DÁIL ÉIREANN

AN COMHCHOISTE UM LEANAÍ, COMHIONANNAS, MÍCHUMAS, LÁN-PHÁIRTÍOCHT AGUS ÓIGE

JOINT COMMITTEE ON CHILDREN, EQUALITY, DISABILITY, INTEGRATION AND YOUTH

Dé Máirt, 16 Samhain 2021

Tuesday, 16 November 2021

Tháinig an Comhchoiste le chéile ag 3 p.m.

The Joint Committee met at 3 p.m.

Comhaltaí a bhí i láthair / Members present:

Teachtaí Dála / Deputies	Seanadóirí / Senators
Ivana Bacik,	Sharon Keogan,
Holly Cairns,	Erin McGreehan,
Patrick Costello,	Ned O'Sullivan,
Jennifer Murnane O'Connor,	Lynn Ruane,
Mark Ward.	Mary Seery Kearney.

Teachta / Deputy Kathleen Funchion sa Chathaoir / in the Chair.

Experiences of Migrant Communities Engaging with the Healthcare System and State Bodies: Discussion

Chairman: Apologies have been received from Deputy Alan Dillon and Senator Erin McGreehan. If any member or witness participating remotely experiences any sound or technical issues, I ask them to let us know through the chat function. Otherwise, we will proceed. I advise everyone that as this is a public meeting, the chat function on Teams should only be used to advise participants of technical issues or urgent matters and should not be used to make general comments or statements. I remind members participating remotely to keep their devices on mute until they are invited to speak. When people are speaking I ask them to put on their cameras where possible and be mindful that we are in public session.

I remind members of the constitutional requirement that they must be physically present in the confines of the place where Parliament has chosen to sit, which is Leinster House, in order to participate in public meetings. I will not permit members to participate where they are not adhering to this constitutional requirement. If members attempt to participate in the meeting from outside the precincts, they will be refused. Those in the committee room should be mindful of their responsibility in relation to Covid-19. I urge people not to move chairs from their current positions and to always maintain an appropriate level of social distancing during and after the meeting. Masks should be used except when speaking.

We are meeting representatives from Safetynet Primary Care, the Amal Association and the Migrant Rights Centre of Ireland. From Safetynet Primary Care, I welcome Dr. Fiona O'Reilly, chief executive officer, and Dr. Angela Skuce, medical director. From the Amal Association, I welcome Ms Yara Alagha, board member and volunteer, and Ms Nor Nasib, treasurer and secretary. From the Migrant Rights Centre Ireland, I welcome Ms Edel McGinley, director, and Ms Sancha Magat, manager. The purpose of this meeting is to engage with the witnesses on their experience of migrant communities engaging with State bodies, the healthcare system and other social services. We are delighted to have the chance today to discuss these very important issues.

Before I go to the witnesses for their opening statements, I want to go through parliamentary privilege. As all witnesses are appearing before the committee virtually, I need to point out there is uncertainty as to whether parliamentary privilege will apply to their evidence from a location outside of the parliamentary precincts of Leinster House. Therefore, if they are directed by me to cease giving evidence on a particular matter it is imperative that they comply with any such direction.

Everyone has three minutes for their opening statements. There will also be questions and answers. Each member will have approximately five minutes to ask questions. Witnesses should be aware this also includes their answers.

Senator Lynn Ruane: Prior to hearing the opening statements, I want to declare a conflict of interest so it is on the public record. Ms Yara Alagha from the Amal Association works with the Civil Engagement group but is here in a different capacity.

Chairman: I thank Senator. That is no problem. We will begin with Dr. O'Reilly. I thank

her for being here and invite her to make her opening statement when she is ready.

Dr. Fiona O'Reilly: I thank the committee for welcoming us this afternoon. Safetynet Primary Care is a medical charity providing primary care and health screening to marginalised groups within society. We work to address the gaps between what vulnerable groups need healthwise and what is provided by mainstream services. The gap is a reflection of priorities in society and is ever changing.

The emphasis of our work has changed from almost exclusively providing care to people who experience homelessness to a new position whereby half of our work is being targeted at who we call the global homeless. In a globalising world, where the arbitrary borders defining countries are not proving as effective at containing destitution and persecution as they were in the past, migrants are increasingly becoming a part of Ireland's present and future and, therefore, need to be included in our health and social service planning. However, where migrants are made vulnerable because of structural barriers imposed through systems and services designed for and by the non-migrant population they can and do suffer. In this way, we as a host country miss an opportunity to reap the economic and social gain. This is where we are at now.

The category of migrants Safetynet encounters, who have high needs and low service levels, include the Roma, protection applicants, who are asylum seekers, and those who end up in homeless services. The situation is complicated when there is no eligibility to social protection or housing, no access to GPs even with eligibility and no interpreting services are available. Pre-migration experiences can leave people with a complete distrust of authority and a lack of confidence in health systems. Navigating health services can be very difficult without literacy or digital literacy. The medical card application process is extremely labour intensive and bureaucratic. It requires people to be taken on by a GP before they can apply for a medical card. Transient addresses and people moving around and being moved around means follow-up medical care is not possible.

Our recommendations involve reversing the structural barriers. Protection applicants should have access to medical care and assessment immediately on claiming asylum. The Roma specifically are very disadvantaged. My colleague, Dr. Skuce, will speak more about them. The systems for engagement with State bodies, health and social services are outdated. They have been designed or have evolved to cater for the needs of a homogenous population born and bred in Ireland, who speak English and who are culturally similar. Access to interpreting so that engagement with State bodies is possible should be mandatory. Our systems and services require future-proofing for the multicultural society we are fast becoming. Largely, people come to Ireland to make a better life, to work and to be healthy and happy. Structural barriers make them vulnerable.

Ms Yara Alagha: I thank the Chair, clerk and members of the committee for inviting us here today. We have often fought very hard to be included in spaces where decisions are being made for us and on behalf of us so it is a really big achievement for us to be here and present today. My name is Yara. I am a board member of, and volunteer with, Amal Association. I am joined by Ms Nor Nasib, the treasurer and secretary of the organisation.

I will explain who we are and what we do. Amal means "hope" in Arabic, and very simply that is what we aim to espouse We give hope to women by supporting them and providing direction and guidance to meet their needs. We are a women-led organisation. We provide front-line services to Muslim women and women with a connection to the Muslim community nationwide, including ethnic migrant women and refugees. Our mission is to create a com-

munity support network that bring hope to Muslim women across Ireland. Our vision is for an Ireland where all women can live free from violence, poverty, racism, discrimination and stigma. We believe in the cultural and religious rights of women and their families to access the services that meet their needs.

Every year, we help hundreds of Muslim and migrant women with a range of issues and challenges. In particular, we help women experiencing gender-based violence and support those accessing health and mental health services. We support families dealing with State services, including housing, immigration and social or domestic problems. We are often the first port of call for these women and families and we then provide a support and referral service.

I will give a background on some of the research and investigative work we have been doing. We recently conducted and launched our A Mother is Born Too research, led by Dr. Camilla Fitzsimons from Maynooth University and supported by the Irish Human Rights and Equality Commission. It explored Muslim women's experiences in maternity care settings in Ireland. The research also included healthcare workers and their experience in caring for Muslim women. Before I discuss the findings, I will preface it by saying that Muslim and non-Muslim women have positive experiences in Irish hospitals, with individual acts of kindness that have made a huge difference in their lives. This is especially so for first-time mothers who do not have family to support them during what is one of the most significant and challenging times of their lives. I pay my respect and great gratitude to the healthcare workers who show heavenly care and patience, both during COVID and in ordinary times.

It is important to note that the findings of the research allude to a more systematic issue. One of the very concerning findings that came out of this research was that 4% of the participants when pregnant presented to the hospital, for the first time during their maternity, when they were in labour. This signals the barriers preventing expectant mothers from receiving the necessary medical attention and support they need before and post labour. Other findings found that many women experienced microaggressions in the form of general negative attitudes towards them. There were also incidents of macroaggressions, mostly verbal abuse, with women reporting being shouted at, told to remove their head scarves and hostile attitudes towards their need to remain as modest as possible in their clothing. Hospitals also frequently fell short in their obligations to provide an appropriate diet and effective interpretation services.

There are massive discrepancies in the State healthcare system when it comes to accommodating and providing culturally appropriate healthcare. Findings from engagement with healthcare workers signalled 31% of healthcare workers witnessing racism and discrimination towards Muslim women by other healthcare workers, 74% of healthcare workers were unaware of any policies in respect of providing quality, culturally specific care for Muslim women and one in five healthcare workers acknowledged shortcomings in their practice, referencing a gap in their knowledge relating to Muslim culture and a lack of confidence in their capacity to deliver appropriate care. As such, we need to remove the impediments for undocumented migrants, establish greater community support, educate healthcare workers in consultation with educators and experts as modelled by the UK's cultural competence programme and ensure clear anti-racism policies in healthcare settings.

To end, I wish to mention some of the many services we have established and some we hope to develop, which like all other grassroots initiatives rely on stable and continual State funding streams. The cultural advocacy and mediation project, CAMP, addresses the difficulties faced by Muslim women and women with connections to the Muslim community. CAMP provides peer-led accompaniment and mediation services to Muslim and migrant women, empower-

ing them with access to public services. The Amal Association court accompaniment service provides culturally appropriate and emotional support for Muslim women required to attend court. This includes practical support such as legal terminology translations and clarifications and guiding the court user on follow-up procedures. We aim to establish a bespoke migrant women's refuge centre.

