




Second National **Intercultural Health Strategy** 2018-2023



Seirbhís Sláinte
Níos Fearr
á Forbairt

Building a
Better Health
Service





“We all should know that diversity makes for a rich tapestry, and we must understand that all the threads of the tapestry are equal in value no matter what their colour”

Maya Angelou

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FOREWORD



I am very pleased to introduce the HSE's second National Intercultural Health Strategy, which builds on the great work done on the first strategy which was launched in 2007.

The world has become increasingly global and migration is an international reality. The United Nations Migration International Report of 2017 states that the number of international migrants worldwide has continued to grow in recent years and reached 258 million in 2017. In 2016, the total number of refugees and asylum seekers in the world was estimated at 25.9 million people.

People move continents and settle in different countries for many reasons. They search for new opportunities and improved quality of life. They are escaping poverty, fleeing persecution, conflict, or forced displacement. While this mobility, and subsequent integration into new communities results in many benefits for both society and for migrant families, it is also true that some migrants remain vulnerable and in need of additional supports and targeted interventions.

Ireland has welcomed people from other countries for many years. People have reached our shores through various means: as economic migrants, through family reunification, via seeking asylum, through the Irish Refugee Protection Programme, or as foreign students.

While this new diversity has enriched Irish society, it has also provided challenges for service users in accessing and navigating unfamiliar public services and for service providers in ensuring delivery of appropriate, culturally competent services.

The HSE is a key point of entry for people of all ethnic, cultural and religious backgrounds. It is incumbent on us to respond sensitively and effectively to their unique needs for care and support. At the same time, given the diversity of our workforce, we must ensure that all staff feel valued, and are encouraged and supported within an ethos of interculturalism.

This HSE second National Intercultural Health Strategy provides such a framework, incorporating elements of other relevant government strategies and associated obligations for ourselves. The Strategy is underpinned by the core principles of equity, accountability and an evidence informed approach.

I am delighted to introduce this strategy which offers a comprehensive, coordinated approach towards ensuring provision of a quality response to the health and social care needs of people from diverse ethnic and cultural backgrounds.

The HSE is firmly committed to its implementation and we look forward to working with you.

A handwritten signature in black ink, appearing to read 'Pat Healy'.

Pat Healy

National Director Community Strategy and Planning

ACRONYMS

AITHS	All-Ireland Traveller Health Study
CRC	Convention on the Rights of the Child
CSO	Central Statistics Office
CSW	Commission on the Status of Women
DCYA	Department of Children and Youth Affairs
DOH	Department of Health
DOJE	Department of Justice and Equality
EEA	European ESTHER Alliance
EHIC	European Health Insurance Card
EIGE	European Institute for Gender Equality
EROC	Emergency Reception and Orientation Centre
ESRI	Economic and Social Research Institute
EU	European Union
FGM	Female genital mutilation
FRHAP	Family Reunification Humanitarian Admission Programme
GBV	Gender-based violence
HSE	Health Service Executive
HCV	Hepatitis C Virus
HIQA	Health Information and Quality Authority
HIV	Human immunodeficiency virus
HPSC	Health Protection Surveillance Centre
HRC	Habitual Residence Condition
ICGP	Irish College of General Practitioners
IFPA	Irish Family Planning Association
IOM	International Organization for Migration
IRPP	Irish Refugee Protection Programme
LGBTI+	Lesbian, gay, bisexual, transgender and intersex
MRCI	Migrant Rights Centre Ireland
NDTRS	National Drug Treatment Reporting System
NGO	Non-government Organization
NIHS	National Intercultural Health Strategy
NPIRS	National Psychiatric Inpatient Reporting System
NTRIS	National Traveller and Roma Inclusion Strategy
NWCI	National Women's Council of Ireland
NYCI	National Youth Council of Ireland
ORAC	Office of the Refugee Applications Commissioner
PHE	Partnership for Health Equity
PTSD	Post-traumatic stress disorder
RCPI	Royal College of Physicians in Ireland
RCSI	Royal College of Surgeons in Ireland
RIA	Reception and Integration Agency
ROI	Republic of Ireland
NI	Northern Ireland
SAC	Scientific Advisory Committee
SATU	Sexual Assault Treatment Unit
WHO	World Health Organization

EXECUTIVE SUMMARY

Context

This HSE *National Intercultural Health Strategy* (NIHS) provides a comprehensive and integrated approach to addressing the many, unique, health and support needs experienced by the continually increasing numbers of service users of diverse ethnic and cultural backgrounds who live in Ireland.

Various cross government strategies contain specific actions assigned to the HSE in respect of the health status, experiences and outcomes of members of minority ethnic communities across the country. This document represents a strategic response to integrating these actions, together with a range of additional specific health related actions arising from consultations, learning from implementation of the first HSE NIHS and evidence from international and national research.

The Health Service Executive (HSE) holds responsibility for provision of a comprehensive system of accessible and high quality healthcare. This means taking into account the increasing ethnic and cultural diversity of the population, planning for the involvement and participation of service users from disadvantaged communities, and, where necessary, adapting services to meet the needs of the entire population, by responding to diversity.

The HSE *Corporate Plan* (2015a) and the HSE's planning and delivery of health services are both underpinned by the principles of social inclusion, equality and a population health approach. This requires development of appropriate measures to reduce health inequalities and to address the range of economic and social factors - including poverty and discrimination - that affect equality of access to healthcare. This approach is further endorsed by the publication of the *Sláintecare* report (2017), which considers the role of social determinants of health, the imperative to address health inequalities and the importance of adequate resourcing of health promotion and public health approaches.

The vision for this second NIHS is:

A health service that provides high quality responsive care to all service users from diverse ethnic, cultural and religious backgrounds.

A health service that empowers service users from diverse ethnic, cultural and religious backgrounds to access services.

A health service where service providers are confident in providing culturally competent services to this cohort.

The second NIHS recognises the important work that has been carried out to date by the HSE to promote equality and reduce health inequalities in Ireland. Building on what has already been achieved, this second NIHS continues to stress the importance of equality of access to health services, particularly for women migrants and disadvantaged minority ethnic communities.

The commitment to develop this strategy is supported by a number of key policy and legislative developments, which have taken place in recent years and have relevance for the situation of members of minority ethnic communities. (A full list and detail of these policy developments relevant to intercultural health can be found in Appendix 2.)

The Strategy

This strategy comprises three parts:

Part 1 (Chapter 1) of this document presents the strategy itself, including its vision, guiding principles, goals, strategic objectives within each goal, as well as actions required. In relation to certain actions, the strategy sets out the timeline, partner and/or lead bodies, and ‘strategic alignment’ – the existing policy document to which each action relates.

Part 2 sets out, in a series of chapters, the context and background to the development of this second NIHS. Chapter 2 outlines the consultation process that informed its development; Chapter 3 provides the evidence base for the strategy; Chapter 4 sets out relevant health system challenges; and Chapter 5 relates to data collection issues. Throughout these chapters, the actions of the strategy are presented, as they relate to the evidence; in this way, this document presents a strong evidence base for each of the strategy’s actions.

Finally, **Part 3** (Chapter 6) is entitled ‘Towards an implementation plan for the second NIHS’. This chapter sets out plans and future milestones for the proposed development of a detailed implementation plan for this strategy, which should be published within four months of the launch of the strategy.

Guiding Principles

- Equality and rights-based approaches underpin the second NIHS.
- A whole organisational approach is advocated, whereby service users are cared for on the basis of need in the first instance.
- The strategy is aligned with all existing policies and programmes.
- An evidence-based approach is taken towards planning and developing interventions.
- Targeted interventions are developed, where necessary, to enable access and participation for all excluded groups.
- Emphasis is on provision of high-quality, patient-centred services.
- The role of community and voluntary organisations is acknowledged.
- Active, meaningful service user involvement is facilitated in the design, delivery and evaluation of services.
- Community development principles are used in engaging with service users and development of peer-led interventions.
- Cost-effectiveness and value for money are key considerations.



Goals and strategic objectives

GOAL 1:

Enhance accessibility of services to service users from diverse ethnic, cultural and religious backgrounds.

- Provide information in accessible, culturally responsive ways.
- Develop a model for interpreting provision across the HSE.
- Develop an evidence-informed system of translating information.

GOAL 2:

Address health issues experienced by service users from diverse ethnic, cultural and religious backgrounds.

- Implement cross-government obligations in respect of health needs of service users.
- Implement national obligations in relevant cross-departmental strategies.
- Promote a model of health screening and prevention.
- Address health inequalities relevant to service users in relation to oral health, sexual health, reproductive health, children and young people, LGBTI+, disability, men, mental health and palliative care.

GOAL 3:

Ensure provision of high-quality, culturally responsive services to service users from diverse ethnic, cultural and religious backgrounds.

- Provide intercultural awareness training to all relevant staff, and take into account the needs of staff who work with a diverse population.
- Ensure that services are planned and delivered in a context of cultural competence and in line with requirements of the public sector duty and related obligations.

GOAL 4:

Build an evidence base.

- Work towards the development of high quality data collection, monitoring and evaluation to build an evidence base on minority ethnic health and ensure evidence-informed practice.

GOAL 5:

Strengthen partnership working to enhance intercultural health.

- Actively promote participation of service users from minority ethnic groups in the design, planning, delivery and evaluation of services.

Strategy Development

This Strategy is informed by a consultation process involving three main stages: engagement with community networks and divisions within the HSE; thematic analysis of submissions; and endorsement and sign off.

Eight main themes were identified through the analysis of submissions: access to good quality intercultural healthcare services; equality, non-discrimination and human rights; interpreting and translation services; cross-cultural communication and cultural competence of staff; gender-based violence, including FGM and other harmful practices; community participation and service user participation and consultation; data and building the evidence base on intercultural health; and implementation of the second NIHS. (A summary of the outcomes of the consultation can be found in Appendix 4.) A more detailed overview of the submissions received, including a list of the individuals and organisations that made submissions, is available at www.hsesocialinclusion.ie.

The first NIHS (2007–2012) was the first intercultural health strategy to be developed in Ireland. Due to the difficult economic environment, complete implementation of the recommendations proved challenging. Instead of being in a position to implement wide-ranging interventions, a more pragmatic approach was taken to produce resources that would support service users in accessing services, and service providers in delivering culturally competent services.

Further detail on the implementation of the first NIHS is available in Chapter 2.

Implementation of the strategy

A detailed Implementation plan will be developed following launch of this strategy. Actions will be prioritised across the time frame of the plan, ensuring a balance between progressing actions that lend themselves to quick outcomes, and those actions that require longer term planning, additional significant resourcing, and associated incremental implementation.

The implementation plan will be structured to allow for flexibility in instances where new issues emerge or where additional targeted initiatives become necessary.

A mid-term review of progress in respect of implementation of recommended actions will be conducted circa 2020–2021.

Resourcing of the strategy

Significant investment is required in any strategy in order to address identified health need, build capacity of services and assure effective, sustainable outcomes. While a number of actions contained in this strategy will demand substantial resourcing over time, many other actions will require a rebalancing of existing resources to achieve desired outcomes. Similarly, certain actions might be aligned to, or leveraged off existing actions or initiatives in other programmes, as mechanisms for innovative, collaborative interventions.

Evaluation of existing expenditure on intercultural health will form a key element of the implementation plan, while strong business cases will be developed in respect of funding for priority actions such as implementation of a model for interpreting provision.

INTRODUCTION

A substantial number of people living in Ireland, from a range of ethnic and cultural backgrounds, make up its minority ethnic population, together creating a rich tapestry of experience, skills, perspectives and creativity. As the first *National Intercultural Health Strategy* (NIHS) 2007–2012 noted, migrants in Ireland make up a diverse group in terms of country of origin, economic and social backgrounds, education and work experience, integration and healthcare outcomes. Some are migrants (including foreign students, asylum seekers and refugees); some are members of the Traveller and Roma community. Some are newly arrived, while others are settled in established communities. They may be in the country legally or may be facing barriers in acquiring permission to remain. This heterogeneity is captured in the recently published *Migrant Integration Strategy*:

The migrant population is itself highly diverse in terms of nationality, ethnicity and religious belief, or absence thereof. The migrant population includes people of different ages, genders and sexual orientation. There are considerable differences between migrants in terms of their situation in Ireland, including whether or not they have the right to work here, and the manner in which they have come to Ireland. The population's profile includes the Irish-born children and grandchildren of migrants. The family situation of the migrant population is also diverse. Some migrants have come with their families to Ireland. Others have formed families since their arrival. Yet others are single. Some migrants have made their home in Ireland. Others plan to remain in Ireland on a short-term basis.

(Department of Justice and Equality, 2017a, p. 6)

When the first NIHS was published, increasing numbers of migrants were entering Ireland and awareness was developing around the need for provision of appropriate services that catered for their diverse health and care needs. That strategy provided a framework for addressing the many health and support needs of this diverse group. However, the economic crisis which commenced during the period of implementation of the first strategy was to impact significantly on migrants, who were most affected by job losses and poverty (ESRI, 2017). At the same time, rates of immigration to Ireland slowed.

The context for the publication of this second intercultural health strategy is quite different; economic prospects are improving, many migrants have attained Irish citizenship and, with continuing growth in diversity, Ireland's population now includes second and third generation service users from minority ethnic backgrounds. Moreover, inward migration is increasing again. Even though the inflow of immigrants to Ireland is now significantly lower than it was at the peak of the economic crisis in 2007, a significant proportion of the population living in Ireland today is of non-Irish origin, with Census 2016 confirming that 17.2% of the population in Ireland are foreign born. The 2016 Census report shows that, in April 2016, there were 535,475 non-Irish nationals living in the country (a 1.6% decrease on the 2011 figure of 544,357) (CSO, 2017a), while the number of people holding dual citizenship (Irish–other country) had increased by 87.4% from 2011 to 104,784 persons.

Non-Irish nationals living in Ireland

The 535,475 non-Irish nationals living in Ireland in April 2016 came from 200 different nations; Polish nationals were the largest group with 122,515 persons, followed by 103,113 UK nationals and 36,552 Lithuanians. In total, only 12 nations, each with over 10,000 residents – America, Brazil, France, Germany, India, Italy, Latvia, Lithuania, Poland, Romania, Spain and the UK – accounted for 73.6% of the total non-Irish national population.

The category “White Irish” remains by far the largest group, accounting for 3,854,226 (82.2%) usual residents. This was followed by “Any other White background” (9.5%), non-Chinese Asian (1.7%) and “other incl. mixed background” (1.5%). The 19,447 persons with Chinese ethnic/cultural background made up 0.4% of the usually resident population, while those of mixed backgrounds (70,603) constituted 1.5%.

Source: CSO (2016).

While the focus of the first strategy was very much on newly arrived minority ethnic service users, with particular emphasis on people seeking international protection, in this much altered landscape attention must now also be paid to the unique care and support needs of people who have lived in Ireland for a period, have built families and are settled in communities. This second NIHS 2018–2023 reflects these and other changes that have affected patterns of migration to Ireland, as well as changes in policy relating to the delivery and organisation of healthcare.

This second strategy also draws on learning and progress made in implementing the first NIHS and points to new and emerging issues that are relevant to current circumstances. In this strategy, with its focus on addressing healthcare and support needs of service users from a range of ethnic, cultural and religious groups, the term “migrant” is defined by the International Organization for Migration (IOM) as “any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person’s legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is.”

This term therefore encompasses a diversity of people, including asylum seekers, refugees, Roma, documented and undocumented migrants, and ranges from individuals who have recently settled in Ireland to those who have been resident in the country for many years. People from these groups have differing health and care needs based on their ethnicity, cultural and religious beliefs and practices, health status and life experiences. In relation to Travellers and Roma, the Department of Justice and Equality (DOJE) has recently launched a *National Traveller and Roma Inclusion Strategy, 2017–2021* (NTRIS), which has involved input from a range of sectors, including the Health Service Executive (HSE). Travellers are an ethnic minority community in Ireland whose health needs and status were extensively profiled through the *All-Ireland Traveller Health Study* (AITHS) (2010). As actions relating to improvement of Traveller health are extensively covered in the NTRIS, and are progressed via structures established under the DOJE, it is not thought necessary to duplicate actions in this document. The unique status of Roma, however, as a particularly marginalised community comprising many migrants – and in light of the findings of *Roma in Ireland: A National Needs Assessment* (2018) – demands that attention is paid to their health status in this second NIHS as well.

Healthcare is a crucial aspect of both immediate and long-term support for the integration of migrants in Ireland. Increasingly, health is recognised as a cross-departmental issue, as reflected, for example, by the new *Migrant Integration Strategy* (Department of Justice and Equality, 2016a). It is incumbent on the HSE to provide a healthcare service that is accessible to all service users and responsive to their needs, regardless of ethnicity or migrant status.

Policy and legislative context

A number of key developments have taken place in recent years that have relevance for the situation of members of minority ethnic communities. These include development of cross-government strategies that contain actions assigned to the HSE around provision of targeted interventions, as well as publication of commissioned reports containing recommended actions aimed at improving specific circumstances of vulnerable migrants. (A full list and detail of these policy developments relevant to intercultural health can be found in Appendix 2.)

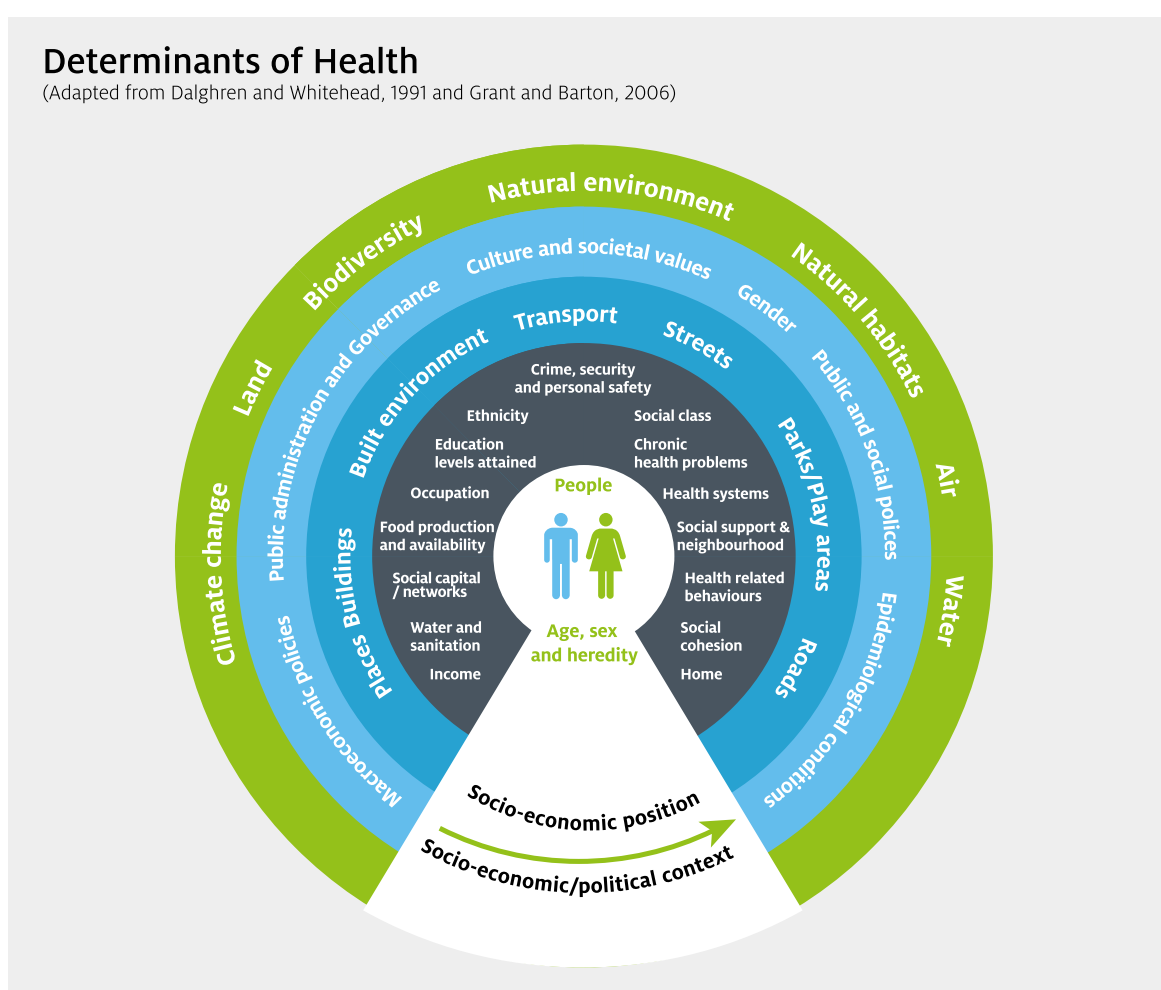
Role and responsibilities of the HSE

The HSE holds responsibility for provision of a comprehensive system of accessible and high quality healthcare. This means taking into account the diversity of the population, planning for the involvement and participation of service users from disadvantaged communities, and, where necessary, adapting services to meet the needs of the entire population, by responding to diversity.

The HSE *Corporate Plan* (2015a) and the HSE's planning and delivery of health services are both underpinned by the principles of social inclusion, equality and a population health approach. This demands development of measures to reduce health inequalities and to address the range of economic and social factors, including poverty and discrimination that affect equality of access to healthcare. The links between poverty, ethnicity and health status are well established, while the broad range and nature of social determinants that have an impact on

health is widely accepted. Migration is increasingly recognised as a determinant of health (Chung and Griffiths, 2018). The approach of *Healthy Ireland: A Framework for Improved Health and Wellbeing, 2013–2025* (Department of Health, 2013a) is based on an understanding of the determinants of health. A key goal of *Healthy Ireland* (2013) is the reduction of health inequalities in line with acknowledgement that health and wellbeing are not evenly distributed across Irish society. This goal requires not only interventions to target particular health risks, but also a broad focus on addressing the wider social determinants of health – the circumstances in which people are born, grow, live, work and age – to create economic, social, cultural and physical environments that foster healthy living. This population health approach is particularly relevant in the area of intercultural health, where service users from diverse cultures and ethnic backgrounds may be regarded as a vulnerable group at risk of social exclusion.

Figure 1.1: Social determinants of health



Source: *Healthy Ireland: A Framework for Improved Health and Wellbeing 2013-2025*

The second NIHS is closely connected to the mission, values and goals of the HSE *Corporate Plan* (2015a), which is based on the values of “care, compassion, trust and learning”, as well as five goals for creating a corporate vision of a “Healthier Ireland with a high quality health service valued by all”. It is expected that a new HSE Corporate Plan will further underpin these values. In addition, the second NIHS is informed by a range of quality and safety improvement measures, as well as by strategies and policies that have been implemented since the first strategy, including *Healthy Ireland: A Framework for Improved Health and Wellbeing, 2013–2025* (Department of Health, 2013a) and *National Standards for Safer Better Healthcare* (Health Information and Quality Authority (HIQA), 2017). In this context, meeting the diverse health needs of migrants, including how culture impacts on health, illness, sickness beliefs and behaviour, has become an important element of the HSE’s focus on managing and addressing chronic disease and in addressing health and wellbeing across the lifecycle. Achieving good quality healthcare, including better access to and coordination of services, and improved information/health literacy, will be crucial in the future to ensuring that migrants can navigate the complex healthcare system.

Role of HSE Social Inclusion

HSE Social Inclusion plays a key role in responding to health needs of service users from marginalised communities. The health and care needs of service users from diverse ethnic, cultural and religious communities fall within the remit of HSE Social Inclusion. The role of HSE Social Inclusion in addressing health inequalities and facilitating the access of socially excluded service users to health and associated support services makes it well placed to lead on development and implementation of this strategy.

See www.hsesocialinclusion.ie for further information.

Vision for the strategy

The vision for this strategy is

A health service that provides high quality responsive care to all service users from diverse ethnic, cultural and religious backgrounds. A health service that empowers service users from diverse ethnic, cultural and religious backgrounds to access services. A health service where service providers are confident in providing culturally competent services to this cohort.

Guiding principles for the strategy

‘Equality and rights-based approaches underpin the second NIHS’: Equality, non-discrimination and human dignity are fundamental principles underpinning the second NIHS strategy. They are particularly important to the provision of intercultural health services as they recognise that service users from diverse cultures and ethnic backgrounds may face health inequalities, requiring a systematic approach to ensure their empowerment and greater participation in healthcare. These principles are reinforced through the introduction of Section 42 of the Irish Human Rights and Equality Commission Act (2014), which gives effect to the Public Sector Equality and Human Rights Duty.

Building on what has already been achieved, the second NIHS continues to stress the importance of equality of access to health services, particularly for women migrants and disadvantaged minority ethnic communities.

‘A whole-organisation approach is advocated, whereby service users are cared for on the basis of need in the first instance’:

This principle is endorsed within the current HSE *Corporate Plan* (2015a), which states, “We will deliver care around the individual patient and service user and put the patient at the heart of what we do”. At the same time, a whole-organisation approach obliges the HSE to provide care and support for its own staff in carrying out their duties.

‘The Strategy is aligned with all existing relevant policies and programmes’: This relates to policies and programmes, both at government level and within the HSE, utilising appropriate levers and recommended actions, including *Healthy Ireland – A Framework for Improved Health and Wellbeing, 2013–2025*, the *Migrant Integration Strategy* (2017), the *NTRIS 2017–2021*, the *National Sexual Health Strategy, 2015–2020*, the *National Maternity Strategy, 2016–2026*, the *Second National Strategy on Domestic, Sexual and Gender based Violence, 2016–2021*, the Public Sector Duty and Section 42 of the Irish Human Rights and Equality Commission Act (2014). Implementation of this strategy demands investment in an approach that is both cross-governmental and cross-HSE, one that is comprehensive and coordinated in ensuring provision of quality public services, and where common issues are collaboratively addressed as a means of harnessing expertise, gaining synergies and devising cost-effective solutions.

‘An evidenced-based approach is taken towards planning and developing interventions’: This relates to the planning and development of interventions, with a strong focus on health outcomes. Flexibility, adaptability and accountability are key elements in implementing agreed interventions, with ongoing monitoring of effectiveness and efficiency built into this.

‘Targeted interventions are developed, where necessary, to enable access and participation for all excluded groups’: Designing services for the majority of the population may have the effect of inadvertently discriminating against certain groups, such as minority ethnic communities, through neglecting to recognise, respond to, or plan for their particular needs and circumstances. While mainstream healthcare delivery should be adapted, where appropriate, to enable access and participation for all socially excluded groups, it may be also necessary to develop additional targeted programmes that address the particular health needs of this group.

‘Emphasis is on provision of high quality, patient-centred services’: All services provided to members of diverse groups should be developed under a quality agenda, with attention to HIQA’s *National Standards for Safer Better Healthcare* (2017).

‘The role of community and voluntary organisations is acknowledged’: This relates to the provision of care and support for service users from minority ethnic groups, from small organisations that promote inclusion and access, to frontline services providing treatment, to those agencies advocating and supporting groups, to non-government organisation’s (NGO) providing specialist services on behalf of the HSE.

‘Active, meaningful service user involvement is facilitated in the design, delivery and evaluation of services’: Enhance engagement with patients, service users and advocates, and involve them in the service design, planning, delivery and evaluation of services.

‘Community development principles are used in engaging with service users and development of peer-led interventions’: Promote consultation, participation and inclusion, using community development principles and practice as a methodology for service user engagement and peer-led interventions towards equal health outcomes.

‘Cost-effectiveness and value for money are key considerations’: Relevant issues here are wide-ranging, for example, ensuring the most cost-efficient approach is taken regarding the cost of interpreting services, and supporting target populations of this strategy to access the relevant health services – primary care and acute hospital care – when they are needed.

Structure of this document

The HSE's first NIHS, produced in 2007, addressed specific care and support needs of minority ethnic health service users in Ireland. This second NIHS builds on outcomes of the first one. In doing so, it brings together the wide range of health-related actions which have been assigned to the HSE across a number of cross-departmental government strategies that have emerged in recent years seeking to ensure that public services are responsive, effective, and of a high quality, for people of all ethnicities, cultures and religions.¹ It also draws on internal expertise, within the HSE, in identifying additional actions that are required.

Part 1 (Chapter 1) of this document presents the strategy itself, including its vision, guiding principles, goals, strategic objectives within each goal, as well as actions required. In relation to certain actions, the strategy sets out the timeline, partner and/or lead bodies, and 'strategic alignment' – the existing policy document to which each action relates.

Part 2 sets out, in a series of chapters, the context and background to the development of this second NIHS. Chapter 2 outlines the consultation process that informed its development; Chapter 3 provides the evidence base for the strategy; Chapter 4 sets out relevant health system challenges; and Chapter 5 relates to data collection issues. Throughout these chapters, the actions of the strategy are presented, as they relate to the evidence; in this way, this document presents a strong evidence base for each of the strategy's actions.

Finally, Part 3 (Chapter 6) is entitled 'Towards an implementation plan for the second NIHS'. This chapter sets out plans and future milestones for the proposed development of a detailed implementation plan for this strategy, which is due to be published within four months of the launch of the strategy.

¹ See Appendix 3 for list of health-related actions relevant to the HSE via cross-government strategies.



PART I: Second National Intercultural Health Strategy, 2018–2023

1. SECOND NATIONAL INTERCULTURAL HEALTH STRATEGY, 2018-2023

This section sets out the vision, guiding principles, goals, strategic objectives and actions that comprise the second NIHS 2018–2023. It is intended that this will provide a framework for the development of an implementation plan, which is to be developed shortly after the publication of this strategy (see Chapter 6 for further detail on the proposed implementation plan).

Vision for the second NIHS

A health service that provides high quality responsive care to all service users from diverse ethnic, cultural and religious backgrounds. A health service that empowers service users from diverse ethnic, cultural and religious backgrounds to access services. A health service where service providers are confident in providing culturally competent services to this cohort.

Guiding principles

- Equality and rights-based approaches underpin the second NIHS.
- A whole organisational approach is advocated, whereby service users are cared for on the basis of need in the first instance.
- The strategy is aligned with all existing policies and programmes.
- An evidence-based approach is taken towards planning and developing interventions.
- Targeted interventions are developed, where necessary, to enable access and participation for all excluded groups.
- Emphasis is on provision of high-quality, patient-centred services.
- The role of community and voluntary organisations is acknowledged.
- Active, meaningful service user involvement is facilitated in the design, delivery and evaluation of services.
- Community development principles are used in engaging with service users and development of peer-led interventions.
- Cost-effectiveness and value for money are key considerations.

Goals and strategic objectives

GOAL 1:

Enhance accessibility of services to service users from diverse ethnic, cultural and religious backgrounds.

- Provide information in accessible, culturally responsive ways.
- Develop a model for interpreting provision across the HSE.
- Develop an evidence-informed system of translating information.

