Migrant Communities *Needs Assessment*

Examining the experience of migrant communities in seeking access to cancer and healthcare services

Authors
Dr. Adeelia Goffe
Maria Pachowicz

Table of Contents

LIST OF BOXES, FIGURES AND TABLES

BOXES

FIGURES

TABLES

LIST OF ABBREVIATIONS

A&E	Accident and Emergency
ADHD	Attention Deficit Hyperactivity Disorder
ASD	Autism Spectrum Disorder
BOTP	Beneficiary of Temporary Protection
CHO	Community Healthcare Organisation
COVID-19	Coronavirus Disease 2019
CSO	Central Statistics Office
CT	Computed Tomography
DA	Disability Allowance
DART	Dublin Area Rapid Transit
DCEDIY	Department of Children, Equality, Disability, Integration, and Youth
DP	Direct Provision
EEA	European Economic Area
ER	Emergency Room
ESRI	Economic and Social Research Institute
EU	European Union
GNIB	Garda National Immigration Bureau
GP	General Practitioner
HCW	Healthcare Worker
HPV	Human Papillomavirus

HSE	Health Service Executive
ICS	Irish Cancer Society
IP	International Protection
IPAS	International Protection Accommodation Services
IPAs	International Protection Applicants
IVF	In Vitro Fertilisation
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual +
MRI	Magnetic Resonance Imaging
N/A, NA	Not Available, Not Applicable
NCRI	National Cancer Registry of Ireland
NGO	Non-Governmental Organisation
NSIO	National Social Inclusion Office
PPSN	Personal Public Service Number
STI	Sexually Transmitted Infection
TASC	Think-tank for Action on Social Change
UK	United Kingdom
USA	United States of America
WHO	World Health Organisation

ACKNOWLDGEMENTS

Authors

Dr. Adeelia Goffe

Maria Pachowicz

Authors would like to thank the following

Funding Organisation: Irish Cancer Society

Research Partner Organisations: Akidwa, Ballyhoura Development, Cairde, and Dublin City Community Co-operative.

Interview contributors from: Ballyhoura Development CLG, Catholic Church, Community Pharmacy, Family Carers Ireland, Gort Family Resource Centre, General Practitioner Surgery, Health Service Executive, Nasc, National Maternity Hospital, Northside Family Resource Centre, Patient Advocacy Service, Ruhama, Safetynet Primary Care, Summerhill Primary Care Centre, The Sexual Health Centre, Tiglin and University Hospital Waterford.

Additional thanks to Dr. Shana Cohen for her feedback throughout various stages of the project; John White, Louisa MacKenzie and Faizan Ali for administrative and research assistance.

TASC receives support under the Scheme to Support National Organisations (SSNO) which is funded by the Government of Ireland through the Department of Rural and Community Development.

EXECUTIVE SUMMARY

Introduction

International research shows that immigrants face health inequalities due to language, cultural differences, and limited resources, leading to poorer outcomes than the general population. This study examines immigrants' healthcare needs in Ireland, highlighting challenges, opportunities, and potential improvements in cancer and other health services.

Key Findings

- **Access to Healthcare and Cancer Services:** Healthcare access remains a significant issue for immigrants and providers, with challenges like limited GP availability, high costs, transport issues, and long waits. Immigrants often face delays in accessing services, including cancer care. While waitlists affect all in Ireland, some immigrants face more structural barriers and therefore may experience greater delays due to cultural, language, and financial barriers.
- **Cultural Competence and Culturally Appropriate Service Delivery:** The research underscores the need for cultural competence in healthcare. Immigrants often face communication barriers that affect care quality. Healthcare professionals must improve cross-cultural skills through ongoing training to better serve diverse populations, including options like female staff for cervical screenings.
- **Collaboration with Community Organisations:** The research highlights the importance of collaborating with immigrant communities and local organisations to improve outreach, develop culturally sensitive practices, and ensure effective, inclusive healthcare interventions.
- **Mental Health Needs:** Immigration-related stress, social isolation, and lack of support networks significantly impact immigrants' mental health. Culturally

sensitive services are urgently needed to address these unique, often unrecognised stressors affecting well-being.

- **Financial Vulnerabilities:** Immigrants often face financial vulnerabilities that limit their access to necessary healthcare. Here, immigrants were found to be more likely in receipt of a medical/GP visit card and less likely to have private health insurance than the general population. Tools for alleviating the financial burden of chronic illness are needed.

Key Policy Recommendations for the Irish Cancer Society

1. **Improving Access to Translated Resources:** Advocate for the HSE and relevant Government Departments to provide healthcare materials, including medical cards, welfare forms, and cancer screening information, in multiple formats (written, audio, video) with captions and interpreters when necessary.
2. **Enhancing Cultural Competency in Healthcare:** Advocate for cultural competency training for healthcare professionals to address cultural barriers, cancer-related stigma, and end-of-life care needs.
3. **Strengthening Community Outreach and Education:** Engage immigrant communities with targeted outreach to raise awareness of healthcare services and preventive care, ensuring accessibility for diverse populations, including working individuals.
4. **Promoting Cancer Awareness and Prevention:** Run culturally sensitive campaigns on cancer care, smoking cessation, and cancer screening to raise awareness and reduce stigma.
5. **Increasing Financial Support for Immigrants:** Advocate for increased welfare payments for vulnerable immigrants, particularly those in need of cancer treatment and care.

6. **Improving Transportation Accessibility for Immigrants:** Assess and expand ICS's Transport Service to enhance accessibility for immigrant patients by providing information about the service in multiple languages and promoting the service to known Direct Provision Centres, particularly those who live in direct provision centres and are known to be in receipt of cancer services.
7. **Addressing the Hidden Costs of Cancer Treatment:** Commission research on the indirect costs of cancer treatment for immigrants, such as interpreters, transport and childcare, to identify areas for financial support.
8. **Continue to Expand Affordable Transportation Options:** Work with the Department of Transport to provide affordable transport for cancer patients and those with chronic conditions.
9. **Ensuring Immigrant Needs in Sláintecare Implementation:** Advocate for the inclusion of immigrant healthcare needs in the full rollout of Sláintecare.
10. **Improving Administrative Data for Service Planning:** Call for the collection of immigrant-specific demographic data to enhance service planning and monitor healthcare provision effectively.
11. **Partnering with Community Organisations for Better Outreach:** Collaborate with immigrant and community groups to develop culturally relevant healthcare interventions and improve outreach.
12. **Advocating for Comprehensive Cross-Departmental Policies:** Promote policies across various government departments to address healthcare needs specific to immigrants in areas like welfare, transport, housing, and childcare.

Key Policy Recommendations for Government and Organisational Actions to Support Immigrant Health

13. **Full Implementation of Unique Health Identifier:** Ensure the Individual Health Identifier is fully implemented to streamline and improve healthcare service provision.
14. **Simplifying Medical and GP Card Applications:** Make applications for medical and GP visit cards more accessible by offering multi-language options.
15. **Improving Access to Translated Resources:** The HSE and relevant Government Departments to provide healthcare materials, including medical cards, welfare forms, and cancer screening information, in multiple formats (written, audio, video) with captions and interpreters when necessary.
16. **Enhancing Cultural Competency in Healthcare:** The HSE to provide cultural competency training for healthcare professionals to address cultural barriers, cancer-related stigma, and end-of-life care needs.
17. **Improving Access for Undocumented Immigrants:** Streamline and improve the Regularisation Scheme for long-term undocumented migrants to ensure better healthcare access.
18. **Stabilising Accommodation for Immigrants in Direct Provision:** Ensure stable, suitable accommodation in Direct Provision, considering the health needs of individuals.
19. **Providing Nutritious and Culturally Sensitive Food in Direct Provision:** Ensure that catering in Direct Provision meets cultural and health needs or provide self-catering options where necessary.

20. **Guaranteeing Interpreter Services in Healthcare Settings:** Ensure access to professional interpreter services to improve communication and quality of care for immigrant patients.
21. **Developing Culturally Tailored Health Services:** Create culturally sensitive health information and services to reduce stigma and ensure more effective care.
22. **Ensuring Accessibility of Health Facilities:** Guarantee that public health services are accessible to immigrants, with language support and culturally appropriate food and services.
23. **Utilising Community Health Workers:** Deploy community health workers to bridge cultural and linguistic gaps in healthcare, ensuring more effective communication with immigrant communities.
24. **Regular Health Screenings for Immigrant Communities:** Implement routine health screenings within immigrant communities to identify and address health issues early.
25. **Providing Childcare Services in Healthcare Settings:** Offer childcare services within healthcare settings to help families access care, especially those with chronic conditions.
26. **Prioritising Mental Health Support for Immigrants:** Focus on mental health services for immigrants, addressing stressors related to migration, illness, and cultural differences, while integrating cancer prevention services.
27. **Expanding the Patient Advocacy Service:** Extend the Patient Advocacy Service to primary care settings to support patients from the beginning of their healthcare journey.

1. INTRODUCTION

1.1 Report Aims

Immigrant health is a complex and multifaceted area of research, encompassing a variety of social, economic, and environmental factors that impact health outcomes. These factors are a product of the previous experience of the immigrant in the context of the host country. Understanding these factors is essential for developing effective public health interventions and policies to support equitable healthcare access and improve outcomes for immigrant communities.

This report aims to investigate the needs and access patterns amongst immigrant populations to cancer prevention information and services, diagnosis and treatment in Ireland. The following literature review sets the stage by briefly describing the major factors affecting immigrant experiences in Ireland, focusing on entitlements, socioeconomics and services. Although the focus of the research is on immigrants living in Ireland, where necessary international research is also used.

1.2 Literature review

This section explores available literature to shed light on the institutional structures, regulations and policies that shape immigrants' experiences in the Irish healthcare system. There are complex factors that affect how immigrants access essential services, which are explained here with the aim of providing a clearer view of the challenges they may face.

Note that this literature review is constrained by the terminology and definitions used in both Irish and international publications, in which a clear distinction is not always made between "immigrants" or "ethnic minorities". These categories are not mutually exclusive. Here we define an immigrant as a person who has come to a different country in order to live. This definition does not assume a particular country of origin or birth. Immigrants may be foreign born, but do not have to be. Some immigrants may be a member of a minority ethnic group. Ethnic minorities may be native born, for example, Irish Travellers.

1.2.1 Overview of Programmes and Services for Immigrants Living in Ireland

Here, healthcare entitlements and social welfare entitlements are discussed in the context of immigration status. To make the different immigration statuses easier to understand, this section looks at healthcare and social services access based on main residency categories, with a special focus on refugees and asylum seekers.

Healthcare Entitlements are Linked to Residency Status and Immigration Status

Entitlement to a range of healthcare services in Ireland is related to residency status and financial means. Those ordinarily resident (living in Ireland for at least a year) qualify for either fully subsidised (Category 1) or partially subsidised (Category 2) healthcare. Non-residents or those residing less than a year must demonstrate plans to stay for a year to gain entitlements, while non-EU dependents may need to meet separate criteria. Eligibility for a medical card, which covers various public health services, often requires a means test, although some exceptions, like financial hardship or specific conditions, may bypass this requirement. Medical cards offer benefits such as free GP visits, inpatient and outpatient care, and reduced-cost prescriptions. For those ineligible for a medical card, a GP visit card may be available, either automatically for certain groups (e.g., children under 8, those over 70) or through a means test. Additionally, the Drugs Payment Scheme caps monthly medication and certain equipment costs, regardless of income.

Additionally, certain healthcare services and schemes are available to people with specific health needs, rather than on the basis of financial circumstances. Certain medical conditions are covered by the Long-Term Illness Scheme (e.g. diabetes, epilepsy, cystic fibrosis), which entitles holders to free medication and appliances needed for the treatment of the condition. The Health Act 1970 provides for additional supports, including the recent abolition of statutory charges for in-patient care in public hospitals. However, this does not alter charges for emergency care/outpatient care or charges for private patients in public hospitals.

Of note is that over the past decade, Ireland has significantly improved its immigrant integration policies. Since the introduction of the Migrant Integration Strategy (2017-2020), Ireland's Migrant Integration Policy Index (MIPEX) showed an improvement of 5 points, which is above the international average of 2 points. Ireland's policy approach indicates an improvement in the rights and opportunities for both immigrants and those born in Ireland across a variety of different areas, including in healthcare (MIPEX 2020). Key improvements include research on immigrant health, stronger consultative bodies, targeted political participation information, and enhanced anti-discrimination policies. However, it is not clear how the implementation of these policies have influenced immigrant's experiences in accessing health and cancer care services.

Healthcare Entitlements and Immigration Status

In addition to the universal requirement of being ordinarily resident in Ireland, healthcare entitlements vary depending on immigration status. In March 2022, the European Union enacted a 2001 Directive calling on member states to provide protection for people fleeing from the Russian invasion of Ukraine (Council of the European Union, 2022). These Beneficiaries of Temporary Protection (BOTPs) include both Ukrainian nationals as well as third country nationals who were living in Ukraine at the time of the invasion. BOTPs arriving from Ukraine have been allowed the same access to health services as those ordinarily resident in Ireland and have access to an abbreviated version of the medical card application form. Medical cards for BOTPs are provided automatically, but are then means tested after their first year of residence in the State.

In general, International Protection (IP) applicants living in direct provision (DP) centres are entitled to a medical card while their application for IP is being processed. IP applicants are expected to complete a lengthy 20 page version of the medical card application form in order to apply. Also, not all GPs accept medical cards and GPs also have the right to decline accepting a patient to their patient list (Health Service Executive, 2022a). GP practices are paid an "asylum seeker/non-EU registration fee" of €173.69 for the first-time registering of an IP applicant (Collins et al., 2020). This fee is available only to the first GP with whom an applicant registers, and not if the IP applicant is moved to another accommodation centre by IPAS and therefore needs to reregister with a local GP. It is unclear how often IP applicants may be moved by IPAS, however anecdotal information indicates that movements across the country do occur (e.g. Dublin to Kerry; Asylum Information Database and European Council on Refugees and Exiles, 2024).

There is no data available on the potential differences in the access to medical care for IP applicants living in different types of accommodation. The National Reception Centre offers a Health Screening Centre (Health Service Executive, 2022b), but residents do not get their medical cards until they move to a DP centre. IP applicants who are granted refugee status are considered ordinarily resident. Once they become ordinarily resident they will no longer be automatically entitled to a medical card when they move out of DP, but can apply for a medical card through the standard, means-tested route.

Under the Reception Conditions Directive, IP applicants are also offered a vulnerability assessment within 30 days of arrival. These vulnerability assessments are in place to provide special care to identify and address the needs of new arrivals who are exceptionally vulnerable (e.g. minors, pregnant women, persons with a serious illness) and in need of special care (e.g. tailored accommodations, medical care, psychological support, etc.).

Undocumented or otherwise irregular immigrants can access basic medical care if they are able to pay for it (Polakowski & Quinn, 2022). Also, undocumented immigrants may gain access to other services if this is in the interest of public health or if the

Minister for Justice chooses to grant access, for example, if healthcare access would enable their repatriation. Access to other services may be provided at a reduced cost or free of charge (Polakowski & Quinn, 2022). The difficulties faced by undocumented immigrants in accessing healthcare were exposed during the COVID-19 pandemic, with a fear of deportation deterring many from going forward for testing and hesitant about seeking medical attention when required (Holland & Pollack, 2020).

Variation in Access to Social Welfare Entitlements

Immigrants may also avail of national social welfare schemes in order to support themselves and pay for healthcare costs. Such schemes that are in place for those who cannot work due to illness include Disability Allowance (DA), Invalidity Pension, Illness Benefit, and Statutory Sick Pay. According to the Vincentian MESL Research Centre, none of the social welfare schemes provide for a minimum standard of living. In addition, none of the aforementioned payments are available to most IP applicants, while others are dependent on a minimum length of employment or length of habitual residence. Table 1. provides an overview of these schemes and how they relate to IP applicants and BOTPs.

Table 1. Potential Social Welfare Schemes

Entitlement	**Beneficiaries of Temporary Protection (BOTPs)**	**International Protection (IP) Applicants**
Back to School Allowance	Eligible	Generally not eligible, unless specific residency conditions are met
Child Benefit	Eligible	Generally not eligible, unless specific residency conditions are met

Daily Expenses Allowance	Not applicable	Eligible: €38.80 per adult and €29.80 per child per week
Direct Provision Accommodation	Not eligible	Eligible, where available
Disability Allowance	Eligible	Generally not eligible
Fuel Allowance	Eligible	Not eligible
Housing Assistance Payment	Eligible	Not eligible
Illness Benefit	Eligible	Not eligible
Invalidity Pension	Eligible	Not eligible
Job Seekers Allowance	Eligible	Not eligible
Labour Market Access Permit	Not applicable	Eligible: after six months of residency, allowing limited employment rights
Statutory Sick Pay	Eligible	Not eligible
Working Family Payment	Eligible	Not eligible
Other Supports	Eligible for various social supports (e.g. Supplementary Welfare Allowance for urgent needs)	Limited access to additional supports, including social work and specific educational supports for children

Source: TASC, 2025. Summarised from the Department of Social Protection, Citizens Information and the Health Service Executive.

Regularisation scheme

In late 2021, recognising the barriers to accessing healthcare and other public services for undocumented immigrants, an amnesty scheme was announced to provide a pathway for long-term undocumented immigrants to regularise their residency status and move towards citizenship (Department of Justice, 2021; Polakowski & Quinn, 2022). The "Regularisation of Long Term Undocumented Migrants Scheme" ran from 31 January to 31 July 2022. To qualify, principal applicants had to be non-EU/EEA nationals, over 18, and living in Ireland undocumented for 3-4 years (depending on whether minor children were included in the application). Partners and dependent children in the application needed to have been in Ireland undocumented for at least two years. Applications for the scheme had to be submitted online and incurred a non-refundable fee of €550 for single applications and €700 for family applicants.

Successful applicants would be granted a two-year Stamp 4 permit; unsuccessful applicants could appeal the decision within 30 working days of its issuing. In total, 6,548 applications were submitted under the scheme, including 8,311 people overall (Oireachtas 2023a). Almost a year after applications closed, 85% of applications had been processed, demonstrating significant wait times for applicants described as "the main more complex cases" by Minister McEntee (Oireachtas 2023a). In September 2023, Deputy Bernand J. Durkan queried Minister McEntee about an applicant whose Garda vetting had been completed and application submitted in April 2022, but who did not receive a decision on their application until the 12th of September 2023 - almost a year and a half later (Oireachtas 2023b). While official figures on average or median processing wait times for applications are unavailable, such cases exemplify the delays experienced by some applicants.

Of the 5,553 processed applications, approximately 82% had been awarded, 16% refused, and 2% withdrawn by the applicant.

While statistics on the reasons for the refusal of these 900 applicants are unavailable, potential reasons could include not meeting the residency requirement, being judged to not be “of good character and of good conduct”, existing criminal convictions, or providing false or misleading information in the application.

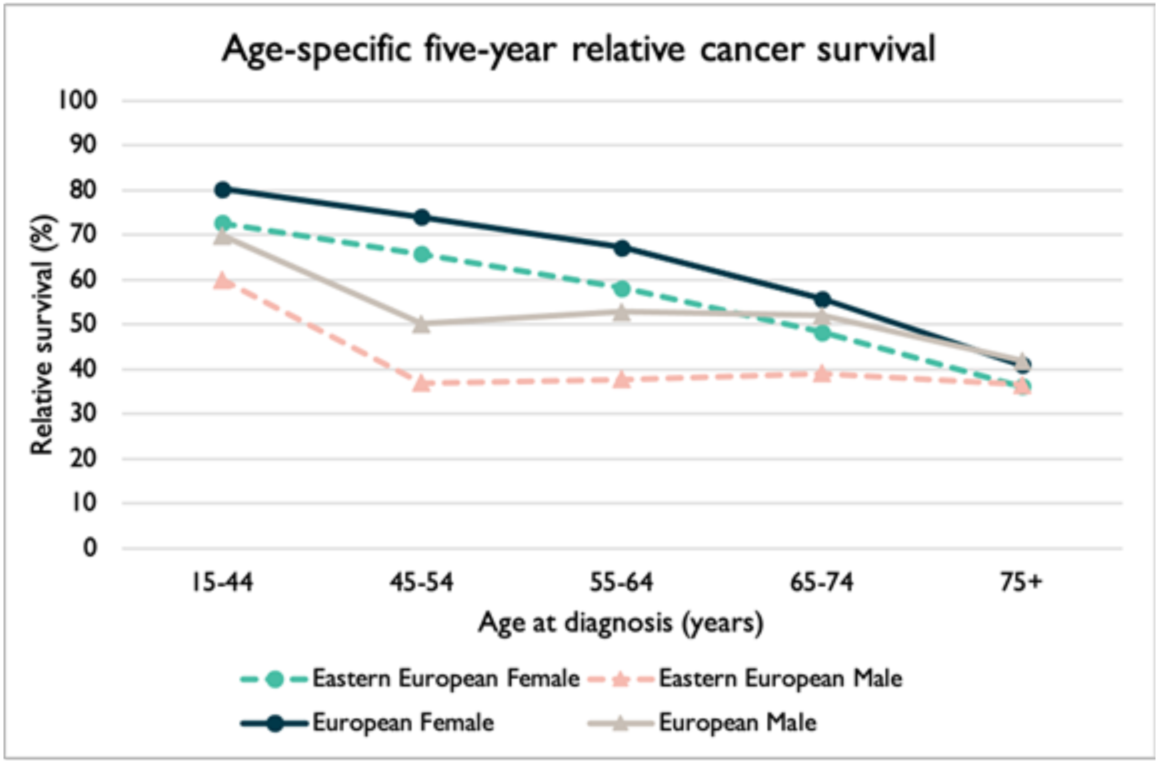
1.2.2 General Variations in Cancer Incidence and Mortality in Ireland and Europe

Immigrants to Ireland may bring with them experiences and patterns of contact with healthcare workers based on their previous countries of residence. Therefore, it could be helpful to look at country trends in cancer incidence and mortality. Figures from the European Cancer Information System (2022) reveal that, in 2022, Ireland had the second highest incidence of all types of cancer (except non-melanoma skin cancer) across the EU-27. Notable statistics on cancer in Ireland, emphasise incidence, mortality, and survival trends. Cancer incidence in Ireland was comparatively high in Europe, with breast, prostate, colorectal, and lung cancers being the most commonly diagnosed types (European Cancer Information System, 2022a). Lung cancer remained the leading cause of cancer-related deaths (European Cancer Information System, 2022a).

