Second National
Intercultural Health Strategy
2018-2023

Summary of Written Submissions

HSE Social Inclusion

Seirbhís Sláinte Níos Fearr á Forbairt | Building a Better Health Service

DETAILED SUMMARY OF THE WRITTEN SUBMISSIONS

The new and emerging issues identified in the submissions are a reflection of the experience of staff providing front-line services, while some are based on recent consultations or research carried out on the issue.

The following gives a detailed summary of the fifty-six written submissions. Each written submission has been allocated a number, which is referenced against relevant points raised. A list of all written submissions can be found at the end of the appendix.

1. ACCESS TO GOOD QUALITY INTERCULTURAL HEALTHCARE SERVICES

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, as this would contribute substantially to better quality services for migrants and minority ethnic communities. Central to this is to mainstream awareness and practices on intercultural health into all policies and into the provision of all services.

Summary of recommendations regarding access to good quality healthcare services:

- Staff, managers and decision-makers at all levels of the HSE need to recognise the cross-cutting nature of intercultural health and how this relates to the overall goals of the HSE Corporate Plan and other relevant health policies and strategies, for example, on health & wellbeing and mental health. This should be embodied in the new HSE Corporate Plan for the period 2018–2020, which will impact on the overall quality of care received by migrant groups.
- Building on the first NIHS, continue to ensure that staff, managers and decision-makers have the knowledge and capacity to mainstream the diverse needs of migrants and the provision of intercultural health services into all service provision.
- It will be important to provide adequate resources in order to meet current and projected requirements.

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 and social welfare. These barriers, which include poverty, legal status, lack of trust in service providers and racism and discrimination, need to be addressed in the second NIHS. (40)

Refugees and asylum seekers

The National Intercultural Health Strategy 2007 – 2012 contains a range of measures for asylum seekers, refugees and programme refugees. Many submissions recommend that further measures need to be introduced in the second NIHS to improve access to health and social care services for adults and children in the asylum system. (13, 21, 46, 48, 57) The physical and mental health and other social needs of people living in Direct Provision centres is of particular concern. Several submissions highlight the important findings and recommendations from the McMahon Report.

Evidence from the Partnership for Health Equality (PHE)[1] project is given in a submission by Professor Anne McFarlane (University of Limerick), which identifies the problems and major frustrations faced by people living in Direct Provision while they await progress with their asylum applications (52). These include lack of opportunities to work, persistent poverty, problems with accommodation and food, and poor planning or access to specialist care when people are moved around the country at short notice. Recommendations include the need for satisfactory accommodation and nutritious food, opportunities to work and to participate in society, and shorten the times for the processing

1 A collaboration of clinicians, medical educators, social scientists, healthcare policy makers 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

of applications. The PHE project has identified a range of complex health issues that GPs may not be familiar with and require training in. (52) They include:

- Physical and psychological effects of FGM, rape, murder of family members, shrapnel and other wounds, post-traumatic stress, depression, anxiety and other mental health problems.
- It is not always possible to have a choice of a male or female GP for consultations.
- Problems arise for GPs where there is no written medical history, for example, of children's vaccinations and a lack of familiarity with infection diseases such as HIV, malaria, TB etc.

> *"I am a GP and I have worked with asylum seekers and refugees and know how complex their health issues, particularly mental health issues, can be. Good primary care, with continuity of care, supported and resourced to look after people with complex health needs is really important, which should be available in every part of Ireland. As GPs are the corner stone of primary care, they have to be involved." (5)*

Further evidence is given of the negative impact of the lack of occupation on the mental health of asylum seekers. Coupled with loss of family, friends and culture, along with racism and stigmatization, the lack of meaningful occupation and barriers to engagement contributed to high levels of anxiety, depression and overall poor mental health of people living in Direct Provision centres.[2] (24) Several submissions refer to research by the Faculty of Public Health Medicine (RCPI) on the health of asylum seekers and refugees,[3] giving further evidence of the urgent need for improved health and support services for people with complex health needs, language and cultural differences.

Feedback is also given from a Public Health SMO who visits an EROC (Hazel) on a weekly basis (for vaccination requirements, to organise schedules for GPs, to develop awareness of Public Health issues etc.). Problems identified include limited interpreting/translation services, lack of support and training at primary care level, absence or paucity of specialised services such as psychological services for survivors of war/ torture, lack of ancillary services such as public health nurse and a lack of/ inadequate advocacy services. (32)

Specific recommendations made in the submissions are as follows:

- The second NIHS should take into account recent research and evidence from the RCPI research and PHE project as well as the findings and recommendations McMahon report relating to the health and wider effects of Direct Provision.
- Include reference to the International Protection Act 2015 in the second NIHS. (21)
- Ensure that children in the asylum system have access to immunization and screening when they arrive in the country and ease of access to the multidisciplinary team in primary care. (11)
- Improve access to mental health services and supports for refugees and asylum seekers, (47, 11) particularly for adults and children in Direct Provision, and give a specific focus to mental health supports for children and young people. (11, 21, 48)
- Address the physical and mental health needs of separated asylum seeking children and 'aged out' separated young people. (42, 48)
- Ensure that the physical and mental health needs of individuals moving out of the Direct Provision system are met, particularly those who may have little contact with services. This is also important for people who arrive in Ireland under family reunification schemes who need emotional support as families adjust to being together again. (46)
- Provide access to services to help with integration and to meet the physical and mental healthcare needs of migrant, refugee and asylum seeking women affected by conflict who have left the Direct Provision system and are integrating into communities should also be given appropriate support. (55)

2 De Mojeed, A., (2010) The effects of lack of occupation on the mental health of asylum seekers. Thesis, NUI Galway. Available at: http://www.oofras.com/rs/7/sites/177/user_uploads/File/Abiola's%20Thesis%202010.pdf

3 Faculty of Public Health Medicine (2016) Migrant Health - The Health of Asylum Seekers, Refugees and Relocated Individuals. A Position Paper from the Faculty of Public Health Medicine. RCPI. https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/06/Migrant-Health-16062016.pdf

- Improve coordination between groups, organisations and government departments and local agencies providing services to migrant communities, including newly arrived refugees and programme refugees. (32)
- Improve liaison between health services and local communities to facilitate the settlement process. (32)
- For asylum seekers living in Direct Provision ensure access to cooking facilities and nutritious and culturally appropriate food, including alternative meal arrangements for Muslims during Ramadan as they would obviously be fasting by day. (47)
- Provide free family planning and sexual health services for refugees and asylum seekers. (49)
- The HSE should prioritise working with the Department of Justice and Equality, RIA and OPMI to Equality address the significant stressors on health and wellbeing resulting from living in Direct Provision - this should have the particular aim of improving delivery of appropriate and culturally sensitive reproductive healthcare to women within the system. (55)

A joint submission from a group of eight Public Health Specialists and Directors of Public Health who work on migrant issues and who have a special interest in the health needs of migrants contains a range of recommendations for the second NIHS. Their submission is based on evidence and research,[4] recommends that focus be given to the assessment of health needs, addressing the health and support needs of vulnerable migrants, improving access to interpreting services, increasing the quality and accessibility of range of generic health services, and staff training. The submission says that priority needs to be given to ensuring that the needs of vulnerable migrants are met, that there is immediate and adequate access to primary care, sexual and reproductive healthcare and mental health services and that these services are adequately resourced. Funding for additional vaccinations for asylum seekers and refugees should be ring-fenced so that all necessary vaccines can be administered in a timely manner. (31)

4 Faculty of Public Health Medicine (2016) Migrant Health - The Health of Asylum Seekers, Refugees and Relocated Individuals. A Position Paper from the Faculty of Public Health Medicine, RCPI. See also Public Health Migrant Health Group, Report on the health needs of Asylum Seekers, presented for discussion with the Department of Health.