GOAL 2:

Address health issues experienced by service users from diverse ethnic, cultural and religious backgrounds.

- Implement cross-government obligations in respect of health needs of service users.
- Implement national obligations in relevant cross-departmental strategies.
- Promote a model of health screening and prevention.
- Address health inequalities relevant to service users in relation to oral health, sexual health, reproductive health, children and young people, LGBTI+, disability, men, mental health and palliative care.

GOAL 3:

Ensure provision of high-quality, culturally responsive services to service users from diverse ethnic, cultural and religious backgrounds.

- Provide intercultural awareness training to all relevant staff, and take into account the needs of staff who work with a diverse population.
- Ensure that services are planned and delivered in a context of cultural competence and in line with requirements of the public sector duty and related obligations.

GOAL 4:

Build an evidence base.

- Work towards the development of high quality data collection, monitoring and evaluation to build an evidence base on minority ethnic health and ensure evidence-informed practice.

GOAL 5:

Strengthen partnership working to enhance intercultural health.

- Actively promote participation of service users from minority ethnic groups in the design, planning, delivery and evaluation of services.

The tables overleaf set out strategic actions and timelines, lead/partners and strategic alignment, within each of these goals and their strategic objectives. While these actions are largely informed by current pertinent cross-departmental strategies, for reasons of clarity and accessibility, these tables do not list all the relevant actions outlined in such documents; instead, these can be found in Appendix 3.

1.1 Strategic actions under Goal 1

Goal 1:		Enhance accessibility of services to service users from diverse ethnic, cultural and religious backgrounds.		
Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
Provide information in accessible, culturally responsive ways.	Provide information in accessible, culturally responsive ways, including information on issues such as eligibility and entitlements.	2018 onwards	HSE Communications	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017b)
	Develop and roll out, in collaboration with Cáirde, an interactive mobile app to support migrants in accessing health services.	2018	Cáirde	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017b)
	Produce and disseminate an accessible document that facilitates orientation to health services and their usage in Ireland.	2018		<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017b) <i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015)
Develop a model for interpreting provision across the HSE.	Progress recommendations of the <i>Report of the HSE Working Group to Develop a Model for the Implementation of Trained Interpreters in the Irish Healthcare System</i> (2018).	2018 onwards		Public Sector Equality and Human Rights Duty, Section 42 of the Irish Human Rights and Equality Commission Act, (2014) <i>Report of the HSE Working Group to Develop a Model for the Implementation of Trained Interpreters in the Irish Healthcare System</i> (University of Limerick, 2018). <i>National Standards for Safer Better Healthcare</i> (HIQA, 2012) <i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Finalise an appropriate model for the phased implementation of interpreting provision across the HSE.	2018 onwards	Acute hospitals, Community services	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a) <i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015)

Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
	Provide training to staff in working effectively with interpreters.	2018 onwards		<i>National Standards for Safer, Better Healthcare</i> (HIQA, 2012) <i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Promote uptake of the resource, <i>Guidelines to Support Communication in Cross-cultural General Practice Consultations</i> (2012).	2018 onwards		<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Implement the recommendations from RESTORE, the European research project on communication in cross-cultural consultations within healthcare settings.	2019 onwards		<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Provide training to interpreters working in palliative care and other services where particularly sensitive communication is required.	2018 onwards	Palliative Care	<i>The Migrant Integration Strategy: A Blueprint for the Future 2017-2021</i> (Department of Justice and Equality, 2017a) <i>Palliative Care Services: Three-Year Development Framework 2017–2019</i> (HSE, 2017)
Develop an evidence-informed system of translating information.	Analyse translation needs; consider community needs, languages most spoken and issues such as literacy.	2018		<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Promote uptake of <i>Lost in Translation</i> resource as a means of ensuring effective translation of appropriate material.	2018		<i>Lost in Translation? Good Practice Guidelines for HSE Staff in Planning, Managing and Assuring Quality Translations of Health Related Material</i> (HSE (undated (b)))
	Implement an evidence-informed system of translating prioritised information and sharing across services.	2019		<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Promote availability of existing resources and continue to build on existing platform for sharing same.	2018		

1.2 Strategic actions under Goal 2

Goal 2:		Address health issues experienced by service users from diverse ethnic, cultural and religious backgrounds.		
Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
Implement cross-government obligations in respect of health needs of service users.	Develop targeted interventions in line with government and related obligations, within resource constraints, including those outlined in the McMahon report (2015), and commitments set out in the Irish Refugee Protection Programme, the <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> and the <i>Migrant Integration Strategy: A Blueprint for the Future</i> .	2018 onwards	Reception and Integration Agency, Department of Justice and Equality Office for the Promotion of Migrant Integration, Department of Justice and Equality Traveller Policy Unit, Department of Justice and Equality	<i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015) Irish Refugee Protection Programme <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017b) <i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)
	Continue to implement the health-related actions contained in <i>Ireland's Second National Action Plan on Women, Peace and Security 2015–2018</i> , and forthcoming Third National Action Plan.	2018	Oversight Group on Action Plan, Department of Foreign Affairs and Trade	<i>Ireland's Second National Action Plan on Women, Peace and Security, 2015–2018</i> (Department of Foreign Affairs and Trade, 2015)
	Progress implementation of health-related actions of the <i>Second National Action Plan to Prevent and Combat Human Trafficking in Ireland</i> (2016).	2018 onwards		<i>Second National Action Plan to Prevent and Combat Human Trafficking in Ireland</i> (Department of Justice and Equality, 2016b)
	Undertake a strategic review of the HSE Anti-Human Trafficking Team.	2019	HSE Community Healthcare Organisation (CHO 6- Community Healthcare East)	<i>Second National Action Plan to Prevent and Combat Human Trafficking in Ireland</i> (Department of Justice and Equality, 2016b)
	Review current service provision to ensure measures are in place for migrant women who experience or who have experienced domestic or sexual violence so that they have access to the support services they require, with particular consideration for women whose immigration status is linked to their partner's status.	2019		<i>Second National Strategy on Domestic, Sexual and Gender based Violence 2016–2021</i> (Department of Justice and Equality, 2016a)
	Implement all relevant health-related actions contained in the <i>National Strategy for Women and Girls 2017–2020</i> .	2018 onwards	HSE Health Promotion and Improvement	<i>National Strategy for Women and Girls 2017–2020</i> (Department of Justice and Equality, 2017c)

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
	Build synergy with relevant actions contained in the <i>National Sexual Health Strategy 2015-2020</i> .	2018 onwards		<i>National Sexual Health Strategy 2015–2020</i> (Department of Health, 2015b)
	Coordinate implementation of the health-related actions of the <i>Second National Strategy on Domestic, Sexual and Gender based Violence 2016–2021</i> , and <i>Ireland's Second National Action Plan for Women, Peace and Security 2015–2018</i> and forthcoming Third National Action Plan, with particular regard to provision of appropriate support and protection for migrant women experiencing sexual harassment.	2018 onwards		<i>Second National Strategy on Domestic, Sexual and Gender based Violence 2016–2021</i> (Department of Justice and Equality, 2016a) <i>Ireland's Second National Action Plan on Women, Peace and Security 2015–2018</i> (Department of Foreign Affairs and Trade, 2015)
	Deliver health-related actions in the <i>National Traveller and Roma Inclusion Strategy 2017- 2021</i> including violence against Traveller and Roma women on a phased, prioritised basis, taking the findings of <i>Roma in Ireland – A National Needs Assessment</i> (2018) into account while implementing agreed actions.	2019 onwards		<i>National Traveller and Roma Inclusion Strategy 2017-2021</i> (Department of Justice and Equality, 2017b) <i>Roma in Ireland – A National Needs Assessment</i> (Pavee Point and Department of Justice and Equality, 2018)
	Continue to develop and implement education and public awareness campaigns, among all health professionals and communities affected by female genital mutilation (FGM), to raise awareness that it is a criminal offence under the Criminal Justice (Female Genital Mutilation) Act (2012) to perform FGM, or to remove a girl from the State for the purpose of FGM.	2019		Criminal Justice (Female Genital Mutilation) Act (2012)
	Provide training to increase the knowledge and competence of healthcare providers, and other relevant frontline professionals, in relation to appropriate care and protection for FGM survivors and women and girls at risk nationwide.	2018 onwards	Akidwa, Irish Family Planning Association	

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
	Work with relevant partners to ensure that FGM training is built into under-graduate and post-graduate training for medical, health and social care professionals.	2019 onwards		
	Provide appropriate support to survivors of FGM, including counselling and access to specialist health services.	2018 onwards	Irish Family Planning Association	
Implement national obligations in relevant cross-departmental strategies: <i>National Traveller and Roma Inclusion Strategy 2017–2021.</i> <i>The Migrant Integration Strategy: A Blueprint for the Future.</i> <i>Ireland's Second National Action Plan on Women, Peace and Security 2015–2018.</i> <i>Second National Action Plan to Prevent and Combat Human Trafficking in Ireland (2016).</i> <i>Second National Strategy on Domestic, Sexual and Gender Based Violence, 2016–2021.</i> <i>Connecting for Life –Ireland's National Strategy to Reduce Suicide, 2015–2020.</i> <i>National Sexual Health Strategy, 2015–2020.</i> <i>Healthy Ireland: A Framework for Improved Health and Wellbeing, 2013–2025.</i> <i>Creating a Better Future Together: National Maternity Strategy 2016–2026.</i> <i>Reducing Harm, and Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland 2017–2025.</i>	Explore legislative or policy barriers that restrict access to services, especially those barriers identified in national documents, as well as social concerns such as poverty and discrimination.	2018 onwards	Department of Health	
	Support and progress recommendations in <i>Connecting for Life –Ireland's National Strategy to Reduce Suicide 2015–2020</i> that have particular relevance to service users in the LGBTI+ community from diverse ethnic and cultural backgrounds.	2019		<i>Connecting for Life –Ireland's National Strategy to Reduce Suicide 2015–2020</i> (Department of Health, 2015a)
	Implement relevant recommendations in the new National Drugs Strategy, <i>Reducing Harm, and Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland 2017–2025</i> .	2020	Department of Health	<i>Reducing Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland 2017–2025</i> (Department of Health, 2017b).

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
Promote a model of health screening and prevention.	Promote the implementation of infectious diseases and other health screening guidelines for migrants.	2019	HSE Health Protection and Surveillance Centre, HSE Public Health	Infectious Disease Screening for Migrants (HSE Health Protection and Surveillance Centre, 2015) Hepatitis C Screening National Clinical Guideline No. 15 (Department of Health, 2017)
	Introduce measures to support uptake of childhood and relevant adult immunisations among members of minority ethnic groups.	2018 onwards	HSE Public Health	<i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017b)
	Work with key stakeholders to develop information and guidance for service users and staff in respect of awareness and management of health-related conditions specific to members of minority ethnic groups.	2019 onwards	HSE Clinical Programmes	<i>National Sexual Health Strategy 2015–2020</i> (Department of Health, 2015b) <i>Creating a Better Future Together: National Maternity Strategy 2016–2026</i> (Department of Health, 2016) <i>Healthy Ireland: A Framework for Improved Health and Wellbeing 2013–2025</i> (Department of Health, 2013)
	Review health screening practice in direct provision centres and emergency reception and orientation centres.	2018	HSE Public Health	<i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015)
	Ensure health screening on arrival of refugees arriving under the Irish Refugee Protection Programme, with onward timely referral to primary care and other services as necessary.	2018 onwards		<i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015)
Address health inequalities relevant to service users in relation to oral health, sexual health, reproductive health, children and young people, LGBTI+, disability, men, mental health and palliative care.	Support HSE Oral Health colleagues to develop an effective, culturally responsive model towards the prevention, treatment and aftercare of the refugee cohort in the first instance.	2018 onwards	HSE Oral Health	
	Work with ethnic groups, especially those from high-burden countries, to reduce risks and spread of HIV, blood borne viruses (e.g. Hepatitis C) and other serious sexually transmitted infections (STIs).	2018 onwards	Representative NGOs	<i>National Sexual Health Strategy 2015–2020</i> (Department of Health, 2015b)

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
	Support access to culturally appropriate information on contraception and services (including referral pathways for women with unplanned pregnancies) to all women, with a particular focus on women living in accommodation centres and women in the Irish Refugee Protection Programme.	2018 onwards	HSE Sexual Health and Crisis Pregnancy Programme, Representative NGOs	<i>National Sexual Health Strategy 2015–2020</i> (Department of Health, 2015b)
	Address medical, cost and information barriers to contraception use and provide sexual health education programmes to minority ethnic groups, refugees and asylum seekers.	2019 onwards	HSE Sexual Health and Crisis Pregnancy Programme	<i>National Sexual Health Strategy 2015–2020</i> (Department of Health, 2015b)
	Work to ensure access to the Maternity and Infant Child Scheme for all pregnant women living in Ireland, regardless of immigration status.	2018 onwards	HSE Maternal and Child Health Programme	<i>Creating a Better Future Together: National Maternity Strategy 2016–2026</i> (Department of Health, 2016)
	Work to ensure that maternity services are responsive to the specific needs of migrant women and women from the Traveller and Roma communities and that they are culturally appropriate. This will include access to culturally appropriate information in relevant languages and interpretation services.	2018 onwards	HSE Maternal and Child Health Programme	<i>Creating a Better Future Together: National Maternity Strategy 2016–2026</i> (Department of Health, 2016)
	Support implementation of relevant actions from the National Women's Council of Ireland and HSE consultation exercise (2015) on priorities for maternity services and ensure synergy with the <i>Creating a Better Future Together: National Maternity Strategy 2016–2021</i> and the priorities of the National Women and Infants Health Programme.	2018 onwards	HSE Maternal and Child Health Programme	<i>Creating a Better Future Together: National Maternity Strategy 2016–2026</i> (Department of Health, 2016) National Women and Infants Health Programme National Women's Council of Ireland and HSE consultation exercise (2015)
	Participate in the EU ORAMMA project and apply outcomes.	2018 onwards	EU partners	https://oramma.eu/

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
	Support the implementation of HSE-assigned actions in the <i>National Traveller and Roma Inclusion Strategy 2017- 2021</i> relating to children and youth.	2018 onwards		<i>National Traveller and Roma Inclusion Strategy 2017– 2021</i> (Department of Justice and Equality, 2017b)
	Promote the development and delivery of appropriate parenting and other relevant programmes as a means of supporting parents in a range of areas, including child protection and associated obligations, healthy living and nutrition.	2018 onwards	TUSLA	<i>Children First – National Guidance for the Protection and Welfare of Children</i> (Department of Children and Youth Affairs, 2017)
	Work with the Ombudsman for Children's Office to address issues and complaints in respect of children living in direct provision centres and emergency, reception and orientation centres.	2018 onwards	Ombudsman for Children's Office, TUSLA	
	Support and progress actions of the <i>LGBTI+ National Youth Strategy 2018-2020</i> that have particular relevance to young service users from diverse ethnic and cultural backgrounds.	2018 onwards	HSE Quality Improvement Division, HSE Mental Health, HSE Sexual Health and Crisis Pregnancy Programme	<i>LGBTI+ National Youth Strategy 2018-2020</i> (Department of Children and Youth Affairs, 2018) <i>Connecting for Life –Ireland's National Strategy to Reduce Suicide 2015–2020</i> (Department of Health, 2015a) <i>National Sexual Health Strategy 2015-2020</i> (Department of Health, 2015b) <i>Better Outcomes, Brighter Futures 2014–2020</i> (Department of Children and Youth Affairs, 2014)
	Support research carried out by TENI in respect of the unique barriers faced by transgender refugees and asylum seekers in accessing health and care services.	2019	TENI	
	Ensure the health and support needs of LGBTI+ service users of diverse ethnicities and cultures are considered in a forthcoming HSE National LGBTI+ Health Strategy.			<i>LGBTI+ National Youth Strategy 2018-2020</i> (Department of Children and Youth Affairs, 2018)

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
	Establish links with relevant HSE structures to explore the extent and nature of disability within the cohort of minority ethnic service users and associated needs for appropriate care and rehabilitation.	2019 onwards	HSE Social Care	
	Promote and support development of programmes to support men of diverse ethnicities and cultures, including proven models, such as Men's Sheds.	2018 onwards	HSE Health Promotion and Improvement	<i>National Men's Health Action Plan 2017–2021</i> (Department of Health, 2016)
	Address actions relevant to men of diverse cultures and ethnicities contained in the <i>National Men's Health Action Plan 2017–2021</i> .	2019 onwards	HSE Health Promotion and Improvement	<i>National Men's Health Action Plan 2017–2021</i> (Department of Health, 2016)
	Explore the reproductive health needs of men from minority ethnic groups living in Ireland.	2020		
	Continue to support the operation of the Mobile Bus, operated by Safetynet in partnership with HSE Social Inclusion, in delivery of health screening and basic primary care service delivery to members of socially excluded groups.	2018 onwards	Safetynet	
	Continue to support implementation of programmes for Roma men, based on projects such as the Roma Men's Training, Development and Health Literacy Programme (Atelier).	2018 onwards	Partner NGOs, Relevant HSE Community Healthcare Organisations	<i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017b)
	Implement the recommendations of the report, <i>Middle-Aged Men and Suicide in Ireland (2018)</i> , which includes an explicit focus on men of diverse cultures and ethnicities.	2020	HSE Mental Health	
	Promote and support research into the mental health needs of service users from minority ethnic communities.	2019 onwards	HSE Mental Health	<i>Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015–2020</i> (Department of Health, 2015a)

Strategic Objective:	Strategic Action	Timeline	Key partners	Strategic Alignment
	Work towards development of a comprehensive model in respect of provision of culturally competent assessment and treatment that is tailored to the unique mental health needs of vulnerable service users from diverse ethnic and cultural backgrounds and with a range of unique care needs.	2018 onwards	HSE Mental Health	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a) <i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015)
	Continue to address the mental health needs of people living in direct provision accommodation, as outlined in the McMahon report (2015).	2018 onwards	HSE Mental Health	<i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report</i> (McMahon report, 2015)
	Continue to encourage the active participation of inter-agency groups, with particular attention to provision of support to refugees and asylum seekers in the resettlement communities phase.	2018 onwards	HSE Community Healthcare Organisations	
	Continue to support the delivery of specialised services to service users who have experienced torture and related trauma.	2018 onwards	Spirasi and related services	
	Work with relevant organisations to explore and tackle the issue of mental health stigma among minority ethnic communities and the promotion of psychological wellbeing.	2018 onwards	Partner NGOs	
	Continue to support the implementation of the HSE <i>National Hepatitis C Strategy</i> (2011) and the National Hepatitis C Treatment Programme, ensuring appropriate and responsive care to members of minority ethnic groups.	2018 onwards	HSE Hepatitis C Treatment Programme	<i>National Hepatitis C Strategy 2011 – 2014</i> (HSE, 2011)
	Support the Clinical Programme for Palliative Care in implementing the <i>Palliative Care Services Development Framework 2017–2019</i> , with particular reference to the recommendation pertaining to ensuring appropriate and responsive care to members of minority ethnic groups.	2018 onwards	HSE Palliative Care	<i>Palliative Care Services: Three-Year Development Framework 2017–2019</i> (HSE, 2017)

1.3 Strategic actions under Goal 3

Goal 3: Ensure provision of high quality, culturally responsive services to service users from diverse ethnic, cultural and religious backgrounds.				
Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
Provide intercultural awareness training to all relevant staff, and take into account the needs of staff who work with a diverse population.	Engage with third level institutions and professional bodies to ensure that intercultural awareness is built into under-graduate and post-graduate training for health and social care professionals.	2019 onwards	HSE Human Resources (HR)	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017)
	Develop an intercultural health awareness online training programme.	2018 - 2019		
	Review, update where necessary, and promote previously published resources for staff, including: the Emergency Multilingual Aid; the <i>Lost in Translation</i> resource, <i>On Speaking Terms: Good Practice Guidelines for HSE Staff in the Provision of Interpreting Services</i> (2009); and <i>Guideline for Communication in Cross-cultural General Practice Consultations</i> (2012).	2018		<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017)
	Review usage and update the HSE's <i>Health Services Intercultural Guide</i> (2009), and related app, with particular attention to content relating to cultural and religious norms around death and dying, with a view to further circulation.	2018	HSE Quality Improvement Division	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017)
	Work with relevant organisations to develop anti-racism and intercultural core competencies for youth workers in order to ensure that organisations are better equipped to support minority ethnic young people.	2020	HSE Health Promotion and Improvement HSE Community Healthcare Organisations	
	Promote provision of programmes that support staff in dealing appropriately and effectively with service users who have experienced trauma.	2018 onwards	HSE HR	

Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
	Train healthcare staff to be aware of violence against women in their practice, providing space for safe disclosures by women in their care and access to referral for services to protect women and children from further harm.	2018 onwards	HSE HR, Specialist NGOs	<i>Second National Strategy on Domestic, Sexual and Gender Based Violence 2016–2021</i> (Department of Justice and Equality, 2016a)
	Provide guidance and support to GPs and other health professionals in providing appropriate, effective care to migrants.	2019 onwards	HSE HR	
	Work with HSE HR Division to proactively champion an intercultural, equality and non-discrimination approach to all elements of support for staff of diverse backgrounds, including recruitment and retention, and learning and promotion opportunities.	2018 onwards	HSE HR	
Ensure that services are planned and delivered in a context of cultural competence and in line with requirements of the public sector duty and related obligations.	Implement the Public Sector Equality and Human Rights Duty, Section 42 of the Irish Human Rights and Equality Commission Act, (2014) taking account of equality and human rights issues in the planning and delivery of services.	2018 onwards	HSE Strategy and Planning	Public Sector Equality and Human Rights Duty, Section 42 of the Irish Human Rights and Equality Commission Act (2014)
	Support colleagues in HSE Social Care to proof policies and practices as a means of ensuring the care and support needs of older service users and people with disabilities from diverse ethnic and cultural backgrounds are fully and appropriately incorporated into all activities.	2019	HSE Social Care	
	Support colleagues in HSE Health and Wellbeing in ensuring that the specific needs of young people from diverse ethnic, cultural and religious groups are taken into account in all aspects of development of strategies, plans and health-related actions.	2019 onwards	HSE Health and Wellbeing	

Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
	Support efforts of the HSE-led Interfaith Group in efforts to assure competent, responsive provision of spiritual care to service users of diverse religions.	2018 onwards	HSE Quality Improvement Division	
	Work to ensure that services provided to members of diverse groups are developed under a quality agenda, with attention to HIQA's <i>National Standards for Safer Better Healthcare</i> (2012).	2019 onwards		<i>National Standards for Safer Better Healthcare</i> (HIQA, 2012)
	Progress learning and research in respect of provision of treatment and support of service users experiencing conditions that disproportionately affect minority ethnic groups, such as sickle cell anaemia and polio and other haematological or metabolic disorders.	2019 onwards	HSE Public Health, HSE Clinical Strategy and Programmes	
	Review the current approach to provision of infant male circumcision with the DOH, with particular reference to the potential revision of the 2006 <i>Cultural Male Circumcision –Report of the Committee</i> and agree any subsequent associated actions.	2018	Department of Health	

1.4 Strategic actions under Goal 4

Goal 4:		Build an evidence base.		
Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
Work towards the development of high quality data collection, monitoring and evaluation to build an evidence base on minority ethnic health and ensure evidence-informed practice.	Develop an identifier throughout the HSE to collect data on access, uptake and referral rates for minority ethnic groups so that cultural or ethnic needs can be identified and accommodated.	2018	HSE Strategy and Planning, HSE Health Intelligence, HSE ICT Department	<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017) <i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017)
	Collect and publish disaggregated data (by sex and complemented by grounds of age, ethnicity, disability) to inform policies and programmes and address inequities.	2019 onwards	HSE Strategy and Planning	
	Develop data collection and analysis of minority ethnic communities' use of maternity services so that policy and service delivery can be more responsive to their needs.	2021 onwards	HSE Strategy and Planning, HSE Acute and Maternity services	
	Develop data collection and analysis of minority ethnic communities' use of sexual violence support services (Sexual Assault Treatment Units) so that policy and service delivery can be more responsive to their needs.	2020 onwards	HSE Sexual Assault Treatment Units	<i>Second National Strategy for Domestic, Sexual and Gender-based Violence 2016–2021</i> (Department of Justice and Equality, 2016a)
	Explore potential for the development of a national database in respect of sickle cell anaemia and thalassemia.	2021	HSE Strategy and Planning, HSE Health Intelligence	
	Provide active input to development of the Individual Health Identifier.	2018 onwards	HSE Strategy and Planning	
	Review trends from complaints under the service user feedback system <i>Your Service Your Say</i> and associated surveys with regard to issues raised relevant to NIHS.	Ongoing	HSE Quality Improvement Division	
	Develop a prioritised programme of research in respect of minority ethnic health.	2018 onwards		

Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
	Support and monitor the new research initiative established by HSE Social Inclusion South East Community Healthcare and the University of Limerick on the health needs of Roma, asylum seekers and refugees.	2019	HSE Social Inclusion South East Community Healthcare	
	Develop and implement a system of recording ethnicity of HSE staff and monitor trends of recruitment, retention and promotion in respect of each staffing discipline and service.	2019 onwards	HSE HR	
	Develop a framework for advancing Intercultural health research and applying learning towards evidenced interventions.	2019 onwards		

1.5 Strategic actions under Goal 5

Goal 5:	Strengthen partnership working to enhance intercultural health.
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Strategic Objective:	Strategic Action	Timeline	Key Partners	Strategic Alignment
Actively promote participation of service users from minority ethnic groups in the design, planning, delivery and evaluation of services.	Establish a partnership mechanism through which the voice of service users from minority ethnic communities can influence progress in implementation and evaluation of actions.	2018 onwards	HSE Quality Improvement Division	
	Ensure that any HSE survey or mechanism intended to capture the views of service users is designed to incorporate feedback from members of diverse ethnic and cultural backgrounds.	Ongoing	HSE Quality Improvement Division	
	Proof health campaigns to ensure practice of culturally appropriate messaging.	2018 onwards	HSE Health Promotion and Improvement	
	Provide ongoing support to NGOs who assist undocumented migrants and other vulnerable groups in accessing appropriate care.	2018 onwards		
	Explore, promote and implement appropriate models of community development that support migrant communities in working towards improving their health status.	2018 onwards	HSE Health Promotion and Improvement	
	Align the work of the Global Health Programme with the NIHS so that the experiences and learning of participating staff can contribute to fulfilment of each of its strategic goals.	2018 onwards	HSE Global Health Programme	HSE Global Health Programme

An abstract, vibrant splash of colors (yellow, orange, red, green, and blue) against a solid blue background, resembling ink or paint being dropped into water. The colors are swirling and blending together, creating a dynamic and energetic visual effect.

PART II: Background to the strategy

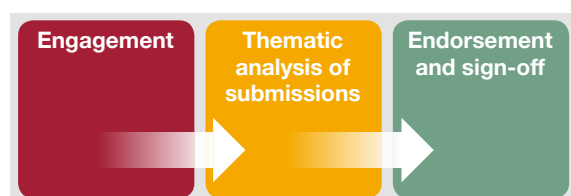
2. DEVELOPMENT OF THE STRATEGY

This section outlines the process that informed the development of this strategy.

2.1 Consultation process

The consultation process for this second NIHS has involved three main stages: engagement with community networks and all sections within the HSE; thematic analysis of submissions; and endorsement and sign off.

Figure 2.1: Consultation process for the second NIHS



2.1.1 Engagement

An invitation for submissions for a second NIHS was circulated across community networks, as well as across the sections of the HSE. Written submissions were made on the basis of an invitation from the HSE for feedback and suggestions regarding what should inform the content and approach of the second NIHS.

Figure 2.2: Breakdown of submission responses



Some submissions involved input from one or more individuals within a service, and several involved joint submissions from groups of public health doctors or other health professionals.² Many of the submissions reflect learning and experience among submitters that arose from working with migrant communities, and the implementation, on the ground, of the first NIHS.

A more detailed overview of the submissions received, including a list of the individuals and organisations that made submissions, is available at www.hsesocialinclusion.ie.

2.1.2 Thematic analysis

All submissions were read and analysed, with both new and emerging issues documented. Many submissions reflected the experience of staff providing frontline services, while some were based on recent consultations or on research carried out on relevant issues. Through this analysis, a number of key themes were identified (outlined in 2.1.4).

Any submissions that required clarification were followed up.

² These submissions came from the following NGOs: NASC, Cork Traveller Women's Network, Irish Family Planning Association, Irish Refugee Council, National Women's Council of Ireland, Spirasi, Cáirde, HIV Ireland, Citywide and YMCA Cork. Submissions from HSE services included primary care (3), pharmacy (hospital), public health medicine / Directors of Public Health (2), the public health nurse service, old age psychiatry (2), community health medicine, HSE Children First, HSE environmental services, HSE midwifery manager (2), and the HSE director of nursing (1). Other submissions were received from Tusla fostering and adoption services (2) and the Food Safety Authority Ireland.

2.1.3 Endorsement and sign off

Drafts were circulated to relevant HSE personnel and other stakeholders for final comment.

2.1.4 Outcomes of consultation for the second NIHS

The development of this second NIHS has been informed by consultations with individuals and organisations who have experience in providing intercultural health services or who work with service users from minority ethnic and/or migrant groups. These services aim to build the capacity and the effectiveness of the healthcare system in meeting the diverse needs of migrants and minority ethnic groups in Ireland.

Eight main themes were identified through the analysis of submissions: access to good quality intercultural healthcare services; equality, non-discrimination and human rights; interpreting and translation services; cross-cultural communication and cultural competence of staff; gender-based violence, including FGM and other harmful practices; community participation and service user participation and consultation; data and building the evidence base on intercultural health; and implementation of the second NIHS. (A summary of the outcomes of the consultation can be found in Appendix 4.)