The statistics (European Cancer Information System (2022a) also suggest poorer outcomes for countries from Eastern and Southern Europe in comparison to the EU average. An examination of survival rates suggests a divergence in outcomes related to location within the EU.

Figure 1 below illustrates the difference in survival rates of males and females for all cancer types between Eastern Europe and the European average. The figure shows a significantly lower rate of survival across all age groups for Eastern Europe (European Cancer Information System, 2022b).

Figure 1. Average age-specific five-year relative cancer survival, Eastern Europe and Europe average comparison.



Source: European Cancer Information System, 2000-2007, figure modified.

Similar analysis conducted on differences between Southern Europe and the European average did not reveal significant variation in survival rates.

Having some knowledge of these regional differences in the EU27 raises the question as to where there are similar disparities in cancer incidence and mortality among immigrants residing. The following section looks for potential variations in cancer health for immigrants in Ireland.

1.2.3 Immigrant Population Trends in Cancer Health

International Trends: Immigrants Face Persistent Challenges Accessing Healthcare

Large scale international studies on the healthcare of immigrants are dated (Fernandes & Miguel, 2009; Rechel et al., 2011) and the need for up to date data on immigrant health is recognised (Chopra & Vidya, 2021; Lebano et al., 2020). A recent review of studies in Europe from 1992 onwards found that asylum seekers and refugees have struggled to access healthcare for over 30 years. Despite these ongoing issues being repeatedly identified, little has been done to improve healthcare access for these groups across the region (Nowak et al., 2022).

More research (albeit dated) indicates that non-Western immigrants to Europe have, on the whole, a lower risk of cancer in comparison to host countries (Arnold et al., 2010; Hjerkind et al., 2020). Recently, the concept of the “migrant mortality advantage” (Vanthomme et al., 2021) has been used to refer to lower mortality rates amongst immigrants compared to the host population and, in a similar vein, some literature from North America refers to a “healthy immigrant effect”, whereby immigrants are at a lower risk of cancer overall potentially due to rigorous health screening and younger age profile (McDonald et al., 2017). Research also indicates that over time, cancer incidence amongst immigrants converges with levels amongst the host country population (Jaehn et al., 2019; McDonald et al., 2017). However, this convergence is not uniform with immigrant men reaching similar cancer diagnosis rates to men born in Canada, including for prostate cancer. For immigrant women in Canada, the only convergence observed is for breast cancer diagnosis rates (McDonald et al., 2017).

Various studies have highlighted the variable risk of specific cancers between different nationalities. For example, research conducted in Norway found that the incidence of liver cancer within the Asian immigrant population was three times higher than that of non-immigrants. In contrast, lung cancer rates were higher among men from other Nordic countries and Eastern Europe than amongst native Norwegian males (Hjerkind et al., 2020). A study of lung cancer incidence amongst immigrant and native Belgian men similarly found differences in incidence related to country of origin, with education level accounting for some differences amongst Italian and Turkish men, but Moroccan men having a lower overall incidence of lung cancer (Vanthomme et al., 2021). Research also indicates that psychological wellbeing and health related quality of life is lower amongst immigrant cancer patients (Sze et al., 2015).

International Trends: Poorer Cancer Outcomes for Ethnic Minorities

In relation to cancer health in particular, the extant research indicates that ethnicity is a key predictor of cancer health (European Cancer Organisation, 2022a), with findings suggesting that ethnic minorities and immigrant groups are disadvantaged in terms of access, treatment and outcomes (Scanlon et al., 2021). There is some evidence of a genetic predisposition or hereditary risk for some types of cancers, with evidence suggesting that refugees and immigrants are at increased risk of cancers associated with infection (Arnold et al., 2010; Walker et al., 2022).

Regardless of the type or incidence of cancer, cancer health outcomes are often worse for ethnic minorities and immigrant groups. Research from the US and UK shows that the incidence of cancers overall is highest amongst the White population, but that Black people have the highest risk of death from cancer (Delon et al., 2022; Tong et al., 2022). While the incidence of breast cancer is similar between Black and White women, the mortality rate is significantly higher for Black women (Giusti & Hamermesh, 2022; Hirko et al., 2022).

The discussion below examines a range of barriers for immigrants in accessing cancer care, recognising that immigrants are a heterogeneous group and that the particular healthcare needs and preferences will vary, depending on their unique circumstances.

International Trends: Variations in Cancer Service Usage Among Different Immigrant Groups

Immigrants' usage of health and cancer services can vary widely within and between ethnic and legal status.

For example, research in the US shows that for Hispanic people, speaking English is a stronger factor in healthcare access than ethnicity. English-speaking Hispanic patients use healthcare services at rates similar to white, non-Hispanic patients, while Hispanic patients who do not speak English are much less likely to use services like GPs, mental health support, and vaccinations (Fiscella et al., 2002). In a similar study, African-born women in Australia were more likely to know about cervical cancer screening if they were not refugees (Anaman et al., 2018).

National Trends: Disparities in the Uptake of Healthcare Entitlements Between Immigrants and Non-immigrants

A study of engagement with healthcare providers amongst immigrant groups found that lower levels of interaction with healthcare services could not be explained fully by differences in healthcare needs or entitlements (Barlow et al., 2021). The authors concluded that access barriers, relating to willingness to the use or knowledge of healthcare services, may be an important factor shaping utilisation levels (Barlow et al., 2021). Barlow and colleagues (2022) went on to find that non-UK immigrant residents of Ireland were less likely to have attended a GP or consultant doctor in the previous 12-months, in comparison to Irish-born residents. While UK immigrants in Ireland had similar GP attendance patterns to Irish-born residents, they were more likely to have attended a consultant.

Cultural issues may also be at play, with immigrants having a preference for treatment in their country of origin (e.g. Romanian nationals living in Ireland seeking healthcare services in Romania (Stan, 2015)).

Research conducted with immigrants to Ireland revealed a number of factors which were influential in shaping decisions to return to their country of origin for medical treatment. Issues discussed included lack of awareness or understanding about healthcare entitlements in Ireland, the costs associated with the healthcare services (perceived and actual), perceptions about the quality of care in Ireland and familiarity with the healthcare system, and social, cultural, linguistic and religious differences (Migge & Gilmartin, 2011).

Recent research into the experiences of Syrian refugees has highlighted deficiencies in healthcare availability and uptake. One study found that 27% of respondents experienced unmet health needs in Ireland. Approximately 25% of respondents had an acute health condition and a fifth had at least one chronic condition. Mental health issues were identified as a key area of concern (Collins et al., 2022). Another project conducted with Syrian refugees in Ireland indicated that a lack of adequate interpreter services had an impact on the quality of healthcare and could have knock-on effects in relation to integration in other areas. The research indicated that 11% of men and 19% of women were unable to work due to health problems. The availability of appropriate healthcare and treatment would enable some of these individuals to enter the workforce (International Organisation for Migration Ireland, 2021). Accessing such services could have been facilitated by a reduction in language barriers and increasing digital literacy, for example (International Organisation for Migration Ireland, 2021).

The health access trends we see in adult immigrants are reflected in the utilisation patterns of their children. The Growing Up in Ireland project indicates that the children of immigrants are less likely to engage with local health services (Mohan, 2021). Mohan and colleagues (2021) found lower healthcare utilisation, particularly GP, emergency, and hospital services, among children of caregivers from non-English speaking and non-EU countries in comparison to children of caregivers from a non-immigrant background.

National Trends: Little Information on National Cancer Trends for Immigrants Living in Ireland

Research on cancer of immigrants in Ireland is scant. However, we know from research in other disciplines, that some immigrants might receive a lower income and/or are more likely to face socioeconomic deprivation (e.g. Huddleston et al., 2013, McGinnity et al., 2022, Boylan, 2023). Much of the national level research on cancer care inequalities examines how deprivation or socioeconomic inequality impacts on the risk of developing cancer, stage of detection, treatment options and survival rates (Sze et al., 2015). The disproportionate risk of cancer amongst deprived and marginalised groups is recognised (Cork Cancer Action Network, 2017) and research has shown a higher incidence of cancer, poorer survival rates, later stage detection and lower uptake of surgery and among those in the most deprived areas (National Cancer Registry Ireland, 2016). Of note is that the National Cancer Strategy 2017-2026 recognises that cancer outcomes are poorer in socioeconomically deprived areas and states that a focus needs to be made to target "hard to reach groups and minority populations". However, the strategy does not specify what "minority" groups are at risk and does not mention ethnicity or nationality being specific risk factors.

1.2.4 General Barriers and Accessing Cancer Care

Even for immigrants who have an entitlement to healthcare in Ireland, there are a wide range of barriers in accessing care, which relate to both their intrinsic characteristics (e.g. ethnicity, religion, language and gender) as well as structural and socioeconomic factors including proximity of services, financial constraints, and lack of appropriate services (Asylum Information Database, 2016; Villarroel et al., 2019). Similar issues have been identified in international studies of immigrant access to healthcare (van Loenen et al., 2018).

Undocumented immigrants can face significant difficulties in accessing healthcare and do not have any entitlement to avail of healthcare services, save for in emergency circumstances (see Section 3.2.1). Difficulties in establishing eligibility to healthcare can have significant ramifications, as highlighted in recent evidence from the UK, where some immigrants have been denied care for up to 37 weeks as their eligibility to access treatment is investigated, with some denied urgent medical care, including treatment for life-threatening cancer (The Guardian, 2018).

Even when immigrants have demonstrated their eligibility to access healthcare, they still face significant barriers.

The discussion below first examines how the intrinsic characteristics of ethnic minorities and immigrant groups can act as barriers to accessing healthcare, before examining broader socioeconomic and structural factors that influence the treatment and outcomes of these groups.

Language is a Barrier to Accessing Appropriate Care

In Ireland, language differences have been known to pose challenges for effective communication in healthcare settings, with nurses particularly concerned about how this affects their ability to conduct thorough assessments essential for quality care (McCarthy et al., 2013). To alleviate some of these challenges, healthcare providers in Ireland have been using paid interpreters and informal interpreters (e.g. relatives or friends) (MacFarlane et al., 2008). In this 2008 study, GPs stated that they would prefer to use an informal interpreter rather than a paid interpreter because of the convenience it afforded. Convenience was a more important concern to the GPs than the accuracy of the interpretation received (MacFarlane et al., 2008). The HSE provides information on using interpreters and translators to support healthcare providers.

International research shows that language proficiency significantly impacts healthcare access and quality for immigrants, with limited proficiency linked to reduced healthcare use (Fiscella et al., 2002), lower insurance access (Ku & Waidmann, 2003), and increased patient safety risks (Chauhan et al., 2020).

In addition, language barriers have been shown to hinder immigrant women's access to quality breast cancer care, with studies showing challenges in accessing cancer screening (Suwankhong & Liamputtong, 2018), accessing care (Chiang et al., 2015), accessing support (Chiang et al., 2015), and needing culturally and linguistically appropriate translators (Alananzeh et al., 2018).

Cultural Differences may be Linked to Disparities in the Uptake of Healthcare Entitlements Between Immigrants and Non-immigrants

The importance of culturally appropriate care, which takes into account cultural perceptions of disease and illness is recognised. Previous research in Ireland points out that healthcare workers understand the need to provide culturally appropriate and sensitive care but have faced personal, professional, and organisational barriers (Mac Gabhann 2012; Boyle 2014), leading to ambivalence and uncertainty in dealing with cultural diversity (Boyle 2014). Healthcare workers in Ireland are open to developing their competence through structured education, interdisciplinary collaboration, and targeted research (Boyle 2014).

In recent decades, Ireland's policy landscape has recognised the need for health provision to match the increasingly diverse population. For example, a series of health policies, the First Intercultural Health Strategy (2007-2012) and the Second National Intercultural Strategy (2018-2023), emphasise the need for the provision of culturally competent care. However, as highlighted by Mac Gabhann (2012) this will require adequate financial and energetic investment.

While there are gaps in knowledge about access to and uptake of healthcare services by immigrant populations in Ireland (Barlow et al., 2022; Villarroel et al., 2019), international studies highlight how cultural factors impact immigrants' access to cancer care. Lower participation in screening programs among ethnic minorities has been linked to language barriers, financial issues, and cultural beliefs (Bhargava et al., 2018). Research on South Asian immigrants in the UK, US, and Canada identified similar barriers, including lack of awareness and structural obstacles (Crawford et al., 2016).

Fatalistic attitudes towards cancer amongst some ethnic minority groups can deter them from engaging in breast and cervical cancer screening practices (Huhmann, 2020; March et al., 2018; Ogunsiji et al., 2017).

Similarly, research on cervical screening for African immigrants identified cultural and religious beliefs as a barrier to accessing cervical screening (Anaman-Torgbor et al., 2017). Research on breast cancer screening among diverse cultural groups in Australia has also highlighted how cultural beliefs can act as an emotional barrier to participation for Arabic speaking women (O'Hara et al., 2018). Cultural beliefs have also been identified as a barrier to cervical cancer screening for Chinese Australian women (Kwok et al., 2011).

A number of studies identify the need to improve health literacy amongst immigrant groups in relation to cancer, taking into account cultural beliefs about cancer (Brzoska et al., 2020; March et al., 2018). Studies conducted in a number of European countries identify the need for a culturally sensitive approach and the enhancement of cultural competence of healthcare providers to increase knowledge about cancer and screening rates, and highlight the importance of engaging with community groups in developing appropriate interventions (Anaman-Torgbor et al., 2017; Kizilkaya et al., 2022; Marques et al., 2022; O'Hara et al., 2018). Examples of a culturally sensitive approach include the provision of female service providers for cervical screening (Anaman-Torgbor et al., 2017) and educational training in the patient's native language (Kizilkaya et al., 2022; O'Hara et al., 2018),

Socioeconomic Disparities Influence Immigrants Interactions With Healthcare Services

There are a range of socioeconomic and structural factors that can hinder access to healthcare.

In Ireland, a study using national data from 2004 found that immigrants were being paid 18% less than non-immigrants and were half as likely to be in receipt of social welfare payments than non-immigrants (e.g. Barrett and McCarthy 2007). However, there is no information on whether this economic disparity is directly influencing the utilisation of health services.

International research indicates that the financial cost of treatment is a significant barrier to accessing cancer screening, prevention, and treatment services in some countries. For example, in the US, minority ethnic groups are less likely to have access to private health insurance and therefore have greater out of pocket expenses associated with treatment (The Lancet Editorial, 2021). Lack of private health insurance has also been identified as a factor in delays in accessing treatment, such as chemotherapy (Tong et al., 2022).

In Ireland, the cost of GP care (at an average €52.50 per consultation) means that many immigrants are reluctant to seek out medical advice from primary care providers when they are ill (Barlow et al., 2022). As stated previously, immigrants are able to access medical cards (see Section 3.2.1), data on immigrants' access to medical cards and private health insurance is not readily available. However, the available historical data from 2010 indicate that immigrants are both less likely to have private health insurance and to qualify for medical cards (Stan, 2015). A more recent study cites "difficulties of navigating the complex healthcare sector" as a contributing factor in the lower rate of private health insurance and access to medical cards amongst non-UK immigrants to Ireland (Barlow et al., 2022).

In addition, research from Ireland shows that economic circumstances may interact with geographic distance. Immigrants may face reduced healthcare access due to the lack of nearby comprehensive services, with some unable to reach distant services due to limited or unaffordable transportation options (Faculty of Public Health Medicine, 2016; Wilson, 2021).

This is supported by research in the UK which illustrated the notable difference in access to services and cancer survival rates between different areas of London (Quaresma et al., 2022). Depending on location, residents of some areas will have access to comprehensive care in one hospital setting while others may have to travel between hospitals or healthcare settings to receive care. Transport difficulties have been identified as a barrier to accessing services (Tong et al., 2022), with minority groups either lacking access to transport or being unable to afford it.

1.2.5 Research Gaps and Limitations

Lack of Demographic Data to Understand Subpopulation Trends

Based on the international trends discussed in the previous sections, immigrants should be a target group for cancer prevention. However, there is unfortunately a lack of research on cancer diagnosis, treatment, and mortality outcomes for immigrants in Ireland. Therefore, in the process of reviewing Irish literature, it was necessary to incorporate international sources to fill in the gaps. The following paragraphs discuss the state of publicly available administrative databases.

Some healthcare and social services in Ireland collect demographic information on patients and clients which have been used as a proxy for immigrant status. These types of data might include information on ethnicity, religion, country of origin and/or language used by patients. According to the Equal Status Acts 2000-2018 discrimination based on "race, religion and membership of the Traveller community" is prohibited when accessing public services. However, there is no indication that this information is collected systematically for all service users or that there is a national standard, other than the categories which are used by the CSO. A recent examination of 97 national health and social datasets indicated that 14% had information about ethnic or cultural background, 10 of which also contained information on the country of birth (Hannigan et al., 2019).

As noted by the Department of Children, Equality, Disability, Integration and Youth (DCEDIY) (2023), while some public agencies have taken steps to disaggregate data by nationality or ethnicity, this is often not done to a sufficient standard, using unstandardised ethnic categories or assigning individuals to groups on the basis of their name or appearance.

Similarly, some hospitals have attempted to collect and, in some cases, analyse ethnicity data, but due to lack of standardisation, ethnicity is sometimes confounded with nationality (e.g. Rowland et al., 2022), making it impossible to determine immigration status of patients.

Recent research on immigrant health in Ireland has focused on the benefits of the routine use of ethnic identifiers in the primary care setting (Maria Roura et al., 2021). However, in a multicultural Ireland, the information on ethnicity does not readily equate to immigration status without some accompanying information on nationality, country of origin, and date of arrival in Ireland.

The National Cancer Registry of Ireland (NCRI) is a publicly appointed body which collects and classifies information on all cancer cases which occur in Ireland. The NCRI collects demographic and clinical data from hospital medical records. The demographic information that they collect includes age at incidence and sex of the patient, but no information which would allow for an analysis of immigration status or potentially associated variables (such as ethnicity, language or nationality) (National Cancer Registry Ireland, 2022). Therefore, there is no national monitoring of cancer trends for immigrant groups living in Ireland.

A recent survey conducted by IPSOS on behalf of the National Cancer Control Programme included questions on ethnicity as well as country of birth and duration of stay in Ireland (National Cancer Control Programme, 2022). This may indicate a move towards the collection of data related to immigration status in cancer research in Ireland.

No mention of Immigrants in the National Cancer Strategy 2017-2026

Ireland's National Cancer Strategy 2017-2026 outlines a comprehensive plan to reduce cancer rates, improve patient outcomes, and enhance quality of life for cancer patients and survivors through prevention, early diagnosis, and access to high-quality treatment and care. The strategy mentions socioeconomically disadvantaged groups, cancer survivors, older adults and people with genetic risk factors as being in need of targeted interventions and additional considerations.

However, no specific mention of immigrants was made in the document, in spite of immigrants consisting of approximately 12% of the population (CSO, 2022). This may be due to a lack of applicable administrative datasets, as discussed previously.

