National Intercultural Health Strategy
2007 – 2012

[Foreword]

I am very pleased to introduce the HSE's first National Intercultural Health Strategy which has been developed on foot of the National Action Plan against Racism launched by An Taoiseach in 2005.

Our population is expanding and becoming a lot more diverse. We have in fact the fastest growing population in the European Union; it increased by 2.5% each year during the last 3 years. There are now 4.4 million people living and working in Ireland and 10% are non Irish Nationals.

Mirroring these trends, the backgrounds of our staff and the people to whom we provide services are also changing. For example, 33% of those working in the medical/dental field are from overseas as are 14% of nurses & midwives. In one of our Children's Hospitals 13 different nationalities are represented by staff and one in six of the children attending the Out Patient Department are from ethnic minority communities.

It is vital that we take full account of these developments when planning and delivering services and recruiting, supporting and retaining staff. We must also ensure our services are provided equally to all and respond appropriately to the specific health and social care needs of new and well established minority communities. This National Intercultural Health Strategy has an important role to play in ensuring we do this in an inclusive, respectful and fair way.

The collaborative and consultative way it has been developed is very much in keeping with our principle of involving service users, staff and service providers in the design and planning of services. It is a well researched and informed plan that sets out where we are now and what we need to do to ensure we provide a quality health service to all and are an employer of choice for many.

I wish to take this opportunity to acknowledge the tremendous work that has gone into preparing this strategy and the tremendous support we received from a wide range of individuals and bodies including service users, Non Government Organisations, the Community and Voluntary sector, key Statutory Agencies and of course my own colleagues working in the HSE. The Equality Unit of the Department of Justice, Equality and Law Reform has also been of immense assistance to us in the development of this plan.

The HSE is firmly committed to this strategy and we look forward to working with all of you in its implementation over the coming years.
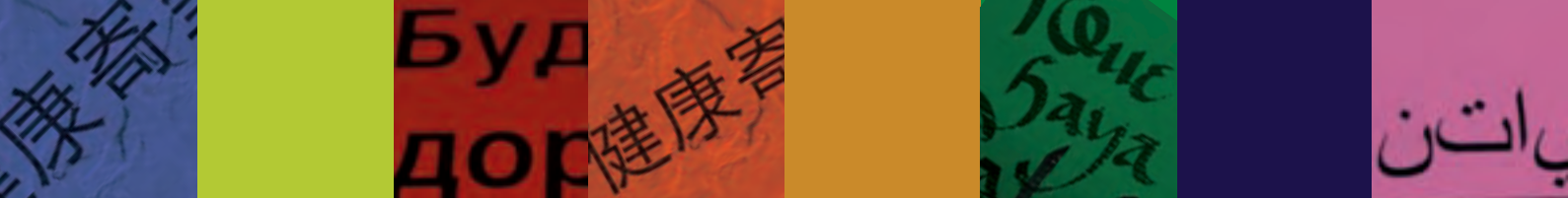
Professor Brendan Drumm,
Chief Executive Officer

IRELAND EMBRACING
CULTURAL DIVERSITY

European Year of 2008
Intercultural Dialogue

[Contents]

Note on Terminology
A number of terms, including consumer, client, service user etc are used when describing people who use health services. During the consultations that informed development of this strategy, it appeared that participants most preferred the term "service user". Literature around the themes of intercultural health also tended to use the term "service user". It is this term, then, that is used consistently throughout this document.

1. Executive Summary

The Health Service Executive (HSE) is undergoing a Transformation Programme, aimed at enabling people to live healthier, more fulfilled lives. Central to this programme is a vision where "everybody will have easy access to high quality care and services that they have confidence in and staff are proud to provide". A number of Transformation Priorities direct attainment of this vision, with focus on development, enhancement or reconfiguration of existing services, together with an emphasis on the improvement of infrastructure around supporting implementation of services.

Among the core objectives of the HSE Transformation Programme, which is currently under way, are two which are particularly relevant in the context of socially excluded groups. These are stated as follows:

• We will improve people's experience of our services and their outcomes through developing, changing and integrating our services, in line with best practice

• We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion

The population health approach, endorsed by the HSE, recognises the range of factors affecting health, and seeks to promote and protect health and well-being, with special attention to measures aimed at reducing health inequalities. The links between poverty, ethnicity and health are well established. Much intersectoral collaboration is required within this approach to work towards attainment of improved health and social gain for people from diverse ethnic and cultural backgrounds.

Further details about the HSE, its approach to addressing health inequalities, and its promotion of a socially inclusive approach to address the health and care needs of disadvantaged groups, including people from diverse cultures and ethnic backgrounds, is outlined in Chapter 4 of this document.

The transformation of the HSE is taking place against a backdrop of changing demographics in Ireland, as increasing numbers of people arrive in the country and make their lives here. Census 2006 indicates that 420,000 foreign nationals are living in Ireland, with continental Europeans, along with Africans and Asians, constituting the fastest growing group. The changing and dynamic nature of Irish society is from one of mass emigration to a net inward migration – in 2030,18% of the population is expected to be foreign born, compared to the current figure of 10.4%. This migration is additional to the diverse minority ethnic and cultural groups already in Ireland, of whom Irish Travellers are the longest established group.

A minority ethnic group may be one of a wide range of groups who live in Ireland and who define themselves by virtue of their race, ethnic or national origin. People from diverse ethnic and cultural minorities in the Irish context may be asylum seekers, refugees, migrant workers, Irish Travellers, Roma, foreign students and members of new and established minority ethnic communities. Each cultural and ethnic group shares a collective identity based on a sense of common history and ancestry. Ethnic groups possess their own cultural identity, language, customs and practices, while each individual within the group will possess his or her own unique life experiences and health, social, emotional, vocational and psychological needs. Religious diversity adds an important dimension to many people's ethnic and cultural identities.
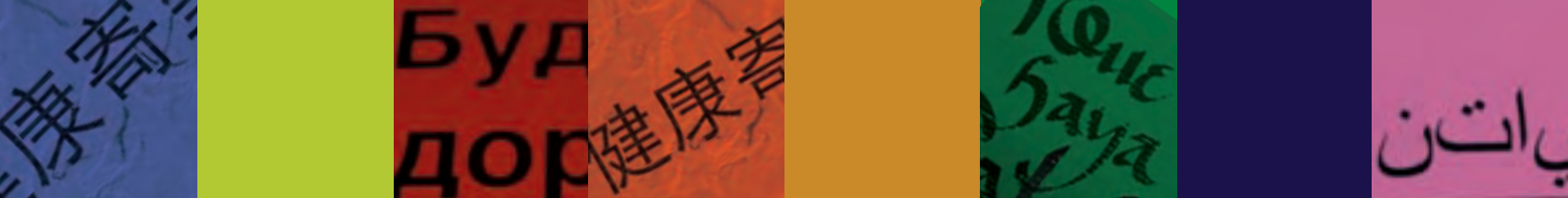
It is acknowledged that people from minority ethnic groups are at increased risk of poverty and social exclusion. Irish Travellers, asylum seekers and refugees are especially vulnerable here, while the situation of migrant workers, many of whom may be living almost invisibly within communities, gives rise to increasing concerns. Within the broad, heterogeneous group of minority ethnic communities, women may be regarded as particularly at risk of social exclusion, while unaccompanied minors / separated children may also be viewed as a very vulnerable cohort. Members of all these groups, as well as of those people living in new and established minority ethnic communities in Ireland, may also experience racism and discrimination. This in turn leads to further social isolation and exclusion. These circumstances, coupled with language and cultural barriers, may further compromise health and well-being.

The profile of different minority ethnic groups, with particular reference to their distinctive situations and the impact they may have on health status and outcomes, is described in Chapter 5.

The broadening of diversity resulting from the rich mix of cultures and ethnicities within the Irish landscape has significantly enriched the fabric of social, economic and cultural life in Ireland. At the same time, this emerging diversity presents challenges for Irish society, both in adapting to the impact of new cultures and in developing collective ways of promoting the integration of people from diverse cultures and ethnic groups into mainstream society. Within this context, the Irish health system has a valuable role to play in implementing an intercultural approach towards planning and delivery of care and support services in an equal, accessible and effective way, acknowledging and valuing the diversity of all service users.

Recognition of the distinct health and care needs of service users from diverse cultures and ethnic backgrounds, coupled with the transformation agenda of the HSE, marks a timely opportunity for the development of a National Intercultural Health Strategy, which – building on the existing good practice already taking place in the arena of health provision for a diverse population – aims to provide a comprehensive framework within which these care and support needs may be effectively addressed. Services around the needs of people from diverse groups have developed incrementally over recent years, with significant expertise built up in response to the needs of the public, as well as to various statutory requirements. A challenge now exists to integrate services and render them accessible and responsive, with the service user always at the centre of newly created ways of working. The principles, themes and recommendations embodied in the model envisioned within the Intercultural Strategy support staff and service users in participating actively and meaningfully in designing, delivering and evaluating provision of health care to minority ethnic service users in Ireland.

The importance of the development of a National Intercultural Health Strategy is reinforced by Governmental documents such as the National Action Plan against Racism and the National Action Plan for Social Inclusion 2007 – 2016, both of which charge different sectors, including the health sector, with specific actions and measures designed to enhance aspects of inclusion of people from diverse backgrounds into all facets of Irish society. A range of health strategies, overarched by the National Health Strategy: Quality and Fairness, and including the Primary Care Strategy, Traveller Health Strategy, and Vision for Change, further confirm the necessity of development of mechanisms securing enhanced health access and delivery for this group. Development of the strategy is underpinned by Equality legislation, with the Equal Status Acts and Employment Equality Acts being particularly relevant. The HSE booklet *Equal Status Acts 2000 – 2004 and Provision of Health Services,* produced in collaboration with the Equality Authority, gives a resonance to HSE obligations in this area.

Aspects of social and health policy, together with legislation governing approaches to provision of effective service delivery to diverse communities are covered in Chapter 7.

Legislation and policy documents directing the need for the development of an Intercultural Health Strategy are rendered meaningful when complemented by a set of values and principles that are core to the development of an approach responsive to the multiple health needs of service users from diverse cultures and ethnicities. The principles of equity, accessibility, quality and accountability contained in the National Health Strategy are fundamental to overall service delivery. However, a number of additional values and principles are intrinsic to the development of an Intercultural Health Strategy, where service users may share specific vulnerabilities and associated care and support needs that require special knowledge, insight and responsiveness on the part of those planning and delivering health services. Key principles and considerations informing development of this strategy are described in Chapter 8, and include:

• Intersectoral Collaboration: The wide-ranging nature of socioeconomic determinants and their impact on health status demands a cross-cutting approach to ensure collaboration of different relevant agencies in addressing the risks and causal factors associated with poverty and inequality. The HSE is committed to fostering and developing joined-up, coordinated approaches within and beyond sectors at national, regional and local level to achieve integrated, sustainable solutions in this regard

• Equality and Targeting: The objective of achieving full equality for all service users in accessing and using services lies at the heart of this strategy. Central to this core value is identification and elimination of inequalities that form barriers to achieving such equality. A whole system approach around ensuring equality of access, participation and outcomes for a culturally and ethnically diverse population requires consideration of elements of both mainstreaming and targeted approaches
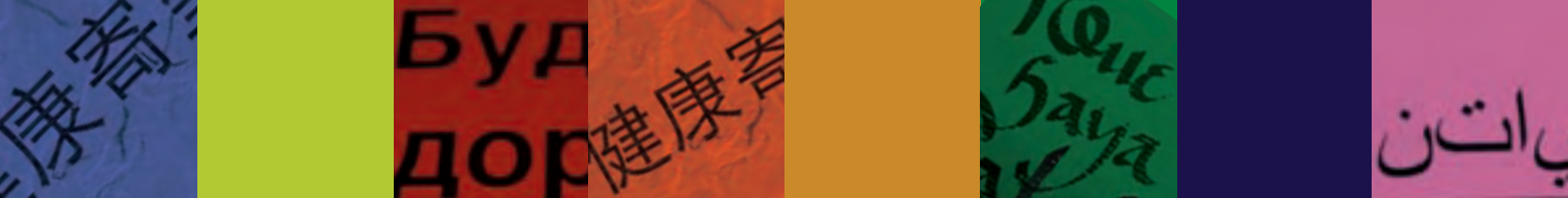
- Interculturalism and Anti-racism: Experience of racism and discrimination has a negative impact on the physical and mental health of people from minority ethnic communities. The intercultural approach proposed within the National Action Plan Against Racism, which includes the development of strategy, policy and practice towards the promotion of interaction, understanding, respect and integration between different cultures and ethnic groups, is consistent with HSE policies concerning the provision of equal, accessible, quality services and should form a core element of planning and delivery of services to people from diverse cultural and ethnic backgrounds

- Community Participation Around Health Needs: The socially inclusive approach of the HSE to promoting empowerment of all service users and communities in participating in decision making around their own health needs endorses active support for a community development approach

- Partnership Working: Planning and delivery of health services for a culturally and ethnically diverse population should be effected within a model of partnership in which all stakeholders, including service users, relevant community and voluntary agencies, representatives of other statutory sectors and representatives from pillars of the HSE itself, collaborate around identifying priorities, agreeing actions and monitoring implementation of the strategy

- Learning and Support for Staff: 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. Appropriate intercultural training and support for staff is a fundamental principle of the strategy, while consideration is also accorded within the strategy to the development of mechanisms that promote recruitment, promotion, development and the retention of staff from diverse backgrounds.

Formal development of the strategy commenced with a series of consultations with service users, service providers and HSE staff throughout the country. Many of these events, taking the form of roadshows, focus groups, small group discussions and surveys, were hosted or coordinated by voluntary agencies, in collaboration with the HSE. Indeed, a feature of the consultations was the support offered by a range of bodies and individuals, including Combat Poverty Agency, National Consultative Committee on Racism and Interculturalism, Cáirde, Spirasi, Pavee Point and the Immigrant Council of Ireland. This cooperation ensured that a wide spectrum of service users was facilitated to participate in consultations.

A series of questions – shaped by information gained via a pre-consultation phase in which questionnaires were completed by a range of stakeholders – formed the basis of discussion at all consultation events.

- *What are the main barriers and problems experienced by people from minority ethnic communities in accessing health services?*

- *How can design and delivery of health services be improved so as to enhance the health and well-being of people from minority ethnic groups?*

- *What do you think are the three most important things that the health services should consider / address in the planning and delivery of services to people from minority ethnic groups?*

- *What support can be given to minority ethnic groups and organisations to enhance access to health services of people from diverse cultures and minority ethnic groups?*

Input from service users and providers, together with HSE staff, offered a wealth of information around issues and experiences in relation to accessing, using and providing health services, together with suggestions to improve, enhance or adapt these, so promoting appropriate, culturally competent responses to the care and support needs of diverse service users.

A separate, detailed report has been compiled around the nature, process and outcomes of the consultations. This report also contains examples of good practice effected throughout the country around addressing the health and care needs of members of minority ethnic groups and cultures.

Key messages emerged from the consultations and are summarised in Chapter 6. The main priorities were identified around aspects of the following:

- *Information, Language and Communication: Provision of accessible information to service users, together with availability of interpretation and translation services, were highlighted as key priorities requiring urgent attention*

- *Service delivery and Access to Services: Issues around enhancing aspects of access, as well as the need for delivering services in an integrated way, dominated discussions here. Aspects of equality and discrimination were recurring themes throughout discussions*

- *Changing the Organisation: A range of priorities were identified, with issues concerning the development of a whole organisational approach, need for training and support of staff regarding culturally competent service delivery, and collection and application of relevant ethnic monitoring data reflecting key themes*

- *Working in Partnership with Minority Ethnic Communities: The provision of support to minority ethnic communities to develop capacity to identify and address their own care needs was regarded as a key element of the strategy*

Views expressed during the consultations, together with submission of questionnaires and written compilations from individuals and agencies, played a vital role in informing development of this strategy. A Literature Review around models of practice in the area of intercultural health served to further support and inform the shaping of the strategy.

Issues and associated recommendations form the crux of the strategy and are explored in Chapter 9. A summary of recommendations also follows this Executive Summary. Major issues are grouped thematically around wide-ranging areas of **1. Access to Services; 2. Data, Information and Research; and 3. Human Resource aspects.**

Access to Services and Associated Aspects of Service Delivery

The ability to access services is acknowledged to be a prerequisite to attaining positive health outcomes. The concept of access in a health context is particularly broad, with many factors affecting the ability of service users to access required services optimally and appropriately. Within the context of the National Intercultural Health Strategy, aspects of information provision, understanding the usual ways of negotiating the health system, accessing a range of services – most especially GP services – and experiences of racism and discrimination presented major barriers to accessing health services. Using health services appropriately also offered challenges to service users, with inappropriate usage often linked to barriers around accessing services at optimal levels of care. While many of these barriers may not be unique to people from diverse ethnic and cultural backgrounds, a number of additional access issues are specific to people from minority ethnic communities. Consideration here should be accorded to situations where cultural and religious beliefs play a critical role in accessing and receiving culturally appropriate, responsive care and support. Aspects of personal care and hygiene, spiritual beliefs and practices around life events, and dietary needs are of particular relevance in this regard. Inpatient facilities have a valuable role to play in responding to these needs and practices.

Mechanisms promoting access to health services, such as accelerated rollout of the Primary Care Strategy, and provision of active support around community participation and development, are regarded as critical to the attainment of enhanced health outcomes. Associated efforts around the provision of accessible, culturally appropriate information and development of a standardised, high quality interpretation service are examples of targeted actions aimed at supporting equal access to health services.

Data, Information and Research

Little information exists around the health status and needs of people from diverse cultures and ethnicities in Ireland. This deficit of data creates a significant barrier to identifying and addressing health needs and monitoring progress around interventions. Development of an ethnic equality monitoring system is an integral part of this strategy, with the rollout of an ethnic identifier a priority, initial action. Equality monitoring is central to efforts around reducing the effects of health inequalities in the area of intercultural health and enhancing health outcomes for this group.

Human Resources and Organisational Development

The role of the Human Resources and Organisational Development Directorate in ensuring delivery of responsive, culturally competent services is pivotal to successful implementation of the Intercultural Health Strategy. While the health service faces challenges in delivering appropriate, sensitive services to diverse, heterogeneous service users, associated issues also exist around the organisational culture of the health system, and its mechanisms of embracing diversity, recruitment, retention and support of staff from diverse backgrounds, and training and support of staff around the delivery of culturally competent, anti-racist, non-discriminatory services.

Implementation of the Intercultural Strategy

The complex, multidimensional health and support needs of the heterogeneous group of service users from diverse cultures and ethnicities requires adoption of a comprehensive, integrated approach to the implementation of the recommendations contained in this strategy. The intersecting and multifaceted nature and extent of health inequalities experienced by service users from diverse cultural and ethnic groups demands a concerted input from a range of stakeholders, both within and beyond the health sector for a coordinated, joined up response to be effected around implementation of the recommendations. Proposals are contained in the strategy around the establishment of an advisory group, which, it is envisioned, will guide and oversee implementation of recommendations of the strategy. Given the cross-cutting, multidimensional nature of the strategy, synergising the input of all stakeholders, including HSE staff, service providers, service users and representatives of the statutory and voluntary sectors is critical to such effective implementation. Associated key components, integral to the transformation approach of the HSE and essential as supporting elements of implementation, include population health input, strengthened monitoring and evaluation components, a social inclusion approach and robust human resource, financial, information and communication systems around aspects of planning, measuring, reporting, resourcing and evaluating appropriate initiatives and interventions.

Given all the factors and issues relevant to the development of the Intercultural Health Strategy, the Implementation Plan contains a number of core objectives:

- *to retain and grow the necessary skills and competencies to meet the health and support needs of service users, service providers and staff, aligned to the principles of a transformed HSE*

- *to ensure that changes within ways of working are effected in a safe, clear manner, while meeting policy and legislative obligations*

- *to ensure that implementation of recommendations is grounded within the fundamental values and principles shared by all HSE and HSE-funded services. Principles of person-centred services, improved accessibility, simple care journeys, responsiveness, partnerships with service users and communities, service integration, multi and interdisciplinary teamwork, and equitable distribution of services are intrinsic principles in this area of intercultural work*

- *to develop an operational framework with staff and partners that explains how recommendations will be implemented within a new HSE model of working and how the transformation around this will be effected*

- *to build a training and development programme with staff that supports them through the implementation of the recommendations and equips them to deliver services appropriately and effectively*

- *to continually communicate and engage with all stakeholders at local, regional and national level*

The Transformation Programme of the HSE, coupled with the socially inclusive approach integral to working with people from groups that have traditionally been socially excluded, demands new ways of working towards effective implementation of this strategy. An Action Plan towards implementation and such collaborative working is mooted in Chapter 10.

The National Intercultural Health Strategy provides a framework via which both staff and service users may be supported to participate actively and meaningfully in designing, delivering and evaluating the provision of health care to minority ethnic service users in Ireland. This strategy, reflecting input from a range of service users and service providers across the country, and informed by best practice, is aimed at reducing the social exclusion experienced by many in this cohort, enhancing their access to health services and, in the longer term, promoting positive health outcomes and social gain.

The anticipated benefits to service users and service providers of implementing this strategy are wide ranging, encompassing improved health and well-being, increased social capital and enhanced integration on the part of service users, and increased cultural competence, pride, confidence and satisfaction of service providers as they strive to deliver an effective, equal, non discriminatory service.

The HSE is committed to addressing the health and support needs of people from diverse cultures and ethnic backgrounds through adoption, launch and active implementation of the National Intercultural Health Strategy and looks forward to translating the recommendations contained in the strategy into effective actions.

2. Summary of Recommendations

2.1 Accessing Services

2.1.1 Training and associated initiatives currently under way around the provision of culturally competent, and anti-racist and non-discriminatory services will be expanded across a range of community and hospital settings.

2.1.2 The costs of accessing and using health services are a significant barrier to using these services. Entitlement to a medical card is a key determinant of utilisation of GP services, with those in receipt of this benefit using services more frequently than those without a card. Consultations demonstrated that many service users had little knowledge of entitlements in this area. Information will be adapted, aimed at ensuring that all service users are supported in being informed of their entitlements and of relevant processes in this regard.

2.1.3 Many of the issues raised around accessing health services are not unique to minority ethnic service users. Enhancement of services for the benefit of one group has the effect of improving services for a range of other groups, including older people, people with disabilities and the broad group of socially excluded service users. A programme will be developed and actions agreed regarding the promotion and implementation of the principles of Universal Access, ensuring that all aspects of health services are accessible, including those areas of the built environment and signage. This will be undertaken in alignment with work presently under way within the HSE around the enhancement of services for socially excluded groups.

2.1.4 Following the rollout of the ethnic identifier, research will be conducted around levels of referrals of minority ethnic service users to secondary and tertiary care. Pending findings, appropriate actions will be developed around this aspect.
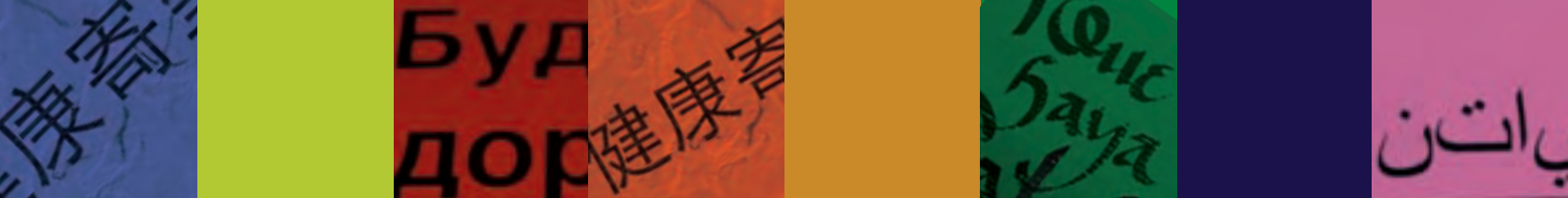
2.2 Service Delivery

2.2.1 The HSE will work with relevant training and professional bodies around the need for awareness and training in respect of aspects of health across cultures.

2.2.2 Research will be undertaken around aspects of the prevalence and management of specific conditions disproportionately affecting minority ethnic communities.

2.2.3 The HSE's Expert Advisory Group on Children has acknowledged the need for exploration of the delivery of male circumcision for religious or cultural reasons. Outcomes here will be observed in discussions around provision of circumcision to young male infants and children.

2.2.4 Training and associated initiatives currently under way around the provision of culturally competent and anti-racist services will be mainstreamed across a range of community and hospital settings. (Links with 2.1.1: Accessing Services)

Women

2.2.5 The HSE Service Plan for 2006 contains a commitment towards developing approaches to gender mainstreaming for planning and delivery of all services. Actions, aimed at addressing specific care and support needs of minority ethnic women, will be initiated, promoted and supported within this context.

2.2.6 An Expert Advisory Group for Maternity Services has been established to advise on the organisation and development of health and personal social services in this area. Actions around addressing the maternal care and support needs of women from diverse ethnicities and cultures will be addressed within the context of priorities and actions agreed by this group. The implementation of the Maternity Action Plan will be a key element of work in this area, while outcomes of the HSE's recently commissioned review on Maternity and Gynaecology services will further inform the planning and delivery of appropriate, culturally responsive services in this area of care. Against this backdrop, efforts will be initiated towards addressing aspects of the take up of services and follow-up care for mothers and families; and mechanisms of provision of emotional and practical support to vulnerable mothers will be explored and implemented. Young and first-time mothers will be priorities in this regard.

2.2.7 Discussion will take place with RIA personnel concerning specific issues related to the maternal health needs of asylum seeking mothers living in direct provision settings; the importance of prioritising the nutritional needs of children and breastfeeding mothers will be addressed in this context. Efforts currently under way under the auspices of the National Breastfeeding Implementation Committee will form a key element of efforts in this area.

2.2.8 The rollout of the ethnic identifier will facilitate the development of evidence-based information regarding maternity and associated needs of women from diverse cultures and ethnic groups. Appropriate actions to address and monitor the birth outcomes of women of this cohort will be provided in line with findings and with existing initiatives.

Mental Health

2.2.9 The report Vision for Change is currently being implemented within the HSE. Support will be provided for the recommendation contained in Vision for Change: "Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard, and mental health services should be resourced to provide services to other ethnic groups, including provision of interpreters."

2.2.10 Specific issues that have an impact on the mental health of members of this cohort, resulting from implementation / lack of implementation of various policies, will be explored with other sectors, in an effort to ameliorate these effects. The HSE is committed to use of all available resources to advocate and highlight the detrimental effects to health of such policies. Discussions with structures in the Department of Justice, Equality and Law Reform around the effects of the direct provision system and with fora in the Department of the Environment in relation to Traveller accommodation, in particular, will be key priority areas in this regard.

2.2.11 Community initiatives aimed at providing care and support around the mental health needs of people from diverse cultures and ethnic backgrounds will be supported and promoted within the context of the model of community mental health endorsed in Vision for Change.

Children

2.2.12 The work of the Expert Advisory Group on Children will guide the development of measures aimed at addressing care and support needs of children from diverse cultural and ethnic backgrounds. Mechanisms will be instituted around collaboration with relevant personnel within the children and family sector towards supporting care needs of children and families of diverse ethnicities and cultures. The care and support needs of separated children will be a priority within this approach.

2.2.13 Recommendations contained in the National Action Plan Against Racism form a key element of ensuring an inclusive, intercultural approach to meeting the needs of children from diverse minority ethnic groups and communities. Support and training for staff may be required in the area of childcare and protection within a framework of interculturalism and diversity. Children and family services will be supported in efforts to develop comprehensive practice in this area.

Older Persons

2.2.14 Research and associated action will be undertaken around the care and support needs of this group, with a special focus on identifying existing issues and planning for future needs.

2.2.15 The situation of carers of older persons from diverse cultures and ethnicities will be explored.

Disability

2.2.16 Implementation of new disability legislation and associated requirements for the development of individual care plans, together with related legislation around education for children with special needs, provides potential for collaborative work around identifying and addressing health care needs specific to disabled service users from diverse cultures and ethnic backgrounds. Mechanisms will be developed to support personnel in disability services in this regard.

Sexual Health

2.2.17 Aspects of sexual health delivery for service users from minority ethnic groups will be addressed within the context of the development and implementation of an anticipated forthcoming National Sexual Health Strategy.

Addiction and Alcohol

2.2.18 The HSE will address relevant aspects of addiction within the remit of the current National Drug Strategy, which is well placed to identify and respond to emerging issues. Similarly, aspects of alcohol-related issues will be addressed within the context of work of the National Task Force on Alcohol.

Health Screening

2.2.19 Follow-up and associated continuity of care of members of minority ethnic groups, particularly as they may be dispersed throughout the country, may present difficulties. The current system of health screening will be reviewed and aligned in accordance with new HSE structures, including population health.

2.3   Mechanisms to Promote Access

Primary Care

2.3.1 The rollout of the Primary Care Strategy will be supported in line with the principles of needs assessments. Participation of minority ethnic communities in this process will be actively promoted.

2.3.2 Some discussion will be initiated with relevant personnel around ways of developing flexible mechanisms to facilitate those socially excluded people, such as Travellers or migrants who have a more mobile lifestyle, in accessing services. Examples such as the use of hand-held health records and the extension of hours outside the usual core hours to accommodate the needs of communities will be highlighted.

Community Development

2.3.3 The HSE is committed to working with the NGO sector in the design and delivery of appropriate health and support services for minority ethnic communities. A strategic approach to this work is required. A review of existing partnership arrangements and associated activities will be undertaken by the HSE in collaboration with relevant NGOs. NGOs will continue to be supported by the HSE, with resources being provided to deliver agreed services.

2.3.4 Minority ethnic communities will be supported in building their capacity for participation in emerging HSE structures and in monitoring implementation of the strategy. Standardised mechanisms of encouraging and facilitating active participation of stakeholders will be developed.

2.3.5 Peer-led approaches have been evaluated as effective tools in facilitating communities to gain an increased understanding of aspects of accessing and using health services appropriately and optimally. This model will be supported and expanded by the HSE.

Cultural Mediation

2.3.6 Cultural Mediation has a role in promoting interculturalism in the health service. Pending evaluation of existing projects in this area, consideration should be given to ways of optimally using Cultural Mediators at community level.

2.4 Underpinning Access

Information

2.4.1 There will be coordinated development of guidelines around production and application of translated material. These guidelines, advised and validated by stakeholders, will be based on evidence of good practice and should focus on aspects of standards, quality and standardisation in relation to production and use of translated information. Guidelines will include direction regarding the type of information that should be provided, languages in which these should be available, and to whom and how the information should be circulated. Aspects of cost effectiveness around a coordinated approach to this action should also be a consideration.

2.4.2 A plan will be developed for a phased, coordinated production and usage of translated material.

2.4.3 Translation of information concerning entitlements, service user rights and ways of making complaints should be regarded as priority actions in the initial phase of this recommendation.

Interpretation

2.4.4 A thorough audit and evaluation of existing systems of facilitating interpretation should be undertaken to inform the nature and design of a national interpretation service. This will include consideration of current models and practices in this area, and some evaluation of their effectiveness. Consideration will be given to the issue of remote areas where need is not sufficient to warrant internal provision of services and yet interpreters may be required suddenly and urgently.