We have a yellow sticker initiative which was created against the backdrop of a very concerning increase in hate crime incidents against the migrant community. The objective of the initiative is that victims of hate crime and racist attacks could enter a space at the nearest point to the incident. That would include a retailer, local business or supermarket and a brief training would be given to the agreed parties about their role as a helper in such an incident. The victim could then access relevant support, assistance and the authorities in the meantime. We have our ongoing essential services and packages to asylum seekers in direct provision centres. Every Ramadan and Eid, we provide packs to families and individuals to ensure their basic needs are being met. This includes non-perishable foods, clothing, sanitary packs and toys and gifts for children.

Ms Nor Nasib and I are happy to take any questions the members may have. I thank the members for their time.

Chairman: Thank you. There will be questions. I call on Ms McGinley to give her opening statement. Then we will open the meeting to questions.

Ms Edel McGinley: I thank the committee for inviting us to the meeting today. I am accompanied by Ms Sancha Magat, who is the Migrant Rights Centre Ireland, MRCI, drop-in centre co-ordinator.

For 20 years, MRCI has been working with migrant workers in precarious and low-wage sectors of the labour market, across agrifood, fisheries, home care, domestic work, car washes, entertainment, cleaning and restaurants. In 2020, we provided information, support and advocacy in 3,442 cases. One third of the people who come to our services are undocumented. How a person enters the country and the person's corresponding immigration status determine the person's rights and entitlements in the State and mediate the person's experiences. This includes how people experience State and social services and receive supports. Many people who access our services are in situations of vulnerability due to their immigration status, the type of employment permit they hold, poor conditions of employment, their housing situation and their family and personal circumstances. These are compounded by delays in immigration processing, problems changing employer, delays renewing employment permits, the habitual residence condition, limits to family reunion, being a victim of trafficking for labour exploitation, domestic violence, lack of access to State supports including sick pay and housing and homelessness support, isolation and numerous other issues including discrimination and racism.

I will set out a number of priorities. It is not an exhaustive list because it is a far-reaching topic. We are happy to take questions on this. Through our experience with workers in the agrifood and meat processing sectors we found there is massive experience of exploitation, bullying, harassment, discrimination and health and safety issues. This is compounded by low levels of training by employers, lack of access to information and supports, vulnerability of being on employment permits and language limitations. Injuries at work go unreported due to the lack of sick pay schemes or State supports. People simply cannot afford to be sick and therefore do not engage with the State. In one's first year in this country one is not entitled to sick pay, so for the first year there is no engagement with the State, particularly for people from non-EEA

countries. Throughout the Covid-19 pandemic there were very difficult circumstances, especially for meat factory workers. There were problems with contact tracing and following up in a language people could understand, so there were more outbreaks than necessary.

Regarding the employment permit system, there is currently a renewed demand for essential workers on employment permits. A number of jobs have been removed from the ineligible list in healthcare and construction and there are new quotas in meat processing and horticulture. The system limits mobility and people are afraid to speak out for fear of bullying and harassment. They continue to be tied to one employer. Putting rights in the hands of workers, which allows people to have control over their lives, is something we would like this committee to support, particularly the Employment Permits (Consolidation and Amendment) Bill 2020 to give gradual mobility to workers after two years, an immediate right to family reunion and the right to work for spouses and dependants, similar to the rights of critical skills workers.

As regards undocumented children, being undocumented impacts on people's ability to access child benefit due to the habitual residence condition. There are also long-term impacts on children in terms of accessing school and education and on their long-term needs. It is important to recognise and welcome the incoming regularisation scheme due to be announced shortly. However, we believe it is vital that as many children of undocumented families as possible are included in this. It is something we will be asking the committee to support.

During the pandemic there was an approach where firewalls were introduced between Departments so that no data were shared if an undocumented person came forward. It was a very welcome development between Departments. It meant it gave confidence to people to access services. We would like to see this retained and then expanded to the labour inspectorate and across all State services. Undocumented people do not have access to the Workplace Relations Commission, WRC. This is a real infringement on workers' rights. The legislation must be amended to ensure all workers have access to these bodies.

With regard to victims of domestic violence, our service sees many people who continue to face barriers in accessing services. Recently, the Department of Justice introduced measures allowing people to retain their status, but those are only applicable to spouses registered as dependants and only under certain conditions. Undocumented people who are victims of domestic violence have little access to shelters, refuges or emergency accommodation. There is a lack of comprehensive policy or legislation in this area.

There is a lack of quality interpretation and translation services across all State services. Currently, there is no accredited training course for interpreters, no accreditation system to establish whether interpreters are competent and no system of control to monitor interpreting. In industries where migrant workers have limited language proficiency and they account for the majority of the labour force, State inspections are often carried out with no language provision. This means that Health and Safety Authority or labour inspectors go into a workplace but no one is able to interpret or understand what is happening. In addition, there is inadequate implementation of language provision across public services. This approach has resulted in people who are victims of crime or who have experienced exploitation finding public sector workers such as gardaí, healthcare workers and community workers as cold, indifferent or disrespectful, which further marginalises people. Obviously, public service workers do their best in very limited circumstances, which can be frustrating for them all.

We would make a number of recommendations. We urge the committee to write to the Minister for Justice urgently to ensure that the upcoming regularisation scheme is broad and

inclusive and reduces some of the qualifying criteria for children and families to access it. The scheme is imminent in the next week or so. We urge the committee to write to the Minister for Enterprise, Trade and Employment in support of giving mobility to workers after two years and to ask him to consider the upcoming sick pay legislation in order to enable workers to benefit from it effectively. As matters stand, it is not clear that people will. We recommend the introduction and maintenance of firewalls and that all front-line staff be provided with the tools to deliver quality services, including access to quality interpretation, and training on bias and anti-racism. We recommend that delays in renewals of immigration status be addressed, that independent status for all victims of domestic violence be ensured, that State accreditation and a quality control system for interpreters be developed and that resources be provided to organisations like the ones at this meeting so as to ensure that their services are quality and can deliver for people.

We welcome members' questions.

Chairman: I thank Ms McGinley. Before I open the floor to questions, I apologise to Senator McGreehan. I gave her apologies at the start of the meeting, but she is actually present. Is she taking Senator O'Sullivan's speaking slot?

Senator Erin McGreehan: Yes. And I am sorry, as I had sent my apologies.

I thank the witnesses for attending. It is important to have them here to highlight issues and offer practical advice and recommendations. I have a question for Ms Alagha. I was struck by the "A Mother is Born Too" research and Ms Alagha's comment about some "individual acts of kindness". That statement says a great deal about our system, namely, that kindness, decency and respect are not the default. I found much in what she said shocking and upsetting, but I found that especially upsetting as a mother who has gone through our maternity services. We have a national maternity strategy. I looked it up just now - "diverse" is only mentioned once or twice, as is "inclusion". In reviewing the strategy, how best can we work to amend it in order to ensure that, when women present to our maternity services, they feel welcome and comfortable and are looked after during one of the scariest and most special times of their lives?

My second question is for Ms McGinley. I have heard an incredible number of stories of exploitation from undocumented people living in this country. They are incredibly frightened. They are living in substandard conditions. They are tied to their employers, as Ms McGinley said, and marginalised from society. Ms McGinley set out a large number of recommendations. I have been working on trying to push measures with the Minister for Justice, so I am glad for Ms McGinley's highlighting of a number of extra ones. Do we know how many undocumented workers there are in the country? They and their families are working and living in this country but the are being treated disgracefully. Some deeply upsetting stories have come across my desk of families being put into terrible conditions and treated badly. We are awaiting legislation. Do we know how many undocumented workers there are in this country? What is the best advice that I can give to someone who comes to my office looking for help? I am trying and am working with the system. Does Ms McGinley believe that these migrant workers feel free to present to the MRCI? I often believe it is seen as officialdom even though it is separate to officialdom and that any sort of authority is seen as a threat. Is there a barrier to putting a hand up to even an open door like the MRCI?

Ms Yara Alagha: I thank the Senator for her questions. The national maternity strategy was Ireland's first ever maternity strategy to be developed. It came about because of recommendations from the Health Information and Quality Authority, HIQA, and was commissioned after

the tragic death of Savita Halappanavar. While it is meant to be an inclusive strategy in light of that context, it fails to address specifically the absence of culturally appropriate services within maternity care. The HSE also has the national intercultural health strategy, which promises an integrated approach to healthcare for users from diverse and ethnic backgrounds who may face health inequalities, but it contains very basic information on religious and cultural contexts.