Reduction in Cancer Services due to COVID-19 Pandemic and Associated Restrictions

In Ireland, detections of cancer reduced as a result of the pandemic, with 9.5% fewer detections of lung, breast and prostate cancer between January and September 2020 in comparison to the same period in 2019 (OECD/ European Observatory on Health Systems and Policies, 2021). Results from an NCRI report (2023) indicate that the estimated shortfall of cancer diagnosis over all in 2020 was no greater than 14%. It is estimated that the rising trend in cancer cases in Ireland up to 2019 would have continued in 2020 and 2021 without the COVID-19 pandemic (NCRI 2023).

Similarly, cancer treatments were significantly curtailed, with activity levels still only at 95% of 2019 levels in August 2020 (OECD/European Observatory on Health Systems and Policies, 2021).

The reduction in cancer care services (including delayed diagnosis and treatment) which occurred as a result of COVID-19, combined with the increased awareness of gaps in data collection relating specifically to cancer are of concern.

2. METHODOLOGY

2.1 Research Objectives

The purpose of the Migrant Communities' Needs Assessment research is to learn about the experiences of people with an immigrant background of accessing healthcare services and cancer services in Ireland, and their understanding of the healthcare system in Ireland. This research aims to fill in the gaps in our knowledge and to enhance our understanding of obstacles, challenges, and effective practices in cancer prevention, diagnosis, and care for immigrants in Ireland. While focusing on cancer services, it also examines the broader healthcare access landscape. A mixed-method approach, including a literature review, survey, and interviews, was chosen. Additional information about the sources and types of contribution are available in Appendix 1. Information on the limitations of this study and ethical considerations are located in Appendix 2.

2.2 Surveys

A patient survey was designed to collect primarily quantitative data concerning immigrant communities' experiences and needs. Any person aged 18 or older living in Ireland, who identified themselves as having an immigrant background, was eligible to participate. The survey was distributed online and available in the following languages:

- English
- Ukrainian
- Brazilian Portuguese
- Spanish
- French
- Arabic

- Mandarin

Snowball sampling was used to distribute the survey through a variety of community groups and organisations working with underserved groups, including immigrants.

A number of partner organisations supported TASC through survey facilitation, in order to reach out to participants who may not be able to complete the survey in any of the available languages, or who, for various reasons, may not have the capacity to complete an online survey. These organisations were AkiDwA, Ballyhoura Development CLG, Cairde, and the Dublin City Community Co-op (see Appendix 3). Their support involved recruiting participants among their clients and assisting with survey completion by discussing it with each participant and submitting their responses online.

After the survey closed, datasets from all language versions and partner organisations were merged, with non-English responses translated into English. The quantitative data were then analysed using R software, and figures to represent the results generated through R and Microsoft Excel. Any qualitative data collected through the survey was coded alongside qualitative interview data to identify patterns and themes across the data. Of the 242 survey respondents, 188 left at least one qualitative comment.

2.3 Interviews

Interview Recruitment

Participants were recruited online, aided by snowball sampling. Semi-structured interviews followed a flexible topic plan to capture participants' experiences and expertise. Interviews were conducted online, in person, or over the phone, as per the participants' preference. The length of interviews varied from 20 to 90 minutes, with most under an hour, depending on each participant's knowledge and contributions. A total of 30 one-to-one interviews with stakeholders were conducted.

- Health care workers (HCWs) (N=9)
- Frontline staff (N=11)
- Family carers (N=2)
- Patients (N=8)

All interviews were audio-recorded. Recordings were subsequently transcribed and coded to identify the key themes. Additional details regarding interviews are outlined below.

Service Provider Interviews

Interviews were open to any frontline or healthcare worker with experience working with immigrants, even if their role wasn't solely focused on immigrant clients. Frontline workers included those in community, non-governmental, or similar organisations that support clients in accessing healthcare or work with those in regular contact with the healthcare system. Service providers were asked about their role, the populations they serve, and observed barriers and facilitators to healthcare access among their clients.

Patient and Family Carer Interviews

Interviews were open to any person aged 18 or older, residing in Ireland with an immigrant background. Participants were asked about the types of healthcare services they have availed of in Ireland, any barriers they have encountered in the process, any facilitators or positive aspects they have come across, and changes they would like to see made that would improve their experiences with and access to healthcare. Questions were also posed around travelling abroad to access healthcare.

3. RESULTS

3.1 Quantitative survey findings

A total of 242 people completed the online survey (146 general, 96 facilitated responses). The Ukrainian-language survey was the most popular of the general survey languages, completed by 72 participants, followed by the English-language version, which was completed by 64. See Appendix 3 for a breakdown of surveys completed by language.

3.1.1 Demographic information

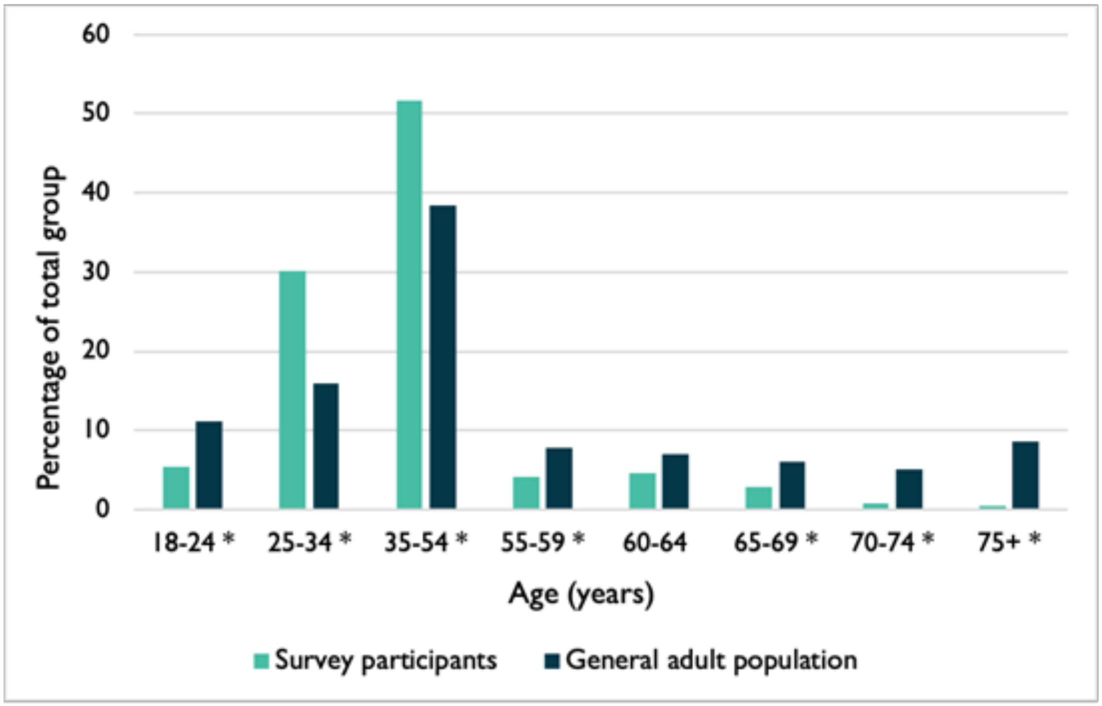
Age & gender

Over three quarters (N=184) of participants were female and approximately one-fifth (N=51) were male. Three non-binary/genderfluid people completed the survey. This differed significantly from the gender distribution of the general adult population of Ireland[1], X^2 (1, N=242) = 81.3, $p < .001$. More than half of the participants (N=125) were between the ages of 35-54, compared to 38% of the general Irish adult population, while 12.8% were 55 or older (N=31), compared to 34.5% of the general adult population (Appendix 4). Again, this differed significantly from the general adult population of Ireland, X^2 (7, N=242) = 86.2, $p < .001$. The highest discrepancy existed in the 25-34 age group, followed by the 75+ age group and the 35-54 age group (see Figure 2).

---

[1] Comparisons are based on the number of men and women only as the 2022 Census did not include any other gender identities.

Figure 2. Age breakdown of survey participants (N=242) compared to the general population[2]



Source: TASC, 2025; CSO, 2022.

Country/region of birth

Seven participants were born in Ireland (Appendix 5). Among those born outside of Ireland, the most common country of birth was Ukraine (N=81, 36.2%), followed by Latvia (N=21, 9.4%), and Romania (N=17, 7.6%). Overall, 61 participants were born in the EU/EEA, three in the UK, and 160 outside of the EU/EEA/UK (see Figure 3).

Significant differences in the proportion of respondents from different countries make direct comparisons between countries difficult[3].

---

[2] Categories marked with * contributed significantly to the difference between the participants and the general population.

[3] Comparing the distribution of participants born in the EU/EEA, UK, and outside the EU/EEA/UK to the general non-Irish-born population of Ireland revealed significant disparities, X^2 (2, N=224#) = 120.1, $p < .001$. The greatest disparity existed in the number of participants born outside of the EU/EEA/UK, followed closely by those born in the UK.

Figure 3. Bubble map summarising the country of birth of participants

Source: TASC, 2025.

Approximately one third of participants (N=76) took up residence in Ireland in 2022 (Appendix 6), 66 of whom were born in Ukraine. Survey participants first began arriving in 1995. A further 10% (N=23) took up residence in Ireland in 2023, 12 of whom were born in Ukraine. The majority of participants moved to Ireland in approximately the last five years[4] (59%, N=143). The median number of years resident in Ireland was 4, while the mean was 6.8 (SD=7.49).

Citizenship

The majority of participants had one country of citizenship (80.6%, N=195; Appendix 7). Twenty-five participants (10.3%) had dual citizenship; 23 participants had dual citizenship with Ireland and another country~~)~~. One participant had triple citizenship. Ukrainian citizenship was the most common, held by 70 participants (29%), followed by Irish citizenship, held by 46 participants (19%). Comparing the country of birth to the

---

[4] In 2018 or later.

citizenship responses, it was possible to determine an estimate 42 participants (17.4%) were born outside of Ireland and subsequently became naturalised citizens.

Ethnicity

The most common ethnic background among participants was "Any other White background (including British)" (47.9%, N=116), that is, any White background other than White Irish (2.9%, N=7). The second most common was African (16.5%, N=40), followed by Roma (7%, N=17). See Appendix 8 for further detail.

Language

English was not the first language of 91% (N=220) of participants (see Appendix 9). Out of these, 59.5% said they feel comfortable speaking with health and social care staff in English, while one person did not respond to the question. In addition, 35% of those whose first language was not English said that they sometimes need an interpreter for healthcare appointments. Lastly, 25% said that they always need an interpreter.

Among those who said that they do not feel comfortable communicating with health and social care staff in English, the most common preferred language was Ukrainian (N=39, 44.3%), followed by Russian (N=18, 20.5%) and Romanian (N=10, 11.4%). Six participants stated that they prefer to speak English, but need certain supports or accommodations. These include the staff member speaking slowly and/or using plain language, or being accompanied by a native English speaker. Interestingly, another person stated that when it comes to language needs, "[i]t's not more about the language but the fear of what [HCWs] are thinking about [them] because of [their] accent". This was echoed by a number of other participants also.

Of the six participants, who prefer to communicate through English but require accommodations, five stated that they have had challenges registering with a GP as they could not be provided with an interpreter.

Five also reported difficulties with understanding or being understood by the person on the phone.

Languages supports required some or all of the time included the following:

- Albanian
- Arabic
- Chinese
- Crimean Tartar
- Dinka
- French
- Latvian
- Moldovan
- Polish
- Portuguese
- Romanian
- Russian
- Serbian
- Somali
- Swahili
- Ukrainian

Religion

The most common religion among participants was Orthodox Christianity (N=83, 34.3%), followed by no religion (N=58, 24%) Roman Catholicism (N=38, 15.7%), and Islam (N=26, 10.7%). See Appendix 10 for further detail.

Occupation and education

Upper secondary or higher education was attained by 85% of participants (N=206), while 37.5% (N=91) had a Bachelor's degree or higher (Appendix 11). Six participants

(2.5%) had no formal education. This differed significantly from the general 15+ population of Ireland, X^2 (8, N=239[5]) = 127.0, $p < .001$. The highest discrepancy existed in the "Technical or Vocational College" category, followed by the "Higher Certificate", "Upper Secondary Education", and "Lower Secondary Education" categories, in descending order (see Figure 4). No other category had a major influence on the discrepancy[6].

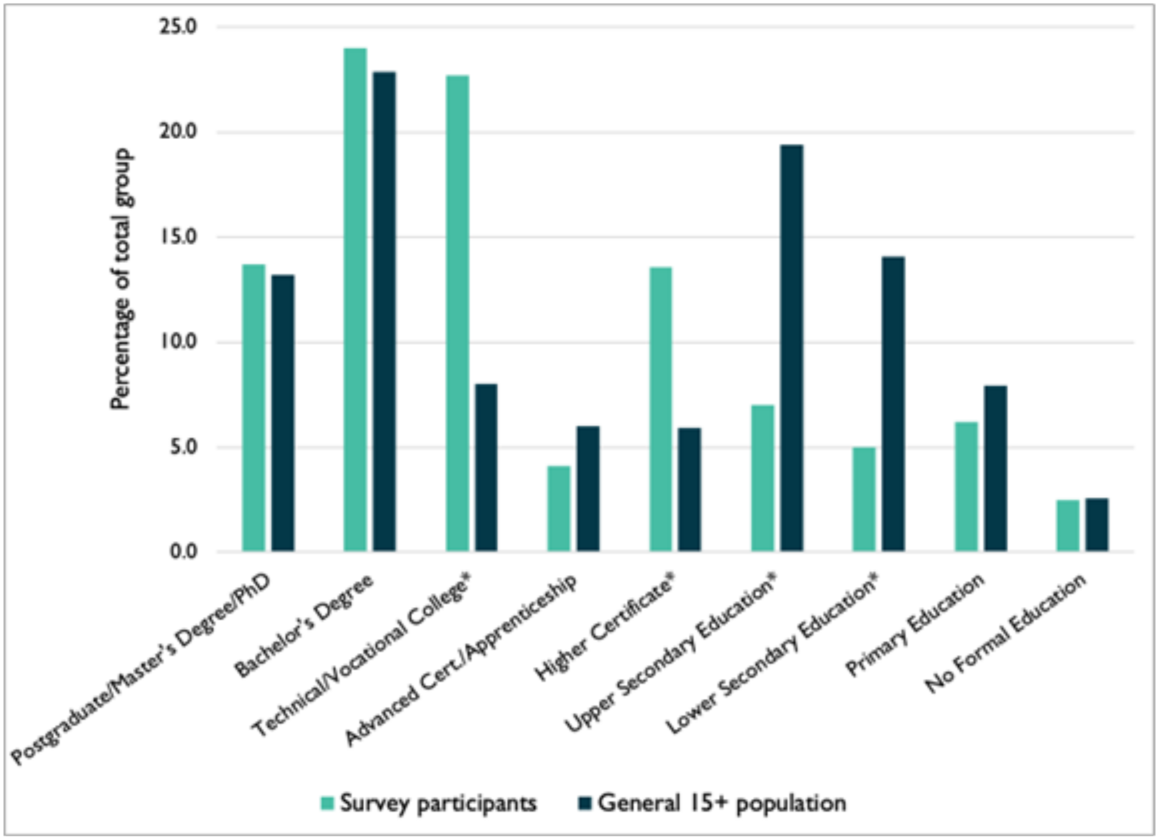
With regards to employment, approximately one quarter of participants (N=61) were unemployed (Appendix 12). Almost one quarter (N=57, 23.6%) were manual workers.

---

[5] Excluding those who did not state their level of education (N=3).

[6] Based on standardised residuals, where any category whose standardised residual had an absolute value of 2 or higher was considered to have a major influence.

Figure 4. Highest level of education among participants (N=242) compared to the general population.[7]



Source: TASC, 2025

Income

Twenty participants (8.3%) received no income of any kind in the last 12 months (Appendix 13). Almost half (45.5%, N=110) received either wages (N=102) or income through self-employment (N=21), while 69% (N=167) received some form of social welfare.

3.1.2 Accessing healthcare

---

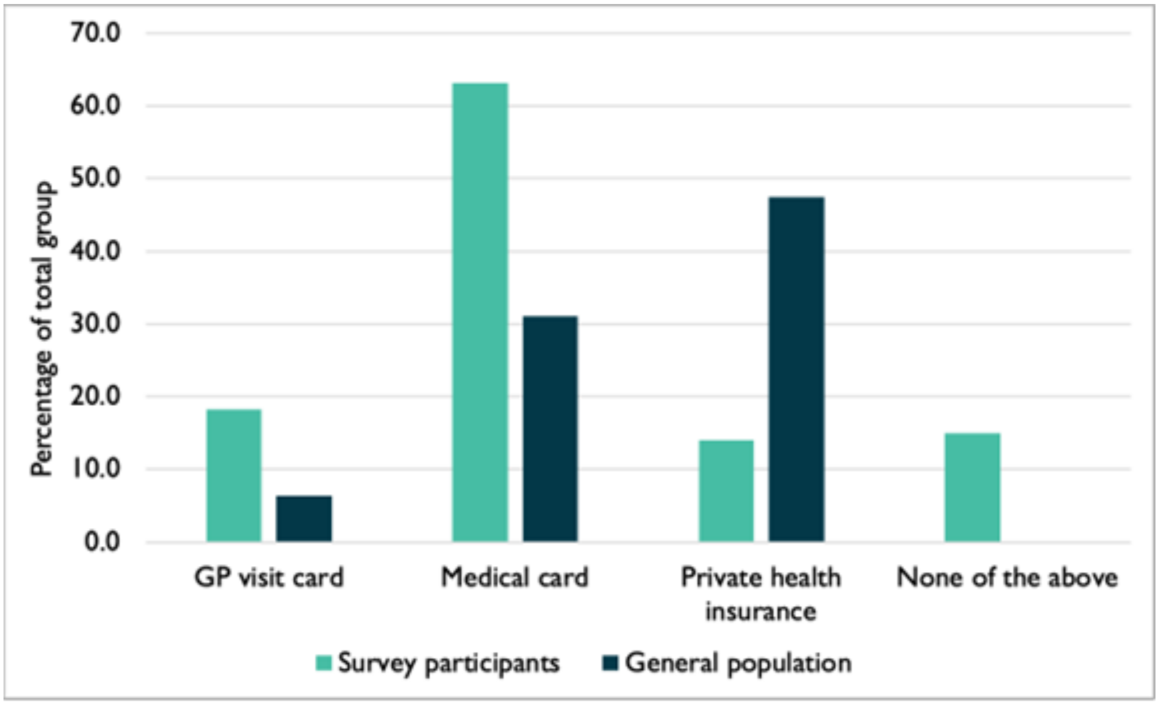
[7] Categories marked with * contributed significantly to the discrepancy between the participants and the general population.

Fewer Immigrants With Private Health Insurance Than the General Population

More than half of the survey participants had a medical card (N=153, 63.2%). A further 18.2% (N=44) had a GP visit card and 14% (N=34) had private health insurance (see Appendix 14). Of those who had a medical or GP visit card, 28 stated that they had both; however, it is not possible for one person to hold both types of card, indicating a potential lack of awareness regarding health care entitlements.

When compared to the general adult population of Ireland, significantly more survey participants had a medical or GP visit card (X^2 (2, N=242) = 209.38, $p < .001$). Of those with a medical or GP visit card, 70 participated through facilitated surveys. On the other hand, survey participants were significantly less likely to have private health insurance when compared to the general population (X^2 (1, N=242) = 107.96, $p < .001$). Approximately 15% did not have any of the above and thus would have to pay the full cost of all medical expenses out-of-pocket.

Figure 5. Healthcare entitlements among participants (N=242) compared to general population



Source: TASC, 2025

Note: Population data concerning the number of people who do not have any of these entitlements are unavailable.

Expected frequencies of the health entitlements in respect to wages were compared, but no significant differences were found across the different categories. Therefore, no evidence was found for a link between socioeconomic status and the likelihood of a respondent having private health insurance.