2.5 Data, Information and Research

2.5.1 The HSE is currently in discussion with the Health Information and Quality Authority concerning ways of synergising efforts in the area of health information and related aspects of quality and standards. The Population Health Directorate is a key player in this area. The Social Inclusion Unit will work within this evolving framework towards development and enhancement of data and its application in the area of minority ethnic health. There will be a particular focus on the application of data in relation to health inequalities.

2.5.2 Rollout of an ethnic identifier on a phased basis across all levels of care will continue to be managed as a strategic priority of the HSE. This identifier, based on the Census population question, should be embedded within datafields, and will complement and strengthen application of information around country of birth and religion, which is already within the suite of data currently collected.

2.5.3 Collection of information around language will be standardised in the longer term.

2.5.4 Collaboration will be effected with HIQA, the Health Intelligence section of the Population Health Directorate, NCCRI and other relevant stakeholders regarding the planning for collection, monitoring and application of appropriate information in respect of the health status and needs of service users from diverse cultural and ethnic backgrounds.

2.5.5 A bank of information will be developed around the field of minority ethnic health, designed to support and resource all stakeholders in informing service design and delivery in this area.

2.5.6 Research will be undertaken around aspects of interculturalism relevant to the health needs, practices and outcomes of service users from diverse cultures and ethnicities.

2.5.7 An integrated approach will be developed for conducting health impact assessments. Aspects of equality and diversity will be developed and conducted in the longer term within a health impact assessment framework. This will be effected within the context of work currently under way within the Population Health Directorate concerning the development of a strategic framework for health impact assessments.

2.6   Human Resources and Organisational Development

2.6.1   A whole organisational approach to work with a diverse population will be actively championed to develop a culture and ethos that supports interculturalism. This approach should be multistakeholder and encompass advancing equality as a principle of service commissioning and planning, equality of opportunity, proactively managing diversity, addressing discrimination and racism, and promoting an approach that is responsive to the range of cultures and religions of service users.

2.6.2   The area of recruitment and retention of staff is the remit of the Human Resources Directorate of the HSE. It encompasses all aspects of this function, including organisation development and design, employee relations, employee well-being and performance and development. Collaborative efforts will be undertaken with the various functions of this directorate and the Equal Opportunities / Diversity Working Group of the HSE EA, in the development of proactive initiatives aimed at the attraction, selection, recruitment, professional development, promotion and retention of staff from diverse backgrounds. Such initiatives will include the proactive and positive management of cultural diversity in the workplace and the promotion of best practice in human resource management for all sections of the workforce, including externally contracted staff.

2.6.3   Current initiatives aimed at the capacity building of staff to plan and deliver appropriate, responsive, culturally competent services to service users from a range of cultural and ethnic backgrounds should be expanded and implemented on a phased basis.

3. Context

Ireland is being transformed into a multicultural society as increasing numbers of people from diverse cultures and ethnic backgrounds live, work and settle here.

Available figures indicate that the population of Ireland has increased from 3,917,203 persons in April 2002 to 4,234,925 persons in April 2006. This represents an increase in population of 8.1% in four years. Migration is named as the dominant factor in this increase. Census 2006 indicates that 420,000 foreign nationals are living in Ireland, with continental Europeans, along with Africans and Asians, the fastest growing groups. Over 600,000 people living in Ireland were born elsewhere. This changing and dynamic nature of Irish society, from one of mass emigration to a net inward immigration, is reflected in the statistic that 18% of the population in 2030 is expected to be foreign born, compared with the present figure of 10.4%. The population is expected to rise to five million by 2030.

Changes in Irish society are reflected in the increasing numbers of families of mixed nationalities. The number of families containing Irish and non-Irish nationals increased from 70,721 in 2002 to 95,636 in 2006. The number of families containing only persons with non-Irish nationality increased from 20,187 to 50,655 in the same period.

Many of the "new Irish" belong to diverse cultural and ethnic groups. A minority ethnic group may be one of a wide range of groups who live in Ireland and who define themselves by virtue of their race, ethnic or national origin. People from this group may be asylum seekers, refugees, migrant workers, Irish Travellers, Roma, foreign students and members of either new or established minority ethnic communities. Each cultural and ethnic group shares a collective identity, based on a sense of common history and ancestry. Ethnic groups possess their own cultural identity, language, customs and practices, while each individual within the group will possess his or her own unique life experience and health, social, emotional, vocational and psychological needs.

The Census of 2006 asked people their ethnic affiliations. While 95% of Irish people are White, around 44,000 people consider themselves African or Black; 16,000 describe themselves as Chinese and 36,000 indicate they represent another Asian background.

There are a number of distinct ethnic groups in Ireland today. Irish Travellers have been documented for centuries as a distinct cultural and ethnic group with their own history, culture, language and lifestyle. Other communities, including Jewish and Muslim groups, have been present in Ireland for many years, while, within the past few years, many new communities have also emerged. While much focus has been placed on the arrival of asylum seekers and refugees in the recent past, this approach has shifted to the increasing number of migrant workers coming to Ireland. There is also a cohort of people from different minority ethnic groups settling in Ireland for the purposes of family reunification. International students form another emerging group.
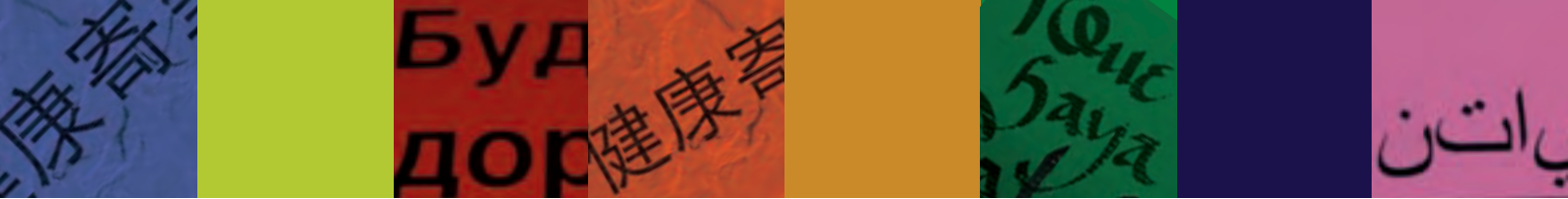
Religious diversity adds an important dimension to many people's ethnic and cultural identify. A long-established Jewish community in Ireland dates back to the 19th century, while the more recently established Muslim community in Ireland dates to the 1950s. Between 1991 and 2002, the number of Muslims in Ireland quadrupled to 19,000 due to inward migration. The Muslim faith now has 32,500 followers, with two-thirds of its adherents being mainly of African and Asian extraction. Muslims have overtaken Presbyterians and other Protestant faiths to become the third-largest religion in the State. Over the same period, the number of Orthodox Christians in Ireland grew from 400 to over 10,000, mainly reflecting inward migration from non-EU European countries. Census 2006 reports that there are now 20,800 Orthodox faith adherents, with some 845 of these from abroad, mainly from non-EU countries in Eastern Europe.

The broadening of diversity brought about by new levels of migration has contributed significantly to the fabric of social, economic and cultural life in Ireland. However, this emerging diversity also brings challenges for society, both in adapting to the impact of new cultures and in developing collective ways of promoting the integration of people from diverse cultures and ethnic groups into mainstream society. The NCCRI (National Consultative Committee on Racism and Interculturalism) states that "interculturalism suggests the acceptance not only of principles of equality of rights, values and abilities, but also the development of policies to promote interaction, collaboration and exchange with people of different cultures, ethnicity or religion. It is an approach that sees difference as something positive that can enrich a society and recognise racism as an issue that needs to be tackled in order to create a more inclusive society."

The term "interculturalism" has been adopted by the Government as most appropriate to define it's policy and approach to promoting integration.

It is acknowledged that people from diverse cultures and ethnic backgrounds may be at risk of poverty and social exclusion. Asylum seekers and refugees are particularly vulnerable in this regard, while awareness is increasing around the socially excluded situation of migrant workers, many of whom may be living almost invisibly within communities. Travellers are an especially disadvantaged group within Irish society, while the poor conditions in which growing numbers of the Roma community are living are also becoming of concern. Members of all these groups, as well as of those people living in new and established minority ethnic communities in Ireland, may also experience racism and discrimination, which in turn leads to increasing social isolation. These circumstances, coupled with language and cultural barriers, may further compromise health and well-being. It is evident that strategic planning is essential across a range of sectors if both the causes and the effects of such exclusion are to be successfully addressed and subsequent health outcomes improved.

Public bodies have an obligation to deliver services to clients in an equal, accessible and effective manner, which acknowledges and values the diversity of all service users. In this respect, it is incumbent on the health services to plan and deliver services to people from a range of cultures and ethnic groups in a competent way, sensitive to their particular needs and beliefs. The HSE is committed to the planning and delivery of health services that values the diversity of client needs and responds sensitively and appropriately to these. An ethos of person-centredness is central to the functioning of a reformed HSE. This entails planning for communication and language diversity, involving users in service development and making appropriate provision for religious and cultural beliefs, such as worship and diet facilities, which aid speedy recovery.

It is timely then that the HSE, in recognition of these changing demographics and the consequent health needs they suggest, is developing a National Intercultural Health Strategy. The primary objective of the strategy is to provide a framework through which service users and providers are supported in addressing the unique care and support needs of people from diverse cultural and ethnic backgrounds.

Within a health landscape, this implies that the health service acknowledges the distinct health and support needs of minority ethnic groups and, through a range of mechanisms, translates this into responsive, flexible ways of facilitating equal and optimal access to and utilisation of health services, with positive health outcomes.

Such an approach does not signal a sudden or dramatic change in direction of the HSE. The health service has always striven to deliver quality care and support services to all service users and the development of an Intercultural Strategy demonstrates an awareness of the needs of a distinctive group in Irish society. The nature and extent of a range of initiatives in working with minority ethnic groups across the country bears testimony to the motivation of service providers and service users alike in this regard. Examples here include Pavee Point's model of Primary Care for Travellers, Access Ireland's Cultural Mediation work, Spirasi's initiatives with asylum seekers, Cáirde Women's Health Action programme and Healthwise Community Action projects, and various migrant-friendly initiatives across hospital and community settings. A characteristic common to these models of good practice is the collaboration between the statutory and voluntary sector in the design and implementation of these programmes.

Similarly, within the former system of health boards, activities took place around responding to care and support needs of people from diverse backgrounds. A number of regional and local strategies were developed around a recognition that the health care and support needs of persons from diverse cultures and ethnic background should be addressed. The Eastern Regional Health Authority Strategy for Ethnic Minorities, launched in 2004, proposed a series of recommendations together with the establishment of a representative forum to oversee the implementation of these recommendations. Recommendations addressed the provision of an interpretation service; ways of supporting non-governmental organisations working in the areas of minority ethnic health; means of providing for the learning, training and support needs of staff; and also focused on actions around specific health issues.

Findings of the Equal Status Review, an initiative of the former North Western Health Board, facilitated an understanding of the means of progressing equality aspects for all service users in mainstream and targeted service provision.

Growing recognition of aspects of equality and discrimination within health care resulted in the production of a booklet by the Equality Authority, in collaboration with the Department of Health and Children and the HSE. This document, *Equal Status Acts 2000 – 2004 and Provision of Health Services,* was aimed at supporting legal compliance by health service organisations through stimulating a focus on the Equal Status Acts. It acknowledged the diversity of clients and committed to adjustments to address practical implications of this diversity. It also stated that steps to achieve particular equality targets or outcomes would be proactively pursued through the use of positive action, among other strategies. Institutional development would involve a move away from ad-hoc, informal or reactive responses to the challenges of equality and diversity.

Despite the good practice already operational within the area of minority ethnic health, it is acknowledged that this tends to be fragmented across the country, with access to services often dependent on geographical location, for example, rather than need. The Intercultural Strategy represents a means of developing a framework within which further good practice may be developed, enhanced and replicated in a strategic, phased manner against a background of equality

4. The HSE

4.1 Current Service Provision in the HSE

Following approval by the Oireachtas of the Health Act, 2004, the HSE came into being on 1 January 2005. The single national health service organisation formed via this legislative reorganisation operates via a number of pillars and Directorates, including Population Health, National Hospitals Office, and Primary, Community and Continuing Care.

The HSE publishes an annual *Service Plan,* detailing priorities and actions around service delivery.

Health services are delivered directly by HSE staff or indirectly via agencies within the community and voluntary sector, funded by the HSE to deliver an agreed quantum of services on its behalf.

The HSE follows a mainstreaming policy with the development of targeted services where these are necessary to address specific health and support needs of groups of service users who might otherwise be disadvantaged in accessing and availing of health services. The dedicated psychological service for asylum seekers is an example of an existing targeted service in this regard.

The appointment of social inclusion managers in a number of HSE areas provides for collaborative work within the HSE itself and with a range of NGOs around a comprehensive approach to operational service delivery for socially excluded groups, including Travellers, asylum seekers and migrant workers.

Health services for people from diverse cultures and minority ethnic groups are, for the most part, delivered within a mainstream setting, while a range of support services offered via NGOs specialise in specific areas of work with minority ethnic individuals and communities. In many instances, NGO service providers are acknowledged to be most appropriate vehicles of service delivery. This is particularly the case where, for example, asylum seekers may have been subjected to torture by mainstream government agencies in their country of origin and are suspicious and distrustful of approaching government agencies. Provision of medical and related support is most appropriately offered in such situations by NGO service providers.

Within the Irish context, health-related activities such as capacity building of minority ethnic service users and communities, provision of support around understanding and accessing services, and specific torture-related services are offered by NGOs via agreements with the HSE.

Examples of specific initiatives and programmes delivered by HSE staff and NGO service providers are mentioned throughout the strategy document and are described in more detail in the accompanying *Consultation Report.*

Service delivery comprises more than a unidirectional provision of services. The importance of community participation in all aspects of health planning and delivery has been increasingly recognised, with Section 43 of the Health Act, 2004 allowing for the HSE to consult with local communities or other groups about health and personal social services. This is particularly resonant for people from traditionally socially excluded groups who will now be supported in actively participating in decision making around their own health. Support to NGOs working in the field of community development is a key element in ensuring service users from diverse cultures and ethnicities are facilitated around this. Aspects of community participation and development are addressed in other sections of this document.

The HSE is committed to the establishment of Expert Advisory Groups (EAGs) that, through harnessing and channelling the insights and experience of people who use and provide services, will advise on the organisation and development of health and personal social services. The composition of EAGs includes health professionals, carers, managers, service users and leaders in health and social care. The anticipated establishment of an EAG addressing aspects of social inclusion will be of value in facilitating implementation of the Intercultural Strategy.

While this section deals with the current provision of health services to people from diverse ethnicities and cultures, consideration also has to be given towards the planning of services that are responsive to the future needs of this service user group. The impact of demographic changes, with growing numbers of diverse groups settling in Ireland, living and ageing here, holds implications for the long-term planning of services that are responsive to a range of diverse health and support needs, and associated proofing around their effect on these groups.

4.2 The HSE and Social Inclusion

The Health Service Executive is charged with managing the operation of the Irish health service as a unified system. The merging of the health boards and other agencies, previously functioning as separate entities, has facilitated adoption of a harmonised, consistent approach to development and provision of high quality health and personal support services across the country.

Core objectives within the HSE Corporate Plan 2005 – 2008[1] are listed as follows:

- *We will improve people's experience of our services and their outcomes, through developing, changing and integrating our services in line with best practice*

- *We will work to protect, promote and improve the health and well-being of the population, based on identified need and with particular focus on measures to address social exclusion*

- *We will empower staff to deliver responsive and appropriate services, making effective team working a priority*

- *We will develop the HSE as a dynamic, effective and learning organisation in partnership with service users, patients, staff, not-for-profit / voluntary / community sector and other stakeholders.*

[1] HSE Corporate Plan 2005 - 2008

The HSE Corporate Plan is underpinned by a population health approach to the planning and delivery of health services. This approach, recognising the range of factors affecting health, seeks to promote and protect health and well-being, with a special focus on measures aimed at reducing health inequalities. A 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. In seeking to improve population health, health promotion plays a distinctive role, moving beyond a disease prevention focus towards a more comprehensive, holistic approach via a range of different settings. Health promotion contains a capacity not only to improve health, but also to contribute to the reduction of health inequalities.

The HSE Transformation Programme 2007 – 2010 builds on the momentum for change derived from the formation of a unitary system. A key focus of this agenda is the acknowledgement of a need for "change in not only what we do, but how we do things, how we work together and how we all commit to each other". Core themes of "easy access", "confidence" and "staff pride" are resonant for service users who may experience barriers to accessing services, leading to diminished confidence in the health system and to a less-than-optimal engagement between staff and service users. The implementation of the Transformation Programme provides much opportunity for the promotion and development of new, responsive ways of delivering quality health services to all service users on the basis of need.

The role of social inclusion within the HSE is closely linked with poverty and the vulnerability of groups to exclusion from equal participation in society. Social inclusion is synonymous with tackling poverty and health inequalities, with inequalities being addressed through such mechanisms as provision of targeted services, enhancement of responsiveness of mainstream services and intersectoral working. The cross-cutting dimension of such work forms part of an approach towards improving access of all service users to health services. In parallel, mechanisms for the empowerment and greater participation of marginalised groups and communities in the designing, planning, monitoring and decision making are put in place alongside associated training and support for staff.

Social inclusion implies being in a position to enjoy full participation in all aspects of society. Conversely, social exclusion carries restrictions from optimal participation in all societal activities.

Socioeconomic factors exert a powerful influence on health status. Poverty is a particularly significant factor leading to health inequality and subsequent poor health outcomes. Those at the lowest socioeconomic level suffer a disproportionate burden of ill health. Poorer socioeconomic groups show higher rates of infant mortality, live less healthy lives, are more vulnerable to illness and die younger. The significant difference in birthweight between babies of the highest and lowest socioeconomic status – with attendant implications of more negative health outcomes – is an example in this regard. Similarly, gaps in life expectancy between the Traveller population and the settled population demonstrate effects of health inequalities on health status. Significant differences exist in respect of premature mortality between the highest and lowest socioeconomic groups in terms of cancers, circulatory diseases, injuries and poisoning.

Often those groups in society who are most at risk of exclusion are the most difficult to reach. At the same time, their vulnerability to effects of social exclusion makes it significantly more difficult to access public services, including health services. The socially inclusive approach of the HSE mandates that proactive actions be undertaken to engage with all stakeholders around reducing causes and effects of health inequalities.

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. Recently published research reveals that the poverty rate for Britain's minority ethnic groups is double that found amongst white British people[2]. Risk factors that may have an impact on an individual's health status include income and socioeconomic status, social environment, level of education, housing, occupation, food and transport. Poverty, unemployment, education, access to health services and environmental factors, including housing and water quality, all play important roles in determining the health of individuals, with inequalities in health status resulting from a multifaceted and interrelated combination of these factors. Within the Irish context, minority ethnic groups are particularly vulnerable in this regard, with Travellers, migrants and asylum seekers identified as being at particular risk of poverty and social exclusion. Non-Irish nationals are reported to be twice as likely to be in consistent poverty as Irish nationals[3]. Multiple discrimination resulting from the intersection of other grounds covered by equality legislation, such as gender or disability, further undermine health and well-being.

For many in Ireland, social, economic, cultural and language difficulties form barriers to participating in society, while experience of racism, discrimination and stigmatisation may further hinder integration.

Health 21 (WHO) confirms that "everyone should have a fair opportunity to attain full health potential and, more pragmatically, no one should be disadvantaged from achieving this potential, if it can be avoided. Inequity refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust."[4] This clear endorsement of the critical importance of equity in ensuring equal access to health services for all service users on the basis of need – and associated targeting of health inequalities – is confirmed by the National Health Strategy and further endorsed by the HSE's Transformation Programme.

The Social Inclusion Unit of the HSE, located in the office of the Chief Executive Officer, is ideally positioned to lead the development and implementation of the Intercultural Strategy. In this context, it has a mandate and a responsibility to promote and support cross-cutting policies and actions aimed at reducing and eliminating health inequalities and improving access to services for socially excluded service users, including service users from diverse cultural and ethnic backgrounds.

[2] Joseph Rowntree Foundation (2007)
[3] Combat Poverty Agency, (2007) Health Policy Statement
[4] World Health Organisation (1998) Health 21

5. Profile of Minority Ethnic Groups in Ireland

While there can be some tendency to homogenise people according to the ethnic or cultural group to which they belong, it is important to emphasise the heterogeneity that exists among the diverse groups and within the individual members of these groups. Nonetheless, within the context of their respective status and structures in Ireland, it is necessary to highlight those aspects unique to each ethnic group that may have an impact on their overall health status.

5.1 Refugees, Asylum Seekers and Programme Refugees

Refugees: A refugee / convention refugee is a person who fulfils the requirements of the definition of a refugee under the 1951 Geneva Convention, which defines a refugee as a person who, owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, unwilling to avail himself of the protection of that society.

Asylum Seekers: An asylum seeker is defined as a person who seeks to be recognised as a refugee in accordance with the terms of the 1951 Geneva Convention relating to the status of refugees and the related 1967 Protocol, which provides the foundation for the system of protection for refugees generally.

The Reception and Integration Agency (RIA) is a single organisational structure with responsibility for coordinating the implementation of the policy on the integration of refugees in Ireland. RIA is located in the Department of Justice, Equality and Law Reform (DJELR) and its functions include:

- *sourcing suitable accommodation and sites throughout Ireland for accommodating asylum seekers*

- *coordinating the preparation of sites at which temporary accommodation for asylum seekers is to be provided*

- *contracting out the management (including arrangements for catering and security) of State-owned accommodation centres*

- *monitoring the operation of accommodation centres on an ongoing basis*

- *accommodating asylum seekers at reception centres in Dublin for an initial period of seven to 10 days for the purposes of orientation, information provision, voluntary health screening, needs assessment and assistance with the first stages of asylum applications*

- *dispersing asylum seekers from reception centres in Dublin to accommodation centres around the country*

- *coordinating the provision of services at accommodation centres*

- *providing training and support to proprietors and management of centres*

- *monitoring the implementation of contracts for services*

- *supporting local asylum seeker support groups established to befriend and be of assistance to asylum seekers*

- *coordinating integration programmes for Resettlement Quota and Programme Refugees*

- *administering the European Refugee Fund in Ireland on behalf of the European Commission*

When an asylum seeker enters Ireland, he or she is accommodated in a Reception centre for a short period, before being dispersed to one of a number of Accommodation centres outside the Dublin area. This is in accordance with the Government policy of direct provision, where asylum seekers are provided with full board, i.e. accommodation, meals and an allowance of €19.10 per week (€9.60 per child).

Figures provided by RIA indicate that, between 10 April 2000 and 28 February 2007, 51,820 applications were received for asylum. Recent figures reflect a downward trend in the number of people seeking asylum in Ireland. As at 28 February 2007, 5,210 people seeking asylum were being accommodated in direct provision while a further 501 people were accommodated via the RIA in self-catering facilities.

Application for Declaration as a Refugee 1991 - 2007 (28/02)
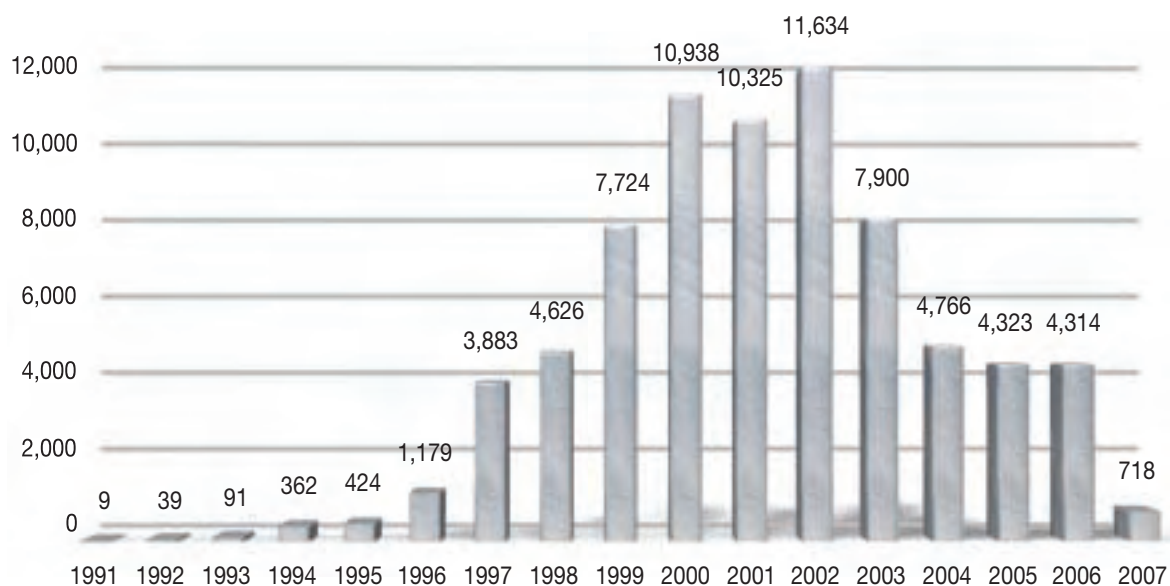
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2000	976	864	972	1036	802	677	773	919	963	1098	1096	762
2001	840	706	763	741	838	882	961	983	855	892	904	960
2002	838	763	932	888	795	869	1133	995	1199	1148	984	1090
2003	979	947	892	667	604	661	646	655	611	496	395	347
2004	392	363	501	377	403	324	371	401	466	329	409	430
2005	393	377	489	320	322	315	325	348	372	320	346	396
2006	405	313	438	282	412	278	313	332	422	394	415	310
2007	385	333										

Source: Reception and Integration Agency

The age profile of people in direct provision is particularly youthful, with 2,559 of the 5,372 people accommodated via this system at the end of November 2006 aged below 25 years; 1,436 of this cohort was aged below 12 years.

Age Profile of Asylum Seekers in Direct Provision

Age	0-4 years	5-12 years	13-17 years	18-25 years	26-35 years	36-45 years	46-55 years	56-65 years	66+ years	Total
Numbers in Direct Provision	1126	444	162	1009	1892	822	186	51	19	5711

RIA Database end February 2007

Length of stay of people in direct provision varies considerably. As at the end of February 2006, 812 asylum seekers were in direct provision for between one and three months, 665 for three to six months, 484 for six to nine months, 671 for 12–18 months, 414 for 18–24 months and 1,315 for more than 24 months.
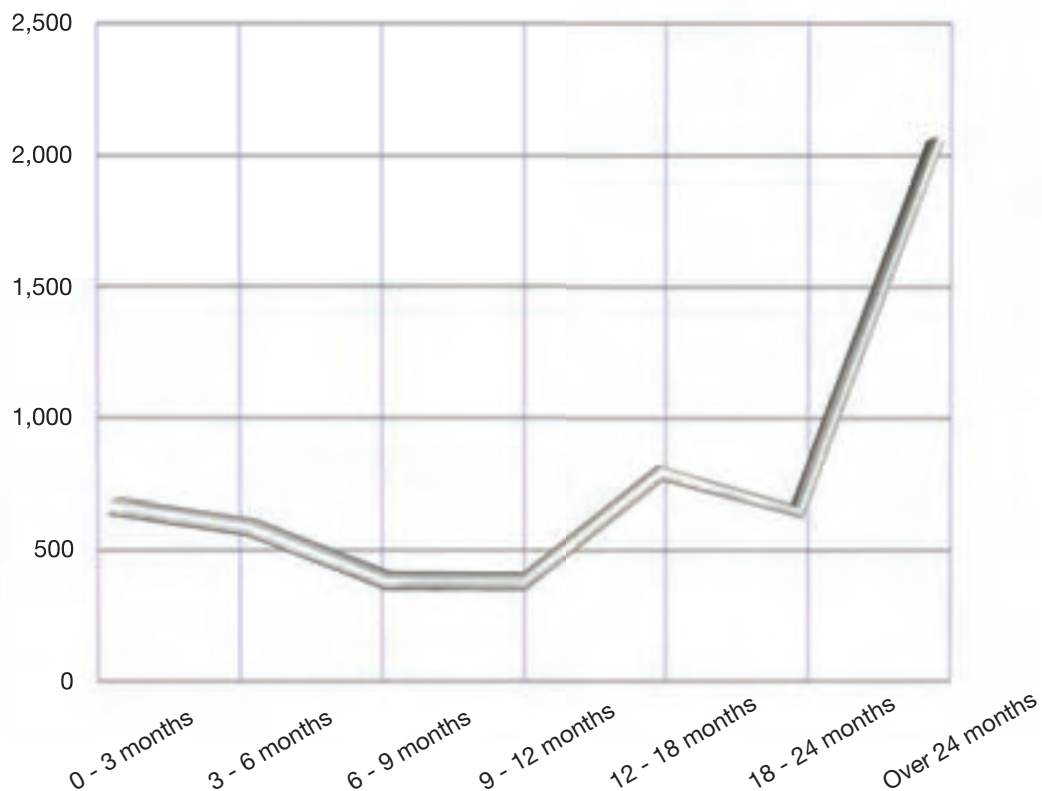
Source: Reception and Integration Agency

Many asylum seekers, refugees and programme refugees face special challenges in relation to their health. It is estimated that between 10% and 35% of those seeking refuge in European countries have suffered torture in their premigratory state (Luton et al)[5]. It would be expected that a significant proportion of these would require torture care services. It is accepted that many asylum seekers and refugees may suffer from a significant burden of mental health problems, including depression, psychological disturbances and / or post-traumatic stress syndrome. Many of these problems develop and / or increase after arrival due to post-arrival stresses. Their mental health is adversely affected by social isolation, pre and post-arrival trauma, culture shock, language barriers and fear of deportation coupled with a lack of understanding about services, poverty and poor housing. Such mental health difficulties are not confined to the adult asylum seeking population, with unaccompanied refugee children and separated children seeking asylum suffering from unresolved effects of physical and / or emotional trauma.

The impact on both physical and mental health of those in direct provision is also important to note. Self-catering facilities do not exist in direct provision settings. Here, the issue of food poverty is especially relevant. Food poverty may be defined in a number of ways, from a nutritional, social exclusion and / or a food security perspective. "Food poverty is the inability to access a nutritionally adequate diet and the related impacts on health, culture and social participation." (Combat Poverty Agency Conference Report, 2004). Issues relating to food poverty among asylum seekers living in direct provision have been reported, with a report by Manandhar (2006), conducted in the North West, highlighting issues of concern for nutritional status and health and well-being, particularly with weight gain, high calorie intake from protein and fats, limited food choice and overall food poverty[6]. The Institute of Public Health has also expressed concerns around the implications for physical and mental well-being of this situation.

While generalisations should be avoided around all direct provision centres and their provision of food, it is clearly important that the HSE work closely with the Reception and Integration Agency (RIA) to ensure the provision of quality, culturally appropriate food and associated aspects around health promotion.

It appears that prolonged length of stay of people within the direct provision system may have a direct negative effect on overall well-being. Lack of entitlement to work, when this restriction extends over a long period, may further compound mental health, with boredom, depression, sense of isolation and loss of self esteem commonly reported symptoms.

[5] Luton

[6] Manandhar, M 2006

The asylum process itself is a stressor, which may have a further impact on health and well-being. Although progress has been made in streamlining procedures around asylum claims and expediting decision making around these, there is no doubt that the nature of the process, as presently applied, causes significant stress to the asylum seeker, with associated effects on physical and mental health.

