Migrant Women’s Awareness, Experiences and Perceptions of Health Services in Limerick
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Foreword and Acknowledgements

This project was undertaken through a partnership formed between AkiDwa and Doras Luimní and it was funded by the Health Services Executive.

Our aim was to engage with migrant women living in the greater Limerick area to explore understandings of health and wellbeing, experiences of access to health services, and perceptions of accessibility and appropriateness of the services. A participatory, mixed methods approach was employed involving a series of four workshops and a short questionnaire survey.

The data gathered gave us an insight into the levels of awareness and service usage amongst this group of local migrant women and a sense of some of the factors affecting their experiences of health services. It is important to appreciate the positive points to take from the findings. Chiefly, the good general awareness of health services amongst the women, and their overall positive experiences of accessing services.

It is important to also recognise and act upon the areas where there is room for improvement. The main focus of dissatisfaction regarding access and availability of services centred on delays and information, while communicative barriers and intercultural competence emerged as a concern regarding the quality and appropriateness of service delivery.

The experience of undertaking this joint project between AkiDwa and Doras Luimní, with the support of the HSE, has strengthened the collaborative relationships between our organisations. We are very pleased to have taken part in this project and we hope that this report will contribute towards ongoing efforts to promote full and equitable access to health services for all members of the community.

We wish to acknowledge the contribution of all involved this project, not least the women who shared their experiences and perceptions and made this project possible. Thanks also to the team who prepared and coordinated the workshops and questionnaire, compiled and analysed the results, and wrote the report: Alwiye Xuseyn, Leonie Kerins, Maria Kirwisa, Siobhán Ní Chatháin and Elham Teymoor.

Karen McHugh, CEO Doras Luimní & Salome Mbugua CEO AkiDwa

November 2012
Context of the Project

The Right to Health

This project is premised on the following understandings which are set out in preamble to the 1946 Constitution of the World Health Organisation:

- that health is not merely the absence of disease or infirmity, but rather it is “a state of complete physical, mental, and social well-being”;
- the right to the highest attainable standard of physical and mental health is a fundamental right of every human being “without distinction of race, religion, political belief, economic or social condition”, and it is essential to a life of dignity.

Furthermore, this project is informed by a social determinants of health model, which is the understanding that

- health and health outcomes are influenced by social, cultural, economic and environmental factors;
- inequalities in health outcomes and access to health services are symptomatic of social inequalities.

The WHO specifies that components of the right to health include the entitlement to avail of health protection, health care, health-related education and information on an equal, nondiscriminatory, and timely basis. The right to health also includes the right to adequate standards of drinking water and sanitation, nutrition and housing. States are responsible for ensuring that health facilities, goods and services are available, accessible (including physically and economically accessibility as well as information accessibility), acceptable and of adequate quality.

The WHO recognises both women and migrants as groups which may face particular hurdles in relation to the right to health. The right to health of migrants is closely related to and dependent on their working and living conditions and legal status. Low pay, poor accommodation, poor working conditions, social isolation, discrimination and racism can lead to migrants experiencing health inequalities (Pillinger 2008). Factors that impinge on migrants’ access to national health services include legal or status issues which have implications for eligibility/entitlement; knowledge and information deficits; communication issues; personal, socio-cultural and economic factors.

As a signatory of the International Covenant on Economic, Social, and Cultural Rights (1966) the Irish State formally recognises and endorses the right of all to “the enjoyment of the highest attainable standard of physical and mental health”.

The HSE’s Social Inclusion Unit was tasked with the development of a National Intercultural Health Strategy (NIHS) for the Irish health sector. A nationwide consultation process was carried out in preparation of the strategy and the resulting policy document sets out a framework for the design and delivery of services based on principles of inclusiveness, participation and community development. The strategy is premised on the acknowledgement of distinct health and support needs of diverse ethnic and cultural groups which comprise Irish society. Based on this understanding, the HSE aspire to pursue “responsive, flexible ways of facilitating equal and optimal access to and utilisation of health services, with positive health outcomes” (HSE 2008, p.28). Due to resource constraints, the NIHS is being implemented on a phased, prioritised basis (Nurse 2010).
Migrants’ Access to Health Care in Ireland

Immigration status is an important factor in determining use of health services in Ireland (Conlon et al 2012). Poor access to services is often experienced by undocumented migrants, low skilled workers, those seeking asylum and those who have refugee status (Pillinger 2008)

Migrants from countries which are not within the EU and EEA are often referred to as Third Country Nationals. Depending on their country of origin, their reason for migrating and their path of entry, these migrants are channelled into different immigration categories with varying sets of entitlements, obligations, permissions and restrictions. The main channels of immigration for non-EU/EEA migrants are as work-permit holders, through the asylum system, as students or as dependents of legal residents.

Migrants’ access to social entitlements is mediated by the Habitual Residency Condition (HRC). Since 2004 applicants have to meet a two year residency criteria in order to qualify for most forms of social support. They must also demonstrate that they have established their main centre of interest in Ireland.

Migrant workers account for 15.1% of the workforce in Ireland (CSO 2012a) and half of the migrants entering the Irish labour market are women (Barry 2010). Just over 10% of migrants are students or pupils (CSO 2012a). Those with student visas are required to have private medical insurance, are entitled to engage in employment only on a ‘casual’ part-time basis, and have "no recourse to public funds" (INIS 2010).

Refugees are people who are recognised as fulfilling the criteria as set out by 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.

Refugees may have been processed through the Irish immigration and asylum system or they may have been invited as ‘programme refugees’. Those with refugee status have almost equivalent rights and entitlement to that of citizens in Ireland. They may apply for family reunification whereby family members abroad are given permission to take up residence in Ireland.

Asylum seekers’ are not permitted to engage in employment and they have very limited entitlement to social welfare supports. Because of these restrictions the vast majority of asylum seekers are housed in the direct provision system, which is overseen by the Reception and Integration Agency (RIA).\(^1\) Officially, asylum seekers’ access to health services in Ireland is provided on the same basis as for Irish citizens. As such, asylum seekers are eligible for medical cards on a means-tested basis. On receipt of a medical card they are entitled to access a range of health services, including primary care through a GP, free of charge.