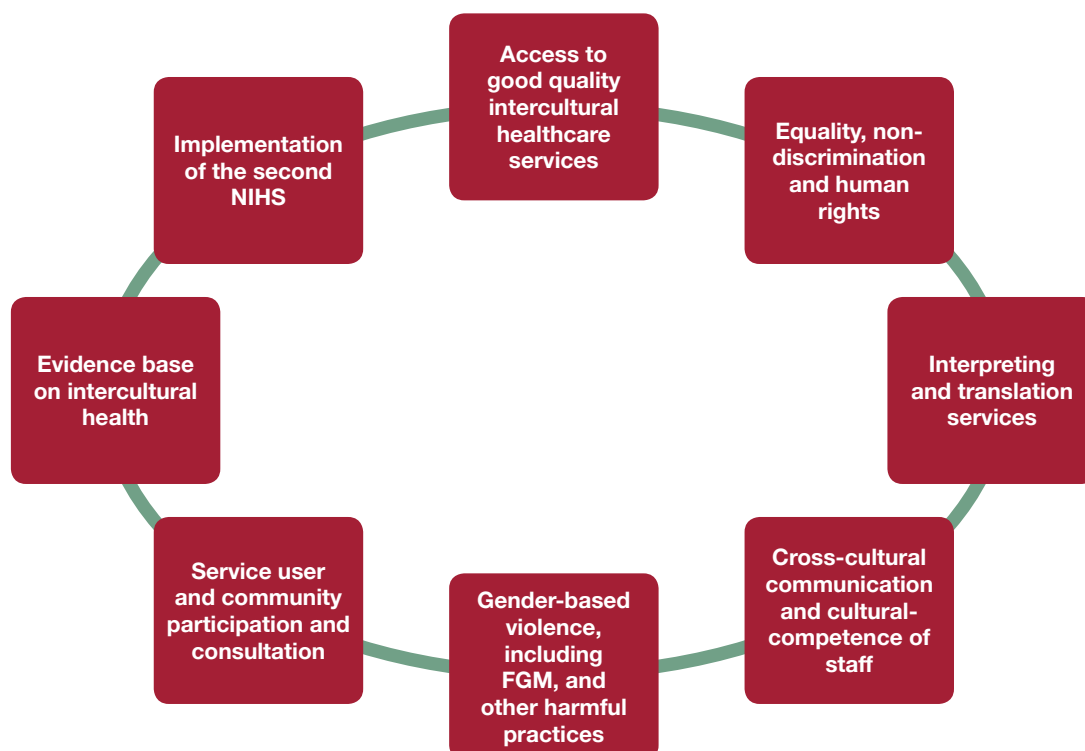
2.2 What did the first NIHS achieve?

The first NIHS (2007–2012) was the first intercultural health strategy to be developed in Ireland. It promoted a strategic, socially inclusive whole-organisation approach to addressing the health and social care needs of an increasingly ethnically diverse population. Its key pillars focused on access to services, developing cultural competence of staff and enhancement of data.

When it was launched, Ireland was enjoying a growing economy and there was a focus in the public sphere on initiatives that sought to combat racism and welcome diversity. Funding was available in the initial phases of the first NIHS for implementing its range of recommendations, with associated structures and processes put in place to progress them.

As the recession deepened, however, the climate changed dramatically, leading to impacts for all health services, including those for service users from diverse ethnic and cultural backgrounds. Funding became limited and initial plans around implementation necessitated a change of approach. Instead of being in a position to implement wide-ranging interventions, a more pragmatic approach was taken to produce resources that would support service users in accessing services and service providers in delivering culturally competent services.

Figure 2.3: Key themes to emerge from the consultation process



Alongside this work, much effort focused on linking the strategy into existing developments across the HSE and beyond, as a means of ensuring that any new policy document or targeted intervention would take account of the unique health and support needs of service users from minority ethnic groups.

2.2.1 Strengths of the first NIHS

In a recent European review of migrant health policy across 25 countries,³ the model used for the development of the first NIHS was cited as an example of inclusiveness and participation. Furthermore, many of its features were all explicitly singled out as good practice, including: the broad and balanced approach it promoted; the population groups it targeted; the health issues it addressed; the focus on both patients/users and providers; the model of implementation using existing health service structures; and the setting up of a process to include and consult with minority ethnic groups. The strategy has been cited in intercultural and/or migrant health policy journals, periodicals and online articles, and is highly ranked in popular search engines.

Acknowledgement of the HSE's contribution to migrant health issues is also reflected in the HSE being invited to participate in a number of cross-European projects. This active participation has proved of benefit, both in enabling the HSE to make an ongoing contribution to policy development, and in its learning regarding new challenges and approaches within a European context.

In the Irish context, the first NIHS is provided as a link on websites of agencies from both the statutory and voluntary sectors, allowing for continuing awareness of its relevance. Similar to its influence at a European level, awareness of the NIHS within Ireland has resulted in invitations to participate in various cross-government committees and in a range of associated initiatives.

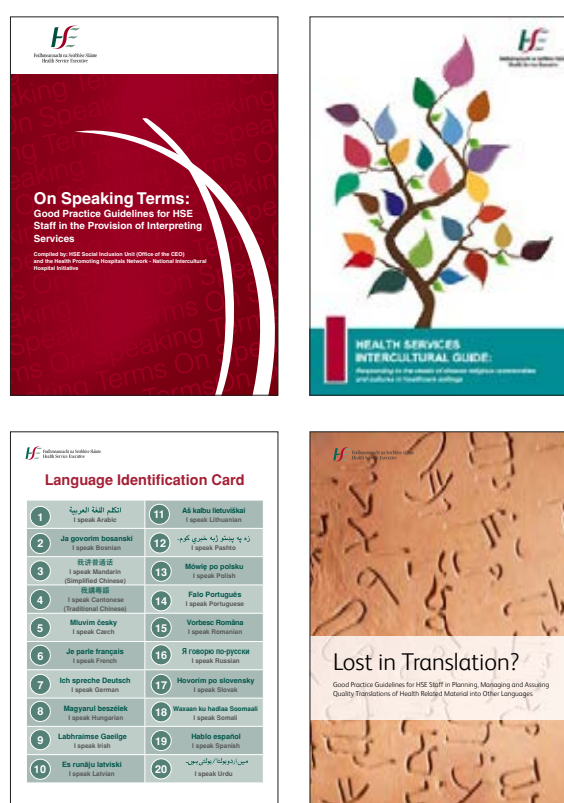
Regarding its implementation, considerable progress was made across key areas, including capacity building, staff training and support, database developments, research, guidelines to translation and interpreting, and development of resources, such as the Intercultural Guide and the Emergency Multilingual Aid toolkits. The findings of a review of the strategy, conducted in 2016, were positive, confirming that 20 of its 43 actions had been completed, with a further 16 being active and the remaining seven suspended.

Valuable learning took place via a range of regional intercultural health projects, such as development of a peer health model for application with asylum seekers, refugees and Roma, a Roma Men's Training, Development and Health Literacy Programme (Atelier) and initiatives around supporting refugees. (Links to these resources are listed in Appendix 5.)

2.2.2 Weaknesses of the first NIHS

Particular difficulties were encountered in the key area of data collection and analysis. A key element of the first NIHS was its emphasis on the importance of enhancing evidence around intercultural health needs and outcomes as a means of planning, monitoring and evaluating appropriate targeted and evidenced initiatives. Efforts towards implementing ethnic equality monitoring have been fragmented, resulting in limited capacity to evaluate the impact of targeted actions.

Figure 2.4: Resources published under the first NIHS (2007–2012)



³ <http://web.minsal.cl/wp-content/uploads/2015/09/BP01-Practicas-Europa-2012.pdf>

3. EVIDENCE BASE FOR THE STRATEGY

This section sets out the research literature and relevant, available data that informed the development of this strategy. Where relevant, objectives are listed.

3.1 Established communities

While greater awareness exists around the influx of new arrivals to Ireland, it is also important to note the existence of long-established groups of ethnic minorities in Ireland, many of whose members have resided in the country for decades. The Jewish community is one example of such a long-established group, with the first wave of arrivals dating from 1772. These established communities coexist alongside growing Islamic, Asian, and African, Eastern European and Chinese communities.

3.2 Migration trends

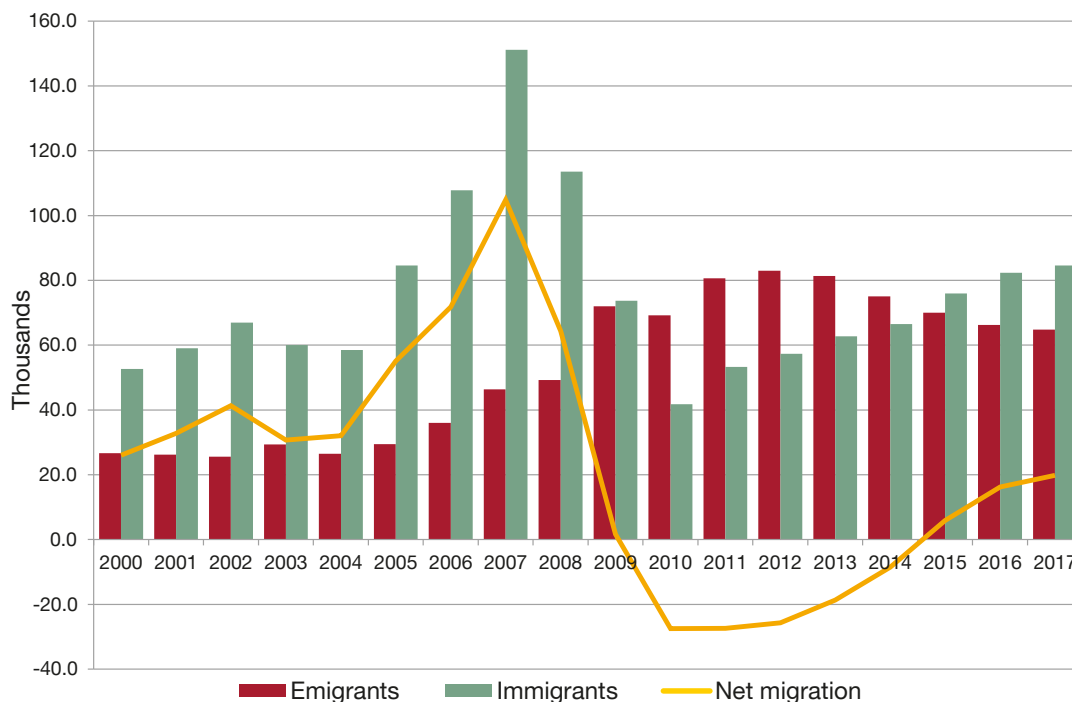
A number of developments, including changes in patterns of migration, have taken place in Ireland since the first NIHS (2007).

3.2.1 Overall migration trends

- Economic growth and the enlargement of the EU in 2004 led to high net inward migration, and inflows of migrants peaked during the economic boom in 2006–2007. Immigration declined following the onset of the economic crisis in 2008.
- According to CSO Statistical Release (2017), the number of immigrants to the State in the year April 2016 to April 2017 is estimated to have increased by 2.8% from 82,300 to 84,600, while the number of emigrants declined over the same period, from 66,200 to 64,800. Of the 84,600 people who immigrated to Ireland in the year to April 2017, some 27,400 (32.4%) were estimated to be Irish nationals. Non Irish-nationals from outside the EU continued to display strong migration flows, accounting for 29,400 (34.8%) of total immigrants and 13,700 (21.1%) of total emigrants. This resulted in estimated net inward migration among non-Irish nationals from outside the EU of 15,700.

- According to figures from the DOJE (2017a), approximately 115,000 non-EEA nationals were registered with permission to live in Ireland, compared to 114,000 at the end of 2015. The current top five registered nationalities, which account for over 48.5% of all persons registered, are Brazil (13.2%), India (12.2%), China (9.2%), USA (7.9%) and Pakistan (6%). The majority of persons with permission to remain in the State are here for work or study purposes. Figures also show that 10,044 citizenship certificates were issued in 2016. The top five nationalities awarded citizenship were Poland (1,328), India (1,028), Nigeria (777), Romania (756) and the Philippines (730).



Figure 3.1: Gross and net migration, Ireland, 2000 – April 2017

Source: ESRI's Annual Report on Migration and Asylum (2016).

Figure 3.1 above, taken from the Economic and Social Research Institute's (ESRI) annual report on migration and asylum (2017), shows gross and net migration for Ireland from 2000 to April 2017. Total net inward migration for Ireland in the year ending April 2017 was 19,800 – the highest level of net migration since 2008.

Labour migration

Immigration in Ireland peaked in 2006 and 2007 and declined sharply thereafter; concurrently, migrant outflows increased noticeably after 2009, particularly among migrants from the new EU Member States. The economic and financial crisis significantly affected labour migration to Ireland, with a decline in migration from within the EU and a pattern of some migrant workers returning to their countries of origin.

In general, non-EEA nationals must have an employment permit to work in Ireland. EEA and Swiss nationals do not need an employment permit. Under the Employment Permits Acts (2003–2014) there are nine types of employment permit, including a General Employment Permit, a Critical Skills Employment Permit and a Dependant/Partner/Spouse Employment Permit. Unless their residence permission states otherwise, non-EU nationals may not enter into employment in the State without holding an employment permit. Dependency of a

non-EU national on his or her employed partner can be problematic in this context.

The total number of valid residence permits held by non-EEA nationals for the purpose of work was just under 18,000 at the end of 2015, and 43,540 valid permits were held for education reasons. According to Eurostat, permits held for work reasons increased by 13 per cent between 2014 and 2015, from 15,831 to 17,947 (ESRI, 2017). Data on the size of the irregularly resident population or the extent of illegal employment of non-EU nationals in Ireland are not currently available from an official or objective source.

The HSE itself is an employer of a significant number of foreign staff, with the Department of Business, Enterprise and Innovation issuing 1,203 work permits to the HSE during 2016. A total of 3,101 medical and nursing permits were issued during the same time period.

Foreign students

There is no single comprehensive dataset for foreign students in Ireland; therefore, exact numbers are not available. The number of non-EEA nationals registered through the Garda National Immigration Bureau registration system in February 2015 who had permission to remain in Ireland as students (on Immigration Permission Stamp 2) was approximately

35,400.⁴ This figure does not include non-EEA students who were in the State to engage in studies for a period of less than three months or who have permission to remain in the State in a different category (for example, as a dependant of an Irish or EEA national).

Under immigration law, non-EU students are required to provide proof of private medical insurance as a condition of their student visa. Students from EU Member States who are in possession of the European Health Insurance Card (EHIC) are entitled to public health services in Ireland. Limited information is available in respect of their uptake of health services; anecdotally, however, it appears that many students wait for holidays to their country of origin to access treatment, self-medicate or devise other innovative mechanisms of accessing care.

Asylum seekers

Despite a significant reduction in the numbers seeking asylum in Ireland in recent years, escalating violent conflicts in Syria, Iraq and Afghanistan, as well as in several African countries, coupled with poverty, on-going discrimination and violence against minorities in some Balkan states, has led to a recent increase in people seeking international protection in Ireland. In 2016, 2,244 applications for refugee status were received by the Office of the Refugee Applications Commissioner (ORAC), which represented a 32% decrease on the 3,276 applications received in

2015. There were 1,448 applications in 2014 and 946 applications in 2013. An average of 187 applications per month was received in the course of 2016. The top five countries of origin for 2018 were Syria (n=278), Georgia (n=252), Albania (n=185), Zimbabwe (n=149) and Pakistan (n=140).

The number of asylum seekers accommodated by the Reception and Integration Agency (RIA) on 31 December 2016 was 4,425, a decrease of 271 persons, or 5.7%, from the same date in 2015.

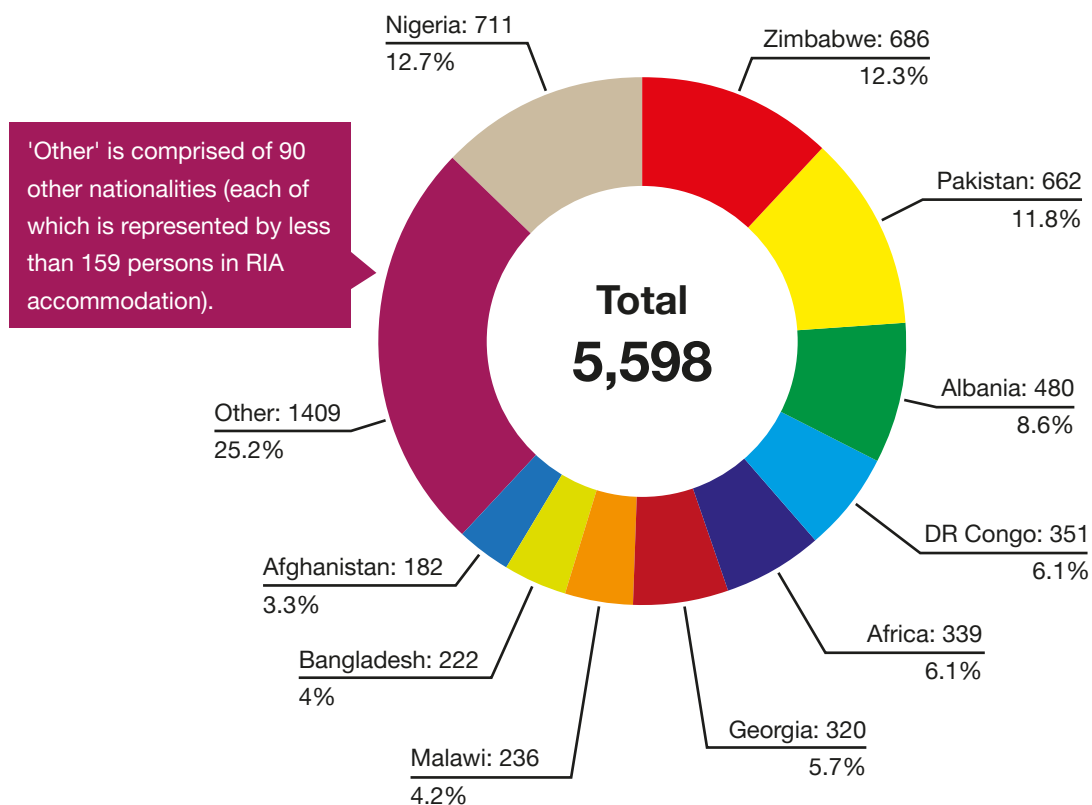
- During 2016, the overall numbers accommodated by the RIA since the introduction of state-provided accommodation in 1999 exceeded 57,480 persons. (See Figure 3.2 on next page for nationality breakdown of RIA residents in July 2018 in Ireland.)
- The number of asylum applications received at ORAC/IPO by the end of December 2017 was 2,927, already representing an increase on 2016 figures (2,224). (See Table 3.1 below.)
- Regarding the age profile of 'RIA residents' in Ireland, the majority are aged between 18 and 45 years; in July 2018, a total of 3,581 RIA residents were 18–45 years, out of a total of n=5,594 (RIA, 2018).
- By November, 2018, 3,324 people had sought international protection.

Table 3.1: Number of asylum seeker applications to Ireland, 2000 – July 2018

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
2000	976	864	972	1036	802	677	773	919	963	1098	1096	762	10938
2001	840	706	763	741	838	882	961	983	855	892	904	960	10325
2002	838	763	932	888	795	869	1133	995	1199	1148	984	1090	11634
2003	979	947	892	667	604	661	646	655	611	496	395	347	7900
2004	392	363	501	377	403	324	371	401	466	329	409	430	4766
2005	393	377	489	320	322	315	325	348	372	320	346	396	4323
2006	400	313	438	282	412	278	313	332	422	394	415	310	4309
2007	385	333	347	277	318	316	358	294	318	356	343	340	3985
2008	329	296	299	299	301	329	339	333	360	357	324	300	3866
2009	254	270	270	241	229	244	218	226	197	203	176	161	2689
2010	189	176	167	161	179	154	162	174	155	143	154	125	1939
2011	133	125	127	87	100	114	111	113	95	72	117	96	1290
2012	101	83	59	69	76	70	91	87	70	105	72	73	956
2013	79	83	65	92	80	73	70	65	80	81	109	69	946
2014	99	83	109	95	106	105	131	126	138	129	155	172	1448
2015	215	201	209	265	257	334	290	332	407	263	291	212	3276
2016	213	193	138	154	139	157	163	197	219	186	223	262	2244
2017	163	222	214	172	295	212	178	218	336	312	297	308	2927
2018	312	287	375	221	218	234	299						1946

Source: RIA Monthly Report (2018)

⁴ Figures provided in response to a parliamentary question; see: <https://www.kildarestreet.com/wrans/?id=2015-04-01a.240>.

Figure 3.2: Nationality breakdown of RIA residents in Ireland (end of July 2018)

Source: RIA Monthly Report (2018)

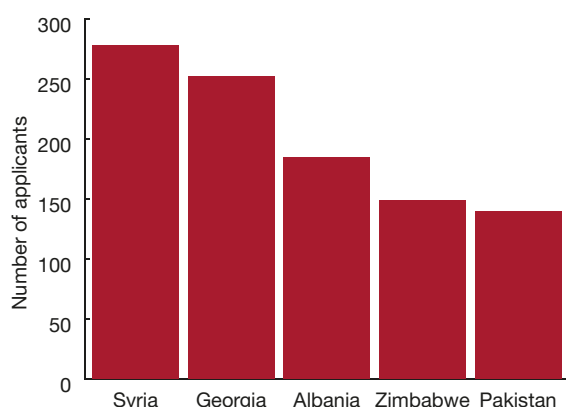
A number of families are housed in RIA accommodation and Table (3.2) shows a total number of 2830 persons in Family Units in July 2018.

Table 3.2 Breakdown of family groups in RIA accommodation

	Number of Family Groups in RIA Accommodation												
Family Type	Lone Parent Families					Married/Partner Families						Single	
Family Size	LP +1	LP +2	LP +3	LP +4	LP +5	M/P +0	M/P +1	M/P +2	M/P +3	M/P +4	M/P +5+	Female	Male
No. of Units	221	136	63	26	16	78	107	108	73	27	11	647	1953
No. of Persons in Family Units*	442	408	252	130	96	156	321	432	365	162	66		
Totals	1328					1502							
Total Family Units						866						647	1953
Total Persons in Family Units*						2830						2600	

Source: RIA Monthly Report (2018)

Figure 3.3: Top five countries of origin to end of July 2018



Source: RIA Monthly Report (2018)

As shown in Figure 3.3 above, Syria was the top nationality for asylum applications to Ireland to the end of July 2018 (DOJ&E, 2018). Syria was not among the top five nationalities in 2015. These figures include both asylum applications from applicants who arrived directly in the State and those made under the EU Relocation Scheme. Arrivals in Ireland on relocation from Greece in 2016 were from Syria and Iraq.

In May 2017, the Irish Supreme Court ruled that the current absolute ban on asylum seekers seeking work is, in principle, unconstitutional. In January 2018, the Irish Government decided to opt into the EU (recast) Reception Conditions Directive (2013). On 30 June 2018, the Minister for Justice and Equality signed the European Communities (Reception Conditions) Regulations 2018 (“2018 Regulations”). These Regulations transpose the EU (recast) Reception Conditions Directive into our national law.

The Directive provides a legislative framework for the provision of reception conditions and related supports for applicants in Ireland’s international protection system including labour market access. Persons outside of the protection process, i.e. those with status or with permission to remain or with a Deportation Order are outside the scope of the Directive/Regulations. Under the Directive, as of June, 2018, people seeking international protection will have access to the labour market nine months from the date when their protection application was lodged, if they have yet to receive a first instance recommendation from the International Protection Office, and if they have cooperated with the process. Eligible applicants may apply to the Minister for Justice and Equality for a labour market permission, which covers both employment and self-employment. The Labour Market Access Unit (LMAU) of the

Irish Naturalisation and Immigration Service (INIS), on behalf of the Minister, will process applications. The permission will be granted to eligible applicants for six months and will be renewable until there is a final decision on their protection application. Eligible applicants will have access to all sectors of employment, with the exception of the Civil and Public Service, An Garda Síochána, and the Irish Defence Forces.

In addition to labour market access, the Directive also includes important provisions in relation to health, education, children’s rights, and material reception conditions for applicants, which include housing, food, clothing and a daily expense allowance. These other benefits will apply to all applicants in the protection process regardless of when they made their application. The Directive will bring the State into line with standards across the EU Member States for reception conditions for international protection applicants, including standards in accommodation centres.

Wider implications of the European Communities (Reception Conditions) Regulations 2018 in relation to the operation of the Common Travel Area and Brexit negotiations are also being examined across government departments.

Irish Refugee Protection Programme (IRPP)

A limited Refugee Resettlement Programme has operated in Ireland since 2000.⁵ The Government established the IRPP in September 2015 as part of the State’s humanitarian response to the migration crisis in southern Europe. The State agreed to accept up to 4,000 asylum seekers and refugees

⁵ The Irish Refugee Protection Programme was established by Government Decision on 10 September 2015 in response to the humanitarian crisis in southern Europe as a consequence of mass migration from areas of conflict in the Middle East and Africa. Under this programme, the Government committed to accept up to 4,000 people into the State, through a combination of the EU relocation programme established by two EU Council Decisions in 2015 to assist Italy and Greece, and the UNHCR-led refugee resettlement programme, which is currently focused on resettling refugees from Lebanon. The Government Decision to accept 4,000 persons into the State did not itself contain a time limit, but the relocation programme had a time limit of approximately two years. It has not been possible for Ireland to deliver fully on the numbers allocated to it, primarily because those numbers did not actually exist on the ground in the relevant countries. Hence, the Government has had to find other mechanisms to deliver on the commitment made by Ireland. The shortfall in numbers will be filled over time by pledges for programme refugees and by family reunification arrivals under the new IRPP Humanitarian Admission Programme 2 (IHAP). All of these additional commitments can be made because the relocated asylum seeker mechanism did not produce the numbers originally envisioned.

overall into Ireland under relocation and resettlement programmes at the earliest time possible. The Minister for Justice and Equality has pledged to take a further 945 programme refugees from Lebanon between 2018 (345) and 2019 (600). A Family Reunification Humanitarian Admission Programme (FRHAP) forms part of the IRPP for 2018. The Government has prioritised family groups and the need to address the position of unaccompanied children, with a commitment to take up to 200 unaccompanied minors from France who were previously resident in the migrant camp at Calais. The majority of those

arriving under the IRPP are family groups, of whom 40% are minors and 32% are under 12 years of age. A pilot Community Sponsorship project will begin this autumn and run for 18 months initially, with up to 50 refugees arriving in Ireland. Community Sponsorship is an alternative resettlement stream to the traditional state-centred model. Table (3.3) below details the origin of resettlement refugees admitted into Ireland since 2010, while Table (3.4) details the profile of resettlement programme refugees from 2015 to November 2018 (age on arrival).

Table 3.3: Origin of resettlement refugees admitted into Ireland since 2010

Arrival by year of entry									
	2010	2011	2012	2013	2014	2015	2016	2017	Total
Afghan	0	0	0	31	0	0	0		31
Cameroonian	0	0	0	0	0	0	0		0
Chadian	0	0	0	0	0	0	0		0
Chinese	0	0	0	0	0	0	0		0
Congolese	0	0	1	0	0	0	0		1
Cuban	0	0	0	0	0	0	0		0
D. R. Congolese	0	0	20	31	7	0	0		58
Egyptian	0	0	5	0	0	0	0		5
Eritrean	0	9	1	0	0	0	0		10
Ethiopian	0	6	3	0	0	0	0		9
Iranian	0	0	0	0	0	0	0		0
Iranian Kurd	0	0	5	0	0	0	0		5
Iraqi	16	6	0	0	0	27	11	12	72
Iraqi Palestinian	0	0	0	4	0	0	0		4
Ivory Coast	0	0	0	0	0	0	0		0
Jordanian Palestinian	0	0	0	0	0	0	0		0
Liberian	0	0	4	0	0	0	0		4
Moroccan	0	1	0	0	0	0	0		1
Burma-Karen	3	0	0	0	0	0	0		3
Burma-Rohinga	0	0	0	0	0	0	0		0
Palestinian	0	0	0	0	0	0	0		0
Russian	0	0	0	0	0	0	0		0
Russian (Chechnia)	0	0	0	0	0	0	0		0
Rwandan	0	0	0	0	0	0	0		0
Serbian	0	0	0	0	0	0	0		0
Somali	0	0	10	15	0	0	0		25
Sri Lankan	0	0	0	0	0	0	0		0
Stateless	0	0	0	0	0	0	0		0
Sudanese	0	23	0	5	0	0	0		28
Syrian	1	0	0	0	89	149	335	254	828
Syrian Palestinian	0	0	0	0	0	0	10		10
Togolese	0	0	0	0	0	0	0		0
Tunisian	0	0	0	0	0	0	0		0
TOTAL	20	45	49	86	96	176	356	266	1094

Source: Office for the Promotion of Migrant Integration (2017)

Table 3.4: Profile of resettlement refugees from 2015 to November 2018 (age on arrival)

Resettlement programme arrivals under IRPP					Updated	30 Nov 2018
Year	People	Adults	Minors	Age 0-4	Age 5-12	Age 13-17
2015	163	73	90	32	46	12
2016	356	167	189	53	101	35
2017	273	123	150	53	84	13
2018	136	63	73	22	36	15
Totals	928	426	502	160	267	75

Source: IRPP (2018)

Refugees are accommodated in an emergency reception and orientation centre (EROC) until such time as arrangements are in place for them to be accommodated in different parts of the country. While living in the EROC, refugees have the opportunity to engage in various educational activities including orientation and English language training programmes for those that are 18 or older. Young refugees under the age of 18 are eligible for childcare and/or can participate in programmes that help prepare them for the Irish education system.

Thirty-four applications for refugee status were made to the ORAC by unaccompanied minors in 2016 (Barrett et al, 2017). In 2016, a total of 126 referrals were made to the dedicated social work team for separated children seeking asylum in Tusla: Child and Family Agency. A total of 82 unaccompanied minors were placed in statutory care. Completed family reunification services were provided to 47 children. Under the Refugee Act, 1996, it is the responsibility of the Refugee Applications Commissioner to refer unaccompanied minors to Tusla in line with Section 8 (5) of the Refugee Act, 1996 (ORAC, 2016).

Family reunification

Family reunification is an important part of the process of integration for migrants in Ireland. The FRHAP was announced in late 2017, whereby up to 530 immediate family members of refugees from UNHCR-recognised conflict zones will be accepted into Ireland as part of the overall Refugee Protection Programme. The family members are to be immediate family members who fall outside the scope of the International Protection Act 2015 (whose definition of family members includes spouses, civil partners, children (under 18) of the sponsor and parents/siblings of the sponsor, if sponsor and siblings are under age 18).

3.3 General issues faced by migrants and minority ethnic groups

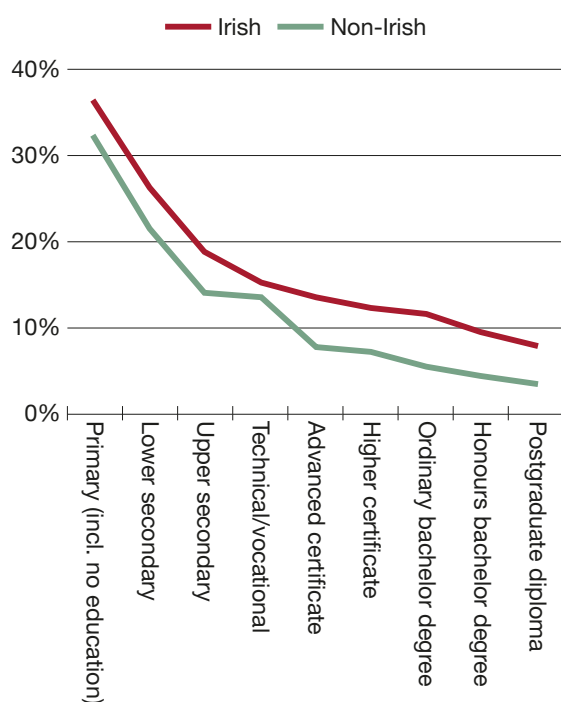
3.3.1 Poverty and disadvantage

Some migrants, including members of minority ethnic groups, can face higher levels of poverty, disadvantage, hardship and marginalisation. While progress made under the first NIHS should be acknowledged, the demanding economic environment led to challenges in the provision of health and other support services to fully meet the diverse social and healthcare needs of migrants, particularly vulnerable migrants and asylum seekers. In many cases, poverty and disadvantage grew during the economic crisis and particularly affected vulnerable migrants, many of whom experienced barriers in accessing services, in some cases relating to the Habitual Residence Condition (HRC) (2004).