Although the number of people seeking asylum in Ireland appears to have stabilised, it is of note that their needs for health care and support may be especially complex. This poses particular challenges for the health services in providing appropriate, coordinated care.

Programme Refugee: A programme refugee is a person who has been invited to Ireland on foot of a Government decision in response to humanitarian requests from bodies such as the United Nations High Commission for Refugees. In 2005, the Government announced an increase in its resettlement quota as part of the country's growing commitment to sharing responsibility for refugee situations, in line with the Agenda for Protection and Convention Plan[7]. Since 2005, the Irish Government has agreed to accept 200 programme refugees into the country each year. An Interdepartmental Working Group has been established around this, with a brief around planning, facilitating and coordinating the integration of these refugees at a national level.

The situation of programme refugees is different to that of asylum seekers and people granted refugee status through the asylum process, in that members of this group are facilitated in settling into communities on arrival in Ireland, rather than being placed into the direct provision system. Unlike asylum seekers too, members of this group are able to seek employment and are entitled to full Social Welfare entitlements from their date of arrival.

Notwithstanding this, programme refugees may share similar experiences and health and support needs to those described by asylum seekers. Despite the level of support offered to this group in settling into Irish society, significant challenges exist around their integration into community life. Many members of this group have been accommodated in refugee or resettlement camps for periods of years and have not been afforded opportunities to engage independently in routine activities of daily living such as attending school or college, entering employment or maintaining a household. The move from these circumstances to such a different society may in itself prove traumatic for members of this group, even before the challenges of settling and integrating into Ireland are taken into account.

Family Reunification

A person granted refugee status in Ireland may apply for family reunification under Section 18 of the Refugee Act, 1996 (as amended)[8]. This allows for a family member to enter and reside in the State and be reunified with him / her. The Office of the Refugee Application Commissioner (ORAC) holds a remit for investigating and processing reunification applications. Statistics from ORAC indicate that 2,505 applications, involving 5,684 dependants have been received in the period 2001 to end March 2007.

Reunification of refugee families may be a fraught process, with delays in processing applications and difficulties in obtaining and verifying required documentation.

[7] Agenda for Protection and Convention Plan

[8] Refugee Act 1996

Overlying the reunification process are fears around the safety and well-being of family members, particularly when these are in precarious situations, together with feelings of loneliness and depression caused by an often enforced separation from close family members. The implications for mental and physical health, particularly when the individual is attempting to achieve reunification with a partner or with children, are evident.

The acceptance of the fundamental importance of the family in Irish society provides a basis for a right to family reunification. Persons who are legally resident in Ireland are permitted to apply for family reunification in respect of dependent family members. While the rights of EU nationals are guaranteed in this respect, policies in regard of people from outside the EU accession states are governed by the immigration status of individual applicants. Figures in the Immigrant Council of Ireland's Annual Report for the period 1 July 2005 – 30 June 2006 confirmed a continuing trend of family reunification being a pressing issue of concern to individuals and organisations accessing the Council's information and advice service[9].

5.2 Migrants and Migrant Workers

The economic success of Ireland has resulted in an unprecedented increase of migrants from other countries, with the numbers coming from EU accession states reflecting a marked increase. The number of people entering the State is a significant element of Ireland's population growth since 1995. The Central Statistics Office Population and Migration estimates of April 2006 indicate that the total immigration flow into Ireland in the 12 months to March 2006 was 86,906. Census 2006 reported 63,300 Polish nationals, while the number of Lithuanians was counted at 24,600. While data on ethnicity is not readily available, it is evident from the figure around nationality that a large proportion of migrants represent a range of minority ethnic groups.

In the 2002 Census, 222,000 non-Irish nationals were counted. This number increased to 420,000 in 2006.

Of the 122,000 persons who immigrated into Ireland in the 12 months before the Census, 83,000 (68.2%) were single and, of these, 51,700 (62.2%) were in their 20s.

A migrant worker is defined in Article 2 of the 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families as "a person who is to be engaged, is engaged, or has been engaged in remunerated activity in a state of which he or she is not a national".

There is considerable diversity among migrant workers in Ireland in terms of country of origin, ethnicity and religion. Nearly 85% of all migrant workers in Ireland are from the European Union and the slightly broader European Economic Area (EEA) and are free to seek work in Ireland without any restrictions. Exceptions here are Romanian and Bulgarian nationals, who require a work permit to live in Ireland or must be self employed. Around 30% of migrant workers are from countries that joined the EU in 2004, in particular Poland, the Baltic countries, the Czech Republic and Slovakia.

[9] ICI 2006

Those arriving in Ireland from outside the European Economic Area are required to have a work permit. The number of work permits issued to non-EU nationals decreased from 47,707 in 2003 to 27,136 in 2005 (including renewals) and to 21,395 in 2006 (including renewals). There are also approximately 20,000 registered non-EEA students in Ireland; many of these students are entitled to work up to 20 hours per week part time, although the Government has indicated planning around a student employment visa that will place further restrictions on part-time student employment. Of the work permits issued in 2006 to persons from approximately 132 countries, nationalities to whom highest numbers were issued were Philippines (3,286), India (1,805), Ukraine (1,476), South Africa (1,469), Romania (1,266), Brazil (983) and China (964).

Many migrants bring their families to Ireland, while others send remittances home. Some migrants will make their homes in Ireland, while others will remain for a short time before returning home or moving to a third country. There are restrictions on family reunification rights for most migrants outside the EEA, with fewer restrictions for those who will be entitled to own the anticipated green cards, reserved for higher paid occupations. Further details in relation to this aspect will be available in the soon-to-be published Immigration Bill.
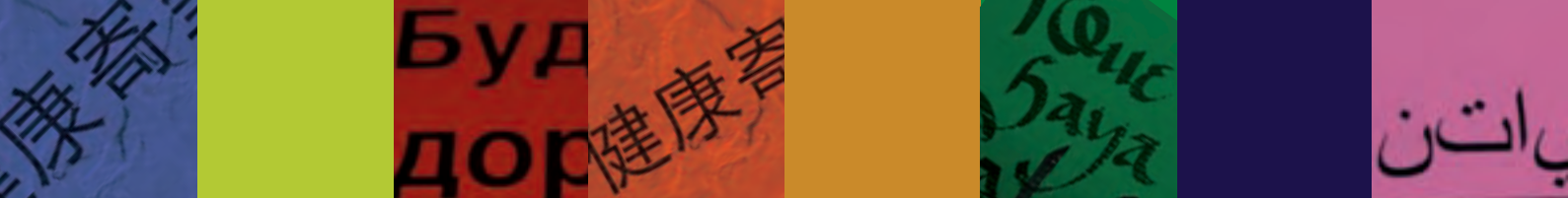
The pattern of migration into Ireland is similar to that experienced by other western European countries. "The classic two-tier nature of patterns of migration stands out, with a strong demand for high skills migrants in certain sectors such as medicine and high-end technology, and a substantial flow of migrants into unskilled or relatively unskilled sectors."[10]

The Habitual Residence Condition – the requirement to be habitually resident in Ireland as a qualifying condition for certain social assistance and child benefit – significantly restricts the access of migrants to Ireland to non-contributory social welfare benefits and linked services. However, amendments made in 2005 changed some of these restrictions to migrant workers, owing to potential conflict with EU legislation. Risks of homelessness for migrants who arrive in Ireland, unprepared for the high cost of living, and experience difficulty in finding employment, are becoming increasingly evident. Findings of a study being conducted by the Homeless Agency, in conjunction with Merchants Quay, are expected to inform further planning in this area.

Findings from the Migrant Rights Centre Ireland's (MRCI) Realising Integration indicate that migrant workers now account for 11% of the workforce. Migrant workers represent 28% of workers in hotels and restaurants, 13.4% of workers in the construction industry, 9.6% in wholesale and retail trade and !0% of care workers[11].

[10] MacEinri, P in Current Immigration Debates in Europe, 2005
[11] MCRI 2007

While it is true that many migrants working and living in Ireland are highly skilled and employed in well-remunerated work, some are in isolated situations, working within poorly regulated sectors, where they are especially vulnerable to exploitation. Workers in the agricultural, construction and domestic services sectors have been identified as being at particular risk in this regard. Poor working conditions may be compounded by sickness or injury with subsequent loss of income and increased risk of poverty and social exclusion. Research by the MRCI and the Immigrant Council of Ireland demonstrates that many migrants are deterred from using health services because of these barriers, coupled with other difficulties, including language and communication barriers, lack of knowledge of entitlements and difficulties in accessing GP services. *The MCRI reports that strategies adopted by migrants to counter these barriers include:*

- *waiting to return to their home countries to access treatment*

- *self medicating*

- *organising familiar medication to be sent via family and friends in their home countries*

- *using medical practitioners in Ireland who, while qualified in their country of origin, are not licensed to practise in Ireland*

Evidence exists that many migrants may work at levels that do not reflect their level of education and training. This is confirmed by the MRCI study, which revealed that, of the 70 participants who completed questionnaires or participated in focus groups, 57% had been educated to third level, while 41% had attended secondary or vocational school. Despite this, 40% earned €9 per hour or less, while 28% of the remaining 60% earned €10 per hour or less.

Experiences of integration revealed stark realities around living in Irish society, with 64% living in houses or apartment blocks where no Irish people live and 72% not socialising with Irish people outside of their work. Work experiences were often problematic, with 65% not having written contracts and 42% not having received sick pay. Accessing services or assistance was a particular issue, with 75% not being aware of mechanisms of accessing help or advice, and barriers reported in accessing health care.

The combination of low income, isolation and lack of information in relation to public services not only compromises health status but also creates additional barriers to accessing necessary health services.

5.3 Travellers

Irish Travellers are a small indigenous minority group with a unique shared history, culture, customs and language. Their distinctive lifestyle and culture, based on a nomadic tradition, makes them an identifiable group, both to themselves and to others. Travellers are not officially recognised by the Irish Government as a minority ethnic group but are described as a cultural group and are recognised by many expert and specialised bodies as an ethnic group. No national studies have been conducted on Travellers health since 1987, but some research has been carried out in recent years that suggests that the health status of Travellers has not improved and may even have deteriorated in relation to the settled population. It is acknowledged that the gap between the health status of Travellers and settled people has widened. This is borne out by the following statistics:

In the national census conducted in 2002, it was found that only 3% of Travellers were aged over 65 years compared to 11% of the settled population. The population pyramid developed in comparison with the national population age groups for 2002 would indicate that the gap between Travellers and the settled population still exists in relation to birth and mortality rates. In a study on Travellers using Tallaght hospital, it was found that only 2% of all the hospital patients were Travellers aged over 65 years, compared to 34% of hospital patients who were settled people aged 65 years and over. The Irish Sudden Infant Death Association's Annual Report 1999 states that the differential in the longitudinal rates of sudden infant deaths among Travellers was 12 times the rate among the settled population.

Irish Population Pyramid by Age and Sex (Source: CSO Census 2006)

Re-created by Pavee Point Travellers Centre
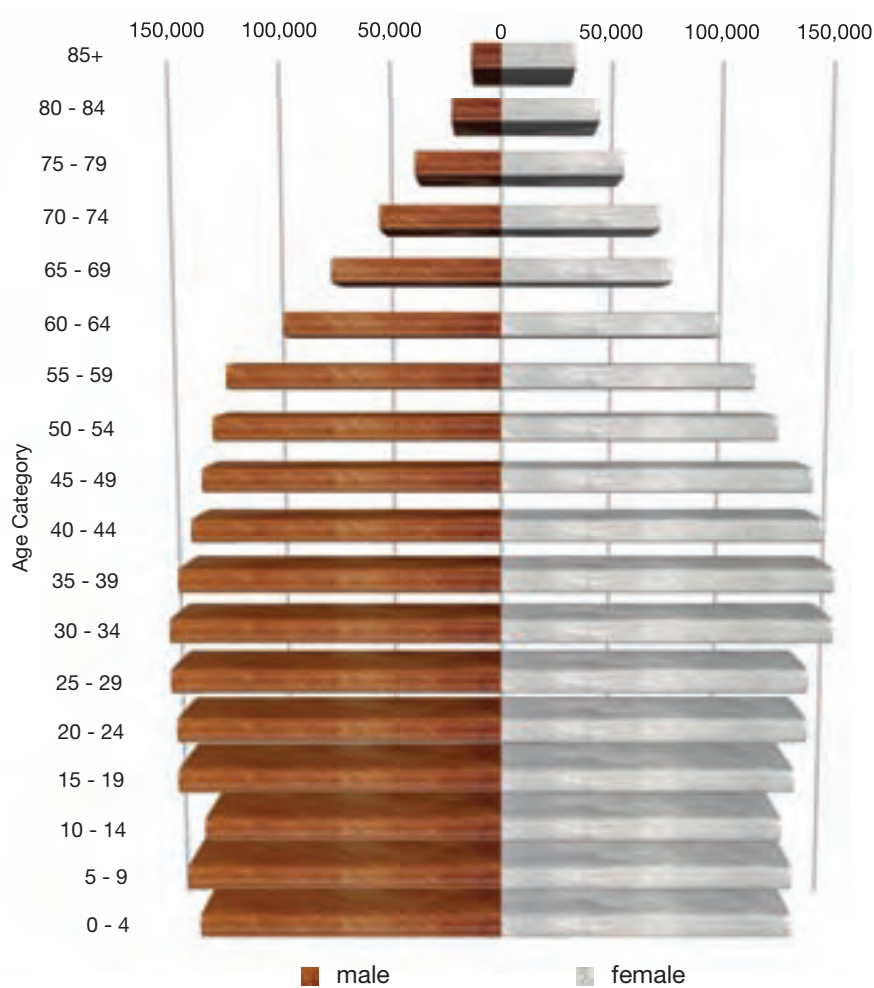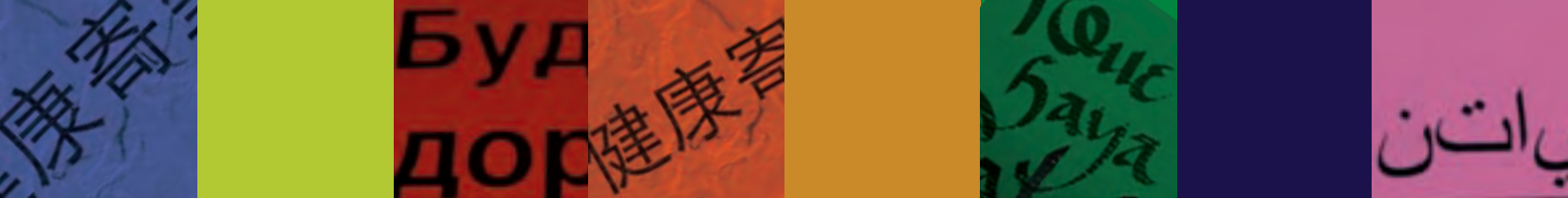
Traveller Population Pyramid by Age and Sex (Source: CSO Census 2006)

Re-created by Pavee Point Travellers Centre
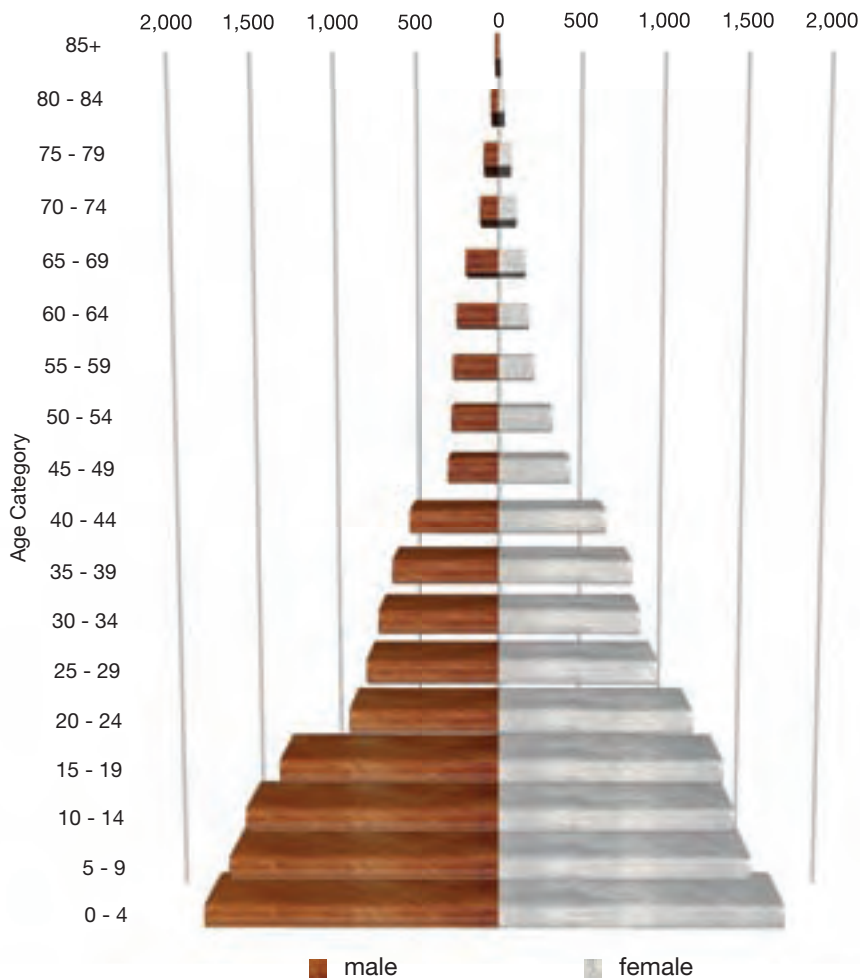
Figures from the 2002 census indicate that the Traveller population in Ireland totalled 24,000 or 0.6% of the population, while Census 2006 showed 22,345 Travellers, or 0.5% of the Irish population, living in Ireland. However, Traveller representatives and agencies working with this group report the figures being closer to 30,000. Census 2006 showed variations in Traveller population at county levels, e.g. County Longford shows the highest percentage at 15.8% per 1,000 persons (542 Travellers), followed by County Galway at 13.4% per 1,000 persons (3110 Travellers), while County Donegal reflected the lowest percentage at 2.5% (365 Travellers) of the Traveller population nationally. Census 2006 indicates that 15,195 of the 22,002 Travellers living in private households in 2006 lived in permanent accommodation. A further 5,489 lived in temporary accommodation, while 1,318 did not indicate the type of accommodation they occupied. Four out of 10 Travellers who responded to the Census question lived in temporary accommodation.

Newly published figures from the Department of the Environment as part of its annual count of Travellers, show there were 7,691 Traveller families in 2006 – an increase of 425 or 5.8% – compared with 2005's figures of 7,266. The number of families living on unauthorised sites or by the side of the road increased by 40 in the same period, from 589 to 629[12]. Living in such conditions is characterised by the absence of electricity, running water, toilet facilities and refuse collection.

The number sharing either official, serviced sites or houses has increased from 538 families in 2005 to 582 in 2006 – an increase of 44 families.

Travellers have a very distinctive population profile, similar to that seen in developing countries, where high birth rates and high mortality rates at a younger age combine to create a broad based population pyramid. This is reflected by the figure that Travellers have a median age of 18 years, compared to the national figure of 33 years. Older Travellers (those aged 65 years and older) accounted for just 2.6% of the total Traveller population, compared with 11% for the general population.

In 1983, the Travelling People Review Body proposed the regular and systematic collection of data on the health status of Irish Travellers. The publication of the *Travellers Health Status Study – Census of Travelling People 1986*[13] and *The Travellers Health Status Study – Vital Statistics of the Travelling People* 1987[14] (HRB, 1989:2) gave rise to considerable concern about the health status of the Traveller community. *These reports found that:*

- *the fertility rate of Travellers in 1987 was 34.9 per 1,000 – more than double the national average and the highest in the European Union*

- *Travellers have more than double the national rate of still births*

- *infant mortality rates are three-times higher than the national rate*

- *Traveller men live on average 10 years less than settled men.*

- *Travellers of all ages have very high mortality rates compared to the Irish population*

- *Traveller women live on average 12 years less than their settled peers*

- *Travellers have higher rates of morbidity for all causes of death*

Traveller health status is inextricably linked to living conditions. The detrimental impact on physical and mental health of poor accommodation, coupled with conditions of cold, damp, lack of basic facilities and overcrowding is evident.
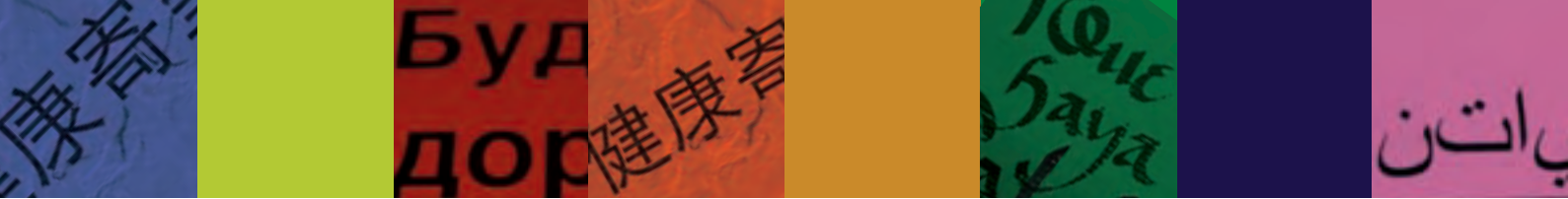
The Traveller Health Strategy 2002 – 2006 was launched in acknowledgement of the need to address the unique health inequalities experienced by the Traveller population. A number of positive actions were initiated on foot of this strategy, such as the establishment of Traveller Health Units.

A National Conference in 2006 on the mental health needs of minority ethnic groups in Ireland highlighted the mental health issues experienced by Travellers, with 41% of the cohort surveyed by the Donegal Travellers' Project having been diagnosed as suffering from depression. Suicide rates among Traveller men are reportedly higher than in the settled population. The compromised health status of Travellers is further compounded by a range of social determinants, most notably by poor living conditions, educational disadvantage and significant experience of racism and discrimination.

[12] Irish Times 25/05/07
[13] Health Research Board 1988:1
[14] IBID. 1989:2

Findings of the All Ireland Traveller Health Study, expected to commence shortly, are anticipated to provide key information around the health status and associated health care needs of Travellers. These findings should further inform any future Traveller health strategy or health policy.

5.4 Other Minority Ethnic Groups

While much has been documented in recent times in relation to the situation of asylum seekers, refugees and migrants, relatively little information is available around the health and care needs of people from established minority ethnic groups and cultures in Ireland, although anecdotal reports of language difficulties causing barriers in access and use of health services have been received. While Polish workers entering the country in large numbers are estimated to represent the largest minority ethnic group in Ireland, it appears from media estimates that the settled Chinese community, comprising approximately 60,000 to 100,000 people, is the largest established minority ethnic community in the country.

Foreign students from a range of cultures and ethnic groups constitute a significant service user cohort. The Garda Immigration Bureau recorded 31,338 student visas in 2004, of which 15,993 were issued to Chinese students.

Most foreign students arrive in Ireland for educational purposes and remain for a relatively short period. Again, little is known of their health needs. Research commissioned by NCCRI confirms that, while there are dense social networks existing among Chinese students in Ireland and between Chinese students in Ireland and their countries of origin, some social isolation does exist due to a combination of cohort effects and language barriers. This, together with the costs of accessing health services, may hold implications for health status and outcomes.

5.5 Irish-born Children

Following the Citizenship Referendum in 2004, changes in citizenship provisions were enacted in the Irish Nationality and Citizenship Act 2004, which was commenced on 1 January 2005. From that date, it was no longer possible for persons born in Ireland to obtain automatic Irish citizenship. New procedures were announced regarding the consideration of claims for permission to remain in the State from the non-national parents of Irish-born children. Via the special scheme then operated by the Department of Justice, Equality and Law Reform, non-national parents of Irish-born children born in the State before 1 January 2005 could apply for permission to remain in Ireland on the basis of such parentage. As of 31 January 2006, of the 17,917 applications submitted under this scheme, 16,693 were approved and 1,119 given refusal decisions. The breakdown of the status of approved applications comprised 10,032 asylum seekers, 2,455 "workers" and 972 students. The remaining 3,243 comprised people from a range of categories, including people residing illegally, people of whom the DJELR was previously unaware and so on.

5.6 Undocumented Migrants

Illegal or irregular migration is known to be present in Ireland. However, due to their irregular status, little information is available in relation to this group. This category may include people who have entered the country legally but are working without a legal right to do so and persons who have entered the country illegally. People in this cohort may become undocumented via a number of channels, including the asylum process, work permit system and educational migration. This renders this group particularly vulnerable, often living in substandard and overcrowded accommodation, forced to work in low-paid unregulated settings in order to survive. Members of this group have no eligibility to receive medical services other than in emergency situations. The lack of easy access to health care is proven to have serious consequences for both undocumented migrants and public health in general. Children of undocumented migrants are in an especially vulnerable situation, while other subgroups at risk include pregnant women and people with chronic diseases. The irregular status of people in this group, together with associated fears and reluctance around accessing health services, holds serious implications for their health status.

From a service provider perspective, feelings of conflict and confusion may characterise encounters with members of this cohort. In practice, it appears that it often falls to NGOs to assist undocumented people in accessing essential health care. Acknowledging the impact of immigration status on health, some exploration of the issues involved around this, together with the best practice solutions found in other countries familiar to this situation is necessary.

5.7 Additional Risk Factors for Minority Ethnic Communities and Cultures

Within diverse cultures and minority ethnic groups, subgroups may be regarded as being particularly vulnerable. Multiple intersecting aspects are relevant here, so that, for example, a woman from a minority ethnic group with a disability or a man from this community who is gay may be at increased risk of social exclusion. While it is not feasible to document all those groups and subgroups with specific vulnerabilities, those populations listed below may be considered to require special attention in any discussion of policy and its anticipated effects:

Gender

The acknowledgement that men from diverse cultures and ethnicities may experience barriers in accessing health care is reflected in the anticipated publication of a National Men's Health Policy. This document will call for a gender-sensitive approach to service provision. Notwithstanding the issues encountered by men in using health services, there is no doubt that women from all minority ethnic groups and cultures are a particularly vulnerable group. Gender is recognised by the WHO as a key determinant of health. Research confirms that women from minority ethnic communities often experience significant ill health due to a variety of reasons mainly linked to the negative aspects of migration. In addition, women have been found to be disproportionately affected by the stress suffered by families on migration to a different country because of their role as cultural and intergenerational mediators responsible for the continuation of cultural traditions and gender roles. Traveller women share strong commonalities with these experiences.

The situation of women from minority ethnic groups may be compounded in circumstances where they are isolated, without extended family support, or belong to cultures where they are traditionally not encouraged to assume responsibility for their own health and support needs.

Circumstances of asylum seeker or refugee women may be particularly harrowing, as their traditional roles may have been disrupted, forcing them to take on additional roles and responsibilities, including that of lone parent, head of household or caring for children in an unfamiliar, often hostile environment. Where a male partner is also experiencing effects of stress, the situation is exacerbated.

All such situations place women at increased risk of poverty, physical assault, sexual harassment, rape and violence. In some minority ethnic communities, women are less likely to be literate, which further disempowers them, while, in situations where a woman's asylum claim is linked to that of her husband, she may be significantly compromised. Similar risk occurs where a woman's presence in Ireland is tied to her partner's employment status.

In minority ethnic communities where men are traditionally spokespersons for the family, the health and social support needs of women may seldom be identified or acknowledged. While little data is available in Ireland around the health needs of women from minority ethnic groups and cultures, it is acknowledged that this group reports increased levels of depression and poor health.

Issues around maternity and reproductive health are also reported to be emerging areas of concern. In most cultures, including Ireland, rape and domestic violence are taboo issues, and women who have experienced such violation are less likely to seek help or treatment. Unwanted pregnancy and / or sexually transmitted infections may be a result of sexual violence, further isolating women in such circumstances.

Anecdotal evidence points to migrant women accessing unsafe or backstreet abortions. This is due to the legislative ban on termination of pregnancy in Ireland and the fact that, because of their precarious residence status, many women are afraid to travel to their home countries for such terminations.

Evidence of trafficking of women for sexual exploitation and bonded or forced labour is also beginning to emerge and requires further exploration.

Some countries may engage in practices that are considered unacceptable in Ireland, such as female genital mutilation. Anecdotally it appears as though this may persist here, although there is currently little evidence to confirm this.

Children

The health and support needs of children from minority ethnic groups are varied and multidimensional, depending on their individual and particular circumstances. While children of long-standing ethnic minority communities may be fully integrated into all aspects of community life, other less-resilient children may experience distinct health and care needs. Depending on the level of supports available, some children living in direct provision settings have access to preschool or crèche facilities. The situation of school-going children in direct provision may be particularly difficult, where they encounter difficulties in participating in extra mural activities, completing homework and socialising on an equal basis with peers. Children from asylum seeking families may be particularly vulnerable, while children moving out of the direct provision system may be at additional risk of poverty. A number of children from families who are seeking asylum have witnessed or experienced traumatic events and a series of losses in reaching Ireland. They may present with a variety of vaguely defined symptoms, including non-specific physical conditions, developmental delay or behavioural difficulties. The physical and mental health needs of their parents in this situation further influence their well-being, while language, cultural and educational barriers may combine additionally to compromise adjustment to a new society and way of life.

For those families of diverse cultural and ethnic backgrounds settling in Ireland, the way of life of Irish society may present challenges to familiar, traditional ways of parenting. Clashes of culture around child-rearing practices may prove particularly problematic as understanding of discipline varies between cultures. Issues of child protection may arise in extreme cases. Children may also experience difficulties in assimilating new practices and behaviours while wanting to retain their own cultural and ethnic identity.

Traveller children are also at severe risk in terms of health and well-being, with inadequate accommodation and living arrangements being a key factor in this situation. The report Caring for Diversity[15] suggests that, until basic inequalities affecting Traveller children are addressed, it is likely that Traveller children will be over represented among the population of children receiving welfare and protection services. Traveller children may also face significant barriers around participating in all dimensions of education, with clear implications for future development and well-being.

Unaccompanied minors / separated children who apply for asylum in their own right, without family members or guardians to care for them, may experience a wide range of complex care and support needs around their physical, psychological, emotional and vocational well-being. These children and adolescents are accommodated in residential settings on the same basis as Irish children in care. Young people aged between 16 and 18 may live in hostels. Interim datasets of the Department of Health and Children's Childcare Division indicate that, of the 759 separated children seeking asylum in Ireland in 2002, 427 (56.2%) were reunited with family, while 282 (37.1%) were placed in care. The remaining 73 (9.6%) were not accounted for. Similar figures are reflected for 2003, with 465 (53.1%) of 858 children being reunited with family, 285 (33.2%) placed in care and 117 (13.6%) in a category marked "other".

As numbers of adults seeking asylum in Ireland have decreased, so too has there been a decline in numbers of separated children seeking asylum. Figures for February 2007 to end May 2007 show a referral of 98 separated children; 56 family reunifications were effected, while 39 children were placed in care.

Although the resilience of this cohort and, indeed, of children generally is acknowledged, this remains a very vulnerable group. Those young unaccompanied children with educational or literacy difficulties require responsive, coordinated interventions, while pregnant young unaccompanied mothers are in need of a range of supports.

Serious concerns are emerging around the situation of aged out minors who leave residential accommodation at the age of 18 and, without adequate follow up and support, are at risk of a range of social ills; a number of anecdotal accounts of members of this cohort engaged in prostitution have been received.