Leave to Remain is a form of residency permission which may be granted for the purposes of employment, study, to operate a business or as a dependant family member of an Irish or EEA citizen, or it may be granted to unsuccessful asylum applicants who are recognised as having humanitarian or other grounds on which to stay in Ireland.

Undocumented migrants are any persons who do not have formal permission or status within the state in which they are living. This includes people entering a state using false documentation or without declaring their presence to immigration authorities, as well as those who have become undocumented due to visas have expired or non-adherence to the conditions attached to their residency permission. There are an estimated 30,000 undocumented migrants in Ireland (Barry 2010). Undocumented migrants do not have any entitlements with regard to accessing public services. The invisibility of undocumented renders them more vulnerable to sexual and economic exploitation and gender-based inequality (Barry 2010).

\(^1\) In general direct provision accommodation is provided by commercial operators on a contract basis; the management of a small number of state-owned centres is also contracted out.
Migrants in Ireland perceive their health status more positively than Irish citizens, with 93% of migrants describing their own health very good or good, compared with 87% of Irish nationals (QNHS 2011). This may be seen as an incongruent statistic given the identification of migrants as a disadvantaged population group in relation to health. However, a host of demographic factors, including the younger age profile of the migrant population, are likely to come into play here with 60% of all migrants aged between 22 and 44 years (CSO 2012a).

Migrants are much more likely than Irish citizens to have private health cover (51% compared with 24%), and slightly more likely to have a medical card (35% compared to 29%). The proportion of migrants with medical cards has increased significantly in recent years (growing from 16% in 2007 to 34% in 2010), while reliance on general public healthcare has substantially decreased (declining from 61% to 42% between 2007 and 2010).²

Amongst the migrant population, some groups have very distinct health issues and needs. Internationally it is recognised that asylum seekers are subject to higher rates of depressive disorders and post-traumatic stress than the rest of the population (Nwachukwu 2009). An Irish study found that asylum seekers were five times as likely to present to health services with a psychiatric condition compared their Irish counterparts, and three times more likely to be diagnosed as suffering from anxiety (McMahon et al 2007).

The direct provision system has been subject to severe and sustained criticism since it was introduced, not least in relation to its impact on the health of residents (e.g. Comhlámh 2001; FLAC 2003, 2009; AkiDwA 2010; Arnold 2012). The HSE (2008) report on the NIHS noted that asylum seekers’ mental health is affected by social isolation, poverty, poor housing and a lack of understanding of services, recognising that the non-entitlement to work as a factor which “may further compound” mental health issues.

Health providers in Ireland perceive themselves to be under-sourced in catering for the specific needs of migrants, and particularly those with specialised healthcare needs such as asylum seekers (Nwachukwu et al 2009; Piper 2011). Frontline staff in statutory services expressed concerns about not having necessary skills relating to communication, cultural, organisational and clinical issues (Piper 2011). Furthermore, health staff have reported stress and anger due to being put under pressure on their services (Piper 2001). Some health workers consider that an awareness of clients’ backgrounds (such as country of origin conflict situations) and that greater familiarity with the religious, cultural or gendered practices of various migrant groups would better equip them to provide appropriate and sensitive care (Ni She et al 2007).

Profile of Limerick Migrant Community

Migrants make up 12% of the population living in the Republic of Ireland: there were over 544,000 ‘non-Irish nationals’ resident in the country in April 2011, including 199 different nationalities (CSO 2012). 12.1% of the population of Limerick city and 8.7% of the population of Limerick are migrants. The highest proportion of foreign nationals, in both the city and county, are Polish citizens (3,518), followed by UK citizens (2,864). People living in RIA provided accommodation constitute approximately 0.12% of the population living within the HSE Mid-Western area.

Presently, RIA is responsible for accommodating 4,989 persons living in 37 centres throughout the country. Two of these centres, Hanratty’s and Westbourne, are located in Limerick city. They have a current occupancy of 93 and 66 residents respectively, including male and female single adults. Knockalisheen accommodation centre is located in County Clare between Limerick city and the village of Meelick. This is a state-owned facility housing families with children as well as

² This information is drawn from the Health Status and Health Service Utilisation module of the Quarterly National Household Survey from the 3rd quarter of 2010 (QNHS 2011).
single adults and currently has 185 residents. Mount Trenchard, which currently accommodates 64 single men, is located outside of the town of Foynes in County Limerick. In the 2011 census, 118,039 of the ‘usually resident’ population of Limerick identified themselves as White Irish; 9,204 identified as Other White; 1,764 identified as Asian or Asian Irish; 1,113 as White Irish Traveller; and 1,111 identified as Black or Black Irish. Women constitute roughly half of all migrants living in Ireland – in April 2011 there were over 272,495 migrant women living in Ireland – and about 60% of them are aged between 22 and 44 years (CSO 2012b).

Project Methodology

The sample is comprised of 35 women who participated in the workshop series and 26 respondents who took part in the survey – with some overlap between the two groups. The women were all migrants with a mix of legal status including undocumented migrants, refugees and those with Leave to Remain, but the majority were asylum seekers living in direct provision accommodation. There was considerable diversity of national and ethnic/cultural backgrounds – with at least 17 different nationalities included in the sample group. All participants were over 18 years, and the majority were aged between 25 and 45 years.

The women who took part in both the workshops and survey remain anonymous to parties outside of the team of Doras Luimní and AkiDwA staff who conducted the study. No identifying information is included this report in order to preserve the confidentiality of the women involved and where they are quoted respondents are identified only by number (e.g. R6).

The women were made aware that participation in the study was voluntary and they were entitled to withdraw at any stage. The purpose of the study and the methods employed were explained verbally and in writing to workshop participants. This was conveyed to questionnaire respondents through the intermediaries in migrant communities who distributed the survey.

Workshop Series

The workshop series was held over a three month period from September to November 2011. The workshops were facilitated by Alwiye Xuseyn of AkiDwA, and centred on a participatory approach in discussing and articulating women’s understanding of health, identifying their health experiences and needs. The discussions were based on the women’s personal experiences as migrant women. As noted above, it was agreed with participants the workshops would not be audio recorded; instead notes were taken by research assistant, Maria Kirwisa, who was present during the four workshops.