Immigrants Face Difficulties in Accessing Primary Care Services

The majority of participants stated that they are registered with a GP (85.5%, N=207). When investigated, the region of citizenship was not found to be a good predictor of whether or not an immigrant in this sample had a GP.[8]

---

[8] These comparisons were made across regions by grouping the following: Ireland+UK+EU (101 of 110 with GP) vs. UKR+RUS+CIS (56 of 61 with GP) vs. rest of the world (35 of 40 with GP). where participants had recorded

Among the 34 who are not, reasons included local GP practices not accepting new patients (N=11), not having tried to register (N=8), and visiting a GP in another country when needed instead (N=5). Nineteen of these participants said that they have needed to see a GP in the last year; when the need to access healthcare arose, these participants instead sought health supports from multiple other sources:

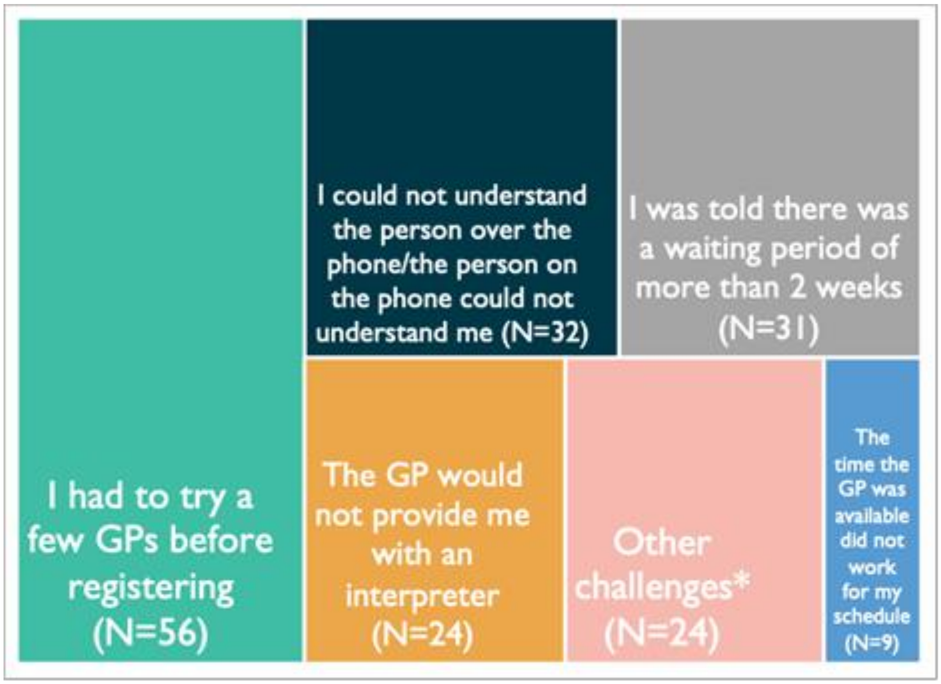
- hospital (N=12)
- pharmacist (N=9)
- alternative medicine (N=3)
- community nurse (N=3)
- travelled abroad (N=3)

Of those registered with a GP, 45.4% (N=94) reported facing challenges when registering (see Figure 6).

---

more than one nationality the group geographically with the nationality which would have afforded them the most advantages in Ireland (e.g. Ireland-Angola was included in the counts for Ireland+UK+EU).

Figure 6. Challenges faced by participants when registering with a GP



Source: TASC, 2025

Other challenges included long wait times (e.g. for appointments, tests, referrals, and results), communication and language barriers, fear (e.g. of being misunderstood by clinicians), geographic barriers, and clinician attitudes (e.g. impatience).

In addition, out of those registered with a GP, one third of participants (N=69) reported facing challenges in booking an appointment with their GP. These were similar to the challenges faced when registering with a GP and included long wait times, GPs lacking availability and being too overwhelmed with patients, communication problems, and language barriers. Over three quarters (N=164) are registered with a GP within 10km of their home. The most common mode of transport to one's GP was on foot, with 85 participants (41.1% of those registered with a GP) choosing this option, 83 of whom had less than 10 km to travel to their GP.

Bus, minibus, or coach was the second most popular form of transport (25.1%, N=52), followed by driving a car or van (20.8%, N=43). See Appendix 15 for an overview of answers to all multiple choice questions concerning GP access.

Immigrants With a Lack of Confidence in Accessing Healthcare

Over half of the survey participants (N=134) stated that they do not feel very confident, or at all confident, that they can access the healthcare they need at present (Appendix 16). A total of 46 participants (19%) said that they feel confident that they can, five of whom said that they feel very confident. Areas of concern included access to diagnostic tests (43%, N=104), accident and emergency (36.7%, N=89), medical (33.1%, N=80) and non-medical (29.3%, N=71) supports in the community, and medical (26.9%, N=65) and non-medical (30.2%, N=73) treatment in public hospitals. Gynaecologists, dermatologists, and assessments for neurodevelopmental disorders among adults were also named.

Immigrants use emergency services due to limited GP access or lack of alternatives

Almost half of all survey participants (N=110) had visited an emergency room (ER) due to illness at some point (Appendix 17). Of these, ten participants had gone to the ER because they could not get an appointment with their GP, and a further 12 had done so as they did not know where else to seek care.

3.1.3 Missed appointments

Questions regarding missed healthcare appointments were posed to participants. Specifically, these questions asked if, in the last year, the participant had needed to attend a scheduled appointment for their own healthcare but did not and, if so, why (Appendix 18).

Hospital appointments

Thirty-one participants (12.8%) stated that they had not attended a scheduled hospital appointment (e.g. to access diagnostics or treatment) in the last year. The most common reason was hospital cancellation or postponement (N=11), followed by language barriers (N=9), and cost - both of the appointment itself (N=5) and travel costs associated with the appointment (N=5).

General practitioner appointments

Almost one fifth of participants who are registered with a GP did not attend a scheduled GP appointment in the last year (N=41). Reasons for missing the appointment included language barriers (N=13), barriers surrounding travelling to the appointment (e.g. cost or lack of transport; N=10), GP cancellation or postponement (N=8), and difficulties with getting an in-person appointment (N=8). Less common reasons included feeling that the issue was not serious enough (N=7), wait times (N=4), cost of the appointment (N=4), and cancelling due to not feeling safe (N=4).

3.1.4 Smoking

Thirty-three (13.6%) participants smoked at the point of completing the survey and 53 (21.9%) had smoked in the past (Appendix 19). More than half of those who currently smoke said they had planned to quit smoking (N=19), only two of whom were aware of available supports in doing so – namely, HSE campaigns and the Quit Smoking website. Of those who had smoked in the past, 12 availed of supports in quitting, including the "We Can Quit" programme (N=4), GP support (N=4), and nicotine replacement therapy (N=2).

3.1.5 Screening services

More than two-thirds of participants were aware of at least one screening service, while 41% of participants reported availing of them in the past five years (Appendix 20).

The most well-known and frequently utilised service among participants was CervicalCheck, with 60.7% (N=147) of participants being aware of it and 29.3% (N=71) having used it. Of those eligible (females aged 25-65), 59.6% did not participate in CervicalCheck.

When looking at low participation CervicalCheck and other screening services, other than a lack of awareness, reasons for not utilising screening services included difficulties with booking an appointment (N=22), not wanting to go (N=18), fear of finding out about illness (N=17), embarrassment (N=6), prior negative experiences with screenings (N=6), and lack of female staff for breast and cervical screenings (N=2). Also, for qualitative information on the fears associated with cancer screening see Section 3.2.9)

More females than males were aware of each of the different screening services. There were a smaller number of respondents for the older age groups, but there was a higher proportion of eligible respondents aware (e.g. 60-64 years). When looking at the awareness between different age and gender categories, females are generally more aware than males, regardless of eligibility for screening. In addition females and males aged 25-34 and 35-44 were the most aware. See Table 2 below for further details.

Table 2. Number of participants (N=242) aware of screening services by age, gender, and language needs.

	Total	**Bowel Screen**	**Breast Check**	**Cervical Check**	**None**
Gender					
Female	**184**	51	98	131	40
Male	**51**	10	15	13	33
Non-binary/genderfluid	**3**	1	2	1	1

Prefer not to say	**2**	1	1	2	0
Prefer to describe	**1**	0	1	0	0
NA	**1**	0	1	0	0
Age (years)					
18-24	**13**	3	4	4	9
25-34	**73**	14	34	48	23
35-54	**125**	33	63	77	36
55-59	**10**	2	7	7	1
60-64	**11**	8	5	5	1
65-69	**7**	3	4	5	2
70-74	**2**	0	1	1	1
75+	**1**	0	0	0	1
Language needs					
Comfortable communicating in English with HCWs	**152**	36	78	102	36
Not comfortable communicating in English with HCWs	**88**	26	39	44	38
NA	**2**	1	1	1	0

Source: TASC, 2025.

3.1.6 Cancer

Eighteen participants stated that they had been diagnosed with cancer, four of whom did not disclose any further details about their cancer diagnosis or treatment (see Appendix 21).

Diagnosis

Thirteen participants stated the year of their most recent cancer diagnosis, all of which were 2015 or more recent. Two participants were diagnosed through the private system and 12 through the public system. Participants reported being diagnosed through diagnostic imaging, blood tests, and various types of biopsies, with 10 individuals undergoing multiple tests (see Appendix 22).

Treatment

One participant accessed cancer treatment privately and 13 publicly. Surgery was the most recent form of treatment for half of those who provided details of their cancer care (N=7); other forms of treatment included chemotherapy (N=5), immunotherapy (N=1), and radiotherapy (N=1). Most participants (N=9) travelled to hospital at maximum once per month while undergoing cancer treatment. The participant who accessed treatment privately reported travelling 1-10 km to their treatment. For the remaining 13 participants, distance to treatment ranged from 1-10 km to 101-150 km. The most common mode of transport to attend treatment was as a passenger in a car or van (N=6), followed by taking a bus, minibus, or coach (N=4) and driving oneself to the appointment in a car or van (N=3). One person reported using the ICS Transport Service.

3.1.7 Sources of information on healthcare

Participants identified a wide range of sources through which they gather information on healthcare (Appendix 23). The most popular sources were GPs and nurses (29.3%, N=71), followed by word of mouth/family and friends (16.1%, N=39). The HSE website (14.9%, N=36) and private messaging apps (e.g. WhatsApp, Signal) were also used by a number of participants (9.5%, N=23). Less common sources included social media, religious communities, and television.

3.1.8 Awareness of Irish Cancer Society services

Approximately one-third of participants (N=75) stated that they were aware of at least one ICS service (Appendix 24). The most well-known services were the Support Line (N=28), Children's Fund (N=22), Transport Service (N=14), and Your Health Matters roadshow (N=14).

3.2 Qualitative data

Transcripts from 20 interviews with service providers and 10 with the public. Interviews with service providers included 11 frontline workers (e.g. patient support workers, social workers, etc.) and 9 healthcare staff (e.g. sexual health officers, GPs, oncology consultants). Interviews with members of the public included immigrants who had chronic health conditions (N=8), including cancer, or were caring for a family member with a long term health condition. One of the immigrant patients included was born in Ireland, emigrated abroad and immigrated back to Ireland.

Interview transcripts were combined with the qualitative survey responses and were analysed. Factors were identified that affect healthcare access and experiences for immigrants, either as barriers or facilitators.

While many of the identified factors may impact the general population as a whole (e,g, the challenges around getting an appointment with a GP, as mentioned in the survey responses), the mechanisms through which they affect immigrants would be different. The following sections detail 12 factors identified by participants (Appendix 25), highlighting their relevance to immigrant communities and cancer care, including both barriers and facilitators, with suggested improvements discussed later.

3.2.1 Immigration status and personal public service numbers (PPSNs)

Concerns Around Legal Status as a Barrier to Accessing Medical and GP Cards

Bureaucratic and practical issues concerning immigration status and personal public service numbers (PPSNs) were mentioned by participants as posing a unique and major barrier to healthcare access among immigrant communities. For those who are documented, immigration status directly impacts service access due to differing entitlements associated with different immigration permissions. For undocumented immigrants, many services are not accessible at all as they may be contingent on providing proof of immigration status. One frontline worker noted:

> "[T]he Department of Health and the HSE have almost transposed immigration rules on to eligibility. So they will look at whether your immigration status allows you to access a medical card. … The criteria of immigration status and eligibility for accessing social supports is not set in legislation, it's not set in regulation. But the HSE has taken upon itself to be a de facto immigration agency. … if you look at the HSE medical card guidance … they say, 'if you are a migrant, we need evidence that you can access these supports, or we will check with immigration to see if you're eligible for a medical card'."

According to the Medical Card and GP Visit Card National Assessment Guidelines (HSE, 2024), non-EU/EEA or Swiss nationals, may have their residency and visa status verified by the Irish Naturalisation and Immigration Service to ensure that they and their dependents meet the eligibility criteria to apply for a Medical Card or GP Visit Card. This participant expressed concern over the possibility that some frontline and healthcare workers may not be aware of these practices and may inadvertently place a person at risk of deportation (e.g. medical social workers who support patients in applying for medical cards). They also noted that the granting of GP Visit or medical cards to children is sometimes made conditional on their parents' immigration status, despite HSE assertions that "[a]ll children under 8 years of age living in Ireland can get a GP visit card". Similar comments were also made by other service providers during a number of other interviews. This highlights problems in the implementation of healthcare policy and additional barriers faced by immigrants when trying to avail of these policies.

Lack of PPSNs as a Barrier to Accessing Some Health Services

Similarly, many services and social supports require applicants to provide their PPSN. This is a barrier even for documented immigrants who are eligible for a PPSN due to substantial delays in the processing of applications, leaving some unable to access services for weeks after arrival. For undocumented immigrants, service providers noted that the requirement to provide proof of immigration status upon applying for a PPSN is enforced inconsistently. On paper, in order to receive a PPSN, applicants must provide proof of ID, proof of address, and their reason for applying. Service providers stated that these requirements alone create major barriers. For example, they stated that providing proof of ID may pose a particular challenge to IP applicants who left their home countries due to war or persecution, while providing proof of address excludes anyone who is homeless or does not have a fixed abode. Service providers also highlighted that in practice, these difficulties may be even greater as applicants may also be asked to also provide proof of their immigration status, often deterring undocumented immigrants from applying at all and thus leaving them locked out of services.

This highlights a further challenge with regards to immigration status, PPSNs, and access to services: concerns surrounding deportation among undocumented immigrants pose a barrier to accessing services, even those which are not contingent on immigration status. Service providers stated that the possibility of being asked to produce proof of immigration status or a PPSN may deter undocumented immigrants from even attempting to access care or utilise other services. One frontline worker stated that "with medical cards and things like that, unless it's very, very, very serious, people will just go without it. And I guess that's where the preventative or early treatment concerns would come."

This risk is further complicated by a lack of consistency about eligibility requirements for healthcare services. We found evidence from multiple service providers that there are differences in the policies around requesting PPSNs from patients. From service providers it seems that an undocumented immigrant may be able to access one GP without any challenges, but place themselves at risk by attempting to access another. This was exemplified by our participants, who occasionally gave inconsistent and contradictory information about PPSN requirements and healthcare access, with some patients stating that a PPSN is necessary to access healthcare and service providers stating that this is a misconception. Examples of this requirement were mentioned: one frontline worker spoke of a client of theirs who could not access vaccinations due to not having a PPSN.

Concerns Around Legal Status as a Barrier to Accessing Services

Both service providers and immigrants spoke of the impact of being an immigrant on health and wellbeing in general during interviews. For example, undocumented immigrants and those whose immigration permits are tied to their partners are more vulnerable to domestic violence, as the threat of deportation can be weaponised to control them. Service providers also noted that undocumented immigrants and IP applicants have been exploited financially by individuals promising to help them. One frontline worker spoke of individuals (who were members of the immigrant community) charging undocumented immigrants large sums of money for support in applying for regularisation, despite their organisation and others offering these supports for free.

One frontline worker recalled a former client who had received a terminal cancer diagnosis after avoiding cancer screening services. Her story demonstrates the impact that being undocumented has on both access to services and the undocumented person's general wellbeing (Box 1).

Box 1. Catherine's Story

> "One example I'll give you is a lady that we knew, some years ago, and she was a grandmother. She was undocumented. She had lived here for so many years, she had the most horrendous domestic abuse experiences. But she was living quite peacefully. She was a huge figure in the lives of her grandchildren. She was like a second mother, and she got terminally ill.
>
> Her GNIB card was out, she was engaging with a local solicitor. I had been on to the Immigrant Council of Ireland, they were saying no, she doesn't have to travel to Dublin. The local solicitor basically came in [when] I was [working] at the front desk, and told me to keep my nose out. Because I had [told] this woman that she didn't have to travel to Dublin. And the solicitor was not happy; I suppose that we were supporting and giving advice.
>
> We worked with a local charity up the road here, they're amazing. They get no government funding or cancer support. And between us, we got her into hospital. I used to visit her on Saturdays … And then we got her into the hospice.
> And she cried, because she had never known such love and kindness, in her whole life here."
>
> During the rest of the conversation it was made clear that Catherine had been fearful of deportation if she accessed health care and cancer screening services. If she had not been fearful and had accessed services, her cancer would have been caught at an earlier treatable stage.

High Levels of Stress Among Immigrants

The stress and general mental health challenges resulting from being an IP applicant or undocumented immigrant were also discussed. With regards to cancer prevention, both service providers and patients identified these stressors as an obstacle to smoking cessation.

Relatedly, both patient survey and interview participants spoke of the impact of not having a support network in Ireland on their mental health and on their ability to access supports and services:

> "As a carer, you really rely a lot on help from others as well, or it helps you a lot if you have that help or connections with others. And if you're from abroad, you wouldn't have the natural network that you would have had, if you grew up here, if you went to school, if you worked with people and have a certain network. So you're more isolated."

The impact of lacking this "natural network" is two-fold. Firstly, having networks and connections in Ireland provides greater access to information as well as contacts in the services who can assist patients in accessing services. As per the above participant, immigrants are less likely to have these structures and so are at a disadvantage. Secondly, social networks reduce feelings of isolation and can provide practical support such as help with childcare. This is discussed further in later sections.

Evidence That Structural Barriers associated with Legal Status can be Reduced

Participants also highlighted the range of structures put in place to support BOTPs and allow them to bypass the above challenges. These were viewed positively by interview participants, as well as noted in a few qualitative comments from immigrants from the Ukraine in the survey. However, failure to extend these structures to IP applicants was a source of frustration expressed by all service providers during interviews. Service providers felt that these changes prove that "[i]t absolutely is possible" to reform the system and alleviate the above challenges.

Thus, maintaining these structural barriers is an active choice. In order to support immigrants through these barriers, service providers spoke of supporting their clients through the provision of information and advocacy.

The fact that access to healthcare services is, at least on paper, not actually contingent on immigration status was highlighted as a facilitator also, alongside specific services that do not require patients to provide a PPSN, such as CervicalCheck which may be conducted at certain sexual health clinics.

However, service providers recognised that immigrant patients may not be aware of these services.

3.2.2 Housing circumstances

Housing and Immigration Status Impact Immigrants' Health and Service Access

The impact of housing circumstances on immigrants' health and access to care was also raised. Although this is not unique to immigrants, housing and immigration status are closely linked. For example, the challenges of living in DP were discussed at length by participants. As mentioned, immigration status also plays a major role in access to services and undocumented immigrants as well as those on certain immigration permits may not be eligible for housing supports, placing them at greater risk of homelessness. In addition to the wide range of health risks associated with homelessness, individuals without a fixed abode face additional barriers to accessing supports such as medical cards and social welfare as many of these require applicants to provide proof of address, as discussed.

Relocation Between DP Centres Disrupts Healthcare Access and Continuity, Causing Emotional Distress to Immigrants

With regards to DP, the issue of relocation poses a major obstacle to healthcare access and continuity of care. Service providers referred to clients and patients of theirs who have been moved between DP centres, typically with little warning and often to different parts of the country.

This poses a range of difficulties: finding a new GP, transferring medical files, etc. According to service providers, GPs are not notified by IPAS when a patient of theirs is to be relocated and so will not know to transfer the files unless asked, while the patient may not know or be able to ask for their files (due to language barriers, etc.). Frontline worker interviewees mentioned that they too are often not aware when a client of theirs is transferred and so cannot support them in the process. The importance of trust in and relationship-building with service providers was also raised, especially as many IP applicants have experienced trauma and may be distrustful of healthcare workers and authority. This is disrupted each time a person is relocated and loses access to their GP and other supports. As explained by one frontline worker:

> “[I]t's very frustrating for us because we do a lot of work around setting the person up in the community. … And IPAS moves them and it's quite a significant distance away, often it's hours away. And we have to start again and we have to apply for college and everything. It unfortunately seems common enough. And it seems very random, there's no way to know if it's going to happen.

They also highlighted that relocation by IPAS often disrupts clients’ lives, causing significant distress as they must restart their lives again in a new place. With this occurring repeatedly service providers have become concerned about the emotional state of clients.

Relocation Between DP Centres Disrupts Ongoing Medical Treatments

These barriers are exacerbated if someone is accessing any kind of medical treatment and so may be in contact with a range of healthcare workers in addition to a GP.

To address this, some frontline workers reported advocating for patients in active treatment (including cancer treatment) to either remain in their current location or, if relocation is unavoidable, be transferred to an appropriate setting where sufficient support is available and medical services are nearby. One frontline worker stated that services are available around the country to assist relocated IP applicants in accessing GP care and medication, while a healthcare worker explained that they preemptively address the possibility of relocation among their DP patients:

> "I know how the system works. … I'll put it in an envelope, and I'll say, 'referral for cancer' in big letters on the front of the envelope, and I say, 'if you get transferred somehow, between now and next week, I want you to show that to the manager' … I know then it will be taken care of, or at least I've done everything at that point I can to make sure it's taken care of. … So you learn that systems are frail."

