for the dissemination of knowledge can be achieved.

An important finding related to this theory is that whilst the programme was operating what we *thought* was a 'whole prison approach'; it was in fact only partly doing so. The correct idea was followed in recognizing the value of the contribution of all players, but it needs to be even more of a 'whole prison approach' through better communication and sensitization of staff involved in each discipline.

In addition, there are other parts of the prison system that could have a useful part in the whole prison approach such as psychology and probation. Also, from an educational perspective, the IRC programme needs to be more aware of other relevant programmes operating in Irish Prisons and seek to partner and avoid duplication.

The central hub of the CBHFA programme management is the Community Health Action Committee (CHAC) who represents the actors of the 'whole prison approach'. These need to be strengthened in all prisons. It is at these management meetings that those disciplines involved in teaching and facilitating effective community based action meet and assist in developing projects and problem solving.

Recommendations in this evaluation are linked to communication improvement and dissemination of the mission of CBHFA in Prisons which in themselves will strengthen a more effective 'whole prison approach' to prison community based health.

Data from interviews also acknowledges that it is not only communication that is needed to increase 'whole prison approach'. Nurses and Governors admitted that high workloads and staff shortages impact on the ability of a well-motivated officer or nurse to give assistance to the programme at certain times. In a prison, operational and security concerns must always come first and prisons have to run on 'regimes'.

One of the main difficulties of the nurse being in a classroom at a certain time agreed with by the CBHFA teacher is the fact that cancellation or delay at short notice can occur due to an emergency or staff sickness. Ongoing shortages of nurses in certain prisons either interrupt the teaching timetable or require the Programme Manager/Director to have to gap fill on medical subjects interfering with national programme management/development work.

14.2. Peer to Peer Education

²The key to CBHFA in prisons was not so much about the classroom learning of the volunteers themselves, but rather on what the volunteers did with that learning outside of the classroom within their communities. This fitted the action-learning design of the programme where the learning in the classroom provided the focus of activity within the local community during the week that followed. Often, this passing on of information might take the form of simple conversations on the landings about what they had learned in class. In some cases, it would be linked with a mini-presentation or part of a larger project.

Peer-to-peer education was identified as an effective method of teaching and learning and had grown in popularity and practice in recent years in the field of health promotion. It is based on behavioral theories; social learning theory, theory of reasoned action and diffusion of innovation theory (Turner & Shepherd, 1999). It was an important aspect of the success of the CBHFA program worldwide (IFRC, 2009). Peer-to-peer education was implemented in health programs (youth smoking cessation, sexual & mental health, and substance abuse) for education and behavioural change (Turner & Shepherd, 1999). It was used in different settings such as schools, colleges, youth centres, community settings and informal networks (Turner & Shepherd, 1999).

Peer-to-peer education was adopted in health promotion in various settings because of its cost effectiveness in comparison to professionally delivered services (Jones, 1992; Jones et al, 2006), peers were seen as credible source of information (Clements & Buczkiewicz, 1993), peer education empowered those involved (HEA, 1993), peers were more successful than professionals in passing information (Clements & Buczkiewicz, 1993), peer education was used to educate hard to reach populations (Rhodes, 1994, Bagnall et al, 2015), peer educators served as positive role models, peer educators reinforced behaviour change through ongoing contact (Kelly et al, 1991).

The IFRC understood the peer-to-peer education dynamics; and created the CBHFA program training objectives around effective volunteerism, effective communication strategies, understanding community dynamics, garnering community support, community sensitization efforts to CBHFA projects, social

² This information section on Peer to Peer education was written by Nikki Abiodun (Western University MPH student) as part of her case study presented as part of the requirements for her course.

mobilization and effective partnerships. All these were contained in the CBHFA volunteer training manual. The creation of credible and effective community-based volunteers was core to CBHFA effectiveness and sustainability. The volunteer manual included training information on communicable diseases, basic hygiene, sexual, mental and reproductive health.

As an innovation in prisons, CBHFA appears to have been very successful in utilizing prisoner peer education. This was apparent from volunteer comments and others who recognized that prisoners listen to other prisoners. It fits Clements & Buczkiewicz (1993) claim that hard to reach populations can be accessed better by peers than by professionals. Qualitative interview data from prisoners post mass HIV testing indicated that they participated because of their peers rather than nurses or doctors. Other evidence of the power of peer to peer advocacy was seen in the weapons amnesty where it is highly unlikely that prisoners would have given up their weapons at the request of staff.

Observation of peer led Violence Prevention and Overdose Prevention workshops also indicated the attention given to the Red Cross facilitators. There was always good engagement and support of the activities within workshops facilitated by inmate Red Cross volunteers which is not always seen in traditional teacher led events.

The primary data from key informants and volunteers themselves recognize the value of learning being provided by 'people of their own'. In data collected from interviews of volunteers after the Mass voluntary HIV testing campaign confirmed the importance of peer education and support in persuading prisoners to avail of testing. One volunteer stated

"If nurses or doctors had told us to do this we wouldn't have come..."

It has also been noted that it is a useful strategy to include in the recruitment of volunteers, high profile prisoners who have what is called 'prison credibility'. This can often be related to the esteem that prisoners hold other prisoners in for whatever reason. However, this part of the selection process has to be carefully balanced and there is a reliance on intelligence information. This is because, it is no good having a high profile volunteer that is still involved in criminal activity as this compromises the IRC and the Fundamental Principles. From a management perspective, it requires prison managers to take calculated risks with certain prisoners in the hope that there will be a useful pay off.

14.3 Creating Change

In his work on problem formation and change, Watzlawick (1974) describes two forms of change as that which creates change from state to state and change in terms of change of a way of behaving. Inmate in this is the sense of going from one level of understanding to the next and it requires a shift or transformation from one level of thinking to the next.

One of the assumptions forming a part of the programme theory therefore is that the methodology employed in CBHFA in Prisons would motivate volunteers and their clientele (other prisoners) to change the way that they feel about themselves and begin to take some responsibility for their own health and well-being.

The change model used in this programme methodology is shown in figure 1. It is derived from an original linear presentation by Dilts (1991) and changed by Betts-Symonds (2006; 2009) into a systems cybernetic format in which there is a relationship between each part of the model such that changes in one will lead to

changes in the others. Dilts maintains that the upper levels of identity, beliefs and values controls the lower levels of capabilities, behaviours and our environment. Therefore, if certain elements of this model can be changed with prisoners about health and well-being through the CBHFA approach, it suggests changes can occur in the others.

14.4 Volunteer Motivation

In a paper on Realist evaluations, the IFRC team formulated the initial programme theory - that explains the link between an intervention, the context, the underlying mechanisms of change and the expected outcomes - as follows:

“Management practices and leadership styles (intervention) that is supportive of autonomy lead to positive work behaviour of volunteers, such as improved task performance and persistence (outcomes), because they satisfy the psychological needs of autonomy, competence and relatedness (mechanism).

More specifically, such management and leadership contribute to a shift from ‘external motivation’ towards ‘internalised motivation’ for the volunteers whose initial engagement was more driven by external motives. Internalised motivation leads not only to positive work behaviour, but also to well-being. Such management and leadership furthermore allow volunteers whose initial engagement was mainly driven by internal motives to remain engaged and perform well’. (IFRC 2015)

This ideally fits the motivation encountered in the CBHFA in Prisons programme with inmate volunteers. Data indicated strongly, the satisfaction that inmate volunteers gained from their volunteering work in the prisons. Some also admitted initial extrinsic motivation for volunteering later becoming intrinsic.

15.0 Discussion of the Findings in Relation to programme Theory



Figure 26

Triangulating Programme Theory with the Findings

Reflecting on the main findings in this evaluation, most can be explained in terms of the programme theories on which the programme was based in discussion with the collaborative group.