The first workshop commenced with a discussion of the notion of health and how it may be defined. In the second workshop, participants were asked to consider their experiences and identify their needs in relation to the categories of psychological, social, physical, emotional, economic, intellectual and spiritual. The third workshop focused on visual depictions of health. Participants were divided into smaller groups and were asked to select pictures from old magazines to create collages illustrating physical, emotional, economic, and social health. In the final workshop the questionnaire was distributed to participants and the questions were

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3 These figures are correct as of the end of August 2012 (RIA monthly statistical reports are available online at www.ria.gov.ie). Notwithstanding the reduced overall numbers of asylum seekers in Ireland, the average length of time that residents spend in the direct provision system has continued to increase. The most recent data shows that the average length of stay in direct provision accommodation is 44 months (RIA 2012). RIA continues to carryout a policy of reducing its capacity by winding down self catering arrangements in preference for full-board accommodation, the implementation of which has proved controversial (e.g. Doras Luimní 2011).

4 This data is available online via the CSO website at www.census.cso.ie
verbally explained by the facilitator in order to ensure full comprehension. Participants were given time to read and complete the survey and were also given the option of taking it home and returning it later.

The fact that both the facilitator and the research assistant present were migrant women themselves, helped establish a sense of the workshops as a ‘safe space’ where women could engage in dialogue with peers. Each woman was given the opportunity to vocalise her experiences and views.

Survey

A small-scale survey complimented the workshop series. A questionnaire was designed to assess respondents overall awareness of health services in Limerick and experiences of accessing such services. As stated above, the questionnaire was distributed to workshop participants. In addition, in order to promote greater inclusiveness, migrant women identified as community leaders were approached to distribute the questionnaire amongst their networks and mobilise women to participate who had been unable to take part in the workshops. The findings of this study were based on an analysis of the data gathered from the total study sample group of 26 women who returned completed questionnaires.

It should be noted that some themes which emerged strongly in the workshops were not addressed in the survey. The focus of the survey was on awareness, experiences and perceptions of health service provision, while the workshops were more flexible and provided a space for exploration of issues raised by participants.

The design of this project employed participatory principles and methods in order to encourage participants to vocalise their experiences. Unfortunately, it is not possible to fully represent participants’ voices in this report. Due to the prerogative to create a space in which participants felt comfortable and confident to speak, the workshops were not recorded. The outcomes of the workshops are reported on the basis of notes taken by the research assistant. The quotes presented in the discussion of findings are qualitative responses written in response to open ended questions in the questionnaire.

Findings from Workshop Series and Survey

This research is descriptive and exploratory; it does not provide an overall picture of the experiences and perceptions of health and health provision of migrant women in Limerick. The sample size is small and it is not possible to make any conclusive assertions based on the findings. In any case, caution should be exercised in making claims about migrant women as a whole, given that Conlon et al (2012) identified clear and distinct patterns in how women from different ethnic or cultural backgrounds viewed and accessed the Irish healthcare system. As Bartlett (2010) points out, migrants’ countries or regions of origin may have complex cultural and linguistic divisions. Those sharing a particular ethnic, nationality or religious background may be very differently positioned in respect of socio-economic situation or legal/immigration status.

This study does not make any claims to representative or proportional sampling and therefore does not endeavour to make any contrasts or comparisons based on nationality or immigration status categories. The findings presented here are best described as “displays of perspective” (Reed and Payton 1997 cited in Lakeman and Matthews 2010).

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The questionnaire may be seen in Appendix A.
Overall, a wide range of issues were raised in the study in relation to personal including understandings and experiences of health, which may be grouped according to the following themes:

- Family, relationships and maternity;
- Mental and emotional health;
- Integration and immigration status.

It should also be noted that these themes are not exhaustive of all aspects of migrant women's health. Indeed some very pertinent issues pertaining to migrant women and service provision are not addressed. For example, the issue of FGM did not arise in the course of this research, although it is estimated to affect more than a quarter of migrant women living in Ireland (AkiDwA 2008). Some service providers have identified high instances of (pre-migratory) rape or sexual violence amongst asylum seekers they have worked with (Galway Rape Crisis Centre 2007) but such issues were not specifically examined in this study.

As regards health service provision, the key issues addressed were:

- Awareness of and access to services;
- Experiences/perceptions of health care services and health care staff.

In exploring these issues, two key themes emerged:

- Delays/waiting times;
- Communication/information and intercultural issues.

In presenting and discussing the findings of this research below, links are made with other relevant research and literature, and particular effort has been made to contextualise the findings in relation to contemporary studies pertaining to migrants in Ireland. In doing so, this report tentatively sketches the Limerick situation vis-a-vis migrant women's engagement with and perceptions of health provision, within the wider Irish health provision context.

**Concepts and Experiences of Health**

**Integration and Immigration Status**

The women who took part in the workshops focussed on everyday experiences of health and wellbeing and they readily engaged with the notion of social determinants of health. As one survey respondent [R1] commented, “Peoples wellbeing is not [just] about being sick with pain...”

However, when asked whether they perceived their immigration status to have an influence on their health, the majority of survey respondents (79%) did not consider this to be the case, while 21% did consider there to be a link.
This was a surprising result given that throughout the workshops, participants repeatedly identified immigration policies and status as negatively affecting their overall wellbeing (e.g. Lakeman and Matthews 2010). This overlapped and interlinked with a host of associated issues pertaining to social and economic exclusion.