Data from the ESRI's Monitoring Report on Integration show that in 2015 the "at risk of poverty" rate was higher for non-Irish nationals, and income poverty was higher among non-Irish nationals than Irish nationals (Barrett et al, 2017). In 2014, 21% of non-Irish nationals were living below the income poverty line, drawn at 60% of median household income, compared to 16% of Irish nationals. In 2015, the unemployment rate for non-Irish nationals was 13%, compared to less than 10% for Irish nationals. Unemployment is higher and employment rates are lower among African nationals than any other national group. Such inequalities are confirmed by findings of Census 2016, where the unemployment rate of non-Irish nationals (15.4%) was found to be higher at all levels of unemployment than that of Irish nationals (12.5%).

Figure 3.4 on the next page presents the unemployment rate by level of education attained. The graph shows that the higher the education, the lower unemployment rate, for both groups. For example, 7.8% of Irish nationals who were educated to Advanced Certificate level were unemployed, compared with 12.3% of non-Irish nationals with the same level of education.

Figure 3.4: Unemployment rate by level of education attained, Irish and non-Irish, 2016



Source: Census 2016

Migration has a significant impact on homelessness. Heightened levels of vulnerability among members of minority ethnic groups are also found in the area of homelessness, where Census 2016 found that – among those who provided a nationality – a slightly higher proportion of the usually resident homeless population was found to be non-Irish (14.1% or 849 people), compared with the entire population, where the proportion was 11.6%.

The Dublin Region Homeless Executive and Dublin City Council confirmed that the official spring (March 2018) count on rough sleeping identified a minimum of 110 persons sleeping rough across the Dublin region (Dublin Region Homeless Executive, 2018). Of the 110 persons, 58% were Irish nationals and 42% were non-Irish nationals. The cohort of homeless non-Irish nationals might include undocumented migrants, asylum seekers, refugees, EU citizens and beneficiaries of international protection. A report to the Minister for Housing, Planning and Local Government (2018) highlighted specific challenges arising for local authorities in dealing with individuals presenting as homeless who do not have the right to reside in Ireland or do not meet the habitual residency requirements to apply for social housing supports. In many cases, individuals without an entitlement to housing supports can spend significant time in

emergency accommodation with no option to move on. In other cases, local authorities may only provide emergency accommodation on a night-to-night basis. This presents particular challenges for families with children.

3.3.2 Racism and discrimination

The Migrant Rights Centre Ireland (MRCI) found that, among migrant workers in Ireland, 38% of those surveyed felt they were treated differently to other staff because of race, colour, nationality, ethnic origin or religion (MRCI, 2015). Similarly, a recent study published by the National Youth Council of Ireland (NYCI) confirmed that young people reported experiencing significant racism in their day-to-day activities (NYCI, 2017).

3.3.3 Accessing services

People from diverse backgrounds may encounter barriers in accessing public services, including health services. This holds significant implications for help seeking, appropriate and timely access to services and uptake of treatment and associated outcomes.

3.3.4 Legal and administrative

Legal status is a key determinant of migrants' access to health services in a country. Habitual residence in Ireland is a qualifying condition that must be satisfied in order to be eligible for certain social welfare payments and child benefit. Inability to prove residence can be a barrier to claiming benefits, often compounded by language and literacy issues. Such a situation places families at risk of poverty and exclusion.

The residency of many migrant women living in Ireland is dependent on the legal status of their partner. Migrant women in this situation may not disclose domestic violence for fear of deportation. Those women who leave a partner and do not satisfy the HRC are particularly vulnerable and may find themselves and their children destitute.

3.3.5 Language

Ability to communicate effectively is a key requisite for optimal health outcomes. Research evidence indicates that there are strong positive relationships between a healthcare team member's communication skills and a patient's capacity to follow through with medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviours (Institute for Healthcare Communication, 2011). Conversely, communication can be seriously impaired if a healthcare provider is

unaware of or insensitive to the role of culture during formal interactions, or the inability of the service user to communicate effectively.

Census 2016 offers a picture of the range of languages spoken by people living in Ireland. A total of 612,018 Irish residents spoke a foreign language at home (up 19% from 514,068 in 2011). Polish was by far the most common language, followed by French, Romanian and Lithuanian.

Of the 612,018 people who spoke another language at home, 508,016 (83%) indicated they could speak English “well” or “very well”, while 86,608 people (14.2%) indicated “not well” or “not at all”. A total of 2,469 persons (20%) aged 65 years and over who could not speak English well or at all. Figure 3.5 below indicates ability to speak English by nationality.

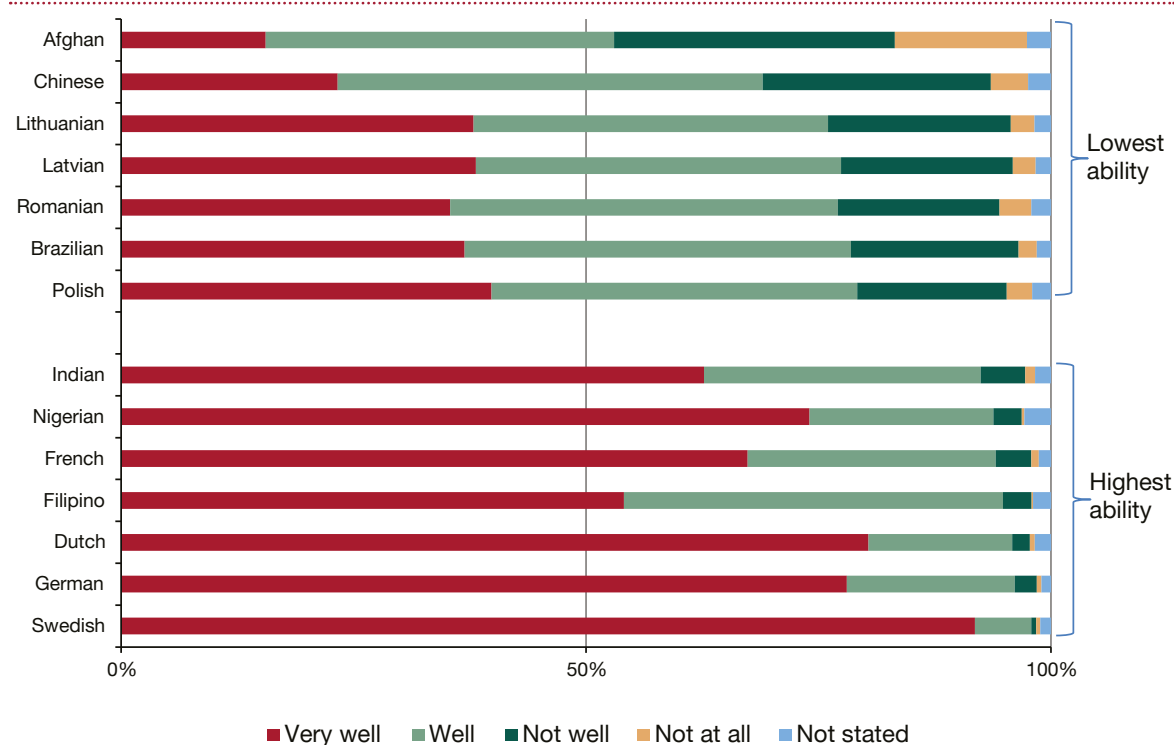
Not being proficient in English exacerbates difficulties in accessing and using health services optimally. Provision of interpreting is a key mechanism for supporting service users to navigate the health system appropriately and effectively. While some

interpreting support is offered in health settings, it is acknowledged that this is inconsistent and fragmented, with attendant risks in respect of assurance of quality.

Additional challenges to the development of a model for quality interpreting provision relate to the absence of standards in Ireland around interpreting, with attendant risks around services availing of untrained interpreters and implications for outcomes. A recently published report by the Immigrant Council of Ireland, *Migration and Language in Ireland* (2017), supports the importance of professionalising and monitoring interpreting services in Ireland.

Staff working in health services also require support in identifying the need for an interpreter and working effectively in an interpreting context (HSE, 2009). Guidelines are available to support communication in cross-cultural general practice consultations. These were developed using innovative participatory research methods to enable the meaningful involvement of health service users from the migrant community and health service providers (HSE, 2012).

Figure 3.5: Ability to speak English by selected nationality, 2016



Source: CSO, 2016, Chapter 5 of *Census 2016 – Diversity*.

Suggested actions: Interpreting

- Progress recommendations of the *Report of the HSE Working Group to Develop a Model for the Implementation of Trained Interpreters in the Irish Healthcare System* (2018).
- Finalise an appropriate model for the phased implementation of interpreting provision across the HSE.
- Provide training to staff in working effectively with interpreters.
- Promote uptake of the resource, *Guidelines for Communication in Cross-cultural General Practice Consultations* (2012).

3.3.6 Provision of health-related information

All service users require access to a range of information around available health services, entitlements, mechanisms of navigating services and so on, in order for them to access health services in an appropriate way. Absence of information in relation to a service user's preferred language can compound any existing difficulties in relation to their access to health services.

Lack of appropriate information, coupled with experience of difficulties in accessing services, results in poor uptake of necessary services and usage of services only when a health situation risks becoming an emergency.

Much of the health promotion material and messages currently in use across the HSE is already utilised by members of diverse groups. In some instances, translation of this material may be all that is necessary to facilitate access to relevant information. However, certain material may need to be culturally adapted. In addition, and as with the indigenous population, some people from different minority ethnic and cultural groups may not be functionally literate, even within their own language. Addressing this issue will require a greater emphasis on visual and spoken messages. In some instances too, health information may need to be targeted at specific groups, such as women and older people.

The manner in which health promotion material is disseminated is of crucial importance. Peer-led approaches are likely to be most successful, from both a language and cultural perspective. Due consideration should be given to the most appropriate settings within which programmes are provided. Traveller primary health projects may offer useful models in this regard. Intercultural health workers (such as Roma health advocates and asylum seeker and refugee health workers) are part of a collaborative model of intercultural health work in the south-east region, where peer health workers are employed to work with their own communities to support access to health information and health services.

The HSE publication, *Lost in Translation*, provides a useful resource for staff in effecting quality, effective translation of health information. Such information should be offered in a range of formats designed to be in line with service user language and literacy needs. It should also be readily available and accessible across different health settings.

The wide range of health information to be translated across HSE sectors suggests a need for the development of a coordinated system of effecting prioritised health-related information.

Suggested actions: Information provision and translation

- Provide information in accessible, culturally responsive ways, including information on issues such as eligibility and entitlements.
- Develop and roll out, in collaboration with Cáirde, an interactive mobile app to support migrants in accessing health services.
- Produce and disseminate an accessible document that facilitates orientation to health services and their usage in Ireland.
- Implement an evidence-informed system of translating prioritised information and sharing across services.

3.3.7 Integration into life in Ireland

Many migrants settle and integrate into life in Ireland without great difficulty. However, it is important to acknowledge and understand the unique experiences and difficulties faced by migrants in integrating into economic and social life. In particular, difficulties in adjusting to and integrating into life in Ireland are compounded by a lack of family support, which presents additional barriers associated with living in a different culture and with different societal expectations. This may especially be the case for people seeking asylum or refugees who have been displaced from their home countries and must attempt to forge new lives in an unfamiliar country without trusted networks or supports. Experiences of racism and discrimination present additional barriers to successful integration.

A recent report of the Irish Human Rights and Equality Commission (2017) revealed that:

- Almost one in eight people in Ireland report that they have experienced discrimination over the preceding two years.
- Compared to White Irish respondents, Black respondents are three times more likely to experience discrimination in the workplace and in access to public services, and over four times more likely to experience discrimination in access to private services. White non-Irish do not differ from White Irish respondents in reported discrimination in any domain; the workplace, seeking work, or in relation to public services.
- Irish Travellers are almost ten times more likely than the White Irish group to experience discrimination in seeking work, and over 22 times more likely to experience discrimination in access to private services.

Ability to access responsive, culturally competent public services is a key determinant of integration. A key focus of the second NIHS is the long-term integration of migrants and improved understanding of, and responsiveness to, the different needs of established black and minority ethnic groups in Ireland and the needs of recently arrived migrants and refugees.

The *Migrant Integration Strategy* (Department of Justice and Equality, 2017a) has been developed as the Government's response to the challenge of promoting integration in a context of increased

diversity. Its vision is to enable migrants or persons of migrant origin to participate on an equal basis with those of Irish heritage.

The HSE approach to intercultural health – and to support for members of diverse ethnic and cultural groups in integrating into Irish society – is underpinned by community development principles of involving migrants in identifying issues relevant to their health and supporting them to address these.

Suggested actions: Integration into Irish society

- Establish a partnership mechanism through which the voice of service users from minority ethnic communities can influence progress in implementation and evaluation of actions.
- Explore, promote and implement appropriate models of community development that support migrant communities in working towards improving their health status.

3.4 Vulnerable groups

Although the majority of migrants living in Ireland have integrated positively into communities, displaying qualities of resourcefulness and resilience, and contributing to wellbeing of Irish society, certain groups from diverse ethnic or cultural backgrounds are acknowledged as particularly vulnerable. These groups include people seeking asylum, refugees, members of the Traveller and Roma communities and people who may have become undocumented. A significant number of service users from these groups have experienced war, trauma and sexual violence in their home countries. Within these groups some people may be victims of trafficking for sexual exploitation, while victims of FGM experience significant health and care needs.

The cross-cutting and intersecting nature of intercultural health means that service users from these groups may experience disproportionately greater needs for healthcare and support.

3.4.1 Asylum seekers and Refugees

Asylum seekers and refugees may share similar experiences of upheaval, distress and trauma, resulting in seeking a new life in Ireland. Refugees accepted into Ireland via the Government Resettlement and Relocation Schemes, together with many asylum seekers, have been subjected to a range of negative experiences, including

displacement, loss of family members, and physical and emotional trauma. Substantial research and evidence from consultations shows the need for improved health and support services for both groups. This includes research recommendations arising from research by the Faculty of Public Health Medicine within the Royal College of Physicians in Ireland (RCPI), on the health of asylum seekers and refugees (RCPI, 2016).

In 2014, the *Working Group Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers* (the McMahon report; Department of Justice, 2015) made some important recommendations for changing the asylum system, including specific recommendations relating to healthcare. The McMahon report noted that the average length of time asylum seekers spend in direct provision has increased annually; in 2015, 41% of residents spent five years or more in the system.

The McMahon report (2015) makes specific recommendations to improve asylum seekers' access to health and other support services, including the quality and accessibility of interpreting services. It highlights a key concern about the negative impact of the direct provision system on the physical, emotional and mental health of residents, and on the wellbeing and development of children. The report also draws particular attention to the negative effect living in direct provision has on vulnerable persons, including victims of torture, rape, FGM, trafficking and other forms of psychological, physical or sexual violence, as well as asylum seekers from the LGBTI+ community.

Suggested action: Asylum seekers and refugees

- Develop targeted interventions in line with government and related obligations, within resource constraints, including those outlined in the McMahon report (2015), and commitments set out in the Irish Refugee Protection Programme, the *National Traveller and Roma Inclusion Strategy 2017–2021* and the *Migrant Integration Strategy: A Blueprint for the Future*.

3.4.2 Traveller and Roma communities

Members of the Traveller and Roma communities represent distinct ethnic and cultural minority groups. The total number of Travellers in Ireland as

enumerated in 2016 was 30,987, an increase of 5.1 per cent from 29,495 in 2011.

The AITHS (2010) presents stark evidence of the disproportionately poor health of members of the Traveller community. One of its key findings is that Travellers of all ages continue to have much higher mortality rates than people in the general population, with Traveller men now living on average 15 years fewer than men in the general population and Traveller women living on average 11.5 years fewer than women in the general population (Department of Health, 2010). Deaths from respiratory diseases, cardiovascular diseases and suicides were found to be more markedly increased in Travellers compared to the general population. Suicide is almost seven times the rate of the general population in adult males and accounts for approximately 11% of all Traveller deaths. Of those tested in the 12 months prior to the research study, one-quarter had been diagnosed as having high cholesterol and over one-third had high blood pressure. Two-thirds (66.3%) said that illicit drug use is a problem in the Traveller community.

In the Republic of Ireland (ROI) and Northern Ireland (NI), 90.3% and 97.3% of Traveller children respectively were reported as having no ongoing health problem (AITHS Team, 2010). For those children who had a health problem, the number one reported condition was asthma, which accounted for 71.9% of reports of chronic conditions in childhood in the ROI. Of the Travellers interviewed, 83% said they received their health information and advice from Primary Healthcare for Traveller projects and Traveller organisations. Positive findings from the survey included evidence of good access to health services and improvements in Traveller women's health.

It is estimated that between 3,000 and 5,000 members of the Roma community live in Ireland. Roma are acknowledged as particularly disadvantaged, with unique care and support needs often compounded by low levels of education, illiteracy and issues in respect of entitlement to public services. A recent report highlighted the need for better access to primary care services as a key issue for the Roma community, a finding that arose through a consultation process with members of the Roma community in the Dublin South region (Jacob and Kirwan, 2016). The inability to access services was found to be directly related to an individual's ability to pay for or qualify for entitlement to state-funded healthcare. Access to services was also highlighted in a seminar on maternal health and Roma in Ireland, where particular focus was placed on the HRC as

a major barrier to women's access to basic GP services (Pavee Point, 2014). Other barriers included a lack of accessible information; in relation to this, the report recommended the provision of information about the Irish healthcare system, where and how to access care, rights and entitlements, and language, literacy and computer training. Such information, it was argued, should be presented in an appropriate, accessible and clear manner, and ultimately aim to empower women to engage in decision making regarding their own care.

Many people from the Roma community in Ireland do not have access to medical cards. This is related to a lack of access to social protection and an inability to prove their means when applying for a medical card. The result is lack of access to basic GP care, which is very costly without a medical card. Roma women report an inability to access GPs and a fear of using accident and emergency departments or maternal health services, in case they receive bills for treatment. Roma women report receiving conflicting reports in relation to payment for maternity services and a lack of knowledge of the Maternity and Infant Care Scheme.

Maternal health emerged as a key concern in *Roma in Ireland: A National Needs Assessment* (Pavee Point and Department of Justice and Equality, 2018). This study found that 24% of women had not accessed health services while pregnant and their first point of access to these services was to give birth. Service providers identified new-born babies living in houses with no heat, food or basic supplies. Almost two-fifths (37.1%) of respondents reported that they did not have adequate supplies for the baby after birth. Poor mental health rates were extremely high; over half (51.3%) of respondents reported more than 14 days of the previous month when their mental health was not good.

The report acknowledged that there are some efforts to address these issues, and the HSE has funded Roma workers to address issues facing Roma. Recommendations are made in respect of demographics, discrimination, poverty, language, employment and social protection, accommodation, health, education and policy development.

The recently published *NTRIS 2017–2021* recognises that Traveller and Roma communities are among the most marginalised in Ireland. It contains a range of cross-sectoral actions aimed at addressing the range of needs of these groups. A large number of health-related actions are included in this strategy. A separate cross-government structure has been put in place to drive the implementation of these actions,

and for this reason, specific actions in respect of improving Traveller and Roma health are not included in this intercultural health strategy. Nonetheless, it is important to note the synergies that should be observed in taking any action that may impact on these groups.

Suggested actions: Traveller and Roma communities

- Deliver health-related actions in the *National Traveller and Roma Inclusion Strategy 2017–2021* including violence against Traveller and Roma women on a phased, prioritised basis, taking the findings of *Roma in Ireland – A National Needs Assessment* (2018) into account while implementing agreed actions.
- Support and monitor the new research initiative established by HSE Social Inclusion South East Community Healthcare and the University of Limerick on the health needs of Roma, asylum seekers and refugees.

3.4.3 Victims of human trafficking

Trafficking in human beings is a heinous practice that continues across the world. Its hidden nature makes it impossible to detect or estimate the true number of victims exploited in this way.

Trafficking of human beings into and within the European Union (EU) is a highly gendered phenomenon with 75% of victims for all purposes being female. Data from Eurostat indicates that a “a distinct gender split can be seen within the different types of exploitation with trafficking for the purpose of sexual exploitation being the most prevalent form of trafficking in the EU (67%), 96% of whom are women; the overwhelming majority of whom are trafficked into the commercial sex trade of destination countries.

Physical and mental health impacts of trafficking on this vulnerable group are significant and responses are required that address the vulnerability of this cohort, offer protection and safety and support recovery.

During 2016, a total of 95 alleged trafficking victims were identified in Ireland, compared to 78 in 2015. Twenty-eight of these victims were third-country nationals, among whom those from Nigeria, Brazil, Pakistan and Zimbabwe were the largest discernible groups. A breakdown of gender, nationalities and type of exploitation is shown in Table (3.5) on next page.

Table 3.5: Trafficking data, Ireland, 2016

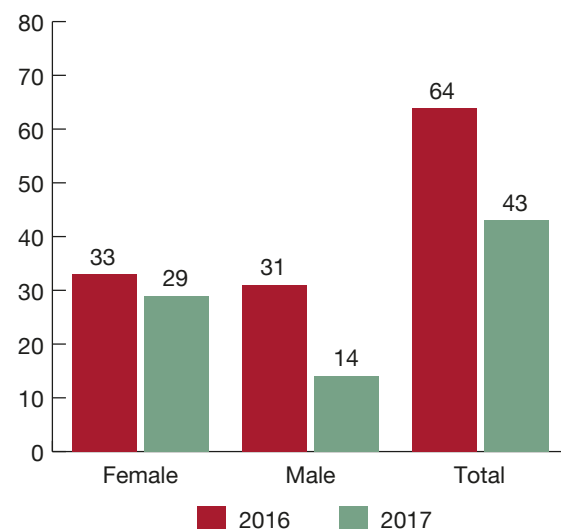
Gender	50 were female and 45 were male
Nationalities	39 were from Romania; 19 were Irish children; 10 were from Nigeria and the remainder were from Eastern Europe, Africa, South Asia and South America. 70% of victims were EU nationals.
Type of exploitation	52 were exploited in sex trafficking, 38 in labour trafficking, one in both sex and labour trafficking and four in forced criminality in the selling of heroin.

Source: Sheridan (2017), originally cited in *Trafficking in Persons Report, 2017*

Between January and April 2016, 16 people were referred to the HSE's Anti-Human Trafficking Team, a 57% increase on the same time period in 2015 (which saw seven referrals). These included alleged victims of sexual exploitation, forced criminality, labour exploitation, and forced marriage (HSE National Social Inclusion Office, 2016). During 2016, 51 suspected victims of human trafficking were reported to the RIA by An Garda Síochána. Of these, eight were asylum seekers (RIA, 2017).

Figures provided by the HSE Anti-Human Trafficking Team reveal the number and nature of cases trafficked into Ireland from 2008 until the present time. (See Figure 3.6.)

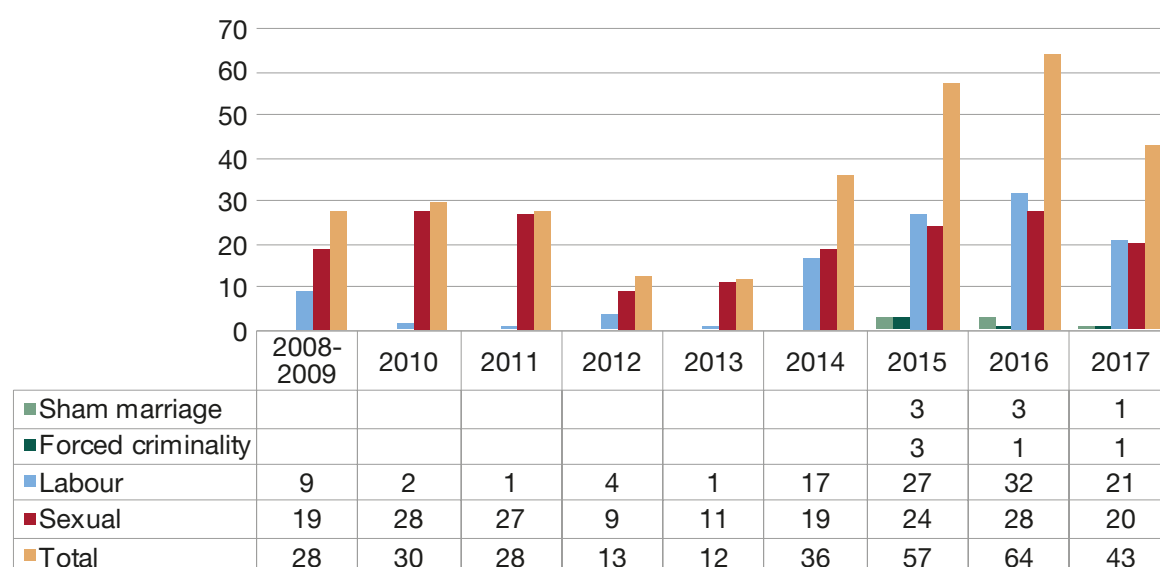
Figure 3.7 presents a gender breakdown of trafficked service users in 2016 and 2017.

Figure 3.7: Trafficked service users by gender, 2016–2017

Source: Anti-Human Trafficking Team, HSE

The Second National Action Plan to Prevent and Combat Human Trafficking in Ireland (Department of Justice and Equality, 2016) underpins approaches taken by the HSE towards provision of care and support for victims of human trafficking. This document contains a number of actions to be delivered by the HSE.

In addition, the HSE is planning a strategic review of its Anti-Human Trafficking Team. The purpose of the review will be to examine the structure, staffing and mode of delivery for these services in order to ensure that they are best able to meet current and future demands.

Figure 3.6: Anti-human trafficking cases by type of exploitation

Source: Anti-Human Trafficking Team, HSE

Suggested actions: Victims of human trafficking

- Progress implementation of the health-related actions of the *Second National Action Plan to Prevent and Combat Human Trafficking in Ireland* (2016).
- Undertake a strategic review of the HSE Anti-Human Trafficking Team.

3.4.4 Undocumented migrants

Undocumented migrants include persons who have entered the country unknown to authorities, those who have overstayed their visas, and those who breach the terms and conditions of their permission to reside. The MRCI estimates that there are between 20,000 and 26,000 undocumented migrants – including children and families – living and working in Ireland. The majority may have entered the country legally as students or tourists, for example, but would then have become undocumented for a variety of reasons. The MRCI reports that undocumented workers are more commonly found in caring positions, particularly in eldercare, and in cleaning roles. A recent ESRI report (Arnold et al, 2017) highlights the vulnerability of members of this group, who may be engaged in precarious employment, often compelled to tolerate exploitation rather than be identified. This is a situation that holds clear implications for health and wellbeing. This cohort also faces many challenges in accessing public services, including health services. Many members of this group live in the shadows of society, with no eligibility to health services, except in emergency situations. This holds implications for health status and for appropriate access to care and treatment.

Suggested action: Undocumented migrants

- Provide ongoing support to NGOs who assist undocumented migrants and other vulnerable groups in accessing appropriate care.

3.5 Health-related needs and issues across the lifecycle

The “super diversity” of service users from diverse groups is reflected in the different health statuses and care needs of the different cohorts arriving and living in Ireland.⁶ Many service users from new or established migrant communities may access mainstream health services without any difficulty.

Refugees and asylum seekers and those who have lived in camps or come from war-torn regions may be at risk of poorer health because of gender-based violence, post-traumatic stress, poor nutritional status and infectious diseases (Gagnon and Redden, 2016). By contrast, economic migrants may be richer and in better health than the native population of their host country, the so-called “healthy migrant effect” (ibid.).

Some migrants experience specific social or medical related healthcare needs, including the need for culturally responsive mental health support, support in dealing with past trauma and violence, as well as the need for health screening and healthcare support associated with living with HIV and AIDS. Those who carry a disproportionate burden of mental and physical health generally make frequent use of health services. The reverse might also be the case, whereby lack of knowledge of the health system results in failure to access services until an emergency situation occurs.

In addition, as migrant groups have become more established in Ireland it is important to take account of the support and care needed for different age groups, and for people with different and changing physical, mental and cognitive abilities.

Within the heterogeneity of the broad cohort of service users from diverse ethnic and cultural communities, certain groups may be considered to be particularly vulnerable, due to their multiple intersecting identities; for example, a disabled woman from a minority ethnic group might experience disproportionately greater social isolation and exclusion due to negative experiences related to all these facets of her identity.

⁶ The term “super diversity” has been used to describe a multicultural or multi-ethnic society. The University of Birmingham established the Institute for Research into Super diversity in 2013; see Phillimore et al (2015).

Specific subgroups of the migrant population may have specific health service needs, across the life cycle: children and young people; women; men; lesbian, gay, bisexual, transgender and intersex people; and older people. Subsections 3.5.1 to 3.5.14 consider the specific needs of these groups in further detail.

3.5.1 Children and young people

The Convention on the Rights of the Child (CRC) is a universal blueprint for the treatment of children under 18 years. Approaches to the care and protection of children in Ireland are governed by *Children First – National Guidance for the Protection and Welfare of Children* (Department of Children and Youth Affairs, 2017). The care of all children in Ireland falls within the remit of Tusla: Child and Family Agency.

Many children living in established minority ethnic communities may be well integrated into Irish society. Those living in the direct provision system, or arriving in Ireland as part of refugee families or as unaccompanied minors, however, may be regarded as among the most vulnerable in Irish society. It is self-evident that, just like children from the majority culture, children of diverse ethnicities and cultures present frequently to health services. In this context, it is essential that health service providers are fully cognisant of the challenges faced by children from this cohort and are equipped to respond sensitively and responsively to them.

When children migrate, they may experience pre-, peri- and post-migration trauma. Immigrant, migrant and refugee children are at higher risk for several health challenges, including mental health difficulties. For example, there is significant mental trauma that is associated with resettlement during childhood, and perceived acceptance or discrimination within the host country is especially relevant (Fazel et al, 2012). Moreover, from a health promotion and prevention perspective, migration is a barrier to children receiving immunisations at an appropriate time. Low uptake of immunisations among Roma children is of particular concern, with this often related to myths about this health practice, fears of accessing public services, illiteracy and unfamiliarity with its value.