Assessing and meeting the needs of vulnerable migrants

Several submissions refer to the importance of the timely assessment of the health needs of new migrants, and in particular of vulnerable migrants. This is seen as very important if the health and other support needs of migrants are to be addressed effectively. (25, 27, 31, 38, 42, 43, 44) This means taking account of 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 in their country of origin, risks associated with exploitation and victimization in their country of origin, and their current support in Ireland.

One of the problems identified is the lack of services for homeless persons, asylum seekers or refugees who present with moderate-to-severe mental health difficulties. Currently they receive limited support from the local HSE Adult Mental Health team. Lack of access to full psychiatric team support is an ongoing identified risk. Persons in homeless facilities can link in with the homeless mental health teams at Ushers Island. However when they move on into supported accommodation access to the teams is often not available. (25, 43)

Recommendations relating to the health and other support of vulnerable migrants:

- Carry out assessment of the physical, psychological, social and health needs of different migrant groups, and do so as quickly as possible after arrival in Ireland to ensure that there is a timely response in areas such as immunisation, mental health, chronic disease management etc. (31)
- The strategy should include the establishment of a formal and effective mechanism to identify vulnerabilities (vulnerability screening) at an early stage in the asylum procedure and to take into consideration such vulnerabilities and adapt the asylum procedure and accommodation facilities of the individual concerned accordingly to ensure that he/she has effective access to protection and access to counselling, rehabilitation services and other health supports as required. (38, 44)
- This requires a systematic and effective vulnerability assessment process that is sensitive to the needs of applicants in providing evidence under the single procedure. This is particularly important as SPIRASI argues that the current voluntary health screening process is not a sufficient assessment process for the

purpose of identifying the range of possible vulnerabilities of asylum seekers; it does not link into the protection process nor does it adequately provide for the monitoring of persons with vulnerabilities and for the coordination of a response. (42)

- Address the health needs of homeless people from ethnic minorities. (25, 43)
- Addressing the needs of new migrants to the country in particular vulnerable migrants should include early and adequate screening for chronic diseases and mental health issues, as well as for infectious diseases. (27)
- There should be immediate and adequate access to primary care, sexual and reproductive healthcare and mental health services which are adequately resourced. (27)
- Funding for additional vaccinations for asylum seekers and refugees should be ring-fenced so that all necessary vaccines can be administered in a timely manner. (27)
- Ensuring quality of generic services, in particular accessibility and equity. Accessibility (health literacy, literacy, interpretation, translation, cultural responsiveness, risk communication). Equity (measuring & monitoring of health inequalities in particular implementation of ethnic equality monitoring throughout the HSE) and HSE compliance with IHREC 2014. (27)

Travellers and Roma

A large number of submissions make reference to the disadvantages and health inequalities faced by Travellers and Roma. (5, 15, 17, 53) In addition to the issues presented in this section some submissions regarding specific services include reference to Travellers and Roma (see for example, sexual health, maternity services etc.).

The National Traveller and Roma Inclusion Strategy (2017-2020), published by the Department of Justice and Equality, contains a range of health-related actions. Travellers are an ethnic minority community whose health needs and status have been extensively profiled through the All Ireland Traveller Health Study (AITHS) (2010).[5] Since 1995, the Department of Health has prioritized the health needs of Travellers through regional Traveller Health Units and the National Traveller Health Advisory Forum, with ring fenced funding to support partnership based initiatives linking Traveller community development organisations and the HSE.

Recommendations made in the submissions regarding Travellers and Roma:

- The recommendations from the AITHS study should be fully implemented in order to address the significant health inequalities and serious discrimination experienced by Travellers, framed through a social determinants of health approach. (5, 53)
- It will be important for the second NIHS to show the synergy with the National Traveller and Roma Integration Strategy 2017-2022. It is important also that the second NIHS incorporates the health needs of Travellers, in addition to other minority groups. (3)
- Carry out a review of the implementation of the AITHS, and show how many of the recommendation have been taken on board by Government Departments, especially in health. (5, 15, 53)
- One submission recommends a mainstreaming approach, by moving away from Traveller specific health services and interventions. (13)
- Specific issues identified for inclusion in the second NIHS include:
  - Partnership decision making, including the continued good practice of partnership based infrastructure of the regional Traveller Health Units. A good practice example is given of the South West Traveller Health Unit which has core values related to recognition of Traveller ethnicity.
  - Implement the Public Sector Duty, and promote equality proofing, training for health service staff and champion culturally appropriate responses to identified mental and physical health priorities and needs. (3)
  - Access to good quality services and information, and culturally competent service planning and provision. (3)
  - Funding of peer-led community health programmes through Primary Healthcare and community led health programmes.
  - Training for staff in communicating with service users and providing appropriate services. (15)
  - Sexual health, consent and domestic violence should be discussed with Travellers,

5 See: http://health.gov.ie/blog/publications/all-ireland-traveller-health-study

especially young Travellers, as part of a wider holistic approach. (49)

» Increase the number of Traveller specific youth workers to encourage the further integration of young Travellers into youth services. (47)

» Address ways to overcome racism, discrimination, poverty and marginalization in access to maternity and other health services for women Travellers. (51)

Recommendations made in the submissions regarding Roma:

- Address the health and social care needs of Roma, with regards to access to social protection services, including medical cards and access to basic GP care and preventative services. (51)
- A great deal needs to be done to build trust and engagement between Roma and healthcare providers, including implementing a programme for Roma along the lines of the successful Primary Healthcare Traveller Projects. For example, many women express fear of using hospital emergency or maternity services in case they will be given a bill for treatment that they cannot pay. There is also a lack of trust and a lack of information about services, including knowledge amongst Roma women of the Maternity and Infant Care Scheme. (51)
- Ensure better access to mainstream health services for Roma, including access to medical cards and social welfare. Strategies need to link health outcomes to the lack of education, lack of employment options, poverty/deprivation, literacy and language. (40)

1.3 Specific areas of service provision

A large number of submissions refer to specific healthcare services, with a focus on ensuring that services are provided in culturally sensitive ways. Particular emphasis is given to 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

Several submissions refer to the importance of addressing mental health issues and the needs of minority ethnic communities, and within an overall context of mental health and wellbeing. (18, 20, 23, 40)