The detrimental health implications of lengthy asylum process and direct provision living conditions featured strongly in workshop discussions. For asylum seekers living in direct provision, the restrictions imposed by their status and their situation of living in direct provision were seen as precluding normal participation in society. Inability to engage in employment limited their opportunities to meet people, while income poverty restricted their ability to partake in recreational or social activities. This was articulated by a survey respondent who gave the following reply to the question as to whether immigration status influences health:

Yes, it does 'cause I have been here five years [and I am] not allowed to study, work and I can not even go places because e.g. club, pub etc., they always ask for ID and I can't get any 'cause of my status. [R1]

Another respondent expressed the view that her access to services was affected by her immigraions status:

Yes. As an asylum seeker some of the services are limited to us. And I believe there is a big issue of discrimination of immigrants. [R15]

Elaborating on the relationship between immigration status and health, she stated:

I feel the problems we're going through is based on the way the Justice office is handling the asylum process. [R15]

This respondent called for speedier processing of asylum applications in response to the question 'How do you think the health care services in Limerick can be improved?' Justice office addressing our case quicker, so that we can stand on [our own] feet would make us feel more useful and the response from the community would improve. [R15]

In identifying immigration status conditions and restrictions as undermining the capacity to integrate, she draws links with negative perceptions of asylum seekers amongst the wider public. This echoes the sense of exclusion imposed by direct provision, and the emphasis placed on integration and acceptance by Irish people expressed by migrants in a Lakeman and Matthews (2010) study.
Family, Relationships and Maternity

From the initial workshop, it became apparent that a priority concern amongst the women was the health and well-being of their families (i.e. partners and children). A pattern emerged of migrant women giving precedence to the financial, physical and emotional well-being of their families over their own needs. Within the workshops participants spent much time discussing the wellbeing of their children.

Many participants said that they did not want to be supported by the State, but would prefer to work in order to support themselves and their families. Being forbidden to engage in employment and not entitled to social welfare, asylum seekers in Ireland only receive a ‘discretionary allowance’ of €19 per week. The women described how income poverty – particularly being unable to afford things for their children – negatively impacted on their mental health and challenged their ability as parents. Workshop participants expressed great concern regarding the mental health of their children in relation to the direct provision system.

They reported that their children suffered as a result of segregation and due to their status and circumstances. The concerns expressed by these women regarding poverty and exclusion impacting on the health, wellbeing and development of children in direct provision, echo the findings of other studies (Arnold 2012; Fanning and Veale 2004)

The women indicated that being in a situation of watching their children suffer from marginalisation and exclusion and being unable to do anything about it, had a severe impact on their own mental and emotional wellbeing.

Family and relationship-related difficulties associated with the dependency, boredom, frustration, tensions, stress and insecurity arising from direct provision conditions have been documented in numerous reports (FLAC 2003; Ní Shé 2007).

Issues of dependency, control and violence within heterosexual relationships, were raised during the second workshop, with the discussion focusing particularly on how these issues interacted with the migration experience and immigration status. During the discussion the women suggested that some migrant women are legally and economically dependent on their husbands due to their immigration status as dependent spouses. This has very significant implications for women experiencing domestic violence because due to the risk of becoming undocumented if they were to seek a separation or divorce. They also expressed concern that women in such situations faced losing contact with their children and were critical of the dearth of state supports for migrant women experiencing abuse.

This issue has been the subject of campaigning by migrant rights organisations and progress has been made towards amelioration of the situation of migrant women in domestic abuse situations by immigration authorities.6 However, there remains room for improvement in ensuring that migrants affected by domestic violence are sufficiently supported.7

The issue of emotional and verbal abuse by partners was also raised. During this discussion, it was said that some migrant women’s husbands expect their wives to behave in a manner according to

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6 INIS has made public guidelines setting out how the Irish immigration system facilitates the acquisition of independent status by migrants, “whose immigration status is currently derived from or dependant on that of the perpetrator of domestic violence” (INIS 2012, p.1). Significantly, these guidelines clearly state that victims of domestic violence will not jeopardise their entitlement to remain in Ireland by reporting violence or leaving an abusive relationship. Furthermore, the definition of domestic violence adopted in the document is not limited to physical violence, but encompasses “emotional abuse, the destruction of property, isolation from friends, family and other potential sources of support, threats to others including children; stalking; and control over access to money, personal items, food, transportation and the telephone” (INIS 2012, p.1).

7 See recommendations of WHC (2009) regarding legislating for the domestic violence concession and provision of a similar concession in respect of the Habitual Residency Condition.
the cultural norms of their country of origin. This reflects findings of other studies in which migrant women themselves reported pressures and conflicts arising from the expectations and monitoring of women’s behaviours by families and communities coming from cultural contexts with more restrictive gender codes and mores (Conlon et al 2012). This is a factor in domestic violence situations within some migrant communities when there are significant differences between country of origin cultural and gender norms and those of Irish society.

During the final workshop some participants related very personal and emotive experiences concerning miscarriages. In the course of this discussion criticisms were voiced regarding inadequate or inappropriate treatment and communication by health care practitioners. This was a very emotive and personal discussion and it is not possible to provide more detailed account in order to respect the confidentiality of the women. There has been little research on reproductive health and maternity specifically in relation to migrant women (Kennedy and Murphy-Lawless 2003; Conlon et al 2012) and this is an area that merits further investigation.

A number of measures to improve maternity service delivery to migrant and ethnic minority women are set out in the current Intercultural Health Strategy (HSE 2008), centring around the implementation of the Maternity Action Plan and a review of Maternity and Gynaecology services which would inform planning and delivery of appropriate, culturally responsive services in this area of care. One strategy the rollout of an ‘ethnic identifier’ to “facilitate the development of evidence based-information regarding maternity and associated needs of women from diverse cultures and ethnic groups” (HSE 2008, p.17). In addition, this policy document states that the HSE would engage with RIA

concerning specific issues related to the maternal health needs of asylum seeking mother living in direct provision settings; the importance of prioritising the nutritional needs of children and breastfeeding mothers will be addressed in this context (HSE 2008, p.17).

Criticisms pertaining to such post-natal and nutritional needs of mothers and babies in direct provision accommodation have been voiced in numerous reports.

**Mental and Emotional Health**

Issues of mental health, psychological illness, and emotional wellbeing featured strongly in the workshop discussions. “The participants articulated mental ill health in terms of “everyday manifestations of distress and psychological ill-health (Lakeman and Matthews 2010) in relation to the women’s post-migration experiences in Ireland.