Inadequacy of DP Centres for Those With Health Conditions

The conditions of living in DP can also pose difficulties, particularly to those with existing health conditions. One HCW noted that unsuitable housing circumstances can lead to patients who are undergoing treatment staying in hospital for longer than is necessary, as it is safer and more appropriate for them to do so than to return to their DP centre.

One challenge concerns overcrowding in DP centres, which poses a particular risk to immunocompromised residents. Single room accommodation is rare, and DP centre residents are often expected to share rooms with individuals who they do not know. Although all IP applicants undergo a vulnerability assessment upon arrival to ensure that their accommodation is suitable to their health needs, it may not be possible to meet those needs within the system. In addition, those needs may change over time, for example, if someone is diagnosed with cancer and begins cancer treatment when already resident at a DP centre.

Service providers, with experience supporting DP residents, stated that the food provided in DP centres is also of concern to DP residents and HCWs. The meals may not contain food which has adequate nutrition for a diverse population.

DP residents may not necessarily have access to adequate cooking facilities in all locations and, where meals are provided through a catering service, meal time may be strictly scheduled. This creates challenges for residents whose health conditions come with certain dietary requirements or who have young children (e.g. children, pregnant mothers, cancer patients, diabetics, etc.).

One patient whose accommodation does provide cooking facilities stated that they cannot avail of them due to overcrowding in their accommodation centre: “I can't stand a lot of people cooking, that's stress, I don't feel safe [with] a lot of people around me”. They also described the unsuitability of their DP centre for people with a history of trauma.

Additional Challenges for IP Applicants not Living in DP Centres

At the same time, IP applicants who chose to source alternative accommodation instead of staying in DP faced other difficulties. A frontline worker highlighted that some IP applicants faced difficulties accessing essential supports like medical cards, even though they were entitled to them. The system struggled to process their eligibility due to the complexity of their situation—being eligible for services while living outside DP accommodation.

This frontline worker indicated that such IP applicants would not necessarily have access to information and supports in the way that those residing in DP centres might. This reflects a gap in the system's ability to accommodate the nuances of individual circumstances, ultimately leaving some clients without necessary assistance despite their rights.

This frontline worker highlighted the comparatively better circumstances of BOTPs who do not have to go through DP and have access to more linguistic supports allowing them to better manage their own situations.

Evidence That Structural Barriers associated with Legal Status can be Reduced

Participants also highlighted the range of structures put in place to support BOTPs and allow them to bypass the above challenges. These were viewed positively by interview participants, as well as noted in a few qualitative comments from immigrants from Ukraine in the survey. However, failure to extend these structures to IP applicants was a source of frustration expressed by all service providers during interviews. Service providers felt that these changes prove that "[i]t absolutely is possible" to reform the system and alleviate the above challenges.

Thus, maintaining these structural barriers is an active choice. In order to support immigrants through these barriers, service providers spoke of supporting their clients through the provision of information and advocacy. The fact that access to healthcare services is, at least on paper, not actually contingent on immigration status was highlighted as a facilitator also, alongside specific services that do not require patients to provide a PPSN, such as CervicalCheck which may be conducted at certain sexual health clinics. However, service providers recognised that immigrant patients may not be aware of these services.

3.2.3 Finances

High Comparative Cost of Healthcare

The cost of both private and public healthcare emerged as a major obstacle to accessing care for many participants, including GP and specialist care. Examples of expensive specialist appointments named by participants included adult ADHD and ASD assessments, private mammograms, and dental care. The low rate of DP payments[9] and potential costs of transportation and childcare and linguistic supports. All were mentioned as compounding factors by multiple participants and also were highlighted as exacerbating factors. This aligns with previous work published by ICS (2019). However, the extent of financial restrictions for immigrants is unclear.[10]

Using Private Services out of Necessity, in Spite of Costs

Participants noted that although public care is often cheaper and at times free, difficulties with access and waiting times force some patients to go privately and pay higher fees. Concerns were raised surrounding the impact of this on prevention and early intervention to address ill health, such as cancer, as some participants saw the cost of healthcare as so prohibitively high that many patients will avoid accessing care unless absolutely necessary. Healthcare fees were also cited by patients as a key reason for travelling abroad for care. In addition, some patients felt that the quality of healthcare in Ireland is too poor to warrant these high prices.

Participants also outlined costs outside of healthcare fees which hinder their ability to access care. The cost of childcare was frequently mentioned, resulting in some patients needing to bring their children into healthcare appointments or, at times,

---

[9] At the time of data collection DP payments were €38.80 per adult and €29.80 per child.

[10] This is the only source of income for many individuals living in DP, as most do not have permission to work or have restrictions on being able to work. Also, the whether or not a person has a medical card, number of dependents and the extent of medical need, would also need to be considered here.

forgo them entirely, if children cannot attend. One participant spoke about needing to take their eldest child out of school, in order to provide childcare to younger siblings when someone in the family needed an appointment. Though childcare-related expenses may affect any parent living in Ireland, it was noted that this issue may impact immigrants to a greater degree, as they are less likely to have family members or other support networks in Ireland who can look after their children. The cost of transport to attend healthcare appointments was also raised as a significant burden; this will be discussed further in the following section.

Social welfare, medical cards, and GP visit cards were recognised as helpful in alleviating this burden. One patient explained that in the past, they stopped availing of healthcare as they could not afford it, and would often worry about the possibility of them becoming ill and the associated medical expenses. Since receiving a GP visit card, much of this stress has been alleviated as they know they can see her GP whenever they need. At the same time, limitations and barriers to accessing social welfare, medical cards, and GP visit cards were raised. As discussed, immigration status, housing, and access to a PPSN can all constitute barriers to availing of these supports. Some social welfare payments are dependent on PRSI contributions and so inaccessible to people who are unable (e.g. due to illness) or not allowed (e.g. due to immigration status) to work. Access to social welfare and medical/GP visit cards is typically conditional on passing a strict means test which, according to participants, is not reflective of the actual cost of living in Ireland.

One patient, who is also a carer to their child with complex needs, was awarded only €4 in Carers' Allowance as their means test indicated that this was sufficient[11]. Yet they face major financial difficulties which impact them, their child with complex needs who needs around the clock care, and their other children. During the interview they compared their situation to that of non-immigrant families:

---

[11] For additional information on Carers Allowance see https://www.gov.uk/carers-allowance.

> “I know some parents who have children with complex needs and if they, for example, need to go to the doctor, they are able to go because the family is financially capable and they also will say, for example, mind the child while you are at that appointment. I don't have that … Once when I was really sick, I had to go to school, collect my daughter, and she was sitting beside the hospital with the child. And that's wrong again, you know, completely wrong … I think for foreigners, it's harder, maybe if you have some neighbours and they are foreigners or if you have extended family around, I don't know grandparents or somebody. … I have other kids like, how they're going to study or how they're going to go on in life because now since [my child] was born everything is about her, every money we save is for [my child] … It affects everything, affects mental well being, affects relationships, affects everything now because it's all about money at the end. … I know friends who [have] Irish parents, the grandparents, the in-laws, somebody who will help, like I'm not in this position.

This participant felt that the challenges they faced stem from a shortage of public services and, as with childcare costs, are further exacerbated by their lack of support networks in Ireland.

Difficulty Completing Medical/GP Card Applications Without Support From Frontline Staff

Even among those eligible, social welfare and medical/GP visit cards are often difficult to apply for and insufficient when awarded. Service providers recognised that application forms for these supports are often convoluted and inaccessible, even to native English speakers and especially to applicants who cannot speak English fluently. To assist with this, some frontline workers provide support to clients in filing these applications. As previously, it was noted that application forms for BOTPs were abbreviated to alleviate these challenges and frontline workers expressed frustration at the fact that these simplified forms are not available universally.

To counter difficulties with accessing medical cards, some service providers have access to a “generic” medical card which they can use for all patients or residents. These cards cover the cost of medication and various medical treatments. Other service providers spoke of specific funds within their organisations which can be used to support any clients who are struggling financially, regardless of their country of origin. It was also noted that some specific GP clinics offer free care to anyone who cannot access it otherwise and that more are currently being established nationwide. Sexual health clinics were also highlighted as an avenue to accessing some forms of care for free for some vulnerable clients, as there are no requirements around legal status in order to access services. A number of patients spoke positively of certain schemes and services which they have been able to access for free: contraception, HPV vaccine, CervicalCheck, and IVF (with limitations on the number of treatments).

Depending on the Prescriptions Needed, Financial Supports Available May Not be Enough

Once received, social welfare payments were seen as too low by participants, even at their highest rates. The cost of prescriptions, even with a medical card, may also still be too high for some. Although one prescription item costs €1.50 with a medical card, some patients are on multiple types of medication, while some medications (e.g. over-the-counter, certain prescription medication) are not covered by the medical card at all. The total costs of these can be substantial, especially for patients relying on the DP payment as their only source of income.

3.2.4 Geographic Location and Transport

High Cost of Transport

Issues relating to the location of services and transport were raised by a range of participants and are closely tied to housing circumstances and finances.

A number of patient survey respondents stated that the cost, schedule, and at times lack of public transport is an obstacle to accessing GP care. Some respondents had to travel far to see their GP due to a lack of available GPs in their local area. Relatedly, others referred to specialist appointments at hospitals and clinics far from their home and the challenges with attending these, for example cancer treatment. In an interview, one patient stated that while public transport is available to them, they have had to get a taxi to hospital appointments as their chronic pain and mental health difficulties make public transport inaccessible. The cost of this is a particular challenge for them as their only source of income is the DP payment.

These sentiments were echoed by service providers. They noted that some DP centres are in remote locations and although designated bus services are sometimes established to assist the residents, these do not operate frequently enough. As will be discussed, patients often have little choice over the timing of their appointments, making it difficult to align healthcare with public transport schedules. Even when public transport is available, this is not a suitable option for all patients, particularly those who are immunocompromised. As a result, residents need to either avail of taxis or miss healthcare appointments. Although some service providers mentioned that the Additional Needs Payment can help with these costs and is available to IP applicants, it was acknowledged that this too comes with obstacles. For example, the applicant will typically need to cover the expense and later apply for reimbursement, which is challenging for those who may not have the disposable income to do so. As summarised by a frontline worker:

> “[Y]ou've got people that are coming into this country. I mean, it's great that we are supporting people. But they're just surrounded by boundaries … it's like, ‘okay, I can't do that, because I barely speak the language’. … With the medical stuff, it's like, okay, if they're living in rural Ireland, like a country town, and they've got an appointment in Limerick or Cork it's like, ‘okay, how do I get there’. Like, that's all day that they need to get there. And then it's like, okay, ‘I

> need to pay for this as well, you know, and then I need to pay for the appointment … and navigate around the city trying to get to the hospital and getting into the hospital'. It's a lot for people … I think we're incredibly privileged. I think, in comparison. I always try to remind myself of that."

Where Available, Organisations may Provide Assistance in Accessing Transport to Some Medical Appointments

To alleviate these challenges, some frontline workers can provide patients with topped up Leap Cards. However, these are only available in certain facilities and are only helpful to patients living in urban areas where Leap Cards are used, as private transport operators often do not accept them. The Irish Cancer Society Transport Service was also named as a facilitator.

3.2.5 Awareness and access to information

Some Awareness of Cancer Screening Services Exists, but Their Importance is not Well Understood

Awareness and availability of accessible information were discussed as both a barrier (where they are lacking) and facilitator to healthcare access. A number of patient survey respondents stated that they have not availed of cancer screening services because they weren't aware of the existence of the programmes or do not know how to access them. Some participants believed that they do not need to attend screenings unless they have symptoms of cancer or due to the belief that they do not have cancer, suggesting misconceptions about the purpose of screening. Notably, one participant stated that they "knew about cervical cancer [screening] from the cases of the women who were tested and given wrong results"[12]. Aside from

---

[12] Note: Cancer screening is not a diagnostic test. https://my.clevelandclinic.org/health/diagnostics/24118-cancer-screening for details.

screening, some patient survey participants expressed confusion over registering with a GP.

General Confusion About Accessing Health and Cancer Care Services

These topics were discussed further during interviews with both patients and service providers. In general, there was a strong sentiment that the Irish healthcare system is confusing and that people arriving into the country struggle to navigate all aspects of the system, from GP care, to specialist care, to psychosocial and mental health supports. One patient, who had private health insurance, reported that they were unaware that they could access private healthcare until months into their cancer treatment, as no one had informed them. For patients, information received from frontline and healthcare workers was often unclear. This was reported even among participants who did not typically face language barriers when communicating with HCWs, but exacerbated among those who require but cannot access interpretation services, as will be discussed in greater detail in later sections. Relatedly, patients felt that the social welfare system was complicated. One patient spoke of cultural differences as well as the often informal ways in which information about Irish systems is distributed and how this disadvantages immigrants who do not have strong existing networks in Ireland:

> "[O]ften you don't have certain insights … There's a lot of things out there that you can avail of, but it's like little dirty secrets you have to look for. And if you want to find them, you need to know what to ask for, and if you don't know what is out there, it's very hard to do that. So that is something and people that grew up with the system, that know the school system, and all these things, these are all things you have to learn if you come from abroad. And that makes it much harder."

Enhancing Community Networks to Improve Health Service Access

Some survey respondents felt that connecting with immigrants at the community level would aid in raising awareness. Accordingly, some frontline workers spoke of community initiatives that they have implemented to provide information to immigrants. Both frontline and healthcare workers identified information provision and raising awareness as central to their roles. Importantly, one frontline worker emphasised the importance of trust and relationship-building in raising awareness, particularly surrounding topics which may be difficult to discuss or stigmatised in certain cultures.

3.2.6 Language and communication

Language and Communication Barriers are Complex and can Hinder Healthcare Access and Information

Language barriers and broader communication difficulties were identified as a considerable obstacle to accessing healthcare and information about available services, across both the patient survey and interviews with patients and service providers. With regards to the language barrier, patients pointed to a range of specific elements which cause them difficulty: understanding the terminology used by HCWs (medical and otherwise), HCWs speaking too quickly, difficulties understanding HCWs' accents, and not being understood by HCWs (sometimes despite feeling that they speak English well). It was also noted that many language classes take place during work hours and so are inaccessible to people who work, making it difficult for immigrants who cannot speak English to learn or improve their English-language skills. Service providers expressed concern that these challenges may pose a major obstacle to early intervention and ensuring a sufficient standard of care, with some providing examples of clients and patients who did not receive appropriate care or faced delays in diagnosis of medical issues due to communication difficulties.

Some patients stated that their interpretation needs vary depending on the service provided. For example, they may be able to communicate with ease with GPs, but require support in communicating with specialist HCWs. Relatedly, one service provider recognised that even among those who can speak English well, medical terminology may pose difficulties, as “it's not your standard, what you learn in school type English”. Others reported that they have difficulties even scheduling an appointment due to language and communication difficulties. There was a general recognition, even among patients who do not need interpreters, that navigating the Irish healthcare system if you do not speak English to a sufficient degree is very challenging, as even those who can communicate through English face barriers:

> “What would I do if I didn't speak the language? We wouldn't know where to begin. Because if I speak the language, and I have all those problems, you know.”

Some Providers Communicate in English in the Hope that Patients Will Learn

Otherwise, some interviewed service providers communicate with their clients exclusively through English, with recognition that this poses an obstacle to clients. One service provider expressed their belief and hope that using English in communicating with their clients may assist them in learning English and so have a positive effect.

Evidence from the survey indicates that this situation may not be ideal, with more immigrants preferring to be given a choice in what language they use for communicating with service providers.

Little Access to Paid Interpreters Across Health Care Services

Both patients and service providers noted that access to paid interpreters is scarce across healthcare and other services. Patients reported not being offered an interpreter or at times being required by the HCW to source (and pay for) their own interpreter. One survey respondent stated that they were once denied access to their GP appointment without an interpreter. At the same time, service providers highlighted the fact that GPs usually have to pay for interpreters out of their own funds. However, they also recognised that access and lack of funds were not the sole obstacle to provision of interpreters. For example, not all hospitals may have a dedicated budget for interpreting services, and if they do, some may choose to spend it elsewhere or run out of funds at the end of the year. One frontline staff member stated:

> "So you know, financial life for the hospital, even I suppose every hospital in the hospital group has their budgets. And some of them have got, some of them can spend, you know, money on some things, and some others can't, for whatever reason, however they're managing their own budget. So I found that even with interpretation services … some hospitals say 'yes, no problem'. And some will say, 'actually, we don't really have the budget for that, can the person bring their own? … especially towards the end of the year, we didn't have that budget available'."

Many interviewed service providers also reported that they cannot provide their clients with interpreters. A small number had used interpreters of varying quality, providing services through different media, including over the phone, online, and in person. These discussions revealed that the quality of interpretation services and the utility of these services to patients and clients is nuanced and complex, varying across communities and languages. For example, some of the utilised interpretation services were not available on short notice. These services would be unsuitable for walk-in services and require the client or patient to disclose that they need an interpreter in advance. On the other hand, services available on short notice usually provide online or phone interpretation services, and so are not suitable for clients and service providers who prefer or require an in-person interpreter. The gender of the interpreter was also mentioned as potentially important, especially in some cultures.

Specific challenges were identified with regards to minority languages and interpreters for minority populations. Service providers noted that it is more difficult to source interpreters for certain less commonly spoken languages. Due to this, if an interpreter is sourced, there is a higher possibility that this interpreter is known to the client or their community, which may be a source of discomfort or anxiety for some clients. One healthcare worker spoke of a patient who "refuses to use phone interpreters because they feel they know everybody in Ireland who speaks [their language], and they don't want to have to speak to someone they know". On the other hand, employing a trusted community member as an interpreter may actually facilitate engagement with service providers as some clients may be more comfortable communicating through someone who they are familiar with. Some service providers utilise interpreters based outside of Ireland, thus minimising the risk of interpreters being known to clients. However, this can come with other difficulties, as interpreters based abroad may not be familiar with Irish systems, leading to potential miscommunication. Additionally, it was noted that some languages, such as Arabic, have a wide range of dialects and so require patients to specify their exact language needs and service providers to be aware of these differences in order to source an appropriate interpreter.

Concerns About Using Informal Interpreters as Stop-Gap

A problematic consequence of the lack of access to interpretation services concerns the use of family members as interpreters. Participants noted that family members are not a suitable alternative to professionally trained interpreters due to lacking the necessary training to accurately interpret, the family members' own perspective of the issue influencing the information they provide, and family members not interpreting directly or literally. One service provider described this as akin to "a game of telephone". Family members may also, intentionally or not, lead the client towards certain medical decisions through their interpretation.

In addition, the presence of a family member may influence the information provided by the patient, for example, due to the patient not being comfortable with disclosing the extent of their difficulties to a family member, or cultural issues surrounding discussing medical issues with loved ones. One HCW summarised the experience as follows:

> "I would say, 'How long have you had the cough for' and there'd be a five minute conversation with all sorts of stipulations. And then the person would come back and say, two days. You'd have no idea what went on. So using informal interpreters, untrained interpreters is a disaster. And using family and friends is equally terrible. Because especially with things like women's health problems, or bottom problems, or something, friends and family can't even use those words, like in the Roma community. In the Roma culture, you don't talk about illness or health or body with men- with other people, only with people who are of the same age as you and very close to you or something. So trying to use informal interpreters is a disaster."

Even more inappropriate is the practice of children stepping in as interpreters for their parents. Service providers similarly recognised that this is a common but inappropriate practice, as children may be exposed to age-inappropriate information and be required to miss school and other activities in order to attend their parents' medical appointments. One patient survey respondent described the impact of needing to rely on her child for interpretation on both them and the child:

> "My daughter is the one who helps me with translation because her English is good. I don't want her to hear my issues as I feel that most of the things she hears in the cause of helping are making her not to enjoy her childhood. And besides, she is only 8 years old. Sometimes I have found myself asking her not to go to school so that she can accompany me for serious appointments and sometimes the things I have to disclose are beyond her age. This makes me sad, very sad but I have no [option] otherwise."

One healthcare worker stated that they do not allow the use of children as interpreters at their service. However, this medical practice had access to professional interpreters and so could provide patients with a suitable alternative. Other service providers noted that implementing such a ban at their service is not feasible as doing so would prohibit some patients from accessing healthcare at all, due to the absence of another option. In addition to children, one frontline worker recalled a client of theirs who was experiencing domestic violence and had to rely on the perpetrator to interpret for them.

Challenges With Literacy Also Impeded Service Access

In addition to difficulties with understanding English, some service providers referred to general and digital literacy as an obstacle. This emerged as a challenge particularly with cancer screening. Registering for BreastCheck, for example, must be done online and so is inaccessible to patients who don't have access to the internet or are not sufficiently digitally literate to do so. This may be a particular challenge for older people, yet the BreastCheck programme is only available to those aged 50 to 69. BowelScreen requires the patient to collect the sample themselves by following the provided written instructions, thus excluding people with visual impairments and those who are not literate in English or in any other language. One service provider highlighted that any service which depends on email, text message, a website, or solely written instructions is not accessible to all.