While children generally may prove resilient in the face of adversity, it is also true that much support – both to them and to their families – is needed to achieve optimal mental and physical health. Parenting programmes have proved helpful in providing support to parents in a new country with unfamiliar practices, different customs, different methods of discipline, and so on. Such programmes should continue to be encouraged.

Learning to cope in a strange new country is especially challenging for older children. The report of the NYCI, *Make Minority a Priority* (2017) offers valuable insights into the experiences of young people from diverse ethnic and cultural minorities growing up in Ireland. Intergenerational issues are prominent among its findings, with challenges for young people highlighted in relation to negotiating a balance between parental values and cultural expectations against the need to integrate with Irish cultural norms and practices, while still maintaining a sense of identity.

Tusla has developed a *Child Protection and Welfare Practice Handbook* (2011), which was designed to complement and be a companion volume to an earlier version of *Children First: National Guidance for the Protection and Welfare of Children* (2011). The handbook advises practitioners:

to be acutely aware of the culturally sensitive approaches required to work with children and families from different backgrounds. It does not mean that cultural differences allow children to be abused. Awareness of cultural factors must remain high since they influence all aspects of child protection, from the occurrence and definition through to its treatment and successful prevention.

(Tusla, 2011, p. 88)

The handbook highlights that issues such as child trafficking, FGM, forced marriage and honour based violence require the practitioner to take advice on the cultural context and work sensitively with the child and family keeping the child's safety and welfare as their primary concern. The new *Children First Guidance* (2017, p.12) mentions that "While

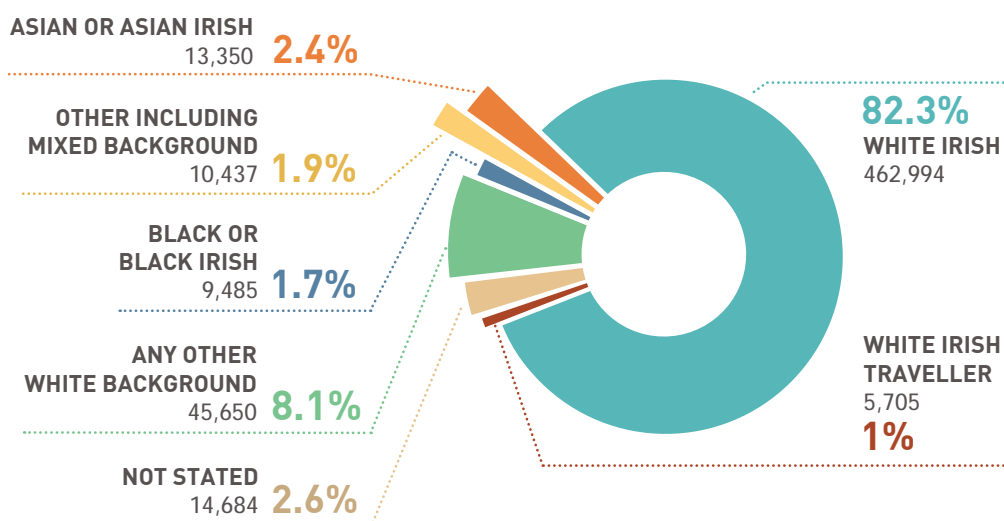
bullying can happen to any child, some may be more vulnerable. These include: children with disabilities or special educational needs; those from ethnic minority and migrant groups; from the Traveller community; lesbian, gay, bisexual or transgender (LGBT) children and those perceived to be LGBT; and children of minority religious faiths".

Figure 3.8: Ethnic diversity and young people in Ireland

ALMOST **1 IN 7**
YOUNG PEOPLE (15%) AGED 15-24 LIVING
IN IRELAND ARE **MINORITY ETHNIC**



ETHNICITY OF YOUNG PEOPLE IN IRELAND AGED 15 – 24 YEARS



The largest minority nationality groups amongst the 15-24 age group are:
POLISH UK LITHUANIAN ROMANIAN IRISH-AMERICAN BRAZILIAN LATVIAN

Source: National Youth Council of Ireland, 2017

Suggested actions: Children and young people

- Support the implementation of HSE-assigned actions in the *National Traveller and Roma Inclusion Strategy 2017-2021 relating to children and youth*.
- Promote the development and delivery of appropriate parenting and associated programmes as a means of supporting parents in a range of areas, including child protection and associated obligations, healthy living and nutrition.
- Support colleagues in HSE Health and Wellbeing in ensuring that the specific needs of young people from diverse ethnic, cultural and religious groups are taken into account in all aspects of development of strategies, plans and health-related actions.
- Work with relevant organisations to develop anti-racism and intercultural core competencies for youth workers in order to ensure that organisations are better equipped to support minority ethnic young people.

3.5.2 Women

Gender is acknowledged as a key determinant of health, with acknowledgement that women from all minority ethnic groups and cultures are a particularly vulnerable cohort.

Many women have lived in Ireland as members of settled communities. Other women may come to Ireland as asylum seekers, refugees, in search of work or to join family members. The experiences of these women are varied and diverse. The different ways in which they enter Ireland will impact on how, when and if they access healthcare services.

Feminisation of migration has emerged as a phenomenon of recent decades. While women have always migrated, their movement used to be more directly related to family reunification or to depend on a male migrant. Today, though, women are moving as primary migrants in their own right.

Women are disproportionately affected by the stresses of migration on their families, often due to their traditional roles of cultural and intergenerational mediators. The challenges faced by women migrants may also be compounded by social isolation, fears for the safety of family members in their countries of

origin, and lack of extended family support networks. Disruption of traditional roles, particularly when having to assume the role of head of a household, may be particularly challenging. In situations where her legal status is linked to that of her partner, a female migrant may be further disempowered. Risks of domestic violence and other abuse in such situations are evident.

Women from diverse ethnic and cultural backgrounds who live in particularly vulnerable, precarious or hostile circumstances may be subject to sexual harassment or may in some situations -- feel forced to engage in transactional sex. Appropriate supports should be in place to support women in such situations. At the same time, care is needed to avoid any potential stereotyping or stigmatising of this vulnerable group.

Ireland's *Second National Action Plan on Women, Peace and Security* (2015) recognises the vulnerabilities of women who have come to Ireland from areas of conflict. This plan contains recommendations in relation to Ireland's commitments to provision of support for women in other countries, as well as to that group in Ireland who have suffered the effects of war, trauma and violence.

Suggested action: Women

Implement all relevant health-related actions contained in cross-government documents, including *Ireland's Second National Action Plan on Women, Peace and Security 2015–2018* and forthcoming *Third National Action Plan*. (Department of Foreign Affairs and Trade, 2015), *the Second National Strategy on Domestic, Sexual and Gender-based Violence, 2016–2021* (Department of Justice and Equality, 2016a), and the *National Strategy for Women and Girls 2017–2020* (Department of Justice and Equality, 2017c).

3.5.3 Men

Gendered approaches to migration acknowledge the vulnerability of women from diverse ethnic and cultural backgrounds; such an approach should, however, not diminish the challenges and hardships encountered by men of diverse ethnicities and cultures living in Ireland. Men who have arrived in Ireland as asylum seekers and refugees may experience particular difficulties in adapting to a new culture which differs markedly in terms of roles and behaviours, with implications for feelings of depression and disempowerment. Migrant men are

also more at risk of STIs, including HIV and hepatitis B, and of sexual violence.

Legal status is a key determinant of ability to integrate into Irish society. At the same time, however, many male migrants encounter significant discrimination and prejudice when seeking employment, accessing services and undertaking activities of daily living.

The *National Men's Health Action Plan* (2016) recognises the health inequalities experienced by subgroups of men, including men from minority ethnic groups, and emphasises the importance of the Public Sector Equality and Human Rights Duty in providing a mandate for maintaining a policy focus on men affected by marginalisation.

Suggested actions: Men

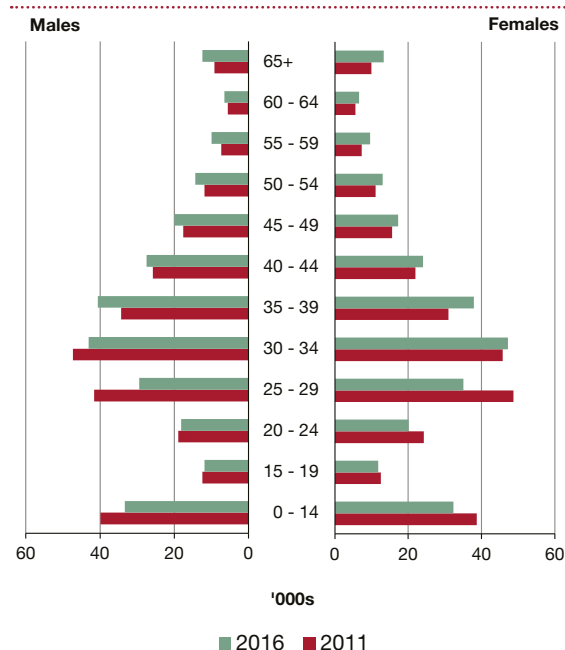
- Promote and support development of programmes to support men of diverse ethnicities and cultures, including proven models, such as Men's Sheds.
- Continue to support implementation of programmes for Roma men, based on projects such as the Roma Men's Training, Development and Health Project (Atelier).
- Address actions relevant to men of diverse cultures and ethnicities contained in the *National Men's Health Action Plan 2017-2021*.

3.5.4 Older people

While many older people from minority ethnic backgrounds have integrated into communities, a significant number may remain isolated in their homes, uncertain of entitlements and unable to navigate services available to them.

Compared with 2016, the population of older adults will increase by 19,800 (3.2%) in 2017 and 131,000 (21.0%) in 2022 (CSO, 2017a). Old age dependency will increase from 18.1 in 2012 to 21.2 in 2017, rising to 24.3 in 2022, resulting in an increased demand on services for older people. Figure 3.9, taken from the CSO's 2017 chapter on diversity, shows the increase in older people of non-Irish origin between 2011 and 2016.

Figure 3.9: Non-Irish population pyramid, 2011 and 2016



Source: CSO (2017) *Census 2016*, chapter on diversity.

The proportionate increase of older people from minority ethnic and cultural backgrounds has implications for planning to ensure access to tailored, culturally competent health and support services for this age cohort. The previously referenced figure of 2,469 people over 65 years in Ireland who could not speak English well or at all is particularly noteworthy here.

A significant number of older people are cared for by migrant workers. The training and support needs of this cohort of caregivers are considered in the 2009 Irish national report, *The Role of Migrant Care Workers in Ageing Societies*.

As with other cohorts, older people from minority ethnic and cultural backgrounds comprise a diverse and heterogeneous group, with some having greater healthcare needs than others. *The National Positive Ageing Strategy* (Department of Health, 2013) notes that particular attention should be paid to the needs of more marginalised, vulnerable, hard-to-reach and minority groups of older people, including older migrants and people from different ethnic backgrounds.

Suggested action: Older people

- Support colleagues in HSE Social Care to proof policies and practices as a means of ensuring that the care and support needs of older service users from diverse ethnic and cultural backgrounds are fully and appropriately incorporated into all activities.

3.5.5 LGBTI+

A small number of migrants who are LGBTI+ come to Ireland from countries where such identity is stigmatised or, in some instances, illegal. Coming from such contexts, the decision to disclose sexual identity may be fraught with anxiety and fear of hostility and discrimination. Young LGBTI+ persons seeking asylum face particular challenges in this regard.

LGBTI+ persons can experience particularly high levels of stress due to the stigma and discrimination they may face as a result of their cultural backgrounds. This in turn creates barriers to accessing services and in integrating into their new lives. It also increases their risk of social isolation.

The intersecting identity of migrants who may also be LGBTI+ is acknowledged in *The LGBT Ireland Report* (Higgins et al, 2016). The *LGBTI+ National Youth Strategy 2018-2020* – under the aegis of the Department of Children and Youth Affairs (2018) – contains reference to the challenges faced by young migrants, refugees and asylum seekers who identify as LGBTI+. Relevant recommendations contained in this strategy will be supported by this intercultural health strategy.

Suggested actions: LGBTI+

- Support and progress recommendations in *Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015-2020*, that have particular relevance to service users in the LGBTI+ community from diverse ethnic and cultural backgrounds.
- Support and progress actions of the *LGBTI+ National Youth Strategy 2018-2020* that have particular relevance to young service users from diverse ethnic and cultural backgrounds.
- Support research carried out by TENI in respect of the unique barriers faced by transgender refugees and asylum seekers in accessing health and care services.
- Ensure the health and support needs of LGBTI+ service users of diverse ethnicities and cultures are considered in a forthcoming HSE National LGBTI+ Health Strategy.

3.5.6 Health screening

The World Health Organization (WHO) document, *Stepping up Action on Refugee and Migrant Health: Towards a WHO European Framework for Collaborative Action* (2015) makes the following unequivocal statement:

Migrants and refugees do not pose a health security threat to the host communities. Health assessments, massive screenings and mandatory examinations are not the solution and ought to be put in perspective and demystified. In this respect, refugees and migrants are no different to international travellers and the risks that they pose to general populations.

WHO, 2015

In 2015, the HPSC's Scientific Advisory Committee (SAC) reviewed and updated the national guidelines on communicable disease screening for migrants in Ireland. The original 2004 guidelines had referred only to asylum seekers. The purpose of these guidelines is to give appropriate guidance in relation to assessment of common infectious diseases in migrants.

Suggested actions: Health screening

- Promote the implementation of infectious diseases and other health screening guidelines for migrants.
- Introduce measures to support uptake of childhood and relevant adult immunisations among members of minority ethnic groups.
- Work with key stakeholders to develop information and guidance for service users and staff in respect of awareness and management of health-related conditions specific to members of minority ethnic groups.
- Review health screening practice in direct provision centres and emergency reception and orientation centres.
- Ensure health screening on arrival of refugees arriving under the Irish Refugee Protection Programme, with onward timely referral to primary care and other services as necessary.
- Continue to support operation of the Mobile Bus, operated by Safetynet in partnership with HSE Social Inclusion, in delivery of health screening and basic primary care service delivery to members of socially excluded groups.

3.5.7 Oral health

Good oral health is closely linked with overall health and wellbeing. Poor oral health has a negative effect on quality of life and can increase the risk for chronic diseases.

Poor oral health has emerged as a priority issue among refugees arriving in Ireland and is pervasive among both adults and children of this cohort. This appears to be a consequence of absent or inadequate dental care over a sustained period and limited opportunities to practice consistent oral hygiene, combined with poor nutrition. High levels of smoking among the refugee male cohort pose an additional risk factor for poor oral health. Dental trauma associated with torture has also been noted among vulnerable asylum seekers and refugees. Finally, certain cultural beliefs and practices may also impact on oral hygiene and on associated uptake of dental health services and adherence to treatment.

Suggested action: Oral health

- Support HSE Oral Health colleagues to develop an effective, culturally responsive model towards the prevention, treatment and aftercare of the refugee cohort in the first instance.

3.5.8 Chronic conditions

It is accepted that the health problems of refugees and migrants are similar to those of the rest of the population, although some groups may have a higher prevalence of certain conditions. A 2017 HSE informal review of IOM medical records of Syrian refugees revealed a significant burden of chronic disease, mostly in the adult population. However, younger people are also affected (for example, regarding weight/inactivity and respiratory conditions). Most of the chronic illnesses reported consist of diseases which are also prevalent in the Irish population, such as ischaemic heart disease, hypertension and diabetes mellitus. A sedentary lifestyle, high levels of obesity and cigarette smoking are recorded in the adult refugee population. These are known risk factors for many of the chronic diseases recorded.

Other conditions, such as G6PD deficiency, are less well known to Irish healthcare staff who may need education and support. As certain infectious diseases have a higher prevalence in eastern Mediterranean countries, the prevalence of chronic hepatitis B and C among people from those countries appears to be higher than in the indigenous Irish population.

Limited access to immediate care before and during transit and arrival phases may increase the burden of untreated chronic conditions. This is especially the case for refugees and people seeking asylum. Conditions of travel in situations of sudden migration may further exacerbate existing chronic conditions, with complications arising from interruption of access to care, loss of prescriptions, medication and other aids and appliances, deterioration in living conditions, exposure to extreme weather and so on.

Health screening of this cohort should be linked to referral to appropriate care.

Suggested actions: Chronic conditions

- Provide guidance and support to GPs and other health professionals in providing appropriate, effective care to migrants.
- Continue to support the implementation of the HSE *National Hepatitis C Strategy* (2011) and the National Hepatitis C Treatment Programme, ensuring appropriate and responsive care to members of minority ethnic groups.

3.5.9 Sexual health

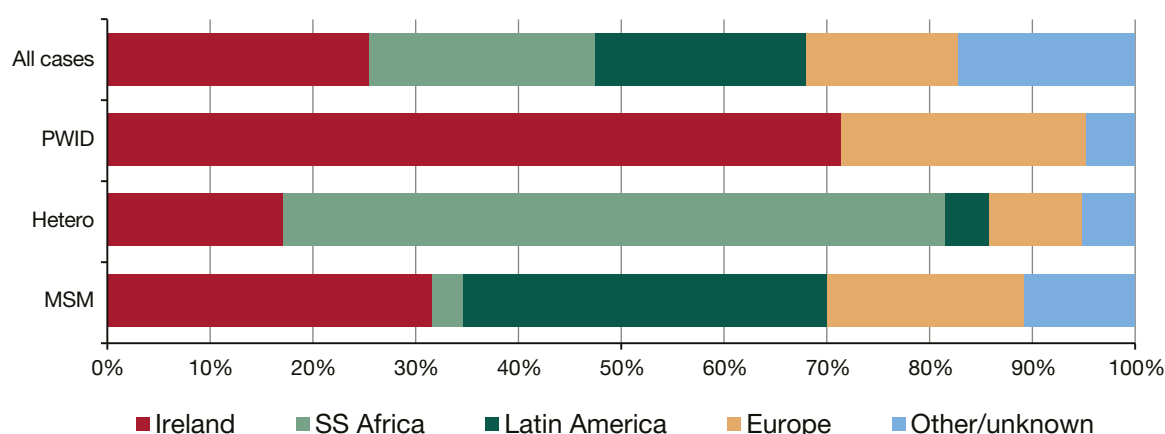
Prior to their arrival in Ireland, the crises that many migrants and refugees encounter disrupt their access to reproductive healthcare and sexual health information. Migrant and refugee women and girls may be vulnerable to gender-based violence and exploitation, unwanted pregnancy, STIs including HIV and maternal illness and death. Men can also be victims/survivors of sexual violence in the context of war and migration.

Living in Ireland does not necessarily remove all barriers to accessing sexual and reproductive services. The *National Sexual Health Strategy* (2015) identified people with a migrant background as a vulnerable group requiring targeted support to improve their sexual health and wellbeing. Research carried out on behalf of the Crisis Pregnancy Programme in 2012 highlighted the need for healthcare staff to provide culturally sensitive care to woman and girls requiring

sexual, reproductive or maternity health services (Conlon et al, 2012).⁷ The research found that legal status was a key factor in determining a woman's access to health services. In addition, cultural and religious background, language, communication and lack of knowledge of services were also identified as barriers. A separate study found that women who experience communication barriers are less likely to receive adequate counselling and culturally sensitive care (Lyons et al, 2008). It also reported that migrant women and girls experience particular problems accessing contraception, due to cost, lack of information and lack of choice of healthcare provider. Migrant women report that the Irish healthcare system does not fully meet their needs, either because they do not know about the services available or how to access them.

HPSC figures show that 508 people were diagnosed with HIV in 2016 (HPSC, 2017). Of these, 77 per cent were male and 23 per cent female. Twenty-five percent (n=129) of new diagnoses were made to people born in Ireland, 61% (n=311) were made to people born abroad and 13% of this group (n=68) did not have information on country of birth. Of those born abroad, 36% (n=113) were born in sub-Saharan Africa and 33% (n=103) in Latin America (see Figure 3.10). Geographic origin varied by route of transmission. The rate of diagnosis among those born in Ireland has remained stable since 2003, ranging from 3.4 to 4.2 per 100,000 population. There has been much greater fluctuation in the rate among migrants, for whom the rate has increased, from 18.4 in 2011 to 38.4 per 100,000 in 2016.

Figure 3.10: HIV diagnoses by region of birth and probable route of transmission

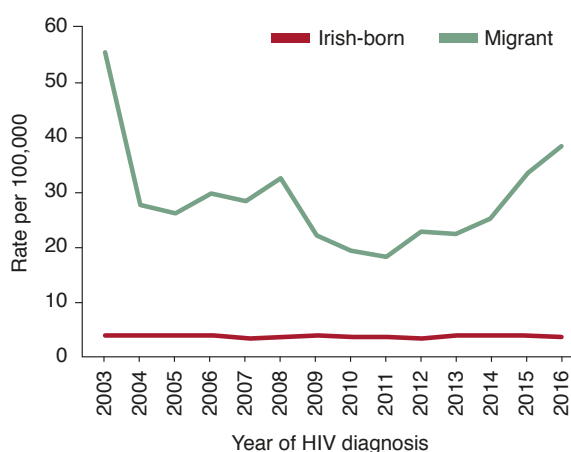


Source: HPSC

⁷ The research report recommended the following: 9.2.1 Increasing cultural sensitivities and partnership in sex education; 9.2.2 Building information and access to sexual and reproductive health services for young migrant women; and 9.2.3 Quality and cultural competence of sexual and reproductive health services.

Figure 3.11 shows that since 2003, the rate of HIV diagnosis has remained consistently higher among the migrant population than among the Irish-born population.

Figure 3.11: Trend in HIV diagnoses by migrant status, 2003–2016



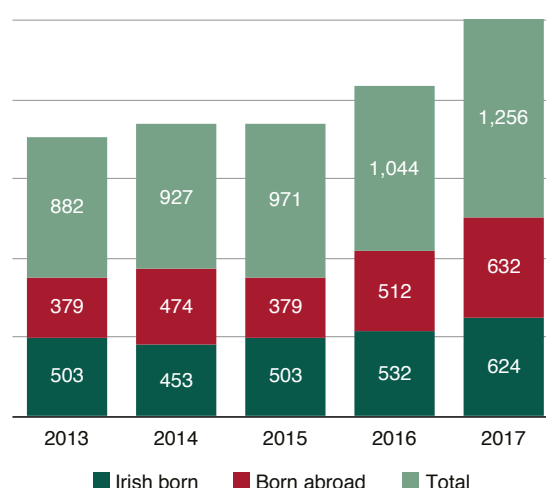
Source: HPSC

There are limited data available on the prevalence of the Hepatitis C virus (HCV) among migrants living in Ireland. The HPSC developed guidelines providing a comprehensive infectious disease assessment for migrants in 2015. The Department of Health's Hepatitis C screening guidelines (2017) recommend that migrants from a country with an intermediate to high prevalence of HCV (anti-HCV $\geq 2\%$ *) should be offered one-off HCV screening.⁸

A number of factors, social, economic and political, affect the risk of infection with HIV and hepatitis viruses among migrants and refugees. The risk is heightened in countries where HIV services are not readily available or where there is stigma attached to accessing such services.

Migrant gay men are also at risk of HIV and other STIs. The HSE's Gay Men's Health Service records an increasing diversity of men attending the STI clinic in Dublin. The Gay Men's Health Service Annual Report (2017), outlines that of the 1256 patients whose first ever presentation to the screening service was in 2017, 632 were born abroad. Figure 3.12 confirms this growing diversity:

Figure 3.12: Patients' first presentation to the HSE's Gay Men's Health Service, 2017



Source: Gay Men's Health Service Annual Report (2017)

Suggested actions: Sexual health

- Build synergy with relevant actions contained in the *National Sexual Health Strategy 2015–2020*.
- Work with ethnic groups, especially those from high-burden countries, to reduce risks and spread of HIV, blood borne viruses (e.g. Hepatitis C) and other serious sexually transmitted infections (STIs).
- Support access to culturally appropriate information on contraception and services (including referral pathways for women with unplanned pregnancies) to all women, with a particular focus on women living in accommodation centres and women in the Irish Refugee Protection Programme.
- Address medical, cost and information barriers to contraception use and provide sexual health education programmes to minority ethnic groups, refugees and asylum seekers.

3.5.10 Reproductive health

The *National Maternity Strategy* (Department of Health, 2016) references the complexity of needs of women from minority ethnic groups. Important considerations for service providers include a mother's nationality, which may have implications for language and service needs, and recognising that women from ethnic minorities may be particularly at risk of domestic violence. The strategy also points out that certain culturally distinct groups in Ireland such as Travellers have a lower average age of mothers

⁸ Recommendation 10.1: Migrants from a country with an intermediate to high prevalence of HCV (anti-HCV $\geq 2\%$ *) should be offered one-off HCV screening (NCEC National Clinical Guideline No. 15 Summary).

giving birth than the general population, with many factors contributing to this difference.

Of the 63,897 births in 2016, there were 49,277 babies (77.1%) born to mothers of Irish nationality compared to 51,352 (77.9%) in 2015. There were 11.7% of births to mothers of EU 15 to EU 28 nationality, 2.3% of mothers were of UK nationality, and 1.8% were of EU 15 nationality (excluding Ireland and the UK). Mothers of nationalities other than Ireland, UK and the EU accounted for 7.0% of total births registered. There were 0.1% of mothers where the nationality was not stated.

Table 3.6 presents data on registered births in 2016, taken from the CSO's *Vital Statistics Yearly Summary* for that year.

Research carried out on behalf of the Crisis Pregnancy Agency identified young Chinese women who were required to have private health insurance in place in order to secure their visa (Lyons et al, 2008). Despite having this insurance they did not view this as giving them access to health services, but rather as a condition to be satisfied to gain entry to Ireland. Not having a sense of entitlement to health services precluded women from informing themselves of how the Irish health system worked.

All women should have access to the same standard of maternity care, including early scanning and testing. Services should be available to all women, irrespective of geographic location, socio-economic circumstance or ethnicity. While all pregnant women who are "ordinarily resident" in Ireland are entitled to

Table 3.6: Births registered, classified by nationality of mother, marital status and age, 2016

Nationality of mother	Total births		Births inside marriage/civil partnership		Births outside marriage/civil partnership		Average age of mother at maternity
	Number	Percentage	Number	Percentage	Number	Percentage	
TOTAL	63,897	100.0	40,549	63.5	23,348	36.5	32.7
Ireland	49,277	77.1	31,230	63.4	18,047	36.6	33.0
United Kingdom	1,455	2.3	768	52.8	687	47.2	32.1
EU15 excl. Irl & UK	1,162	1.8	663	57.1	499	42.9	34.4
EU15 to EU 28 *	7,468	11.7	4,378	58.6	3,090	41.4	31.1
Other	4,483	7.0	3,484	77.7	999	22.3	31.7
Not stated	52	0.1	26	50.0	26	50.0	33.3

* Croatia included in EU 15 to EU 28 from q3 2013.

Source: CSO's *Vital Statistics Yearly Summary* 2016.

The National Women's Council of Ireland (NWC), in partnership with the HSE, held consultation workshops around the country in 2015 to explore priorities for maternity services in Ireland. One of the main recommendations to arise from this consultation process was the need for maternity services to be more responsive to the specific needs of migrant women, and for them to be more culturally appropriate. Synergy with the *National Maternity Strategy 2016–2026* should be observed.

The intersection of gender and ethnicity has significant implications for the maternal health of minority ethnic women in Ireland, including Traveller and Roma women. Many face significant barriers in accessing maternal health services, often linked with poverty, marginalisation, racism and discrimination. In many ethnic and cultural groups too, rape and domestic violence are taboo and women from these groups who have suffered such abuse are often unwilling or unable to seek appropriate care and support.

free public maternity care once they are in receipt of permission to live in the country, some categories of pregnant women face obstacles to accessing maternity services. In some cases, women who fail to satisfy an individual hospital's requirements are asked for a deposit, which many cannot afford to pay. Fear of hospital bills, lack of knowledge of the Maternity and Infant Care Scheme and fear of children being taken into care can act as key barriers to undocumented migrant women accessing maternity services.

Data collection and analysis of minority ethnic communities' use of maternity services is necessary so that policy and service delivery can be more responsive to their needs.

In Ireland, over the period 2013–2015, a total of 15 maternal deaths (occurring during 42 days of pregnancy end) were reported, of which four were classified as "direct maternal deaths (due to obstetric causes)" (Maternal Death Inquiry, 2017, p. 6). While

numbers are very small, it is of concern that a high proportion of the deaths occur to women born outside Ireland. The *Confidential Maternal Death Inquiry in Ireland* report for 2009–2012 notes:

Significantly, 38.7% of maternal deaths 2009-2012 (includes direct and indirect causes) occurred in women born outside Ireland, who represented 24.2% of all maternities in Ireland for that time period. Women born outside of Ireland were over-represented in reported deaths, reflecting findings from successive UK CEMD reports which found an increased risk of maternal death among migrant ethnic minorities.

(Confidential Maternal Death Inquiry in Ireland, 2015, p. 7)

The above confirms that additional attention should be paid to addressing the unique care needs of woman from diverse ethnic and cultural groups who access maternity services.

In 2010, the National Institute for Healthcare and Excellence (NICE) in the UK developed clinical guidance covering antenatal care for pregnant women with complex social factors, including alcohol or drug misuse, recent migrant or asylum seeker status, difficulty reading or speaking English, aged under 20, and those experiencing domestic abuse (NICE, 2010). The guidance document acknowledges that pregnant women, who are recent migrants, asylum seekers or refugees, or who have difficulty reading or speaking English, may not make full use of antenatal care services. This may be because of unfamiliarity with the health service or because they find it hard to communicate with healthcare staff. NICE offers advice on improving access to care, maintaining contact with antenatal carers, and additional information and support for these women. The guidance also recommends that healthcare professionals undertake training in the specific needs of women in these groups and allow sufficient time for interpretation.

The HSE participates in the EU-funded Oramma (Operational Refugee and Migrant Maternal Approach) project.⁹ The aim of this cross-country initiative is to promote an integrated, mother- and

woman-centred, culturally-oriented and evidence-based approach for all phases of migrant and refugee women's perinatal healthcare, including detection of pregnancy, care during pregnancy and birth, as well as support after birth. Outcomes of this initiative will offer further opportunities for ensuring provision of quality competent care to this vulnerable group.

Much emphasis tends to be placed on the reproductive health needs of migrant women. However, reproductive health needs of men from diverse ethnicities and cultural backgrounds are also critical to positive physical and mental health of themselves, their partners and their families. Little information appears available on this aspect.