A number of workshop participants attributed health problems they had experienced to the conditions and confines of living in direct provision – as noted above they specifically cited the impact of watching their children becoming socially marginalised and excluded through the isolation of the direct provision system as being detrimental to their personal well-being.

The participants who were involved in the asylum process felt that the long duration of this process greatly impacted on their mental health. This resonates with other research in which asylum seekers have identified prolonged sense of “insecurity over their immigration status and the constant threat of deportation as being inconsistent with positive health” (Lakeman and Matthews 2010).9

Participants expressed frustration and bitterness with the proscription against asylum seekers engaging in employment or education in Ireland. They noted an absence of mental stimulation or distraction. Several participants described repeating the same FETAC Level 3 and 3 courses

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8 The survey did not explicitly addressed such issues but three respondents referred to them in their answers.
9 Lakeman and Matthews (2010) carried out research investigating the perceptions of mental health and experiences of mental health care provision, amongst members of new community groups in Dublin.
over and over again, simply to keep busy. Some of these women were highly educated, overqualified for the limited courses they are permitted to access.

In the workshops, women living in direct provision talked about how their emotional health was compromised by having no private space of their own, being forced to share living space (including bedrooms) with strangers. This was also articulated by a survey respondent [R1] who referred to the pressure of “sharing three people per room from different culture”. This respondent noted that the food choices available to residents were limited to “one menu throughout the year” [R1]. She called for psychological and therapeutic services to be provided for direct provision residents “to lighten the pressure of sharing three people per room from different culture[s]” [R1]. In the workshops, participants asserted that there were insufficient counselling services available to them to help them cope. It also emerged in the workshops that women felt that the level of discrimination they faced affected their mental wellbeing.

Traumatic pre-migratory and migratory experiences are recognised as influencing the mental health and well-being of forced migrants (Lakeman and Matthews 2010). Post-migration conditions and experiences can also contribute to or exacerbate mental-ill health. There is now significant evidence linking direct provision with mental health problems (see Ryan et al 2008). In Ireland, primary health care practitioners have lent support to the view that enforced unemployment and direct provision conditions have a deleterious effect on the mental health of residents (e.g. Browne 2008). Earlier research in the Irish context found that migrants associate “good mental health with having sufficient and secure resources to meet basic needs and being able to build and maintain a home” (Lakeman and Matthews 2010). The Irish immigration system effectively incapacitates asylum seekers in this regard, thereby denying them the means to cultivate positive personal mental health. It is noteworthy that over the course of a longitudinal study examining psychological distress and the asylum process, the only group demonstrating decreased levels of distress were those who had been granted a secure legal status (Ryan et al 2008). We believe that the case has sufficiently been made that long-term institutionalisation has a negative impact on the health and wellbeing of direct provision residents.

Awareness of and Connectedness to Services

The questionnaire revealed that there was a good awareness of services amongst the sample group. All except one of the respondents reported that they were aware of some health services in Limerick and only one was unable to name some form of health service. In total, respondents identified 14 different categories or types of services, indicating a good overall level of familiarity with the diverse range of health-related services. The majority of survey respondents (21) stated that they had tried to access some of the health services they had identified.

The most commonly identified health service was GP services (17 respondents), followed by hospitals (15 respondents). There was a high level of recognition of three local hospitals in Limerick city – St. Johns Hospital, the Midwestern Regional Hospital and the Regional Maternity Hospital, each of which was named by at least 3 respondents.

The other services mentioned by respondents were dental services (4), social services (4), HSE (3), Public Health Nurse (3), medical services (3), Family planning clinic or family clinic (2), maternity services (5), ambulance services (1), Red Ribbon Project (a local sexual health promotion organisation) (1), chemist (1), optician (1), councillors or psychologists (1). It is noteworthy that this list includes a very broad spectrum of health service providers pertaining to a range of health areas or specialisations, as well as variety of kinds of service providers including public, private practices and non-profit organisations.

On the whole, the findings indicate a general awareness of the range of health services available, and a good level of familiarity and usage of primary care services. This is a positive finding and
is to be welcomed. However, it should not be assumed that migrant women's knowledge of the availability and means of accessing health services is complete, particularly in relation to more specialised services. For instance, Lakeman and Matthews (2010) found that whilst most of the migrants who took part in their research had experience of accessing health services, they had little contact with specialist mental health services. Similarly, Conlon et al (2012) found low levels of familiarity and connectedness to crisis pregnancy support services amongst migrant women.

Although the survey suggested that respondents were relatively at ease with accessing primary health care, some barriers to access emerged more strongly during discussions over the course of the workshop series. In the workshops, participants disclosed reluctance to engage with health services, in some instances until their symptoms were unbearable. Several reasons were cited for this, including:

- lack of information, or misinformation, regarding entitlements;
- dissatisfaction with previous treatment acted as a deterrent to further access;
- the cost of accessing primary healthcare, such as GP appointments, was prohibitively expensive;
- deprioritisation of their own health needs relative to the needs of their families.

Conlon et al (2012) also found that some groups of migrant women tended to refrain from accessing health services unless absolutely necessary. That study also found that cost, information and entitlement issues (associated with immigration status) were factors inhibiting access to health services (Conlon et al 2012).

Specifically, the researchers found that,

In practice not having entitlement to services operated as a key barrier to becoming informed of the various elements of health services and options for support in the event of a health issue or crisis arising (Conlon et al 2012, p.17).

The HSE Intercultural Health Strategy recognises that the costs of accessing health services pay present a significant barrier, acknowledging entitlement to medical card and knowledge of entitlement was “a key determinant of utilisation of GP services” (HSE 2008, p.16).

In the present study, workshop participants described encounters with service providers who were unsure, had incomplete or inaccurate information regarding the entitlements of migrants to accessing health services. Consequent confusion or ignorance regarding eligibility and entitlement deterred them from engaging with services.

**Experiences and Perceptions of Services**

Sections of the survey posed a series of both positive and negative statements describing experiences of health care services or service providers and respondents were asked to rate in terms of a scale of 1 to 5 ranging from very bad to excellent.