- The second NIHS should acknowledge that people from minority ethnic and migrant backgrounds, their families and carers may face complex mental health needs and may require specialist services.[6] (18)
- The second NIHS should take account of mental health issues, including undiagnosed mental health issues, and provide access to culturally sensitive mental health supports. (38)
- The National Office of Mental Health Engagement (NOHME), as part of its remit and early operation is currently consulting with representative bodies, and would be happy to further discuss this work and share its insights. (18)
- The national consultative forum, to be established for a national taskforce on youth mental health (recently announced by Helen McEntee, Junior Minister with responsibility for mental health) should involve key stakeholders who work with asylum seekers and refugee youth. (38)

Specialist trauma counselling services

Several submissions refer to the need for specialist services and in particular trauma counselling services, and assessment and treatment for victims of torture. (29, 33, 38, 42, 44)

- Improve access to trauma counselling and other support services provided by SPIRASI, by funding a regional service that meets the needs of people living in Direct Provision outside of Dublin. A regional service would reduce travel costs currently funded by the Department of Social Protection (estimated to be approximately €14,500 in 2015). (15, 38, 44)
- The Direct Provision system should not hinder access to specialist services for vulnerable asylum seekers and refugees. (15, 40)
- Take into account the resettlement of vulnerable refugees with high mental health support needs. (40)
- In light of an increase in the numbers claiming asylum, coupled with the Irish Governments

6 Further information can be found in the following publications which address these issues in more detail: Murphy R and Leavey G (2014) "Mental health needs of minority ethnic communities in Ireland: contexts and controversies" in Higgins A and McDaid S (2014) Mental Health in Ireland: Policy, Practice and Law, Gill and Macmillan.

commitments under the Irish Refugee Protection Programme and the UNCHR re-settlement programme, NGOs such as SPIRASI should have adequate funding to meet the demand for specialist support services for vulnerable asylum seekers and refugees. (42)

Maternity services

Several submissions refer to the importance of providing good quality maternity services that take account of the diverse needs of women, so that they are more responsive to migrant women's needs.

- NWCI's submission (51) specifically refers to consistent recommendations - from consultations held in partnership with the HSE across the country in 2015 - on the need for maternity services to fully meet the needs of migrant women and for services to be more culturally appropriate.
- Ensure there is a synergy between the NIHS and the National Maternity Strategy, 2016-2026. (51)
- Address ways to overcome the barriers faced by Traveller and Roma women in accessing good maternal health and in accessing maternal health services. (51)
- Information should be aimed at prenatal care, Foetal Alcohol Awareness and the dangers of smoking during pregnancy. For example, this should address the findings of the Roma Health Report EU 2014, which notes that 85% of Roma women smoke in pregnancy and lack prenatal care. Given low general public awareness of the effects of alcohol in pregnancy in Ireland this is an area that needs to be targeted. (16)
- Ensure that there is a specific focus on intercultural care in the neonatal unit and in intensive care unit, as cultural differences and language barriers puts an added strain on staff and parents. (41)

Sexual and reproductive health services

The previous strategy included reference to sexual health as a distinct area and also acknowledged that issues around maternity and reproductive health were emerging areas of concern. In addition, the strategy stated that the forthcoming strategy on sexual health would include 'sexual health aspects of sexual health delivery for service users from minority ethnic groups'. However, HIV Ireland point out that the National Sexual Health Strategy (2015-2020) does not identify asylum seekers or refugees as a specific sub-group of migrants who are vulnerable and have specific needs regarding sexual health information, treatment and care. (4)

According to the IFPA's submission, evidence from clients and outreach work in the context of the FGM Project shows that women living in Direct Provision continue to face many barriers to accessing quality sexual and reproductive healthcare. Research, by Catherine Conlon et al.,[7] identified a range of barriers facing young women from Ireland's migrant communities. (49, 53) It found that knowledge and information about sexual health and crisis pregnancy prevention services is poor, and that there are limited experiences of accessing reproductive health services, compared with others in the same age group. Barriers to accessing services are cultural and religious backgrounds, pre-migration experiences, impact of legal status on access to services, costs, and language and communication issues. (53)

This is an important area – although attitudes to sex and sexuality have changed in recent decades, there are still major barriers in talking openly about sex and sexuality. (53, 55)

- Sexual and reproductive health should be a separate theme in the new Intercultural Health Strategy. (49, 51, 53)
- Integrate the recommendations on sexual and reproductive health contained in the McMahon report. (49, 51, 53)
- IFPA's submission states that this should cover issues such as FGM treatment and prevention; access to contraceptive information and services; and referral pathways for women with unplanned pregnancies. (49)
- Better resources are needed for sexual health promotion, education and prevention and targeted outreach. (53, 55)
- Ensure access to culturally appropriate reproductive and sexual health services and information, and ensure that there is a specific focus on asylum seekers, refugees and other vulnerable migrants. (6, 42, 51, 53, 55)
- Ensure that there is synergy with the National Sexual Health Strategy (2015-2020) and the vision "that everyone in Ireland experiences

7 Conlon, C., O'Connor, J., and Ní Chatháin, S., (2012) Attitudes to Fertility, Sexual Health and Motherhood amongst a Sample of Non-Irish National Minority Ethnic Women Living in Ireland. Crisis Pregnancy Agency. Available at: http://crisispregnancy.ie/wp-content/uploads/2012/06/migrant-women-report.pdf

positive sexual health and wellbeing", with reference to vulnerable groups that require targeted support, e.g. refugees, asylum seekers, migrants and migrant workers, unaccompanied minors, Travellers and other minority ethnic groups. (53)

- Ensure that healthcare professionals receive high quality training in working with people from diverse cultural and ethnic backgrounds as a crucial element of promoting sexual health and wellbeing, and in reducing negative sexual health outcomes. (53)
- Recommendations from the Sexual Health Crisis Pregnancy Programme (SHCPP) include:
  - » Strengthening partnerships with migrant organisations and NGOs working with migrant communities.
  - » Support organisations working with migrant communities to promote a) condoms through the national Condom Distribution Service to Direct Provision Centres, b) Parent RSE training programmes and resources, c) culturally sensitive and appropriate information, d) crisis pregnancy counselling and post-abortion services, e) primary care services for SRH consultations, f) pharmacies for SRH advice and emergency contraception, g) HIV and STI testing options nationally.
  - » In partnership with migrant organisations, review and develop education print and online information supporting migrant women and men in the area of crisis pregnancy, family planning and sexual health.
  - » Continue to promote the accessibility of emergency contraception.
  - » Consider training needs of relevant professionals working with people from diverse cultures and ethnic backgrounds.