15.1 Taking Health Awareness down to communities – Whole Prison + Peer Education + Motivation of all

The programme's success in getting health and well-being into the community is related to the fact that it was peer lead and that there was some success in the 'whole prison approach' in involving different staff disciplines. Data from staff shows that there was generally an acceptance that it was a useful programme and different motivating factors were identified. Motivation from a sense of 'giving back' was identified by volunteers as a motivator amongst others.

The communication issue created a positive change in relationships between staff and prisoners and was implicated in areas of the 'whole prison approach' for both higher and lower output CBHFA programmes. Motivation of both teaching staff and volunteers was affected by good or less effective communication. Equally, the levels of communication within a CBHFA programme affected the degree of peer to peer education that could be affected in different prisons.

15.2 Having the right motivated Structure in place

The management structure for CBHFA in prisons has been shown to be critical to the optimum performance of the programme. The 'whole prison approach' is obviously central to this. The responses to various questions in the interviews and data produced shows that where there are shortcomings in this, motivation of volunteers is reduced as well as teaching staff, which are the anchor for the programme in each prison.

Examples of well-functioning CBHFA management structures lead to high output projects. High levels of motivation and more effective peer to peer educational outcomes were seen.

The evaluation has shown that volunteers once trained can lose motivation when they sense that their training has been completed and do not feel a sense of 'belonging' as they did whilst in a training class.

Changes are being planned, linked to the whole prison approach, where trained volunteers would become attached to the healthcare department through the Chief Nurse Officer in two pilot prisons, thus giving them an improved sense of purpose. In this new role, they will be used by the healthcare department to promote peer education linked to current health issues.

It is also expected that this operational role will help in creating more landing based activities and a higher profile for inmate IRC volunteers thus increasing peer to peer health benefits and greater recognition amongst staff represented in the whole prison.

15.3 Transitioning for Society – a goal for 2015-2019

In terms of preparing for re-entry into society, the programme content from 2009-2014 did not specifically cater to this since the objective was to improve community based health awareness within the prisons. However, there is clear evidence from the data collected from volunteer focus groups and key informants that volunteers have been empowered and have developed as a result of being involved in the programme. This in itself is preparation but was not a specific objective of the original plan.

Both volunteers and key informants have indicated in the data that the programme should develop in such a way as to provide a supportive link from prison back into the community that utilizes their skills and development.

There is motivation from volunteers to want to continue their association with the Irish Red Cross on the outside and the Irish Red Cross is committed to supporting this. In terms of the whole prison approach and the idea of partnerships, work has already begun by adding into the partnership, the Probation Service.

The particular skills and assets inmate volunteers have is the peer to peer capacity that they could have with specific 'at-risk' groups in the wider community such as drug users, drug treatment centres, homeless groups and working with local volunteer groups and organizations.

The potential of personally developed prisoners (as IRC volunteers) in the post-prison phase of offender management has been recognized by the Probation Service. As such they have aligned their strategic plans with the Irish Prison Service to utilize ex-IRC inmate volunteers within their own service development in working with ex-prisoners.

The focus of early work is to bring inmate volunteers eligible for the Community Return Scheme into what is to be the 2015-19 *Prison to Community* Phase to run alongside the consolidation of the CBHFA in Prisons programme.

Significant problems in Irish Prisons are the result of drugs and violence. In Ireland generally, it is well known that prisoners released from prison are at the greatest risk of fatal overdose due to their loss of tolerance. As such, the CBHFA programme includes a module on Overdose Prevention developed in partnership with Merchants Quay Ireland drugs counsellors and facilitated regularly within prisons. The focus of this work is on Harm Reduction in an attempt to prevent deaths in custody from drugs overdose. It is also presented particularly in open prisons and amongst those prisoners due for permanent or temporary release to reinforce the dangers of overdose and promote safe drug use if it cannot be avoided.

A Violence Prevention module has been advocated by IFRC Geneva as part of the CBHFA programme due to the global problem in all societies of various forms of violence within communities. These two modules have been particularly adapted to the prison environment by prisoners for prisoners linked to initiatives to reduce the number of cutting weapons in circulation in prisons as described earlier in this report.

Other organizations also have initiatives as Alternatives to Violence in some prisons. The IRC CBHFA Violence Prevention module attempts to assist in the much needed violence reduction initiatives and ensures a violence prevention module in all prisons where other organizations do not have the capacities.

These two modules have been identified as two useful learning packages that could be facilitated by ex-inmate volunteers during their community service days within local at-risk groups and with other ex-offenders undergoing Community Service Orders and Community Return Scheme days. Violence is often connected to drugs and the IRCs/Probation Service can have an important contribution to reducing harm and providing post-prison direction activities for volunteers beyond the walls of the prison.

15.4 Personal Development and Building Communities

Community development, empowerment and personal development are intertwined. A common theme over the five years of the CBHFA programme development in each prison has been the sense of

'community' through volunteer engagement with prisoners in project work. This is reflected in the interview data of most of the samples. There are ample examples in the data about personal development and empowerment.

However, this is to some extent linked to the effectiveness of the local 'whole prison approach' through the CBHFA management structure and motivation levels. This also affects volunteer motivation to engage in effective peer to peer activities.

One of the sampled prisons was the Dochas women's prison which did not develop beyond the first cycle and the data indicates that there was a lack of motivation amongst the female prisoners to engage with the programme at the start of the second cycle. Interview data suggested that women did not find the course content of interest to them. According to key informants, the women in that prison have a much greater degree of freedom within the confines of the prison – unlike male prisons that are locked down. Teaching staff also acknowledge that there is a large choice of courses and activities for women and therefore they are less available to engage in a programme such as CBHFA. In addition, women in Irish Prisons tend to be on shorter sentences and less likely to be able to complete the programme.

15.5 Measuring Impact

Measuring the outcomes of volunteer activity would allow a better understanding of how volunteer activity contributes to prison healthcare. During the programme there are examples of quantifying action as described earlier. In two out of the five prisons sampled, volunteers assisted by staff collect pre and post project data mostly to do with the uptake of knowledge within campaigns.

In one of the sampled prisons, NCD work focused on weight loss through healthy exercise and sensible eating/nutritional awareness. Volunteers worked with healthcare staff and the campaign lead to positive outcomes in terms of successful weight loss. In addition, some diabetic participants were able to reduce medication reductions in partnership with the prison doctor. In other prisons, nursing staff report that more prisoners are seeking vaccinations but there is no specific data to quantify this.

Discussions with programme staff indicate that volunteers appear very motivated where pre and post campaign surveys are undertaken as they can see for themselves, the positive effects of their activities. The evidence base of volunteer activities would also be a useful part of promoting the programme to prison staff and assist in applications for funding in the future.

16.0 Programme Theories Revisited

When designing the CBHFA in Prisons programme, developers based their thinking on the 'Whole Prison Approach' to health, peer to peer education and motivation because of the in-depth understanding of both prison life and the working model of CBHFA. Volunteering is a worldwide model and the Red Cross Movement extends from a global to household level through its millions of volunteers. Red Cross/Red Crescent volunteering in every country is about supporting communities and vulnerable people. The Irish Red Cross recognized through CBHFA that prisons are a community within a community and that volunteering could work in the same way as in the wider community.

The developers also recognized that prisons are very restricted places and that making the CBHFA model work would be a complex operation that would need the assistance of many different people and disciplines. This makes the notion of a Whole Prison Approach a useful theoretical model.

Linked to this is the importance of creating partnerships and it was important to recognize that the three institutions necessary to make such a programme work was the Irish Prison Service, the Education and Training Board and the Irish Red Cross. None of these three organizations could have achieved this in isolation but as equal partners. The Irish Prison Service controlled the prisons and the different staff types that could make volunteering work practically. They also controlled healthcare and nursing services that could provide health education. The ETB was present in all prisons and controlled classroom space, timetabling and teachers as the anchor for the course.