When asked to rate health related staff according to the categories of occupation/specialisation, the resulting findings were overwhelmingly positive with security getting 68% approval, reception staff getting 59% positive responses, nurses rated good or excellent by 65% of respondents, doctors 67%, midwives 67%, hospital managers 63%, cleaners 50%, social workers 53%, pharmacists 73%, and other medical staff 80%. The only category of staff where the trend was inversed was that of translators who were rated as bad or very bad by 46% of respondents.
When specifically asked if they had “experienced any difficulties while accessing these health services in Limerick”, 38% indicated that they had no difficulty and 35% reported that they had encountered some difficulty.10

More than half of respondents gave a positive response (either good or excellent) to the statement describing the health services as “helpful to your need and felt satisfied”; 31% indicated their experience was ‘fair’ in relation to this statement; while 17% rated their experiences as bad or very bad.

10 However, some of those who indicated that they had not “experienced any difficulty while accessing these health services”, or who did not respond to this question, mentioned issues such as delays in their responses to other questions.
Another set of statements expressed negative views or experiences concerning discrimination, attitudes and treatment by health service providers as well as communication issues.

Similarly, the statement characterising health services as “very understanding of your situation” elicited positive responses (good or excellent) from 54% of respondents. The rest saw this statement as ‘fair’ (23%) or bad/very bad (23%).

36.5% felt that health service providers “went out of their way to help” them to a good or excellent extent with the same proportion as a fair statement, while 27% dissented from this view.

38% reported bad or very bad experiences of being “discriminated due to your gender race and background”; another 38% rated their experience as fair while 24% indicated that their experience was good or excellent in relation to discrimination.
The survey also posed a number of open-ended questions, for instance inviting respondents to give suggestions as to how health care services in Limerick could be improved.

Overall, 13 of the 26 survey respondents (50%) made some kind of positive qualitative comment about their experiences of Irish health services or service providers. Some gave straightforward statements of satisfaction with treatment by health providers. For example:

*I experience a good behaviour with them* [R5]

However, few respondents reported either complete satisfaction or dissatisfaction; more often respondents gave mixed accounts of their experiences in which they referred to both positive and negative aspects (7 respondents). This is an example of one such qualified statement concerning staff attitudes/behaviour:

*Dealing with the service depends on who you meet at a particular time. There are some staff who are understanding. Some are totally unfriendly. I cannot condemn them but some staff has to change their attitudes.* [R2]

Negative qualitative comments made by survey respondents referred to an array of experiences and concerns which are presented below.

24% (6 of 25 respondents) indicated that they had negative experiences in relation to being "ignored", while 60% (15) assessed their experiences as good or excellent, and a further 16% as fair in response to this statement.

32% had negative experiences of “rude and not welcoming” treatment when accessing health services; 18% characterised their experience as good or excellent; half of the respondents described their treatment as fair in relation to this statement.
In response to the question “How do you think the health care services in Limerick can be improved?” respondents recommended more adequate staffing levels, facilities, and patient assessment procedures:

Proper patient assessment and more staff. [R26]

There should be sufficient facilities and enough staff to attend to patients at any time. [R24]

There should be more specialists, medical facilities and hospitals in Limerick... [20] More staff. Quick respond to patient. [R4]

Overall, 6 survey respondents made reference to inadequate staffing levels. Other respondents suggested that health services could be improved through staff pay or training:

Good payment for staff. Equal treatment for the sick. More equipment... [R14]

Food, payment, equal treatment. [R13]

Well trained and understanding nurses and doctors. [R12]

More training. Good pay. [R10]

Two other respondents focused on patient care, recommending prioritisation of critical cases: ...They should look after those serious patients with preference [R22]

...They should look thoroughly all those patients that really need special attention or when they are very sick [R21]

One respondent called for improved cleanliness and reduced reliance on antibiotics: It have to be more cleaner. Don't use antibiotics so much. Sometimes they just [aren't] needed at all [R23]

Overall, however, the two main areas of dissatisfaction to emerge from the survey were delays/waiting times and communication/information related problems. These issues will be detailed in later sections, but first the survey findings regarding health care providers will be outlined.

Delays and Waiting Times

The issue of delays was by far the most commonly cited grievance, referred to by half of the respondents. Thirteen out of twenty six survey respondents reported encountering delays or waiting times when accessing or attempting to access Irish health services. Below are a selection of the statements they made regarding this issue.

...The public health system has some serious problems in Ireland. An ongoing issue is waiting lists for those requiring serious operations... It has been a year since I applied to consult with a neurologist. And I am still waiting for an appointment. [R20]

Ambulance – they delay too much. General hospital appointment took long time. Some staff were not welcoming. [R2]

In the Regional – too [long] waiting, even when you are in emergency or casualty dept. [R22]

Some respondents gave mixed accounts of their experiences of primary healthcare provision. For example:

[At the] GP centre, the staff there are doing well. But I have been experiencing delay while waiting. Every other conduct is good. [R14]

My GP is OK but when I visited the hospital I had to wait for 5 hours before [I was] seen by a doctor... The amount of time that patients need to wait before [being] seen by a doctor in Limerick hospitals needs to be reduced. [R19]

Although the issue of delays and lengthy waiting times applies to all service users11, it may act as an additional deterrent to those who already have a weaker attachment to the system.

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11 QNHS data shows that 8% of the adult population in Ireland were on a hospital waiting list at the end of 2010.
In the survey 45% of respondents reported negative experiences whereby health care providers were “not able to understand your need”; 32% responded to this statement with a rating of good or excellent; and 23% with a rating of fair.

When the statement was framed in terms of respondents own ability to communicate with service providers, 59% rated their experience as good or excellent; 32% rated as fair; 9% reported negative experiences.

The availability of translators in the area of health service provision which elicited the lowest number of positive responses. The response rate to this question was low, with several respondents indicating that the issue of translators was not applicable to them. Only 20% of those to whom it was relevant characterised their experience as good or excellent; 47% described their experience as fair; and 33% had a bad experience regarding the provision of translation services.
In terms of intercultural issues, when asked if health service providers were “culturally sensitive to your need?” 50% of respondents answered positively; 17% rated their experience as fair; and one third responded negatively.