Child protection services and migrant children in the care of the HSE

A number of recommendations are made about child protection services and migrant children in the care of the HSE:

- Several submissions suggest the Inclusion of child protection, specifically in relation to *Children First: National Guidance for the Protection and Welfare of Children*,[8] as a theme in the second NIHS.
- Although the HSE no longer holds statutory responsibility for the protection and welfare of children (this rests with TUSLA), it continues to hold significant responsibilities for children, and as a result *Children First* continues to be prioritised and integrated throughout all aspects of HSE service development in supporting best practice in working with children and young people, irrespective of their ethnicity or nationality. It is important to be aware and sensitive to the individual situations and needs of minority ethnic groups. (20)
- There is a need to respond appropriately to child protection and welfare concerns, while also avoiding any practice that could give rise to minimisation of child welfare or protection issues due to cultural context, and victimisation of a particular ethnic/cultural group (e.g. over-reporting or stereotyping). (20, 57)
- Ensure that accessible information is provided for service users regarding policy, procedures, guidance and the law in relevant languages (e.g. in areas such as physical discipline/punishment, FGM, early/child marriage etc.).
- Consider the relevance of including in the second NIHS key child safety promotion and unintentional child injury prevention. (14)
- Address the rights of children in the care of the HSE to naturalization/citizenship. An example is

8 *Children First* provides guidance for organisations working with children to promote children's welfare and protect them from harm or abuse. It outlines what organisations need to do to keep children safe, and what different bodies, and the general public should do if they are concerned about a child's safety or welfare. It emphasises the importance of multi-disciplinary, inter-agency working in the management of concerns. A key message is that child protection is everyone's responsibility. *Children* First was first published in 1999 and revised in 2011. In line with recent legislative change (Children First Act 2015), this guidance has been further revised and is due for publication by the DCYA later this year. 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. These supports will be launched in September 2016.

given of a child who has been in long term foster care since 2009 who is only allowed to remain in the country legally until the age of 19 years. Currently the child has no nationality and there is no knowledge of the country of origin of her mother or father. (48)

- In disability services for younger children, there is a need for further support to engage all new service users and to ensure that they are receiving an equitable service for their children and families. (15)
- It will be important for TUSLA to consider the needs of children in foster care and the possibility of recruiting carers from within these communities. (44)
- Consider the needs of the continually expanding diverse population of Irish Intercountry adoptees and their multi-cultural families and in particular the barriers to accessing health services appropriate to their particular needs. (6)

Services for people with disabilities

Services for people from migrant/minority ethnic backgrounds with disabilities are highlighted in several submissions:

- Ensure that the second NIHS addresses disability issues and the needs of persons and families from ethnic minorities. (43)
- Integrate the National Guidelines for Accessible Health and Social Care Services (2014) into the second NIHS. The Guidelines offer the practical guidance to implement the Disability Act 2005.[9] If steps are taken to routinely provide accessible services for all, it will have a positive influence on the experience of everyone accessing healthcare services. (22)
- A mechanism should exist to help fund the healthcare of a vulnerable person. (25) An example was given of the problems faced by a young adult asylum seeker with a learning disability who did not have the capacity to live independently. Following an admission to hospital, there was no agreement about who would fund his after care in supported accommodation such as a nursing home.

9 The Disability Act 2005 is a positive action measure, which provides a statutory basis for making public services accessible. It gives effect to the underlying principle that mainstream public services provided to the general public must also serve people with disabilities as an integral part of the service they provide. The health service is obliged to ensure that its buildings, its services, the information it provides, and how it communicates with people, are all accessible to people with disabilities.

Older peoples' services

Several submissions referred to the need to take account of the health and other support needs of migrants and minority ethnic groups across all age groups, including the needs of older people.

- One old age psychiatrist highlighted the support needs of minority ethnic elders who experience dementia or psychiatric issues. Because of language and cultural difficulties, assessment and treatment can be complex, as is supporting families to access home care and day centre services. (28)

Other services

Nutrition services

- Appropriate educational materials, information and diet sheets should be provided in a range of languages for new migrants, including children. For example, immigrants may suffer a loss of support from their peers which makes it difficult to maintain cultural/traditional food practices and preparation of traditional dishes. (50)
- Interpreting services should be more readily available to help carry out nutritional assessments and interventions. Where the HSE provides catering services – cultural and religious needs must be addressed proactively through menu planning. (37)
- Provide support to help migrants integrate and adopt good food practices e.g. cooking clubs previously run by Healthy Food for All and Safefood. Active interventions to support these groups to adopt best practice for food preparation, breastfeeding and healthy eating are needed. FSAI for example has drawn up information on healthy eating and infant feeding on its website which could be adapted to different target groups.

Environmental health services

- Educate all staff, including Environmental Health staff, on providing intercultural health services. Of particular relevance to environmental health staff are cultural issues, such as the importance of family, gift acceptance, hospitality acceptance, hand washing taboos, non-importance of female members of family, right of veto by others, etc. (35)

Refusal of medical assistance

- Introduce a policy on refusal of medical assistance on behalf of women and children by

a male relative when someone is sick, or when screening or vaccination are carried out, and if women request it against male relative wishes.

Death and dying and support

- Include in the second NIHS the death and dying and support needs of persons and families from minority ethnic groups, including palliative care needs of persons and families from minority ethnic communities. (43)
- Greater emphasis should be given to providing appropriate help and support for bereavement, loss and grief, and in training those providing the services in a culturally-sensitive way. This is considered to be an area of mental health where migrants and minority groups are underserved. (39)

Other issues to take into account in the provision of services

- Improve access to literacy support and health literacy as they can impact on a person's ability to navigate and access the complex health systems. (26)
- Improve support for family carers from minority ethnic groups who are supporting their own family members. (43)
- Consider how health services respond to the needs of staff and service users from different faith communities. (43)
- Create safe and supported youth spaces for young people. (47)
- Include risk communication with vulnerable groups as part of preparedness (e.g. getting vaccinated to avoid vaccine-preventable diseases) and response (e.g. in an outbreak setting). (26)

Assisted Decision Making

- The Assisted Decision Making (Mental Capacity) Act 2015 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. (22)

HR issues

- Implement a policy on abuse and aggression towards female staff, including sexual harassment of female staff. (35)
- Consider the needs of health service providers including admin and healthcare professionals when working with this special population. (19)
- Ensure coordination with Diversity, Equality and Inclusion in HR and the development of the DEI strategy in areas such as recruitment, selection and retention. (9)

1.4 Specific health conditions

HIV and AIDS

A detailed submission from HIV Ireland (4) sets out recommendations that are informed by the HIV Ireland project on the needs, behaviours and attitudes of minority ethnic groups, which have helped to develop and deliver appropriate support and prevention services. The project involved migrants in the development of information materials,[10] and has provided a free-condom service which has been crucial because most asylum seekers cannot afford condoms.

Recommendations include:

- Improve access to information about the availability of infectious disease testing (e.g. HIV, STI's, TB), including breaking down fears that a person could be deported if tested as HIV positive.
- Address living conditions in Direct Provision so that people can live in privacy to engage in medication taking, and have access to NGO and peer support.
- Develop a 'one stop shop' orientation guide to the Irish health system, with emphasis on free NGO and statutory services.
- Include reference/links to the goals of 'Healthy Ireland 2013-2025' to ensure that people in the asylum system have equal access to health goods, service and supports, for example, by providing free travel to access HIV clinics and free condoms available to asylum seekers in Direct Provision.