The Irish Red Cross represents the worldwide Movement in Ireland and owns CBHFA and the uniqueness of the Red Cross volunteer. Without the Irish Red Cross, the prisons CBHFA programme could not exist. Also, its reputation makes it attractive to become a volunteer and experience has shown that it is highly motivating for prisoners to aspire to be a volunteer.

Peer to peer education is well understood to be a powerful way for adults to learn and motivating to the learner. In the design stage, it was postulated that prisoners might listen to other prisoners with some basic health knowledge better than prison nurse officers. Peer education was also considered as the best approach in order to begin to change prisoners' thinking about taking some ownership for their own health. In addition, it could be motivating for representatives of the prison community (as Red Cross volunteers) to have some say in relation to prisoner health and well-being.

The Programme staff report that the experience of implementing the first phase of this programme from 2009 to 2014 has been rewarding and challenging. The data from interviews of the sampled prisons have provided the primary data in this evaluation and the main outcomes have been discussed and indicate that the theoretical underpinning of the programme is appropriate. However, there needs to be better communication among the people within each part of the prison system such as prison officers and nurses for it to be truly 'whole prison'.

The data and the experience of the programme, as seen through the secondary data reporting and projects, support the use of peer education within this project. Professional teaching staff have recognized the impact of the approach educationally and in particular relating to personal development.

Also, whilst motivation was originally seen to be more attached to prisoners and peer to peer education, interviews of key informants indicate that the motivation of different staff types to get involved with the programme is equally important. This is particularly true considering that staff recognize that actively supporting the programme increases workload. The motivating factor appears from some of the data collected to be related to the benefits that certain staff see in the potential for prisoner rehabilitation. For many staff though, it is important to demonstrate the value that the programme has for them such as a cleaner, more hygienic and safer work environment.

17.00 Ethical Considerations

The permission of the Research Ethics Committee of the Irish Prison Service was acquired through the Prison Service College Research Officer. All interviewees as key informants were given a clear explanation of the purpose of the interviews and the research study. They were reassured that their data would be kept confidential and that no personal names would be attached to their interview transcripts. Only a code known to the interviewer was used in order to be able to return to the respondent was kept in order to

clarify any points. Each candidate was asked to read and sign a consent form and assured that at any time they could cease to be a respondent without any repercussions since participation was voluntary.

Since the interviews were to be taped, permission for this was also recorded on the consent form and all respondent told that if they did not wish to be taped that that would be honoured and that the tapes would be destroyed following transcription and analysis.

18.00 Limitations

There are a number of limitations to this evaluation and these are presented here:

18.1 Whilst in the period being evaluated from 2009-2014 the CBHFA programme was introduced to all fourteen of Ireland's prisons, only five were sampled in terms of collecting primary data representing a 30% sample.

18.2 The evaluation was a collaborative investigation rather than totally external due to the limited time available for the independent evaluator to be in Ireland.

18.3 The independent component of the evaluation team from Western University Ontario was responsible for the interviews in country and their transcription as her project for the practicum module of her MPH degree rather than a hired evaluation consultant.

18.4 Data analysis, identification of findings and recommendations were completed and created collaboratively.

19.00 Conclusions

This evaluation has endeavoured to follow a 'realist approach' where the aim was to identify the processes involved and ask questions about how and why certain outcomes have occurred so that suggestions can be made for the improved operation of the programme. To do this a convenience and purposeful sample of 5 prisons was used to home in on specific types of examples of experiences of the programme. These were three closed male prisons, an open prison and a female prison. They were chosen because one closed prison operated less effectively and the other two closed prisons operated well and similar to the other prison programmes in the country. The female prison was chosen because there were specific challenges that appeared unique to female prisoners.

The CBHFA programme was designed based upon certain assumptions that fed into the programme theories. These were related to the WHO (2007) 'Whole Prison Approach' to Health, Peer Education and Motivation. The evaluation has indicated that these theoretical underpinnings are justified though there is a need to make a number of changes for these to be a more effective basis for the programme.

In addition, it was hoped, through a review of the secondary data and programme staff interviews, to identify the extent to which the original aim of the programme in Wheatfield and beyond has been achieved.

The findings of the evaluation have indicated that the aim of the programme was achieved in that landing level health awareness through peer to peer education was implemented in all fourteen prisons in Ireland between 2009 and 2014.

In that period, one of the prisons (the Juvenile Prison) was transferred to Wheatfield Prison and the programme incorporated into Wheatfield's. The Women's Prison (the Dochas Centre) implemented the first cycle of CBHFA and is waiting to commence a revised programme as described in the report.

The success of the programme in Ireland has been well documented and is known internationally. The report details the types of health promotion and voluntary work undertaken by inmate volunteers in the various prisons.

The primary data was developed from the interview of volunteers and key informants as described in the methodology. The questions posed in the interviews were developed by the team leader and a collaborative group of critical friends to explore the factors around the experiences with the five prisons sampled. The purpose of the evaluation was not to show whether it works or not because clearly it has had a profound impact on prisoners within Ireland as shown in the various documents and films.

The purpose was to ask questions about the context of the programme and try to understand the factors behind certain types of responses in different prisons and different actors.

The outcome of the evaluation has provided programme management with important lessons learned that will help to make the programme more effective in the future.

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Annexe 1
Irish Red Cross Survey Post Rapid Voluntary HIV Testing

Questions asked of the prisoner community on Rapid HIV Testing Days in Mountjoy Prison

11th June 2013, Day 1

How did you know about today?

- Red Cross lads talked to us few weeks ago and paper (information) into cell
- Red Cross great thing, lads sit and talk to us, info into cells great help
- Red Cross guys explained everything
- Red Cross answered all our questions

Why did you come today?

- To get it (the test) out of the way and deal with it if I have it, Red Cross helped
- Devastated if I passed it on
- Nice to keep on top of it (the test)
- Peace of mind
- Don't use needles but good to get it done

What do you think of the Irish Red Cross volunteers?

- Boys in the Red Cross did all the work
- Red Cross guys doing serious good job
- Would not know nothing without Red Cross
- If going through bad time they talk you through
- A lot will join Red Cross next time
- Handy having Red Cross lads
- Red Cross getting a lot done
- Fair play to Red Cross

What do you think of the process today?

- Good, fast process, might be 2 waiting years on outside
- Some afraid of needles so swab test good
- Counsellors very nice and helpful
- Counsellors letting know how works, symptoms, all explained
- Everyone very nice, think it's going great
- Red Cross guys kept door closed for privacy
- Testing magnificent
- Process very slow before

Do you think most people will come for testing?

- Yes, all coming from our landing
- Whole landing coming

What would you do if you heard someone on your landing tested positive for HIV

- If you get bad news doctor talk to you in private and Red Cross there for us
- If positive, try to help, great what you can do now
- If someone positive, would not mind cause can't catch it
- HIV positive, can look after before too late
- Say nothing
- If positive give support, stigma changed now

Comments about IRC projects

- Seen a big change, like a new age prison
- Washing themselves more
- Different coloured mops now, hygiene packs in cells
- Lots of changes, even small changes good

- Milk 3 times a day great, not warm milk now
- Food covers great, hygiene much better, all a lot cleaner
- Better awareness about catching things

General comments

- Anything to do with health is good
- Doing something worthwhile, can't fault it
- Some terrified
- If our life made easier, officers/staff made easier
- Prisoners that does not get test done, something to hide
- Would like advice on prostate cancer, how to check etc and other men's health.
- Talk to nurses all the time
- Cameras all around good

A lot of comments on shop

- Prices too high in shop, i.e. Shower gel €4.50, Tomato ketchup €5. Polo biscuits €3
- Few mentioned some kind of razer/shaving blades costing €18 a pack
- Too much sweets, not enough fruit
- Would like nutrients in shop,
- Protein tubs, they can last about 6 weeks

12th June 2013, Day 2 in Mountjoy

Why did you come today?