In the review of the strategy, we need to consider more comprehensive guidelines and best practice guidance similar to those adopted by the NHS in the UK, which deals with best practice from the moment a child is born and maternity care to elderly care and end-of-life care. At every point, we need to ensure that a person's dignity is preserved and faith is respected. We can all agree on that, but the question is how to do a better job. While our research covered a small proportion of people from one faith, I am sure that much could be said about research done on people of different faiths and their experiences of engaging in healthcare and other State care settings. The extent to which these strategies are implemented and met remains uncertain because we do not have the necessary disaggregated data. We will never know until we have the relevant research. Our research highlights that perhaps these strategies are either not being implemented or are not enough. This matter needs to be investigated, starting with reviews of the guidelines. Are they working in practice? Do they need to be strengthened? Do they need to be better enforced? Do healthcare workers need to be better informed and how do we go about doing that? For example, would it be through mandatory training sessions? These are all questions that the Department of Health, in conjunction with the Departments of Justice and Children, Equality, Disability, Integration and Youth, needs to be looking into. We in the Amal Association would love to see this matter being hashed out further and discussed in committee and by the relevant Ministers. I hope that answers the Senator's questions.

Chairman: Does Ms McGinley wish to answer the other question briefly?

Ms Edel McGinley: I thank the Senator. There are an estimated 15,000 to 17,000 undocumented people in the country, of whom between 2,000 and 4,000 are children or young people. We are concerned that, given the way the current scheme is being drawn, it will exclude a significant number of people, so people will remain in situations such as those described by the Senator. We are conscious the scheme is imminent. A push from a committee such as this one would be very welcome.

The barriers faced by those who come to us are isolation, exploitation in particular sectors, language limitations and, perhaps, a lack of knowledge of the Migrant Rights Centre Ireland as an entity. Another key aspect if people are to take action or combat exploitation is that they need to be able to take cases to the Workplace Relations Commission, WRC. It is a fundamental right for workers to be able to access the instruments and apparatus of the State that are set up to protect workers, but these workers are being excluded from that, which is a real issue.

Senator Mary Seery Kearney: I thank our guests for their contributions and opening statements. For the representatives of Safetynet Primary Care, how do their patients connect with their organisation? How do they know it is there to avail of its services? I note annex 1 to the written submission it provided sets out the various services on offer. I ask Dr. O'Reilly and Dr. Skuce to elaborate on that because it is comprehensive and there are some excellent elements within it.

As regards Amal Association, I thank Ms Alagha. The research is excellent. It is horrifying to hear of the experiences and discrepancies she described, as well as the macroaggressions and microaggressions. I can only imagine just how invasive, difficult and challenging that is,

particularly in maternity, but also across all health services. It is very important. I am a little shocked that no training in cultural and religious sensitivities is available at this stage, given that having a fantastic multicultural society is not a new thing in Ireland. It has been the case for pretty much my entire adult life, which is, unfortunately, a longer period than I care to accept. There is no excuse at this point for that need not to foreseeable and taken on board. I am appalled that has not been done.

I ask Ms Alagha to share more detail on the yellow sticker initiative. I would like the committee to promote that initiative and do what we can to have a voice in it.

I propose that the committee write a letter to the relevant Ministers for a start based on the recommendations of Ms McGinley and put the weight of the committee behind that because she made very sensible suggestions. Outside the Houses, I am an employment lawyer by profession and have been approached for advice on many occasions through the years by undocumented people. I have had to explain to them that if one does not have the right to work, one does not have a right to the protections in place for workers, and that is unfortunate. However, it is a criminal offence for an employer to employ an undocumented person, so there is leverage. I have tended to use that leverage when negotiating with and pushing back on an employer, on a *pro bono* and unofficial basis, in such cases.

It is problematic that employment permits are attached to employers. It gives them too much say and control and, invariably, that is at the root of bullying, control and coercion of people in many instances. Arising from the issues relating to the meat processing industry during Covid, I spent a long time thinking about how to get employment rights into the hands of people. Even if there were an information campaign on national radio or in newspapers, it would probably be in English. There is a need to meet people in their communities. For example, I started thinking about whether the church on High Street is a Polish church and whether that area is frequented by the Polish community. We need to consider where people gather and whether we could get information to them in those sites. I would be interested in any ideas our guests have to empower people to know how and to where they can reach out. For example, they should know that going to the WRC should not cost money. Having those rights of access is important. I would be interested to hear any ideas our guests have in that regard.

Chairman: I thank the Senator. I invite Ms Alagha to respond, to be followed by Ms McGinley. If Dr. O'Reilly wishes to come in at any point, she should indicate that.

Ms Yara Alagha: I thank the Senator for her question. The HSE has the national intercultural health strategy which includes basic information on Islam and other religions and sets out guidelines on interactions with people of faith in terms of their different essential practice points in areas such as modesty, hygiene or dietary requirements. It is crucial for staff to be informed on all those aspects to deliver the necessary care and offer dignity to patients at a time when they may feel at their most vulnerable. As I mentioned, the extent to which that strategy is implemented is uncertain. Our research indicates it is not being adhered to.

As I mentioned, our yellow sticker initiative was created or established as a result of the increase in hate crimes against the migrant community. The initiative is that the Amal Association, in partnership with local business, retailers and supermarkets, would provide visible yellow stickers to signal that victims can expect help in the places displaying the symbols. Brief training would be given to the agreed parties in respect of their role in assisting victims. That role could involve offering the victim a place to sit or a glass of water or placing an urgent phone call to the Garda or the ambulance service. The victim could be allowed to sit in a public

place and consoled by a partnered supporter until he or she is stable or further help arrives.

Senator Mary Seery Kearney: Is the initiative in operation somewhere? I apologise for cutting across Ms Alagha.

Ms Yara Alagha: This is another issue we have. We do not have a continual funding stream. We rely solely on public donations through GoFundMe pages and this is obviously disrupted. We have no consistent funding stream from any State Department. We rely almost exclusively on public donations and goodwill, mostly from migrants, to sustain and fund our activities. We are still developing it. It is still in the works. As yet, we have not fully established the initiative-----

Senator Mary Seery Kearney: There are enough of us at this meeting to support and help Ms Alagha on that.

Ms Sancha Magat: We discussed with the Garda starting up the initiative but then Covid hit, so we had to postpone it until we have a stable operation. The Garda clearly mentioned it is a great initiative. We want it to be in Dublin 8 first because of our capacity there. If there is funding, that would be great. This is needed. I, personally, have been victimised previously. That is why we are starting this. It is to be hoped it will go somewhere.

Senator Mary Seery Kearney: Excellent. It is a brilliant initiative.

Dr. Fiona O'Reilly: I thank the Senator for her question and the opportunity to give a brief overview of how we engage with the migrants about whom I spoke. Dr. Skuce is our medical director and general practitioner, GP. She works across many of our services and will be able to relate how people come to meet her as a doctor in those services. Safetynet Primary Care provides homeless services to homeless populations and people in homeless hostels. We also have outreach services, such as mobile GP and nursing services, that meet rough sleepers and bring healthcare there. We also have a number of clinics for people who find it particularly difficult to access healthcare. We have a GP clinic in Summerhill in the HSE inclusion health hub. That area has a lot of migrants living in it who have no access to primary healthcare. The clinic is a safety net for them and it provides daily GP clinics. The Roma population is very marginalised and has quite poor health. Dr. Skuce will tell the committee about the Cappuchin centre where she runs a GP clinic and we have another clinic out in Tallaght for Roma people. We have been asked by the HSE to provide a mobile clinic in Carrickmacross.

Our work with asylum seekers and refugees comes under our mobile health and screening unit. In 2017 when Ireland was taking in Syrian refugees it was recognised by the HSE's social inclusion unit that there were lots of emergency reception and orientation centres, EROCs, around the country in small places like Ballaghderreen where local GP services did not have the capacity to take in a big number of Syrian refugees. We we did assessments whereby we sat with people for an hour, with interpreters, and packaged their healthcare needs and then passed them on for further care to the GPs. Now the GPs are doing that as a matter of course. That model actually works well. As there is no room now in the national reception centres, a lot of asylum seekers are in emergency accommodation in hotels around the city with no medical cards and no access to healthcare. Our teams are going in and providing clinics once or twice a week but this is not adequate. I will let Dr. Skuce follow up on the question about how the people we engage with get to our clinics.

Dr. Angela Skuce: The clinics that we have are easy to access, especially for migrants.

They are based in areas or organisations where those people tend to be anyway. We go to where people congregate. The Cappuchin clinic is based in the Cappuchin day centre which is mainly a dinner hall for people in need. Years ago that centre identified a need for healthcare so we started a small GP clinic there. More and more Roma people who were living in homeless accommodation, in squats in the inner city or in very poor quality private rental accommodation came to the clinic and the service grew out of that. We realised that we needed an interpreter, for example. Now we have a big clinic and we see between 70 and 100 people per week. The Tallaght clinic started in response to demand in Tallaght hospital. There were Roma people living in Tallaght who did not have GPs and they were using the hospital's emergency department as their GP service which was not appropriate for them or for the hospital. The HSE provided funding for a clinic which we run in Tallaght once a week in a building quite near the hospital. It is supported by the Tallaght Roma integration project and volunteers from the local Roma community come and act as intermediaries. People can just turn up at both of those clinics. They are open-access, walk-in clinics and people find out about them through word of mouth. In the Cappuchin clinic, we used to get people coming in from Carrickmacross because they had friends or relatives in Dublin who told them about it. People come to the clinics from the local community.