Concerns Around Use of Apps as Stop-Gap

Where paid or informal interpreters are unavailable, patients and service providers sometimes resort to using translation applications.

Translation applications are a cheap and easily accessible alternative to interpreters, but resulting translations are not always accurate, and some service providers reported that certain languages are translated more poorly.

Translating Resources to Support Patients in Accessing Health Information

With regards to raising awareness, both patients and service providers felt that it would benefit immigrant communities to provide a greater range of resources in languages other than English and Irish. At the same time, it was acknowledged that some translated resources already exist and are helpful, while some service providers spoke of work that they have done to provide more such resources and fill in existing gaps. One interviewed patient spoke highly of the HSE website and the information it contains, describing it as one of the best things about the Irish healthcare system. In particular, this patient recalled finding answers to questions about getting a medical card, seeking specific medications from their GP, and accessing cervical tests and HPV tests on various parts of the HSE website. They felt that they "had access to the information and it is so easy to find."

Service Providers Show Ingenuity in Addressing the Language and Health Needs of Patients

Some service providers reported that they make accommodations for their clients' communication needs. For example, where verbal communication was a difficulty, some use text messaging apps or visual aids to assist their clients. Dedicated clinics and services for certain populations were also viewed as a positive, as the staff working at those clinics often come from their target communities and thus have both the language and cultural competency to adequately support their clients.

Advocacy Performed by Irish Friends to Reduce Concerns of Discrimination

A small number of survey respondents bring Irish friends with them to appointments, the role of whom may extend beyond interpreting alone and also involve advocating for the immigrant client. These survey respondents also felt that having an Irish person accompanying them improves the quality of care they receive, revealing possible discrimination in HCWs' treatment of their patients, as will be discussed later:

> "Sometimes it is not about having an interpreter but being accompanied by a local Irish person to communicate with the GP on your behalf. I also feel that

> having an Irish person makes you to be taken seriously. My friends have also reported the same issue that they feel having an Irish friend accompany them for appointments makes their lives easier during appointments."

While some patient survey respondents spoke positively of the assistance offered to them by their friends and felt comforted by their friends' presence, the harms of relying on others to access healthcare were noted too. One patient reported having to miss a healthcare appointment as their Irish companion was unavailable.

3.2.7 Service Provider Factors

Healthcare Workers Need to be Patient When Interacting with A Patient who Needs Communication Supports

As mentioned, barriers concerning language and communication are exacerbated by HCWs who do not take the time to adequately communicate with patients or who express impatience when faced with someone who needs additional language-related supports, for example due to not being fluent in English. One frontline worker recalled a client who communicates in a manner considered atypical by their fellow staff, and how this was responded to by those staff members:

> "I actually had this conversation yesterday, somebody dropped in there … and [the staff] were a little taken aback by, I suppose the communication or the way that this person was speaking, and they were upset, and they came to me, and I was kind of going, 'oh, no, this person for 16 years at this, this is not the person that I know'. I just sometimes have to explain that people can get really stressed, and it affects mental health, and with language barriers, and you just have to be really aware of all of these things, when you're working with somebody."

Healthcare Workers may Cause Harm When Interacting Incorrectly with Patients

Several patient survey respondents and interviewed patients spoke of their experiences of HCWs' attitude towards and treatment of them causing harm. Some patients felt that HCWs are impatient with them, for example, due to their language needs. They felt that they are "wasting people's time" when seeking care. Participants recalled situations where they were not given sufficient information by HCWs, for example, concerning their diagnoses or medical procedures. Interviewed patients identified this as additionally difficult for them to cope with due to the fact that medical professionals in their home countries are much more forthcoming with information. Others stated that they are rushed by HCWs and not given enough time to discuss their difficulties; one survey respondent said:

> "Hospitals and clinics [need] to be ready to treat us by listening carefully to what we are saying we are feeling and not being rushed and conclusions being arrived at. That hurts and affects my mental health because it makes me be afraid of visiting hospitals and GPs."

Many explicitly stated that HCWs do not care enough about them and do not show enough compassion or concern for their wellbeing. One interviewed patient stated that "it's really really difficult to find [a] GP that really cares about you". Others described coming across a caring HCW as a matter of luck. This lack of empathy was also contrasted with patients' experiences of HCWs in their home countries. At times, this manifested as outright dismissal of patients' symptoms and difficulties, with patients' reports of their symptoms not being trusted or believed. One interviewed patient presented to A&E with symptoms of sepsis but was sent home, and was only admitted when they received a referral to A&E from their GP, implying that their difficulties were only believed after a HCW confirmed them. Similarly, a number of survey respondents felt that they are not "being taken seriously" by HCWs. Some patient survey respondents and interviewed patients reported having their symptoms ascribed to stress or other mental health challenges, without sufficient investigation of potential physical causes. At its worst, this led to the delayed identification of serious medical emergencies, as in the case of this patient survey respondent:

> “It was an emergency, my husband had a stroke and the doctor prescribed a meditation app and he didn't see [him] that same week. He didn't ask for any tests.” One patient survey respondent discussed their experience of severe HCW malpractice and felt that they were being discriminated against. She felt that system offered no avenue for her to manage these challenges (Box 2).

Box 2. Anne’s Story

Anne is a woman in her 60s, who has been living in Ireland for over 20 years. Anne spoke of her experience of clinician malpractice and the impact this had and continues to have on her life. She felt that her immigrant status and lack of knowledge of the healthcare system were critical factors in her not being listened to and taken seriously my medical professionals:

> “My relationship with the consultant surgeon had collapsed due to this doctor's dishonesty. He did not show me the results of my examinations, fabricated them, tricked me, did not organise the examinations specified in the guidelines in order to hide the mistakes he made during the operations. … In 3.5 years, I have not received and seen the confirmation of my cancer diagnosis and the expert's conclusions about the operations performed on me. I could not settle the disability allowance for a long time, because the consultant did not give examinations results. I was forced to give up further medical investigations because I did not see the point in them.”

Anne’s GP further exacerbated these challenges as they deliberately fabricated her medical history to conceal the surgeon’s actions. Anne continues to face difficulties with her healthcare, as her consultant surgeon still influences her GP and new consultant. She still has not received the answers she has been seeking surrounding her diagnosis and results of her tests.

Some patients discussed Irish HCWs’ reliance on outdated systems and worldviews. One survey respondent criticised the use of the body mass index, “despite it being decades outdated & proven as a bad metric”.

Another patient reported that HCWs do not show sufficient awareness of LGBTQIA+ identities and do not give patients an opportunity to self-identify, instead assuming that they are cisgender and heterosexual.

Though some participants referred to the above attitudes as general problems among Irish HCWs, not necessarily affecting only or especially immigrants, others expressed being treated particularly poorly due to their ethnicity or immigrant background. Multiple patient survey respondents called for a need to target discrimination and change of attitude towards minorities in healthcare settings, with one person feeling that their GP "hates" people of their nationality and another stating that they have observed their GP "spending 30, 40 minutes with" Irish patients while "when [they] go in, [they are] out within 5 or 10 minutes". They expressed feeling "dissatisfied and not well listened to … not important". One interviewed patient had a similar experience while hospitalised, where they felt that doctors were friendlier and provided more information to Irish patients than to them. Another patient survey respondent recalled being "told that people like [them] have a lot of problems". Of the 40 survey respondents who identified as being "African", nine wrote comments reporting having experienced discrimination when accessing Irish healthcare services. One Ukrainian survey respondent also experienced discrimination. One Roma participant reported being denied care on the basis of their ethnicity:

> "Sometimes I feel nervous going to the hospital with my wife because she dresses in traditional dress and they don't treat us well, including staff like security. Sometimes I have been kicked out of the hospital when visiting family. I usually feel more confident going on my own."

As with the above participant, these experiences had a tangible impact on patients. Some participants had to attend several services and appointments in order to receive sufficient care or due to the progressing of medical symptoms previously dismissed by HCWs, thus costing them more money. Multiple patients expressed distrust in the healthcare system and HCWs due to either their own past experiences or hearing of others' encounters with HCW discrimination. One healthcare worker stated that, from their experience, "Roma women, [Irish] traveller women, and women in international protection" are particularly likely to experience discrimination.

The Gender of Healthcare Workers is Important to Some Patients

Separately to HCWs' attitudes towards and treatment of patients, a number of participants considered the gender of their HCW to be of importance, and this was echoed by service providers. Lack of female staff was identified as a reason for not availing of breast and cervical screenings by three patient survey respondents. Relatedly, one interview patient spoke of the response she faced from a male gynaecologist when she refused a procedure due to his gender:

> “I went to a gynaecologist once … I usually prefer to go to a woman, but I couldn't get an appointment on time. So I had to go to a man and I wasn't comfortable with like an internal exam, but … it was just like, awkward trying to explain that because he basically said, 'Why did you book the appointment there?'”

Trust Needed in the Patient-Healthcare Worker Relationship

Trust and relationship-building with service providers was identified as very important by patients and service providers alike, especially for patients with a history of trauma. Some patient survey respondents complimented specific doctors or clinics, while others spoke more generally of “the good attitude of the doctors and nurses towards me” and “skillful and helpful” doctors. One service provider recalled a HCW at their previous workplace and the strength and value of her relationship with the local community:

> “… patients refusing to speak to anybody else except a specific [staff member]. So there was a lot of kind of, like, loyalty and trust in like, there's one [staff member] in particular that just half of [the town] adore. And they won't speak

> to anybody except her and she is amazing. And she's so good and so kind hearted. I think people pick up on that because she would just do anything for them. She'd never see them stuck."

One interviewee reported that in addition to the lower costs of healthcare in their country of birth, another reason for travelling abroad to access healthcare is their familiarity with the HCWs and the healthcare system. Four of the immigrants interviewed (40%) stated that they had repeatedly travelled outside of Ireland (to their country of birth) to access healthcare services.

3.2.8 Quality of Healthcare (system)

Service providers' attitudes towards and treatment of clients is closely tied to the topic of quality of care, which was discussed at length by participants. Participants spoke of both the quality of the healthcare system as a whole, including its structures and the ways in which it operates, as well as the quality of the care provided on the ground.

Patient Concerns of Service Adequacy and Training of Health Care Workers

In terms of the care provided by HCWs, some patients felt that clinicians working in the Irish healthcare system do not have sufficient knowledge or training, due to the substandard services that they had received from them in the past. Follow-up care was considered poor too, including follow-up regarding test results as well as follow-up plans post-treatment and post-discharge from hospitals, across both private and public healthcare settings. One interviewed patient waited approximately six months for the results of their bowel screening. Another stated that their only effective method of receiving communication from the HSE and access to their child's medical files is to submit a complaint. Lack of access to one's medical files and test results was a source of frustration among other patients too.

Continuity of care was also described as substandard. Participants engaging with specialist services reported seeing a different doctor each time they had a specialist appointment. HCWs not reading patients' files also emerged as a difficulty:

> "[O]f course, bureaucracy, I mean, my son had to go into hospital and you arrive to A&E and they take your details, they take everything they have to refer, maybe from your doctor that sent you there. And then they bring you in, and you have to give your details every single time they take them again … I just gave these details you have on file, you have to file in your hand. And it's not only that, they ask your name again, they ask the whole story. It makes it so long. And you feel it's useless."

The above challenges are all captured within the story of one interviewed cancer patient whose cancer was missed by her GP in Ireland, but caught by a GP when she travelled abroad (Box 3).

Box 3. Mary's Story

Mary is an immigrant woman in her mid-40s with a previous cancer diagnosis. A year after completing treatment, Mary contacted her GP about pain in her back. The GP diagnosed this as a pinched nerve and prescribed muscle relaxants. **Mary's GP was not sufficiently knowledgeable of cancer or aware of her medical history to realise that back pain in a cancer patient is a warning sign that the cancer has metastasised.**

Mary had not been informed by her oncologist that this is a symptom to look out for. With her oncology appointments becoming less and less frequent, Mary's opportunities to discuss her pain with her oncologist were scarce. At the same time, her GP gave her little reason to think that she should mention this to her oncologist. Each time she had an oncology appointment she was seen by a different doctor, offering little continuity of care. The oncologists did not think to ask about potential signs of metastatic cancer.

It was only when Mary travelled home to seek further care for her pain that her metastatic cancer was diagnosed. During the interview she spoke of the lack of preventative care in Ireland and how this contributed to her delayed diagnosis, as well as her difficulties in adapting to this cultural difference:

"[T]he mindset [in my home country] is different, you have a small pain, you run to do exams. ... Here it is totally different ... The doctor [doesn't request] the exam. He asks why you want the exam. ... **So you have to go to the GP, like five times for him, to go and ask for an exam. And sometimes you don't have this time, it was what happened with me.** ... Unfortunately, I am that part of the population that doesn't have the time." She went on to say that because she does not have the time to repeatedly go to the GP and ask for exams, that she is less likely to be "cured" "because [doctors in Ireland] say, 'Oh, the chance that this happens, it's really low'". Mary went on to say that she would like to see the mindset of healthcare workers changed to better address the needs of their patients.

Patient survey respondents and interviewed patients also criticised the lack of focus on preventative care in Ireland. Patients struggled to avail of scans and other tests, as access to these requires a GP referral and many faced reluctance from their GPs to refer them for testing. This will be discussed in greater detail in a later section. As summarised by one survey participant:

> “From what I've experienced in the country, they wait for cancer to appear or have a heart attack to ask for tests, when it's already too late.”

The Irish System of Healthcare Provision not Preventative, but is Slow and Reactionary

Comparisons were made between Ireland and participants’ home countries across all of these dimensions. Patients who reported travelling abroad for care cited many of these factors as the reasons for their decision to seek healthcare abroad, alongside costs and waiting times. The culture of reactive, rather than preventative care emerged as a particularly strong reason. A Ukrainian patient survey respondent summarised their experience with the Irish healthcare system as follows:

> “I think that medicine in Ireland is at the lowest level. I now have a shoulder injury. I have been going to the doctor for 3 months and he cannot help me. They did an MRI, I need an operation, but he does not refer me to a specialist surgeon. In general, I will leave for the country where there is a war, so that I can be diagnosed and have an operation.”

With regards to systemic issues, waitlist management, gaining access to the system, scheduling of appointments, and reliance on postal communication were discussed by a range of patients as sources of confusion and frustration. The system of removing patients from waitlists if they miss or cancel an appointment was criticised. For example, one interviewed patient recalled choosing not to avail of surgery for their medical issue and as a result being discharged from the hospital entirely, despite still needing their care. This is related to and exacerbated by issues surrounding the scheduling and communication of appointments.

Appointment dates are typically set by the hospital or doctor and usually within working hours, making it more likely that patients will need to cancel or not be able to attend due to other responsibilities (e.g. caring responsibilities) and an inability to choose appointment dates that suit their schedule. More detail on this area will be provided in later sections: Autonomy and preferences and Access to General Practitioners.

In addition, appointments are often communicated by post. This was seen by participants as a problem due to the possibility of post being lost or delayed, as well as patients' address changes, particularly when waitlists can be very long and so a lot of time may pass between referral and the appointment being scheduled. One interviewed patient noted that immigrants in particular tend to move a lot. As discussed, relocation when living in DP is also common. In addition, receiving post when living in DP or any other congregated setting causes further challenges due to the possibility of post being misdelivered. Issues surrounding language barriers and communication challenges also reemerge here, as not all patients can read, understand English, or communicate that they cannot make it to an appointment. One interviewed patient recalled receiving their appointment letter the day before the appointment date. When they tried to phone the hospital to reschedule, their calls were unanswered. Relatedly, the lack of good IT systems in the HSE was criticised.

Immigrants at a Disadvantage due to Unofficial Pathways to Access Services

A number of interviewees, both patients and service providers, spoke of the unofficial pathways through which patients can gain access to the system and how these disadvantage immigrants. One person aptly described this as the "phone a friend system", whereby one can bypass waitlists and difficulties with referrals if they have the "right" contacts and connections, such as medical professionals or elected representatives. Patients felt that this system is unfair and expressed discomfort in using these pathways to access care, simultaneously recognising that their reluctance to do so limits the services they can access:

> "I could have gotten a lot more if I would have had access to typical Irish ways that you go to your elected representatives. But it's not in our culture really to do that. … I needed an MRI, I went to my GP with the pain, it took half a year

> before I got an appointment with a specialist. … And I saw the specialist and the specialist looked at it and he said, I can't do anything without an MRI. And I was put on the waiting list and it took three and a half years before I got an MRI. … By the time I got the MRI, the pain was more or less gone, I had seen the specialist again. And he said yeah, it's not as bad anymore we'd rather do nothing. … I had the feeling [that] with the right name and the right connections, I would not have waited three and a half years. That's just a feeling that you sometimes get and my kids say that sometimes as well. … I have come around to it. But at the time, I definitely wasn't going to a TD because I don't think it's fair to push yourself forward just because you have a connection. … I don't think it's right. I think if you have to wait and everybody has to stay in their place and wait and maybe urgency, but not the connections [should] decide it."

In addition to immigrants' unfamiliarity and thus possible discomfort in participating in this, in their view, unfair system, participants also highlighted that immigrants are less likely to have these connections at all. Some service providers also reported relying on their connections and contacts to support their clients in gaining access to care:

> "[I]t's the Irish way, it's phone a friend. So you try and find somebody that you know in the hospital … who will go down and knock on the secretary's door. And if you can't find a personal contact like that, you find the secretary and you go through them, because secretaries are usually much more humane and approachable. You can't get, often you can't get consultants on the phone, they just don't take phone calls. But if you can get to, if you can make a human contact and speak to the secretary and explain it to them, they often have the ear of the consultant. And it's kind of a bit of a bridge of trust thing if you can, the consultants usually trust your secretaries. And if you can get the Secretary on your side then, you know, Bob's your uncle."

Irish Health Services Lack Proper Systems to Engage with Transnational Patients

In relation to cancer care for immigrants in particular, several service providers noted that there are no set systems in Ireland for navigating the care of patients who arrive in Ireland with a cancer diagnosis. They recalled clients they've supported who faced delays in receiving care or long breaks in their cancer treatment as a result, with some highlighting the inflexibility of HCWs as a barrier. Immigrants who move to Ireland mid-treatment may not have all their medical records and prior test results with them, particularly if they left their home countries under unpredictable circumstances such as war or natural disasters. Yet service providers recalled clients of theirs whose HCWs required them to provide these files and struggled to navigate their care without these. Where these files are unavailable, patients need to be re-diagnosed and their treatment effectively re-started, which can cause substantial delays and gaps in treatment. Even when files from abroad can be accessed, other difficulties may emerge. For example, one healthcare worker recalled a patient who "had a stack of paper records … and the hospital didn't want to see them until they were translated", but the cost of translating them amounted to €3,000. Another frontline worker recalled a client of theirs who was faced with challenges concerning different pathways of treatment in Ireland, compared to their home country:

> "So we will get some people who arrive with cancer already who've been diagnosed in other countries. And that can be a bit messy, because I've just one person at the moment who was on cancer treatment in [his home country]. And he arrived in Ireland … and then he went here on a waiting list for a long time in the public system … for an MRI, and that would take a year.
>
> So he's falling between two stools. He was on medication and surgery in [his home country]. And he's here, six months now and hasn't had any treatment. And so they insisted on him getting all his documents from his doctor in [his home country], which he did get. And they are currently reviewing those now

> with a view to seeing if we can, they can treat them. So it's tricky. And now having said that, they said …. that even with the results that he provided, they wouldn't have, in Ireland he wouldn't be treated for that with medication or surgery yet, whereas in other countries [he would be] so he's extremely anxious about it, as you can imagine, he feels like it's spreading. But that's just an example of how things can get lost on transit between countries. And the treatment is discontinued. Same would have happened with Ukrainians, they'd be on treatment, and then they're starting in our system fresh."

Some patients expressed that these issues with the quality of care and the healthcare system in Ireland heighten their frustrations with the high costs of accessing care, as they see these costs as unwarranted. Again, this leads to some patients travelling abroad for healthcare, where the costs may be cheaper and the perceived quality of care higher, in spite of the travel costs. Another important consequence concerns the resulting emotional impact, as many interviewed patients and patient survey respondents spoke of the stress, worry, exhaustion, and hopelessness they feel due to the range of barriers they've encountered. One interviewed patient, who is also a carer, stated that "[t]he amount of stress level wouldn't be there if [they] didn't need to fight for everything". Another patient spoke of their concerns about their future in Ireland resulting from their experiences of the healthcare system:

> "[I]t seriously makes me question my ability to stay in Ireland in the long run. … you're gonna get older, you're gonna need the system more often, I have two elderly parents as well. And thank God, they have access to everything they need back home. But what if I want to bring one of them here someday? What am I going to do with them? What's going to happen to me? If I ever develop, you know, something a little bit more serious? Because literally what's happening now, like, every time that I need something done, I have to go to [my home country] to get it sorted. And I know that that's not sustainable. And seriously, I don't know what I'm gonna do in the long run."