- Heard from Red Cross but paid no attention, then heard again and came over
- Share cell with men and have sex
- Better safe than sorry
- Red Cross asking everyone to get involved
- If ended up having it, not good

Feedback re first day of testing

- All said it was grand yesterday
- Heard it was very good

What do you think of the Irish Red Cross volunteers?

- See Red Cross t-shirt on a fellow prisoner have more respect
- Red Cross walking around helping and making sure everything is alright
- Red Cross working well, lads go out of their way for you
- Red Cross organising things and doing a good job

What do you think of the process today?

- Very nice, pleasant and relaxed
- Hospitality brilliant
- Good to be with women for a change

What would you do if you heard someone on your landing tested positive for HIV

- Give him a rope
- Ask them to make a will
- Try to help, something can be done
- Have a discussion and then want him out of cell
- Going to tell everyone I have it so get cell on my own (laughing)
- Not a problem

Comments about sweets

- Sweets are fabulous Miss
- Sweets are lovely cause I spend all my money on tobacco
- Really nice to get sweets
- Question, Do you think most people will come for testing, definitely because of sweets
- Are ye pumping me full of sweets to keep me sweet!

Comments about IRC projects

- See difference in jail, cells kept much better
- Hygiene packs great
- Food covers very good

General comments

- New cells are great
- Treated like human beings now
- Should put sanitizer on landings not in toilets (better chance not interfered with)
- Mountjoy much better now
- Need more towels when using gym

A lot of problems with teeth mentioned on both days

- People's teeth hygiene not good
- Not allowed enough fillings
- Teeth cleaning would be good
- Me teeth not good cause of drugs

Questions asked of the prisoner community on Rapid HIV Testing Days in **Cloverhill Prison**

6th December 2011, Day 1

How did you know about today?

- Red Cross told us about it on the landings
- Last 2 weeks Red Cross talking about it
- XX (prisoner) works for Red Cross and went around with a form, doing great job
- Heard from Red Cross, got leaflet, very good

Why did you come today?

- Don't use needles but have been with a woman who does
- Have a habit of going to hookers outside
- Have wife and kids, a rope job if I have it
- Had sex other night with a man
- Test free should get it done
- Very handy having it here
- To know if you have it and not spread it
- Peace of mind

Do you think most people will come for testing?

- Foreign prisoners not interested because they are not on heroin and don't use needles
- A lot waiting at gate but their names not down
- Some don't want to know
- They don't use needles so not coming

Fearful, Hope I haven't got it

- I would crack if I have it
- Inmate had Invalid 1st test, following 2nd test, "worst experience I went through in long time, can feel my heart pounding".
- One inmate blessed himself 3 times, very fearful

What would you do if someone on your landing tested positive for HIV

- Have to get rid of them off the landing
- Know people who have it and are fine
- I would support him

What do you think of the Irish Red Cross volunteers?

- Would love to join Red Cross
- Ah Red Cross great, they are all over the world
- Great, really want to get into Red Cross course but can't, could you help me get in.
- Red Cross doing great job

General comments, TV channels very good compared to other prisons, food not bad and gym good.

- When asked why throwing sweet paper out the window, “if you did not throw stuff out windows black fellows would not have jobs”
- Have been asking for this for ages
- Practice safe sex and don’t share needles

Funny comments, Gave blood so my sugar levels low, can I have another sweet

- Miss, do you get a commission for everyone who goes through
- Few nice looking women here
- Should not be taking sweets off strangers
- Feel dizzy after that (test)
- As long as sweets coming I don’t mind being here
- These are lovely sweets

Comments about TB

- Need more Red Cross leaflets about TB
- Red Cross leaflets given out before I came in
- Hard when you are in a cell with 3, might catch it
- Quite a few comments about the fear of catching TB

8th December 2011, Day 2 in Cloverhill

How did you know about today?

- Red Cross let me know, leaflet very good
- Teachers, very helpful in the school
- Red Cross spread news
- Heard it from Red Cross in School

How have you found today?

- Everything fantastic here, very fast and better than waiting weeks
- Staff very friendly and nice in dealing with situation
- Good, eased into it
- Counsellors very nice, keep them
- Nurse made me laugh
- Everyone very good, very relaxed
- All very good

Why did you come today?

- Would not think of doing it outside
- Came to see if I am wrecked or not
- Better to be safe than sorry
- Better to know if you have it and not spread it

What would you do if someone on your landing tested positive for HIV

- I know through Red Cross that it’s not end of world
- I would tell him to move before I move him
- Talk to them, no difference
- Relative has it for years and fine
- I have shared cell with someone who has it, no problem
- Not end of world, medication there for you
- Try and help them, I would read my Red Cross book

Do you think this will help remove stigma

- People talking about it, stigma reducing
- Yes, very taboo subject
- Think so, could be intimidating

How have Irish Red Cross Volunteers helped

- Definitely doing good job, few issues they are working on

- Sit and listen to Red Cross but still a bit anxious
- Interested in making people aware of this

General comments

- Why are they all gone before me, I have been waiting longest
- Foreigners afraid if they test positive it will effect residency application
- If I am positive, will hang myself
- Thought negative would be good and positive result bad, not sure about this
- Hope this cost prison money as more chance of getting out

Questions asked on Rapid AIDS testing days in **Wheatfield Prison**

1st June 2010, Day 1

How did you know about today?

- Heard about it in the School, Red Cross on the landings, Maeve
- Red Cross lads going around the landings and talking to individuals
- There would not be anyone who did not hear about it
- Films shown by Maeve VG
- We all got leaflets, very good and easy to follow
- Shay big influence, nice fellow
- Talking about it on the landings and saying everyone should go
- Red balloons and ribbons
- All out there for everyone to notice
- Shay is the man, 100%
- Advertising
- Everybody talking/knows about it

What do you think of the Irish Red Cross volunteers?

- Red Cross told us all about it, TV, leaflets & talks
- Any time you bumped into RC team they told you about it
- Began with RC volunteers
- Volunteers very confident, positive, not holding back
- Red Cross explained all
- If not sure you can ask questions
- Very convincing
- Balloons & ribbons on every landing
- 80% will come and if you asked again In 2 months there would be a higher percentage
- RC volunteers very busy
- Very encouraging
- If it were not for Shay ½ the prisoners would not have come down
- Shay unbelievable, all boys look up to him
- Shay has right manner, good bloke
- Shay brilliant, top marks
- Would not get it done if not for Shay

General comments

- Aware how to get HIV AIDS, what to stay away from
- Can control and live normal life
- Fear they might have AIDS so good to see in black and white
- Quick result rather than waiting weeks
- Opened people's eyes to it
- Give peace of mind
- Better off to come for test
- Treatable now
- If you had a lump that might be cancer you would go about it

- Would be good to know
- Make prisoners more comfortable
- Better treated early if you have it
- Red balloons and chocolates better than Christmas
- Some afraid to go for test
- More aware now
- Better safe than sorry

Do you think this awareness has removed the stigma of having AIDS

- Definitely reduced stigma
- Not a shameful thing
- Out in the open now, not shying away
- Yes removing stigma
- Definitely getting rid of stigma
- Would not slag someone who has it now, did before this
- No shame in it
- Not look at as years ago

3rd June 2010, Day 2 in Wheatfield

How did you know about today?

- Well publicized, school, medical staff, nuns
- Red Cross (RC) volunteers and Maeve going around
- RC involved big time
- Heard on landings, encouraging each other, great idea
- Leaflets in every cell, red ribbons
- Campaign, leaflets and films very good

What do you think of the Irish Red Cross volunteers?