Suggested actions: Reproductive health

- Support implementation of relevant actions from the National Women's Council of Ireland (NWCI) and HSE consultation exercise (2015) on priorities for maternity services and ensure synergy with the Creating a Better Future Together: *National Maternity Strategy 2016–2021* and the priorities of the National Women and Infants Health Programme.¹⁰
- Participate in the EU ORAMMA project and apply outcomes.
- Develop data collection and analysis of minority ethnic communities' use of maternity services so that policy and service delivery can be more responsive to their needs.
- Work to ensure access to the Maternity and Infant Child Scheme for all pregnant women living in Ireland, regardless of immigration status.
- Work to ensure that maternity services are responsive to the specific needs of migrant women and women from the Traveller and Roma communities and that they are culturally appropriate. This will include access to culturally appropriate information in relevant languages and interpretation services.
- Explore the reproductive health needs of men from minority ethnic groups living in Ireland.

⁹ For more information on the ORAMMA project, see <https://oramma.eu/>.

¹⁰ The National Women and Infants Health Programme will ensure that the following actions are undertaken: additional supports will be provided to pregnant women from vulnerable, disadvantaged groups or ethnic minorities, and will take account of the family's determinants of health, such as socio-economic circumstances. An online resource for maternity services is to be developed, to act as a one-stop shop for all maternity-related information; any information provided will be understandable and culturally sensitive.

3.5.11 Mental health

The psychological impact of migration is acknowledged to be significant in “normal” circumstances (WHO, 2015c). Vulnerable groups of refugees, asylum seekers and irregular migrants are at heightened risk for certain mental health disorders, including post-traumatic stress, depression and psychosis.

Many migrants and refugees can experience trauma before, during and after their migration. The ways in which they respond to this trauma will vary considerably. Some groups may be particularly vulnerable or at risk, such as survivors of torture or those who have been exposed to violence.

Refugees and asylum seekers constitute one of the highest-risk groups in terms of developing mental disorders and are one of the most vulnerable groups in society (Bhugra et al, 2014). Given the significant stressors endured by refugees, members of this group are approximately ten times more likely than the age-matched general population to experience post-traumatic stress disorder (PTSD) (Fazel et al, 2005). In particular, child refugees are at heightened risk of psychological trauma following experiences of fleeing their homeland, encountering physical danger, witnessing traumatic events and suffering emotional uncertainty.

Loss of family, familiar support structures, income and material possessions is a common characteristic of the migration experience, with consequent emotions of grief, disempowerment and loss of identity. Migrants arriving in Ireland as asylum seekers and refugees may have faced great hardships, both while living in their countries of origin and while journeying to life in a new country. These difficulties pose significant challenges for mental health and psychosocial wellbeing. Some are more vulnerable to mental health problems than others.

Common mental health responses to new circumstances may vary, but include extremes of mood, depression, anxiety, feelings of disempowerment, fear, heightened tension, numbness and detachment from reality. Some mental health difficulties may manifest in somatic symptoms, such as headache, backache or gastric disorders. Daily functioning may be affected. Moreover, any pre-existing mental health issues may also be exacerbated by forced migration, loss of family networks and other former protective supports.

Stressors persist in these new circumstances, often exacerbated by worries for family members from whom they have become separated. Continuing emotional suffering is directly related to current stresses and worries, and uncertainty about the future. Lack of social support, isolation, experiences of racism and discrimination in the host country further exacerbate mental distress.

These are all normal responses to stressful situations, and give rise to a need for varied and different types and levels of support for this group. Such supports may include community-based programmes, therapeutic interventions and psychosocial activities that encourage resilience, active participation and a reestablishment of routines. With the appropriate supports, many families are able to adapt and adjust to the changes in their new homes. Many refugees will find ways to cope with what they have experienced and many build resilience.

The most important strategy for reducing the risk of mental disorders in refugees once they have arrived in the host country, is provision of support that ensures their basic needs are met, that ensures their safety and that they are accepted and integrated into mainstream society. Integration, including support in the national education system, is especially important for children and adolescents among refugee groups (Fazel et al, 2014).

Finally, cultural beliefs and taboos around mental health may risk willingness or ability to access or use mental health services. Health services should also work to support migrants with pre-existing mental disorders/psychosocial problems to access services, with a view to overcome fears of discrimination or concerns around stigma within their own community.

Mental health needs of those in the direct provision system

Protection applicants use general practitioner services more often and experience higher levels of self-reported symptoms of depression than persons granted refugee status, and suffer higher rates of anxiety and depressive disorders than other sections of society (Working Group on the Protection Process on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, 2015). The McMahon report – cautions that “this is a complicated subject” and that the “issue of whether poor mental health of some asylum seekers is a function of pre-migration stress, of the stress of the migration itself, of post-migration issues, of living

in direct provision, or a combination of these factors, is a complex matter and as such great caution should be exercised before drawing conclusions” (ibid, p. 50). In 2016, the Faculty of Public Health Medicine of the RCPI published a position paper on the health of asylum seekers, refugees and relocated individuals. Recommendations emphasised the importance of availability and accessibility of specialised services, such as psychotherapy for survivors of torture and other traumas.

It is acknowledged that prolonged stays in accommodation centres exert a negative impact on mental health. Alongside this, asylum seekers are often dealing with the mental health consequences of often traumatic experiences, both prior to and during their migration journey to Ireland. While the psychological impact of living in traumatic or violent situations may lessen, the effects of torture may be prolonged. In such circumstances, specialised mental health services are required. Input of NGOs is crucial in this element of mental health provision. International experience tends to demonstrate that many survivors of torture find it more acceptable to avail of services provided by an NGO than by a statutory agency. In this context, the HSE funds Spirasi to provide such specialised services.

At the same time, it is necessary to ensure that staff at all levels of the health service are equipped to recognise distress and trauma among service users from vulnerable cohorts and respond appropriately. The WHO report, *Mental health: New Understanding, New Hope* (2001), confirms that much treatment of mental health issues may be delivered within a primary healthcare setting. Consideration should thus be given to ways of ensuring that the mental health needs of patients from diverse ethnic and cultural communities are addressed within an appropriate framework. In this regard, a range of programmes are underway to assist staff in this area. The DOH has commissioned a review of Ireland’s current mental health policy *A Vision for Change* (2006); this provides an opportunity to ensure the mental health needs of asylum seekers, refugees and other migrants are considered.

Suggested actions: Mental health

- Work towards development of a comprehensive model in respect of provision of culturally competent assessment and treatment that is tailored to the unique mental health needs of vulnerable service users from diverse ethnic and cultural backgrounds and with a range of unique care needs.
- Continue to address the mental health needs of people living in direct provision accommodation, as outlined in the McMahon report (2015).
- Continue to encourage the active participation of inter-agency groups, with particular attention to provision of support to refugees and asylum seekers in the resettlement communities phase.
- Promote provision of programmes that support staff in dealing appropriately and effectively with service users who have experienced trauma.
- Continue to support delivery of specialised services to service users who have experienced torture and related trauma.
- Promote and support research into the mental health needs of service users from minority ethnic communities.

3.5.12 Disability

Service users from diverse ethnic backgrounds may also experience a range of disabilities; such disability may be physical or intellectual in nature. In some cases, disability stems from inadequate health service provision in country of origin, or as sequelae of physical assaults or torture.

Limited information is available in respect of the numbers of minority ethnic service users requiring or accessing disability services. Links should be established with relevant HSE structures to explore the extent and nature of disability within this cohort and associated needs for appropriate care and rehabilitation.

Suggested action: Disability

- Establish links with relevant HSE structures to explore the extent and nature of disability within the cohort of minority ethnic service users and associated needs for appropriate care and rehabilitation.

3.5.13 Alcohol and drugs

The recently published national drugs strategy, *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025*, references the importance of improving the capacity of services to accommodate the needs of people from specific communities, including service users from “new communities” who use drugs and alcohol.

Suggested action: Alcohol and drugs

- Implement relevant recommendations in the new national drugs strategy, *Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025*.

3.5.14 Palliative care

Palliative care deals with people with life-limiting illnesses and their families. As diversity increases in Ireland, increasing numbers rely on palliative care services as they and their families cope with the physical, emotional and spiritual challenges of this period.

The HSE launched the *Palliative Care Services Development Framework 2017–2019* in November 2017 (HSE Primary Care Division, 2017). This framework informs the development of adult palliative care services, both generalist and specialist, in Ireland for the three-year period from 2017 to 2019. Its aim is to ensure a seamless care pathway across inpatient, homecare, nursing home, acute hospital and day-care services. The framework identifies service users from minority ethnic groups as a cohort for whom consideration is needed around best ways of extending appropriate care.

Unique challenges exist in respect of providing palliative care to people from different cultures. Examples here include awareness of cultural norms about information disclosure, engagement with healthcare decision making, acceptance of the progressive nature of illnesses, acknowledgement of impending death and observance of appropriate rituals and practices around death and bereavement. The *Palliative Care Competence Framework* (2014) – developed by Palliative Care Competence Framework Steering Group – contains a number of domains that are particularly relevant to intercultural health; ongoing support and monitoring is necessary to ensure all such required competencies become integral to practice with service users and families from diverse backgrounds.

Practical issues also exist in situations where, for instance, a patient with a life-limiting illness desires repatriation to his or her country of origin. Up to date information is required in such instances to facilitate these requests.

The sensitive, intensely personal nature of palliative care places significant demands on all staff working in such environments. In this regard, training is required to support staff in caring for families from diverse ethnic and cultural backgrounds, with consideration towards the challenges referenced above. Interpreters also require additional training and support in this environment, especially in situations where – due to cultural norms – family members may wish to protect the patient from information relating to their diagnosis or prognosis.

Suggested actions: Palliative care

- Support the Clinical Programme for Palliative Care in implementing the *Palliative Care Services Development Framework 2017–2019*, with particular reference to the recommendation pertaining to ensuring appropriate and responsive care to members of minority ethnic groups.
- Provide training to interpreters working in palliative care and other services where particularly sensitive communication is required.
- Review usage and update HSE’s Health Services Intercultural Guide (2009), and related app, with particular attention to content relating to cultural and religious norms around death and dying, with a view to further circulation.

3.6 Conditions disproportionately affecting minority ethnic groups

As Ireland becomes more diverse, service providers may be required to identify and treat a range of conditions that have traditionally been unfamiliar in an Irish health system. Sickle cell anaemia and other haematological or metabolic disorders are examples of conditions that are more prevalent in certain minority ethnic groups than in the indigenous Irish population. Clinicians might require additional training in respect of the management of such conditions.

Suggested action: Conditions disproportionately affecting minority ethnic groups

- Progress learning and research in respect of provision of treatment and support of service users experiencing conditions that disproportionately affect minority ethnic groups, such as sickle cell anaemia and polio and other haematological or metabolic disorders.

3.7 Cultural practices relevant to intercultural health

Much debate takes place in respect of the practice of infant male circumcision. Infant male circumcision is an expected religious and cultural duty of families from certain cultural and religious backgrounds. The 2006 report of the committee appointed by the DOH to consider the issues surrounding cultural male circumcision made a number of recommendations around provision of a safe infant male circumcision. However, this service is presently only offered on the basis of clinical need, due to the many other pressures being experienced by hospitals. This situation presents risks around the procedure being performed by unqualified persons outside of a healthcare setting. As medical advances have progressed, it does now seem feasible that infant male circumcision could be performed within a general practice setting, pending agreement in relation to issues such as training and follow up. The potential for this procedure being performed in a minor surgery type environment is presently being explored.

Suggested action: Cultural practices relevant to intercultural health

- Review the current approach to provision of infant male circumcision with the DOH, with particular reference to the potential revision of the 2006 *Cultural Male Circumcision –Report of the Committee* and agree any subsequent associated actions.

3.8 Gender-based violence (GBV)

The term gender-based violence is, in a sense, an umbrella term, encompassing many forms of violence against women. As defined by the EU agency, European Institute for Gender Equality (EIGE), these include (though are not limited to) the following direct forms of GBV: intimate partner violence, sexual violence (all forms, in both public and private spheres), trafficking in human beings, slavery and sexual exploitation, harmful practices such as child and forced marriages, FGM and so-called “honour crimes”; as well as emerging forms of violations, such as online harassment. It also includes indirect forms of violence, specifically institutional or structural violence against women. As EIGE notes, the “gender-based” component of this term is important, as it draws attention to the fact that “violence against women is an expression of power inequalities between men and women” (EIGE, undated).

The Council of Europe's Convention (2011) on preventing and combating violence against women and domestic violence echoes this emphasis; Article 3d states “gender-based violence against women shall mean violence that is directed against women because she is a woman or that affects women disproportionately”, while Article 3 defines violence against women as follows:

“Violence against women” is understood as a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in private or public life.

All social groups throughout the world share specific traditional cultural practices and beliefs, some of which are beneficial to all members, while others are harmful to a specific group, such as women. These harmful traditional practices include FGM; forced marriage or female infanticide. Such practices violate rights to health, equality and personal dignity and are not compatible with the values and beliefs of Irish society.

The highly traumatic and gender-specific nature of sexual exploitation calls for special competence and gender-sensitivity by all those who are likely to come in contact with women and girls traumatised by sexual violence. It is recognised that gender sensitive approaches should be provided by specialist services who are experienced in responding to sexual assault and rape. Where possible, services should offer male/female examiners so that the patient can make a choice as to what gender he/she feels comfortable with.

3.8.1 Female genital mutilation (FGM)

Female genital mutilation (FGM) is the practice of partial or total removal of female genitalia for non-medical reasons. The procedure has no known health benefits but can cause serious immediate and long-term obstetric, gynaecological and sexual health problems.

Prior to migration from FGM practising countries, this practice was an unknown phenomenon in Europe. It is now estimated that more than half a million first generation women and girls living in Europe have probably undergone FGM. A prevalence study undertaken by EIGE (2015) – based on 2011 Census data- estimated that 5,277 women and girls had been subjected to FGM prior to coming to Ireland.

Legislation prohibiting female genital mutilation was enacted in 2012. This legislation includes the principle of extraterritoriality.

Recent years have seen some positive developments in terms of policy responses to FGM. FGM is now included in the new Irish National Maternity Healthcare Record under “risk factors”, which makes national data collection on this issue possible. In addition, since May 2014, girls and women who have undergone FGM can access a free specialised primary care service based at the IFPA’s clinic in Dublin city centre. This service was developed with the support of the HSE National Social Inclusion Office and AkiDwA - the Migrant Women’s Network, (IFPA, 2014).

3.8.2 Early or forced marriage

Early or forced marriage is carried out, as an accepted social norm, in some communities. This practice poses social, economic, health and educational risks for girls. Early motherhood as a consequence of such marriage presents an additional source of distress, often involving the loss of support of parents or peers. Attendant health risks associated with early motherhood pregnancies and access to healthcare are further concerns.

While the practice of forced marriage does not appear to be prevalent in Ireland, isolated cases of marriage of young girls have been reported. Within the Irish context, legislative and child protection concerns are accorded due priority in such instances. In such cases, the safety and welfare of a child is regarded as paramount.

In 2013, the United Nations Commission of the Status of Women (CSW) adopted a resolution which calls on states “to *end the practice of child, early and forced marriage*”, challenging the cultural, religious and traditional motives that justify it by specifying a legal age for marriage.

3.8.3 Domestic and sexual violence

While domestic violence affects people of all races, classes and ethnic origins, it is possible that some populations of women can be at greater risk, such as migrant and minority ethnic women. Records show that 31% of women have experienced intimate partner violence at some point, with women from minority ethnic groups particularly at risk (FRA, 2014). In particular, the nature of migration is often linked to isolation, which can heighten women’s risk to intimate partner violence; it can also create barriers to seeking help. For example, women can be more vulnerable to manipulation if they are dependent on a partner for their visa, do not speak the language of the country to which they have migrated and have no financial independence. Isolation, language barriers, unfamiliarity with services and institutional racism all serve as barriers in the help-seeking process of such women and further increase their vulnerability to domestic violence.

Migrant women have left behind their social support system in their country of origin, are often unaware of local laws and support services and may have cultural beliefs, which hinder their ability to seek support. Some women may have experienced conflict-related gender-based violence, particularly sexual violence, during their migration and may continue to face the risk of intimate partner violence once they arrive in their destination country.

Intimate partner violence carries with it the risk of death for its victims/survivors. It also causes physical and psychological injury, functional impairment, and negative health behaviours (such as smoking, and drug and alcohol abuse), chronic conditions, reproductive health problems, and mental health problems (WHO, 2013). As acknowledged in the *National Maternity Strategy 2016–2026*, victims/survivors of intimate partner violence are particularly vulnerable during pregnancy.

Women affected by intimate partner violence may access health services more frequently; therefore, health professionals are in a key position to recognise, respond to their needs and refer them to appropriate support services. Maternity and primary care settings are critical entry points for women experiencing violence and the training of health professionals from these settings should be prioritised.

Extra measures need to be put in place to ensure that migrant women who experience or who have experienced intimate partner violence, or other forms of sexual violence or sexual harassment, have access to all the support services that they need. There needs to be synergy between the HSE NIHS and the recently published *Second National Strategy on Domestic, Sexual and Gender-based Violence 2016–2021* and the commitments that are contained within.

Suggested actions: Gender-based violence

- Coordinate implementation of the health-related actions of the *Second National Strategy on Domestic, Sexual and Gender-based Violence 2016–2021*, and Ireland's *National Action Plan for Women, Peace and Security 2015–2018*, with particular regard to provision of appropriate support and protection for migrant women experiencing sexual harassment.
- Review current service provision to ensure measures are in place for migrant women who experience or who have experienced domestic or sexual violence, so that they have access to the support services they require, with particular consideration for women whose immigration status is linked to their partner's status.
- Train healthcare staff to be aware of violence against women in their practice, providing space for safe disclosures by women in their care and access to referral for services to protect women and children from further harm.
- Develop data collection and analysis of minority ethnic communities' use of sexual violence support services (Sexual Assault and Treatment Units) so that policy and service delivery can be more responsive to their needs.
- Continue to develop and implement education and public awareness campaigns, among all health professionals and communities affected by female genital mutilation (FGM), to raise awareness that it is a criminal offence under the Criminal Justice (Female Genital Mutilation) Act (2012) to perform FGM, or to remove a girl from the State for the purpose of FGM.
- Provide training to increase the knowledge and competence of healthcare providers, and other relevant frontline professionals, in relation to appropriate care and protection for FGM survivors and women and girls at risk nationwide.
- Provide appropriate support to survivors of FGM, including counselling and access to specialised health services.

4. HEALTH SYSTEM CHALLENGES: RESPONDING TO DIVERSITY

While many service users of differing ethnic and cultural backgrounds navigate the health system without difficulty, it is a truism that for many members of these groups, accessing and using the health system can be a frustrating and bewildering exercise.

The values and principles of the HSE demand that additional measures are put in place to ensure equal access and opportunities for all groups requiring care. Provision of supports in this regard include access to interpreting services, and availability of accessible, translated information.

Cultural competence is that set of behaviours, attitudes and policies that shape the ability of a system to provide effective responses in cross cultural interactions. Developing a good level of cultural competency among service providers is a key strategy towards reducing health inequalities and improving access to quality care for members of diverse minority ethnic groups.

Developing and embedding cultural competence among service providers, however, demands a sustained focus on knowledge, skills, awareness and behaviour across all levels of the health system, including administrative, managerial and operational levels. It should therefore form an integral part of quality improvement measures across the health service.

Cultural beliefs and practices impact on service users' understanding of health, expectations of a health service, and usage of these services. The health service, in turn, is required to deliver services that are culturally competent, responsive and respectful of the cultural understandings of members of diverse groups. Training around this area remains a priority of the HSE in order to ensure that patients can feel confident of accessing responsive, appropriate and effective care.

4.1 Training

Appropriate intercultural training and support for staff was a fundamental principle of the first NIHS (2007), while consideration was also accorded within the strategy to the development of mechanisms that promote recruitment, promotion, development and the retention of staff from diverse backgrounds. Provision of culturally competent health services that

are respectful of, and responsive to, the cultural and ethnic diversity of service users is intrinsic to quality, effective service delivery. The goal of culturally competent healthcare services is to provide the highest quality of care to every patient, regardless of ethnicity, cultural background, English proficiency or literacy. Patients are at higher risk of negative health outcomes, receiving poor quality care or being unhappy with their care, if providers, organisations and systems are not collaboratively working to provide culturally competent care. The HSE report, *Learning, Training and Development Needs of Health Services Staff in Delivering Services to Members of Ethnic Minority Communities* (2005), confirmed the desire and willingness of staff in the health services to be supported in providing a culturally competent service.

An extensive review (Bainbridge et al, 2015) was carried out in Australia to examine available evidence on cultural competence in healthcare settings to identify key approaches and strategies.

The review notes that:

developing and embedding cultural competence in health services requires a sustained focus on knowledge, awareness, behaviour, skills and attitudes at all levels of service, including at operational or administrative service level, health practitioner level, practitioner-patient level and student-training level

(Bainbridge et al, 2015, p.2)

Organisational commitment to all elements of intercultural health is required to support staff who have gained the necessary knowledge and skills through training. This organisational support extends to: supporting staff to access training; implementation of intercultural health policies and practices; organisational support for sufficient training time; management support for training; continued professional development; and support for staff affected by the issues. Furthermore, Verdonk and Janczukowicz (2018) identified several

approaches to teaching cultural competence in medical education: a cultural expertise approach, a cultural sensibility approach and a cross-cultural approach with the more recently emerging call for reflexivity.

Much effort has taken place in relation to development and initial rollout of intercultural training within the HSE. A Train the Trainer training programme “intercultural-awareness and practice in health and social care” was developed by HSE Social Inclusion South East Community Healthcare (2016), providing a useful model for ongoing rollout nationally. The HSE will develop an intercultural health awareness online training programme to support HSE services to integrate cultural competency into the workplace through self-assessment and training of staff.

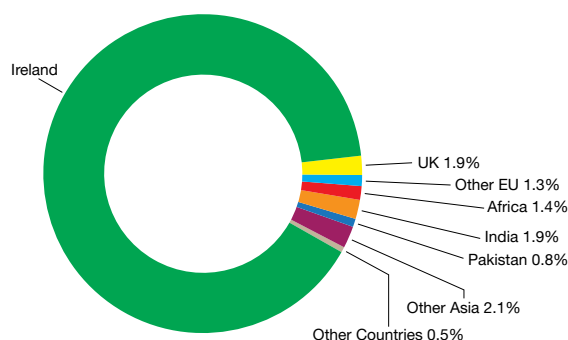
Suggested action: Training

- Engage with third level institutions and professional bodies to ensure that intercultural awareness is built into undergraduate and post-graduate training for health and social care professionals.
- Develop an intercultural health awareness online training programme.

4.2 Workplace diversity

At the end of 2016, the public health service was the largest employer in the Irish state, with over 128,000 personnel (including home helps, directly employed by the HSE, and Section 38 agencies in the provision of public health and social care). A profile of this workforce found that, in total, 90.1% of staff were recorded as holding Irish nationality (HSE, 2016). For non-consultant hospital doctors, the rate was 54% and for staff nurses it was 84.3% (ibid).

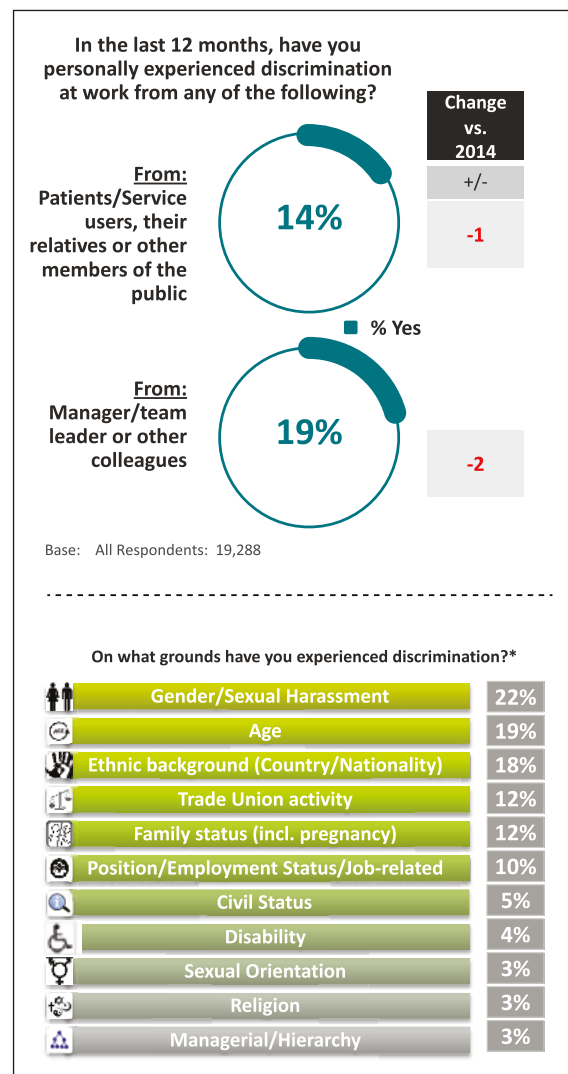
Figure 4.1: Nationality of public health service workers, December 2016



Source: HSE, 2016

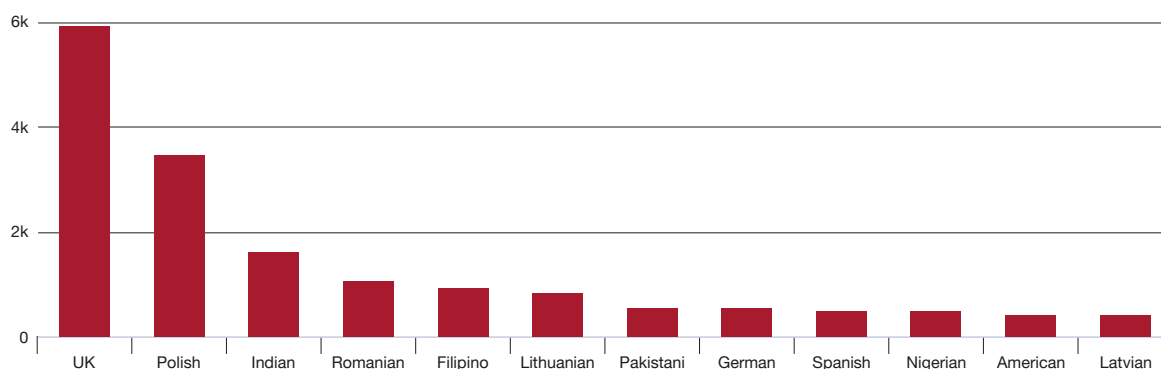
A HSE staff survey found that 18% of 19,288 staff who participated said they had experienced discrimination relating to ethnic background (HSE, 2016).

Figure 4.2: Evidence of discrimination at the workplace, HSE



Source: HSE, 2016b

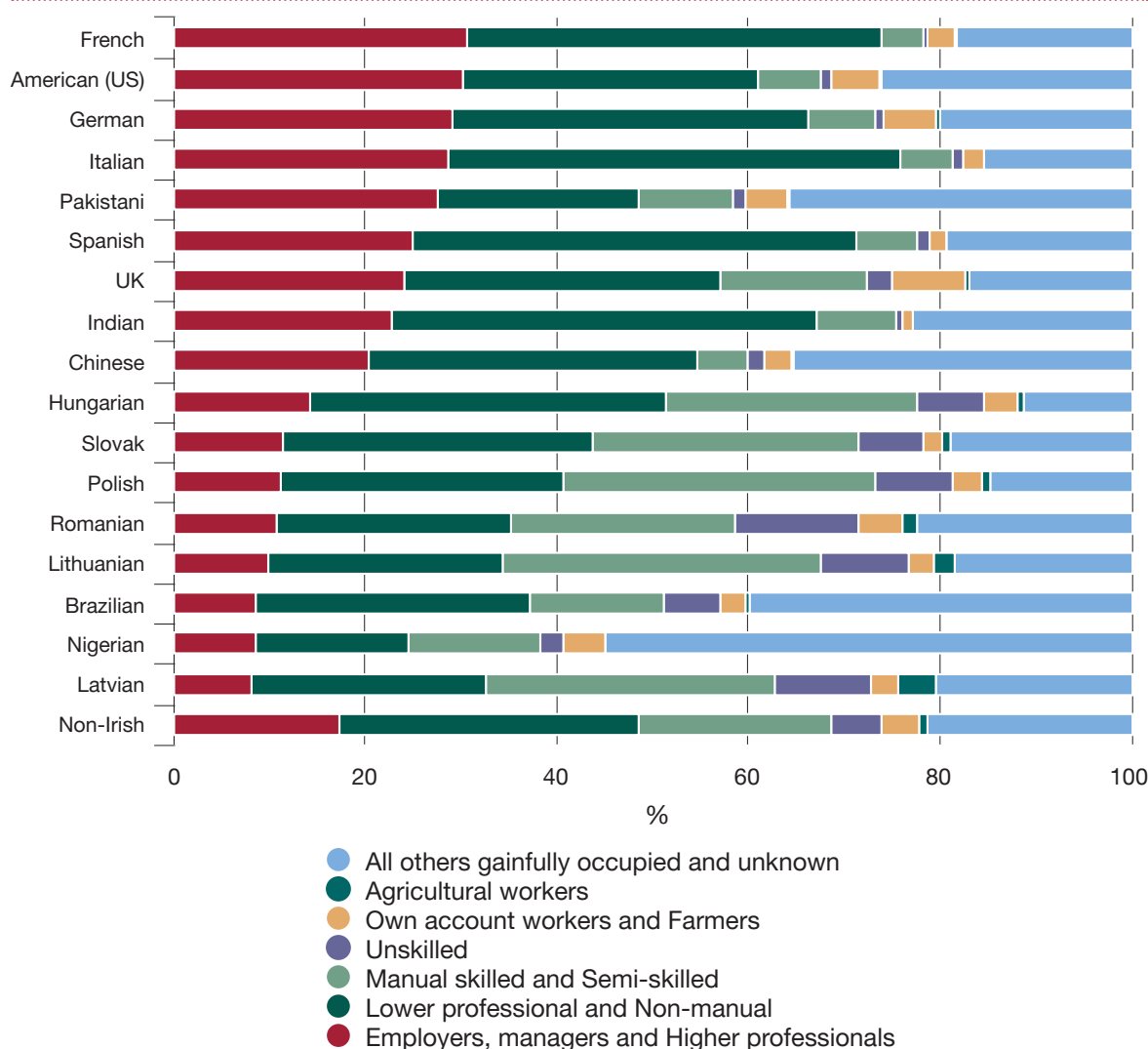
In 2016, according to Census 2016, British, Polish and Indian nationals accounted for more than half (50.3%) of all non-Irish workers in the health sector (CSO, 2017a). Figure 4.3 on the next page shows the dominant nationalities among non-Irish workers in the human health and social work sector in 2016, while Figure 4.4 presents an overview of the socio-economic status (defined by work category) of Irish workers, by nationality.