Nonetheless, some positive comments about certain aspects of the healthcare system were made. One patient survey respondent praised the high level of hygiene in Irish healthcare settings. Both patients and service providers referred to specific areas where the quality of care is high, such as certain forms of cancer, some disabilities, and some cancer screenings. With regards to cancer in particular, one healthcare worker noted that certain cancers have a "pathway", such as breast, lung, prostate, skin, and ovarian cancer. The care received by patients with these types of cancer is better and easier to navigate as a result. Other participants echoed the general statement that if you have a serious illness, the care you receive can be quite good, consistent with earlier discussions surrounding the over-reliance on reactive, rather than preventative care. Positive feedback was also made in relation to cancer screenings such as CervicalCheck, with patients and service providers describing the booking systems as uncomplicated, although, as discussed, others criticised their accessibility to people who are illiterate or have poor digital literacy. Service providers also spoke of their attempts to bypass or mitigate the challenges faced by their clients. For example, one HCW stated that while they have the ability to refer patients to A&E through an IT system, they also always provide patients with paper copies of their referral, in recognition of the unreliability of these IT systems. Another HCW reported that they "keep an eye out" for patients who are more vulnerable to ensure that they are notified of and access their healthcare appointments. For example, patients living in hostels who may not receive postal communication might need additional support. In an interview, another HCW who worked directly with cancer patients raised concerns that single older males are the most vulnerable; they can be easily overlooked as well as less likely to step forward for screening and supports.

Finally, one HCW spoke of their experiences providing end-of-life care and challenges in accommodating their patients' wishes surrounding funeral arrangements and repatriation of their body. This service provider felt that there was more ambiguity around what would happen to this person's body and that their wishes might not be respected as the person did not speak English and no move was made prior to their death to come up with an end of life plan. They recalled that the family could not come to an agreement with regards to the patient's funeral wishes. The HCW reported that due to the lack of formal structures to navigate such situations, this conflict was eventually resolved by another HCW of the same faith as the family stepping in to mediate and facilitate their wishes.

3.2.9 Fear

Patient survey respondents and interviewed patients disclosed that fear may impede their ability to access healthcare. A wide range of fears was discussed, many of which stemmed from prior negative experiences with healthcare in Ireland. These reports were also echoed by service providers. Broadly speaking, patients' fears can be categorised into fear of illness and cancer, pain, accessing healthcare, communicating with HCWs, discrimination, and deportation.

The Fear of Illness, Particularly Cancer, can be a Significant Concern for Patients

Fear of illness in general and cancer in particular emerged particularly strongly among patient survey respondents. One respondent stated that they are "very afraid of getting sick, because [they would] have to wait a long time" to receive care. Fear of cancer in particular was framed as a cultural issue:

> "[C]ancer is a very scary subject as we come from countries where many people die when they get cancer. A cancer diagnosis is a death sentence for many people so you can imagine the fear. I was not expecting to live after bowel cancer but I am still here." (Patient survey respondent)

One patient survey respondent described their cancer journey as particularly scary as they "are far from home and [they] don't want people back home to know what [they] are going through", highlighting the additional challenges of having a serious illness when you are an immigrant. Some respondents named their fear of cancer as a reason for not accessing cancer screenings, with one person additionally stating that their fear stems from having a family member who died of cancer. They added that wait times for screenings exacerbate their anxiety. Relatedly, another person recognised that "[s]ome of these illnesses can be stopped on their tracks if discovered early but currently there is a lot of fear around some illnesses and are caught late when not much can be done", further underscoring the importance of targeting these fears. The need to address these fears, for example through information campaigns, was highlighted.

The Fear of Pain and Discomfort Hinders Patients from Attending Cancer Screenings

On the topic of cancer screenings, a few patient survey respondents stated that fear of pain and discomfort has prevented them from accessing screenings. These concerns often stemmed from prior, painful experiences (e.g. for patients with female genital mutilation). One patient also reported that their past screenings were done with a male gynaecologist, causing them discomfort and anxiety surrounding availing of screenings again.

Sometimes Patients Don't Attend Appointments Because They Fear Discrimination

In addition to screenings, a range of fears emerged with regards to accessing healthcare more generally. Tied to fear of illness was the fear of discrimination due to illness. One patient survey respondent recalled hearing "scary things from people here in the [DP] centre about hospitals and how people with scary diseases are treated". Relatedly, one interviewed healthcare provider spoke of a patient who feared stigma surrounding their cancer, for example, that it would be "regarded as kind of something unclean or that could be contagious".

Fear of discrimination due to one's immigrant status or ethnicity was mentioned by several patient survey respondents. As above, these concerns stemmed from participants' prior experiences as well as, at times, the experiences of others in their communities. One patient stated that they have "horror stories from people who look like [them] in the hands of health care professionals" (survey respondent). Another participant feared seeking healthcare with his wife due to her traditional Roma dress and the discrimination they had experienced previously as a result.

Patients Have Concerns Around Communication Problems and Bad Experiences

Related to fears of discrimination were more general fears of communicating with HCWs and HCWs' attitudes towards them. Fear of not being understood, judged or met with impatience due to one's accent or command of the English language, as well as concerns about "saying the wrong thing", and, more generally, "fear of having a bad experience" were named as barriers to seeking healthcare by patient survey respondents. One patient outlined the following concerns surrounding seeing a GP:

> "Not being understood is a fear and then feeling embarrassed. People not understanding what I am complaining about and not being taken seriously."

Potential Deportation as Another Concern for Immigrants

Interviewed service providers also spoke of fear of deportation among undocumented immigrants and resulting anxieties surrounding accessing healthcare. One social worker stated:

> "[T]he biggest question to me is … whether people are being deterred from accessing healthcare due to fear of coming to the attention of the authorities or deportation. So the chilling effect of, 'I'm just not going to engage with them'. … I guess, anecdotally, we would hear about people who are even kind of like risking giving birth at home, because they don't want to engage with the

> system and risk [bringing] attention to [themselves]. … The hardest part is that people are undocumented, and they're afraid of accessing the system in any way. … And I guess that's where the preventative or early treatment concerns would come."

Relatedly, some service providers recognised that this fear of being made known to the authorities and fear of authority more broadly may prevent immigrants from accessing their services too. Although it was noted that no and low threshold services would not require PPSN and other forms of documentation, which would be supportive of immigrants, including those who are undocumented.

3.2.10 Autonomy and preferences

Desire for Immigrants to have More Autonomy Managing Healthcare

A range of challenges and concerns surrounding patients' autonomy and respect for their wishes and preferences were raised by both patients and survey providers. The lack of options to self-refer to specialists and tests, combined with GPs' frequent reluctance to refer patients emerged as a particularly major obstacle. Relatedly, age restrictions on referrals to certain services were discussed. Other difficulties concerned patients' lack of control over the timing of appointments, as previously mentioned, and patients' and their families' wishes to do with burials.

Immigrants Struggle with the Lack of Self referral Pathways and Medical Culture in Ireland

A number of interviewed patients expressed frustration at the lack of self-referral pathways to medical specialists and diagnostic procedures. In Ireland, GPs operate as gatekeepers of most specialised healthcare services, whereby access to these services is conditional on a GP referral. This system was seen as particularly problematic due to participants' difficulties with acquiring a GP referral. Both patient survey respondents and interviewed patients recalled their experiences of GPs refusing to refer them to specialist care and diagnostic tests. Specific named examples include ultrasounds, x-rays, MRIs, gynaecologists, orthopaedists, oncologists, and dermatologists. This was linked to the poor preventative care in Ireland discussed by a range of participants, as they felt that GPs will only provide referrals once the patient is severely unwell. Patients contrasted this with systems in their home countries, where patients can self-refer to many services and GPs, in general, are more willing to refer patients to any services and tests they feel they would benefit from. Many reported struggling to adjust to this cultural difference:

> "This also is a point that I struggle to understand that here, you don't have autonomy to go to a doctor. Like [if] I have a pain in the back. I would go straight on to the orthopaedist. I didn't want to … go to the GP and pay the GP because I know that he's not [an] expert in back issues, and here, I cannot. I have to go to the GP first and I have to insist a lot to have the referral to go to the doctor or to a consultant. And I don't understand, because it should be my right if I want to go to another doctor or not. … I think the patients should have more autonomy to choose the doctors, the hospital and also ask [for] exams." (Interviewed patient)

Even if a patient is able to receive a referral, further issues of lack of autonomy and control over one's healthcare emerge. Patients noted that they have little choice over who they are referred to and when their appointments take place. Given these challenges to accessing specialist care as well as long waitlists (discussed in a later section), it is particularly important that patients can attend any appointments they receive, yet during interviews patients have stated that accommodations are not always made to ensure this. Immigrants interviewed stated that when they had experienced challenges around attending appointments, that they were moved back to the end of the waiting list or removed from the service entirely.

A further restriction on access to screening tests concerns age restrictions on the BreastCheck programme, which is only available to patients aged 50 to 69. One interviewed patient was advised by a doctor in her home country to attend regular mammograms, but was turned away by BreastCheck due to her age. This was particularly challenging for her as she had grown up in a country with a different medical approach. Unable to seek public access to breast cancer screening in Ireland she then sought to access the scan privately, but found the cited cost of €460 prohibitive. She eventually came across a more affordable - though still expensive - alternative by chance, after seeing a post in an online forum for her community where another member recommended a specific service. This patient recognised that if it weren't for her checking social media that day, she may not have been able to access a mammogram at all.

3.2.11 Access to General Practitioners

General Challenges Around Accessing GPs may be Higher for Immigrants

The lack of self-referral pathways to specialist care and consequent reliance on GPs for access to healthcare underscores the importance of GP access, as without a GP, patients are locked out of many services. However, participants reported considerable barriers to accessing GP care. These barriers begin at the point of entry, with a range of patient survey respondents, interviewed patients, and interviewed service providers noticing a shortage of GPs nationwide and resulting challenges in registering with a GP, as many are at full capacity and thus not accepting new patients.

Although this shortage may impact all patients seeking a GP, participants noted that it may pose an even greater difficulty to immigrants. One frontline worker explained that "if you always lived here, your family might have a family GP, and you might be able to get yourself in there. But if you just moved to the area, and not knowing how the system works, or not having someone who knows you or someone who vouched for you" causes additional challenges to immigrant patients. In addition, as discussed, people living in DP may be relocated, sometimes multiple times, and so have to re-register with a new GP each time they are moved.

One frontline worker discussed the “three refusal rule”, whereby the HSE may sometimes assign a person a GP, but only on the condition that they have a medical card and have already been refused by three GP clinics. They spoke of the problems with this rule, highlighting once again the contrasting systems in place for BOTPs, and the lack of a similar mechanism in place for those who do not have a medical card:

> “I've had to literally write letters for my clients to take them to surgeries that we know are going to refuse them so that the surgery refuses them because they need the three refusals before the HSE will appoint them one. … [T]he HSE has shown that they can address that because for Ukrainian refugees who came on temporary protection, they got assigned a GP right away. But everyone else, Irish and migrant, everyone who's not a BOTP, has to show that three refusal rule, which is ridiculous and a waste of time. And then you have people who are not eligible for a medical card, so people who might be migrants, who maybe have a work permit or are here on a student visa, who by the conditions of their permission, are not allowed to access social supports like a medical card. They can't really have the HSE force a GP to accept them. Forcing is a very strong word, but they can't appoint one there.”

Difficulties Getting GP Appointments

Even patients who are registered with a GP reported challenges with availing of primary care services. Several patient survey respondents had experienced difficulties with seeing their GP due to lack of available appointments, either at all or at suitable times. One such patient stated that they suspect that they may have cancer but cannot investigate this due to their inability to book an appointment with their GP. Some patients were instead offered phone consultations, highlighting that these are not always a suitable alternative. With regards to timing, patients noted challenges in aligning their appointment with public transport and their other commitments.

One patient survey respondent stated that when they were unwell, their GP's availability "did not suit [their] student schedule so [they] decided to take over the counter medications". Another had "registered with about 5 GPs because of poor experiences or lack of availability", disrupting continuity of care and relationship-building with their doctor. Other participants similarly reported changing their GP due to the unsuitability of their previous GP to their needs.

3.2.12 Resources and wait times

Immigrants Face Long Wait Times When Accessing Healthcare Services

Wait times to access healthcare were identified as a barrier by approximately 80 of the 188 patient survey respondents who had left a qualitative comment and over half of the interviewed participants (see Appendix 25). This was tied to the topic of resources, with some respondents highlighting insufficient funding and shortages of HCWs as contributing to these delays. Long wait times were reported across all aspects of healthcare - GPs, specialist doctors, diagnostics, and generally across the system.

Some specific examples of wait times experienced by patients included: six months for a kidney biopsy which resulted in a diagnosis of cancer; six months for a neurologist; 18 months for an orthopedist; 24 months for cataract surgery; three years for a "general surgical procedure"; six months for an ultrasound; a year for a multiple sclerosis specialist; 40 days for blood tests; 30 months for occupational therapy and speech and language therapy; nine months for a dermatologist; one year for an endometriosis specialist; three years for an MRI; and three years for postnatal gynaecology. Some of these patients were still waiting for their appointments at the time of their participation. Other examples of areas described as having long wait times included adult ADHD and ASD assessments, ultrasounds, breast screenings, CTs, ambulances, psychotherapists, psychiatrists, general gynaecologists, endocrinologists, and genetic testing.

Long Wait Times are Cited as the Major Reason to Travel Abroad to Access Healthcare Services

These long wait times were cited as a major reason for patients' decision to travel abroad to access healthcare. In fact, one interviewed patient reported being advised by their GP to travel home to seek certain services, partly due to long waiting lists and partly due to certain services not being available in Ireland at all. Some patients emphasised that while wait times may be tolerable for some non-urgent medical problems, they are unacceptable for people with serious illnesses, with a few participants explicitly stating that patients may die before they receive an appointment. A number of participants reported stress, anxiety, and avoidance of healthcare due to the long waitlists. One interviewed patient described the experience of waiting for an appointment concerning possible cancer:

> "[My GP] said, 'don't worry about it, this can be nothing' but I will have to refer you [for further testing]. And I remember that I waited more than one month. And for me, it was terrible. I waited more than one month for an appointment, wondering what it can be."

One patient survey respondent expressed that they feel their needs are not urgent enough to warrant utilising an over-extended healthcare system, when, in their eyes, others may need it more:

> "I avoid accessing health care because I know so many are in more urgent need, but I would like to be able to attend my doctor without it being an emergency, i.e. to get a check on things that worry me."

Some interviewed patients expressed additional frustration and confusion at the existence of equally long waitlists for private care across some areas. Participants expressed that while waitlists are to be expected, they should not be as long, and patients who are able and willing to pay for private care should be seen quicker.

Comparisons were drawn between the Irish system and patients' home countries, where waitlists are shorter in general and even non-existent for private care.

Wait times were also discussed in terms of the length of time a patient needs to wait to be seen on the day of their appointment. It was noted that this can cause difficulties for patients who are in employment and need to take time out of work to attend appointments, as they cannot accurately estimate how long they will have to leave for. One interviewed patient, who is a carer, described the challenges faced when attending appointments with their child with additional needs, who can become "aggressive" or engage in self-injurious behaviour if they have to wait for long. Another patient, who had received cancer treatment, spoke of the emotional toll of waiting up to four hours for their appointment, surrounded by other cancer patients:

> "It's a drain of energy, you will leave feeling like you will die the next day. It's terrible. Because you see the people really struggling, sick there. And so you will start to overthink when you are waiting." (Interviewed patient)

Some participants understood these long wait times as resulting from underfunding of the HSE and a shortage of HCWs in Ireland, with a few patients particularly emphasising the shortage of narrow specialists (e.g. endometriosis specialists).

One patient survey respondent questioned whether "people in [this] country do not want to be doctors" or "they want to, but don't have the opportunity". Another patient spoke of emigration among Irish HCWs, with the understanding that some choose to do so due to the pressure on the Irish healthcare system and associated stress levels among HCWs. A lack of physical healthcare infrastructure, such as clinics and hospitals, was also noted. Aside from long wait times, patients felt that the shortage and resulting over-working of HCWs contribute to their poor attitudes towards patients and the quality of care they have received (see Section 3.2.7 Service Provider Factors regarding patient attitudes regarding care quality).

3.3 Community and Informal Supports in Enhancing Healthcare Access

The literature review summarises the comprehensive healthcare and cancer support programmes which immigrants to Ireland may access. A number of these supports were mentioned specifically by research participants in surveys, interviews or both. Those include general and targeted healthcare supports (e.g. medical cards), interpreting and translation services (e.g. through some hospitals and specialised health services immigrants and other marginalised groups), immigrant specific health units and NGOs targeting immigrants' needs (e.g. Crosscare Migrant project, Nasc, Immigrant Council of Ireland).

Cancer-specific supports which were identified as being useful by participants included the National Cancer Screening Service, the multilingual resources provided by the ICS, psycho-oncology services.

As detailed in the previous sections, survey and interview participants mentioned informal supports which have been provided on an ad hoc basis to support immigrants (e.g. interpretation and translation by multilingual staff), financial support for costs (e.g. clothing, food or travel), and help from family resource centres or other community organisation in completing medical card and other paperwork.

While existing supports address many challenges immigrants face in accessing healthcare (e.g. language barriers, cultural differences, financial constraints, and lack of awareness), their implementation is not consistent across all providers and regions. Specialised services, used to provide health services to immigrants and have processes in place to reduce the structural barriers, are invaluable and serve as examples of how equitable healthcare can be provided in Ireland (e.g. see the section on no/low threshold services).

These supports already address many of the challenges immigrants face when accessing services:

- Language Barriers: professional interpreters and multilingual resources (e.g. Balseskin Health Screening Centre, Cairde and Safetynet Primary Care).
- Cultural Sensitivity: training healthcare workers and fostering culturally appropriate care (e.g. HSE and some specific healthcare providers).
- Financial Constraints: access to medical cards, reduced-cost services, and transport support (e.g. HSE, Dublin Wellwomen's Centre, HSE and Safetynet Primary Care).
- Community Organisations: outreach and education initiatives to inform immigrants about healthcare entitlements and services (e.g.Citizens' Information, Family Resource Centres, and Nasc).

3.4 Summary List of Immigrants' Needs

- Awareness raising (e.g. cancer screening services, prevention, etc.)
- Culturally competent providers and structures
- Enforcement of anti discrimination policies in a healthcare settings
- Financial support regarding additional needs around accessing medical appointments (e.g. cost of child care, transport, etc.)
- Immigrant peer workers
- Improved public transport links
- Language and communication supports in all health care settings
- Professionalisation and certification of interpreters
- Promotion of ICS supports (e.g. support line, children's fund, etc.)
- Provision of adequate and stable housing
- Reduce paperwork needed for medical card and GP card applications
- Reduction in barriers due to immigration status
- Shorter waiting lists
- Supports and services that reduce overall stress
- Trauma informed mental health supports

4. DISCUSSION

4. 1 Supporting Service Access for Immigrants

Global Recognition of Immigrant Health Inequalities

It is widely recognised that some immigrants face significant barriers in accessing healthcare services and that these disadvantages may result in adverse outcomes. In this study, significant differences between survey participants and the general population indicate that immigrants are more at risk of health inequalities (e.g. health entitlements vs. health insurance). Understanding cultural differences is crucial for effective healthcare delivery. Healthcare systems are able to reduce discomfort, harm or misunderstandings experienced by immigrants by being culturally sensitive (Latif, 2020). As such, some policies and processes have been put in place to address the issues around service accessibility.

A recent international study of primary healthcare innovations to improve access to healthcare for vulnerable populations indicated that many programmes in place focused on the supply side or structural innovations. However, there was little evidence of demand side innovation (i.e. programmes which aimed at increasing knowledge or awareness amongst target populations (Richard et al., 2016)). Richard and colleagues suggest, however, that it is important to engage both with service providers and users in order to improve health literacy and engagement with healthcare services. The WHO recognises community engagement as a key strategy to tackle health inequalities (Cork Cancer Action Network, 2017). National level strategic policy documents acknowledge the importance of fostering community engagement in order to achieve positive health outcomes for health service users from a range of diverse ethnic and cultural backgrounds. The role of community and voluntary organisations is one of ten guiding principles which shape the Second National Intercultural Health Strategy, 2018-2023 (Health Service Executive, 2018).

Community Integration is also a key pillar of the Migrant Integration Strategy 2017-2020 (Office for the Promotion of Migrant Integration, 2019).