One respondent described cursory treatment and a sense of not being listened to by staff:

_They conclude for you before you finish your conversation with them._ [R4]

Another respondent experienced difficulty in making herself understood to health care staff:

..._They don’t understand me at all. Every time they give me paracetamol for any kind of diseases that never heal me._ [R2]

Another mentioned experiencing an unspecified “language problem” [R23] as creating difficulties for her in accessing health services in Limerick.

Two respondents [R9 and R7] made similar statements articulating dissatisfaction with the level of information or explanation provided to holders of medical cards:

_Other services [are] acceptable [but] on the medical card are not explanatory to the patients._ [R7]

One respondent suggested that the availability of translation services in health care settings would contribute to improving service provision.

_I suggest that, let there be translators to improve the health care services in Limerick._ [R25]

As noted above, translators had the lowest rating of all categories of health care professionals with 46% of respondents who had need to use translators rating them as either bad or very bad. Trained interpreters are rare in many settings and much interpretation is provided in an ad hoc manner (for example through family members, janitorial staff, and other patients). This raises ethical concerns of confidentiality, informed consent, and privacy between health professionals and patients.
Conclusions and Recommendations

The main themes to emerge in the project were immigration status and integration, family and relationships, and mental and emotional health. The women identified a number of issues and concerns pertaining to these aspects of health or factors which have implications for physical, social and psychological wellbeing.

While there were inconsistent results relating to the connection between immigration status and health, there was consensus amongst workshop participants that meaningful integration into the local community in Limerick is particularly difficult for asylum seekers. For this group, social isolation and economic exclusion was associated with poor physical, emotional and mental health.

In summary, the main way in which immigration status was identified as affecting health was in relation to the situation of asylum seekers, whose non-entitlement to engage in employment and education imposed economic dependence and income poverty which had implications for social, emotional, psychological and social wellbeing.

This reinforces our belief that national and local integration measures must be accompanied by structural reform of the immigration system. The women involved in this study have again highlighted that having opportunities to access education, employment and appropriate accommodation – all of which are affected by immigration policies – are essential to positive health and wellbeing. Therefore, we recommend policy reform to dismantle the legal and policy barriers which prohibit or undermine migrant women’s ability to participate economically and socially. All migrants resident in Ireland for a minimum period of time (e.g. more than 6 months), including asylum seekers, should be permitted to participate in and to contribute to the social, economical and cultural life of the communities in which they live. We reiterate our call for an immediate review of the direct provision system. We advocate the introduction of measures to reduce delays in processing asylum and Leave to Remain applications, while adhering to the highest standards of transparency and quality decision-making. We believe that in the long-term, such measures have the potential to alleviate and reduce the incidence of some health problems experienced by migrant women.

Overall, the women who took part in this project had positive experiences and perceptions of health service provision and health care providers in Limerick. This echoes the findings of other local studies (Ní Shé et al 2007; Piper 2011) observing broadly positive experiences and favourable attitudes towards health care providers and perceptions of health service quality amongst immigrant client groups. We believe that this is an affirmation of the hard work being done by service providers on the ground often operating in challenging circumstances with limited resources. Its staff is one of the key assets of the HSE and their efforts and achievements should be recognised.

Of course, there are aspects of service delivery where interventions and improvements are necessary. The finding that communication and information are key issues of concern for migrant women in Limerick is unsurprising given that language and communication barriers were identified as significant factors affecting access in a HSE (2008) assessment of the health and social service needs of ethnic minority groups in the Mid-West. The Integration Working Group (IWG) plan, Integrating Limerick (2010-2012), points to the need for the targeted provision of basic information to immigrant communities to improve understanding of the Irish health system.
The latest Integration Working Group progress report (2012) documents the measures taken to date with regard to migrants’ health and welfare in Limerick. It notes that despite progress made, language continues to cause difficulties for service users and providers. One of the major themes of the NIHS is the provision of training and support to staff in working towards delivery of a responsive, culturally competent health service. Ad hoc or piecemeal implementation of this objective is inadequate. It remains the case that most healthcare workers in Ireland are not adequately trained or equipped to deal with the specific needs of diverse migrant population (Lynch 2012). We advise that training in multi-cultural awareness, inter-cultural communications and migrants rights should be mainstreamed as core and mandatory elements of the education, training and ongoing professional development of all staff in healthcare settings.

We endorse the recommendation put forward by Conlon et al (2012) that all public health information and awareness campaigns be accessibility-proofed in terms of the language used, methods of dissemination, inclusion of multi-cultural content, and where relevant, targeted components for specific communities.

In this regards, the Multilingual Health Promotion materials should be displayed and widely available in public places while the HSE should continue to support intercultural awareness training, in particular awareness of health practices and beliefs which are often not understood or appreciated by health professionals. This process can be assisted by widely promoting existing HSE tools i.e. translation toolkit, Emergency Multilingual Aid Box.

Furthermore, it is important that structures are put in place for informed, consistent inputs and participation from migrant women in all levels of planning and delivery of health services. The continued implementation of the HSE National Intercultural Health Strategy is essential to an effective response to the needs of migrant women.

Training in health information and awareness should also be made available to members of migrant community groups on a local basis in order to assist the dissemination of information through existing networks via word of mouth. Such training should provide information to community members as to how the primary healthcare system works and the eligibility/entitlements of migrants. Cairde’s community development approach to building the capacity of ethnic minority community communities in the area of health rights is instructive (see Cairde 2006), and the Peer Health Worker pilot project in Galway provides a model as to how this could be carried out is provided by (see Bartlett 2010).