Child trafficking and related exploitation and abuse of children is emerging as an additional issue in this area.

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[15] Traveller Health Unit Eastern Region (2006), Caring for Diversity

6. Consultations Informing the Strategy

Real participation within a climate of equality and partnership was a key consideration in the development of this strategy. The need to engage meaningfully with service users and service providers is a recurrent theme within the transformation process taking place in the HSE and is an intrinsic principle of any work within a social inclusion context. Extensive national consultations took place with service users, statutory and voluntary sector, NGOs and HSE staff in informing the development of the Intercultural Strategy. All themes emerging from the consultation process have been reflected in the report of the consultations and are incorporated, as far as is possible, into this strategy.

6.1 The Consultation Process

A wide-ranging national consultation with service users and service providers took place from May 2006 to January 2007. Full details of this process are contained in the Consultation Report, which accompanies this strategy. A pre-consultation exercise commenced in May 2006 in which interested stakeholders were invited to forward their views around the current provision of health and support services to persons from diverse cultural and ethnic backgrounds together with suggestions around the enhancement of the development of these services. This process was advertised mainly through HSE networks and community websites, while each member of the Steering Group also circulated relevant information around this to their own constituencies. A total of 126 responses was received.

The views and information submitted via this process were then used to shape a series of focused questions to be used in the subsequent major consultation events. These events were extensively advertised through HSE communication channels, community networks and mainstream media, with invitations to these events circulated in English, Chinese, Arabic, Polish, Russian, French and Spanish. Supports around interpretation and childcare were offered to facilitate optimal participation by service users in the consultations. At the same time, Steering Group representatives continued to actively circulate information to their own networks and to support their members in participating in the consultations.

A series of consultations for service users as well as for HSE staff were held during November and December in Galway, Sligo, Limerick, Cork, Dublin and Dundalk. A total of 121 service users and 105 service providers attended these events.

A broad range of people attended the consultation events, with Travellers and asylum seekers being particularly strongly represented at the service user consultations. HSE staff who participated in these consultations also represented a range of disciplines, with people involved in direct service delivery, including public health nurses, therapists, and medical doctors especially prominent. A list of participants is found in the Appendix.

The format of the national consultations was one of service users and members of the voluntary sector attending morning consultations, and HSE staff participating in the afternoon sessions. Questions for each session were the same. Participants worked in small, facilitated groups, using the questions as themes for discussion and suggestions. Feedback was provided to the overall group by designated reporters, with all comments being documented for use in the Consultation Report.

All consultation events raised the following questions as a focus for discussion:

- *What are the main barriers and problems experienced by people from minority ethnic communities in accessing health services?*

- *How can design and delivery of health services be improved so as to enhance the health and well-being of people from minority ethnic groups?*

- *What do you think are the three most important things that the health services should consider / address in the planning and delivery of services to people from minority ethnic groups?*

- *What support can be given to minority ethnic groups and organisations to enhance the access to health services of people from diverse cultures and minority ethnic groups?*

Conscious that no service user should be excluded from the process, other consultative mechanisms were utilised to ensure that more vulnerable, less visible service users could be afforded opportunities to express their views. A series of individual interviews with undocumented migrants and migrant women, among others, were held, while a number of focus groups were also held, many of which were facilitated by NGOs active in the field of ethnic minority health, such as Spirasi, Cáirde, Access Ireland and Pavee Point. Further consultations and events funded and supported by Combat Poverty Agency and hosted by Pavee Point and Cáirde took place with Travellers and with members of the Ethnic Minority Health Forum respectively. A broad survey, aimed at capturing the views of service users from a range of communities across the country, was facilitated by the Immigrant Council of Ireland. These surveys were conducted with members of Polish, Lithuanian, Slovakian, Brazilian, Nigerian, Congolese, Burundian, Angolan, Cameroon, Muslim and Sikh communities. The survey covered 270 migrant workers from nine communities.

From a policy perspective, a seminar was hosted by the National Consultative Committee on Racism and Interculturalism (NCCRI), during which representatives from a range of sectors including Justice, NCCRI, Women's Health Council, MCRI, HSE and the ESRI discussed issues relevant to the provision of ethnic minority health. Written submissions were also invited and 25 written submissions were received.

A Literature Review was commissioned from University College Dublin, designed to inform best practice in the provision of health care and support to people from a range of cultures and ethnic communities.

Regular updates around overall progress of the strategy were provided via the same networks.

6.2 Report of Consultations

A detailed report of all the consultations has been published in a number of the languages spoken in Ireland and is available either separately or with the strategy. This report contains direct accounts of service user and service provider experiences and views, and is most usefully read in conjunction with the strategy.

All participants have been acknowledged in both documents.

6.3 Key Messages from the Consultation Exercise

The consultations encouraged an open, frank expression of views from service providers and users alike. The summary below reflects outcomes of the group presentations within the regional consultations and the discussions of various focus groups with stakeholders, as well as findings of surveys conducted and written submissions received. It outlines the key messages communicated via this process.

- The consultations found that migration to Ireland has brought many benefits to the economy. However, established minority ethnic groups, including Travellers, as well as people that have recently migrated, experience higher levels of social isolation and exclusion, and greater barriers in accessing services than the majority population. Health services will need to play a key role in the integration of migrants into Irish society. The consultations confirmed the need for a comprehensive strategy in line with the framework for the integration of migrants outlined in the National Action Plan Against Racism. The groups and organisations that contributed to the consultation for the strategy welcomed the strategy

- Implementing the strategy will require specific attention to the enhancement of the cultural competence and capacity of service providers in the HSE, including language and communications and in improving access to information and services. Communities also need to be empowered, through community participation and community development, so that they can be better informed and resourced to improve access to health services and improved health outcomes. This will require ongoing additional resources, a commitment from the top of the organisation to implement the strategy and a continued dialogue with minority ethnic communities in Ireland

- The strategy should be informed by the principles of human rights, equality, inclusion, involvement and participation of minority ethnic communities, community-based approaches, partnership, accountability and accessible high quality services for all. This should encompass a broad-based approach to health, including measures to address inequalities in health and the social determinants of health

- The implementation of the targets, objectives and principles in the National Health strategy, Quality and Fairness: A System for You (2001), was seen as very relevant to the development of an inclusive and equitable approach to the provision of quality health care services to minority ethnic groups. The principles of equity and fairness, a people-centred service, quality of care and clear accountability were cited by many groups as being important underpinning principles that needed to be realised in the Intercultural Strategy. The priorities of reducing health inequalities and providing equitable access to health services on the basis of need are considered to be particularly important, the full implementation of which could substantially enhance the possibility for services to be provided in culturally competent and inclusive ways

- The implementation of the Traveller Health Strategy, Traveller Health, A National Strategy (2002 – 2005) was viewed as a comprehensive strategy to address Travellers' health issues that needed to be fully implemented and further developed

- A key factor will be to enhance the engagement of migrant communities themselves, particularly through peer-led and community development approaches. Providing resources for migrant-led and community organisations will need to increase if there is to be a wider engagement with migrant communities in the future. This should also be developed through effective systems in the HSE for the involvement and participation of people from and organisations representing migrant communities in the planning, delivery, monitoring and evaluation of services

- *There needs to be more attention given to the vulnerability of those migrants living and working in Ireland who experience poverty, poor living conditions, social exclusion, racism and poor access to employment, particularly well-paid and secure employment. In particular, the vulnerability of unaccompanied minors, spouses of work permit holders and migrant workers who do not fulfil the Habitual Residency Condition raise important challenges for Irish health and social policy*

- *Specific issues were raised about the need for a gender-based approach in order to identify issues that are unique to minority ethnic women regarding full access to services around childcare and maternity health, and specific targeted support and outreach programmes for women who are socially isolated and at risk of abuse or violence*

- *There are many examples of good practices already in place that are a basis for learning and development. In local communities, these include peer-led schemes, community development approaches, cultural mediation, advocacy and the development of community health networks. In the HSE, this has included the development of intercultural projects designed to enhance service delivery, staff training and capacity building, and pilot projects in the areas of an interpretation service for GPs and an ethnic identifier for the utilisation of health services.*

6.4 Summary of Suggested Priorities and Areas for Development

The consultation process asked participants at the workshops and those providing written submissions to summarise their three main priorities for the Intercultural Strategy.

The main priorities identified through the consultative process are grouped into four main areas:

Priority 1: Information, language and communications

- *Information: accessible information, advice, advocacy and cultural mediation*

- *Language and communications: professional interpretation and translation service; provision of training for community interpreters*

Priority 2: Service delivery and access to services

- *Equality of access: access to services and specific emphasis given to enhancing access to GP services, children's and family services, hospital and community-based services, mental health services and other front-line services*

- *Coordination of services: intersectoral and coordinated actions that draw on the wider determinants of health, linking with education, training, work, housing and social welfare*

- *Developing a population health approach: address the social determinants of health and links to health inequalities*

Priority 3: Changing the organisation

• *Organisational culture: change the organisational culture to reflect a multicultural society; commitment from the leadership of the organisation and mainstreaming of interculturalism and equality throughout the organisation*

• *Human resources: recruitment of ethnic minority staff*

• *Learning: learning and development of staff, peer-learning networks, training, awareness tools and resources, learning from and building on what works*

• *Data and monitoring: the development of indicators on minority ethnic health outcomes (qualitative and quantitative), including evidence of progress and monitoring of the strategy; ethnic identifier, monitoring and data collection on service utilisation and quality of service*

Priority 4: Working in partnership with ethnic minority communities

• *Supporting community groups: support for minority ethnic community groups as co-producers of services, community-based planning and development approaches that link to the wider determinants of health*

• *Participation and user involvement: provide for ongoing participation and involvement of minority ethnic communities in the design, delivery and monitoring of services, e.g. through a consultative forum, as well as regular feedback on the implementation of the strategy*

These priorities, together with issues emerging from the written submissions and Literature Review, are addressed, with associated recommendations, in Chapter 9.

6.5 Additional Learning from the Consultations

A number of recurrent themes permeated the discussions in the consultations. While some differences existed among service users, providers and HSE staff based on their individual needs and geographical situation (particularly with respect to those in rural locations), the general themes are grouped above and are discussed in detail in Chapter 9.

Other learning from the consultations arose around the process of consultation itself. The mechanisms of consultation used regarding the development of the strategy were aimed at maximising participation from a traditionally excluded cohort of service users. The learning from the innovative models used during the process is detailed in the Consultation Report. However, an aspect particularly relevant to future strategic collaboration with service users is that of the development of robust mechanisms of providing support for service users to contribute to consultations. With the participation of service users a critical component around informing development of the strategy, all means of facilitating their involvement should be encouraged. Support in this respect may include provision of interpretation services and assistance with childcare, transport and related costs incurred in attending consultations.

One outcome of learning from the overall process was the development of a consultation checklist, which provides a means of ensuring accessible, appropriate planning and management of consultations with service users from all groups, with particular reference to socially excluded cohorts.

Learning from the consultation process will inform ongoing work with communities in terms of supporting their participation in similar events.
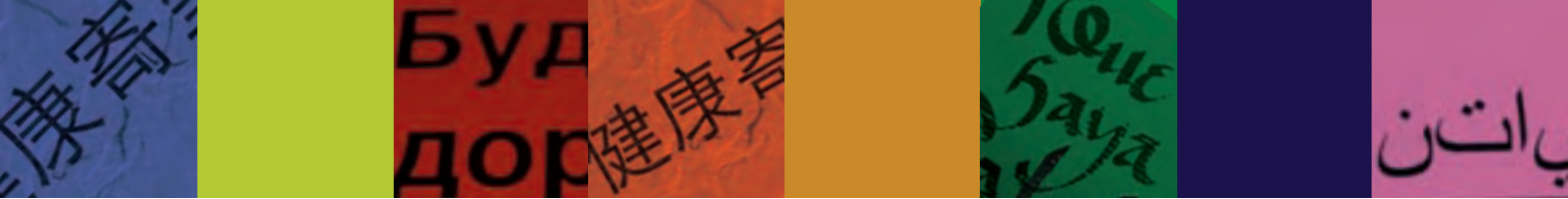
7. Policy Frameworks

Growing worldwide migration and mobility, increasing awareness of the urgency of achieving integration of newcomers, developing understanding of the role of health inequalities and enhanced attention to aspects of equality all contribute to the development of a range of European and national legislative, social and health policy frameworks that underpin the planning and delivery of appropriate health care and support services to persons from minority ethnic groups.

The following acts, policies and strategies are most relevant within the context of the health of people from diverse cultures and ethnic groups.

7.1 Legislation

Equal Status Acts 2000 and 2004

These Acts promote equality of opportunity and prohibit discrimination, sexual harassment / harassment and victimisation in the provision of goods and services, accommodation and education across nine equality groups. Within an Irish legislative context, these Acts confirm that discrimination in relation to access to, and the provision of services on these nine grounds, including race and membership of the Travelling community, is outlawed. Furthermore, the Act allows for positive action to cater for the needs of disadvantaged groups or persons who may require services, facilities or assistance.

Employment Equality Acts 1998 and 2004

These Acts serve to complement the Equal Status Act above and outlaw discrimination in relation to access to and the conditions of employment on the same nine equality grounds, including race, religion and membership of the Travelling community. Under this legislation, service providers and employees may provide preferential treatment or take positive measures that are genuinely intended to promote equality of opportunity for those who are disadvantaged.

7.2 Social Policy

Much international and European policy around poverty and social exclusion has relevance to the situation of minority ethnic groups in Ireland. Addressing health inequalities and developing associated strategies around these has formed part of ongoing work of the World Health Organisation (WHO). The Health 21 Targets of WHO contain specific targets around reducing health inequalities of social groups; here, the target of "people having special needs as a result of their health, social or economic circumstances should be protected from exclusion and given easy access to appropriate care" is pertinent to minority ethnic health.

Within Europe, a wide range of policy documents focuses on the key issues required of member states to address and reduce identified health inequalities. With acknowledgement that vulnerable groups face additional barriers in accessing services, including health services, much attention is focused on improving access for all users to public services. The EU's Joint Report on Social Protection and Social Inclusion[16] (European Commission, 2005) addresses priority issues and actions around access to quality services, discrimination experienced by groups and aspects of integration of disadvantaged groups, including ethnic minorities and immigrants.

[16] EC

A key EU policy development is the National Action Plan against Poverty and Social Exclusion, which provides a common social inclusion framework within which member states are required to develop and report on strategies and associated targets aimed at reducing social and health inequalities, and the poverty and exclusion resulting from this. Further mention of this plan, as it applies to the Irish context, is made above.

Within an Irish context, a number of broad, overarching documents provide a strategic framework governing the nature and direction of major national social and economic strategies. Social partnership is a key concept in the formulation of policy in Ireland, with a succession of multiannual agreements determining policy in key areas, including social policy. A focus on building an inclusive society characterises much social policy in this regard. Key policies relevant to the situation of different cultures and ethnic groups include:

Sustaining Progress

Social Partnership Agreement 2003-2005: This document expresses commitments towards the building of a fair and inclusive society for all via various means, including actions aimed at reducing health inequalities, improving access to public services, and ensuring equality for all. Health services are specifically mentioned in this context. The modernisation clause of Sustaining Progress also contains Action / Commitment 10: "The Public Service will continue to build on the significant progress which has been made in regard to policies on equality and diversity in order to promote equal opportunity in all aspects of civil and public service employment."

Toward 2016

This new Social Partnership Agreement follows that described under "Sustaining Progress". It outlines a new framework within which key social challenges have been developed around a lifecycle approach. This offers a streamlined, cross-cutting and visible approach to tackling poverty and social inclusion, as well as supporting improved social protection. The introductory overview to this document contains a statement of overall goals, including one of more successfully handling aspects of diversity, including immigration.

National Action Plan against Poverty and Social Exclusion

The strategic approach of this document towards combating poverty and associated social exclusion embodies a recognition of the complex multifaceted nature of poverty and emphasises the need for a coordinated cross-sectoral response to this. The revised plans for 2002-2007, Building an Inclusive Society, aim, among other things, to address poverty and social exclusion among migrants and to tackle barriers to their integration. The newly published National Action Plan on Social Inclusion (NAP inclusion) 2007-2016 for the Irish context, states that access to quality health services is a prerequisite for participation in the social and economic life of society and cites the importance of the National Intercultural Strategy in addressing the unique health and support needs of minority groups, such as Travellers, refugees and migrants.

National Action Plan against Racism: Planning for Diversity 2005 – 2008

This document, developed by the Dept of Justice, Equality and Law Reform was launched in 2005 in accordance with commitments made by Ireland at the World Conference against Racism in 2001. The overall aim of the plan is to provide strategic guidance to combat racism and to develop a more inclusive, intercultural society in Ireland, based on a commitment to inclusion by design and based on policies that promote interaction, equality of opportunity, understanding and respect.

The plan provides a template that should guide the implementation of a range of Government initiatives. One of the five primary objectives underpinning the NPAR is stated as: "Accommodating diversity in service provision, including a focus on common outcomes, education, health, social services and childcare, accommodation, and the administration of justice." From a health service perspective, this objective is particularly relevant, with it's proposed focus on measuring outcomes, rather than on a one-size-fits-all approach.

The focus on specific policy areas within this objective includes an expected outcome for health of the "development of a National Intercultural Health Service Strategy with reference to equality / diversity policy". Other relevant outcomes detailed in the NPAR include actions around data collection, active promotion of participation / consultation with cultural and ethnic minorities, and proactive work to address health inequalities among these groups. Overall expected outcomes for health, social services and childcare are:

- *the development of a National Intercultural Health Service Strategy with reference to equality / diversity policy*

- *the building of an intercultural dimension into health impact assessments*

- *the development of a more inclusive, intercultural approach to social service provision, with reference to equality / diversity policy*

- *the development of a more inclusive approach to childcare policy, with reference to equality / diversity policy*

- *the development of proactive strategies to address health inequalities*

- *evolving data systems with health, social services and childcare provision to accommodate cultural diversity*

- *the enhancement of participation / consultation with cultural and ethnic minorities within the health, social service and childcare sectors*

7.3 Health Policy

The most relevant policies in the health arena are:

National Health Strategy

Quality and Fairness 2001: Guided by Core Principles of Equity, People-centeredness, Quality and Accountability, this document contains a number of recommendations and actions aimed at targeting health inequalities, especially as they apply to socially excluded groups with special health and support needs. Specific reference is made in the strategy of the need for improvement in Traveller health, while mention is made of specific initiatives around the health of asylum seekers and refugees. The strategy emphasised the need for the health system to reflect and respond to the increasing diversity in Irish society. A commitment was made in the strategy that services will be provided in a culturally sensitive way as an integral part of the service provided to the wider community.

Primary Care Strategy 2001

This emphasises the commitment of the health system towards ensuring a more equitable, accessible, appropriate and responsive range of quality basic health and personal social services for all. The role of community involvement in the planning and development of appropriate services was emphasised in the strategy.

National Health Promotion Strategy

This acknowledged the need to develop appropriate, sensitive, responsive health promotion programmes to facilitate the improvement in health status and social gain of all persons from traditionally excluded or disadvantaged groups.

Traveller Health Strategy 2002 – 2005

This strategy provides for a series of targeted actions aimed at improving the health of the Traveller population. A number of outstanding actions from this strategy still need to be implemented. Findings of the All Ireland Traveller Health Study are expected to inform development of future Traveller health policy.

Action Plan for People Management 2002

The Action Plan for People Management entails a number of Human Resources actions to support the implementation of the National Health Strategy: Quality and Fairness. The plan contains specific actions relating to the promotion of diversity and equality measures in employment practice.

National Health Information Strategy: 2003

The primary aim of this strategy is to put frameworks in place to facilitate optimal development and utilisation of health information. A stated objective is promotion of an integrated, national approach to the development and expansion of information sources and systems to best meet strategic health information needs.

Vision for Change: Report of the Expert Group on Mental Health Policy 2006

This report provides a comprehensive framework for building and fostering positive mental health across the entire community and for providing accessible, community-based specialist services for people with mental illness. Much attention is paid to the nature and effects of social exclusion in this document, with mention made of the unique requirements of service users from diverse cultures and ethnic backgrounds for the provision of sensitive, culturally appropriate mental health services.

National Women's Strategy 2007-2016

This recently published strategy contains a range of broad objectives around its vision of "an Ireland where all women enjoy equality with men and can achieve their full potential, while enjoying a safe and fulfilling life"[17]. While there is little specific reference to the situation of women from diverse backgrounds, its wide-ranging actions around ensuring the well-being of women, equalisation of socioeconomic opportunity and facilitating engagement as equal and active citizens have a direct bearing on the care and support needs of this group.

Other Strategies

Given the interrelatedness of factors that have an impact on health, many more broad strategies and policy documents may be regarded as relevant to minority ethnic health. While it is not practical to detail each of these, examples of such strategies range from the Cancer and Cardiovascular Strategies, and National Drugs Strategy to the National Children's Strategy, National Suicide Strategy and the National Breastfeeding Strategy.

[17] National Women's Strategy 2007

Values & Principles underpinning the Strategy?

The National Health Strategy: Quality and Fairness defines a framework of service delivery where principles of equity, accessibility, quality and accountability are fundamental to all aspects of the planning, development and evaluation of services. Intrinsic to such an approach is the acknowledgement that each individual is at the centre of the health system and should be treated with respect and dignity. The central importance of these overall principles in enabling service users to access and use services was confirmed throughout the consultation process.

Additional values and principles are core to development of an Intercultural Health Strategy, where service users from a range of ethnic backgrounds and cultures may have specific vulnerabilities and associated care and support needs that require specific knowledge, insight and responsiveness on the part of those providing health services. Key principles and considerations informing development of the strategy are detailed below.

8.1 Intersectoral Collaboration

Given the wide-ranging nature of socioeconomic determinants and their impact on health status, a comprehensive, cross-cutting approach is necessary to ensure that different agencies collaborate in addressing risks and casual factors associated with poverty and inequality. This is consistent with the National Health Strategy, which confirms that "achieving full health potential does not depend solely on the provision of health services…one aim is to ensure that health is given priority across all the sectors with a role to play in improving health status…" In this context, a key principle underpinning the Intercultural Strategy is a HSE commitment to such cross-sectoral and intersectoral collaborative work aimed at reducing the effects of social exclusion on the cohort of service users from minority ethnic backgrounds, and actively promoting their inclusion and associated health outcomes. The HSE plays a leading role in this aspect, with its Transformation Programme confirming a commitment to the development of an organised approach to working collaboratively with the statutory and voluntary sectors, including working with other Government departments. Bodies such as the National Traveller Health Advisory Committee, the High Level Group on Travellers and the Interdepartmental Working Group on Refugee Resettlement and Integration provide relevant examples of such cross-sectoral collaborative working. Continued efforts towards the development of joined-up, coordinated approaches within and between sectors at national, regional and local level are critical to achieving integrated, sustainable solutions to combating the social exclusion experienced by several groups, including people from minority ethnic groups.

Within this context, the HSE should play an advocacy role, where appropriate, in promoting cooperation with relevant sectors regarding the risks associated with certain policies or actions. In this regard, strong advocacy with the Justice sector around exploring / understanding, and working to counteract the potentially harmful health-related effects of direct provision on the mental and physical health of asylum seekers, is a particularly relevant instance. The recently established HSE / RIA Strategic Forum provides an appropriate platform for ongoing collaboration on a range of issues affecting the physical and mental health of asylum seekers and refugees.

Similarly, the negative impact of the continuing lack of provision of appropriate accommodation on Travellers' health will be emphasised in ongoing interactions with the Department of Environment, Heritage and Local Government. The HSE will also continue to highlight the potentially detrimental impacts on physical and mental health of the period of time taken around the recognition of an entitlement to work of asylum seekers.

Other collaborative intersectoral work should involve the support of measures designed to facilitate the integration of people from minority ethnic groups into Irish society. The provision of support towards English language classes might be a positive action here.
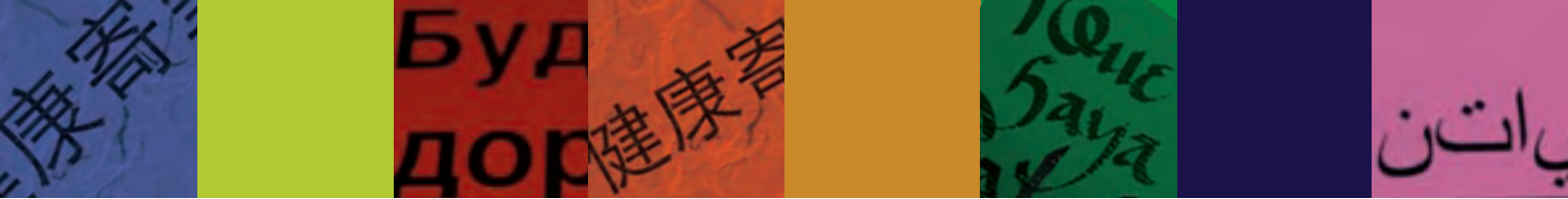
8.2 Equality and Targeting

The objective of achieving full equality for all service users in accessing and using services lies at the heart of this strategy. "Providing services that are efficient, effective, culturally sensitive, equal, and that value equality and diversity leads to an overall improvement in quality of service provision and meets the diverse needs of a range of service users."[18]

The HSE's *Equal Status Acts 2000 to 2004 and Provision of Health Services* booklet, produced in collaboration with the Equality Authority, highlights a commitment to equality and the further development of equality competence in the provision of health services. Central to such a principle is the identification and elimination of inequalities that form barriers to achieving equality. Issues around equality should be considered in all aspects of the design and implementation of services, with adjustments effected around diversity to ensure full equality. Associated initiatives such as equality-proofing and health impact assessments form key tools of this approach, with particular attention paid to the effects of multiple discrimination caused by intersection of grounds outlined in equality legislation. Equality- and poverty-proofing are key to ensuring that policies do not have a negative impact on people from diverse ethnic and cultural backgrounds.

A whole system approach to the provision of health services to a culturally and ethnically diverse population demands that elements of mainstreaming and targeted approaches be considered for the health service to ensure equality of access, participation and outcomes. Designing services for the majority of the population may have the effect of inadvertently discriminating against certain groups, including minority ethnic groups, through neglecting to recognise and respond to their particular needs and circumstances. While mainstream healthcare is the primary vehicle through which all service users should be enabled to access care and support, it may be necessary to develop additional programmes that target the specific needs of this group. Interpretation services designed to reduce barriers to communication in accessing and using health services are a particular example. However, any targeted programme designed to overcome the inequalities experienced by minority ethnic groups should be informed by an evidence-based approach and should demonstrate clear, explicit objectives and expected outcomes, with associated ongoing monitoring around it's effectiveness

[18] Pillinger

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8.3 Interculturalism and Anti-racism

Racism, whether overt, covert or unintended, has a negative impact on the health of people from minority ethnic communities. Ethnocentrism and racism have also been highlighted as contributing factors to health inequalities. Direct racial discrimination occurs when a person or body treats someone less favourably than others on racial grounds. Racial grounds may be defined as grounds of colour, race, nationality, ethnicity or national origin. Indirect discrimination occurs when a condition or requirement, which is applied equally to everyone, cannot be met by a considerably smaller portion of people from a particular racial group, to their subsequent disadvantage.

Racism is likely to have an impact on different minority ethnic groups in different ways. Ferry (2007) states that racism and discrimination are commonly experienced on the basis of ethnicity but with different consequences for different communities that can be translated, in the Irish case, into a hypothesis that racism in Irish society has a differential impact on migrants from different backgrounds. Experience of racism may have a devastating effect on sense of belonging within a society, relationships of trust and overall well-being. Experiences of racism and discrimination by Travellers are frequently reported, with a similar impact on mental health and well-being. This has implications for ways in which health services are accessed and the stage at which they are accessed.

Planning for Diversity: National Action Plan Against Racism confirms that racism has no place in any sector of Irish society. It proposes the application of an intercultural approach, which includes the development of strategy, policy and practice that promotes interaction, understanding, respect and integration between different cultures and ethnic groups on the basis that cultural diversity is a strength that can enrich society, without glossing over issues such as racism. Given the associated commitment of the National Health Strategy towards the provision of equal and accessible high quality services for all service users, with these priorities further embedded within the HSE's Service Plan, it is evident that an intercultural approach is consistent with HSE policies and should form a core element of the planning and delivery of services to people from diverse cultures and ethnic backgrounds.

8.4 Community Participation in Health Needs

Community development and participation supports communities to identify and address underlying issues that cause inequality, including health inequalities. This approach is informed by the social determinants of the health model, which recognises the broad-ranging economic, social, physical and psychological factors that have an impact on the health of people and their communities. Utilisation of a community development approach, in which all communities are actively engaged in the planning, design, development and implementation of health programmes, is critical to effective management of ethnic minority health needs. Such active participation implies opportunities to influence and contribute towards decision making in minority ethnic health. Implicit in a community development approach is a commitment to forging alliances with communities and NGOs, and an associated commitment to appropriate resourcing to enable them to build their own capacity to participate meaningfully in this way, thereby ensuring positive, sustainable health and social gain for persons from these communities. The socially inclusive approach of the HSE to promoting empowerment of all service users endorses and supports active adoption of this principle.

8.5 Partnership Working

The planning and delivery of health services for a culturally and ethnically diverse population should take place within a model of partnership of all stakeholders. This is in line with the Service Transformation Programme 1 of the HSE's Transformation Programme, i.e. "develop integrated services across all stages of the care journey….develop and implement a framework for involving service users and communities in service development". The model of the Expert Advisory Groups further promotes the principle of partnership working.

Such working should involve collaboration between service users, community and voluntary agencies in relevant areas, and representatives of other statutory sectors and the HSE. A partnership model implies mutual respect and support of skills, experiences, insights and areas of expertise. Within this model, a climate should be fostered where information is shared, priorities and responsibilities agreed, and actions implemented.

This model of partnership will be further promoted within the HSE, with enhanced collaboration being effected among the various pillars of the organisation (i.e. NHO, PCCC, Population Health), and with respective care groups, such as children and families, mental health and so on, to facilitate a consistent, integrated approach to cross-cutting issues that have the potential to have an impact on service users from diverse cultures and ethnic groups.

8.6 Learning and Support for Staff

The report *Learning, training and development needs of health services staff in delivering services to members of minority ethnic communities* **(2005)** confirmed the desire and willingness of staff in the health services to be supported in providing a culturally competent service, which is respectful of and responsive to the cultural and ethnic diversity of service users. Provision of appropriate intercultural training and support in this regard is a fundamental principle of this strategy.

At the same time, mindful of the importance of the health service reflecting the demographic profile of the population it serves, priority should be accorded to the development of mechanisms that promote the attraction, recruitment, promotion, development and retention of staff from diverse backgrounds.

9. Issues and Recommendations

Key messages from the consultations were outlined in Section 6.3. Issues and associated recommendations related to these messages are grouped thematically around the broad areas of **1. Access to Services, 2. Data, Information and Research, and 3. Human Resources and Organisational Development.**

9.1 Accessing Services and Service Delivery

The ability to access services is a prerequisite to attaining positive health outcomes. "A basic requirement of an equitable society is the accessibility of services to all. Public and private service providers have a responsibility to lower and eliminate any access barriers that specific groups may face."[19] Improving access to health care for all service users by reducing the barriers preventing easy access is recognised as key to overall health improvement in a range of documents and policies, most notably by the National Health Strategy and by the National Primary Care Strategy. Additionally, the recent NESC report, *The Developmental Welfare State*[20]*,* states that access to a wide set of services is essential to maintaining social cohesion and combating social exclusion.