Figure 4.3: Dominant nationalities of non-Irish workers in the human health and social work fields, 2016

Source: Census 2016

As shown in Figure 4.4, higher-than-average rates of employment in the “employers, professionals and higher professional” category were recorded for Sudanese (51.4%), Sri Lankan (25%), Greek (22.3%) and Israeli (20.9%) nationals, reflecting the

high numbers of medical doctors among these nationalities. Indians and Filipinos had the highest percentages in the “lower professional and non-manual” group (which includes nurses and midwives), at 35.8 per cent and 25.3 per cent, respectively.

Figure 4.4: Socio-economic groupings for selected nationalities, 2016

Source: Census 2016 (CSO, 2017a)

In 2017, the HSE published its Diversity, Equality and Inclusion Statement, in which it is noted:

Employees of the HSE bring a range of skills, talents, diverse thinking and experience to the organisation. The HSE is committed to creating a positive working environment whereby all employees inclusive of race, religion, ethnicity, gender, sexual orientation, responsibilities for dependents, age, physical or mental disability, civil status, membership of the Traveller community and geographic location are respected, valued and can reach their full potential. We aim to develop the workforce of the HSE which reflects the diversity of HSE service users, and which is strengthened through accommodating and valuing different perspectives, ultimately resulting in improved service user experience.

This is reflective of the HSE *People Strategy 2015–2018*, which makes a commitment to promoting diversity, inclusion and equality across the system, valuing different perspectives, depth of experience and the strengths and potential of individuals and teams.

Suggested action: Workplace diversity

- Work with HSE HR Division to proactively champion an intercultural, equality and non-discrimination approach to all elements of support for staff of diverse backgrounds, including recruitment and retention, and learning and promotion opportunities.

4.3 Connecting beyond the HSE

An intercultural approach within the HSE is enhanced by a globally-oriented health service that is connected to and learns from other countries. This is facilitated by the HSE Global Health Programme, which was established in 2010. The dual aims of the Global Health Programme are: to make an effective contribution towards improving health in less developed countries; and to engage strategically on global issues in order to improve health in Ireland. The programme responds to the global nature of health issues, including those arising from migration to Ireland.

A main focus of this programme is to facilitate the HSE and related institutions to develop and strengthen links with counterpart institutions in low-income countries in Africa and Asia. An explicit objective of these linkages is to strengthen capacity of the Irish health service through learning from less developed countries. Aspects of this learning include a deepening of intercultural knowledge and understanding among health service providers, which will enhance their capacity to provide culturally competent services.

In 2012, Ireland joined the European ESTHER Alliance (EEA), a coalition of governments committed to institutional health partnerships. The HSE also has a memorandum of understanding with Irish Aid, the official Government aid programme (renewed in 2017) and has formal partnership agreements with the Ministry of Health in Mozambique (2014) and in Sudan (2017).

Suggested action: Connecting beyond the HSE

- Align the work of the Global Health Programme with the NIHS so that the experiences and learning of participating staff can contribute to fulfilment of each of its strategic goals.

4.4 Cultural and religious beliefs and health behaviours

Cultural beliefs influence a person's understanding of their health status, their attitude towards their care, ability to understand a diagnosis and compliance with proposed treatment. According to EuroMed Info:

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how healthcare will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making.

EuroMed Info (online)

Health service providers are more likely to have positive interactions with patients and provide better care if they understand what distinguishes their patients' cultural values, beliefs and practices from their own. Ensuring culturally responsive communication is of the utmost importance in building and maintaining optimal relationships with service users. Understanding this and understanding cultural health norms is a key part of the *Intercultural Awareness and Practice in Health and Social Care training* (2016) developed by HSE Social Inclusion South East Community Healthcare.

Religious diversity adds a unique dimension to the ethnic and cultural identity of many service users. Religious diversity in Ireland has increased dramatically in Ireland in recent years; although Ireland remains a predominantly Catholic country, findings from Census 2016 show that the proportion of the population identifying as Catholic fell from 84.2% in 2011 to 78.3% in 2016 (CSO, 2017c). In the same time period, the fastest growing religions in Ireland were Orthodox, Hindu and Muslim, with a 37.5% increase in the Orthodox population, a 29% increase in the Muslim population, and a 34.1% increase in the Hindu population. In addition, the number of people with no religion grew from 269,800 in 2011 to 468,400 in 2016, an increase of 198,600, or 73.6%; by 2016, those with no religion accounted for 9.8% of the total population.

Religious beliefs and practices impact significantly on patient's experience of healthcare and recovery. Again, the importance of being sensitive to diverse religious needs is key to effective and respectful communication between service provider and user. The HSE's *Health Services Intercultural Guide* (2009) provides a valuable resource to staff in understanding and responding to the range of patient cultural and religious beliefs and practices around key life events.

Suggested actions: Cultural and religious beliefs and health behaviours

- Review usage and update the HSE's *Health Services Intercultural Guide* (2009) with a view to further circulation.
- Support the efforts of the HSE-led Interfaith Group in efforts to assure competent, responsive provision of spiritual care to service users of diverse religions.

5. DATA COLLECTION

Responsive, appropriate and cost-effective services depend on the widespread availability of robust data. This includes data that provide information on: the nature of services and interventions that are most effective in addressing health inequalities affecting service users from diverse backgrounds; trends in uptake of services at different levels of care; and the range of risk and protective factors. Such data are especially important in the area of intercultural health, given the fact that minority ethnic groups and migrants have generally poorer experiences and outcomes regarding their health, wellbeing and health service utilisation experiences than majority ethnic groups.

Without data disaggregated on the basis of ethnicity, it is impossible to provide evidence to highlight the impact of health inequalities, existence of systemic or indirect discrimination or inform good policy and practice.

The importance of recording ethnicity as a means of addressing inequality and preventing discrimination is underpinned by the Public Sector Equality and Human Rights Duty.

It should be noted that this Act places a duty on public sector bodies – including the HSE – to “take proactive steps to eliminate discrimination, promote equality and protect human rights of people who use their services, people who are affected by their policies and people who are employed in the organisation”. That the Duty is applicable to staff employed in the HSE, as well as to service users, suggests that recording ethnicity of HSE staff should also be considered.

Ethnic equality monitoring is “a process whereby information about the relevant aspects of people’s ethnic origins is collected, recorded and used to establish patterns, which can be compared with other information about their relationship with society and need” (Johnson, 2002, p. 77). While country-specific ethnic identifiers have been developed and adapted in several countries (including the United States, United Kingdom, Australia, New Zealand and Canada), ethnic equality monitoring is not routinely collected across statutory agencies in Ireland. Where ethnic data is collected, data is often incomplete or of poor quality

Box 5.1 below contains a list of national data collection registries in Ireland that presently record ethnicity.

Box 5.1: National registries that record information on ethnicity

- Census (CSO)
- Cystic Fibrosis Registry
- European Social Survey (Ireland)
- Irish Childhood Diabetes National Register
- National Drug Treatment Reporting System (NDTRS)
- National perinatal epidemiology databases
- National Psychiatric Inpatient Reporting System (NPIRS)
- Health Protection Surveillance Centre (HPSC)
- SLÁN –Survey of Lifestyle, Attitudes, and Nutrition
- Growing Up in Ireland.

The HSE paper, *Planning for Health –Trends and Priorities to Inform Health Service Planning* (2017) states:

Ethnicity data (an ethnic identifier) – as part of ethnic equality monitoring – should be routinely and systematically collected across all health and social care data systems, including: HIPE, performance monitoring, National Cancer Screening Service data, immunisation coverage data and the new National Maternity Healthcare Record. This will facilitate assessment of on-going health needs and service utilisation, enable monitoring of health outcomes and inform commissioning to address health inequalities for Irish Travellers and other ethnic minority groups.

(HSE, 2017, p.13)

This issue is also addressed in the *Migrant Integration Strategy*; Action 50, which lists the HSE as the responsible body, reads:

the recording of ethnicity as part of ethnic equality monitoring across the health service will be promoted as a means of identifying unique needs of migrants and developing interventions to address these needs.

(Department of Justice and Equality, 2017a, p.30)

Similar recommended actions around recording ethnicity as part of a suite of disaggregated data are contained, inter alia, in the *Second National Strategy on Domestic, Sexual and Gender based violence 2016-2021* and in the *NTRIS 2017-2021*.

Although the importance of implementation of ethnicity recording was emphasised in the first NIHS, progress in this area has been disjointed. Where ethnicity recording is effected – via the question used in recent censuses, for example – information gathered has enabled a coherent identification of need and associated development of evidenced targeted interventions. A renewed, whole-organisation effort is necessary in order to embed such equality monitoring across all parts of the health service.

The findings of a HRB-funded participatory research project that is currently underway as a collaborative partnership led by the University of Limerick and with participation from HSE Social Inclusion - *Ethnic Minority Health in Ireland: Advancing the Evidence Base to Address Health Inequities*, are expected to provide further guidance for implementation of ethnic identifiers in primary care and other settings across the HSE.

Current efforts in respect of development of an Individual Health Identifier – a number that safely identifies a person who has used, is using or may use a health or social care service in Ireland – offer a positive opportunity to incorporate ethnicity data in a coherent, evidenced manner and to use the data arising as a means of forming a complete picture of an individual service user's medical history.

With migration and health defined as a global public health priority, the role of research in informing evidence informed health responses in this area is crucial (Wickramage et al, 2018). A sensitive, ethical approach to design of such research and dissemination of findings is critical as data around migration and health may risk misuse or stigmatisation of minority ethnic communities. An approach that both explores factors and issues specific to diverse ethnic communities and aims to integrate intercultural health issues, into overall health systems research, appears to offer a positive model.

Suggested actions: Data collection

- Develop and implement an identifier throughout the HSE to collect data on access, uptake and referral rates for minority ethnic groups so that cultural or ethnic needs can be identified and accommodated.
- Collect and publish disaggregated data (by sex and complemented by grounds of age, ethnicity, disability) to inform policies and programmes and address inequities.
- Provide active input to development of the Individual Health Identifier.
- Develop and implement a system of recording ethnicity of HSE staff and monitor trends of recruitment, retention and promotion in respect of each staffing discipline and service.
- Develop a framework for advancing Intercultural health research and applying learning towards evidenced interventions.

PART III: Implementing the strategy

6. TOWARDS AN IMPLEMENTATION PLAN FOR THE SECOND NIHS

Implementation of such a broad, wide-ranging strategy – within a context of available resources, on-going change within the health service and a climate of heightened expectations of service users – will be a challenging process. For success to be achieved in implementing the recommendations of the strategy, a high level of commitment from all stakeholders will be required, along with strong leadership that assures an evidenced, coordinated approach to its management.

6.1 Framework for the implementation plan

The strategy presented in Part I of this document will act as a framework for the development of the implementation plan. Goals, strategic objectives and actions identified therein will be used to create a detailed implementation plan that will list all actions assigned to the HSE via the cross-government strategies referenced in this strategy, together with all specific HSE-focused actions agreed for inclusion in this document. The implementation plan will also list timeframes and key partners where evident. Key indicators will be identified to support implementation and allow for on-going monitoring and reporting of progress.

6.2 Implementation and governance structures

The broad, cross-cutting and multidimensional nature of diversity and the range of actions contained in this strategy document demands a comprehensive, concerted, coherent approach to its implementation. Implicit in implementation is, the establishment of robust implementation and governance structures that support effective, coordinated, systematic and accountable delivery of key actions.

Although HSE Social Inclusion holds a remit for the health of vulnerable groups, including those cohorts from diverse ethnic, cultural and religious groups, the principle of a “whole of organisation approach” suggests that responsibility for implementation should be shared across HSE divisions, with implementation of the strategy coordinated by HSE National Social Inclusion. Input of the voluntary and community sector, together with that of service users, will be integral to this approach.

Governance will be provided through a representative Implementation Committee, chaired by HSE Social Inclusion. This committee will report through the HSE National Intercultural Health Governance Group to the HSE National Social Inclusion Governance Group. The National Social Inclusion Governance Group will, in turn, forge a reporting relationship to HSE Leadership, Commissioning Teams aligned to Primary Care, Social Care, Mental Health, Health and Wellbeing as well as to relevant cross-government oversight committees.

The Implementation Committee is expected to comprise key HSE actors, together with partners from the community and voluntary sector. Representation will include service users from diverse ethnic and cultural groups.



6.2.1 Timeframe

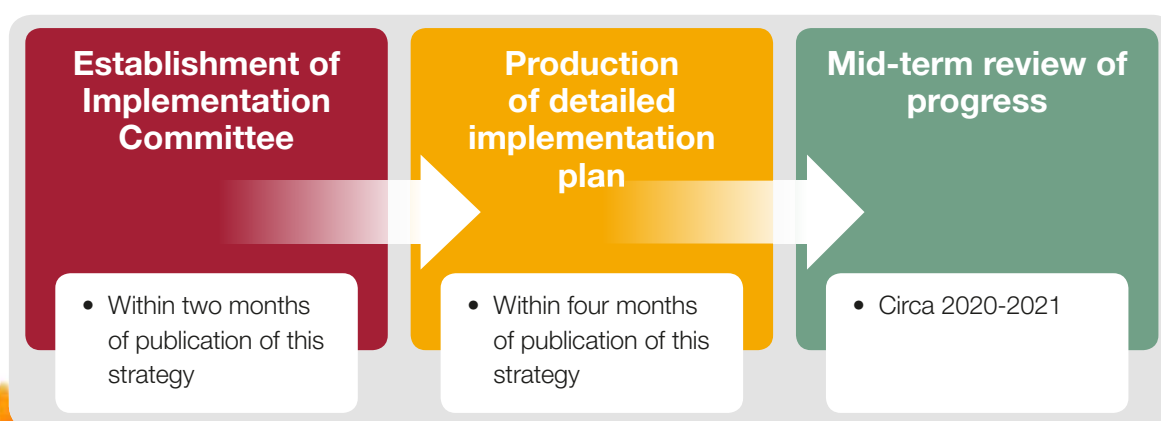
The establishment of the Implementation Committee and agreement around terms of reference should be completed within two months of launch of the strategy. A detailed implementation plan, including agreement around outcomes, indicators and time frames, will be produced within four months of the launch of the strategy. The development of indicators will take into account the challenges associated with measuring outcomes versus activity.

A Communication plan that targets service users and service providers will form part of work around development of the plan and ongoing updates on its progress.

Associated arrangements in respect of monitoring and evaluation will form part of governance agreements.

A mid-term review of progress in respect of implementation of recommended actions will be conducted circa 2020–2021.

Figure 6.1: Key milestones for development of the implementation plan



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APPENDICES

The background of the page is an abstract composition of soft, billowing clouds of color. On the right side, there are large, rounded shapes in shades of lime green and yellow-green. To the left of these, there are darker, more muted green and blue-green clouds. At the bottom right, there are vibrant pink and magenta clouds. The overall effect is a dreamy, ethereal atmosphere with a light green background.

APPENDIX 1

Glossary of terms

These definitions are taken from the websites of the DOJE, IOM, Universities Scotland and the Irish Refugee Council.

Asylum seeker	An asylum seeker is someone who is seeking international protection but whose claim for refugee status has not yet been determined. Asylum seekers are legally entitled to stay in the State until their application for protection is decided. They also have a right to a fair hearing of that application and to an appeal if necessary.
Direct provision	Direct provision is the system for accommodating asylum seekers in Ireland. Asylum seekers are accommodated in hostel-style accommodation run on a for-profit basis by private contractors. The centres provide food, board and for asylum seekers' basic needs. In addition, they receive a weekly cash allowance of €21.60 per adult and €21.60 per child, as well as a medical card. From January 2019, this Daily Expenses Allowance, formerly the Direct Provision Allowance, will rise by €17.20 to €38.80 per week for adults and by €8.20 to €29.80 per week for each child. The Government recently announced new measures to allow eligible asylum seekers to work while their applications for refugee status are being considered.
Emergency reception and orientation centres	These centres have been established to accommodate people arriving to Ireland under the EU Relocation and Resettlement Schemes. The centres provide food, board and for the basic needs of the people residing there, as well as providing an initial orientation programme operated by the Office for the Promotion of Migrant Integration.
Habitual Residence Condition (HRC)	The HRC is a question of fact , which seeks to ascertain whether the claimant has established his or her "centre of interest" in the host state by examining factors such as family connections, length of stay and employment history. In practice, however, the Department of Social Protection has tended to treat it as also a test of the claimant's legal status in the State, holding that asylum seekers cannot satisfy the HRC because of their status.
Migrant	The IOM states that, although there is no universal definition of migrant and the heterogeneity of terms in use can cause confusion, the broad definition of a migrant used by the IOM is: <i>"any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is".</i>
Minority Ethnic	The term "ethnic minority" is mainly used to denote people who are in the minority within a defined population on the grounds of "race", colour, culture, language or nationality. Government documents and those involved in the work of race equality tend to use the term "minority ethnic" instead of "ethnic minority". Both terms are in common usage and are generally acceptable.
Refugee	A Refugee is defined in Section 2 of the International Protection Act 2015 as "a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country; or who, not having a nationality and being outside the country of his or her former habitual residence, is unable or, owing to such fear, is unwilling to return to it." Refugees are entitled to be protected against forcible return to their countries of origin.
Right to reside test	The right to reside test is a question of law , which seeks to ascertain whether the claimant has a lawful right to reside in the host state. The right to reside test does not replace the HRC. It is an additional test which all claimants of social welfare payments subject to the HRC are required to satisfy.
Trafficking	Trafficking refers to situations where people are moved from place to place or country to country against their will or under duress, by means such as deception, coercion or force, usually for the gains of others, in that the person(s) trafficked will be exploited for financial gain.

APPENDIX 2

Policy developments with relevance to intercultural health

Policy	Summary
Second National Strategy for Domestic, Sexual and Gender-based Violence 2016–2021 (Department of Justice and Equality, 2016a)	Envisages a range of actions to be implemented by State, voluntary and community sector organisations aimed at preventing and responding to domestic, sexual and gender-based violence. Includes actions in relation to vulnerable groups, including Travellers and Roma.
Second National Action Plan on Women, Peace and Security 2015–2018 (Department of Foreign Affairs and Trade, 2015)	Aims to strengthen women's leadership and participation in decision making in conflict and post-conflict situations; to ensure that a gender perspective is incorporated into Ireland's engagement in overseas humanitarian and development aid, peace-keeping, governance, post-conflict activities and interventions; to bolster Ireland's ongoing work on protection from and prevention of gender-based violence; and leverage Ireland's participation in global and regional fora to champion the implementation of the Women, Peace and Security resolutions.
Working Group Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers (2015) (Department of Justice and Equality, 2015)	Provides a significant number of recommendations on the protection process in Ireland and the system of direct provision.
Second National Action Plan to Prevent and combat Human Trafficking in Ireland (Department of Justice and Equality, 2016)	Contains 65 actions designed to crack down on individuals and gangs involved in this crime, to support victims, to raise public awareness, and to enhance training for those likely to encounter victims.
Reducing Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland 2017–2025 (Department of Health, 2016)	Identifies a strategic action to improve the capacity of services to accommodate the needs of people who use drugs and alcohol from specific communities, including the Traveller community, the LGBTI+ community, new communities, sex workers and homeless people.
Connecting for Life – Ireland's National Strategy to Reduce Suicide 2015–2020 (Department of Health, 2015)	Characterises minority groups as a priority group for whom there is evidence of vulnerability to and increased risk of suicidal behaviour. Minority groups are defined as members of the LGBT community, members of the Traveller community, people who are homeless, people who come in contact with the criminal justice system (e.g. prisoners), people who have experienced domestic, clerical, institutional, sexual or physical abuse, asylum seekers, refugees, migrants and sex workers. The strategy contains a goal to enhance accessibility, consistency and care pathways of services for people vulnerable to suicide.
National Strategy for Women and Girls 2017–2020 (Department of Justice, 2017)	Proposes targeted measures to encourage Traveller and Roma women to engage as equal and active citizens.
National Sexual Health Strategy 2015–2020 (Department of Health, 2015)	Identifies people with a migrant background as a vulnerable group regarding knowledge and information about sexual health and crisis pregnancy prevention services and accessing sexual and reproductive health services. The strategy contains recommendations for "at risk" or vulnerable groups.
Creating a Better Future Together: National Maternity Strategy, 2016–2026 (Department of Health, 2016)	Sets out the vision for the future of Ireland's maternity services. The Strategy recommends that services should be woman-centred, and provide integrated, team-based care, with women seeing the most appropriate professional, based on their need. The strategy contains an action to develop an online resource for maternity services, to act as a one-stop shop for all maternity-related information; any information provided will be understandable and culturally sensitive.

Policy	Summary
National Consent Policy (HSE, 2015)	The National Consent Policy provides one overarching HSE policy to guide staff. The need for consent, and the application of the general principles in this policy, extends to all interventions conducted by or on behalf of the HSE on service users in all locations. Thus, it includes social as well as healthcare interventions and applies to those receiving care and treatment in hospitals, in the community and in residential settings. How these principles are applied, such as the amount of information provided and the degree of discussion needed to obtain valid consent, will vary with the particular situation.
Assisted Decision Making (Capacity) Act 2015	This Act has implications for all health and social care providers – there is a need for a clear and robust understanding of the Act with particular regard to supported decision making based on the presumption of capacity and the principle that everyone has the right to be supported to make decisions. The Act places an obligation on health and social care professionals to support a person to make their own decisions as far as possible, and where the person's capacity is in question, to provide all practicable support to facilitate the person to make the particular decision.
Palliative Care Services: <i>Three-Year Development Framework (2017–2019)</i> (HSE, 2017)	This Framework informs the development of adult palliative care services, both generalist and specialist, in Ireland for the three-year period 2017–2019. Its aim is to ensure a seamless care pathway across inpatient, homecare, nursing home, acute hospital and day-care services. The framework identifies service users from ethnic minority groups as a cohort for whom consideration is needed around best ways of extending appropriate care.
<i>Healthy Ireland: A Framework for Improved Health and Wellbeing (2013–2025)</i> (Department of Health, 2013) (And <i>Healthy Ireland in the Health Services: National Implementation Plan 2015–2017</i> , HSE, 2015d)	This Framework sets out a series of themed actions aimed to improve the health of people living in Ireland. One of its goals aims to reduce health inequalities in Ireland, with a focus on the broader social determinants of health. In a section on partnership and cross-sectoral work, it sets out a series of actions that involve cross-sectoral partners. In the HSE's implementation plan for <i>Healthy Ireland</i> within the health services, 'Theme 2' is: 'Contribute to the implementation of the priority programmes for Healthy Ireland – healthy eating and active living, wellbeing and mental health, positive ageing, alcohol, tobacco free, and healthy childhood - with a particular emphasis on addressing health inequalities between different sub-populations of men'.
<i>National Men's Health Action Plan Healthy Ireland – Men HI-M 2017–2021 Working with Men in Ireland to Achieve Optimum Health and Wellbeing</i> (DOH, 2016)	This plan sets out a new vision and roadmap for men's health in the years ahead. The Plan works in tandem with existing structures and programmes within the HSE and is designed to contribute to more effective implementation of programmes and services by mainstreaming men's health across a broad spectrum of policy areas. Theme 2 focuses on contributing to the implementation of the priority programmes for Healthy Ireland – healthy eating and active living, wellbeing and mental health, positive ageing, alcohol, tobacco free and healthy childhood, with a particular emphasis on addressing the health inequalities between different sub-populations of men.
<i>Children First: Guidance for the Protection and Welfare of Children (Department of Children and Youth Affairs, 2017)</i>	This revised version of Children First: National Guidance for the Protection and Welfare of Children describes the four main types of abuse and sets out the steps which should be taken to ensure that the child or young person is protected from harm. It has been updated to include new information about the Children First Act 2015 and it includes specific information for the professionals and organisations that now have legal obligations to keep children safe.

APPENDIX 3

Health-related actions relevant to the HSE in cross-government strategies

This appendix lists all the relevant actions outlined in the various strategies cited in this document. The numbering approach taken within each strategy has been maintained for ease of cross-reference; for example, the *Migrant Integration Strategy* numbers its specific actions, while others simply provide a bulleted list of actions.

Strategy	Actions
<i>The Migrant Integration Strategy: A Blueprint for the Future</i> (Department of Justice and Equality, 2017a)	<ul style="list-style-type: none"> • Action 15: Information will be provided in language-appropriate formats and in a manner easily accessible by migrants. • Action 16: Government Departments and State Agencies will ensure that staff are trained to inform migrants accurately of their entitlements. • Action 18: Mechanisms for providing adequate interpreting facilities will be explored in order to facilitate equality of access to services. • Action 19: The availability of interpreting will be prominently displayed in a range of languages in relevant public offices. • Action 48: A second National Intercultural Health Strategy will be developed by the end of Q2 2017. • Action 49: An appropriate model will be developed for the provision of interpreting services to users within the health area who are not proficient in English. • Action 50: The recording of ethnicity as part of ethnic equality monitoring across the health service will be promoted as a means of identifying unique needs of migrants and developing interventions to address these needs. • Action 61: Intercultural awareness training will be provided by all Government Departments and Agencies and it will be reviewed at intervals to ensure that it is adequate and up to date. Frontline staff will receive ongoing cultural awareness training appropriate to their role and operational requirements.

Strategy	Actions
<p><i>Working Group to Report to Government on Improvements to the Protection Process, including Direct Provision and Supports to Asylum Seekers, Final Report (McMahon report, 2015)</i></p>	<ul style="list-style-type: none"> • The existing HSE health screening service for protection applicants be reviewed and strengthened so as to facilitate a multi-disciplinary needs assessment at an early stage – and this includes early identification of medical, psychological and social needs. • The early implementation of the HSE plan for the rollout of the decision that residents in direct provision accommodation should not have to pay the prescription charge of €2.50 per item. (This action has been completed.) • The implementation of the HSE's commitment for the introduction of a programme of mental health awareness training for staff in direct provision accommodation to enable staff to recognise mental health issues, to take steps to improve mental health awareness and to know how to contact appropriate services. • Introduction of specific health promotion initiatives that are available free of charge, including breast screening, cervical checks, and bowel and diabetic screening services free of charge. • Carry out a review by the relevant organisations of services for persons in the system experiencing a crisis pregnancy and implement a protocol being agreed to guide State agencies and NGOs supporting such persons. • Develop an initiative to facilitate access by persons in the system to information and services concerning sexual and reproductive health and family planning. • Ensure access to good quality interpreting services, provide sensitivity training for interpreters and encourage general practitioners to offer interpreting services to this client group. • Improve access to information through provision of information leaflets, posters, talks and confidential contact details in every centre, and kept up to date to target vulnerable groups and promote dignity. Issues to be identified include FGM, torture, HIV, mental health, LGBT, disability, religion, domestic violence, human trafficking, exploitation, prostitution and older people's needs. • Ensure that residents are able to access appropriate transport provision or financial assistance to ensure attendance at medical appointments and safe return to the centre. • Include in the HSE National Operational Plan an account of progress on the implementation of the health-related recommendations made by the Working Group that are adopted by Government.

Strategy	Actions
<p><i>National Traveller and Roma Inclusion Strategy 2017–2021</i> (Department of Justice and Equality, 2017)</p>	<ul style="list-style-type: none"> • 62. The Health Service Executive will examine how drug and alcohol services engage and educate family members, as appropriate, in the development and delivery of service user care plans. • 63. The Health Service Executive will ensure that the new Mental Health Clinical Programme to tackle dual diagnosis will take account of the needs of Travellers and Roma with co-morbid mental health and substance abuse problems. • 64. The Health Service Executive will facilitate the establishment of a network of regional Traveller peer support workers through Traveller organisations and/or primary healthcare projects to support service users in accessing addiction rehabilitation services. • 65. The Department of Health and the Health Service Executive will ensure that there is Traveller and Roma representation on their national and local health-related structures relating to Travellers and Roma, as appropriate. • 66. The Health Service Executive, in consultation with Traveller organisations, will continue to address the prevalence, range and treatment of chronic health conditions among Travellers e.g. diabetes, asthma, cardiovascular and circulatory conditions, poor mental health and suicidal ideation. • 67. The Health Service Executive and other relevant bodies, in consultation with Traveller organisations and other stakeholders, will work towards a phased, incremental implementation of a standardised ethnic identifier across all health administrative systems to monitor access, participation and outcomes of all groups, including Travellers and Roma, and to inform the development of evidenced-based policies and services. • 68. The Department of Health and the Health Service Executive will support the implementation of the findings of the National Roma Needs Assessment for Roma in Ireland. • 69. The Health Service Executive will review the legislative and policy restrictions that impact on the provision of medical cards for Roma with no income. • 70. The Health Service Executive will promote immunisation uptake among members of the Roma community, with a particular emphasis on early childhood vaccinations. • 71. The Health Service Executive, in consultation with Roma representatives, will assess the primary care and basic needs of vulnerable Roma. • 72. Acknowledging the results of the <i>National Roma Needs Assessment for Roma in Ireland</i>, the Health Service Executive will support Roma women to access maternal health services in a timely and appropriate manner. • 73. The Health Service Executive will develop and implement a detailed action plan, based on the findings of the All-Ireland Traveller Health Study, to continue to address the specific health needs of Travellers, using a social determinants approach. • 74. The Department of Health and the Health Service Executive will review the existing arrangements for engagement between them and Traveller representative organisations with a view to agreeing improvements to the current arrangements. • 75. The Department of Health and the Health Service Executive will continue to ensure that specific funding is allocated for Traveller and Roma health initiatives. • 76. Pending a review of service, the Health Service Executive will develop a plan to expand the Primary Healthcare for Traveller projects and take into account also the needs for targeted initiatives for men. • 77. The Health Service Executive, in conjunction with the education authorities and local Traveller organisations, will examine how primary healthcare programme workers can access and receive accreditation for their work so as to improve employment prospects for members of the Traveller and Roma communities who are employed on these programmes.