Sickle cell anemia

One submission recommended that awareness raising is urgently needed amongst hospital staff that patients of an African heritage are more likely to suffer with sickle cell anemia. There is a lack of knowledge of symptoms or of treatment / requirements for opioid pain relief. Cultural stereotypes can result in a person being seen as

10 'Don't Panic Guide to Sexual Health'; 'Living with HIV in Ireland: a Self-Help Guide'; and 'HIV: Our Responsibilities'.

drug seeking rather than in need of appropriate pain relief and urgent prioritisation. This submission highlighted the excruciating pain suffered by a friend for six hours because of lack of knowledge of healthcare staff of condition. (30)

Another submission referred to an experience where a child in care who required a general anesthetic and as a male African national required a blood test for this potential risk/ medical presentation. This submission suggested that this should be a standard procedure for any child being take into care as the delay in obtaining this check prior to surgery caused an unnecessary delay and discomfort for this service user. (45)

Polio

One submission notes a significant number of Polio survivors under the Neurology service in Beaumont Hospital who have migrated from countries where polio is still endemic, including Nigeria, Afghanistan and India. Polio survivors have lifelong complex rehab and equipment needs including requirements for complex orthoses (splints). The Irish Polio survivor population is aging with very few born after 1962 and so there is a risk of skills required in management of these complex patients being lost. It would be beneficial if the skills of the healthcare professionals involved in these patients could be maintained and developed. (1)

2. EQUALITY, NON-DISCRIMINATION AND HUMAN RIGHTS

The first NIHS noted the importance of equality and human rights, including the need for a gender-sensitive approach, and 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.

Several submissions refer to the importance of the second NIHS being underpinned by the principles of equality, non-discrimination and human rights. The public sector duty (Section 42 of the Irish Human Rights and Equality Commission Act 2014) is seen as an important tool in ensuring that the second NIHS and its implementation take full account of equality and human rights issues, including a gender sensitive approach to service provision. Recommendations include the following:

- All future policy and service developments s*hould be planned and provided in line w*ith the public sector duty.
- The HSE, with the Equality and Human Rights Commission, should draw up guidance for health service providers and staff about how they can implement the public duty in the planning and provision of services.
- Several submissions recommend that the second NIHS continues to give a focus on gender-sensitive approach and for this to address multiple discrimination (intersectionality), for example, in relation to the vulnerabilities and disadvantages faced by migrant women and Traveller women. (53, 57)
- Improve awareness of intersectionality and the impact on migrants, refugees, ethnic minority and vulnerable communities (taking into account issues such as lack of education, low literacy can impact access to social welfare/medical cards, low income or low security employment, knowledge deficits of services available and how to access them, need for interpreter services, religious and/or cultural needs/requirements). (40)
- Gender should be recognised as a key determinant of health and this should be addressed through a gender mainstreaming approach, which is an internationally recognised tool for addressing gender inequalities and the provision of gender-sensitive health policy, planning and service delivery. (53, 57)
- A social inclusion framework is also highlighted as being important by including people affected by addiction, people at risk of and/or experiencing homelessness, Irish Travellers, Roma and other members of diverse ethnic and cultural groups including asylum seekers, refugees and vulnerable migrants, LGBTI service users and those with HIV/AIDs. While these categories are used for practical purposes, the intersecting nature of conditions and circumstances of people from these groups means that issues such as access to services, risk of discrimination and stigma, a range of health needs, poor mental health and a lack of general wellbeing, are common to many excluded groups.

Some submissions refer to the need to implement existing government / HSE commitments to equality and gender mainstreaming:

- Government commitments to incorporate a gender perspective into the planning, delivery, implementation and monitoring of healthcare under the National Women's Strategy 2007-2016 and the HSE's gender mainstreaming framework drawn up in partnership with the National Women's Council of Ireland (NWCI).[11] (51)
- The NWCI notes that the provision of gender sensitive health services under the National Women's Strategy 2007-2016 have not yet been fully met and argues that: "It is critical that this commitment is continued and that all health policies, strategies and services are gender proofed to ensure they meet the needs of a diversity of women in Ireland today. One of the key priorities of the HSE is to eliminate health inequalities and this would be an important step in working towards that stated objective." (51)
- The second NIHS should take account of the implementation of the 2nd National Action Plan on Women, Peace and Security (NAP) 2015-2018, which contains a range of commitments

11 HSE/NWCI (2012) Equal but Different: A framework for Integrating Gender Equality into HSE Policy, Planning and Service Delivery. Available at: https://www.nwci.ie/download/pdf/equal_but_different_final_report.pdf

in fulfilling the UN Security Council Resolution (UNSCR) 1325, adopted in 2000. These issues are included in a submission on behalf of the independent Oversight Group to Ireland's 2nd National Action Plan on Women, Peace and Security (WPS). This includes:

- Commitments to implement WPS for the HSE, which includes adopting a WPS-sensitive approach in dealing with women affected by conflict on the island of Ireland, including migrant women, refugees and asylum seekers, and those affected by the conflict in Northern Ireland.
- The second NIHS can complement the NAP and be mutually reinforcing - coherence between the two documents will contribute to a consistent, whole-of-government approach to the implementation of Women, Peace and Security objectives in Ireland.
- The NAP recognises the intersection of ethnic and cultural diversity, gender and the impact of conflict-related trauma which creates specific health-related challenges for women and girls. (55)
- A number of NAP commitments and actions under Pillars 2 and 3 link directly to the aim of meeting the health and care needs of asylum seekers, refugees and migrants. One particularly relevant commitment under NAP Commitment (3c) is to strengthen outreach to women and girls in Ireland who have been affected by conflict, including migrant women, diaspora communities, those seeking asylum and women who have experienced Female Genital Mutilation, and ensure raised awareness and increase utilisation of the services available. (55)
- The physical and mental healthcare needs of migrant, refugee and asylum seeking women affected by conflict who have left the Direct Provision system and are integrating into communities should also be given appropriate support. (55)

3. INTERPRETING AND TRANSLATION SERVICES

A large number of submissions refer to the importance of improving access to good quality interpreting, translation and training/information about cross-cultural communications.

3.1 Interpreting services

Evidence from research and from the Partnership for Health Equality project is that many migrants continue to rely on interpreting from family members or friends, or using google translate or other language apps. Many GPs lack knowledge about community resources for interpreting in primary care and the services that are available for high quality interpreting. This creates major challenges where patients have complex health histories and problems.