- Have been in prison over 20 years, Red Cross absolutely brilliant
- RC big influence and made easy to come
- Absolutely good to get this going in other prisons, definitely good to have RC volunteers in Mountjoy
- Brilliant to get help in prison
- RC very busy, brilliant, good attitude
- Lads from IRC did very good job, getting as many as possible to have test
- Should be RC in every prison, you would want it in Mountjoy
- RC guys 1000% better doing this than staff doing it
- RC very helpful and have made the difference
- If medical people came around prisoners would go back into cells

General comments

- 18 of us were to come on 1st June but because changed to 3rd only 12 came
- This is a good prison
- Not having HIV spurs you on to do more and more
- 20 minutes wait is grand, waiting 6 weeks would drive you insane
- When I saw red ribbons I started singing Happy Birthday to myself
- Sweets are lovely
- Mad not to get test
- Have test for peace of mind

Do you think this awareness has removed the stigma of having AIDS

- A lot of people were ignorant and this will remove stigma
- Not really understood before this
- Slowly but surely coming together and removing stigma
- Going in groups removes stigma

Feedback re first day of testing on 1st June

- Heard there was a good attitude from everyone
- Nothing to be worried about
- There was a good turn out
- Heard it was great
- Everyone looked after
- Run very well
- Sweets

You seem to be encouraging each other to come for the test

- More have come together than if on outside because of camaraderie
- Get support from RC volunteers because we know them
- Everyone I know coming for test
- Support within groups on landings
- Would have been nervous doing it on my own

How did you find the counselling session today

- Any fear instantly allayed by information you get from lady
- Very professional and informative
- Everything done powerful
- Counselling grand
- Very helpful
- Ask question and get answer

Fearful, My nerves gone

- Some terrified, leaflet very good
- My nerves at me and wanted to know if I had it, I know I don't but want to put my mind at ease
- A lot of the guys anxious
- Frightened shite out of me 2nd test
- Hardest part is waiting, freaking out
- Not worry as much when you get answer straight away
- After 2nd test feel very anxious
- Thank God it's done

Awareness of HIV AIDS

- Makes you more on the ball about HIV AIDS, especially about unprotected sex
- A lot did not know how you get HIV AIDS
- Leaflet gets to point
- Serious thing better to find out

Since Irish RC volunteers have raised hygiene awareness have you noticed a difference?

- Yes, because RC went on landings it gave everybody incentive
- Have been in most jails in the country and this is cleanest
- More aware of cleanliness, more bags, RC signs up a help
- Opened a lot of people's eyes to washing hands
- Jesus Christ hygiene much better, prison cleaner, landings cleaner
- Hand washers very good when filled, when not used for drinks
- One of the cleanest prisons I was in
- Definitely working, wipes for phones, wipes on landings, in gym, computer shop
- Showers are cleaner, more chemical cleaners available

Suggestions made

- Should do HEP tests as well
- Should have support group for people with HIV

29th June 2010, Day 3 in Wheatfield

How have you found today, is there anything we could improve on

- Very well done today
- Test is done before you realise it's done
- Nothing to improve on, made a lot of difference
- All sound, great
- Everyone very nice
- Girl explained very well (re counselling)
- All very good, stops you thinking maybe I have it, if I was told yes I would look for a rope

Did you receive the letter from Graham explaining why the delay in testing for some people

- Yes, the letter was very good, let people know you are thinking of them
- Everyone thought they were not getting done, good to explain everything, not forgetting about us
- Nice to know we are not being ignored
- Letter and posters very good
- Letter a good idea

Have you heard about the Smoking Cessation Classes?

- Yes, new approach to stopping smoking
- Good idea, anything to get people off cigs
- Yes, a guy on our landing is off a few weeks now, having the odd sly one but on the way
- It's very boring in here, nearer the end of my sentence I will give up
- Half the jail on a dummy cigarette with the cartilage, very good, have cut down a lot
- Would like to give up smoking but not while in jail, it's very boring
- Smoking course only on Thursday but can't go on Thursdays
- Definitely want to give up, will go to next course
- Everyone smokes here, it's very hard to give up

Any examples of how Irish Red Cross volunteers have helped

- They highlight diseases and how to prevent catching them
- Think they are doing a fantastic job, keep it up
- Definitely making a difference
- Good ideas came from IRC volunteers
- Would never have known about the RC until they started explaining health and safety
- Water filter one big improvement, crystal clear now, water in cells is putrid
- RC wear t-shirts and put stickers on drinking water
- RC made us all very aware
- Bins and filtered water very good, water in cells is still very bad

Comments made re Hygiene

- RC do good work, they make sure the landing is nice, very clean now
- Definitely without a doubt there is a huge difference in the hygiene
- Don't have to wait around for cleaning stuff
- Do a lot with hygiene awareness
- Get proper cleaning equipment now, nowhere close before
- RC doing v. good work, they go around every Sunday checking and get cleaning stuff for us

General comments

- This(Wheatfield) is like the Hilton compared to Mountjoy
- Maeve is my number 1 here
- Had to wait 4 months for results of previous AIDS test, too long, like a weight off my back when I was ok
- I only came because of the sweets
- You could improve the music was first thing I thought about
- Flowers very nice
- Good getting done on mass scale
- You don't just do test for yourself, do for family and friends
- 3 years waiting for test
- The films about AIDS they showed on the landings were very good

Annexe 2

Examples of the Guided Reflective Exercise undertaken with IRC volunteer inmates

To do this exercise you need to deeply reflect on yourself both before and after becoming an IRC volunteer and make some statements about how you feel about yourself and the place you live in.

Think of a time in prison before you became a Red Cross Volunteer What can I see, hear and feel about myself?	Level	Think of a time since you have been working as a Red Cross volunteer in the prison What can I see, hear and feel about myself?
I see a lot of inmates doing Red Cross and they introduce me as well	Goals What are my goals?	I'm proud of myself of being a volunteer of Irish Red Cross and want to continue after prison.
I'm always down, thinking of can I make it in prison?	Identity Who am I?	I have really changed from who I am when I first came to prison.
All my belief is in doing my time and learn something while I'm in prisons	Beliefs and Values What do I believe in and what is important to me?	To make myself available whenever I'm needed for volunteering.
I'm not very bold to express myself to any inmate before	Capabilities What am I able to do?	I'm bold to do some volunteer work, like going to landing telling inmates about the Red Cross.
My behavior was very bad before	Behaviours What am I doing?	My behavior is totally changed at the moment.
I feel not safe when I came into prison	Environment What is this place like?	I feel really safe now with the work of Irish Red Cross

Before		After
No goals	Goals What are my goals?	Since starting Red Cross my goal was to complete the course and pass on my experience to other prisoners.

Before starting – didn't know who I was. I was very shy especially talking in front of a group.	Identity Who am I?	Since starting I'm able to speak in front of a large group and not shy anymore.
I didn't believe in getting educated in prison	Beliefs and Values What do I believe in and what is important to me?	Now I believe it's important to learn and get educated whilst in prison because of the Red Cross
I wasn't capable of doing anything	Capabilities What am I able to do?	I'm capable of doing things for myself such as going to school, working and communicating with other people.
Unsure of the unknown	Behaviours What am I doing?	I find myself taking time out to talk and listen to other people
I was on a basic landing.	Environment What is this place like?	I'm on enhanced and the environment is much better

Before		After
To get off drugs. Girlfriend. Settle down within family.	Goals What are my goals?	My past goals are active
Nobody. Drug addict	Identity Who am I?	I have friends who are drug free, keeping fit. Caring person. Not violent anymore
Nothing	Beliefs and Values What do I believe in and what is important to me?	Family, future, staying drug free. Getting a job
None. Drugs Fighting. Waste time	Capabilities What am I able to do?	Read. Live drug free. Talk to people. Have my family back
Violent. Angry. Drug abuse. Medicated	Behaviours What am I doing?	Red Cross. I am drug free. Works in the kitchen
Horrible	Environment What is this place like?	Good because of the Red Cross.