The concept of access in a health context is very broad, with many factors affecting the ability of service users to access required services. Service users unfamiliar with the systems and processes, who feel unwelcome or experience a lack of respect in relation to their individual needs, will be unwilling or unable to access services. The provision of culturally competent services in which service user needs and beliefs are valued and addressed is fundamental to ensuring equality of access to health services.

Service users from different cultures and minority ethnic groups, often coming from other countries with different healthcare systems, may be unfamiliar with the referrals, waiting lists, appointments and processes used in accessing health services in Ireland. This may result in inappropriate usage of health facilities, causing increased pressure on health services. Expectations relating to healthcare may also be different, with similar potential for difficulty in accessing health care appropriately and in interfacing positively with health care personnel. Such a situation may result in frustration for service users and service providers alike. Understanding of health and disease may vary, while people from diverse cultures and backgrounds may also exhibit a range of cultural beliefs and practices around health. This, coupled with a limited access to information concerning the means of accessing services, may lead to the service user using less conventional pathways to access forms of care and treatment. That a person doesn't access health services via usual routes should not imply that health care is not sought or required.

A core tenet of the provision of primary health care in an inclusive, intercultural setting is the enhancement of access to services. The structure of health services in Ireland directs that, in most instances, the General Practitioner is the first point of entry to the health services for the majority of service users. Enhanced access at this gateway is thus a key element to promoting appropriate uptake and usage of health services by people from diverse cultural and ethnic backgrounds.

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[19] Pillinger 2007
[20] NESC 2005

Barriers to Accessing Services

Barriers to accessing health services formed a large part of discussions during consultations with service users and staff as well as in all written submissions received. Major barriers cited included lack of accessible information in different languages together with unavailability of interpreters. Different groups experienced difficulties in accessing specific services, with access to GP services reported as providing particular barriers for Travellers, asylum seekers and migrant workers.

A range of positive and negative experiences were reported in accessing health care. It is necessary to note that negative experiences around accessing health services, particularly where they relate to such examples as waiting times, availability of services or perceptions of being rushed or ignored, may not be unique to members of migrants or minority ethnic groups. However, the frequency with which these issues were raised, together with their evident effect on the motivation and capacity to access services on subsequent occasions, confirmed the importance of these aspects to service users, and the associated urgency of addressing them. Additional negative experiences linked to institutional barriers, including language, information and some racism, further compound access to services and are viewed as particular to this group. Issues raised by service users around such negative experiences were, in the main, endorsed by service providers.

Reports of negative experiences included refusals to be accepted onto a GP's list, perceptions / experiences of racism and discrimination, and a lack of understanding around entitlements and ways of using the health services. Client satisfaction with services varied considerably, with complaints around consultations including perceptions of symptoms not being adequately investigated, questions and discussions being rushed, and medication being prescribed without examination or explanation as to its purpose or potential side effects. Such negative experiences, often coupled with communication and cultural difficulties, and associated tension, anxiety and confusion concerning the negotiation of an unfamiliar system, combined to render the service user feeling frustrated, isolated and disempowered.

It is important to note too that a number of GPs working in typically busy, pressurised situations reported similar feelings of frustration and helplessness in respect of communication with patients.

Difficulty in accessing specific services, such as cervical screening or Breast Check, was reported by a number of Traveller women.

The cost of health services was also seen as a difficulty for low-paid migrants in attempting to access services, with a series of reports of migrant workers only accessing health services on return to their home countries. Costs of medication not available via the medical card were also reported as causing barriers to using services.

Significant transport costs in reaching the GP or Health centre were cited frequently as an additional barrier to accessing services. Little information appeared readily available to migrants around entitlements to medical cards, GP visit cards or Drugs Payment Schemes.

Migrants who were working long hours reported being generally unable to access GP services due to the absence of out-of-hours services in their geographical areas of employment. Increased mobility of migrant workers, often due to insecurity of tenure in work and accommodation, further compromised their capacity to access services, with associated implications for continuity of services in terms of follow-up care.

Fears around their legal status appeared to prevent a number of service users accessing and using health services optimally. The situation of undocumented migrants is particularly relevant in this respect. Reluctance or an inability to link in with certain services became evident through a range of submissions received. Concerns around compromising status appeared particularly evident in addiction services, where those stakeholders in this area of healthcare were conscious that service users were not being reached via existing service structures.

However, other factors also appeared to contribute to barriers in accessing such services, including lack of knowledge of existing services, stigma and shame attached to drug use within ethnic groups, and a perception that addiction services may not be culturally sensitive or neutral. Although these concerns were expressed via addiction services, it is reasonable to suppose that similar perceptions exist among service users around accessing other services, especially those of a more sensitive or intimate nature. Difficulties in accessing mental health services appeared to have a similar basis.

Institutional barriers also exist to militate against optimal access to health services. Attitudes of staff could be perceived as hostile, while the bureaucratic procedures around filling in forms presented significant difficulties. Certain services were structured in such a way as to present challenges in responding to diverse needs. The example of the historical development of addiction services to respond in the main to opiate-injecting drug users was cited as marginalising certain groups of users, including Travellers, who tend to prefer a range of illicit non-opiates. Clearly, there is scope for exploring the structuring of a range of services, and the ways in which services are delivered, to ascertain the extent of institutional barriers across health services at all levels of care that may undermine accessibility and equality of treatment.

Health services may be located in areas that are difficult to reach via public transport or in settings unwelcoming to certain groups. Certain services may present an image of judgement or stigmatisation.

Community Health Centres may be perceived as unfriendly and confusing, with little appropriate signage, directions, information available in languages other than English or Irish, or available staff to assist in facilitating their usage. While some work has commenced nationally on implementing a range of measures to ensure health centres are perceived by all community members as personalised, welcoming and accessible, there is a clear need to develop a programme aimed at enhancing such a socially inclusive approach. Principles of universal access are relevant in this regard.

Much discussion focused on access to community services, due to the fact that this level of health care was the one of which service users had most experience. However, reports of accessing hospital services shared fewer common themes and experiences appeared to be varied, based very much on the nature and level of care needed within the hospital setting. A number of initiatives that respond to diverse cultural and religious needs of patients have been developed in various hospitals. These include the Migrant Friendly Project in Connolly and Galway Hospitals, the appointment of a cultural diversity officer at St James's Hospital and an established diversity programme at Children's University Hospital.

Recommendation

Training and associated initiatives currently under way regarding the provision of culturally competent and anti-racist services will be expanded across a range of community and hospital settings.
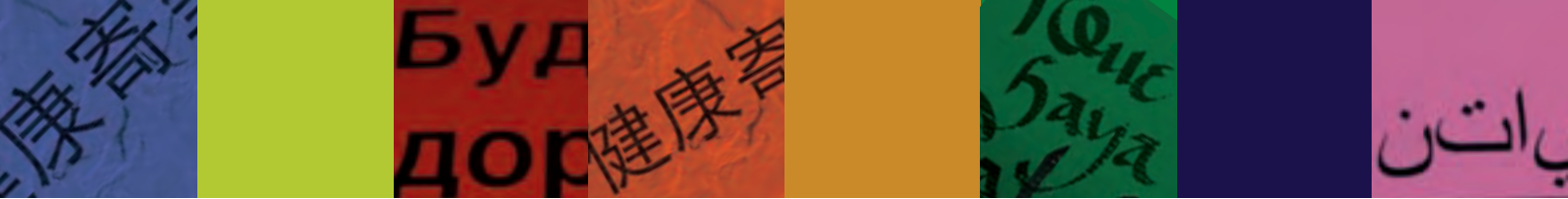
Costs of accessing and using health services are a significant barrier to using these services. Entitlement to a medical card is a key determinant of the utilisation of GP services, with those in receipt of this benefit using services more frequently than those without a card. Consultations demonstrated that many service users had little knowledge of entitlements in this area. Information will be adapted, aimed at ensuring that all service users be supported in being informed of their entitlements and of relevant processes in this regard.

Many of the issues raised around accessing health services are not unique to minority ethnic service users. The enhancement of services for the benefit of one group has the effect of improving services for a range of other groups, including older people, people with disabilities and the broad group of socially excluded service users. A programme will be developed and actions agreed around promotion and implementation of the principles of universal access, ensuring that all aspects of health services are accessible, including those areas of the built environment and signage. This will be undertaken in alignment with existing work under way within the HSE around enhancement of services for socially excluded groups.

Using Health Services

While it is evident that the health needs of minority ethnic service users have resulted in increased pressures on certain services, including Maternity services, Children and Families services and Infectious disease clinics, it is not possible to accurately assess the true impact, in the absence of ethnic monitoring data. The need for an ethnic identifier to assist in informing need for services, uptake of services and associated resourcing aspects is underlined in this situation.

Inappropriate usage of health services may be a contributing factor in putting pressure on specific services. This is borne out by a study in the *Irish Medical Journal*, which demonstrated that, over a three-month period, children of asylum seekers were four times more likely to have been referred by a GP to Galway's University College Hospitals Accident and Emergency Department (A&E) or Out-patient Department, but were more likely to travel to the A&E unit by ambulance and less likely to require admission. The report claimed that many of the presenting complaints could have been managed in a GP setting and offers language and information difficulties as possible reasons for such inappropriate usage of services.

This is similar to the results of research conducted on Travellers' access to hospital services by the Traveller Health Unit in the Eastern Region, which found a low referral rate of Travellers by GPs to hospital care. It also indicated that the only access Travellers had to inpatient and outpatient services appeared to be via A&E. This challenged the notion of inappropriate use of services, which could be further exacerbated by difficulties of registration with GPs in certain areas.

Little information exists around levels of referral of persons from diverse cultural and ethnic backgrounds to secondary and tertiary services. Anecdotal reports of low referral rates for socially excluded groups appear to be supported by international literature, an example of which cites: "Minority ethnic groups experienced some of the worst health outcomes in the country and their access to health services was limited. Those with the worst levels of heart disease had the lowest referral rates to hospital and there were obstacles for ethnic minorities in accessing secondary care, mirroring the experience elsewhere."[21] Further research may be necessary to explore such aspects.

Peer-led health information programmes, such as those delivered at certain Reception centres by Spirasi, in collaboration with health structures, have been reported as effective models in facilitating the understanding of access and interaction with health services, as well as building confidence in accessing health services. Their expansion should be supported across a range of settings. Clear understanding by service providers of cultural beliefs and practices, and sensitive means of responding to this, is of paramount importance in promoting timely and appropriate access to health care. Likewise, the provision of accessible information to the service user will support and promote willingness and confidence in accessing and using services. At the same time, it is expected that the expansion of local primary health initiatives, planned in consultations with service users, will be of similar value in reducing the need for this cohort to access hospital services directly. The Community Intervention Teams, currently being phased into community areas, should prove of especial value in this regard.

Recommendation

Following the rollout of the ethnic identifier, research will be conducted around levels of referrals of minority ethnic service users to secondary and tertiary care. Pending findings, appropriate actions will be developed around this aspect.

[21] Crowley,P., 2005

9.2 Service Delivery

Specific Intercultural Health Issues

Certain minority ethnic service user groups may be predisposed to, or suffer from, a variety of medical conditions not familiar within the Irish health landscape, e.g. sickle cell anaemia and other haematological conditions are more prevalent in people from other nationalities than in the Irish population. The prevalence of conditions, including diabetes, renal and ophthalmological disease, also bears further examination. Management of these conditions may present additional pressures to clinical services. Opportunities for the training of medical and allied health personnel around awareness and treatment of these conditions should be explored.

Service users from minority ethnic groups may also express certain cultural or religious beliefs and practices that lead to specific requirements of the health services. The practice of circumcision is an example in this regard, where early circumcision of infant males is an expected cultural or religious duty.

Recommendation

The HSE will work with relevant training and professional bodies regarding the need for awareness and training in respect of aspects of health across cultures.

Research will be undertaken around aspects of prevalence and management of specific conditions disproportionately affecting minority ethnic communities.

The HSE's Expert Advisory Group on Children has acknowledged the need for exploration around the issue of the delivery of male circumcision for religious or cultural reasons. Outcomes here will be observed in discussions around the provision of circumcision to young male infants and children.
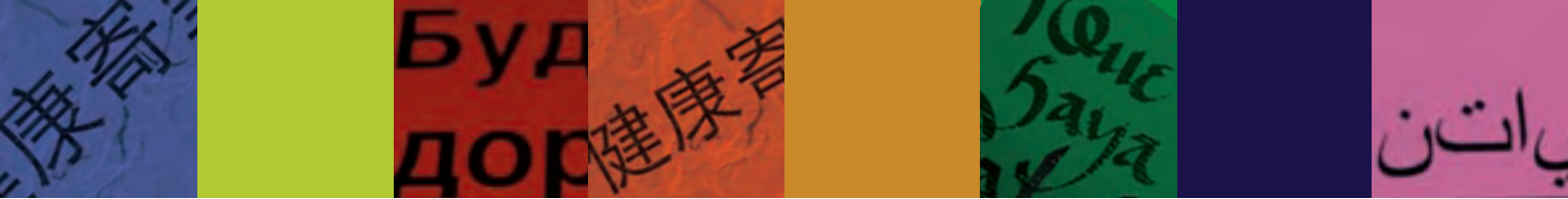

Specific Intercultural Access Issues

The need for culturally competent service provision is exemplified in situations where service users from diverse cultural and ethnic backgrounds have specific cultural and religious needs around their health care. Aspects of personal care and hygiene, spiritual beliefs and practices, and dietary needs are of particular relevance in this regard. Accommodation of such diverse needs in inpatient facilities is a key component of competence in responding to intercultural needs. In this respect, hospitals play a key role in facilitating responsive, culturally competent care and support for patients from diverse backgrounds. The Migrant Friendly Hospital Project, developed to respond to the care needs of culturally diverse patients in hospital settings, is an example of good practice here, with outcomes resulting in the Amsterdam Declaration providing recommendations for hospital services around the improvement of health and health literacy of migrants and ethnic minorities[22]. A description of this European initiative is provided in the *Consultation Report*.

Provision for patients with particular spiritual or religious needs to perform appropriate ablutions, to have access to facilities for worship, meditation and religious counselling, and to be offered a diet in accordance with religious beliefs is fundamental to culturally competent service delivery.

Knowledge of, respect for and the observance of certain cultural and religious customs and rituals around events such as birth, death and illness is integral to person-centred care. Training and support for staff around provision of competent, responsive intercultural health care has commenced at a number of health settings, with further phased implementation planned to take place.

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[22] Amsterdam Declaration Website www.mfh-eu.net

> **Recommendation**
>
> Training and associated initiatives currently under way concerning the provision of culturally competent and anti-racist services will be mainstreamed across a range of community and hospital settings.

Women's Health

The vulnerable situation of women from diverse cultures and ethnic groups was highlighted in Chapter 5.

The Women's Health Council[23] quotes Australian research that confirms that women from minority ethnic groups and cultures experience particular barriers in participating in health and health promoting activities, due to a number of factors. These include:

- *family responsibilities – for many women, family obligations have to be met before undertaking other activities such as health promoting activities. Their role as primary carer of children may also limit their involvement in recreation or sporting activities. For some women, conventional methods or activities, such as the use of music in aerobics, is not permitted due to their religious or cultural practices*

- *cultural restrictions regarding movement in public places (e.g. needing a chaperone, not being allowed to drive or being financially dependent)*

- *cultural restrictions on education and employment for women, which puts them in a highly dependent position when living in a culture where they do not know the language, legal system or their rights, may have limited family and social networks and do not know how to access appropriate services, and appropriate health services*

- *cultural imperatives for women to see female health workers*

The double discrimination experienced by women as a result of their gender and ethnicity has an impact on all aspects of their lives, including on health.

Access issues discussed earlier in this document resonate with women from diverse cultures and ethnicities. For asylum seeking women, who have experienced significant trauma and whose traditional gender roles may be very different to Irish gender norms, requiring them to adapt to a new reality, accessing services may be particularly difficult. Women coming from countries where they would not have been expected to make any decisions find it hard to cope on their own, often singly in charge of their children. Women are less likely to access services for a variety of reasons: they might require the permission of their husbands / partners, they might require childcare and they might be unwilling to be examined by a male GP or use the services of a male interpreter.

Many women are reluctant to access services for fear of contact with official services or, in the case of migrant workers, because they are afraid of negative repercussions for any health-related absences. Women from this group find the costs of services prohibitive and may self medicate, using medication from their own countries, while waiting for an opportunity to travel to their country of origin for treatment.

Lack of appropriate information around accessing services may also present barriers, especially where women from diverse backgrounds are unfamiliar with health practices. The concept of health screening, for example, may be unfamiliar, and women from this group may be unaware of the benefits of this practice and reluctant to attend such prevention and treatment services.

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[23] Women's Health Council: Submission to Intercultural Strategy

In consultations with organisations representing minority ethnic women in Ireland, conducted by the Women's Health Council, violence against women emerged as a key issue, with domestic violence regarded by these organisations as being widespread. Women who hold spouse-dependent visas are not entitled to work and may often be isolated at home. Moreover, exiting a violent relationship in this situation risks loss of the legal right to remain in the country and becoming undocumented. These circumstances lead to the under reporting of the level of domestic violence and create significant barriers to accessing services.

Women parenting alone or experiencing health problems may have difficulty accessing or availing of practical supports. For women who experience miscarriage or still birth, lack of such support is particularly harrowing, while the inability to access assistance weighs especially heavily on women living with HIV, as this illness carries an associated stigma.

Maternity care for this group is an area of particular challenge for service users and providers. Pregnancy-related problems have been reported to be a major issue throughout the European Union, where studies have found that migrants receive inadequate or no antenatal care and exhibit higher rates of stillbirth and infant mortality[24]. While there is no suggestion that this is reflected in the Irish situation, it does highlight the need for awareness of the distinct maternal health and support needs of women from diverse ethnicities and cultures, new to Ireland, and the need for additional means of responding to these.

From a service user perspective, women reported a number of barriers to their optimal access to services. Many of these difficulties related to lack of awareness of entitlements and processes, with the cost of medical care for those without a medical card proving a major deterrent to accessing services appropriately. That many women appeared unaware of the Mother and Infant scheme, where free antenatal care for expectant mothers and medical care for infants up to the age of six weeks is provided, irrespective of eligibility category, highlighted the importance of ensuring information around services is effectively disseminated. Women in direct provision expressed concern regarding a lack of follow up of their own and the baby's health following discharge from the Maternity hospital. Emotional support appeared particularly absent in these situations. Practical issues such as lack of supply of nappies to mothers of new infants added to difficulties of adapting to and caring for their babies.

Women who are unfamiliar with specific maternity-related procedures such as induction of labour, may feel disempowered if choices and decision making around this are not appropriately presented and facilitated.

A common challenge reported by service providers in this area of care is that of expectant mothers from minority ethnic groups and cultures presenting on an unscheduled basis to Maternity hospitals in advanced stages of pregnancy, with significant medical complications and suffering from a range of conditions to a higher extent than usually found in the Irish population. These conditions include Hepatitis B and C, HIV and, in particular, haematological diseases such as sickle cell disease and thalassaemia.

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[24] Women's Health Council: Submission to Intercultural Strategy

Other issues of concern reported by service providers around the provision of maternity care included the low uptake of antenatal and postnatal care programmes, reported low uptake of family planning services and an apparent decline in breastfeeding rates. Combat Poverty Agency states that the achievement of those specific targets to reduce inequalities in breastfeeding among "higher professionals" and poorer mothers from minority ethnic communities in Breastfeeding in Ireland: A 5 Year Strategic Action Plan 2005 will make a significant contribution in this area[25]. The mobility of many of this cohort results in problematic follow up.

Communication and cultural barriers between patients and staff, together with administrative difficulties encountered in, for example, confirming identity, test results, multiple bookings and follow up may lead to immense frustration and stress for all parties. Additional issues cited around maternity care for expectant mothers, those in labour and post delivery, relate to the situation faced by hospital staff in having to access appropriate care for other children who may accompany the mother to hospital.

Women who have experienced female genital mutilation have special care needs during pregnancy and labour, as well as postnatally. Awareness and associated training around the provision of appropriate care and support in this situation is needed for staff unfamiliar with the effects of this procedure.

Exploration of the issues described above suggests that many may be linked to barriers in accessing appropriate information around ways of using maternity services and in associated communication around available options. Provision of support to service users and service providers around enhancement of such aspects would appear to progress the resolution of difficulties.

The HSE has recently initiated a comprehensive review of all maternity and gynaecology services in Dublin City, County and surrounding areas, which will inform recommendations and an Action Plan for the development of consistently high quality, safe and sustainable maternity and gynaecology services in both community and hospital settings in the Greater Dublin area. Within this review, attention will be paid to the situation of women from diverse cultures and ethnicities accessing and using these services.

Different groups mark events such as birth with specific cultural and religious observations (e.g. during the process of delivery in the Muslim faith, special prayers and supplications may be recited in the baby's ear). Accommodation of such practices within a labour ward setting requires sensitivity and flexibility on the part of the service provider. Training around aspects of cultural proficiency in responding to such cultural needs is under way in a number of settings. This training is being expanded on a phased basis.

Outreach programmes have been established to respond to the maternal health needs of pregnant women classified as asylum seekers and refugees. While these initiatives, such as the Outreach Maternity Clinic at Balseskin Reception Centre, have improved the coordination of antenatal services for this group, there is a need to address the maternal health needs of all minority ethnic women in a comprehensive, integrated way.

[25] Combat Poverty Agency (2007) Health Policy Statement

While little data exists around the proportion of low birthweight babies born to minority ethnic women in Ireland, international evidence suggests that ethnicity plays an important role in socioeconomic inequalities in birth outcomes. Birth outcomes of Traveller women are proven to be poorer than those of the settled population. The Institute of Public Health's report, Unequal at Birth, recommends that research as well as appropriate surveillance and action be undertaken around birth outcomes of women from minority ethnic groups. The Born Unequal report[26], recently launched in the UK, confirms that the "risk of having a low birthweight baby is much higher for some groups than for others…. mothers of Indian, Pakistani and Bangladeshi origin have a high risk of having low birthweight babies. These mothers also attend fewer antenatal appointments than other ethnic groups."

Recommendations

The HSE Service Plan for 2006 contains a commitment towards developing approaches to gender mainstreaming for the planning and delivery of all services[27]. Actions, aimed at addressing specific care and support needs of minority ethnic women, will be initiated, promoted and supported within this context.

An EAG for Maternity services has been established to advise on the organisation and development of health and personal social services in this area. Actions regarding the maternal care and support needs of women from diverse ethnicities and cultures will be addressed within the context of priorities agreed by this group. The implementation of the Maternity Action Plan will be a key element of work in this area, while outcomes of the HSE's recently commissioned review on maternity and gynaecology services will further inform planning and delivery of appropriate culturally responsive services in this area of care. Against this backdrop, efforts will be initiated towards addressing aspects of take up of services and follow-up care for mothers and families; mechanisms for the provision of emotional and practical support to vulnerable mothers will be explored and implemented. Young mothers and first-time mothers will be priorities in this regard.

The rollout of the ethnic identifier will facilitate the development of evidence-based information around the maternity and associated needs of women from diverse cultures and ethnic groups. Appropriate actions to address and monitor the birth outcomes of women of this cohort will be provided in line with the findings and existing initiatives.

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[26] Fabian Society (2007), Born Unequal

[27] HSE Service Plan 2006

Mental Health

Issues around mental health needs emerged as major areas of concern and distress for many service users. Aspects of mental health as this applies to the situation of asylum seekers, refugees, migrants and Travellers, in particular, have been touched upon throughout Chapter 5.

Women from diverse cultures and ethnic backgrounds bear a disproportionate burden of ill health, with particular risk to mental health. Additional vulnerabilities as a result of gender were described in Chapter 5. Heightened awareness of the difficulties faced by women is required by service providers, with a special focus on cross-cutting strategies designed to ensure that women's care and support needs are effectively targeted.

Even with the paucity of data available, it is generally acknowledged that people from minority ethnic groups may experience a greater level of psychological distress than the local population. Incidence of depression, psychosis and post-traumatic stress disorder is accepted to be higher in people from minority ethnic groups than in the indigenous population. This may be related to experiences of loss or displacement, coupled with difficulties in adapting to life in a new country. The number of migrant service users in the consultations who had left their children in their country of origin was striking, as was the sense of distress accompanying this.

Mental and physical health may be further affected by social isolation, pre- and post-migration trauma, cultural shock, language barriers, insecurity around the asylum process, loss of traditional support structures, separation or death of family members, fear of deportation and poverty, coupled with a lack of understanding about services, and poor accommodation conditions and arrangements.

For many people arriving as asylum seekers or refugees, the impact on mental health of experiences of migration only becomes apparent once they have settled into a new country.

Mental health difficulties are not confined to asylum seekers and migrants. The mental health issues relevant to Travellers are equally pervasive, with significantly higher numbers of Travellers diagnosed as depressed. The National Suicide Strategy: Reachout[28] specifically identifies Travellers as a group affected by suicide. Additionally, the strong stigma within the Traveller community attached to mental health difficulties tends to further restrict Travellers from seeking or availing of mental health services. Initiatives including Traveller Primary Health Care Projects, operating in partnership with the HSE, may play a key role in the design and delivery of culturally appropriate and accessible services aimed at promoting mental health and well-being and reducing stigmatisation.

Experience of hostility, prejudice, racism and discrimination further compound mental well-being.

The length of time spent by asylum seekers in direct provision, together with their lack of entitlement to access employment, has an additional detrimental effect on mental health. Feelings of disempowerment, isolation and loss of self esteem are common themes around this aspect.

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[28] National Suicide Strategy

Cultural factors may exert a profound influence on the motivation and ability to access mental health services, with concepts around mental health differing greatly within and between various ethnic minority groups. When assessing health status, cultural factors should be taken into consideration and care should be exercised before pathologising what may, in fact, be a natural response to an abnormal situation. Evidence suggests that a holistic, multiagency approach to care provides a good model here, with some attention being directed towards the resolution of practical issues, where appropriate. The area of mental health – where effective, trusting communication is a critical element of work – is one in which the provision of trained interpreters and, often, cultural mediators is necessary in assessing mental health status and agreeing on appropriate management. Community development models generally are acknowledged to have particular value in the provision of mental health and related services to people from diverse cultures and ethnic backgrounds.

Persons from minority ethnic communities will also experience mental health issues identical to that of the indigenous population, unrelated to torture, dislocation and so on. Here the support of flexible, person-centred community services, utilising close links with community mental health personnel as well as with relevant local representative community agencies, is critical to the resolution of such issues.
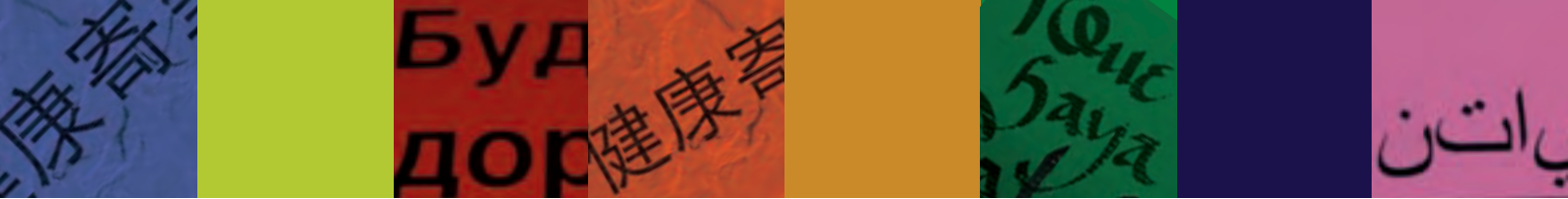
A dedicated psychological service is available for asylum seekers. This service is currently being reviewed in the light of changing trends in the numbers and needs of service users from a range of minority ethnic groups. The findings of this review will inform further work in the area of mental health for this cohort.

Psychiatric illness may be present in certain members of minority ethnic groups, either of a long-standing nature or linked with experiences such as torture and violence. Cultural differences and language barriers may increase potential for misdiagnosis. Again, the need for the provision of interpreters and Cultural mediators is highlighted, as is the importance of staff training around culturally competent service provision in responding to such sensitive areas of need.

A Vision for Change: Report of the Expert Group on Mental Health Policy acknowledges the mental health vulnerabilities of people from minority ethnic groups and recognises that sensitive, flexible responses are required. The document endorses the importance of employment of professionals from a range of cultures in mental health services to further develop understanding and respond to the distinctive needs of this group. It confirms that "culturally sensitive mental health services will be aware of the different understanding of such things as mental health, mental health services, healing, family structure, sexuality and spirituality that exist in other cultures..... immigrant communities often have many different ways of dealing with distress: through prayer and spirituality, traditional healing and mechanisms of negotiating conflict through the extended family, and service providers can learn through these approaches."

Recommendations

The *Vision for Change* report is currently being implemented within the HSE. Support will be provided for the recommendation contained in *Vision for Change*, i.e. "Mental health services should be provided in a culturally sensitive manner. Training should be made available for mental health professionals in this regard and mental health services should be resourced to provide services to other ethnic groups, including provision of interpreters."

Specific issues that have an impact on the mental health of members of this cohort, resulting from implementation / lack of implementation of various policies, will be explored with other sectors, in efforts to ameliorate these effects. The HSE is committed to use all available resources to advocate and highlight the detrimental effects to health of such policies. Discussions with structures in the Department of Justice, Equality and Law Reform around the effects of the direct provision system and with fora in the Department of the Environment in relation to Traveller accommodation, in particular, will be key priority areas in this regard.

Community initiatives aimed at providing care and support around the mental health needs of people from diverse cultures and ethnic backgrounds will be supported and promoted within the context of the model of community mental health endorsed in *Vision for Change.*

Children

The vulnerable situation of many children from diverse ethnic and cultural backgrounds has been highlighted in Chapter 5. The National Children's Strategy contains a number of key commitments around the provision of social support for children and young people, including commitments to accommodating cultural diversity. The National Action Plan for Social Inclusion confirms that access to good quality health care "is essential for the well-being and development of children"[29]. The recently published *State of the Nation's Children* report identifies children from diverse ethnicities as prone to lower levels of well-being in areas of health, education and access to family and community resources[30].

Apart from the issues expressed by service user parents around accessing childcare, and concerns around children being supported in participating in educational and social activities, little emerged from the consultations in relation to the overall health and well-being of children from minority ethnic groups and cultures.

However, significant concerns were raised by service providers regarding a range of childcare-related issues, with the situation of young unaccompanied minor children proving especially worrying.

Issues around child protection, where disciplinary practices appeared excessively harsh, were also raised during consultations. Cultural norms may be at odds with legislation governing the appropriate treatment of children. In some instances, where HSE staff or service providers may be concerned about the well-being of children, there may be associated fears of being perceived or labelled as "racist" if these issues are confronted. This is an area where clear, unambiguous guidelines are required, with the best interest of the child paramount in all instances. Supportive, sensitive and responsive approaches to the needs of service users and service providers are required.

The care needs of children living in direct provision are overseen by a division within the RIA, with some collaboration around childcare needs being effected with the HSE. Much has been achieved within this division concerning the enhancement of the welfare of asylum seeking children in this setting, including development of infant feeding guidelines and programmes around child development. Ongoing collaboration between the RIA and the HSE will continue to be a key element in ensuring optimal development of young children within this system.