We have very strong links with local community organisations like Pavee Point. There is also a national Roma Covid information line that was set up in response to the pandemic because we realised that Roma people who do not speak English could not seek healthcare when they had Covid-19 or symptoms of Covid. We get referrals through that information line. We also have links with organisations like Mendicity which works a lot with people from eastern Europe and with people who have addiction and homelessness problems. Mendicity refers people to us. We also have very strong links with the local hospitals.

In reference to the maternity hospitals, there is a really good recent initiative involving the three Dublin maternity hospitals which have created a new post of inclusion health social worker. We have met the three of them in the last few weeks and they are our direct line in and out for people who are vulnerable for many reasons including being homeless, having addiction issues, not being able to speak English, being undocumented and so on. We had a problem recently where one of the maternity hospitals, in a drive to modernise and become more efficient and user-friendly, had developed an online registration form for pregnant women. In one of the maternity hospitals now people do not need a GP referral but can just refer themselves but they must do so by filling in an online registration form in English and uploading documents. We can now bypass that system by emailing the inclusion health social worker and she will make the appointment. At the other end, when people have had a baby and are leaving hospital, they may want long-acting contraception because their family is complete or they want to delay another pregnancy but if they do not have a medical card, they do not have access to that. The inclusion health social workers can refer them directly to one of our clinics, we can book an interpreter and get that sorted. That works really well.

Senator Mary Seery Kearney: Thank you.

Chairman: We will now move on to Deputy Bacik.

Ms Edel McGinley: Does the Chairman want us to answer the questions?

Chairman: I will come back to Ms McGinley after Deputy Bacik has spoken because we are running out of time.

Deputy Ivana Bacik: I thank all of the witnesses for their very useful presentations. It is really valuable for us to hear about the experiences of migrant communities engaging with State bodies, particularly in the context of Covid, and to hear how Covid has impacted on communities. We are all very conscious of the really disproportionate effect that Covid has had on so many migrant communities for so many reasons.

I am interested to know how we as legislators can support the work the witnesses are doing. Having listened to the presentations and read the submissions, it strikes me that there are three different areas that the witnesses are all addressing. The first is immigration law and it has been a pleasure to work with Ms McGinley of the Migrant Rights Centre on the Labour Party's Born Here Belong Here campaign, where we were trying to get more generous pathways to citizenship for children born in Ireland to non-national parents. I am really glad that the Minister for Justice, Deputy McEntee, is working very constructively with us and that we will see reform of our immigration law. I note that the Migrant Rights Centre in its recommendations asks this committee to write to the Minister for Justice to ensure that the scheme that is forthcoming to regularise people living here is as broad and inclusive as possible. We hear that clearly from the centre. How can we help to support that objective?

The second area is practical entitlements around work permits, driver licences and so on. I am conscious that an amendment to the Road Traffic Bill from the Minister for Transport, Deputy Ryan, is coming which will give effect to the entitlement to driving licences for asylum seekers. That is long overdue. Is there any other way we can support, through legislative initiatives, those practical entitlements? Finally, on the supports that the witnesses mentioned, things like the yellow sticker initiative is such an interesting and practical idea or the bystander initiative to support bystanders in intervening where they see a hate crime being carried out. Do the witnesses have any further thoughts on that? I am also interested in the interpreting service, particularly the Roma Covid information line that Dr. Skuce described. Are there any practical ways we can help the witnesses in those three areas or any other areas? I thank them again for their presentations.

Chairman: Thank you Deputy. I will invite Ms McGinley to respond first. If any of the other witnesses wish to respond, please indicate and I will invite them to speak after Ms McGinley.

Ms Edel McGinley: I will talk about immigration and will ask my colleague, Ms Magat, to respond to the question about practical entitlements and employment permits. What we are asking this committee to do, Senator Bacik, is very practical. My apologies, Deputy Bacik-----

Deputy Ivana Bacik: I am only getting used to it myself.

Ms Edel McGinley: It is very practical. We are asking for a letter, possibly from the Chair, outlining a reduction in the year requirements. As some people may have secured short immigration status for a period of time, they are in and they are out. That situation is not included right now so it is about trying to capture as many people as possible. We are asking for a reduction in the years that are currently proposed. I can certainly follow up directly with the Deputy or the Chairperson with more detail, if that is useful. Ms Magat will say something on employment permits.

Ms Sancha Magat: As members may be aware, the employment permit is issued to the employee for two years and is tied to one employer. There are many factors that prevent the employee from changing employer, such as the fear factor, especially in the first year. Even if

an employee is experiencing exploitation, he or she is afraid to raise the issue with the employer because of the fear of not getting a new employment permit. As I said, the factors are language and fear. It is not easy to change employers and most employees do not know how to do it. There is a lot of information. Some employees are also afraid to take cases to the Workplace Relations Commission. That is the main issue for the work permit holder.

When comparing mobility between permit types, we have a general work permit and a critical skills work permit. For the latter, an employee will be granted stamps after two years and he or she will have the capability to change employer without applying for a work permit whereas an employee needs to have worked for five years in order to change a general permit. We are asking the Government to introduce the same entitlements for the general work permit as for the critical skills work permit. There should not be a barrier to an employee changing a work permit because to get that general permit, an employee who applies for another job needs to have an employer who will support his or her application. In addition, that employee will have to go through the different criteria stipulated in the general work permit, including that the job is advertised, has a salary and so on.

There is also so much bureaucracy involved in the processing time. It takes three months to process a new permit. That is the current situation. In order to prevent exploitation, the Government needs to introduce a mechanism in this upcoming legislation whereby there will be the same mobility after two years for general permit holders as for critical skills permit holders, an immediate right to family reunification and a right for employees' spouses to work.

Dr. Fiona O'Reilly: Interpreting, which also came up frequently with the other groups, is a big issue. People do not have access to healthcare if they cannot talk to their doctors. GPs in this country do not have access to interpreters. Many of our patients could access mainstream healthcare if those working in it could communicate with their patients. Interpreting needs to be mandatory in the legislation where people require healthcare. I am sure Dr. Skuce will give us some examples regarding the need for that.

The other major legislative issue is medical cards. Saying that people have access and are entitled to a medical card, as asylum seekers are, means nothing if they cannot get a doctor first. They have to get a doctor to take them on before they can apply for a medical card, which means they cannot get their teeth done or anything done with their eyes. We know that general practice is busy and practices are full. The GP whose practice is full is the gatekeeper to all health services for people who are supposedly entitled, but it is not an entitlement. I will ask Dr. Skuce to address the interpreting issue.

Dr. Angela Skuce: The Deputy asked about the Roma Covid information line, which is a very good example of the issue. We knew when Covid hit that people who could not speak English would not be able to access anything, including testing, registering for vaccines or anything like that. Very early on in the pandemic, the HSE gave funding to Cairde, which is an organisation that helps people from other countries to access their healthcare entitlements. It operates a mobile phone number that, for a long time, seems to have run 24-7, though officially it runs from 9 a.m. to 5 p.m. from Monday to Friday. That line is manned by a member of the Roma community who is trilingual and speaks Roma languages, Romanian and English. As he works for Cairde, he can help people to get PPS numbers, medical cards and so on. He also serves as a link for people who do not speak English and also tend to have a great distrust and fear of state services. He has had hundreds of phone calls over the past year and a half from people who were at home with symptoms of Covid, some of whom were very ill, and were afraid to come forward. They were afraid that if testers arrived at their house, their neighbours

would realise, their house would be burned or they would be evicted. They were afraid that if they called a doctor, they would be deported or if they went to hospital in an ambulance, they would be given an injection that would kill them and they would die. They had very deep-seated fears, in addition to the barrier of interpreting.

Even though the Capuchin clinic has been working with this community for approximately 15 years, Roma still did not trust us when it came to Covid. The Covid information line acted as a first point of contact for people who did not speak English and as a trust link. People would ring up and trust that information line. The person manning it trusts us and the other services we work with. Through that information line, he was able to refer people to us for testing and to the self-isolation facility for vulnerable groups. He was able to link people in with GP services and food delivery services, if they were self-isolating at home.

I believe very strongly that interpreting needs to be accessible to the people who need it. GPs in some areas of the country have access to interpreting services but they have to be booked by the GP. People cannot make an appointment in the first place if they cannot ring up the GP practice. There is one very good example of an interpreting project in the south east, which is the south-east Roma project. It has valuable support workers who are freely available in the community. People who share a language with those support workers can ring them up or contact them. Those workers will then phone the local hospital or the patient's GP to say that a particular person needs an interpreter and an appointment at this time.

While the HSE has very good and meaningful guidelines on the need for interpreting in healthcare, access to it is in the hands of healthcare providers who are not always best placed to decide if somebody needs an interpreter and are not available as a first point of contact. That is one matter that should be addressed. When people are ordinarily resident here, they are entitled to healthcare. It needs to be accessible and meaningful healthcare. Interpreting is part of that.

Deputy Mark Ward: I thank the witnesses for their input. I am enjoying this discussion. None of the four witnesses we have heard from has mentioned Covid, so I will raise it. The pandemic has shown us the challenges migrants face. It has also shown that the Government can introduce emergency measures and powers. For example, when we sought to introduce a ban on rent increases and evictions in the past we were told it would be unconstitutional and impossible to do so. Such bans were later introduced, however, and that prevented a number of people from becoming homeless who otherwise would have.