Before		After
No goals	Goals What are my goals?	Get released and now make a difference
Me	Identity Who am I?	Red Cross volunteer
Do your time and get out	Beliefs and Values What do I believe in and what is important to me?	Help people while doing your time and make a difference.
Not been able to make a change	Capabilities What am I able to do?	Give input into changes and have positive results.
Gym / work	Behaviours What am I doing?	Getting involved in projects and interacting more.
Bad, dirty place	Environment What is this place like?	Since the Red Cross it's got a lot cleaner.

Before		After
To get out of jail.	Goals What are my goals?	To improve living conditions
Just another prisoner	Identity Who am I?	Volunteer taken serious by inmates and staff.
Need a cleaner, friendlier place to live	Beliefs and Values What do I believe in and what is important to me?	Achieved cleanliness. Keep it that way.
Very little in relation to movement around the prison	Capabilities What am I able to do?	Free movement. Act as a role model for the lads.
School / Gym	Behaviours What am I doing?	School/gym. Cleaner landing. Helping people.

Bad place. Dirty and violent	Environment What is this place like?	Much cleaner – less hostile.
Before		After
I had no goals when I came to prison	Goals What are my goals?	It all changed for me when I joined the Red Cross. Now I want to better myself.
Confused to everything	Identity Who am I?	Now I know I can do anything with the confidence I have gained through the Red Cross.
Beliefs and values – had few.	Beliefs and Values What do I believe in and what is important to me?	Now I know there's more to life than prison.
Not cooking	Capabilities What am I able to do?	Now working in the kitchen. Learned to cook.
Kept things bottled up.	Behaviours What am I doing?	Now I can talk to others.
Dirty	Environment What is this place like?	Cleaner and more relaxed

Annexe 3

Community Based Health & First Aid Programme

Summary of Modules & Topics

7 Modules, some compulsory, others optional depending on the health needs identified

- Modules 1, 4 topics
 - The International Red Cross Red Crescent's history and organizational structure, Emblems, Seven Fundamental Principles, National Red Cross Society, Community Based Health & First Aid (CBHFA) *in action* volunteer.
- Module 2, 4 topics.
 - Communication and building relationships, volunteers identify groups and meet with potential partners for the CBHFA programme, implement an awareness-raising meeting to inform the community, promote CBHFA *in action* activities.
- Module 3, 8 topics.
 - Assessment of the community by volunteers through direct observation and community mapping, identify and prioritize health, first aid and safety issues, develop a CBHFA action plan, learn specific skills and knowledge based on needs identified during the assessment, report on activities in the community.
- Module 4, 20 topics.
 - Accredited First Aid Course. Volunteers learn how to assess, plan, implement and evaluate first aid for various injuries and illnesses and practice communicating injury prevention messages with members of their community.
- Module 5, 2 topics.
 - Major emergencies and how that may affect the community, preventing and responding to epidemics.
- Module 6, 16 topics.
 - Disease prevention and health promotion including Nutrition, Immunization and Vaccination Campaigns, Safe water, Hygiene and Sanitation, Diarrhoea and Dehydration, Acute Respiratory Infections, HIV and Sexually Transmitted Infections, Reducing Stigma and Discrimination, Tuberculosis, Influenza. Volunteers support the community to adopt healthy behaviours.
- Module 7, 8 topics.
 - Focuses on providing community education and assistance, for example, volunteers learn about Overdose Prevention highlighting the dangers of taking drugs.
- Additional Module
 - Non communicable diseases such as Cardio Vascular & Chronic Lung Disease, Cancer and Diabetes.

Additional topics relevant to the prison context such as Mental Health Awareness and a Culture of Non-Violence & Peace are also included.

The projects that are undertaken by the Irish Red Cross Volunteer Inmates either emerge from the Community Assessment in Module 3 or as a result of a Health Emergency that arises, or linked in with national health educational campaigns

Annexe 4

Interview Questions/Focus Group Guideline Developed by the Western University MPH Student and Collaborative group of Critical friends

Governors:

1. What contributions do you think the Red Cross Volunteers Inmates/the program has made in your prison?
2. How has the prison changed since the Red Cross program has been in operation in your prison?
3. Can you comment on the behavioral changes seen in the Red Cross Volunteer Inmates?
4. What factors have contributed to the success of this program in your prison?
5. What factors have impeded the success of this program in your prison?
6. How do you increase awareness of the program amongst current and new employees in your prison?
7. Can you roughly quantify how many man-hours the program has saved in your prisons since implementation?
 - a. Thinking about health initiatives, weapons amnesty, drug over dose initiatives etc.?
8. Can you discuss the program in relation to the strategic plan for your prison?
9. How do you see the program evolving in your prison?
10. What other needs in your prison would you like the program to address in your prison?
11. Do you have any other general comments or ideas that you would like captured?

Prison Staff: Chief Officer/Officer:

1. What motivates you to volunteer with the program?
2. How has the prison changed since the Red Cross program has been in operation?
3. Can you comment on the behavioral changes seen in the Red Cross Volunteer Inmates?
4. Describe how the CBHFA has contributed to your work (Think of making your work easier or harder)?
5. What factors have contributed to the success of this program in your prison?
6. What factors have impeded the success of this program in your prison?

7. Can you comment on the perceptions of your colleague who are not directly involved in the program about the program?
8. How do you change the perceptions of your colleagues about the program?
9. How do you increase awareness of the program amongst your colleagues?
10. Do you have any other general comments or ideas that you would like captured?

Red Cross Volunteer Inmates:

1. What motivates you to volunteer with the Red Cross in your prison community?
2. What are the advantages to being a Red Cross volunteer?
3. What are the disadvantages of being a Red Cross volunteer?
4. Can you describe how the program has affected you?
5. Can you explain some barriers you face as a volunteer?
6. Can you explain some things that help you as a volunteer?
7. Do you have any other general comments or ideas that you would like captured?
8. Can you comment on the perceptions of your peers who are not directly involved in the program about the program?
9. How do you increase awareness of the program amongst your peers?
10. Do you have any other general comments or ideas that you would like captured?

Teachers

1. Can you give examples of how the prison management (staff, prison guards, ACO) have supported or not your role/function in the CBHFA trainings and action in the community?
2. Can you give examples of how the prison management (staff, prison guards, ACO) have not your role/function in the CBHFA trainings and action in the community?
3. What motivates you to be involved in the teaching aspects of the Red Cross?
4. Can you comment on educational interests or pursuits of the inmate Red Cross volunteers compared to non-volunteers?
5. What factors have contributed to the success of this program in your prison?
6. What factors have impeded the success of this program in your prison?
7. Do you have any other general comments or ideas that you would like captured?

Nursing staff

1. What health effects do you think the inmate Red Cross Volunteers have made in your prison?
2. Can you describe what effect the program has had on the health of the prisoners?
3. Describe how the CBHFA has contributed to your work as a nurse/pharmacist?
4. Can you describe your first impression or thoughts of the Red Cross initiative?
 - a. Can you describe your current impression or thoughts?
5. What factors have contributed to the success of this program in your prison?
6. What factors have impeded the success of this program in your prison?
7. Can you comment on the perceptions of your colleague who are not directly involved in the program about the program?
8. How do you change the perceptions of your colleagues about the program?
9. How do you increase awareness of the program amongst your colleagues?
10. Do you have any other general comments or ideas that you would like captured?