Strategy	Actions
	<ul style="list-style-type: none"> • 78. The Health Service Executive will develop primary healthcare projects for Roma based on the Traveller Primary Healthcare Project model and informed by the findings of the National Roma Needs Assessment for Roma in Ireland. • 79. The national framework for action to improve health and wellbeing, Healthy Ireland, will continue to take a whole of Government approach to drive change at population level and will focus on specific targeted actions and interventions for disadvantaged communities and at-risk groups including Travellers and Roma. • 80. The Department of Health and the Health Service Executive will work with the relevant training bodies and the Higher Education Authority and also with Traveller organisations to include training on Traveller health status and Traveller and Roma cultural awareness as well as anti-racism training on the under-graduate and graduate curricula for health professionals. • 81. The Health Service Executive will design and disseminate culturally appropriate and culturally competent, accessible information and healthcare materials in partnership with Traveller and Roma organisations. • 82. The Health Service Executive will support and train healthcare staff to use clear language in dealing with diagnosis and treatment options. • 83. The Department of Health and other relevant Departments will collaborate with educational institutions and programmes including the Royal College of Surgeons in Ireland (RCSI), the Schools of Nursing and Midwifery and the Irish College of General Practitioners (ICGP) programme to develop initiatives that promote access by Travellers to education and accreditation programmes that enhance their ability to compete on an equitable basis for mainstream health posts. • 84. The Health Service Executive will engage with Traveller representative organisations to establish pathways to employment and support existing employees. • 85. The Health Service Executive will seek funding for Roma health advocates on the basis of a needs assessment. • 86. The Health Service Executive will work towards ensuring access to interpreters for Roma in GP consultations and across health services as appropriate. • 87. The Health Service Executive will support and further develop culturally appropriate services to respond to the mental health needs of Travellers and Roma in consultation with Traveller and Roma organisations. • 88. The Health Service Executive will develop targeted interventions and educational materials to support good mental health, suicide prevention and promote self-esteem and self-acceptance for young Travellers. • 89. The Health Service Executive (National Office for Suicide Prevention) will develop communication campaigns to reduce stigmatising attitudes to mental health and suicidal behaviour at population level and within priority populations including the Traveller and Roma communities. • 90. A review by the National Office for Suicide Prevention of its funding of Traveller projects will assess the effectiveness of existing programmes and provide guidance in relation to future initiatives. • 91. The Health Service Executive (National Office for Suicide Prevention), in consultation with Traveller organisations, will conduct research on suicide and self-harm in the Traveller community, as part of the implementation of Connecting for Life, Ireland's National Strategy to Reduce Suicide 2015–2020. • 92. In collaboration with Traveller organisations and other relevant stakeholders, the Health Service Executive (National Office for Suicide Prevention) will provide training and guidance to improve recognition of, and response to, suicide risk and suicidal behaviour among Travellers through programmes such as Assist and Safe TALK. The National Office for Suicide Prevention will link with the Health Service Executive's Social Inclusion Unit to ensure effective approaches are taken.

Strategy	Actions
	<ul style="list-style-type: none"> • 93. The Department of Justice and Equality will review the Traveller Counselling Service with a view to supporting its continuation. • 94. The Health Service Executive will explore prescribing practices to Travellers as evidenced among a cohort of the Traveller community with a view to rationalising prescribing patterns and medication management for individuals. Relevant recommendations will be integrated into policy, guidance, protocol and training programmes. • 95. The Health Service Executive will review the access and barriers to primary and secondary mental health services for Travellers and Roma, in the context of the implementation of the ethnic identifier, and in partnership with Traveller and Roma service users, carers and families in order to develop and implement appropriate steps to ensure greater inclusion and continued use of these services by Travellers and Roma. • 96. The Health Service Executive will recruit nine mental health service co-ordinator posts to support access to, and delivery of, mental health services for Travellers, in each Community Health area, as outlined in the Mental Health Division's strategic priorities in its Operational Plan for 2017. • 102. All Departments and agencies will be mindful of the National Strategy on Domestic, Sexual and Gender-based Violence and will implement and report on the commitments in that Strategy appropriately in accordance with the structures set out in that Strategy. • 103. The Health Service Executive and Tusla will develop joint approaches, as needed, to implementing community-based outreach and referral programmes that can achieve the best outcomes for victims of gender-based violence in the Traveller and Roma communities. • 105. The Health Service Executive will continue to deliver training to service providers on violence against Traveller and Roma women to remove barriers to services. • 106. Tusla, and the Health Service Executive, will ensure that policy and practice across all components of specialist domestic, sexual and gender-based violence services, including Sexual Assault and Treatment Units, is non-discriminatory towards service users from the Traveller and Roma communities.

Strategy	Actions
<p><i>Second National Strategy on Domestic, Sexual and Gender Based Violence 2016–2021</i> (Department of Justice and Equality, 2016a)</p>	<ul style="list-style-type: none"> • Action 1.500: Develop a shared approach between Tusla and HSE – in collaboration with service provider organisations – towards commissioning of training of frontline professionals in each agency that assures a consistent, appropriate and culturally competent response to persons presenting to services. Training should also include a focus on establishing standards, addressing quality improvement and measuring outcomes. • Action 2.100: Develop appropriate mechanisms for commissioning of psychological support services in line with the SATU National Guidelines (3rd edition) for victims of sexual violence attending at SATUs. • Action 2.400: Review current approaches and outcomes in respect of domestic, sexual and gender-based violence questions used by all staff in different community and hospital contexts / environments and with specific target areas: child protection and welfare; pregnant women; addiction services; accident and emergency services; mental health services; primary care services; maternity services; and social inclusion services. Agree further actions and consistency of approaches as appropriate. • Action 2.1100: Develop appropriate, evidence-based, targeted interventions in domestic, sexual and gender-based violence in communities of particular vulnerability, including migrants, Traveller and Roma women and people with substance misuse difficulties. • Action 2.2100: Implement option for self-referring victim to sexual assault treatment units to have forensic examination and report, pending a decision to report or not to An Garda Síochána. • Action 2.2200: Promote and support high quality data collection within sexual assault treatment units to ensure accurate collation of national key service activities to assist with service planning and delivery. • Action 2.2600: Develop therapeutic intervention programmes for voluntary participants in sexual violence programmes for non-convicted abusers.
<p><i>Ireland's Second National Action Plan on Women, Peace and Security, 2015–2018</i> (Department of Foreign Affairs and Trade, 2015)</p>	<ul style="list-style-type: none"> • Action 3(b) Work to protect women and girls in humanitarian crises, including those crises as a result of conflict: Prioritise the fight against trafficking in human beings, both domestically, cross-border, and as an international policy priority • Action 3(c) Support the relief, recovery and rehabilitation of women on the island of Ireland affected by conflict: Strengthen outreach to women and girls in Ireland who have been affected by conflict, including migrant women, Diaspora communities, and those seeking asylum, and those who have experienced FGM, to ensure raised awareness and increased utilisation of the services available.
<p><i>Second National Action Plan to Prevent and Combat Human Trafficking in Ireland</i> (Department of Justice and Equality, 2016)</p>	<ul style="list-style-type: none"> • Action 13: To continue to collect and analyse data on trafficking in human beings. • Action 23: Maintain the provisions of the full range of services to victims of trafficking. • Action 24: To monitor and examine the adequacy of, and where necessary, make recommendations to improve, the services provided to victims of trafficking in human beings. • Action 27: To ensure that victims of trafficking in the asylum process are recognised, provided with safe, secure and appropriate support without prejudice to their right to seek asylum.
<p><i>Reducing Harm, Supporting Recovery: A Health-led Response to Drug and Alcohol Use in Ireland, 2017–2025</i> (Department of Health)</p>	<p>2.1.27 Improve the capacity of services to accommodate the needs of people who use drugs and alcohol from specific communities including the Traveller community; the lesbian, gay, bisexual, transgender and intersex community; new communities; sex workers and homeless people. Fostering engagement with representatives of these communities, and/or services working with them, as appropriate:</p> <p>b) Considering the need for specialist referral pathways for specific groups who may not otherwise attend traditional addiction services (i.e. those who engage in chemsex);</p> <p>c) Providing anti-racism, cultural competency and equality training to service providers; and</p> <p>d) Ensuring all services engage in ethnic equality monitoring by reporting on the nationality, ethnicity and cultural background of service users for the NDTRS and treat related disclosures with sensitivity.</p>

Strategy	Actions
<p><i>National Men's Health Action Plan Healthy Ireland - Men HI-M 2017-2021 Working with Men in Ireland to Achieve Optimum Health and Wellbeing</i> (Department of Health)</p>	<p>2.2 Support the Irish Men's Sheds Association (IMSA) with the implementation of the Quality Assessment and Outcomes Framework for Men's Sheds in Ireland.</p> <p>2.3 Support the Gaelic Athletic Association (GAA) with the implementation and ongoing evaluation of the Healthy Clubs Initiative.</p> <p>2.4 Support the implementation of the 'Connecting for Life' Implementation Plan by developing and implementing new initiatives (e.g. with middle-aged men) that promote positive mental health and resilience among at risk groups of men.</p> <p>2.5 Support the HSE's Plan for Wellbeing and Mental Health by continuing to implement and expand existing initiatives (e.g. Engaging Young Men, Mojo Project, 7 Key Questions) to promote positive mental health and resilience among at-risk groups of men.</p> <p>2.6 Develop and implement new initiatives targeted at engaging Traveller men, with a particular focus on mental health and resilience building.</p> <p>2.7 Support the implementation of the <i>Men and Cancer</i> Report recommendations with a particular focus on cancer and health literacy (focusing on the cancer information needs of men over 40 years of age and from lower socio-economic groups).</p> <p>2.8 Implement the <i>Farmers Have Hearts</i> evaluation recommendations in the future roll out of cardiovascular risk screening targeted at men.</p> <p>2.9 Support those tasked with implementing the National Sexual Health Strategy and social, personal and health education (SPHE) in schools, with a particular focus on promoting increased self-awareness and emotional intelligence among boys and young men.</p> <p>2.10 Contribute to the development of the 'Healthy Workplace Framework' and support the implementation of workplace health promotion initiatives with a particular focus on men.</p>

APPENDIX 4

Summary of the outcomes of consultation on the second NIHS

A4.1 Access to good quality intercultural healthcare services

A4.1.1 Implementation of existing strategies and policies

A significant theme running through many submissions is the importance of improving access to good quality health services for all, while taking into account the specific and diverse needs of migrants and minority ethnic communities. Several submissions refer to the need to fully implement existing health policies and strategies, including the *HSE Corporate Plan* (2015a). A number of submissions also refer to the need for adequate resourcing in order to meet current and projected requirements.

A4.1.2 Improving access to healthcare for vulnerable migrants and minority ethnic groups

Undocumented migrants: Several submissions note that undocumented migrants face significant barriers in access to healthcare. They stress that identified barriers, which include poverty, lack of education and language, lack of access to Department of Social Protection payments, legal status, lack of trust in service providers and racism and discrimination, need to be addressed in the second strategy.

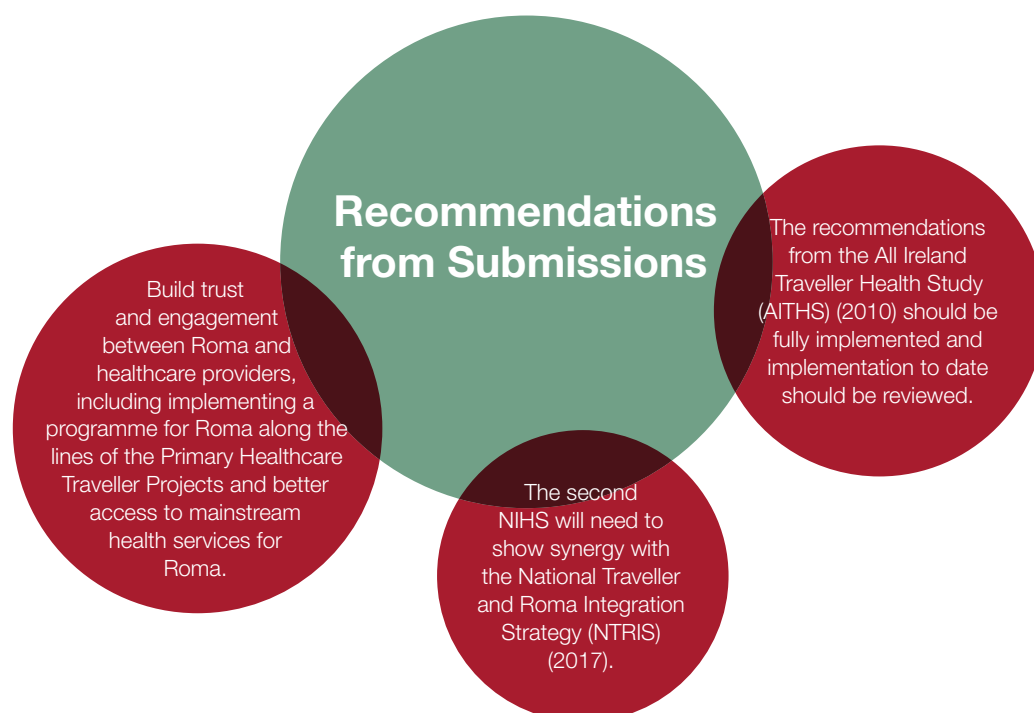
Refugees and asylum seekers: A large number of submissions include recommendations to improve access to health and social care services for refugees and asylum seekers, including measures that build on the achievements of the first NIHS (2007) and that implement the recommendations contained in the McMahon report (Department of Justice, 2015). The physical and mental health and other social needs of people living in direct provision centres are highlighted as being of particular concern. These submissions highlight the significant problems and major frustrations faced by people living in direct provision while they await progress with their asylum applications, which negatively affect their mental and physical health and wellbeing. Poor mental health, anxiety and depression are among the range of complex health issues faced by people living in direct provision; in addition, some asylum seekers are suffering from physical and psychological effects of FGM, rape, murder of family members, shrapnel and other wounds, as well as problems of post-traumatic stress, depression, anxiety and other mental health problems. Many of these submissions reflect the findings and recommendations of the McMahon report (2015).

A number of suggestions fall outside the immediate remit of the HSE; for example, those relating to aspects of accommodation and legislative requirements. However, strong collaborative structures established between the HSE and the Department of Justice and Equality and other stakeholders will facilitate a cross-cutting approach to addressing such issues, wherever feasible and appropriate.

Figure A4.1: Key recommendations regarding migrants from submissions for the second NIHS

Several submissions refer to the need for timely assessment of the health needs of new migrants, and in particular of vulnerable migrants. This is crucial to ensuring that the diverse health needs of migrants, particularly refugees and asylum seekers, are addressed effectively. This means taking into account a migrant's life experiences prior to migration, access to healthcare in their country of origin, the circumstances of their migration, risk of infection and potential health issues, risks associated with exploitation and victimisation in their country of origin, and their current situation and support in Ireland.

Travellers and Roma: A large number of submissions focus on the health and wellbeing of Travellers and Roma, highlighting problems relating to access to good quality healthcare, including access to specific services such as mental health, sexual health and maternity services.

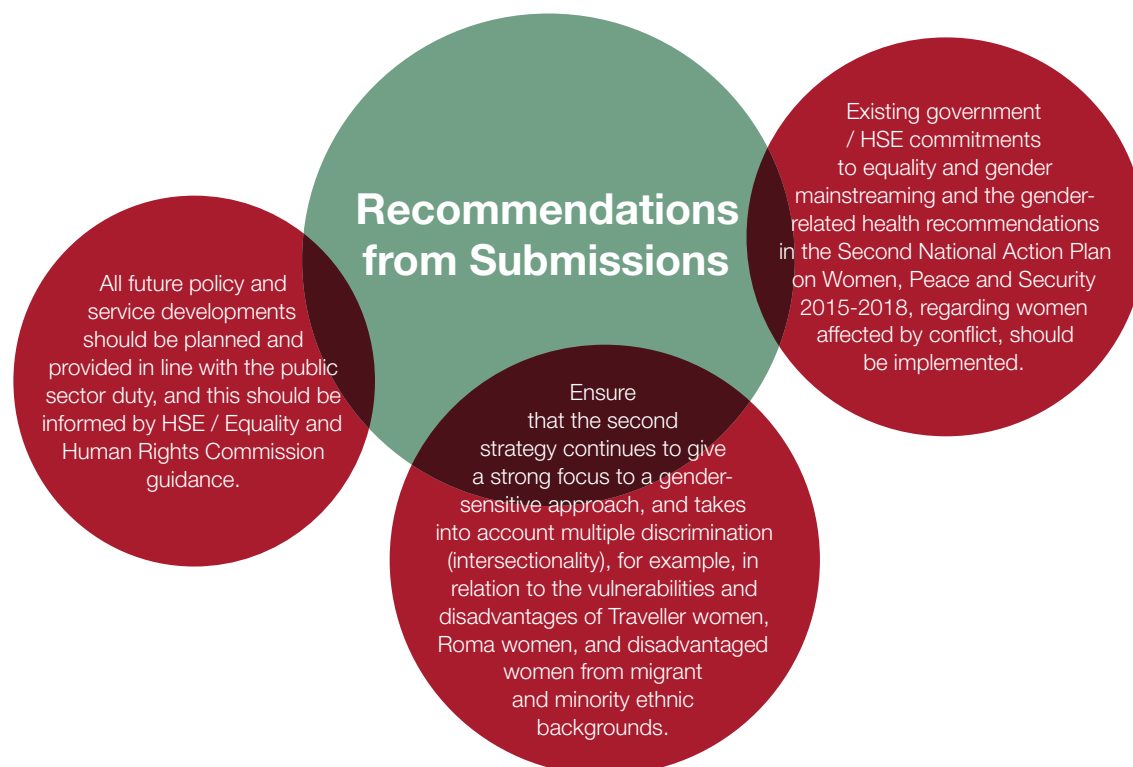
Figure A4.2: Recommendations regarding Travellers and Roma from submissions for second NIHS

A large number of submissions made recommendations for culturally sensitive health services in specific service areas, with particular emphasis on mental health services, maternity services, sexual and reproductive health services, child protection services and the needs of migrant children in care of the HSE, services for people with disabilities, and older people's services.

- **Mental health services:** Many submissions state that the second strategy needs to be explicit in acknowledging that people from minority ethnic and migrant backgrounds, as well as their families and carers, may face complex mental health needs and may require specialist services. (For further information, see Murphy and Leavey (2014) and McDaid (2014).)
- **Maternity services:** Several submissions stress that priority needs to be given to provision of good quality maternity services that take account of the diverse cultural and communication needs of women; this should include access to good quality interpreting services. A submission by the NWCI provides detailed recommendations based on consultations held in partnership with the HSE across the country in 2015. This highlights the need for maternity services to fully meet the needs of migrant women, for services to be more

culturally appropriate, and for there to be synergy between the second NIHS and the *National Maternity Strategy, (2016–2026)*.

- **Sexual and reproductive health services:** The first NIHS strategy acknowledged that issues around maternity and reproductive health were emerging areas of concern. Recommendations are made in several submissions for the second NIHS for provision of culturally appropriate reproductive and sexual health services and information, and for ensuring that there is a specific focus on asylum seekers, refugees and other vulnerable migrants. The IFPA recommends that sexual and reproductive health be included as a distinct theme within the second strategy, covering issues such as: FGM treatment and prevention; access to contraceptive information and services; and referral pathways for women with unplanned pregnancies. Several submissions refer to the importance of implementing the recommendations in the McMahon report (2015) and to ensure that there is synergy between the second NIHS and the implementation of the *National Sexual Health Strategy (2015–2020)*.
- **Child protection services and migrant children in the care of the HSE:** A number of submissions recommend that the second strategy gives priority to child protection issues, specifically in relation to *Children First: National Guidance for*

Figure A4.3: Recommendations regarding the public sector duty

the Protection and Welfare of Children.¹ A crucial element of this is to build on best practice in working with children and young people, and to ensure that staff are aware and sensitive to needs of minority ethnic groups, for example, in relation to FGM or early/child marriage.

- Other services: Several submissions recommend that the second strategy address the needs of migrant and minority ethnic people with disabilities, as well as older people. This includes integrating the *HSE National Guidelines on Accessible Health and Social Care Services* (2014) into the second strategy and recognising the support needs of minority ethnic elders who experience dementia or psychiatric issues. Recommendations are also made in relation to nutrition services, environmental health services, addressing the issues related to refusal of medical assistance, death and dying and support, support needs of family carers from minority ethnic communities, safe and supported spaces

for young people, assisted decision making, and HR issues.

The need for dedicated services and intercultural staff awareness is highlighted in relation to specific health conditions, for example, in relation to human immunodeficiency virus (HIV) and AIDS, sickle cell anaemia and polio.

A4.2 Equality, non-discrimination and human rights

A recurrent theme in many submissions is the need to implement the Public Sector Duty (Public Sector Equality and Human Rights Duty, Section 42 of the Irish Human Rights and Equality Commission Act, 2014) in ensuring that the second strategy and its implementation take full account of equality and human rights issues, including a gender sensitive approach to service provision.² The previous NIHS (2007) noted the importance of equality and human rights, including the combined impact of ethnicity, gender, conflict-related trauma and culture-shock of unfamiliar gender norms in Ireland as compounding barriers to health services for migrant women.

¹ *Children First* provides guidance for organisations working with children to promote children's welfare and protect them from harm or abuse. It emphasises the importance of multi-disciplinary, inter-agency working in the management of concerns. The HSE has developed a suite of tools, including a Child Protection and Welfare Policy, to assist staff in meeting their responsibilities under the revised Children First guidance (2016) and the Children First Act (2015).

² Section 42 of the Public Sector Equality and Human Rights Duty sets out three core steps to be taken by public bodies: strategic planning, policies and practices, and reporting. For further information see: <https://www.ihrec.ie/our-work/public-sector-duty/>.

Figure A4.4: Recommendations regarding interpreting and translation services

A4.3 Interpreting and translation services

A large number of submissions identify access to good quality interpreting and translation services as being critical to ensure equality of access to health services. Evidence from research and from the Partnership for Health Equality (PHE) project,³ among other sources, suggests that many migrants continue to rely on interpreting from family members or friends, or on using “Google Translate” or other online language app. Many healthcare professionals lack knowledge about community resources for interpreting and/or how to access professional interpreting services. Staff highlighted a lack of preparedness for working through interpreters and

some expressed a concern about the quality of care resulting from using an interpreting service.

A number of submissions refer to the need for the second strategy to include provision for training for interpreters and healthcare staff. Other submissions refer to the importance of having access to information in multiple languages, with sufficient resources and facilities to translate written information.

A4.4 Cross-cultural communication and cultural competence of staff

Intercultural training and support for staff was a fundamental principle of the first NIHS (2007), and several submissions refer to the importance of building on this to ensure that staff are facilitated to avail of continued access to training. Several submissions refer to the importance of understanding cultural expectations held by patients regarding healthcare services and how the health system works.

³ A collaboration of clinicians, medical educators, social scientists, healthcare policymakers and planners funded by the University of Limerick and the North Dublin City GP Training Programme and the HSE’s Social Inclusion and Primary Care Services. The aim of PHE is to improve access to primary healthcare for marginalised groups, including homeless people, drug users, Travellers, migrants and others. For information see: <http://www.healthequity.ie/about-us>.

Figure A4.5: Recommendations regarding cross-cultural communication and cultural competence of staff

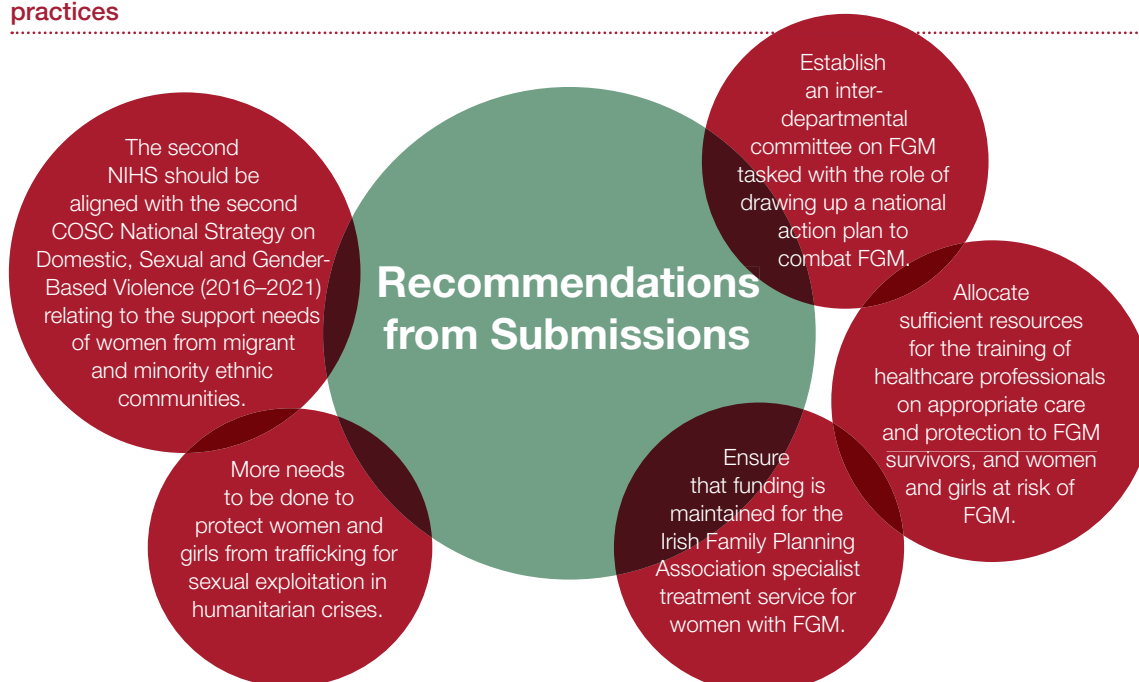


A4.5 Gender-based violence, including FGM and other harmful practices

The first NIHS (2007) recognised the need for specific targeted support and outreach programmes for women who are socially isolated and at risk of abuse or violence. Several submissions highlight the need to continue this support in order to address the specific vulnerabilities and risks of domestic violence, FGM and other harmful practices that may be faced by women from migrant backgrounds. The practice of FGM is widely regarded as a serious infringement of the human rights of women and girls.

In Ireland, FGM was made illegal under the Criminal Justice (Female Genital Mutilation) Act, 2012. The voluntary organisation AkiDwA has drawn up a framework for the coordination of services on FGM, including healthcare provision, entitled "Towards a National Action Plan to Combat Female Genital Mutilation 2016–2019". In relation to trafficking for sexual exploitation, the Department of Justice and Equality (Anti-Human Trafficking Unit), the HSE and An Garda Síochána are committed to prioritising the fight against trafficking in human beings, both domestically, cross-border, and as an international policy priority.

Figure A4.6: Recommendations regarding gender-based violence, including FGM and other harmful practices



A4.6 Service user and community participation and consultation

Community participation and service user engagement in health service development and evaluation was an underpinning principle of the first NIHS (2007). A strong message from the submissions for the second strategy is that it should build on existing good practices on service user participation, community participation and partnership working.

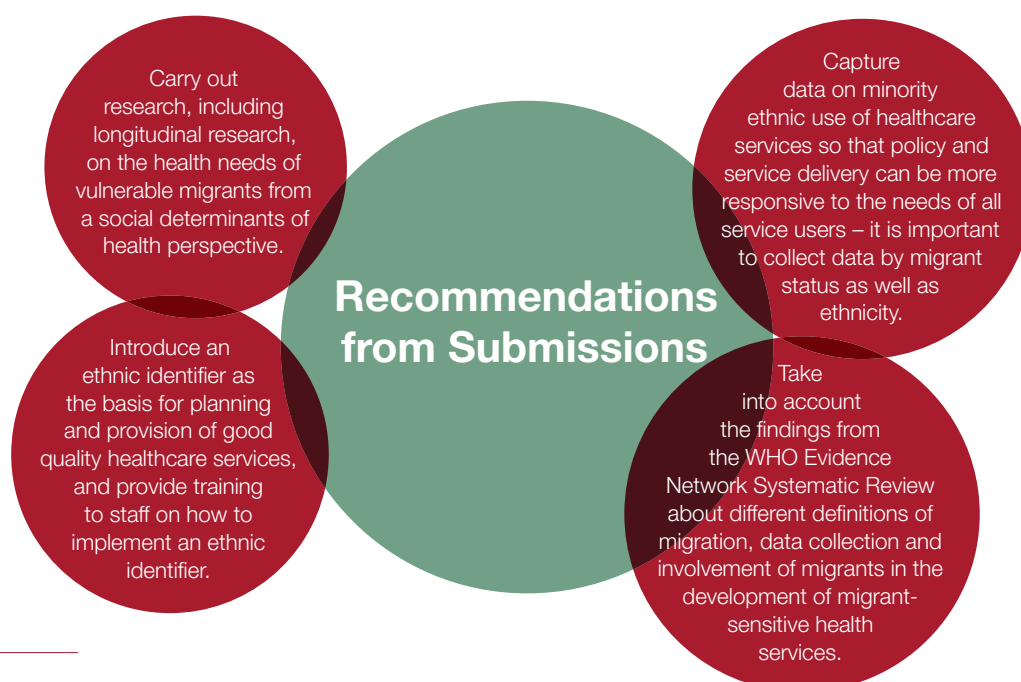
Figure A4.7: Recommendations regarding service user and community participation



A4.7 Evidence base on intercultural health

Several submissions refer to the need for better data collection on minority ethnic access to healthcare and for more research in this area, in order to build the evidence base regarding migrant /minority ethnic health. The issue of introducing an ethnic identifier was raised, particularly in the context of Travellers being recognised in 2017 for the first time as an ethnic minority group in Ireland (Department of An Taoiseach, 2017).

Figure A4.8: Recommendations regarding the evidence base on intercultural health



A4.8 Implementation of the second NIHS

Some submissions give suggestions about the implementation of the second strategy, including the need for clear and defined goals, targets, indicators, timeframes, funding mechanisms, and a monitoring and evaluation framework. Submissions emphasised the need to ensure there is adequate funding and resources to meet current and projected health needs, and to ensure effective monitoring/evaluation and dissemination of the second strategy.

APPENDIX 5

Resources

Considerable progress was made during the period of the first NIHS, regarding implementation across key areas including:

- capacity building;
- staff training and support;
- database developments;
- research;
- guidelines to translation and interpreting;
- the Intercultural Guide; and
- the emergency multilingual aid toolkits.

These resources are listed below, together with links to enable access.

Resource	Online link
Emergency Multilingual Aid	https://www.hse.ie/eng/services/Publications/SocialInclusion/EMA.html
Intercultural Guide	http://www.hse.ie/eng/services/publications/SocialInclusion/InterculturalGuide/
Lost in Translation report	https://www.hse.ie/eng/services/Publications/SocialInclusion/lostintranslationreport.html
Guideline for Communication in Cross-cultural General Practice Consultations	http://www.integration.ie/website/omi/omiwebv6.nsf/page/AXBN-A32N54188566-en/\$File/Guideline%20for%20Communication%20in%20Cross-Cultural%20General%20Practice%20Consultations.pdf
HSE Translation Hub	http://www.hse.ie/eng/about/Who/primarycare/socialinclusion/about-social-inclusion/translation-hub/Multilingual-resources-and-Translated-material/
Understand Me mobile app for healthcare professionals	http://www.hse.ie/eng/about/Who/primarycare/socialinclusion/about-social-inclusion/translation-hub/Mobile-Health-Apps/

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A copy of this strategy is available at www.hsesocialinclusion.ie



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