I was especially interested in the Migrants Rights Centre Ireland's presentation on the introduction of a firewall for undocumented migrants which made it easier for them to access the pandemic unemployment payment. Similar assurance was given to undocumented people in accessing healthcare and vaccinations. That was very welcome. I support the centre's call for that model to be maintained. I ask Ms McGinley or Ms Magat to elaborate on the call for that model to be expanded into the labour market. What would be the benefit of that, not only for the undocumented migrants but for society in general?

Ms Edel McGinley: I thank the Deputy for his question. What happened during the pandemic was very welcome. For years we have been trying to introduce a separation of powers. That is essentially how we can separate powers. We want this model to be expanded into the labour inspectorate. When labour inspectors come into a workplace they should be there to inspect employees' conditions of work, not their immigration status. If employees see inspectors in their workplace, they may mistrust them as they may think they are immigration police who will deport them. The inspectors should be there to inspect their conditions of employment. We

want a firewall to be introduced between the immigration service and the labour inspectorate.

We also want the firewalls that have been established in healthcare and social protection to be continued to ensure people have a floor of decency, can access services and overcome some of their fears. People are awfully afraid to approach An Garda Síochána if they are the victim of a crime because they may be issued with a letter notifying them of an intention to deport order. The expansion of the firewall model would be good for society from a crime prevention perspective and for the economy in terms of rooting out exploitation. It is good for our healthcare system because people need to have access to healthcare for their long-term health. The same applies to schools and all sectors of society. If people are asked for a personal public service number and do not have it, they will not engage with the service in question again unless they have supports and people to help them to navigate the service. That is where we normally step in and provide assistance to people. Putting those rights into the hands of people is, ultimately, is what we want to see happen.

Deputy Mark Ward: My second question is for Ms Alagha. I will make an observation before I ask the question. The yellow sticker initiative is a brilliant idea. I love seeing such grassroots initiatives. It is a simple measure that could have a great effect. I would like it to be introduced in my area. Ms Alagha might drop me an email on it. I would like to support the initiative in my office and for my staff to be trained to provide support. I would give whatever donation is required for that to happen. I will look into that. I am sure others businesses in my area would gladly take up that initiative. Ms. Alagha might forward me information on that initiative after the meeting.

My question is on the court support service offered by the Amal Association. As a layperson, I find it difficult sometimes to follow the legal proceedings and language used in court. I can only imagine the difficulties a migrant involved in legal proceedings would experience in following what is happening in court. What supports does the association offer people? I would be afraid to think how migrants would survive if such supports were not available. If supports were not available to them, how does Ms Alagha think they would survive in dealing with court proceedings?

Ms Yara Alagha: I thank the Deputy for his question. The objective of the court accompaniment service is to provide culturally appropriate and emotional support for Muslim women required to attend court. The goal is to provide support before, during and after court proceedings along with practical support. As the Deputy said, legal terminology and jargon can be difficult to understand and navigate. We would provide the necessary translations, clarifications and guidance when it comes to follow-up procedures and different processes within the court process. Ms Nasib might comment on this directly as she has worked in this area.

Ms Nor Nasib: We recently launched that service. Some of our cases are starting to become the subject of court proceedings. The people we support do not have the language and there is, therefore, a language barrier. We help them by providing emotional support as well as a translation service. All the courts should have a translator but sometimes Amal needs to translate for the person in court because the court does not have a translator available at the time.

Deputy Mark Ward: I apologise for cutting across Ms Nasib but I have a brief question on that. During court proceedings, would the judge allow an Amal staff member to interpret for the person attending court? How is that person expected to participate and understand what is happening if staff member of the association is not able to provide guidance or translation at that stage?

Ms Nor Nasib: If the court does not have a translator a staff member of Amal has to be swear an oath to tell the truth and then that staff member can translate for the person we brought with us to court. In a court session where the court has a translator, the translator can translate for the person attending court if he or she does not understand what has been said. In the case of translation, languages are different. Even Arabic has different jargon. If the person attending court does not understand what is being said, that person will ask a member of our staff who will be present to clarify what has been said. That is the service we provide.

Court proceedings can be very long. Normally, we also provide some food for women who need guidance. Some sessions are held outside Dublin and sometimes we have to travel with the person concerned to Tullamore or other areas to be present with them in court. That is new for us. Our cases mainly involve domestic violence. We provided training to our staff on what needs to be done if other issues arise. Some of our staff members have been harassed by perpetrators. We have trained our staff in the accompaniment service to be better able to provide support to people involved in such cases.

Senator Lynn Ruane: I still have not mastered taking off a mask while wearing earrings. This has been a very informative session, which has covered a great deal. I note the number of solutions each witness provided, as opposed to simply identifying the issues. This session is helpful in that rather than simply naming the situation, the witnesses are offering a number of solutions with regard to how we can address it. That is good for us as a committee in our follow-up after this session in terms of support.

I would like to focus on Safetynet and, in particular, the Roma community. I gained some experience from my work on the Safetynet helpline throughout Covid. I am aware of the work Safetynet does across direct provision and different counties, including in Summerhill and in the hubs. It spans a wide area. Dr. O'Reilly mentioned that services at one of the Safetynet clinics are inadequate. Are they inadequate in terms of provision because of manpower and funding? What more could be done with more adequate funding streams and different initiatives?

I ask the witnesses to keep note of my questions. We have spoken a little about the fear of particular communities and the lack of translators. What is the human cost of that? What is the impact of it? Safetynet deals with a large community. Is a large part of the Roma community completely underground because of the experience of Roma people in terms of them receiving no healthcare? What is the impact of not having a translator for those who fear being deported?

Maternity services were mentioned a number of times. Are Roma women and girls giving birth at home and, as such, living completely under the radar even at that stage? What is the health status of members of the Roma community on presentation and are the services that the witnesses can provide at that stage adequate enough given the level of comorbidity and so on? I ask Dr. Skuce to comment on the impact on transience and constant changing of address in terms of healthcare provision. For example, in the case of a healthcare intervention, are people lost along the way because they are constantly moving? What happens to their healthcare? Is it constantly interrupted? I ask the witnesses to speak a little more to the impact on people's health status because of the issues identified today.

Dr. Fiona O'Reilly: I thank the Senator. I will comment on the inadequate service provision and what, owing to capacity, we can or cannot do. I will ask Dr. Skuce to comment on the impact of those barriers and transience on the health and welfare of, particularly, the Roma community. Earlier this morning, I spoke to one of our general practitioners, GPs, who is look-

ing after some asylum seekers in emergency accommodation. She had just seen a man who is new to the country, having fled persecution. He has physical ailments as a result of being beaten and tortured, but it is his mental health she is really concerned about. A couple of weeks ago, she referred him to psychiatry for suicidal ideation and he was admitted. He is now back in the emergency accommodation. The hospital recommendation was for GP follow-up care, but she is seeing him in his emergency accommodation. He has no GP, except her, because, as the committee will be aware, we visit sites. She will need to see him again in two weeks' time but she does not know where he might be in two weeks' time. This man does not have a phone or an Irish SIM card. She put him on whatever medication she could, which would be antidepressants which mean follow-up is required. She also gave him a contact number for Safetynet so that he could call us because we have no idea where he will be in two weeks' time. That is just an example of the transience issue. On the Roma community specifically, as I said, Dr. Skuce, will comment on that.

In terms of the adequacy of service provision, it is more than just a funding requirement for Safetynet. What I was talking about in my opening address is the completely different world we are coming into, which we have not recognised yet. Our health systems are built for an Irish population in the Ireland of 50 years ago. They are built for the local general practitioner who was born in the community and knows everybody in it, including their parents and grandparents. You cannot even get into services as adults, in particular disability services, because access is reliant on you having grown up here. We are trying to catch up. Safetynet is providing emergency primary care, but that is not a system of care that will ever have the capacity to provide primary care for incoming-----

Chairman: We have lost contact with Dr. O'Reilly. We will move to Dr. Skuce if she is still with us.

Dr. Angela Skuce: There are a number of organisations across the country working with Roma people. We all came together and we held teleconferences every two weeks because we knew that they would be very vulnerable to Covid, as they are to every other illness. Organisations, including the HSE and public health services, went into the local communities and populations of Roma people were identified across the country that previously nobody knew about. At all levels, some of them were well established and working in mainstream jobs, but many of them for cash-in-hand or on zero hours contracts. These people are not on anybody's radar because they are bunking in with other people, friends and families who might have tenancies. Covid revealed this and attempts are now under way to try to map the Roma population across Ireland to identify need, including for services.

We started collecting ethnic identifiers for health, especially in regard to Covid. That revealed two things. Prior to the vaccination coming on stream, we reckoned that Roma people were ten times more likely to die from Covid than the background population in Ireland. That is, probably, a reflection of their general health and the circumstances they live in, the social determinants of health more than anything. Now that we have such good vaccination rates, Roma people are approximately 50 times more likely to die from Covid because they have enormous vaccine hesitancy. They see the vaccine as an instrument of State control. They have such distrust in the health service, they think it is going to do them harm. It has proven very difficult to get any significant vaccine uptake with the Roma community.