Annexe 5

Secondary Data showing the lists of Types of Projects Implemented by Volunteers within each prison from their year of commencement

Wheatfield Prison Commencing June 2009

- Hand washing technique and glow box demonstrations
- Hygiene awareness and prison cleanliness
- Swine flu awareness
- HIV testing and Anti Stigma campaign
- Better drinking water
- Facilitate Smoking Cessation Courses with good success rate
- F.A.S.T Campaign (Stroke)
- Drug awareness & counselling project
- Weapons Amnesty launched in June 2012 and re launched from time to time, results show between 95% and 100% success rate
- Winter vomiting bug prevention
- Assisting prisoners with reading difficulties
- Hepatitis survey
- Red Cross newsletter
- Tuck shop survey and promotion of healthy eating
- Actively involved with new committals
- First Aid demonstrations on landings & First Aid competition
- Dental Hygiene Project linked to the Dublin Dental Hospital with results showing there were 40% less appointments with the dentist
- TB awareness
- Provide information relating to probation and psychologist services
- The design of a Christmas card for prisoners who in some cases never send a card due to literacy problems, the volunteers wrote whatever message was required
- Supported Liberty Community Outreach project to supply 500 Hampers to families for Christmas
- Red Cross Restoring Family Links
- Paracetamol project and a reduction in use of approx 30%
- BMI & Blood Pressure recording
- In 2013, a Sun Care Awareness project relating to skin cancer
- The Blue September campaign covering Testicular, Prostate, Bowel, Lung & Skin Cancers

- Safe use of antibiotics and unnecessary proscribing in cases of viral infection
- Recycling clothes for Enable Ireland
- Flu vaccination promotion for vulnerable inmates
- Insanity Fitness Regime since end of 2013 is a massive success as fitness really appeals to inmates
- Survey on Institutional intercourse & homophobia in the prison
- IRC Culture of Non Violence & Peace (CNV) Workshop
- Along with MQI Addition Counsellors IRC volunteers facilitate Overdose Prevention training

Cloverhill Prison Commencing February 2011

- General Hygiene Awareness
- 6 stage Hand wash & use of Glow box
- TB awareness
- Mass HIV testing and Anti Stigma Campaign
- Paracetamol Reduction project
- Colour coding cleaning equipment for different areas
- Underwear project
- No spitting
- Winter Vomiting bug awareness
- F.A.S.T. Stroke Awareness Campaign
- Supported the Golden Mile Charity Fundraiser
- Red Cross Notice Boards around the prison
- Risks of taking Benzos project
- Introduction leaflet for new prisoners
- A Christmas Food Appeal for Crosscare, 3 wheelie bins of food collected

Shelton Abbey Open prison Commencing February 2011

- Hygiene awareness around toilets, showers & gym
- Hand washing technique
- New soap dispensers and bin disposal
- Re-cycling project
- Stroke awareness
- Red Cross Newsletter and information board
- Men's health promotion
- Hepatitis C awareness campaign

- Induction meetings with new committals
- Adapting to a new environment launched in later quarter of 2013, this involves meetings every Tuesday facilitated by IRC volunteer inmates for all newcomers, topics include
 - Staying drug & alcohol free
 - Being in an open prison
 - The newness of open spaces
 - Consequences of doing a runner
 - What do I do in the evenings
 - Any difficulties as they arise
- Drinking water filters
- Fixed sterotone pumps
- Smoking cessation group
- Fitness & Health Project
- Movember, raised over €600 for charity
- Xmas Santa and face painting for children
- Mental Health Awareness
- Party for the elderly
- Suggestion box
- More payphones
- Medication in Possession
- Sun smart awareness/sunscreen dispensers
- Tuck shop survey and implementation of healthy options
- Access to Health promotion channel
- Providing maps of Dublin/other and useful phone numbers for Temporary Release packs.
- Halloween Party

Training Unit Commencing January 2012

- Hand washing technique demonstrated & hand gel dispensers installed in visiting area
- Cholesterol checked on up to 90% of the prison population
- Nutrition Awareness
- Deep cleaning implemented & promotion of hygiene in communal areas
- Preventing sunburn and the placing of sunburn lotion dispensers
- Facilitate Smoking Cessation Courses
- Winter Vomiting Bug Awareness
- Sexual Health linked to leaving prison

- Supported fundraising for Crumlin Children's Hospital
- Clothes collection for St. Vincent de Paul
- Tuck shop healthy options
- Induction for prisoners in for the first time
- Personal & Community Hygiene Awareness week in December 2012
- Red Cross Health Challenge supported by medics
- Volunteers produced a DVD giving info on CBHFA course and sample projects undertaken
- IRC Newsletters
- In advance of the exodus for Christmas, a drug carrying campaign along the lines of the Packing Project in Cork Prison
- On 6th March 2014, a cheque presentation of €1,500 to the IRC in aid of the Philippines Appeal. Funds were raised through a sponsored football match between inmates in the Training Unit & Shelton Abbey held in Wheatfield on 28th January and the sale of IRC Christmas cards

Dochas Centre Women's Prison Commencing February 2012

- Contraception protection for women being released from prison
- Promotion of Smear Tests
- 6 stage hand washing technique and using the Glow box
- Winter vomiting bug and disease prevention
- Avoiding sunburn
- Vaccinations against diseases such as Hepatitis
- Influenza awareness
- Personal hygiene
- Support to new prisoners

Mountjoy Prison Commencing May 2012

- Food covers for prisoners when collecting their food to bring back to cells
- Demonstrations of the 6 stage hand washing technique and Glow box
- Colour coded mop system and new washing machines
- Instillation of new sinks
- IRC Newsletter
- Suggestion boxes and information boards on landings
- Mass Chest X-ray screening for TB, with just over 80% /400 prisoners screened which was considered a record and attributed to the encouragement by the IRC volunteer inmates.
- Rubbish disposal arranged

- Milk project to get cold milk with each meal
- Tuck Shop survey re healthy options
- To mark International Day for the Elderly on 1st October, in 2012 & 2013 a group of elderly & their carer's were provided with afternoon tea, entertained with music and dancing.
- Flu prevention campaign
- Gojo soap dispensers in all areas
- Hepatitis vaccinations awareness
- Mental Health First Aid
- Anti stigma Awareness campaign
- Rapid HIV testing in June 2013, 72% tested
- Hepatitis awareness
- Smoking Cessation Course
- No Spiting campaign
- Training CBHFA volunteers in St Pats
- General waste recycling and instillation of green bins
- Exit Packs for prisoners
- Gojo shower gels
- Phone Bubbles for the yard
- Provision of defibrillators on four landings
- MoVenber project, 15 volunteers grew moustaches to raise funds for the Cancer Society
- Volunteers promoted activities during the Christmas period i.e. Bingo, Karaoke & Games
- X-Factor event in December 2013 that disabled people and carers
- Money raised by prisoners for Cancer Society and IRC Philippines Appeal doubled by Governor
- Donor Awareness Week in April 2014 with a talk by a double lung transplant recipient
- €1,000 cheque presentation on 16th May 2014 to Irish Cancer Society by volunteers from funds raised through a cake sale with an extra donation by the Governor.
- Volunteers with the support of staff organised *Mountjoy Got Talent* event on 14th July 2014 for 26 guests from two organisations that look after people with Downs Syndrome and Autism
- Testicular Cancer Awareness on 8th October 2014
- Mental Health & Suicide Awareness on 10th October 2014

Portlaoise Prison Commencing January 2013

- Hand washing technique and glow box demonstration
- The provision of hand sanitizers and water dispensers

- Colour coded buckets & mops for cleaning project
- Tongs & Hats to be used by staff in kitchen
- TB Awareness
- Stroke Awareness FAST Campaign
- National No Smoking Day 31st May, no smoking signs, survey carried out
- Men's Health Awareness
- Body Mass Index recording
- STI, Sexually Transmitted Infections
- Hepatitis A, B and C awareness
- Medical form for prisoners attendance at the hatch has helped to create privacy
- Focus on drug addiction
- Red Cross Buddy, card on cell door identifies IRC volunteer inmates
- Don't be a SAP follow the Sunscreen Action Plan
- Relapse Prevention Group
- Tuck shop, healthy options introduced