[29] National Action Plan for Social Inclusion 2007 – 2016.
[30] Department of Health and Children, 2007, State of the Nation's Children

The National Action Plan Against Racism contains a number of wide-ranging recommended measures in relation to an identified objective for health services to "develop a more inclusive, intercultural approach to childcare policy, with reference to equality / diversity policy"[31]. Relevant measures include:

- *developing an equality / diversity handbook for childcare practitioners to provide practical guidance for those working in the childcare sector to make reasonable accommodation of cultural diversity and take positive action measures*

- *developing a range of proactive and targeted measures to ensure equal opportunities for cultural and ethnic minorities in accessing childcare, including targeted information strategies*

- *positive action measures to encourage childcare initiatives that promote intercultural interaction*
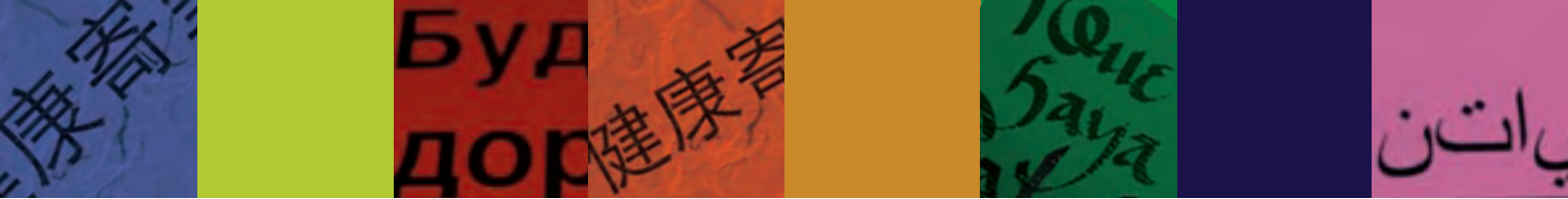
The overall provision of care and support to children falls within the remit of the HSE's Children and Families Directorate, with specialised care teams responsible for the health care needs of separated children. The Social Inclusion Unit will work with, and be guided by, relevant sectors of this directorate towards supporting its efforts to respond to the many and varied care and support needs of this group. Associated priority actions of the Expert Advisory Group on Children will offer key direction in this area. The recommended measures of the NPAR, outlined above, will form a critical context for the development of appropriate phased actions to address the multifaceted needs of children from diverse cultural and ethnic backgrounds.

Recommendation

The work of the Expert Advisory Group on Children will guide the development of measures aimed at addressing the care and support needs of children from diverse cultural and ethnic backgrounds. Mechanisms will be instituted for collaboration with relevant personnel within the children and family sector towards supporting the care needs of children and families of diverse ethnicities and cultures. The care and support needs of separated children will be a priority within this approach.

Recommendations contained in the NPAR form a key element of ensuring an inclusive, intercultural approach to meeting the needs of children from diverse minority ethnic groups and communities. Support and training for staff may be required in the area of childcare and protection within a framework of interculturalism and diversity. Children and family services will be supported in their efforts to develop comprehensive practices in this area.

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[31] Department of Justice, Equality and Law Reform, 2005, Planning for Diversity: National Action Plan against Racism

Ageing and Ethnicity

Members of minority ethnic groups in Ireland typically tend to be a youthful population. Where mention was made in consultations around the situation of older persons in this group, this tended to be within a context of a need for all necessary care and therapy to accommodate cultural practices and beliefs. Older people from diverse cultures and ethnicities may be a rather invisible group, not often accessing or availing of health services unless compelled to do so by onset of illness. Where language and cultural barriers exist, the anxiety and distress caused by such circumstances is compounded, and the experience of receiving care in unfamiliar surroundings may prove highly stressful. The stereotypical myth that older people from minority ethnic groups will be cared for by family members within an extended family network further undermines the potential for appropriate planning around discharge from hospital and long-term care needs. The support needs of carers in these situations may also require some exploration.

The urgency of consideration and planning of the care needs of this group is reinforced by demographic projections concerning its increase in size as the present migrant working population ages.

Recommendation

Research and associated action will be undertaken around the care and support needs of this group, with a special focus on identifying existing issues and planning for future needs.

The situation of carers of older persons from diverse cultures and ethnicities will be explored.

Disability

Although few issues emerged around the area of disability among service users from diverse cultural and ethnic backgrounds, it should not be assumed that members of this group do not require disability-related treatment. While the current demographic profile of migrants, asylum seekers and Travellers is one of a non-disabled, youthful population, this may belie the existence or emergence of a range of disabling conditions that will require ongoing planning and management. At the same time, those situations experienced by many asylum seekers and refugees of physical trauma, displacement, inadequate or absent health care in countries of origin or transit, would suggest a heightened requirement for disability-related care.

The compounded social exclusion caused by intersecting grounds of ethnicity and disability is significant.

In some cultures, disability may represent a taboo, with associated stigmatisation, and it may not be regarded as appropriate or acceptable to access disability services. Flexible, sensitive approaches are required in the planning and delivery of services to disabled people from minority ethnic groups.

Recommendation

The implementation of new disability legislation and the associated requirements for the development of individual care plans, together with related legislation around education for children with special needs, provides potential for collaborative work to identify and address health care needs specific to disabled service users from diverse cultures and ethnic backgrounds. Mechanisms will be developed to support personnel in disability services in this regard.

Sexual Health

The area of sexual health is particularly broad, with different needs, practices and issues present at various stages of the lifecycle. Sexual health services range from services for adolescents, contraception and family planning services, to services for sexually transmitted infections. People with disability, older people and lesbians, gays, bisexuals and transsexuals may all require services tailored to cater for their sexual health needs. People from diverse cultures and ethnicities will need to access this range of sexual health services.

Young service users from minority ethnic groups may experience feelings of isolation and stress in attempting to reconcile a desire to comply with cultural expectations while assimilating the values of their peer group. They may require additional support around sexual health choices.

HIV / AIDS may be a significant issue for members of some minority ethnic communities, with associated potential implications for stigma, isolation and depression. Women with HIV / AIDS are particularly at risk in this regard. The provision of appropriate, sensitive, emotional and practical support is necessary in these situations.

Relevant issues, including aspects of women's sexual health, have been highlighted in previous sections. Such issues include the provision of responsive services for victims of sexual violence, while women and young girls engaged in prostitution require sensitive responses to their situations. Sexual health for men did not arise as a particular theme during consultations, but it would be expected that a number of issues related to male sexual health practices and customs could be explored.

Aspects of information around the nature and availability of sexual health services emerged as particularly important during consultations, while the provision of sexual health care in a manner respectful of cultural and religious practices and beliefs was regarded as critical to facilitating access to sexual health services.

Development of a National Sexual Health Strategy is anticipated. While approval is awaited from the Department of Health and Children for the development of this strategy, a group, led by the Directorate of Population Health, is proceeding with some preliminary, associated work concerning this. Mechanisms of collaboration around the provision of input to this process will be consolidated to ensure that the distinct sexual health needs of people from different ethnic groups and cultures are identified and appropriately addressed.

Recommendation

Aspects of sexual health delivery for service users from minority ethnic groups will be addressed within the context of the development and implementation of an anticipated forthcoming National Sexual Health Strategy.

Addiction and Alcohol

Although issues concerning the accessing of addiction services were not prominent in regional consultations and focus group discussions, concerns around drug usage in minority ethnic communities were raised in a number of written submissions. Communities at most risk in this regard included Travellers and members of new minority ethnic communities in the country.

The link between ethnicity, drug use and social exclusion is acknowledged to be strong, while factors such as lack of knowledge of existing addiction services and means of accessing them, fears around stigmatisation, and concerns around compromising legal status further contribute to a reluctance or inability to access addiction services. Members of the Traveller community and minority ethnic service users share similar experiences here. It appears too that, in both Traveller and other minority ethnic communities, drug use by women is often hidden and stigmatised.

Recommendations from written submissions around addiction issues commonly included reference to the importance of outreach work with minority ethnic communities as a proven model in this field, with all future work in this area taking aspects of equality and diversity into account.

Similar issues around the provision of and access to responsive alcohol-related services have also begun to emerge. The work of the National Task Force on Alcohol will provide a context to develop approaches concerning prevention and education in relation to emerging issues around access to alcohol and alcohol-related services.

Recommendation

The HSE will address relevant aspects of addiction within the remit of the current National Drug Strategy, which is well placed to identify and respond to emerging issues. Similarly, alcohol-related issues will be addressed within the context of the work of the National Task Force on Alcohol.

Health Screening

Communicable disease health screening for asylum seekers and refugees is Department of Health and Children policy. Health screening, including screening and vaccination for TB, hepatitis and polio, is offered on a voluntary basis to asylum seekers and refugees entering the country and accommodated via the direct provision and dispersal system. Screening for varicella and rubella is also offered to women of childbearing age and those who are immunocompromised within the asylum seeker / refugee group. All pregnant women attending maternity services are offered antenatal serological screening for HIV, syphilis and rubella.

Follow-up and associated continuity of care of members of this group, particularly as they may be dispersed throughout the country, may present difficulties. Following consultations, it appears that the current health screening system should be reviewed and aligned in accordance with new HSE structures.

Recommendation

Follow up and associated continuity of care of members of this group, particularly as they may be dispersed throughout the country, may present difficulties. The current system of health screening will be reviewed and aligned in accordance with new HSE structures, including Population Health.

9.3 Vehicles to Promote Access

Primary Care

Primary health care is a key enabler in effecting improved access of service users to appropriate care, treatment and support. It is the first point of contact for the majority of people needing health services and should address at least 90% of all health and personal social service needs. Implementation of primary care mechanisms, with its intrinsic elements of integration, accessibility and community participation, gives clear expression to the principle of people centredness.

This is supported by the national policy on primary care, which states that "a greater input from the community and voluntary sector will enhance the advocacy role of primary care teams in ensuring that local and national social and environmental health issues which influence health are identified and acknowledged"[32]. The HSE Transformation Programme declares a priority objective as the "configuration of primary, community and continuing care, so that they deliver optimal and cost effective results"[33].

Principles guiding the design and development of the Primary Care Teams, as this is related to service users, are cited in the Transformation Programme.

- *Primary Care Teams should be the first access point for those who need to access the health system. They facilitate people's access into, through and out of the system, and make sure quality care is provided in a manner that maximises the convenience for patients / clients*

- *They should provide patients / clients with greater access to services. This involves improving the availability of current services through the provision of extra health professionals, reconfiguration of existing health professionals and extended working hours, and providing services, currently restricted to the hospitals, within local communities*

- *Patients / clients should be able to access the services of a Primary Care Team member through any health professional – they do not need to see the GP first*

- *When a person is enrolled with their local team and needs a range of services from their Primary Care Team, they will have a key worker assigned to them if appropriate. Key workers will be allocated in more complex cases. This key worker will be their main point of contact with the team over their care lifecycle. Any team member may be a key worker*

- *Patients / clients should be involved in the design and development of their Primary Care Teams*

[32] Primary Care: A new direction, 2001
[33] HSE Transformation Programme, Booklet A

Accelerated implementation of the Primary Care Strategy, through the development of new and enhanced community Primary Care Teams and networks, offers positive opportunities for improved access to services at community level for persons from diverse cultural and ethnic backgrounds. The anticipated establishment of 217 Primary Care Teams across the country by the end of 2007, each team serving a population of approximately 10,000 people, should provide for access to a wide range of health and social care services in one location, including GP, public health nurses, physiotherapists, occupational therapists, and a range of other professionals and support workers. A key feature of the Primary Care Team structure is that each service user accesses services through his or her key worker; with a single care plan and shared file, the frustrations involved in accessing a range of community services should be avoided for many service users. The health needs of Travellers moving between areas and other more mobile migrants will need consideration towards the development of a flexible model, based on adaptation of these elements.

The composition of each Primary Care Team is being agreed on the basis of a needs assessment for each area; the demographics of the area will be identified, together with consideration of the needs of minority ethnic groups (including Travellers), the impact these needs will have on health, and associated access to health services. Needs assessment in this context will ensure a holistic approach to responding to the needs of the local community. An integral principle of these assessments is the active participation of communities in determining their needs and priority health issues. Thus, where a minority ethnic community comprises a large proportion of a particular community, or as a smaller population, demonstrates clear and distinctive health needs, the unique health needs of this group will be reflected in the overall composition of the Primary Health Team. Such a team is ideally positioned to respond appropriately to the health and care needs of a diverse community.

Similarly, the continuing establishment of Community Intervention Teams, designed to provide a rapid community-based out-of-hours response from community services to patients in order to avoid unnecessary hospital admission, should prove of much benefit.

Recommendation

The rollout of the Primary Care Strategy will be supported in line with the principles of needs assessments. Support for the participation of minority ethnic communities in this process will be actively promoted.

Some discussion will be initiated with relevant personnel concerning ways of developing flexible mechanisms to facilitate those socially excluded people, such as Travellers or migrants who have a more mobile lifestyle, in accessing services. Examples such as the use of hand-held health records and the extension of hours outside the usual core hours to accommodate the needs of communities will be highlighted.

Community Participation and Development

Community development, where communities are facilitated to identify and make decisions around their health needs, is closely linked to issues of access.

Community participation in health has been acknowledged as a key component of improving the health status of individuals and communities since the Alma Ata Declaration by the World Health Organisation in 1978. Support of a community development approach in facilitating communities to play an active role in determining and addressing their own health needs is an integral principle of social inclusion strategies designed to promote optimal participation of service users in issues concerning their health. Engagement with service users is a key tenet of the HSE's Transformation Programme.

The positive role of community involvement in improving access to services and in promoting enhancement of service delivery is accepted in a range of documents, including the HSE's Transformation Programme. Through active community participation, outcomes have been evidenced in the form of new or improved services, reduction in the unit costs of service provision, reduced costs in other aspects of service provision, and increased user satisfaction. User involvement in the health services is acknowledged to be particularly useful. Work commissioned by the HSE and undertaken by Cáirde regarding the training of minority ethnic community members to conduct research among disadvantaged minority ethnic groups in Dublin's north inner city demonstrates the value of involving service users in aspects of identifying their own health needs and priorities.
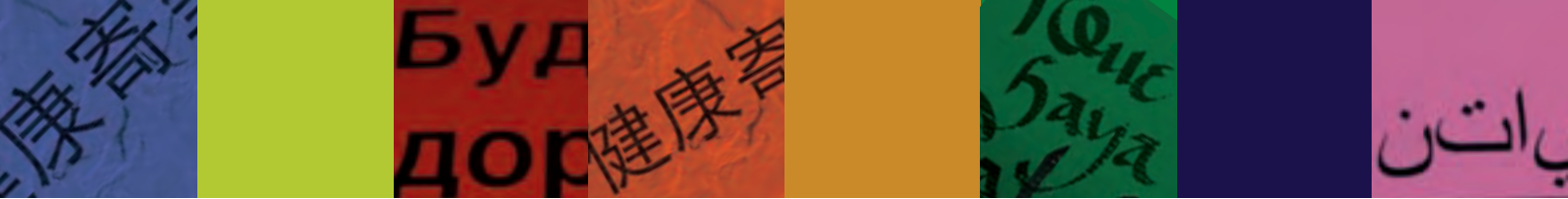
Positive outcomes appear most effective where community involvement is implemented with:

• *clear objectives for involvement, mutually understood by providers and the community*

• *stable and long-term structures and processes for involving service users*

• *a mix of mechanisms to provide the widest opportunities for users to become involved in ways best suited to their circumstances*

The proven benefits of engaging with the community around health needs and actions will continue to be emphasised within the HSE. The current establishment of Primary Care Teams marks a timely opportunity for linking in with work at primary and community level, in particular. The National Primary Care Steering Group produced a position paper on Guidelines for Community Involvement in Health. This document identifies the "key enablers" to effectively involve communities and sets out key values and principles that should inform the work of the Primary Care Teams in this area.

Themes around meaningful involvement of service users from diverse cultures and minority ethnic groups recurred throughout all consultations, with service users and staff endorsing the importance of actively fostering community development.

Community members from diverse backgrounds possess a wealth of skills, knowledge and personal resources. These capabilities should be identified and harnessed within an intersectoral framework to ensure optimisation of such resources. Outreach methods in engaging with and supporting the diversity and talents of members of minority ethnic communities in contributing to aspects of health service planning, delivery and evaluation should be supported

Implicit in any community participation is a commitment to promote the building of capacity within communities so that community members may be empowered to develop their own skills and knowledge in partnership with voluntary and statutory agencies. Combat Poverty Agency's Building Healthy Communities initiative provides an example of a community development model of such capacity building. Co-funded by the Department of Health and Children, this initiative supports the formation and sustainability of community groups established to respond to identified health needs and health inequalities.

The model of peer-led programmes is acknowledged as an effective means of facilitating capacity building among community members.

Emerging Minority Ethnic Forums, formed to facilitate development of capacity and advocacy of minority ethnic communities to explore health-related concerns, are relevant models through which the HSE may give effect to ongoing dialogue and mutual collaboration in areas of minority ethnic health.

Similarly, national and regional Traveller Health Networks have been shown to be positive models through which partnership and capacity building may be effected.

In this context too, the role of non-governmental agencies in facilitating community building, as well as in delivering agreed health and support services, should be acknowledged and appropriately supported. These agencies, many of which support groups comprising members of minority ethnic communities, have a vital role to play in the overall provision of an effective health service to a diverse population. NGOs are well positioned to be aware of the issues affecting access to health care and are able to be creative and flexible in the ways that they respond to the emerging and existing needs of members of diverse cultures and ethnic groups. Examples of NGO programmes commissioned or funded by the HSE include Cáirde's Community Development Programme, Spirasi's Health Information Peer-led Programme, Access Ireland's work with cultural mediators, Galway Refugee Support Group's work with asylum seekers and refugees, and Pavee Point's long-established Training of Traveller Women as primary health care workers.

Submissions from a range of NGOs regarding the consultations for the Intercultural Strategy are testimony to the valuable role played nationally by NGOs in providing care and support to members of diverse cultures and minority ethnic groups. In this respect, the input of minority-led NGOs is critical to effective partnership working. Such agencies will require appropriate support to assist them in building their own capacity to contribute optimally to such working.

While it is evident that much partnership working is enjoyed between the HSE, NGOs and other voluntary agencies, it does appear that differences in approaches, perspectives and insights may exist among all stakeholders. Some development of common understanding and associated criteria around this may be useful in promoting optimal collaboration in this area.

Recommendation

The HSE is committed to working with the NGO sector in the design and delivery of appropriate health and support services for minority ethnic communities. A strategic approach to this work is required. A review of existing partnership arrangements and associated activities will be undertaken by the HSE in collaboration with relevant NGOs. NGOs will continue to be supported by the HSE, with resources being provided to deliver agreed services.

Minority ethnic communities will be supported in building their capacity for participation in emerging HSE structures and in monitoring implementation of the strategy. Standardised mechanisms for encouraging and facilitating active participation of stakeholders will be developed
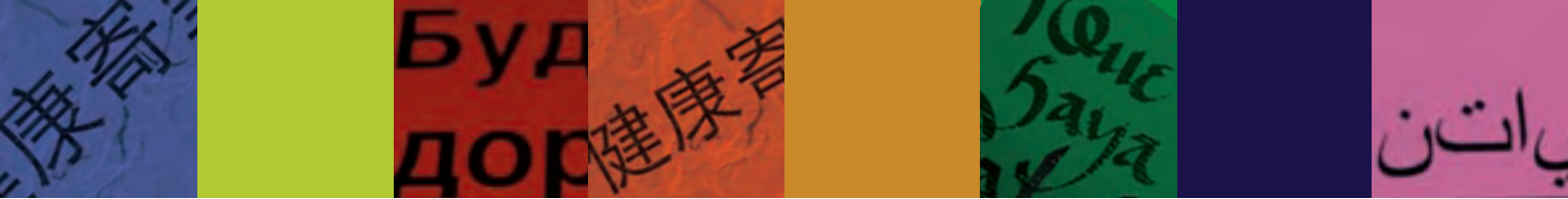
Peer-led approaches have been evaluated as effective tools in facilitating communities to gain an increased understanding of aspects of accessing and using health services appropriately and optimally. This model will be supported and expanded by the HSE.

Cultural Mediation

Cultural barriers to accessing health services were also mentioned frequently in all aspects of the consultation process. Persons from diverse minority ethnic backgrounds and cultures coming to Ireland may have different understandings of, and approaches to, health and illness, have a lack of knowledge of Western health systems and are often prone to different illness patterns. The use of cultural mediation in supporting service providers to deliver culturally appropriate services has been proven to facilitate access to health care for members of minority ethnic groups and to improve the nature and quality of services provided to this group. Cultural mediation is the process through which a cultural mediator or a bicultural link worker facilitates communication and mutual understanding, by acting as a cultural broker between service providers and clients from minority ethnic backgrounds. Cultural mediators are a resource for service providers and the different minority ethnic communities in society. They assist service providers to deliver a culturally sensitive and competent service while, at the same time, they empower minority ethnic communities[34]. The expertise of Cultural mediators, acting as brokers or link workers, can also be utilised in the planning and delivery of services to people from diverse cultures and ethnic backgrounds, as well as in the development of culturally appropriate health promotion and information messages and materials.

Few Cultural Mediators are currently utilised within the health services, while the Access Ireland Cultural Mediation programme receives limited support from the HSE. An EQUAL-funded Roma Cultural Mediation project is currently under way with the aim of equipping Roma people with improved equality of access to health, social and related services, while, in parallel, developing appropriate skills and intercultural competencies among service providers. Findings of both programmes should inform future work in this area.

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[34] Calvo, 2007: In Report of Conference around Health Needs of Minority Ethnic Groups

9.4   Underpinning Access

Provision of Information

The importance of accessible information in enabling decision making and choices for optimal participation in daily life has been acknowledged by Comhairle, which has a statutory remit to support people in understanding their needs and options, and in accessing their entitlements to social and civil services. Groups that face the greatest barriers in accessing services often also face the greatest barriers in accessing information. The National Action Plan Against Racism endorses the critical nature of the provision of information as a proactive means of addressing health inequalities, recommending the development of targeted approaches to increase awareness of general health services to cultural and ethnic minorities, including the provision of information in different languages.[35]

Lack of accessible information around the health systems and mechanisms of accessing it has a direct impact on the ability of service users to understand entitlements, access health services appropriately, navigate routes through services, make complaints or requests, and enjoy optimal health outcomes. At the same time, it appeared from consultation that service providers too were unsure of rights and entitlements of service users, with this uncertainty causing further barriers to accessing services.

Literacy levels also play a significant role in deterring migrants from accessing services. Filling out forms and making sense of the information contained in them, especially when these are not in one's home tongue, can be extremely difficult, while not having information available on a range of potentially life-threatening issues can be very dangerous.

Language and literacy difficulties, characteristic of many members of Travellers and other minority ethnic groups in Ireland, may further compromise ability to access information relating to health services.

A business case approach, as well as the principle of promoting equity and inclusion, demands improvement in the provision of information. Enhancing the provision of information to service users from diverse cultures should be viewed as a dynamic, interactive process, rather than a static, unidirectional transmission of information. Creative, innovative means of making information available to this group need to be devised. The involvement of people from the cohort of minority ethnic service users in the design of culturally appropriate materials and messages, the adaptation of existing materials and the delivery of health messages is of critical importance to ensuring the production of appropriate, effective and acceptable health-related information.

Information should be presented in clear, understandable language, using universally accepted symbols wherever possible.

All translated material should contain common core, standardised information, with scope for adaptation in response to locally identified needs.

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[35] DJELR, 2005, NPAR

Much health information and promotion material, currently available in English or Irish, may merely need to be translated or simplified to "plain" English. However, in many cases, the material may also need to be culturally adapted. An example here is that of health promotion around breast screening – visual materials here should be adapted in accordance with the social and cultural practices of certain religious groups around bodily modesty and privacy, with a shawl or other covering draped over the breast / shoulder area.

Some people from minority ethnic backgrounds may not be functionally literate even within their own language. Responses here will require a greater emphasis on visual and spoken messages. In some instances too, health information may need to be targeted for special groups, such as age and gender.

It is important to note, within the context of equity, that improving access to health services for one group commonly results in enhancing access for other groups as well, with a consequent overall improvement in the quality of services. Just as improving physical access for persons with disabilities facilitates easier negotiation of physical barriers for groups including mothers with prams, older people and so on, the provision of information in clear, understandable language facilitates access to health services of people from minority ethnic groups as well as those with low literacy skills.

The manner in which health information material is disseminated is of crucial importance. Peer-led programmes, in which members of diverse cultures and ethnic backgrounds are provided with relevant information around the health system, ways of using it and other pertinent issues, have proven to be successful interventions from both a language and a cultural perspective. Due consideration should be accorded to the most appropriate settings for the provision of such peer-led interventions, while timing of appropriate interventions is also critical; it would seem that information is more readily absorbed once new arrivals into the country have had an opportunity to settle and are aware of their destination in the country. The application and effectiveness of appropriate information programmes may need to be evaluated, with a view to its potential adaptation and replication to a range of other appropriate target groups, including migrant workers, and other appropriate settings. The Travellers' primary health projects have proved to be a useful model around the empowerment and resourcing of people to act as health promoters within their own communities.

Information within the complex organisation of the HSE may not be consistently circulated to all levels of care, resulting in confusion and frustration around responding to the care and support needs of service users from other cultures. Mechanisms developed via the HSE Transformation Programme's stated priority of engaging enhanced, effective staff communication and feedback will facilitate improvement in this area. Attention will be paid to ways of ensuring that key information around aspects of minority ethnic health and associated efforts within areas of the HSE is disseminated to all regions across all levels of care.

Training of staff in the use of translated material is also essential to optimise effective communication.

Recommendation

There will be coordinated development of guidelines for the production and application of translated material. These guidelines, advised and validated by stakeholders, will be based on evidence of good practice and should focus on aspects of standards, quality and standardisation in relation to the production and use of translated information. Guidelines will include direction around the type of information that should be provided, languages in which these should be available, and to whom and how the information should be circulated. Aspects of cost effectiveness around a coordinated approach to this action should also be a consideration.

A plan will be developed for a phased, coordinated production and usage of translated material.

Translation of information around entitlements, service user rights and ways of making complaints should be regarded as priority actions in the initial phase of this recommendation.

Interpretation Services

It has been reported that 167 languages are currently spoken in Ireland. Inability to communicate effectively in the language of a host country forms a major barrier to accessing and participating in health service delivery. It leads to misunderstanding, confusion and ultimate poor outcomes for service users and providers. Consultations with service users, in particular, revealed much distress concerning attempts to engage with GPs, and an associated perception that they were often a source of frustration to the doctor. Communication barriers also resulted in a sense that their complaints were not fully understood or accurately diagnosed and treated. Health service staff reported similar feelings of frustration and helplessness in situations where communication was problematic.

Use of family members and friends as interpreters was commonly reported by service users during consultations as a means of enhancing communication with GPs, and facilitating their own understanding of any diagnosis and associated treatment. Such informal interpreting raises a number of serious issues around privacy, confidentiality and empowerment, and should – in line with international guidelines – be discouraged except in extreme or emergency circumstances.

Due to cultural and social circumstances, women from minority ethnic groups may often be less likely than their male counterparts to be able to communicate in English, if this is not their first language[36].

Where a service user is able to communicate in English, any stress or distress may act to impede language skills.

It is easy to assume greater language skills on behalf of both service user and service provider, with potential for inaccurate diagnosis, inappropriate treatment and disempowerment of the patient. Issues around informed consent are emerging as areas of concern, where service users may not be fully informed or aware of the implications of a diagnosis made or a procedure recommended or conducted. Hidden costs around such situations may include excessive time spent on consultations and reliance on unnecessary tests and procedures. Standards of clinical governance, together with medico-legal concerns relating to issues of confidentiality and information consent, demand that a professional interpretation service be in place to address such communication issues.

[36] Women's Health Council, Submission to the development of the HSE Intercultural Strategy, 2007.

In a survey conducted by the Irish College of General Practitioners in 2003, GPs identified a lack of interpreters in the health system as the single biggest barrier to offering quality medical care to asylum seekers and refugees. Subsequent consultations with service users and service providers confirmed the urgency of improving communication between members of minority ethnic groups and service providers. However, evidence shows that availability of interpreters does not necessarily imply take up by service providers of this option. This is borne out by a preliminary evaluation of a pilot scheme in Dublin mid-Leinster, where GPs did not appear to take maximum advantage of an advertised interpretation service, but tended to rely on informal strategies for communication. In this regard, serious concerns exist around the not uncommon use of children as interpreters.

The complexities around the provision of interpretation services were confirmed in *Forum* magazine, a journal of the Irish College of General Practitioners, where research findings recommended the urgent development of a comprehensive structure for a statutory interpretation service[37].

A number of issues exist around the development of quality interpretation services, ranging from training and accreditation of interpretation standards and guidelines for practice in this area, and appropriate codes of practice, to the provision of training for service providers using interpretation services, evaluation of the effectiveness of such services and the provision of support to interpreters involved in particularly emotional interactions. Proficiency in interpreting medical terminology is an added challenge in this area.

The current provision of interpretation services is, as with availability of information discussed above, available on a patchy and fragmented basis across the country, at both hospital and community level, with limited evidence around its quality, effectiveness, appropriateness or service user / service provider satisfaction. Rural areas in particular experience difficulties in securing quality, timely interpretation services when these are necessary.

Those principles of equity, accessibility and person-centeredness in particular offer pressing reasons for action around the provision of an evidence-based standardised interpretation service. This service should use trained, accredited interpreters whose practice is registered and regulated. Information about aspects of this service, including accreditation, codes of practice for interpreters, modes of access, funding costs and sources should be shared with staff across all pillars of care.

The introduction of an interpretation service should be accompanied by appropriate training of service providers in the use of such a service. Such training should be conducted in the context of broader cultural competence training, wherever possible.

Similarly, information around the service should be communicated to minority ethnic service communities so that they know about the supports available to them.

[37] Forum, Vol. 23, Number 1, January 2006

9.5 Data, Information and Research

The National Health Information Strategy provides a framework for the more effective collection and application of data, through which evidence-based decisions may be made regarding policy and subsequent health actions. At the same time, the newly established Health Information and Quality Authority (HIQA) will progress work in the area of information and standards. The development of improved health intelligence on the health status and future health and support needs of a culturally and ethnically diverse population forms a central element of this Intercultural Health Strategy. Information collected should reflect access to various services as well as service utilisation patterns, trends and uptake at all levels of care. Collaboration with the Health Intelligence section of the HSE's Population Health Directorate will be critical to the design of appropriate services, allocating resources according to need across different cultural and ethnic groups, and across different areas with different needs.

Little information exists around the situation of people from minority ethnic communities. This deficiency of data creates a barrier to identifying and addressing health needs, and monitoring progress around interventions.

Differences in health outcomes amongst minority ethnic groups suggests that data gathering and research need to consider the diversity of ethnic grouping when datasets are formulated. Collection of data in respect of non-nationals is not helpful as this merely reflects all service users who are not Irish and fails to capture accurately the cohort of people from diverse groups. In this respect, development of an ethnic equality monitoring system is critical, with the rollout of an ethnic identifier a priority. The rollout of this identifier will deliver much valuable information, which will provide a baseline around health needs and direct further intervention, and monitoring and evaluation of outcomes.