A submission from a group of PHNs noted a study of PHNs in Limerick where many staff highlighted a lack of preparedness for working through interpreters. In the study, some expressed a concern about the quality of care resulting from not using an interpreting service. (33) Issues raised about working with interpreters include concerns about informed consent if there is no interpreter or family member; managing communications where there are a variety of dialects; isolation faced by older people; and isolation and risks of depression, including post-natal depression of service users, who experience communication barriers. (33)

Recommendations for the second NIHS in relation to interpreting services include:

- Several submissions highlight the importance of providing good access to interpreting services, including training on how to work through an interpreter, which is viewed as a prerequisite for providing good quality health services. (15, 17, 28, 31, 33, 36, 38, 42)
- Health providers should work in partnership with relevant agencies in developing a strategy and action plan to ensure access to a professional language and interpretation services. (2)
- It is important to address language barriers as they can compromise patient care and cause difficultly for therapist and patient, especially when discussing complex issues, such as chronic pain. (15, 36)
- It is vital that there is a provision of an interpreter available to attend initial meetings. Communication through texts for appointments, dates and times are useful ways to communicate. (15)
- Ensure that there are clear guidelines for interpreting in the context of cases of child protection/welfare concerns. (20)
- Interpreting is crucial for the settlement and integration of refugees and migrants in Ireland and needs to be provided in culturally appropriate ways, and on the basis of professional standards and training. (13)
- Good quality interpreting services and the availability of female interpreters when required, is important for migrant women who have been victims of gender-based violence in their home countries. (55)
- Ensure that people living in Direct Provision centres have access to interpreters and information about health services in their first language. (38)
- Assessments of need should include language needs and access to interpretation/translation services. (26)
- Interpreting services should be available in primary care (52) and be readily available to carry out nutritional assessments and interventions. (37)
- Ensure access to and use of translation and interpretation services, and to take into account literacy supports across all health services and in particular in primary care. (40)

3.2 Training for interpreters and healthcare staff

Several submissions make recommendations for training for interpreters and healthcare staff:

- Provide training for healthcare staff on working with interpreters. (29, 33, 42)
- Carry out training of interpreters who work with asylum seekers and refugees. SPIRASI notes that currently interpreters employed in Ireland are interviewed but are not tested to assess

their linguistic and interpreting skills. Their qualifications are not verified by either the private company employing them nor by ORAC (Office of the Refugee Applications Commissioner) or other service users. Other state agencies such as The Refugee Appeals Tribunal have noted "The quality of interpretation is a constant source of complaint from applicants and Tribunal members." (42)

- Implement the recommendations of the McMahon report on formal procedures, training and registration of interpreters; coordinated system of reforms where all interpreters working in the protection process receive appropriate training and are listed in a register and have appropriately accredited qualifications. (42)

3.3 Translation of written materials

Several submissions refer to the importance of having access to resources and facilities to translate written information.

- A minimum requirement is that all literature / information should be published in the main languages spoken. (15, 17, 34, 38)
- It would also be useful to have availability to flyers/posters in different languages to explain how the health system works and services that are available. (15)
- It would also be helpful to have a central facility within the HSE to arrange for translation of leaflets/letters. (34)

4 CULTURAL COMPETENCY/ CROSS-CULTURAL COMMUNICATIONS

Several submissions note the importance of ensuring that staff have the capacity to provide culturally competent services. Appropriate intercultural training and support for staff was a fundamental principle of the first NIHS, and several submissions refer to the importance of staff training in contributing to improved access to services and better quality service delivery, which are viewed as being prerequisites for cultural change in the HSE. (4, 29, 33, 42, 44, 54) However, several submissions referred to the problems for healthcare staff in having time for training. (8, 10, 33) One submission suggested that staff feel under-prepared in dealing with differing cultures – often finding that the advice offered regarding healthcare conflicts with differing cultural practices. (33)

The Partnership for Health Equality project identified different expectations held by patients about the way in which healthcare is delivered, for example, in a hospital environment rather than in the community, or how the health system works. This raises implications of how communications can take account of different cultural expectations. (52)

Recommendations relating to training for healthcare staff include the following:

- Ensure that staff have access to training in cross-cultural communication and in working with interpreters, (8, 10, 33) and ensuring that needs of healthcare professionals and admin staff who work with a diverse population are taken into account. (19)
- Intercultural health training should be mainstreamed in order to enhance the provision of culturally competent health services and quality effective service delivery. (12)
- Draw up a clear plan on how training will be sourced, developed and delivered. Currently it is very difficult to source appropriate training for staff in this area. (8)
- Ensure that intercultural healthcare is integrated into the training for social care/social work programmes at third level and for registered social care/social work professionals in Ireland, preferably provided at least in part by members of the identified communities. (40)
- Training should focus on the provision of services with equality of outcome as a goal, as opposed to equality of opportunity. (40)
- Training should also reflect the need to engage with communities and make use of their capacity to improve and maintain competences amongst service providers. (4, 42, 44)
- It is important to take account of and raise awareness amongst staff and service users about expectations, which differ from the home country/society. (13)
- Implement the recommendations from the RESTORE project on cross-cultural communications (see box below)

Recommendations made of the RESTORE project on cross-cultural communication (submission from Professor Anne McFarlane) (52)

- National health systems need to ensure that patients can communicate adequately to ensure that patient safety is maintained at all times, to ensure informed consent and effective doctor-patient communication.
- Situating support and enabling cross-cultural communication and the right to an interpreter may be better placed within patient safety legislation in each country.
- National health systems need to engage with all providers of care – including social insurance and private insurance organisations – to address who funds what, for whom and when.
- A strong primary care system should be able to provide a setting which facilitates the use of professional interpreters due to its structural advantages. However, additional requirements such as resourcing and the removal of financial barriers to patient access must also be addressed.
- Support for cross-cultural communication should not rely on increasing the diversity of health systems' workforce in order to provide interpreting support.

Model good practices

- Model good practices, for example, of the prison culture of Dochas which has aimed to improve the respiratory well-being of prisoners and staff, and has involved training one of their own staff as a Respiratory Nurse and work to detect undiagnosed respiratory problems or medication problems. This collaboration between respiratory professionals and a national patient support group COPD_SI in previous years facilitated similar testing on a Traveller halting site. (32)

Guidelines and awareness raising for staff

- Produce an information guide for staff working in primary care teams. As one submission noted: "Working in a busy primary care, where a third of our service users are immigrants, it will be great to have some information to guide practice." (19)
- Develop guidelines for best practice in communication in cross-cultural research and support implementation of guidelines for improved communication in cross-cultural consultations. (52)

5. GENDER-BASED VIOLENCE

The first NIHS 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, including the submission from the NWCI, note the importance of continuing this focus in the second NIHS. This includes the need to highlight the specific vulnerabilities faced by women from migrant backgrounds and specifically in relation to domestic violence, FGM and other harmful practices, and to ensure that this includes migrant, refugee and asylum seeking women affected by conflict.