In relation to health policy and health provision, we agree that minority ethnic populations must be actively included in the development of “intercultural dialogue and processes of decisionmaking, implementation, monitoring and accountability” (O’Brien Green 2010). Finally, ongoing collaboration between the health service and NGOs must be maintained to ensure that appropriate and effective health provision for migrant women remains on the agenda.
References


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Appendices

Appendix A: Questionnaire

1. Are you aware of any health services in Limerick?

   a) Can you name them?

   b) Have you tried to access any of these health services?

   c) What have been your experiences

2. Have you experienced any difficulties while accessing these health services in Limerick?

3. How would you rate your experience in the following areas:

   Excellent (5) Good (4) Fair (3) Bad (2) Very Bad (1)

   a. Helpful to your need and felt satisfied
   b. Very understanding of your situation
   c. Went out of their way to help you
   d. Discriminated due to your gender, race and background
   e. Ignored
   f. Rude and not welcoming
   g. Not able to understand your need
   h. Not felt welcomed or as they were doing you a favour by assisting you with in their job/duties
   i. Not able to communicate to them due to language difficulties
   j. Were translators readily available
   k. Were you put off accessing health services by the behaviour of the staff
   l. Were they culturally sensitive to your need
   m. Any other comments
4. How would you rate the approach and treatment from the following service providers:

   Excellent (5) Good (4) Fair (3) Bad (2) Very Bad (1)

   a. Security
   b. Clinic/Hospital receptionist
   c. Nurses
   d. Doctors
   e. Midwives
   f. Hospital Managers
   g. Health Care Cleaners
   h. Translators
   i. Social Workers
   j. Pharmacists
   k. Other Medical Staff

5. Do you think your immigration status in Ireland has an influence on your health? If yes, explain

6. How do you think the health care services in Limerick can be improved? Please List your suggestion.

7. Any other comments
Appendix B: Terms and Abbreviations

**AkiDwA**: Akina Dada wa Africa is a Swahili phrase meaning sisterhood. AkiDwA a national network representing African and migrant women throughout Ireland. In 2001 a group of African women living in Ireland established AkiDwA as a non-governmental organisation with charitable status, in order to advocate the interests of the growing population of migrant women resident in the country. AkiDwA represents the diverse cohort of migrant women, irrespective of national or ethnic background, traditions or religious beliefs, socio-economic or legal status. AkiDwA’s advocacy approach seeks to strengthen migrant women’s voice in Ireland, to promote justice, and to enhance equality of opportunity and access to resources in the social, cultural, economic, civil and political spheres.

**Asylum seeker**: An asylum seeker or asylum applicant are terms used to refer to people who have formally requested protection and recognition as a refugee in a particular state.

**Cairde**: This is a non-governmental community development and advocacy organisation, working to reduce health inequalities amongst ethnic minorities in Ireland.

**CIC**: Citizens Information Centre.

**CSO**: Central Statistics Office.

**CWO**: Community Welfare Officers, HSE staff responsible for administering social welfare payments and services.

**DJLR**: Department of Justice and Law Reform.

**Documented migrants**: According to the WHO, documented migrants are those people whose entry, residence and where relevant, employment in a host or transit country has been recognised and authorised by official state authorities.

**Doras Luimní**: This is an independent non-governmental organisation founded in 2000 in response to the establishment of the direct provision and dispersal system by the Irish government. Since then the organisation offers support to and promotes the rights of all migrants living in Limerick, as well as delivering services to the local community including the business community, community groups and service providers. The three core areas of the organisation’s work are: advocacy and campaigning at the regional and national levels, collaborative integration planning, and the provision of direct support through its Advice and Information Centre and Legal Service. The vision that Doras Luimní works towards is a society where equality and respect for the human rights of migrants are social norms. Doras Luimní is registered as a company with charitable status.

**DSP**: Department of Social Protection.

**EEA**: European Economic Area.

**EU**: European Union.

**FETAC**: Further Education and Training Awards Council, statutory body which certifies third level education and training in Ireland from levels 1-6 within the National Framework of Certification.

**GNIB**: Garda National Immigration Bureau.

**GP**: General Practitioner.

**INIS**: Irish Naturalisation and Immigration Service.

**IRC**: Irish Refugee Council.

**IWG**: Limerick City and County Integration Working Group.
HRC: Habitual Residency Condition.

HSE: The Health Service Executive is the statutory body responsible for the provision of public healthcare and social services in the Republic of Ireland since 2005. The national organisation is divided into four regions: HSE Dublin Mid-Leinster, HSE Dublin North East, HSE South and HSE West. Limerick is located in the latter region which also includes counties Clare, Donegal, Galway, Leitrim, North Tipperary, Mayo, Roscommon and Sligo.

Mainstreaming: The National Intercultural Health Strategy describes ‘mainstreaming’ as a process of ensuring that policies and processes are inclusive of the needs of minority ethnic groups.

NIHS: National Intercultural Health Strategy, HSE policy document providing the framework for the delivery of health services responsive to the needs of ethnic minority and migrant service users. The strategy pertains to the period from 2007 to 2012.

QNHS: Quarterly National Household Survey.

Red Ribbon Project: This is a Limerick based non-profit organisation which provides a range of screening and support services in relation to sexual health and sexual identity.

Refugee: Under the 1951 UN Convention relating to the status of refugees, the United Nations High Commission for Refugees defines a refugee as a person who, owing to well-founded fear of persecution for reasons of race, religion, nationality or membership of a particular social group or political opinion is outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself or herself of the protection of that country; or who, not having a nationality or being outside the country of his or her former habitual residence, is unable or, owing to such fear, is unwilling to return to it.

RIA: Reception and Integration Agency, the statutory body charged with overseeing the initial reception of asylum seekers and coordinating the delivery of ancillary services including health and social services.

Undocumented migrants: This is a broad group encompassing any persons who do not have formal permission or status within the state in which they are located. Other terms used to refer to this group include illegal or irregular migrants. This includes people enter a state using false documentation or without declaring their presence to immigration authorities, people who whose visas have expired or have failed to adhere to the conditions attached to their residency permission.

WHC: The Women's Health Council, a statutory body which advises the Minister for Health and Children on all aspects of women's health.
Appendix C: The Right to Health in International Human Rights Law

The 1965 International Convention on the Elimination of All Forms of Racial Discrimination: art. 5 (e) (iv)

The 1966 International Covenant on Economic, Social and Cultural Rights: art 2(2)

The 1979 Convention on the Elimination of All Forms of Discrimination against Women: arts. 11 (1) (f), 12 and 14 (2) (b)


The 1990 International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families: arts. 28, 43 (e) and 45 (c)

The 2006 Convention on the Rights of Persons with Disabilities: art. 25