Ideally, information around ethnicity should be collected once, at the first point of contact with the health system.
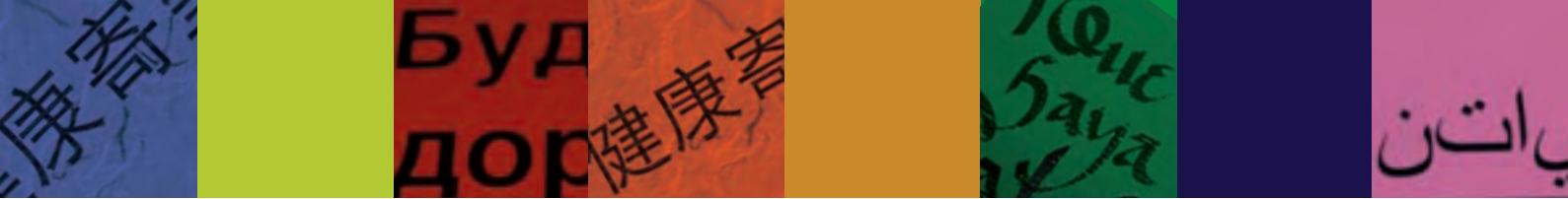
It is important to note that Ireland is at a very new stage of development in respect of the collection of information around health and related aspects pertaining to the situation of minority ethnic groups. Within the country, work concerning data collection and application in this area is at varying stages of development. It is evident too, that other countries – with different experiences of welcoming minority ethnic service users – have reached a more advanced stage of development in this regard. The HSE takes due cognisance of the availability and value of a range of toolkits and related resources in an international and European context. It acknowledges the need to work towards adoption of such methods in benchmarking and evaluating aspects of minority ethnic health. It is realistic to accept that this will be a longer-term aim and that efforts around embedding the ethnic identifier across the HSE should assume priority as a first step towards the collection of data.

Notwithstanding this though, the HSE is committed to the collaborative, coordinated building of a bank of information and resources around all aspects of planning and delivery of services to people from diverse cultures and ethnic backgrounds. Such information will be developed and used as a dynamic resource to stakeholders in the field of minority ethnic health, as well as informing all work concerning the development and implementation of quality services in this area.

While the enhancement of data collection and application regarding health needs and outcomes of people from minority ethnic groups is a priority for the HSE, the importance of promoting research around intercultural aspects of health service planning and delivery should also be emphasised. Ireland's relatively new experience of immigration is reflected in the relatively small body of local research in this and related areas of interculturalism and integration. "Research in the broad area of immigration has been heavily focused on asylum issues. There is a small, but mainly recently and growing body of material on immigration in general, with as yet very few studies on labour migration. There are few studies of integration and intercultural issues as yet."[38] Clearly, there is an urgent need to promote the conduction of research aimed at developing knowledge and skills around aspects of interculturalism as these relate to health beliefs and practices of service users from diverse cultural and ethnic backgrounds, and any associated relationship between intercultural health and health inequalities. Evidence derived from such research will support planning, enhancement and evaluation of quality service delivery that is responsive to these aspects.

A shift in approach from monitoring inputs and outputs to measuring outcomes is supported, together with a corresponding development of appropriate performance indicators that incorporate health-related outcomes that reflect minority ethnic perspectives of health.

[38] MacEnri, P in Current Immigration Debates in Europe

The Institute of Public Health in Ireland confirmed the importance of the following activities in efforts to develop data around intercultural health care needs[39]:

- *mining a battery of datasets from which information on the numbers, health and well-being of members of minority ethnic communities can be drawn. This would include findings of the 2006 Census SLAN 2006, the anticipated Travellers' All Ireland Health Study, the anticipated study Growing Up in Ireland, as well as data on migrants in Ireland from key Government departments, such as The Department of Enterprise, Trade and Employment and the Department of Social and Family Affairs*

- *mainstreaming of the ethnic identifier across key health information systems. Preliminary efforts have commenced around the rollout of the ethnic identifier. Learning from the pilot study on the ethnic identifier question, conducted as a recommendation under the Traveller Health Strategy, by the Department of Health and Children in association with Pavee Point, should assist with the mainstreaming of an appropriate question across health systems nationally. This question will be based on the question used in Census 2006. Information around language used by the service user complements data around ethnicity. Data around language usage may already be collected in some services across the country. Such information should be standardised in the longer term. The inclusion of the ethnic identifier and associated information would allow for the collection of a wide range of data around health needs of people from diverse groups. For example, its inclusion within the National Perinatal Reporting System would permit monitoring of the birth outcomes of children born to minority ethnic families in Ireland. Similarly, including an ethnic identifier within HIPE and health information systems relating to cancer, cardiovascular disease and dental health could provide invaluable policy direction for the years ahead*

- *developing a real understanding of the increased genetic and biological susceptibilities of certain minority ethnic groups to common diseases such as diabetes and obesity, and to less common conditions, including haematological and renal diseases*

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[39] Institute of Public Health in Ireland; Submission to the development of the Intercultural Strategy

• *providing accessible information through online services that can be utilised to inform regional and local policy making and practice for the benefit of community groups and health service providers alike. The work of the Ireland and Northern Ireland Population Health Observatory is particularly relevant in this regard*

Monitoring and evaluating the impact of interventions, aspects of service delivery and a range of outcomes is critical to progress in the reduction of the effects of health inequalities in the area of intercultural health and the enhancement of health outcomes for this group. Equality monitoring is central to efforts to improve the health of people who are traditionally socially excluded. Equality and diversity impact assessment is a useful tool in this regard, ensuring that, as far as is possible, any equality consequences of particular policy initiatives may be anticipated and identified, and potentially negative impacts for any group may be eliminated, minimised or counterbalanced by other measures. Proposed work in this area is consistent with a recommendation in the National Action Plan Against Racism that an intercultural dimension is built into health impact assessments. An integrated approach to the development and conduction of health impact assessments will be adopted, with aspects of equality and diversity impact assessment being considered a longer-term aim of the HSE.

Any indicators developed and applied in relation to monitoring aspects of health of disadvantaged groups should be flexible to local circumstances, and thus meaningful for the communities being served.

Recommendation

The HSE is in discussion with HIQA to agree ways of synergising efforts in the area of health information and related aspects of quality and standards. The Population Health Directorate is a key player in this area. The Social Inclusion Unit will work within this evolving framework towards the development and enhancement of data and its application in the area of minority ethnic health. There will be a particular focus on the application of data in relation to health inequalities.

The rollout of an ethnic identifier on a phased basis across all levels of care will continue to be managed as a strategic priority of the HSE. This identifier, based on the Census question, should be embedded within datafields and will complement and strengthen the application of information regarding country of birth and religion, already within the suite of data currently collected.

The collection of information around language should be standardised in the longer term.

Collaboration will be effected with HIQA, the Health Intelligence section of the Population Health Directorate, NCCRI and other relevant stakeholders around planning for collection, monitoring and application of appropriate information in respect of the health status and needs of service users from diverse cultural and ethnic backgrounds.

A bank of information will be developed around the field of minority ethnic health, designed to support and resource all stakeholders in informing service design and delivery in this area.

Research will be undertaken concerning aspects of interculturalism relevant to the health needs, practices and outcomes of service users from diverse cultures and ethnicities.

An integrated approach will be developed to the conduction of health impact assessments. Aspects of equality and diversity will be developed and conducted in the longer term within a health impact assessment framework. This will be effected within the context of work currently under way within the Population Health Directorate regarding the development of a strategic framework for health impact assessments.

9.6 Human Resources and Organisational Development

Demographic trends point to an increase in the foreign-born population in Ireland from the current percentage of 10.4% to 18% in 2030. A large proportion of this increase represents people from different cultures and minority ethnic groups. In order to deliver culturally appropriate services, it will be necessary to develop a culture that supports interculturalism. An integral aspect of this is developing the capacity of staff and managers to work interculturally. In addition, it will be necessary for the health services to use a more proactive approach to attract, recruit, progress, train and retain staff from diverse backgrounds.

Organisational Culture to Promote Interculturalism

The HSE Transformation Programme focuses on a shift in ways of thinking and working in response to the changing needs of a diverse population. This wide-ranging and radical reform programme emphasises commitment at all levels of the organisation to a new approach in which services are more responsive to need. Staff are encouraged and supported as they champion innovative good practice in developing and delivering enhanced services. Within these new ways of working, the service user is placed at the centre of the health service system. Such a new culture welcomes and values diversity and devises means of embedding and integrating this into all aspects of health service delivery. New structures at all levels within the HSE, from the Expert Advisory Groups established to support the CEO, through to working groups at national level, and similar models at local level, are designed and positioned to facilitate a comprehensive and coordinated approach to identifying and accommodating the unique health and support needs of service users from diverse cultures and ethnic backgrounds.

The health service itself, and all those agencies it commissions to deliver services on its behalf, should therefore be supported to develop a whole organisational approach to promoting equal opportunities and managing diversity. A whole organisational approach to intercultural issues in the health system represents a commitment to ensuring that inclusive, culturally sensitive strategies are developed, practiced and continually reviewed within an organisation. The approach addresses all systems, processes and practices of the organisation including culture, human resources practice, planning of services and service delivery. Key tools of a whole organisational approach include the commitment and support from managers, development of intercultural policies that clarify the organisation's approach and expectations in approaching diversity issues, implementation of ethnic equality monitoring within a framework of equality, learning and development for staff and managers, support programmes for staff in approaching cultural issues and potential conflicts with current models of service delivery, and facilities and services that respond to the diversity of cultural needs. Work currently being pioneered in health services in relation to aspects of equality and associated elements of service delivery will underpin and reinforce this approach.

Promoting interculturalism necessitates addressing racism and discrimination experienced by staff and service users. The Equal Status Acts and Employment Equality Acts provide clear guidance in relation to aspects of discrimination and harassment. The HSE is liable for discriminatory acts or harassment by an employee or individual acting on its behalf, unless it can be proven that reasonably practicable steps had been taken to prevent such discrimination. The HSE has developed a Dignity at Work in the health services policy to address workplace bullying and harassment. Together with training of staff in culturally competent care delivery, a gap at present is the absence of a policy that addresses issues of discrimination and racism in relation to service users. Such a policy should clarify the nature of direct and indirect discrimination, an organisational stance on discrimination, a process for proactively preventing issues of discrimination and racism from arising and a clearly documented process for handling cases that do arise.

Recommendation

A whole organisational approach to work with a diverse population will be actively championed to develop a culture and ethos that supports interculturalism. This approach should be multistakeholder and encompass advancing equality as a principle of service commissioning and planning, equality of opportunity, proactively managing diversity, addressing discrimination and racism, and promoting an approach that is responsive to the range of cultures and religions of service users.

Recruitment and Retention of Staff from Diverse Backgrounds

An element of a responsive health delivery system implies that employees of the health service should reflect the demographic profile of population they serve. International evidence demonstrates clear benefits for both the service user and health system in facilitating employment of health workers, health professionals and managers from the diverse cultures and backgrounds that reflect the overall population. The HSE, as the largest employer in Ireland, has an obligation to demonstrate a commitment towards equality in this area and an aspect of this will necessarily involve a proactive approach to managing diversity as part of the overall human resources strategy.

Data sourced from the national PPARS project indicates that at least 59 foreign nationalities are represented within health service settings. This data indicates that 90.19% of HSE staff are Irish, while 5.16% come from Asia, 2.47% from EU / EAA states, 1.65% from Africa, 0.22% from Oceania and 0.05% from the remaining countries in Europe and other states[40]. Within the minority ethnic cohort, 20.86% are from India, 20.38% from the Philippines, 17.48% from the UK and Northern Ireland, 6.92% from Nigeria, 6.39% from Pakistan, 3.26% from South Africa, 2.95% from Sudan and smaller percentages from a range of countries such as the United States, Poland, Australia, Germany, Iran, New Zealand and Spain.

Certain disciplines within the HSE appear to be more diverse, with 33.38% of the medical / dental category representing minority ethnic staff, and 14.68% of nursing / midwifery personnel from minority ethnic groups. Minority ethnic staff in the categories "health and social care", "other patient services", "general support" and "management / administrative" make up 8.81%, 4.52%, 3.89% and 2.17% of these disciplines respectively.

Little consistent information is available in respect of minority ethnic staff employed at different grades within the range of positions and disciplines within the health services. However, a breakdown by nationality of non-consultant hospital doctors within the HSE and voluntary hospitals at 1 October 20/10/06 reveals that 2,445.5 foreign nationals – or 54% of this category of doctors – were employed at this time. Of this overall complement, foreign nationals comprised 29% of all interns, 57% of all house officers, 76% of all registrars and 20% of all senior / specialist registrars[41].

The development and enhancement of systems aimed at producing data around numbers of staff from diverse cultures and ethnicities in different grades and categories will provide valuable information around aspects of promotion and retention of staff from diverse backgrounds.

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[40] The data in this section was sourced from the HSE National HR Director by the National Intercultural Healthcare Project, who analysed the data and made it available to the strategy. The data includes over 62,000 staff profiled under Phases 1 and 2 of PPARS. The areas of the health services covered correspond to the 3 HSE administrative areas – West, Dublin / mid Leinster, and Dublin / North East and St James's Hospital

[41] Personal Communication: N. Patil

The health service has engaged in targeted recruitment campaigns in several countries overseas to fill labour force shortages in key professions and, more recently, has recruited migrant staff into the services from the new EU accession states and other countries. There are examples of proactive measures being undertaken within the health services to integrate and manage cultural diversity in current teams. For example, the health services site of the overall EU-funded Equal at Work Project in the Greater Dublin area includes a project on integrating and managing intercultural working; in advance of a recent intake of overseas nurses into the system, the HSE National Nursing Recruitment and Retention Project implemented an Intercultural Training Initiative to prepare current teams to embrace diversity; the nursing and midwifery profession implements a preceptorship programme to support the integration of staff; and some healthcare settings include managing diversity as part of their management development programmes. These and other actions should be considered for further development and replication to other professions. The overall human resources strategy and approach of the health services, including the Equal Opportunities / Diversity Working Group sponsored by the HSE EA, should consider how to mainstream and replicate these and other initiatives.

Further consideration should be given to barriers to recruitment of employees from the diversity of minority ethnic communities living in Ireland into a variety of disciplines and grades. Good practice does exist in this area, with employment of Traveller primary care workers as an example. Consideration may need to be given towards the implementation of positive actions in this regard, such as target setting around the percentage of health personnel from diverse groups employed at all levels of the health sector.

Consideration also needs to be given to the range of factors that act as barriers to the promotion and development of staff from diverse backgrounds. Some settings have implemented development programmes for overseas nurses, for example, to encourage them to avail of promotional opportunities.

Research conducted by the British Medical Association in 2004 suggests that discrimination is a factor in aspects of access to training and in promotion opportunities for doctors from minority ethnic backgrounds[42]. The response of the Kings Fund[43] to the BMA's consultation confirms that barriers exist for minority ethnic applicants and doctors to access training, selection for posts and subsequent promotion. There is clearly scope within an Irish context for learning from this type of research in considering the overt and subtle barriers that may exist for staff from diverse ethnic and religious backgrounds in accessing promotional opportunities.

In addition to employing staff in professional grades, the health service is engaging minority ethnic staff in support professions, including catering, portering and cleaning, many of whom are engaged through contracted services. Evidence from overseas indicates that staff members from minority ethnic backgrounds tend to become an increasing part of this section of a workforce. The health service, as a public sector body, has a duty to ensure that staff engaged through external agencies benefit from employment conditions that conform to best practice, including equality practice.

The introduction of equal opportunities data collection, which should include data on ethnic origin, will allow for the monitoring of progress made in recruiting and retaining employees from diverse groups.

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[42] BMA 2005
[43] Kings Fund, 2004

Recommendation

The area of recruitment and retention of staff is the remit of Human Resources Directorate of the HSE, and encompasses all aspects of this function, including organisation development and design, employee relations, employee well-being, and performance and development. Collaborative efforts will be undertaken with the various functions of this directorate and the Equal Opportunities / Diversity Working Group of the HSE EA, in the development of proactive initiatives aimed at the attraction, selection, recruitment, professional development, promotion and retention of staff from diverse backgrounds. Such initiatives will include the proactive and positive management of cultural diversity in the workplace and the promotion of best practice in human resource management for all sections of the workforce, including externally contracted staff.

Learning, Development and Support for Staff

Central to a culture of equality promotion within organisations is the development of a culturally competent workplace where all staff members are equipped with requisite knowledge and skills to enable them to respond effectively and appropriately to the health needs of a multicultural, multiethnic society. Cultural competence is more than an awareness and knowledge of different cultures and ethnicities; Lister describes a culturally competent staff member as one "who provides or facilitates care which respects the values, beliefs and practices of the client, and which addresses disadvantages arising from the clients position in relation to networks of power".

Both service users and HSE staff agreed during consultations that issues around staff training should be accorded priority in the development of an Intercultural Strategy. Service users alleged incidents of racism and discrimination while service providers acknowledge a lack of understanding of the backgrounds, cultures and health care practices of minority ethnic service users. Misunderstandings between staff and service users, causing difficulties in accessing and using services, were also recounted.

Service providers participating in the consultations emphasised the need for training and support in a number of areas. Areas that were highlighted for training included intercultural awareness, skills in intercultural interaction, understanding norms of other cultures as they pertain to specific areas of healthcare including birth practices, death and bereavement, family and parenting, and dietary practices. Staff equally indicated a need to understand the specific issues facing refugees and asylum seekers, including victims of torture. Issues concerning the care of women who have been subjected to female genital mutilation are also pertinent.

Over the past few years various initiatives have been undertaken within health care settings to create services that are more accessible, sensitive and responsive to service users from minority ethnic communities. Significant investment has been made available to support awareness training for staff in Traveller health and culture, which has been developed and implemented locally by Traveller Health Units. In addition, cultural diversity training has been implemented in respect of other groups, including asylum seekers, refugees and migrant workers. This latter work has usually been on a pilot or local basis, involving staff in front-line and direct provision roles.

The report *Learning, training and development needs of health services staff in delivering services to members of minority ethnic communities* sets out a framework and action plan to support the upskilling of staff to work with the diversity of ethnic communities in Ireland today. This report was commissioned in the former Eastern region under the auspices of the Regional Health Strategy for Ethnic Minorities Implementation Forum. The framework that resulted was brought together by a working group comprising NCCRI, the Reception and Integration Agency, minority ethnic community representatives, health services staff and staff from provider agencies who had commenced intercultural initiatives. The framework was the first endeavour of the Irish health services to assess and respond to the intercultural learning needs of staff in a way that was more coordinated at organisation level, systematic, focused on the sustainability of learning activities and concerned with return on investment in training and development.

The research highlighted the widespread willingness and motivation of staff to be supported in responding more effectively to service users from diverse cultural and ethnic backgrounds. The report sets out a framework and action plan to support the upskilling of staff in working with diverse groups through the creation of learning, training and development initiatives for them. The framework recommends that many elements of a whole organisation approach need to be implemented concurrently in order for learning, training and development interventions to be fully effective. In addition, the approach ensures that the environment of health care is user friendly, accessible and inviting to minority ethnic service users, which in turn has benefits for staff working in cross-cultural health care. The framework identifies the elements of the whole organisation approach that need to be implemented under three strands: organisational ethos, workplace environment and service elements.

In 2006, the HSE programme of innovation and reform provided resources to commence the implementation of actions in this area. The purpose of this project is to create a culture in healthcare settings that supports the delivery of care in a culturally appropriate manner. Central to this are learning and development programmes aimed at developing the capacity of staff and managers to work interculturally, as well as developing actions around the environment in which health care is delivered

A set of demonstration sites, which have already developed some capacity in intercultural healthcare, are commencing the lead on the implementation of the initiative. Six of these sites are Local Health Offices that are located across the four administrative areas of the HSE. Namely these are Meath LHO, Dublin North Central LHO, Dublin South West LHO, Sligo / Leitrim LHO, Limerick LHO and Cork South Lee LHO. The remaining six are hospital settings, namely the Children's University Hospital Temple Street, the Rotunda Maternity Hospital Dublin, Connolly Hospital Blanchardstown, St. James's Hospital, Adelaide and Meath incorporating National Children's Hospital, and Sligo General Hospital.

Each demonstration site participating in this intercultural project, is implementing initiatives under each of the three elements of the whole organisation approach. This includes the development of a diversity structure that includes minority ethnic representation, assessing the stage of development of the organisation in supporting an intercultural approach, implementing programmes of intercultural training for staff and managers, developing initiatives to make the environment of health care accessible and inviting to members of socially excluded groups through for example signage and producing information in various languages, conducting outreach to minority ethnic communities, and developing prayer facilities and intercultural food projects in hospital settings.

The National Intercultural Healthcare Project is currently being evaluated; outcomes here will inform recommendations on the strategic direction of the project.

> **Recommendation:**
>
> Current initiatives aimed at the capacity building of staff to plan and deliver appropriate, responsive, culturally competent services to service users from a range of cultural and ethnic backgrounds should be expanded and implemented on a phased basis.

10. Implementation

10.1 Model of Implementation

The complex multidimensional health and support needs of such a heterogeneous group of service users requires the adoption of a comprehensive integrated approach to the implementation of the recommendations contained in this strategy. The intersecting and multifaceted nature and extent of health inequalities experienced by service users from diverse ethnic and cultural groups demands a concerted input from a range of stakeholders, both within and beyond the health sector, if a coordinated, joined-up response is to be effected regarding the implementation of the recommendations. Strong leadership and commitment from the HSE is required to progress such implementation, with roles and accountabilities agreed from the outset of the process.

At the same time, it is critical that such principles as equity, equality, interculturalism, partnership and community development govern the implementation of recommendations and continue to be used as criteria for reviewing existing services and commissioning new programmes.

Translating recommendations of a strategy into strengthened and enhanced service delivery is an ongoing challenge. The enthusiasm of so many stakeholders in their contribution to the development of this strategy confirms an interest and passion around the need for transferring the energy gained in this process into the subsequent implementation process. It is essential to honour this contribution through timely, coordinated efforts towards effective implementation.

The transformation of the HSE, together with the nature of the strategy and its associated vision and principles, suggests that the Implementation Plan should contain a number of core objectives:

- to retain and grow the necessary skills and competencies to meet the health and support needs of service users, service providers and staff, aligned to the principles of a transformed HSE

- to ensure that changes within ways of working are effected in a safe, clear manner, while meeting policy and legislative obligations

- to ensure that the implementation of recommendations is grounded within the fundamental values and principles shared by all HSE and HSE-funded services. Principles of person-centred services, improved accessibility, simple care journeys, responsiveness, partnerships with service users and communities, service integration, multi and interdisciplinary teamwork, and equitable distribution of services are intrinsic principles in this area of intercultural work

- to develop an operational framework with staff and partners that explains how recommendations will be implemented within a new HSE model of working and how the transformation around this will be effected

- to build a training and development programme with staff that supports them through the implementation of the recommendations and equips them to deliver services appropriately and effectively

- to continually communicate and engage with all stakeholders at local, regional and national level

To maximise a coherent response to the actions required in the strategy, it is proposed that an advisory group be established to guide and oversee the implementation of the recommendations outlined in the strategy. Such a body, coordinated by the Social Inclusion Unit within the office of the Chief Executive Officer of the HSE, should be broad based, with representation from HSE sectors, the Department of Health and Children, other statutory and voluntary agencies, and service users. This body, linking in with other relevant structures would, in the first instance, be charged to develop an action plan with clear actions, responsibilities and deadlines around the implementation of the recommendations of the strategy, co-opting additional members where appropriate. The action plan will accord some priority to the development of performance indicators, through which progress of implementation can be objectively monitored. Application of data gathered via ethnic monitoring will also be particularly relevant here.

Progress regarding the implementation of the strategy should be monitored, with regular reporting effected to stakeholders.

10.2 Supporting Implementation of the Strategy

Ensuring effective implementation of the strategy demands a willingness to adopt innovative and flexible ways of working which are responsive, person-centred and respectful of the principles underpinning the strategy. At the same time, methods of working should be planned around synergising collective efforts within and beyond the health sector. A joined-up approach to a coherent, prioritised, phased implementation is critical in this regard. Given the cross-cutting, multidimensional nature of this strategy, it is essential that efforts be directed at harnessing the key policies and activities of various core elements of the health system. Key components, integral to the HSE's transformed structures and essential for the effective, synergistic implementation of the strategy include:

- *a social inclusion approach aimed at improving access of all service users to services at all levels of care*

- *population health input in informing issues around health inequalities and associated actions, designed to promote appropriate local and regional knowledge regarding the health and support needs of specified populations. The inclusion of health impact assessments is a key element of this approach. Collaboration with community agencies around assessments is desirable. The information derived from these activities would promote improved identification of priority needs and gaps in service provision. It would also facilitate enhanced planning concerning the means of addressing issues, health promotion components, aimed at preventing and promoting health and social gain, and the associated effort around reducing effects of health inequalities*

- *a strengthened service planning approach, based on evidence of need and of the effectiveness of specific interventions and models of best practice*

• *a monitoring and evaluation component, continuously measuring effectiveness and quality of programmes and interventions against agreed criteria, and monitoring around equity of access, participation and outcomes, is critical to enhancement of service delivery*

• *a human resource element equipped to create and implement sustainable programmes of intercultural learning and development for staff and managers, as well as implement proactive strategies to attract, integrate and retain staff from diverse cultures and ethnic backgrounds*

• *financial management and accounting systems which provide for appropriate, targeted resourcing, effective reporting and related accountability*

• *communication and information strategies designed to inform all stakeholders of progress concerning the implementation of the strategy and to elicit feedback from them. In line with the nature of the strategy and its principles of facilitating improved accessibility, information should be provided and exchanged in appropriate, accessible ways*

10.3 Ways of Working

The importance of utilising partnership and community development models in designing, implementing and evaluating services for users from a range of cultures and minority ethnic groups is a core theme of this strategy.

Additional elements to be considered in working to achieve the implementation of recommendations of the strategy include:

• *the utilisation of existing structures. The reform of HSE structures lends itself to a coherent, integrated approach to a coordinated implementation of recommendations. Newly configured structures should be used to full capacity in driving and supporting such implementation. In this regard, structures such as the Expert Advisory Group, the National Working Group on Travellers and Ethnic Minorities and regional health forums may be appropriate vehicles with which the proposed National Advisory Body should be aligned*

• *the utilisation of existing mechanisms. The Primary Health Care Strategy is an ideally positioned mechanism via which much implementation of the strategy could be effected. Principles of primary health care are entirely consistent with the socially inclusive approach of the strategy, and the collective strengths of these approaches should be synergised towards effective strategy implementation*

- *harnessing and replicating good practice. Various models of good practice in working with members of diverse cultures and ethnicities have been acknowledged throughout this document. It is evident that much good practice exists in the area of minority ethnic health. However, this can be fragmented and patchy across the country. Principles of equity and equality demand that all good practice be identified and reviewed, with the aim of supporting their phased replication across all regions, where feasible. At the same time, with acceptance of the value of promoting integration, efforts should be undertaken to identify and explore good practice within the mainstream, where, with some enhancement or additional supports, service users from different cultures and ethnic groups could be facilitated in participating in relevant programmes. Service users should be involved in evaluating relevant mainstream initiatives. Various youth programmes offer positive opportunities and models in this regard*

10.4 Action Plan for Implementation

Given the wide-ranging and multidimensional nature of the issues raised in this strategy, it is imperative that a comprehensive, coordinated approach be used in implementing the recommendations of the strategy.