On the health in general of the Roma community, they suffer the same health problems as everybody else but their conditions tend to be worse, to occur at higher frequency and to be less well looked after. They have higher rates of infectious diseases such as hepatitis and tubercu-

losis, TB. They tend to have lower childhood vaccination rates and, as such, they might have greater incidence of measles and so on. They are things that GPs and hospital can manage and the kinds of things that we are used to. They tend to have large families, starting at a very early age. That has health and social implications going forward. When they are able to access good healthcare, good maternity care and appropriate contraception, they do access it. That improves the outlook for the families as well.

On transiency, it is a huge problem. Our waiting times for hospitals are long and the bureaucratic processes onerous. If I refer people to a hospital for something, they might get a validation letter six months' later to ask if they still want to be on the list, because they have moved and missed an appointment. Those people then come in to tell me that they have moved, and I have to re-refer them to the hospital in the area where they live now, which means that they are back at the bottom of the waiting list. It is especially striking in cases involving children with special needs because the waiting times in those services are years' long. There are many instances of children with autism spectrum disorder, ASD, or learning disabilities who have moved only a few miles each time, but on each occasion they go back to the bottom of the waiting lists. Children have got to secondary school age without ever having been assessed. If we could have a provision where it would be possible for people to go in on the same place on the waiting list as they were at when they were at their last address, that would really help people.

We have had one good example of how an integrated system and of organisations working together can help. Early in the pandemic, the HSE funded a self-isolation facility for people who could not access any other such facility. In the end, as we suspected, most of the people who came through that facility were Roma people. Many of them were people newly arrived in Ireland, or newly arrived back in Ireland, and who did not have anywhere to quarantine. It was a nurse-led facility, so everybody coming in got health assessments and their initial applications completed. They were linked with the health services then and that meant that once they left the facility they were able to continue on in those services. People presented in labour in that facility and babies were almost born there, but at least there was a nurse on-site who was able to get them into the right place. However, that facility closed recently.

Team members have been following up with those who have come through City West, which is closing. Yesterday, they visited one family in homeless accommodation. When the family arrived, I think the dad had a job in the waste recycling industry. They could not afford accommodation, so they applied for Dublin Region Homeless Executive, DRHE, homelessness accommodation. They were eligible, and they were placed in a bed and breakfast in private emergency accommodation. Unfortunately, there was a problem with domestic violence, and the dad had to leave the facility because his behaviour was unacceptable. The mum and the five children are now living there. They are provided with a room to sleep in, bathroom facilities and breakfast every day. It turns out, however, that the mum's only income is from the children's allowance payments for her four children. She has no other income, so she is feeding her children for the rest of the day on approximately €500 a month, as well as buying school uniforms and schoolbooks etc. As a result, the 14-year-old in the family is wearing shoes that are two sizes too small. All that family needs is an intermediary who can help them to apply for what they are entitled to.

Senator Lynn Ruane: I thank Dr. Skuce.

Dr. Angela Skuce: I could go on, but I will not.

Chairman: I thank Dr. Skuce and Senator Ruane. I call Deputy Cairns.

Deputy Holly Cairns: I thank all the witnesses for joining us today. I have two questions. The first is for the representatives from the MRCI, and it concerns domestic violence. I am concerned by the point they made about migrant women continuing to encounter barriers in exiting situations of domestic violence, accessing support services and retaining their immigration status. Most disturbing of all is that our immigration system actually facilitates domestic violence and coercion, in that people' status is linked to that of their partners' and there is no entitlement to retain immigration status following a separation. The witnesses indicated that some limited measures had been undertaken, but I ask them to explain the importance of proper reform in this area.

My second question is for the representatives of the Amal Women's Association and concerns the issue of maternity. I commend the organisation's research and practical engagement on maternity care. I am aware of the barriers faced by different minority groups and disabled people, but these findings highlight the need for staff training and more bespoke interventions. Reference was made to the 4% of the participants who were pregnant and who presented to the hospital for the first time when they were in labour. Do the witnesses have suggestions for what measures need to be put in place to address that issue? The research also found that 15% of participants reported incidents of macro-aggressions, mostly verbal abuse, with women reporting being shouted at, being told to remove their headscarves and of there being hostile attitudes regarding the need to remain as modest as possible. I ask the witnesses to elaborate on that aspect as well.

Chairman: Does Ms McGinley want to come in first on this issue?

Ms Edel McGinley: My colleague, Ms Magat, will address this question.

Chairman: I call Ms Magat.

Ms Sancha Magat: On domestic violence, I am attending to domestic violence issues now and it is still fresh in my memory. The issue here is that the Department of Justice has a policy in this area, but it does not include undocumented people. This policy is highly dependent on the spouse, that is the person who is a kind of guarantor in respect of immigration issues. People, mainly women, in this type of domestic violence situation are afraid to lose their immigration status. Without that status, they will not have rights and entitlements. Even if they wish to access women's refuges, they will have a limited time in that regard. They will also not be entitled to any social welfare. There will be issues with child benefit, for example, which might be stopped. That is why people in these situations are afraid to raise these issues, especially undocumented people. Therefore, it is probably time for the Government to renew the policy for domestic violence in use in the Department of Justice and to include people who are undocumented in its scope. There is nothing there now for people who are undocumented, it is just a case of it being tough luck.

Chairman: Does Ms Alagha wish to contribute regarding the query posed in respect of the Amal Women's Association?

Ms Yara Alagha: I will come in on this question, and perhaps Ms Nasib may also wish to comment. It is important to note the context in which our maternity research was conducted and commissioned. One of our non-migrant board members, who was pregnant at the time and attending maternity-related medical appointments noticed that while Muslim women and women of minority backgrounds were attending the necessary pre- and post-maternity medical appointments, other services offered by maternity hospitals, such as breastfeeding groups or

baby massage classes or other sessions and meetings were also important, especially for new mothers. That sparked an interesting discussion among the board members, and we decided to investigate further.

We have concerning findings. We found that what is necessary are translation services and culturally-appropriate services, which includes catering for dietary needs, language barriers and proper communication. Our research also found that many women went without labour pain relief because of simply not understanding and the challenges posed by language and culture. There is much to be said about this issue, if Ms Nasib wishes to come in here as well.

Ms Nor Nasib: I think about this issue because I have experience in the maternity services here. Being Muslims, we need to cover ourselves and there are also dietary issues. It was very difficult for a colleague of mine who delivered a baby during Covid-19, because the room and the toilet were so far apart. Every time she needed to go to the toilet, she had to leave her baby alone and cover herself. Sometimes as well, those toilets were being cleaned because of Covid-19. It is especially difficult for us, therefore, and especially during Covid-19.

I thought about this issue, and I do not know if perhaps this might be too much to ask, but I wonder if it would be possible for there to be some way to have a session or a place where only Muslim women would be present. That would mean the women there would be among women who are covered and the toilet facilities would also be nearby. I know it is hard with everything that is happening now, but something like that arrangement is one of the suggestions for improvements that I think it would be great to have. As Ms Alagha has mentioned, the language barrier is very difficult and sometimes they do not really understand what the doctor or the midwife is saying. Perhaps there could be training for the midwife and the doctors, just to make sure that the migrant or the woman they cater for really understand what they are being asked at the time. The research tells us that the woman may not understand but she will just nod because she does not want to lose face. She may then ask her husband or the immediate family what did the doctor talk about as she did not really understand.

I also wish to mention that this research does not cater for some migrants. We would appreciate it if we could continue the research to get better service, not just for Muslims, but for all migrants in the future.

Chairman: Was that all of Deputy Cairn's questions?

Deputy Holly Cairns: How are we for time? If there is more time, I have more questions.

Chairman: I will come back to the Deputy. There should be more time at the end as we are not under too much time pressure.

Senator Sharon Keogan: I thank the witnesses for their statements today. My first question is about undocumented children who may come into the State without parents. What happens to those children? They end up with Tusla and they end up in care. Sometimes they have difficulties in getting interpreters when they arrive into the immigration centre the following day. What happens to the undocumented children? Do we have a record of how many children per year come into the country?

I also have a real concern around the statement about translation and interpretation. Do we have enough translators? What do we need to do to improve in respect of making sure that those who arrive into our country have quality interpretation services?

To reiterate, my first question was on undocumented children who have no family in Ireland but who just arrive in on an aeroplane and into emergency accommodation and was on where do they go from there. My second was whether the language barriers and the interpretation services are adequate and what we need to do to improve them.

Chairman: Would Dr. O'Reilly or Dr. Skuce want to come in there? I ask the other witnesses to indicate if they wish to come in on those questions. Ms McGinley has also indicated.

Dr. Angela Skuce: On the question around interpreting, there are no standards for interpreting here. We have a Romanian interpreter in the Capuchin clinic and we are hanging on to her with our fingernails because we know that she is really good. I have worked with a lot of interpreters when she goes on holidays, and other interpreters in different languages. The standard is wildly variable. I have had to ask some interpreters to leave because they were having conversations with the clients and I did not know what they are talking about. It would be really important that we have standards. Different countries have accepted standards for interpreting and methods of accreditation. It would not be difficult for Ireland to do.