Castlereagh Prison Commencing January 2013

- Hand washing & soap dispensers project
- Kitchen food hygiene
- Principles written in different languages including Russian on posters around the prison
- Induction support by IRC volunteers to new committals
- Tuck shop healthy options
- Toilet seats in cells
- Cut out spitting posters
- IRC volunteers revamped gym in the Grove Area
- Room turned into a library in the Grove and books supplied by staff and local book shops
- General Health, Cancer, TB, Mental Health & Suicide Awareness projects
- F.A.S.T. Stroke Campaign
- Vaccinations for Hepatitis and Flu
- Toe to Toe Literacy support
- Health Screening
- Yoga promotion
- NCD's, Heart attack and Stroke, Blood Pressure monitoring, Cancer Awareness, Diabetes
- Drug Awareness

- Intercultural Day, i.e. Polish, Irish Travellers, Romanian, Chinese etc,
- Safe Zone introduced in the school
- Fitness week
- New committals information leaflets
- Mental Health Awareness Week in February 2014, 296 prisoners visited
- Christmas Concert & Quiz
- Stress awareness questionnaire
- Visiting room, made a section friendlier for children
- RC Meeting area with a computer
- Mural in yard
- Photos of volunteers on landings and stickers on cell doors
- Hep B awareness
- Suicide awareness campaign
- Notice boards & suggestion boxes now on landings
- Harm Reduction Awareness on leaving prison
- First Aid skills demos
- Cancer Awareness Week

St. Patricks Institution (Juvenciles) Commencing January 2013

- Cell packs and cell bin bags
- Wheelie bins on landings
- Shop, toothbrushes, toothpaste, porridge and pasta now on sale
- Colour coded mops and buckets
- Store rooms cleaned and painted
- Volunteers promoted a men's health clinic
- New Triage system promoted by volunteers
- Hand washing demonstrations in the school
- Circuit training and bleep test
- Railings painted on landings by a rota of volunteers
- Showers painted, pest control was used for clearing cock roaches
- Mural painted in the yard with Red Cross emblem

Cork Prison Commencing January 2013

- 1-page info on the CBHFA programme distributed by volunteers to each cell

- Interviews & Questionnaire to medics, teaching, discipline staff and prisoners
 1. What health concerns do you have?
 2. How do you think you can help us address our health concerns in the prison?
 3. What hygiene concerns do you have?
 4. Is there a suggestion you can make to reduce drug abuse in the prison
 5. What are the major mental health issues in the prison?
 6. How can Red Cross improve any/all health issues?
- IRC Information Boards installed
- Packing campaign around carrying drugs and mobile phones internally.
- Reinstatement of toilet seats in toilet areas
- Hand wash dispensers
- Health Awareness Day
- Induction information for prisoners
- Committal cell, paint IRC logo
- Tuck shop survey, healthy foods allowed
- Diabetes Awareness Day
- Shaving heads in aid of the Irish Cancer Society
- Mental Health Awareness project made a huge impact and as a result Cork Prison Focus Group on Mental Health Concerns led by their Chief Nursing Officer Joe Faulkner and HSE Mental Health Services were featured at a HSE event in Cork on 11th June.
- A Bullying project through films showing scenarios drawn up by IRC volunteer inmates, actors were brought in for filming purposes

Limerick Prison (Males) Commencing January 2014

- Personal, hand and environmental hygiene to include demonstrations with the Glow Box, Towels now being provided in the Gym
- Dental Hygienist session
- Red Cross Times Newsletter produced as joint initiative between male & female volunteers
- Drop boxes installed for healthcare leaflets
- Deep Cleaning Programme initiated
- Health & Fitness event on 28th May
- Photo ID's for volunteers and stickers for cell doors
- Personal, hand and environmental Hygiene Project
- Dental Hygiene project
- Soap dispensers installed

- Colour coded Mops & Buckets
- Induction leaflet
- Non slip mats in showers
- Paracetamol project
- IRC notice boards
- 300 plate covers and 200 toilet brushes provided
- Non spitting campaign
- Fit & reach exercise training
- Focus on sugar and how it is contained in foods/drinks and the damage it can cause
- Fundraiser for Pieta House which is a suicide and self harm crisis centre
- Took part in Movember campaign
- Focus on Men's Health and had a doctor speak about prostate cancer
- A3 Calendar for 2014 showing Healthcare projects for each month
- Making changes for the better to visiting box area

Limerick Prison (Female Section) Commencing February 2014

- Personal & Prison Hygiene
- General health & wellbeing
- Women knitting baby blankets for the Irish Premature Babies charity
- Articles produced for Red Cross Times Booklet
- IRC Therapeutic Hand Care Course and Neck & Shoulder massage training provided to females on 12th July 2014. The volunteer leader & secretary will provide the training to other inmates on a monthly basis

Midlands Prison Commencing January 2014

- Community Assessment Survey with nearly 900 questionnaires distributed by volunteers
- Hygiene awareness and Glow box demonstrations
- Survey results showed the need for awareness on Mental Health, Diet & Smoking
- Milk Carton Recycling project aimed to improve hygiene standards, reduce waste & save money
- IRC volunteer inmates provided with a 2 day cleaning course in advance of the colour coded mops & buckers system being introduced.
- Cleaning the whole jail
- Anti litter campaign
- Tuck shop survey and new healthy options available
- Recycling taking place

Arbour Hill Prison Commencing January 2014

- Prison & personal hygiene awareness,
- Cleaning packs for cells
- A questionnaire survey carried out by volunteers on their prisoner community that included, age range, health issues, recreational activities etc showed very interesting results including the fact the 20% of prisoners are diabetic. This is possibly because Arbour Hill has a large population of elderly men.
- Educating prisoners to be more aware of elderly.
- Volunteers helping older prisoners by cleaning their cells, collecting their meals & bed making
- Tuck Shop survey, more healthy options available and diabetic chocolate
- IRC volunteer inmate First Aiders carry a small black bag that has an IRC emblem on their belt, it contains disposable gloves and mouth shields. They also keep all first aid boxes properly stocked.
- Awareness campaigns on Paracetamol misuse, Testicular Cancer, Stoke and Smoking
- Meet new committals and a rotas of volunteers on call for prisoner support
- Prison visiting area being updated so it's more pleasant
- Washing up liquid & toothpaste to every cell was really appreciated by prisoners
- Art competition re mural in the yard
- Now have fresh fruit in the shop
- Suggestion box
- Keeping an incident report book i.e. when First Aid provided by volunteer

Medical Unit at Mountjoy Prison Commencing February 2014

- *Rub a dub dub – Give your hands a scrub* and glow box demonstrations
- Colour coded Buckets & Mops system
- Testicular Cancer Self Awareness project
- Stop spitting posters
- Coughing & Sneezing etiquette
- New laundry service on landings now in place, this entails each cell having 2 net bags, large for clothes and small for socks and underwear and an allocated day for collection.
- New washing machines installed

Loughan House Open Prison Commencing February 2014

- Hygiene & Cleanliness
- Organ Donor awareness

- Non smoking day
- Blood pressure screening
- Projects around men's health & fitness
- Cancer awareness
- Setting up a Monthly Red Cross newsletter.
- Supporting charities - Making an album '*THE FF Henders*' they hope will sell in tuck shops in other prisons with proceeds going to 3 charities including the Irish Red Cross.
- Volunteers completed an Industrial Cleaning Course
- Colour coded Mops & Buckets
- Health Promotion Week with 2 guest speakers who were recipients of kidney donations
- Have taken responsibility for keeping the gym clean and tidy encouraging healthier environments
- Induction pamphlet for new committals
- Cleaning of the tennis court so that it's fit for use, thus encouraging exercise amongst inmates contributing to NCD promotion.
- Recycling