- *Following the launch of the strategy, a National Advisory Body should be established to guide the implementation of recommendations of the strategy. This representative, multisectoral group will link closely with appropriate HSE structures and mechanisms, which may include the National Working Group on Travellers and Ethnic Minorities and the anticipated Expert Advisory Group on Social Inclusion. Mechanisms will be put in place to ensure close linkages with existing regional and local ethnic minority fora, Traveller networks and other representative bodies. A reporting relationship will be in place through the Social Inclusion Directorate to the CEO of the HSE. Time frame for establishment of the advisory body and agreement of its terms of reference should be within three months of the strategy launch*

- *While the Intercultural Strategy provides a framework for addressing the care and support needs of service users from a range of cultures and minority ethnic backgrounds, it is not practical that all actions be defined within it. It seems most appropriate that a first priority of the advisory body be development of a detailed action plan around a coordinated, phased implementation of the recommendations of the strategy. This action plan should be produced within six months of the launch of the strategy. Resourcing of the implementation of the Intercultural Strategy and its associated actions will be a first consideration in this regard. Funding requirements should accompany each proposed action, with provisional figures being used towards motivation for new development funding for 2008/2009 onwards. Exploration of funding requirements will also allow for some examination of existing resources in the area of minority ethnic health*

- *Priority Actions: While a detailed action plan is required to facilitate a coordinated implementation of recommendations, certain priority actions may still be initiated immediately following the launch of the strategy. Major priority actions concern the design and development of a national interpretation service and associated actions regarding the enhancement of accessibility of translated material. Other actions that could be initiated within a short timeframe include identifying and reviewing current good practice in the country and making recommendations around its replication*

- *Work concerning the development of an interpretation service and associated communication supports should link closely with findings of the recently established multisectoral group led by the NCCRI in collaboration with RIA. Immediate actions in relation to interpretation services include the mapping and evaluation of current pilots and existing service delivery, and associated recommendations around further actions*

- *A formal review of identified good practice in the area of minority ethnic health should commence immediately, with findings reported and used to inform development of the required action plan. This review should comprise best practice in a range of health areas, including health assessment, health promotion and prevention, care, treatment and follow up. It should identify the target populations, e.g. children, women, older persons. Given the importance of other determinants, a review should be undertaken from a health system perspective, rather than from a rigid health service view, and thus may include relevant settings such as schools or community organisations*

- *A formal mid-term review of progress made in the implementation of the recommendations of the strategy and its associated areas will be conducted in 2010*

11 Appendices

11.1   References

Amnesty International (Irish Section) and The Irish Centre for Human Rights (2006), **Breaking Down Barriers: Tackling Racism in Ireland at the Level of the State and its Institutions, Available at:** www.amnesty.ie

British Medical Association (2005), **Tackling Racism in Medical Careers,** www.bma.org.uk/ap.nsf

Cáirde (2005), **The Experiences of Minority Ethnic Women Living with HIV, Dublin: Cáirde**

Cáirde (2006)**, Assessing the Health and Related Needs of Minority Ethnic Groups in Dublin's North Inner City, Dublin: Cáirde**

Census 2006, **Central Statistics Office, Dublin**

Clarke, K & Broring, G (2006), **HIV/AIDS Care and Support for Migrant and Ethnic Minority Communities in Europe, Netherlands: Netherland Institute for Health Promotion and Disease Prevention**

Comhairle (2005), **Access to Information for All, Dublin: Comhairle**

Combat Poverty Agency (2006), **Poverty and Social Inclusion: Linking Local and National Structures, Dublin: Combat Poverty Agency**

Combat Poverty Agency (2007), **Health Policy Statement, Dublin: Combat Poverty Agency**

Crowley, Dr P, (2005), **The Mental Health Needs of Asylum Seekers in Newcastle upon Tyne, Journal of Public Mental Health, Vol. 4, 1, 17–23**

Crowley, Dr P, (2005), **Ethnic Monitoring – Is it Important? Community Action on Health, Newcastle**

Department of Health and Children (2001), **Primary Care, A New Direction, Dublin: Stationery Office**

Department of Health and Children (2006), **A Vision for Change, Report of the Expert Group on Mental Health Policy, Dublin: Stationery Press**

Department of Health and Children (2006), **State of the Nation's Children, Dublin**

Department of the Taoiseach (2006), **Towards 2016, Ten-year Framework Social Partnership Agreement 2006-2015, Dublin: Stationery Office**

Directorate-General Justice, Freedom and Security (2006), **Handbook on integration for policy-makers and practitioners, Available at:** http://europa.eu.int/comm/justice_home/

Department of Justice, Equality and Law Reform (2006), **Planning for Diversity: The National Action Plan Against Racism, Dublin: Equal Status Division**

Department of Health and Children (2001)**, Quality and Fairness: A Health System for You, Dublin: Stationery Office**

Department of Health and Children (2002), **Traveller Health: A National Strategy, Dublin: Stationery Office**

Doyle, S (2006), **An Evaluation and Audit of the Asylum seeker Communicable Disease Screening in the Eastern Region**

Durie, M (2003), **Providing health services to indigenous peoples, Available from: www. bmj.com**

Eastern Regional Health Authority (2003), **Regional Health Strategy for Ethnic Minorities, Health Service Executive**

Fabian Society (2007), **Born Unequal**

Fanning, Dr B, Moore, Dr R, Ryan Dr D, O'Connell (2007), **Anti-Racism and Intercultural Health: Draft Literature Review, University College Dublin**

Harvey, B, (2007), **Evolution of Health Services and Health Policy in Ireland, Dublin: Combat Poverty Agency**

Health Service Executive (2005), **National Service Plan 2006**

Health Service Executive (2005), **Reach Out: National Strategy for Action on Suicide Prevention**

Health Service Executive (2005 - 2008), **Corporate Plan**

Health Service Executive (2006), **Transformation Plan**

Health Service Executive (2006), **Addressing the Mental Health Needs of Minority Ethnic Groups and Asylum Seekers in Ireland, Health Service Executive**

Immigrant Council of Ireland (2005), **European Commission Green Paper on an EU approach to Managing Economic Migration, Dublin: Immigrant Council of Ireland**

Irish Medical Journal (2007), **A survey of asylum seekers' general practice service utilisation and morbidity patterns, Volume 100, Number 10**

Joseph Rowntree Foundation (2006), **Ethnicity and poverty** www.jrf.org.uk/knowledge/findings/socialpolicy/2057.asp

Kelleher, K (2007), **Personal Communication**

Kelly, M (2005), **Immigration-related Detention in Ireland, Dublin: Irish Refugee Council.**

Kings Fund (2004), **Response to Consultation**, www.kingsfund.org.uk/publications/consultation_responses/tackling_racism.html

Kropiwiec, K (2006), **Polish Migrant Workers in Ireland, Dublin: NCCRI**

Manandhar M, Share M, Friel S, Walsh O and Hardy F (2006), **Food Nutrition and Poverty Among Asylum Seekers in North West Ireland, Combat Poverty Agency: Research Working Paper Series 06/01, CPA Dublin**

McAvoy, Dr H, Sturley, J, Burke, S, Balanda, Dr K (2006), **Unequal at Birth, Institute of Public Health in Ireland**

McFarlane, Dr A (2007), Draft Conference proceedings: **Participation of Ethnic Minority Communities in Primary Care, Department of General Practice, National University of Ireland, Galway**

McFarlane, Dr A (2006), **Overcoming Multicultural Language Barriers, Dublin: Forum magazine**

Migrant Rights Centre (2007), **Realising Integration, Dublin**

Ministry of Labour, Finland (2005), **Shaping our Future: A Practical Guide to the Selection, Reception and Integration of Resettled Refugees, Finland: Ministry of Labour**

National Report for Ireland on Strategies for Social Protection and Social Inclusion 2006-2008

National Economic and Social Development Office NESDO (2005), **NESC Strategy 2006: People, Productivity and Purpose, Dublin: The National Economic and Social Council**

National Economic and Social Development Office NESDO (2005), **The Developmental Welfare State No. 113, May 2005, Dublin: The National Economic and Social Council**

National University of Galway (2006), **General Practice Care for Asylum Seekers and Refugees, Galway: National University of Galway**

Niessen, J, Schibel, Y, & Thompson, C (2005), **Current Immigration Debates in Europe: A Publication of the European Migration Dialogue, Brussels: Migration Policy Group**

National Forum for Directors of Children and Family Services (2004), **Making Reform Work for Children, Dublin: National Forum for Directors of Children and Family Services**

National Resource Centre for Ethnic Minority Health, **Case Studies for Change, Scotland: National Resource Centre for Ethnic Minority Health**

National Resource Centre for Ethnic Minority Heal**th Executive Summary, Checking for Change, Scotland: National Resource Centre for Ethnic Minority Health**

National Consultative Committee on Racism and Interculturalism (NCCRI) (2003), **Changing Ireland, Dublin: NCCRI**

National Consultative Committee on Racism and interculturalism (NCCRI) (2006)**, Rationale, Principles and Model of Data Collection for Public Authorities on Ethnic Equality Monitoring at an Administrative Level (Focus on Education, Health and Policing), Dublin: NCCRI**

Office for Social Inclusion (2005), **National Action Plan against Poverty and Social Exclusion 2003-2005, Implementation and update report, Dublin: Office for Social Inclusion**

Office for Social Inclusion (2005), **National Action Plan against Poverty and Social Exclusion 2003-2005, Dublin: Office for Social Inclusion**

Office for Social Inclusion (2007), **National Action Plan for Social Inclusion 2007-2016, Dublin: Office for Social Inclusion**

O'Shea, T & Mongan, AM (2007), **Study Punctures Myths on Non-national Patients, Dublin Forum**

Pfizer (2007)**, Health Index**

Pierce, M (2003), **Minority Ethnic People with Disabilities in Ireland, Dublin: The Equality Authority**

Pillinger, J (2005), **Equal Status Review of HSE North Western Area, Health Service Executive**

Smyth, K, Whyte, J (2005), **Making a New Life in Ireland, Dublin: Children's Research Centre**

The Equality Authority (2000), **Building the Picture: The Role of Data in Achieving Equality, Dublin: The Equality Authority**

The Equality Authority (2007), **Play your Part, 2007 European Year of Equal Opportunities for All, Dublin: The Equality Authority**

Thrive Consulting (2005), **Learning, Training and Development Needs of Health Services Staff in Delivering Services to Members of Minority Ethnic Communities, Health Service Executive**

Traveller Health Unit Eastern Region (2006), **Caring for Diversity**

Wang, Y (2006), **Chinese Students in Ireland, Dublin: National Consultative Committee on Racism and Interculturalism**

Watt, P (2006), **An Intercultural Approach to "Integration", Dublin: National Consultative Committee on Racism and Interculturalism**

Watt, P, McGaughey, F (2006), **Improving Government Service Delivery to Minority Ethnic Groups, Dublin: National Consultative Committee on Racism and Interculturalism**

Women's Health Council (2005), **Integrating the Gender Perspective in Irish Health Policy: A Case Study, Dublin: The Women's Health Council**

Women's Health Council (2007), **A Guide to Creating Gender-sensitive Health Services, Dublin: The Women's Health Council**

11.2   Glossary of Terms

Anti-racism and intercultural training
Anti-racism and intercultural training seeks to challenge racism and to contribute to creating the conditions for a positive and inclusive environment for everyone within an organisation.

Assimilation

Assimilation was an unsuccessful policy aiming to absorb minority ethnic groups into the majority community, with an expectation that communities, their needs and their culture would become invisible or would expire. It was applied in countries with a longer history of migration (for example the UK and Australia), but also in Ireland in relation to Travellers. The 1963 Commission on Itinerancy referred to the "absorption" of Travellers into the general community. Assimilation has been largely discredited and has been superseded by concepts of integration, multiculturalism and interculturalism.
(See also integration).

Asylum seeker

An asylum seeker is a person seeking to be recognised as a refugee under the 1951 United Nations Convention Relating to the Status of Refugees, to which Ireland is a signatory. If someone is granted this recognition, they are granted refugee status and are no longer considered to be an asylum seeker.
(See also refugee).

Benchmarking

Benchmarking is about setting and reaching targets within a timescale. It relies on data collection through ethnic or equality monitoring to establish targets and measure progress against those targets.

Black

People can describe themselves as Black for a number of reasons, for example in relation to their physical appearance, their ancestry, as a political term or all of the above. Some people use the word Black to mean "of African origin"; whereas others mean "non-white" and would include people from Asia for example. Black is not generally considered to be a derogatory term and, in Ireland, the term "Black and minority ethnic group(s)" is often used.

Capacity building

This refers to the development of knowledge and skills in individuals, organisations and communities to enable them to participate more fully in social, political and work contexts. It enables individuals and communities to become more powerful in a sustainable way, and more able to influence decisions that affect them as individuals and as communities.

Citizenship

Citizenship can be a problematic concept, particularly in relation to migrants who may not have legal citizenship of the country in which they are living. It is often seen as a legal status with associated rights (for example voting) and responsibilities (for example paying taxes); however, broader definitions of citizenship recognise it as civil, political and social in nature.

Consultation

Seeking the views of interested parties on a particular service or policy. Interested parties can include people from minority ethnic backgrounds, staff, NGOs and special bodies. Engagement and participation are sometimes preferred as approaches and terms, as they suggest more ownership and power for minority ethnic groups.
(See also engagement).

Cultural competence

Cultural competence is having the right policies, knowledge and skills to meet the needs and practices of people from different cultural backgrounds. Culture is often taken to include aspects such as lifestyle, dress, diet, language (including art and music) and spiritual needs. Religious practices may cross cultural boundaries.

Data collection

In the context of improving Government service provision to minority ethnic groups, data collection refers to the process of capturing data from one or more primary or secondary sources. Some key data categories are: ethnicity, country of birth, religion and language.
(See also ethnic / equality monitoring)

Diversity

"Diversity" is often used to mean the wide range of minority ethnic or black / minority ethnic communities. A broader usage of the term is developing and "diversity" is now used to refer to the range of individual differences demonstrated among people. Diversity can include aspects such as class, educational background, accent, mental health and political beliefs as well as traditional aspects of equal opportunities such as sex, age, disability and race. A diversity approach focuses on mainstreaming and on the business case which values the opportunities and benefits of having diverse people. Diversity is complementary to traditional equality work and not a replacement for it.

Engagement

Engagement is about the participation of key stakeholders in the policy and service provision processes, including people from minority ethnic backgrounds, NGOs and special bodies. Engagement involves identifying those who should be involved and developing culturally appropriate strategies to engage with them. It includes consultation.
(See also consultation).

Ethnic minority

In the UK, an ethnic group was defined by the House of Lords as a group that regards itself or is regarded by others as a distinct community by virtue of certain characteristics that will help to distinguish the group from the surrounding community[44].
(See also ethnicity and minority ethnic group).

Ethnic monitoring / equality monitoring

Ethnic or equality monitoring is the process used to collect, store and analyse data about people's ethnic backgrounds. Ethnic monitoring can be used to:
  - highlight possible inequalities
  - investigate their underlying causes
  - remove any unfairness or disadvantage[45]
(See also data collection).

[44] Commission for Racial Equality, www.cre.gov.uk/duty/grr/glossary.html
[45] Commission for Racial Equality, www.cre.gov.uk/gdpract/monitoring.html

Ethnicity

Ethnicity is the shared characteristics such as culture, language, religion and traditions that contribute to a person's or group's identity. Ethnicity has been described as residing in:
- the belief by members of a social group that they are culturally distinctive and different to outsiders
- their willingness to find symbolic markers of that difference (food habits, religion, forms of dress, language) and to emphasise their significance
- their willingness to organise relationships with outsiders so that a kind of "group boundary" is preserved and reproduced[46]

Equality-proofing

Ensuring that all policies and decisions have taken full account of the needs of different equality groups and considered the possible impact of policies on different groups.

Foreign national / non-Irish national / non-national

These terms are increasingly used in Ireland, particularly in a legislative context. However, such terminology can be limited in other contexts. Terminology that solely focuses on nationality will become obsolete for most second- and third-generation migrants living in Ireland.

The term "non-national" should be avoided altogether as it is both inaccurate (most people have a nationality from their country of origin) and has negative connotations. "Foreign national" has most recently been used in draft immigration legislation to refer only to people who are not EU citizens and so using the term to refer to all migrants to Ireland may also cause confusion. "Non-Irish national" may be the least problematic.

However, outside of a legislative context where nationality is relevant, it is useful to ask why the word "national" is required. For example, would I describe myself as Irish or "an Irish national"? Or, as an Irish person living in France, would I describe myself as "a non-national / non-French national"? Also, would I describe people from the UK or America as "non-nationals"'? Where possible, the term minority ethnic groups"' is preferred.

Harassment

Any form of unwelcome conduct related to any discriminatory ground; conduct which has the purpose or effect of violating a person's dignity and creating an intimidating, hostile, degrading, humiliating or offensive environment for the person.

Illegal

Migrants who do not have a valid work permit or visa in Ireland are sometimes described as "illegal". There are a number of reasons why someone could find themselves in such a situation, sometimes through no fault of their own – for example, people who have been trafficked or workers whose employer did not renew their work permit. In this context, an alternative to the use of the term "illegal" is "undocumented".

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[46] Tovey, H and Share, P (2003) "A sociology of Ireland", pp.470-471 in Equality Authority (2006) "Traveller Ethnicity".

Asylum seekers are sometimes described as "illegal". This is a misnomer. Asylum seekers cannot be illegal as everyone has a recognised human right to seek asylum[47]. There are then processes in place to decide whether an asylum seeker has met the definition of refugee.

Institutional racism

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin which can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages minority ethnic people."[48]

Institutional racism is similar to systemic racism, except that systemic racism primarily relates to systems, policies and procedures, whereas institutional racism relates to the entire institution, including people.
(See also systemic racism).

Integration

The concept of integration is a complex one and, while there are many different views as to what constitutes integration, it is still part of an ongoing debate in Ireland. In the most simplistic terms, integration can be a one-way process (in effect assimilation) where minority communities are expected to adapt or change without any expectation of change from the state or majority communities. On the other hand, integration can be a multi-faceted, intercultural process that requires the state, majority and minority ethnic communities to work together to accommodate diversity, without glossing over challenges and barriers such as extremism or racism.
(See also assimilation and interculturalism).

Interculturalism

Interculturalism is essentially about the interaction between majority and minority cultures to foster understanding and respect. It is about ensuring that cultural diversity is acknowledged and catered for. "Developing a more inclusive and intercultural society is about inclusion by design, not as an add-on or afterthought. It is essentially about creating the conditions for interaction, equality of opportunity, understanding and respect."[49]

Irish-born child

"Irish-born child", sometimes referred to as IBC, usually refers to a child born in Ireland whose parents are not Irish or EEA citizens. Prior to January 2005, Irish-born children were entitled to Irish citizenship. Following the Citizenship Referendum in 2004, legislation was passed so that it was no longer possible for persons born in Ireland to obtain automatic Irish citizenship.

Leave to remain

Also known as "permission to remain". This is a statement of the conditions and duration on which a non-EEA citizen is permitted to remain in Ireland. It is given on behalf of the Minister for Justice, Equality and Law Reform in the form of a stamp in the person's passport. The main grounds upon which further permission to remain can be obtained are: for the purposes of employment, to study, to operate a business or as a dependant family member of an Irish or EEA citizen residing in the State.

Another type of leave to remain is humanitarian leave to remain, typically granted to an asylum seeker who does not succeed in being recognised as a refugee through the asylum process but who is recognised as having humanitarian grounds on which to stay in Ireland.

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[47] For example under Article 14(1) of the Universal Declaration on Human Rights.

[48] "The Stephen Lawrence Inquiry: Report of an Inquiry by Sir William Macpherson of Cluny", (1999) Cmd 4262-I, London: HMSO.

[49] Department of Justice, Equality and Law Reform, (2005) "Planning for Diversity, the National Action Plan Against Racism", p.38.

Mainstreaming

Mainstreaming means ensuring that policies and processes are inclusive of the needs of minority ethnic groups, including consideration of these needs in the planning, implementation and review of policies and practices for their impact on minority ethnic groups. Mainstreaming does not mean that there is one "mainstream" model of service provision of the one-size-fits-all kind, rather that the awareness of different needs and thus different models of service provision becomes central to an organisation's *modus operandi*.

Migrant worker

The term "migrant worker" refers to a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a state of which he or she is not a national[50].

Minority ethnic group(s)

Sometimes also described as 'Black and minority ethnic group(s)', this means a group whose ethnicity is distinct from that of the majority of the population. The term "ethnic minority" is sometimes used, but the term 'minority ethnic' draws attention to the fact that there are majorities and minorities, all with their own ethnicity – white Irish people are the majority ethnic group. Although this is the NCCRI's preferred term, one limitation of the term 'minority ethnic group' is that it can infer that people from a minority ethnic background are immediately identifiable with, or would wish to be identifiable with, a particular group. Service providers should be aware that this is not always the case.
(See also ethnic minority and ethnicity).

Multiculturalism

Multiculturalism acknowledges the need for the recognition and celebration of different cultures in a society. Multiculturalism varies from one country to another and has had varied success. One criticism has been that it allowed the growth of parallel communities with little interaction between them, whilst glossing over issues such as racism and economic deprivation.
(See also interculturalism).

National Action Plan Against Racism (NPAR)

Ireland's National Action Plan Against Racism: Planning for Diversity covers the period 2005–2008. It originates from commitments given by governments at the United Nations World Conference Against Racism in South Africa in 2001. The decision to develop the NPAR was further reaffirmed in Sustaining Progress, the Social Partnership Agreement 2003-2005. The NPAR sets out a plan of action for key areas of public life in order to develop measures to accommodate cultural diversity in Ireland.

Prejudice Prejudice involves "pre-judging" someone and is frequently used to describe the negative attitudes some people have towards certain groups, such as religious or ethnic groups.

Programme refugee

A programme refugee is a person who has been invited to Ireland on foot of a Government decision in response to humanitarian requests from bodies such as the United Nations High Commission for Refugees. Programme refugees are facilitated in settling into communities on arrival in Ireland, rather than being placed into the direct provision system. They are also able to seek employment and are entitled to full Social Welfare entitlements from their date of arrival.

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[50] Article 2, United Nations International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.

"Race"

The term "race" is a social construct used to classify people. Originally race was based on a false belief that biologically there were different species of humans, with the implication that some races were superior to others. However, research has proved that there is no single race-defining gene and, therefore, no biological basis for dividing the human population into different races.

The term race is still widely used in legislation. In Irish equality legislation, the "race" ground is described as "race, colour, nationality, or ethnic or national origins". The NCCRI encourages the use of inverted commas when use of the word "race" is unavoidable.

Racial discrimination

Racial discrimination can be direct or indirect.

Direct racial discrimination occurs when a person receives less-favourable treatment or a less-favourable outcome than another person in the same situation would have received on the grounds of their "race". In Irish equality legislation, the "race" ground is described as "race, colour, nationality, or ethnic or national origins".

Indirect racial discrimination occurs when a seemingly neutral policy or requirement actually has an adverse impact on a person from a minority ethnic background. Indirect discrimination can be unintentional.

Racism

Racism is a specific form of discrimination and exclusion faced by minority ethnic groups. It is based on the false belief that some "races" are inherently superior to others because of different skin colour, nationality, ethnic or cultural background.

The International Convention on the Elimination of All Forms of Racial Discrimination defines racial discrimination as "any distinction, exclusion, restriction or preference based on 'race', colour, decent, or national or ethnic origin which has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise, on a equal footing, of human rights and fundamental freedoms in the political, economic, social, cultural or any other field of public life".

Refugee

A refugee is a person who has left his / her country and cannot return due to a well-founded fear of persecution on the basis of their race, religion, nationality, membership of a particular social group or political opinion[51]. In Ireland, membership of a social group includes "….membership of a trade union… membership of a group of persons whose defining characteristic is their belonging to the female or male sex or having a particular sexual orientation."[52]
(See also asylum seeker, leave to remain and subsidiary protection).

Stereotyping

Generalising about particular minority ethnic groups and labelling them, thus creating false expectations that individual members of the group will conform to certain (often negative) traits or characteristics that have been attributed to the wider group or community.

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[51] According to the 1951 United Nations Convention Relating to the Status of Refugees, to which Ireland is a signatory.
[52] Section 1 Refugee Act 1996 (as amended).

Subsidiary protection

Under an EU Directive implemented in Ireland in 2006[53], a status of subsidiary protection was introduced. A person eligible for subsidiary protection is described as "a third-country national or stateless person who does not qualify as a refugee but in respect of whom substantial grounds have been shown for believing that the person concerned, if returned to his or her country of origin…would face a real risk of suffering serious harm…"

Systemic racism

System racism is found in the "systems" of an organisation, for example in policies, procedures and practices. It is often unintentional but can have a negative impact on a minority ethnic group(s). It is unlikely to be identified and tackled unless proactive steps are taken by the organisation.

Systemic racism is similar to institutional racism, except that systemic racism primarily relates to systems, policies, and procedures, whereas institutional racism relates to the entire institution, including people.

Targeting

Targeting is about the development of specific policy and service provision priorities and strategies tailored to meet the needs of minority ethnic groups. Targeting can include, but is not limited to, positive action measures.

Third-country national

The term "third-country national" is often used to describe people who are not citizens of the EU. This term is problematic for some of the same reasons as described above in relation to foreign national / non-Irish national / non-national.

Tolerance

Tolerance was once a commonly used term in relation to inter-ethnic and inter-faith relations. However, it is now considered inadequate as it assumes superiority of the persons who tolerates towards the supposedly inferior group / person to be tolerated. Tolerance is most often used in connection to something people do not like; as such, to tolerate another person or persons is a minimum standard, not an ideal such as interculturalism (see above).
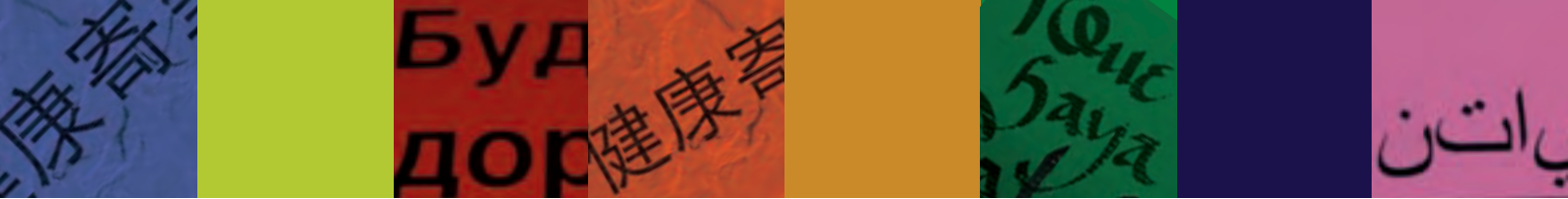
Traveller

"Travellers are an indigenous minority, documented as being part of Irish society for centuries. Travellers have a long shared history and value system which make them a distinct group. They have their own language, customs and traditions."[54] Travellers may or may not live a nomadic lifestyle.

The recognition of Travellers as an ethnic group is a contested issue. To date, the Irish Government has not recognised Travellers as an ethnic group whereas many NGOs, expert and specialised bodies do recognise Travellers as an ethnic group and, in Northern Ireland, Irish Travellers are recognised as an ethnic group. Until this issue is resolved, the compromise achieved in the National Action Plan Against Racism is to refer to "cultural and ethnic minorities in Ireland", a term which is inclusive of Travellers, without necessarily recognising Travellers as an ethnic group.

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[53] Council Directive 2004/83/EC of 29 April 2004 on minimum standards for the qualification and status of third-country nationals or stateless persons as refugees or as persons who otherwise need international protection and the content of the protection granted.

[54] Pavee Point, www.paveepoint.ie/pav_culture_a.html

Universal access

A person-centred approach that guides the design of creating buildings that can be used fully and freely by all. It creates equitable access for everyone, thereby creating ease of use of the space for the intended function, regardless of a person's physical, sensory or cognitive ability.

Whole organisation approach

A holistic approach to address racism and support inclusive, intercultural strategies within an organisation, with reference to equality policies and equality action plans. The National Action Plan Against Racism uses a whole organisation approach with four components: mainstreaming, targeting, benchmarking and engagement.

Xenophobia

Fear or hatred of foreigners or people perceived to be from a different ethnic or cultural background.

Definitions above, were, for the most part, taken from the NCCRI's recently published booklet *Useful Terminology for Service Providers*. Additional definitions were sourced in *Progressing the Race, Ethnicity and Health Agenda in NHS Scotland.*

11.3 Abbreviations

EAG: Expert Advisory Group
EEA: European Economic Area
HIQA: Health Information and Quality Authority
NHO: National Hospitals Office
PCCC: Primary, Community and Continuing Care
NPAR: National Action Plan Against Racism
NCCRI: National Consultative Committee on Racism and Interculturalism
NESC: National Economic and Social Council
ORAC: Office of the Refugee Applications Commissioner
RIA: Reception and Integration Agency
WHO: World Health Organisation

11.4 Membership of Steering Group

Diane Nurse, Social Inclusion, HSE, **Chairperson**
Bridget McGuane, Human Resources, HSE
Caoimhe Gleeson, Human Resources, HSE
Eileen O'Neill, Population Health, HSE
Fergal Black, Primary, Continuing and Community Care, HSE
Fidele Mutwarasibo, Immigrant Council of Ireland
Fidelma MacHale, National Hospitals Office, HSE
Issah Hussein, Ethnic Minority Health Forum
Jane Pillinger, Researcher
Naishadh Patil, ENT Consultant, HSE (from 01 / 07)
Paddy Connelly, Cáirde
Philip Crowley, Deputy Chief Medical Officer, DoHC
Philip Watt, NCCRI
PJ Boyle, Asylum Seeker Services, HSE
Rebecca Loughry, Community Services, HSE
Ronnie Fay, Pavee Point
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11.5   Participation in Consultations

11.5.1 Questionnaire Responses

Community and Voluntary Sector, Service Providers and Service Users:

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Ann Delany	Josephine McGourty	Noeleen Kealy
Bryan Clancy	Lilian C Harris	Paul Madden
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Deirdre Twomey	Mary Ryan Rose	The Loft LK Youth Project
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Anne Marie Feely	Denise Robinson	Mairead Connolly	Paula Gilvarry
Aoife Byrne	Dolores Gallagher	Margaret Armstrong	Pauline McCarthy
Aoife Hayden	Dr Patricia O'Flynn	Margaret Campbell	Rebekkah Woolfson
Audrey Crawford	Eifion Williams	Marianne Healy	Rosemary Orr
Bernie Convey	Elaine Bowe	Mary Carey	Ruth Dawson
Breda McLeavey	Elizabeth Kelly	Mary Connolly	Sandra Judge
Brian McKeever	Ena Poelenjee	Mary Egan	Sinead Donohue
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Cait McKeon	Frances O'Keeffe	Mary Jordan	Theresa Kearney
Caren Pfiffer	Genevieve O'Halloran	Mary Leahy	Theresa Shryane
Carmel Donohoe	Ger McCormack	Mary Martin	Tommy Mc Larnon
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Catherine Flynn	Grainne Dowdall	Maureen Long	Yvonne Martin
Catherine Kennedy	Helena Heagney		

11.5.2 Participants in Consultation Events

Community and Voluntary Sector, and Service Users:

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Alice Binchy	David Collins	Louise Mullen	Ronan Williams
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Alvina Grosu	Deo Ladislas	Margaret Meehan	Rose Ward
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Anna Chinezeezema	Hugh Byrne	Michael	Sharon O'Meara
Anne Brady	Iretiola Sobanyo	Missie Collins	Sndlk Siamand
Anne Cronin	Isaac Durosaye	Mollie Collins	Sr. Breege Keenan
Anne MacFarlane	Jacob Nwazoti	Muhamad Reja Bazaz	Sr. Teresa O'Neill
Arthur Mbala Yanga	James Zacharias	N. O'Brien	Stefania Minervino
Avril Elliott	Jennifer Ryan	Namdi Ikah	Stephanie Abbasah
Barbara Marx	Jo Hunt	Niall Behan	Theresa McCarthy
Beth Wallace	Joanne Ozdarska	Noeleen Kealy	Tony Murphy
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Breda O'Donnell	John Duffy	Noreen Obrien	Una Darby
Bridget McDaid	Jonas Bakikematura	Nuala King	Ursula Mullan
Bridget Nevin	K.Dawo Alphonse	Olarewaju Okeolu	Utachi Ehirim
Bridget Ward	Karl Quinn	Olive Onono	Uzma Ahmed
Bridgie Collins	Kate Morris	Orla Ni Eili	Victoria Newton
Carmel Gornall	Kate Quinlan	Pa Philip	Wilberforce O'ansaa
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Chinenye Uicah	Laura Griskeviciute	Q Esperance	

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Angela Hughes	Eileen Connolly	Maria Forde	Patricia Mathiasz
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Ann Gallagher	Fiona Hardy	Marie Kee	Paul McGilligan
Ann Marie Quigley	Fionnuala Sheen	Marie O'Flynn	PJ Guinnane
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Anne Canty	Ger Hanna	Mary Creedon	Ronnie Dorney
Anne Condon	Ger McCormack	Mary Martin	Rose Foley
Anne O'Neill	Geraldine O'Callaghan	Mary Morrissey	Rosemary Orr
Anne Tully	Gerry Healy	Mary Roche	Ruth Dawson
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Caroline Callaghan	Helen O'Shea	Mary O'Donnell	Sue Curley
Caroline Fitzgerald	Helena Heagney	Mary O'Riordan	Susan Kelleher
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Catherine O'malley	Joan O'Doherty	Maurice Delaney	Theresa Kearney
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Chris Sheridan	John Cullinane	Michael Geaney	Tim Hanly
Colm Byrne	Julie Cruikshank	Michelle Donnelly	Tim McCarthy
Conal Dillon	Katherine Farrelly	Mike Rainsford	Tom McGuire
Deirdre O'Donoghue	Keith Brennan	Mona Albertini	Tricia McLaughlin
Deirdre O'Reilly	Kevin O'Farrell	Nick North	Trish Martyn
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Dolores Mullahy	Laura McHugh	Noreen Keating	Valerie Minogue
Dr Fiona Ryan	Lisa Daly	Noreen Spillane	Vincent Crossan
Dr Tim Jackson	Liz Faherty	Olive Butler	Vincent Gilgunn
Edel Healy	Madeleine Munnelly	Olive Carolyn	
Eileen Deflores	Maeve Dooley	Paddy Crampsey	

11.5.3 Written Submissions

Access Ireland, Dublin
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Children's Research Centre, Trinity College, Dublin
City wide Drugs Crisis Campaign, Dublin
Combat Poverty Agency, Islandbridge, Dublin 8
Community Nutrition and Dietetic Service, HSE West, Galway
Cork University Hospital
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Dr Anne McFarlane, Dept General Practice, NUI, Galway
Dún Laoghaire-Rathdown County Council
Galway Refugee Support Group
GRACE: GORT Regional Alliance for Community and Environment
Irish Traveller Movement / Traveller Specific Drugs Initiative – Pavee Point
MARTA: Migrants, Asylum Seekers and Refugees Training for Action
Mayo Intercultural Action
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Ms Emer Nowlan
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