Recommendations relating to gender-based violence are as follows:

- The second NIHS needs to be aligned with the provisions in the second COSC National Strategy on Domestic, Sexual and Gender-Based Violence (2016-2021). This should be in line with the Council of Europe Convention on preventing and combating violence against women and domestic violence (Istanbul Convention), which provides an important framework for an integrated approach to tackling violence against women. The government has signed the Convention and will soon ratify it. (51)
- Draw up additional measures to ensure that migrant women who experience or who are at risk of domestic violence and abuse, sexual violence or sexual harassment, have access to all the support services that they need. (43, 51)
- Account needs to be taken of the addition risks, linked to poverty and social exclusion, faced by women and from minority ethnic and migrant groups who are particularly vulnerable to gender-based violence, including domestic violence and abuse, sexual abuse and trafficking of unaccompanied minors, and risks of trafficking for sexual exploitation. (55)
- Of particular concern in this area are reports that up to 23% of migrant women have experienced domestic or sexual and/or gender-based violence in Direct Provision centres. The development of policies in conjunction with the Reception and Integration Agency to address this situation should be considered. (55)
- The Garda Racial Intercultural and Diversity Office and Domestic Violence and sexual assault Investigation Unit must have the capacity to implement best policing practices which reflect the particular issues affecting women who have migrated to Ireland from conflict areas. (55)
- Work towards ratification and implementation of the Istanbul Convention on Preventing and Combatting Violence against Women, and to develop a robust National Strategy on Sexual and Gender Based Violence which reflects the principles of the Women, Peace and Security Agenda. (55)

FGM and other harmful practices

The practice of FGM is widely regarded as a serious infringement of the human rights of women and girls. The WHO defines female genital mutilation (FGM) as any procedures involving the partial or total removal of a woman's external genital organs, or any other injury to a woman's organs, for non-medical reasons. Approximately 3,780 women and girls between the ages of 15 and 44 in Ireland have experienced FGM, [12] and between 1% and 11% of girls in Ireland from FGM practicing countries may still be at risk of having the procedure done to them.[13] In Ireland, FGM was made illegal under the Criminal Justice (Female Genital Mutilation) Act 2012.

AKIDWA has drawn up a framework for the coordination of services on FGM, including healthcare provision. The framework, 'Towards a National Action Plan to Combat Female Genital Mutilation 2016-2019', has the objective to press the government to introduced a National Action Plan and inter-agency group on the issue, in line with international best practice. FGM is outlined in 'Children First: National Guidance for the Protection and Welfare of Children' as an issue of child protection.[14]

A specialised clinic was established and opened in May 2014 at the Irish Family Planning Association (IFPA) Everywoman Centre, with financial support from the HSE social inclusion office and provides free comprehensive physical and psychological care to women in Ireland who have undergone FGM.

12 Akidwa/RCSI (2013) FGM: Information for Health Care Professionals Working in Ireland. 2nd Edition.

13 EIGE (2015) Estimation of girls at risk of female genital mutilation in the European Union. Available at: http://eige.europa.eu/rdc/eige-publications/estimation-girls-risk-female-genital-mutilation-european-union-report

14 Department of Children and Youth Affairs (2011) Children First: National Guidance for the Protection and Welfare of Children. Available at: http://www.dcya.gov.ie/documents/Publications/ChildrenFirst.pdf.

The following recommendations are made in relation to FGM:

- Several submissions argue that better measures are needed for protection and prevention of FGM, including a comprehensive plan to safeguard women and girls from this violation. (31, 40, 42, 53, 57)
- Allocate resources for the establishment of an inter-departmental committee on FGM, with representatives from government agencies and NGOs. This would be tasked with the role of drawing up a National Action Plan to Combat FGM. (51)
- Ensure that funding is maintained for the Irish Family Planning Association specialist treatment service for women with FGM. (51)
- Allocate sufficient resources for the training of healthcare providers and other frontline professionals, to provide appropriate care and protection to FGM survivors and women and girls at risk of FGM. (51)
- It is important to address FGM as a negative cultural practice. (29)

Trafficking for sexual exploitation

The Department of Justice and Equality (anti-Human Trafficking Unit), 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.

- More needs to be done to protect women and girls from trafficking for sexual exploitation in humanitarian crises, including those crises as a result of conflict. (55)

6. COMMUNITY PARTICIPATION, AND SERVICE USER PARTICIPATION AND CONSULTATION

Many submissions refer to the importance of service user participation and community participation in underpinning the strategy and its implementation:

- Community participation in health was noted as an underpinning principle in the first NIHS and should be further reinforced and developed in the second NIHS. (4, 28, 57)
- Implement community and service user engagement and empowerment and development of peer worker schemes and peer educators, (28, 29) and carry out community and service user engagement with vulnerable migrants and asylum seekers. (31)
- Empowerment, participation and representation of women in decision making, and in relation to personal healthcare choices, should be a crucial element of community participation in health needs (as provided for under the 2nd National Action Plan on Women, Peace and Security, Pillar 2). (55)
- Consultations should be carried out with conflict-affected women as part of the consultation process in the second NIHS, to facilitate their input and make their voices heard in the design and implementation of services which meet their needs. (55)
- Introduce community consultative mechanisms that involve minority ethnic communities in the planning of services, in giving feedback on the quality of services, and in actively involving communities in the process of change in service ethos and service provision. (2)
- HSE structures and processes and those of its funded bodies should engage and consult with minority ethnic communities. (43)
- There is a need to highlight the value of using a community development approach to working with diverse ethnic and cultural groups in tackling health inequalities and also consideration of implications for HSE. (12)

Capacity building of vulnerable migrants

- Carry out capacity building of vulnerable migrant population to engage with, access and inform health services. (12)
- Ensure that when people secure Refugee Status that they are given support in their transition out of the asylum system with budgeting, CV preparation, interview skills and employment seeking skills etc. (47)

Partnership working

- There is a need to highlight the value and benefit of planning and delivering health services and supports for culturally and ethnically diverse communities within a partnership model of all stakeholders - including HSE and other statutory service providers, service users and community and voluntary agencies. (14, 17)
- The strategy should make clear reference to the social determinants of health and ensure that there is an inter-sectoral approach and linked to all the divisions within the health service. (12)

7. DATA ON ACCESS TO HEALTHCARE FOR MIGRANTS / MINORITY ETHNIC GROUPS

7.1 Improved data collection

Several submissions refer to the need for better data collection on minority ethnic access to healthcare. (40, 52, 53).

- It is important to capture data on minority ethnic use of healthcare, there may be differences between migrants' and black and minority ethnic service users use of health. There is thus a need to collect data by migrant status as well as ethnicity. (52)
- Take into account the findings from the WHO Evidence Network Systematic Review about different definitions of migration, the collection of data and an agreed set of variables, monitoring of data, migrant-sensitive health systems and involvement of migrants in the development of migrant-sensitive health services.[15] (52)
- Include in the second NIHS the collection of data and analysis of minority ethnic communities' use of maternity and other services so that policy and service delivery can be more responsive to their needs. (42, 53)

7.2 Ethnic identifier

The issue of introducing an ethnic identifier was raised particularly in relation to Travellers, and is particularly relevant in the context of Travellers being recognized in 2016 for the first time as an ethnic minority group in Ireland.