Certainly, in general practice there is not nearly enough access to interpreting. We have a special funding stream for that but most of the GPs that I know do not know how to access an interpreter and do not even know that the service exists. It seems to be dependent on which part of the country one lives in. Even with the GPs who do have access, it is often difficult to access. We need a lot more interpreters. It need not be expensive. There are different models of providing interpreting that can be very cost effective. Years ago, I worked in London and there are lots of different languages spoken in the area in which I lived. The local GP practices informally divided up the populations between them. For example, three practices would do Portuguese, where those practices would have all of the Portuguese and Brazilian community and a full-time interpreter between the three practices so there an interpreter was available every day. The practice down the road might do Somali and so on. If a practice employs an interpreter on site all day, he or she can interpret for up 30 different people. I believe that it worked out at something like €5 per head. If it is being done in an *ad hoc* way, however, through booking an interpreter for somebody for a particular appointment that can work out at €30 per head. There are lots of very established ways of providing high-quality and cost-efficient interpreting that we could just copy from other countries.

Ms Edel McGinley: To follow up on that point, right now we feel that it is a form of institutional racism. We do not provide the services that people need. Equally, it would not be that difficult to introduce a State accreditation system. People train for years to be interpreters. It is a very skilled job to interpret professionally for people. That needs to be recognised. There are so many very important services that people use such as health, the judicial system or taking a case to the Workplace Relations Commission. These are very important things that people must navigate. We do need that system. Such a skills and accreditation system could probably come under the role of the Department of Education and that ministerial competency. It could be part of the qualifications framework that we have. It is important that people have a particular qualification or experience in the area.

I believe that Senator Keogan's question referred to unaccompanied minors rather than undocumented children. The Migrants Rights Centre Ireland works predominantly with children who are born to parents who are undocumented or who came with their parents who are not undocumented. We do not necessarily work with unaccompanied minors, so I do not have figures for those numbers, unless somebody else may have them. I understand that if those children are unaccompanied and under the age of 18, they go into the care of Tusla. Depending on their

age when they arrive there will be different tracks with regard to foster care or State care. I do not have extensive knowledge on that.

Chairman: Is Senator Keogan okay with that?

Senator Sharon Keogan: Yes that is fine. It was unaccompanied minors I was referring to. I was just wondering what happens to them. Do they automatically go into the State care system?

Ms Edel McGinley: Pretty much. Often, however, there are issues around proving one's age with questions being posed such as what age is the person and whether the person is 16 or 17 or 18 or 20. There also can be issues around establishing the age of the unaccompanied minor because he or she may have fled persecution and not have documents. This is part of the asylum process. It can, therefore, be difficult to try to prove a person's identity and age. It can be an issue for children that they are not believed when they say the age they might be.

Senator Sharon Keogan: I thank the witness.

Chairman: We will move on to Deputy Costello.

Deputy Patrick Costello: Interpretation can be an interesting thing. I have worked through interpreters in the past, face to face and over the phone. There are times when the person you are working with talks for five minutes and the interpreter gives a one-word answer. It is not always the best. An accreditation scheme would be excellent. One question I wanted to ask that has been pre-empted is whether any other countries are doing accreditation right. Dr. Skuce mentioned England. I agree with Senator Seery Kearney that this is not a new issue for us in terms of multiculturalism but as we are coming to it after other countries, surely we can learn lessons from them. Can our guests point to other examples of positive things?

I am curious about structural issues with interpreters. Do we have enough interpreters in this country? Do we have enough people who can speak the right languages? I have worked with interpreters over the phone and it not the best but it is not the worst and it is certainly better than not having interpreters. Can we not use a pool of interpreters sitting in the UK, Brexit notwithstanding, or in France? Perhaps these are questions I should be asking the Department. I would like an insight into the structural issues around the set-up of the interpreting services. Are there other places we can learn from in terms of accreditation? Do we have enough interpreters speaking the right languages?

Where a parent does not have any English and his or her child has better English, the child can often be pulled in as an informal interpreter, which can be unfair and problematic as it can be an inappropriate level of responsibility for the child. There can also be implications relating to the privacy of the parent.

Ms Alagha mentioned policy relating to multicultural sensitivity and awareness within the HSE. I missed the name of the policy, if she would give it again. I am curious as to what that policy looks like. Is it aimed at the hospital at large? If it is, it is probably gathering dust in the office of the hospital administrator or manager. Is there something on the ward? Nurses and doctors have all sorts of reference books to which they can turn for correct administration of medication and things like that. Surely it would be easy to require them to have a folder which tells them about basic cultural awareness. I appreciate that basic cultural awareness, by definition, is basic and will not meet everyone's needs but it is certainly better than nothing. It is better than getting the person to try to explain themselves.

Dr. Angela Skuce: I will answer a few of the Deputy's questions about interpreting. There are some very good examples of positive things. In the Capuchin clinic, we are lucky to have a specialist diabetes clinic. The Roma population tends to have a high incidence of metabolic syndrome, which includes diabetes, and all the complications that come with it if it is not managed. We are lucky enough to have a consultant diabetologist, who volunteers and runs a clinic once a month with an outreach nurse and with our interpreter. Almost all of her patients are non-English speaking Roma people and that clinic has been running for a few years. Its figures are better than the national average. These are people living in very poor circumstances, who do not have medical cards, do not speak English and do not have much money to buy great food and that kind of thing. Their parameters for everything, including eye tests, foot care, blood tests and everything, are better than the national average. That is because we have a good, familiar and trusted interpreter who has worked with that team for a long time. That costs a certain amount of money but saves enormous amounts of money, down the line, because if diabetes is poorly controlled, people end up in hospital with lots of complications. They can be on dialysis for years. The cost savings for the health service and for disability benefits are enormous.

The Deputy is absolutely right about using interpreters from abroad. We used to have access to a multinational interpreting agency. We probably have enough interpreters for the more common languages but every now and then, somebody who speaks Mongolian or a language we have little demand for will come in. When we have that demand, we need interpreters. We used to be able to access interpreters in the UK through an agency that has offices in Ireland so we would get an interpreter on the phone straight away. That is not ideal but it is adequate, most of the time.

Dr. Fiona O'Reilly: I will come in on another positive point. As I briefly mentioned, the mobile health and screening unit is another positive. It is funded and provided through the HSE social inclusion services, and applies for migrants in the Irish refugee protection programme when we know they are coming over and Ireland has accepted them. It is designed to ensure they all get a proper 45-minute or one-hour consultation with a doctor and a nurse to unpack their medical problems, any issues with their documentation or the medical history that have come over with them, or assessments that have come from the refugee camps they have been in. An interpreter for whatever language is required can be booked to be available on-site. The children's vaccinations record is looked at because they may have missed a load of vaccinations, having been in refugee camps for a number of months or years. All of that can be packaged and provided to their primary care doctor whose list they will be put on. That kind of assessment and integration of healthcare does work in those circumstances.

That does not necessarily apply to those who do not arrive in a planned way and are not people we have agreed to take. However, there is no reason why, with additional resources, specialised integration and health integration teams could not be made available. Such a team could be assigned to each HSE community healthcare organisation, CHO, area or something like that. When new migrants come in, those teams would be able to smooth the pathway of integration into the healthcare system.

Ms Edel McGinley: I will come at this slightly differently. If we believe people have a right to health, a right to legal redress and other fundamental rights, then we should be adding a layer that states that to access those rights, one must have a fundamental right to understand the services. This is the conversation we are having now. We need to get there. We need to determine what rights people need to understand. In fact, that is all rights. There are some basic

and fundamental things that people need access to in a language they can understand.

Translation is low paid and not very attractive so there is an issue with attracting people into the profession. There are issues around pay and rights. There are also issues as to how it translates from a service. There are a number of issues to overcome in this area. I am certainly not an expert on translation services but there are some basics that need to be hit. They are something the Department of Education really needs. The committee, in its function of examining equality and integration issues, needs to make demands on that Department to come up with some kind of framework in this area.

Deputy Patrick Costello: We seem to be having network trouble at this end. My sound was cutting in and out.

Chairman: Yes, unfortunately, we are experiencing technical difficulties on and off.

Ms Nor Nasib: I might add to the point about translation because that is where Amal stands. We are the bridge for people who need our service because we have the language and culture. We support many migrant women, mainly Muslims, with the language and skills we have. We are so fortunate to have the help of our funder, Hanan Amer. She is an amazing woman who helps women all along the way. She goes from hospital, to the social worker, to the court with women, hand in hand, from the start of the issue they face to the end. We try to give this service. We are the bridge between women who need the service and the service itself because we have the language and culture and they trust us to give support as best we can. A better translation service would help a great deal, especially in hospitals, where many people do not really know what the doctor or midwife is saying.

Ms Yara Alagha: The Deputy asked about the strategy I was referring to. It was the HSE national intercultural health strategy. It is really good and well designed. It obliges active, meaningful service user involvement in the design, delivery and evaluation of services. It is a prescriptive list of guidelines, including basic information on different religions, including Islam, and various cultures and sets out guidelines on interaction with people of faith in the context of their different practices relating to hygiene, dietary requirements or whatever the case may be. As I mentioned, however, the extent to which these strategies are implemented remains unknown, and without the necessary disaggregated data, we will never know. It is important we get the provisions we ask for, including disaggregated data and an independent group that oversees the implementation of the strategy, on a statutory footing and equality-proofed.

Deputy Jennifer Murnane O'Connor: I apologise that I had to go back and forth to the Chamber. I thank our guests. I listened to as much of the meeting as I could and we have all learned a lot. Many of the questions I had intended to ask have been asked. The biggest issue today has related to communication and the language barrier, something we need to address. I know from working with my local authority that there are language barriers and we need to address that. We need to put more funding into the various Departments, whether in regard to healthcare or social protection. We all need to ensure there will be funding in order that language will cease to be a barrier.

Women's refuges were mentioned. In my area, Carlow, we do not have one. It is so important that every county has a women's refuge, and that too needs to be addressed.

As I said, my questions have been asked, so I say, "Well done" to our guests. This is about awareness and we need to highlight the issue. There is a lack of communication and we in the

Oireachtas need to address that. It is beginning to happen - I can see changes - but we need much more change. I was very impressed by the yellow stickers idea, another issue for which funding is required. All these initiatives are so important. Something small like that can make such a difference and we need to examine it. Our guests spoke about Covid.

(Interruptions).

Deputy Jennifer Murnane O'Connor: I hope we will have learned. We can see more areas now where we are falling down and we need to address them.

Chairman: I ask members to be brief because we seem to be experiencing technical issues. We have been able to get through the meeting thus far and I do not want contributions to be cut off.

Senator Lynn Ruane: Our guests from Safetynet mentioned medical cards a couple of times and the issue whereby someone might have one but have nowhere to go with it. Will they speak to how we can remedy that? Should there be something in policy whereby if someone has a medical card, he or she could, especially because of his or her migrant status, access any doctor, or perhaps there should be a quota per type of surgery? What solutions should we consider to address that?

My second question is directed at either our guests from Safetynet or Ms McGinley. It relates to migrants with professional qualifications who come here and then struggle to have their qualifications recognised in Ireland. I refer in particular to healthcare workers being unable to progress as an asylum seeker or migrant with their qualifications. Is that a barrier for people to their development here and to being able to flourish and be paid for the job they are qualified to do?

Dr. Fiona O'Reilly: The medical card process is a significant barrier, partially because the GP practices are so full and it is difficult for anybody to get access to a GP. A person cannot get a medical card as the first step. Rather, the first step to be taken is to get a GP who will accept you on his or her list and then you can apply for a medical card. If those two issues were delinked, whereby there would be a health card that allowed people to get a certain number of services but not a GP, given that there might not be a GP who had room on his or her list to take more people, they would still be able to go to the dentist, the optician or the hospital if necessary.

The other potential solution in respect of medical cards, although this is only in the policy or structural areas, relates to the fact our GPs operate private practices. They are self-employed. As a charity, Safetynet is funded. If more practices or GPs were funded by the State, there would not be that barrier. Similarly, integration health services, for example, are a potential solution. The situation today is that asylum seekers come in through traumatising transitions in emergency accommodation and do not have access to any doctor, and they cannot get a medical card because no one in their area can take them on. Another policy implication is that asylum seekers require access to medical care when they claim asylum.

The Senator's second point was on people progressing. It is linked because-----

(Interruptions).

Dr. Fiona O'Reilly: -----asylum seekers. There are many well-qualified healthcare workers. Safetynet has employed some through Covid and it has worked out great. They may be in direct provision and may not have their work permit. Even if they do, they do not know how to navigate the difficult systems. There are doctors with qualifications from other countries who cannot navigate the systems. There are nurses who do not know where to go to navigate the systems to translate their requirements, which we need in this country. I would love to see an initiative focusing on that. That would match up with our lack of capacity in that area.

Senator Lynn Ruane: I seek clarification on the medical cards and the idea of uncoupling the two things from each other. I think that worked well for homeless medical cards when it came to decoupling the idea of having a medical card from having an address. Is there a similarity in what needs to happen? Did an individual need to have a doctor take him or her on to get the homeless medical card or what was the situation?

Dr. Fiona O'Reilly: There is a medical card number for asylum seekers through which that can be done but it is not widely known about. I do not think GPs know about it either. For migrants in general, that would probably work. They could get seen by a doctor anywhere in the country and get prescriptions if it was done with a number and that is what can be done with homeless people.

Ms Edel McGinley: This is an ongoing problem for years. We carried out research in late 2020 and early 2021 looking at the experiences of people in the labour market and what would help them progress. A number of recommendations arose from that, one of which concerned recognition of qualifications. However, it was more than that. It was recognition of experience. People have worked for many years in different contexts and that is not taken into account by employers. It is almost like they go back to zero.

People also identified early career guidance. If people arrive here and their skills are not recognised, they would receive guidance on where and how they should retrain and what they should retrain in. Mentorship and coaching was another area people mentioned. When they move, they do not have the same social, historical and local networks. People identified the need for mentoring and coaching to be connected with people and help them navigate the labour market and skills and training. That was felt to be important.

The role of employment services and recruitment agencies was raised, particularly the former, to help people navigate the labour market. It is not just about a job, but about the labour market, what it looks like and how an individual can progress in it over time. In the workplace, skills for work were identified, such as employment support for language acquisition that helps people progress in a particular employment setting. There is different vocabulary for different settings. A lot of that was carried out by the old FÁS and these programmes have been cut over the years. They are important. How do people acquire good language skills and how is that supported by the State and employers?

Many people talked about transparency in recruitment and promotion processes internally and addressing discrimination more broadly in accessing the labour market and while in it. These recommendations came out of what people were saying and what they felt would have helped them in the labour market. We can send the research to the clerk to the committee if that is of interest and use to the committee.

Ms Yara Alagha: Deputy Bacik mentioned practical assistance that could be given to the organisations present. There was no time to come in there but can I speak to that?

Chairman: Go ahead.

Ms Yara Alagha: Like many community developments, we plead for safe, adequate and ring-fenced funding. I should make clear in the context of our recommendations and requests that Amal Association, Safetynet and MRCI are not born out of the desire for migrants to have extra rights or more provisions granted to them through growth needs. The migrant community is still at a level of securing its existence. Amal Women's Association was established on that basis and is meeting the needs of the most disadvantaged communities. In the absence of necessary State provisions for migrants, Amal Association fills those gaps and does the work of the State. For example, there are our yearly Ramadan and Eid campaigns during the most important and holiest month and festivities for Muslims during which they engage in day-long fasts for 30 days. Amal Association visits direct provision centres and low-income households with packs containing food items that can be consumed when they break their fasts, which in most cases is outside the food-serving hours in direct provision centres. We also provide essential items such as sanitary packs and try to incorporate a festive feeling for the children with toys and activities during our visit. They would otherwise be stuck within the four walls of the rooms in the direct provision centre. We provide basic human necessities to allow a migrant to live a dignified life. We would love to work with the State to ensure the organisations doing the work of the State are properly funded and supported, that there are no disruptions to our services and that we can expand them. I thank the Chair and members.

Chairman: We have come to the end of our questions. There were some specific asks and Senator Ruane said it was great to see people coming who were solution-focused and who had solutions. I echo those comments. There were asks in respect of us writing to various Ministers and we will follow that up as a committee. Many of the proposals the witnesses make are common sense. On the waiting lists and addresses, Dr. Skuce made the point that if someone moves while on the waiting list for a medical procedure, he or she should not fall off the list and have to start at the beginning. I have often come across cases where people said they tried to update addresses and everything fell through the cracks. The yellow sticker situation has been mentioned a number of times. Translation services were also mentioned. They are basic human rights. To understand the situation you are in, you need to understand what people are saying to you.

I am glad we were not rushed, as committees often are. Particularly now with Covid restrictions, it feels we are constantly moving people on. I am glad we had the opportunity to allow members and witnesses to engage in a good discussion. There have been some technological issues on and off, so if anybody wants to make concluding remarks, I will allow them to do so now.

Ms Edel McGinley: I thank the committee for the invitation. We appreciate it and it is great to talk about these important issues. On the request to write to the Minister, that is urgent and I ask that it be done in the next couple of days. That would ensure that the committee's views are with the Minister because a decision on that scheme will be going to the Cabinet quite soon. I urge the committee to try to prioritise that. Finally, we believe that giving more rights to people is the way forward in terms of people accessing any of these services or engaging with the State. When one diminishes rights, one diminishes people's ability to engage and to take control over their lives. For us, that other request regarding the general employment permits and having equality in the system is very important as well.

I thank the committee again for its time.

Dr. Fiona O'Reilly: I thank the committee for inviting us to appear this afternoon. As Dr.

Skuce said, the Covid-19 pandemic has been a stark time and has revealed many of the inequities in our society. Some of our migrant communities were shown to be extremely vulnerable, particularly the Roma community in our experience. We are thankful for the support we get from State bodies, such as the HSE social inclusion, and we worked really well around the country particularly during the pandemic with public health throughout the country. That has been very positive and solution-focused. We would like to see Ireland as a multicultural society. As stated earlier, migrants are not vulnerable, but they can be made vulnerable by barriers, including structural barriers. We believe we have much to gain from the migrants who come to the country, and it is a missed opportunity if we do not do that. We strongly believe that people should have the same rights as the indigenous population, and communication is the first step on that. I thank the committee.

Chairman: Again, I thank the witnesses for their engagement today. Hopefully, we will engage with them further. We look forward to doing so. Is it agreed that the opening statements be published on our website? Agreed. I also thank the members for their attendance.

The joint committee adjourned at 5.13 p.m. until 3 p.m. on Tuesday, 23 November 2021.