- Several submissions refer to the importance of an ethnic identifier and note that the previous strategy mentioned a roll out of an ethnic identifier. (5, 14, 15, 53)
- An ethnic identifier is important for planning and provision of good quality healthcare services. (3)
- One submission stated that it would be interesting to review the success or not of the roll out of an ethnic identifier and what effect it had. (13)
- A new National Traveller Health Implementation Plan should be developed to address the findings of the All Ireland Traveller Health Study, to develop and fund a primary healthcare project with the Roma community and to develop and fund an ethnic identifier on access, uptake and referral rates of services, throughout the HSE. (51)
- The introduction of an ethnic identifier should include training for staff. (12)

7.3 Building the evidence base

Several submissions highlighted the importance of evidence-based research, including longitudinal research to improve evidence, knowledge and learning about intercultural health:

- Continue to build the evidence base effective responses to the specific needs of minority ethnic persons and their families, and those of health service staff. (43)
- Include ethnic equality monitoring in the HSE as part of measures to monitor health inequalities. (26)
- Carry out research, including longitudinal research, on the health needs of vulnerable migrants from a social determinants of health perspective.

15 Hannigan A, O'Donnell P, O'Keeffe M, MacFarlane A. How do variations in definitions of "migrant" and their application influence the access of migrants to health care services? Copenhagen: WHO Regional Office for Europe; 2016 (Health Evidence Network (HEN) synthesis report 46).

8. IMPLEMENTATION OF THE SECOND NIHS

Some submissions give suggestions about how the strategy can be implemented, including the need for clear and defined goals, targets, indicators, timeframes, funding mechanisms, and a monitoring, accountability and evaluation framework. (12, 14, 29, 33, 56 57)

8.1 Funding and resources to meet current and projected health needs

- Community medical/nursing services, primary care, mental health and acute services should be adequately resourced as a priority to meet current and projected requirements. (27)
- In relation to the provision of human and financial resources, it is recommended that the HSE ring-fence funding for the provision of quality and appropriate services for migrant women. It is recognised that the HSE Social Inclusion Unit, which deals with the health issues of migrant communities, covers a broad and complex remit, and as such needs to be better resourced and should have a dedicated person or persons within the Unit to deal specifically with the critical issues facing migrant women in a range of settings. (55)

8.2 Monitoring and dissemination of the second NIHS

- Put in place measures to monitor and evaluate the strategy and its implementation. (29, 33)
- Include the role of NCHDs as healthcare workers delivering care to members of diverse cultural and ethnic groups and can play a role in disseminating the strategy. (10)
- Create a version of the second NIHS document that people will pick up and read and be able to identify what individual staff and services can do to deliver on the intended outcomes. (54)

LIST OF WRITTEN SUBMISSIONS RECEIVED

1	Deirdre	Murray	Clinical Specialist Physiotherapist in Neurosciences	Beaumount Hospital
2	Tonya	Myles	General Manager	Cairde
3	Louise	Harrington		Cork Traveller Women's Network
4	Erin	Nugent	Community Support Manager	HIV Ireland
5	Chantal	Migone	SpR in Public Health Medicine	HPSC
6	Fiona	MacNamara		HSE
7	Philip	Crowley	National Director, Quality Improvement Division HSE	HSE
8	Ellen	O'Dea	Primary & Community Care Operations Manager	HSE
9	Siobhan	Patten	National HR Lead: Diversity, Equality and Inclusion	HSE
10	Catherine	Diskin	National Lead NCHD/NDTP Fellows	HSE
11	Grace	Turner	Programme Manager, Integrated Programme for Children	HSE
12	Derval	Howley	Regional Drug Co-ordinator	HSE - CHO5
13	Justin	Parkes	Primary Care Manager	HSE - CHO7
14	Brenda	Shannon	HSE Child Safety Awareness Programme Project Leader	HSE - Dept of Public Health
15	Katharine	Twomey	Social Worker (0-18 years)	HSE - Disability Services
16	Cynthia	Silva	Senior Psychologist	HSE - Early intervention, Disability
17	Gerry	Burke		HSE - Finance - External Service Providers
18	Liam	Hennessy	Head of Service User, Family Member and Carer engagement	HSE - National Mental Health Division
19	Maria	Kehoe	Chartered Physiotherapist	HSE - Primary Care
20	Barry	Higgins	Childrens First National Office	HSE - Primary Care
21	Carolanne	Buckley	Senior Counselling Psychologist	HSE - Psychology Service for Refugees and Asylum Seekers
22	Jacqueline	Grogan	ADM Project Manager	HSE - Quality Improvement Division
23	Fionnuala	Killoury	Assistant Director of Nursing	HSE - Rehabilitation & Recovery Service
24	Abiola	de Mojeed	Psychiatry of Later Life	HSE - Roscommon
25	Declan	Mulvey	Manager of Services for Social Inclusion CHO9	HSE - Social Inclusion
26	Aileen	Kitching	Consultant in Public Health Medicine	HSE - South
27	Sinead	Donohue	Specialist in Public Health Medicine	HSE - South
28	Mia	McLaughlin	Old Age Psychiatry	HSE - St. Luke's Hospital
29	Paul	Stewart	Community Health Doctor	HSE - St. Mary's

30	Naomi	Martin	Pharmacist	HSE - UCH Pharmacy
31	Caroline	Mason Mohan	Specialist in Public Health Medicine	HSE - West
32	Maire	O'Connor	Consultant in Public Health Medicine	HSE -East
33	Mary	Shanahan	DPHN	HSE- Limerick
34	Aoife	Byrne	Principal Speech and Language Therapist	HSE South Dublin
35	Anne	Deacon	SEHO- Environmental Health Services	HSE-Environmental Health
36	Anita	Harte	Physiotherapist	HSE-Physiotherapy
37	Grainne	O'Connell	Senior Community Dietitian	HSE-Primary Care
38	Maria	Hennessy	Legal Officer	Irish Refugee Council Independent Law Centre
39	Jennifer	Stritch	Dir- Loss and Grief Research Group	Limerick Institute of Technology - Dept of Applied Social Sciences
40	Jennifer	DeWan	Campaign and Communications Manager	Nasc Ireland
41	Irene	Beirne	Clinical Midwifery Manager	Regional Maternity Hospital Limerick
42	Robert	King	Spirasi Fundraising & Development Officer	Spirasi
43	Robert	Gilligan	Professor School of Social Work and Social Policy	TCD
44	Alice	Moore	Fostering Social Work Senior Practitioner	Tusla
45	Hilda	Arfield		Tusla
46	Muireann	Ní Raghallaigh	Lecturer in Social Work	UCD - School of Social Policy, Social Work and Social Justice
47	Catherine	Leahy	Co-ordinator Heart and Soul	YMCA - Cork
48	Cathal	Flynn	Foster Parent	
49	Alison	Spillane	Project Officer	Irish Family Planning Association
50	Mary	Flynn	Chief Specialist Public Health Nutrition	Food Safety Authority of Ireland
51	Jacqueline	Healy	Women's Health & Human Rights Co-ordinator	National Women's Council of Ireland
52	Anne	MacFarlane	Professor of Primary Healthcare Research	Graduate Entry Medical School, University of Limerick
53	Stephanie	O'Keeffe	National Director, Health and Wellbeing	HSE
54	Audrey	McEntagart	Quality Improvement Division	HSE
55	Olivia	Lucas	Secretariat	Oversight Group to Ireland's 2nd National Action Plan on Women, Peace and Security.
56	Anna	Quigley	Citywide	Citywide Drugs Crisis Campaign