National level strategic policy documents acknowledge the importance of fostering community engagement in order to achieve positive health outcomes for health service users from a range of diverse ethnic and cultural backgrounds. The role of community and voluntary organisations is one of ten guiding principles which shape the Second National Intercultural Health Strategy, 2018-2023 (Health Service Executive, 2018). Community Integration is also a key pillar of the Migrant Integration Strategy 2017-2020 (Office for the Promotion of Migrant Integration, 2019).

A number of studies on cancer screening recommend that partnerships with community-based organisations be fostered (Seay et al., 2015) and research has shown that health promotion programmes for ethnic minorities can be successfully implemented through partnership with faith-based organisations (Islam & Patel, 2018). Research in Australia found that a culturally appropriate education programme implemented with a number of culturally and linguistically diverse communities was effective in improving knowledge and attitudes about cancer screening (Cullerton et al., 2016). As stated previously, some immigrants to Ireland may also be ethnic or linguistic minorities and the use of such targeted, community based interventions may also be useful to reduce some of the cancer inequalities which immigrants in Ireland may be experiencing.

Improving Health Literacy Through Diverse Communication Channels

Improving health literacy amongst minority groups has been identified as a strategy for combating inequalities in cancer outcomes (European Cancer Organisation, 2022b). This includes the provision of navigation assistance (i.e. enabling immigrants to learn about the types of services that are available and how to access them). The need for awareness programmes tailored to the needs of minority groups, which are culturally and linguistically appropriate is well recognised.

Health literacy can be improved through the use of a variety of mediums, including pamphlets, posters, digital communications and face-to-face education. Research has highlighted the benefits of a range of strategies to disseminate information about cancer and improve screening rates, including digital/online (Cha & Chun, 2021; Fang & Ragin, 2020), physician-led face-to-face (Lei et al., 2022) and video based (Ornelas et al., 2018) interventions.

The preferences or learning styles of specific immigrant groups in relation to knowledge acquisition may vary, and thus the specific approach taken must be considerate of the cultural preferences and linguistic abilities of the target audience. For example, one study in Australia found a preference for spoken rather than written advice and a desire for the use of illustrations and charts amongst Arab immigrants in Australia (Alananzeh et al., 2019). While in Norway, a community-based intervention to increase cervical cancer screening amongst Somali and Pakistani immigrants found that participants had a preference for information to be delivered through a seminar format and that approximately 30% of the participants were unable to read or understand written documents in the form of letters, posters or brochures (Qureshi et al., 2019). In relation to information seeking behaviour, a study on liver cancer conducted in Australia illustrated that while Vietnamese speakers relied on information from their healthcare providers, other respondents (English, Cantonese, and Mandarin speakers) often used the internet to source information (Robotin et al., 2017).

Targeted Outreach Programmes

The benefits of outreach initiatives which provide information and screening services in non-traditional settings have been established. For example, provision of oncology services targeted specifically at immigrant populations (e.g. outpatient clinics) can lead to increased engagement (Casolino et al., 2017). A recent review of studies aimed at improving access to cancer screening amongst immigrants in the US concluded that the availability of non-clinic based screening programmes could be beneficial in increasing participation (Fang & Ragin, 2020).

The utilisation of a call-back service to increase participation in screening programmes has proven successful for improving screening rates for colorectal, breast and cervical cancer amongst Black and immigrant communities in Canada (Nnorom et al., 2021).

Healthcare service-focused initiatives

Evidence suggests that improving knowledge of immigrant health issues amongst GPs can improve health of immigrants (Møen et al., 2020) and in relation to cancer care in particular, research points to the need to provide education to healthcare providers regarding the adverse cancer outcomes for minorities and immigrants (Huhmann, 2020; Nnorom et al., 2021).

Research shows that prompts by healthcare professionals regarding cancer screening are significant in determining attendance at cancer screening (De Jesus et al., 2021). Education sessions and evaluations of the delivery of cancer screening information with healthcare providers can lead to increased uptake of screening services (Lei et al., 2022).

Facilitated written and oral communication within healthcare settings has also been shown to be a need for some patients. The lack of which is an obvious barrier to those patients not fluent in English when communicating with health care professionals. Patients may be encouraged to bring a family member, friend or colleague with them when attending appointments. However, the benefits of trained interpreters (e.g. increased trust between immigrants and service providers) in healthcare settings have been identified in the Irish context (Puthoopparambil et al., 2021).

Structural and Practical Supports

In order to address problems in access to cancer services, it is necessary to remove financial barriers for minority groups. This could include widening access to free healthcare, for example through universal entitlement or social insurance (Seay et al., 2015; Tong et al., 2022). Research indicates that the countries which have been most successful in implementing healthcare interventions to support refugees are those with a strong foundation in universal healthcare (Sullivan et al., 2019).

Various studies highlight the importance of financial and logistical supports for immigrants in order to facilitate engagement with cancer care services (Casolino et al., 2017). Practical supports, such as providing a straightforward path to access primary care with ongoing interaction with healthcare professionals, as well as assistance with transport, financial aid and child care assistance, would ensure patients can engage with treatment (The Lancet Editorial, 2021).

4.2 Improving Health Care and Cancer Care Access for Immigrants: Current Initiatives in Ireland

In the Irish context, there is little evidence of research which focuses specifically on the cancer care needs of immigrants. However, a recent national study on ethnic minorities and mental health in Ireland emphasised the need for communication and language supports, respect for diverse cultural beliefs and values, involvement of advocates and family and the need for training for healthcare providers (Mental Health Reform & Mental Health Commission, 2021). These issues mirror the discussion above of international literature relating to strategies to improve cancer care for immigrants.

There is some evidence of a national level strategic approach to improving immigrant health. At present, the HSE partners with various NGOs to help disseminate information to immigrant groups about their entitlements, including Crosscare, Cairde, Safetynet Primary Care and the Immigrant Council of Ireland. The development of links with key interest groups is a key strategy to improve knowledge in the community about immigrant health (Ledoux et al., 2018).

Each department within the HSE is responsible for ensuring that its materials are accessible to patients (be it through interpreters or translating materials). However, to the authors' knowledge until recently such provisions were not always being made. Large number of immigrants from Syria were provided with an Arabic guide to the Irish Health System as they were a part of the resettlement programme. In addition, the Cork-Kerry Resettlement Initiative has been developing extensive online resources over the last few years in English, Arabic and a variety of languages to support the large number of international protection applicants, beneficiaries of temporary protection and other immigrants who have moved to CHO 4 (Cork Kerry Community Healthcare, 2022). The recent launch of accessible information on healthcare entitlements for immigrants was publicised in the media and online platforms, (CrossCare, 2022; European Website on Integration, 2019; Health Equity, 2022; Hoare, 2022) for example My Health My Language, gives a broad overview of some of the key areas where health care need has been identified.

In 2009, the HSE published an "Intercultural Guide" aimed at informing health care staff about some of the major ethnic and religious groups coexisting in Ireland (Health Service Executive, 2009). Information is not available on how this guide has been used within the health service or how many staff have availed of the intercultural training on HSEland. However, some service providers said that they were aware of it during interviews conducted during this study.

The Partnership for Health Equity, an alliance of stakeholders from academia, the HSE, and healthcare planners and practitioners, focuses specifically on immigrant health as a core area of interest. The Partnership aims to contribute to health equity through research and education which will influence healthcare policy and practice.

While the WHO underscores the importance of engaging communities in health decision making processes, immigrants are significantly underrepresented in healthcare research, policy and service development in Ireland and other European countries (MacFarlane et al., 2021). Recent work in Ireland takes a participatory research approach, emphasising the importance of engaging immigrants in efforts to improve healthcare service provision. This involves engaging immigrants in the identification of research priorities (MacFarlane et al., 2022; Roura et al., 2018; M. Roura et al., 2021) and in implementing programmes to improve access to healthcare for immigrants, particularly in primary care settings (Hannigan et al., 2018; M. Roura et al., 2021; Teunissen et al., 2017). The World Music Café (MacFarlane et al., 2022; University of Limerick, 2021) is one example of participatory research which aims to improve immigrant health through the identification of research priorities.

There is little evidence of a coordinated national approach to cancer care for immigrants. There is, however, some evidence of cancer care initiatives targeted at specific immigrant groups. The Marie Keating Foundation has partnered with the Roscommon LEADER Partnership to improve health literacy amongst Syrian women, through the development of culturally and linguistically appropriate and accessible information leaflets on cancer. In response to the arrival of immigrants from Ukraine the Irish Cancer Society set up a dedicated page with Cancer Information for Ukrainians.

With regards to information provision, the HSE compiles a range of translated healthcare-related resources across two sources: *My Health, My Language;* and the Translation Hub, managed by the National Social Inclusion Office. As part of these resources, the HSE has also prepared a guide to the healthcare system for refugees and other immigrants.

With regards to cancer care in particular, a number of resources surrounding cancer screening services have been made available by both the HSE and other organisations, some of which are linked in the Translation Hub and others available elsewhere. An overview of these resources is provided in Table 3.

Table 3. Overview of available non-English-language resources on cancer screening and care (valid as of November 2024).

Resource	**Cervical screening information videos**	**Cervical screening information sheets and screening forms**[13]	**Bowel screening information videos**	**Breast screening information videos**	**Breast screening guides**	**Information on cancer for people from Ukraine**
Format	Video	Leaflet, form	Video	Video	Guide	Factsheets
Source	CervicalCheck	CervicalCheck	BowelScreen	BreastCheck	BreastCheck	Irish Cancer Society
Available languages/ resources	Albanian	Arabic	Albanian	Albanian	Irish	**Ukrainian:** Bowel cancer Breast cancer Lung cancer Prostate cancer Chemotherapy Chemotherapy side-effects Radiotherapy External radiotherapy Internal radiotherapy Radiotherapy side-effects Palliative care
	Arabic	Bengali	Arabic	Arabic	Russian	
	Bengali	Chinese	Bengali	Bengali	Ukrainian	
	Croatian	Croatian	Bulgarian	Bulgarian		
	French	Filipino	Croatian	Croatian		
	Irish	French	Dutch	Dutch		
	Latvian	Georgian	Filipino	Filipino		
	Lithuanian	German	French	French		
	Mandarin	Hindi	Hindi	Hindi		
	Pashto	Irish	Hungarian	Hungarian		
	Polish	Latvian	Italian	Latvian		
	Portuguese	Lithuanian	Irish	Lithuania		
	Romanian	Polish	Lithuanian	Pashto		
	Russian	Portuguese	Mandarin	Portuguese		
	Slovak	Romanian	Pashto	Romanian		

---

[13] From the CervicalCheck website: "These documents are to aid you in explaining what cervical screening is to participants where English is not their first language. However, you must use the English screening form when you are submitting the screening sample. ... If you would like to suggest a language the forms should be translated into, please email communications@screeningservice.ie."

	Somali	Russian	Polish	Russian		Emotional effects
	Spanish	Spanish	Portuguese	Slovak		
	Swahili	Ukrainian	Romanian	Somali		
	Ukrainian	Urdu	Russian	Spanish		
	Urdu		Slovak	Swahili		
	Yoruba		Spanish	Ukrainian		
			Swahili	Urdu		
			Ukrainian	Yoruba		
			Urdu			
			Yoruba			

Source: TASC, 2025

4.3 Enablers Facilitating Service Access and Experience

This report has reviewed the programmes, services, government policies, legislation and barriers affecting immigrants' residency and healthcare entitlements. Studies from Ireland and abroad repeatedly show that access to healthcare does not equate to equity in care, thus indicating that it is not sufficient to simply ensure that the structures of healthcare services are present. It is also necessary to consider various routes and support structures that allow for the usage of services in order for the experiences of patients and providers to be equitable and to reduce health inequalities. In other words, the quality of care received is the same for all residents of Ireland regardless of characteristics such as nationality, country of origin, race, ethnicity or religious beliefs, and is culturally and linguistically appropriate.

As stated previously, immigrants are not a homogenous group and within and between immigrant communities there can be significant differences in access to healthcare. With the additional factor of time spent in residence potentially influencing the way that they interact with healthcare professionals. The importance of taking a multifaceted approach to examining ethnicity and cancer health outcomes is recognised, with the interplay of individual, behavioural, socioeconomic, geographic, and infrastructural factors (amongst others) influencing outcomes (Zavala et al., 2021).

A number of service providers have found ways to enable access to health and cancer services for immigrants. Some of these enablers use existing structures in place already for individuals with low income. However, many of these solutions are conducted on a micro level and affect proportionally a small number of immigrants or only those immigrants accessing a certain service. Expanding such initiatives nationally would be of benefit to both patients and healthcare workers.

No/Low Threshold Services

No/Low-threshold health services are accessible, barrier-free healthcare options designed to reach marginalised populations by minimising requirements for entry (e.g. referrals, appointments, or fees). Safetynet Primary Care and the Dublin Wellwomen's Centre are some examples of such programmes, which by decreasing barriers to access open their doors to support a range of individuals who would not otherwise be able to access health services.

Language, Interpretation & Communication

In both the patient survey and interviews with patients and service providers, language barriers and more extensive communication challenges emerged as significant hurdles to accessing healthcare and information about available services. Concerning the language barrier, patients cited various specific elements causing difficulty, including challenges understanding the terminology employed by healthcare workers (both medical and non-medical), healthcare workers speaking too rapidly, struggles with comprehending healthcare workers' accents, and instances where patients felt their English proficiency was not fully understood by healthcare workers.

This research found that the lack of information provided in a language and/or a format which was accessible to patients by recognised bodies caused patients to be unclear of where to turn to for information. Of particular concern are patients who do not read or understand English to a level adequate to understand written material provided by healthcare workers.

Translation

Apart from the written information provided by the HSE on their website, immigrants have the opportunity to obtain information from a variety of sources, such as Citizens Information, Area Partnerships/Local Development Companies, and numerous non-governmental organisations. However, the official HSE website does not provide translations of the information contained on their website[14]. Thus, the detailed information available directly from the HSE is only available to those who read and comprehend English at a high enough level. Service providers stated that they had found My Health My Language, and other translated information helpful for providing general guidance and support to non-English speaking patients. As such various public hospitals, NGOs and community organisations work constantly to put together translated materials to support patients and clients.

The National Screening Service and the Irish Cancer Society have recognised the need for translations of important information on cancer care, as demonstrated by the amount of translated materials available (see Table 1). The availability of such materials benefits those linguistic groups who can access them and reduces the strain on healthcare workers. However, there are additional language groups which have been excluded from these benefits and have expressed that they would prefer to be able to access linguistic support when interacting with healthcare workers (this study).

---

[14] However, this is also true for Irish. (See the Official Languages Act 2003 and 2021).

Interpretation

The routine use of paid professional interpreters in some healthcare settings is best practice. Some healthcare providers (e.g. HSE's Balseskin Health Screening Centre and SafetyNet Primary Care), commonly working with immigrants have made special arrangements to reduce the barriers to accessing their services: hiring multilingual staff and hiring interpreters. However, it is not clear how often professional interpreters are used in general primary care settings and hospitals.

The Irish Translators' and Interpreters' Association was requested to review the codes of ethics of the associations of medical professionals to determine if they mentioned or encouraged the use of trained interpreters (Puthoopparambil et al., 2021). In addition, there is no published information on the extent to which informal or alternative forms of communication are being used in medical settings. Therefore, it is difficult to assess how many immigrants are being affected by the lack of access to interpreters.

However, the response to the arrival of BOTPs from Ukraine provides a clear indication that the need for interpreters in healthcare settings are needed (e.g. Working with Ukrainian and Russian Speaking Interpreters). In addition, the HSE National Social Inclusion Office has also produced general training on working with interpreters. However, the progress towards paid professional interpreters is unclear and there are multiple ethical issues that also need to be considered. The Association of Translators and Interpreters Ireland code outlines best practices in community interpreting, guiding users on what to expect and interpreters on professional conduct. Additional considerations may be found in Moorkens and Rocchi's (2020) article on ethics in the translation industry.

Finances and Economic Challenges

Costs and financial concerns came up repeatedly for research participants: currently high cost of living, medication, transport, costs of special diets and heating costs.

Patients often skipped appointments, or only attended emergency services in order to avoid the costs of attending GP surgeries.

Of additional interest is the cost of treatment. Although the specific costs of cancer treatment was not covered in this research, stakeholders brought up the costs of medications that may still need to be paid by patients, whose medications might not always be covered by schemes. Under the current system, a DP resident who is dependent on social welfare payments would be unlikely to be able to afford the cost of multiple medications without additional support. As highlighted in the literature review, the cost of some prescriptions may be reimbursed or capped, however the number of people benefitting from these schemes is not clear and extension on them may be necessary.

Transportation

A number of issues around transportation were raised. Access to adequate public transportation was a systemic assumption. However, this is not always the case, with some individuals living far from train and bus routes, thus requiring personal transport to get to appointments.

Where public transportation was not possible the cost of transportation was high for patients, the cost of fuel for their own vehicle, paying a friend/family member's costs to drive them to an appointment or paying a taxi. For some patients, taxis were frequently used as they were immunocompromised or struggled with chronic conditions that did not allow them to stand up for long periods of time or walk to a bus stop.

The Irish Cancer Society Transport Service was mentioned in both surveys and interviews as a useful service that supported patients' transportation needs. Other supports mentioned was the use of providing travel vouchers for use on public transport.

Nutrition

Access to nutritious food and lack of cooking facilities came up during a number of interviews with patients and service providers–particularly in reference to those immigrants living in direct provision centres which may not have access to their own cooking facilities or those facilities may be overcrowded. There are a variety of community services located all over Ireland that work towards supporting those experiencing food insecurity (e.g. Crosscare, Feed Cork, The Lighthouse, and a host of other soup kitchens and pop-up food banks).

Regularisation and Reducing Barriers of Legal Status

The changing regulations and lack of clarity among frontline staff supporting immigrants means that trusted individuals may be giving conflicting information. In addition, we heard evidence that some businesses have been taking advantage of the lack of clarity and lack of trust that some immigrants might have of conventional Irish institutions in order to take financial advantage of vulnerable immigrants (e.g. regarding regularisation).

People with irregular legal status have been known to avoid accessing services which may result in them being drawn to the attention of authorities. They may fear deportation or legal consequences and this could prevent them from seeking medical care, even in emergencies. For example, the story of Catherine, who was undocumented and diagnosed with terminal cancer, which may have been caught earlier if she had availed of screening. Such avoidance behaviour and endurance of hardship may lead to untreated health conditions that could have severe consequences to the patient (Sabates-Wheeler, 2009).

Certainly, the Department of Justice's "Regularisation of Long Term Undocumented Migrants Scheme" may be able to reduce the overall numbers of individuals with irregular paperwork to becoming legal residents of Ireland.

However, it is not clear if regularisation on its own will be enough to encourage people to come forward and access health services.

5. POLICY RECOMMENDATIONS

Meeting the healthcare requirements of immigrants in Ireland necessitates a comprehensive strategy to guarantee fair access and culturally competent and sensitive healthcare. The following are a set of recommendations to progress towards achieving these goals. Recommendations are categorised into sections based on relevant actors.

Irish Cancer Society

1. Translation of Online and Offline Written Resources

ICS should advocate for translated and plain English documents and websites that match English versions (e.g. for cancer screening services, medical supports, and social welfare). ICS should also advocate for resources to address literacy and numeracy needs through diverse formats, including written, audio, video, captions, and sign language interpretation.

2. Cultural Competency Training

ICS should advocate for the HSE to engage with stakeholders on delivering cultural competence training for healthcare professionals to enhance understanding of diverse cultural backgrounds. This training should focus on the awareness of barriers, addressing cancer-related stigma and end-of-life care in culturally sensitive ways that honour patients' traditions and wishes.

3. Community Outreach and Education

ICS should conduct outreach programmes to educate immigrant communities about cancer care and screening services available, the importance of preventive care, and how to navigate the healthcare system in Ireland. This can be achieved through community workshops, information sessions, and collaborations with community organisations and can have a significant impact on uptake in immigrant communities that are unaware of ICS's work or have expressed concerns around uptake of services. For example, reaching out to women preferring female healthcare staff and women experiencing female genital mutilation about cervical screening to address their concerns and counter myths. Also, the option of asking for or offering the use of a smaller speculum should be considered more widely. These programs must be accessible in terms of language needs and provided at a range of times, such that those in employment can avail of them.

4. Awareness-raising Campaigns

ICS should carry out awareness-raising campaigns with immigrant communities to promote the work of smoking cessation supports, cancer screening and cancer care services. Campaigns should be targeted and relevant community organisations should be consulted to ensure that they are culturally sensitive and linguistically appropriate. These campaigns should address fears and stigma surrounding cancer and raise awareness of available services.

5. Funds for supporting those in Financial Need

ICS should look to support and advocate for increasing the DP payment as well as other social welfare payments (e.g. DA and Carer's Allowance). Findings from this research hint that some immigrants are more vulnerable to financial hardships because of the lack of an extended network which they can rely on in times of need. As of yet, it is not clear that the Irish government takes this into account when determining welfare payments and allowances.

The Government needs to look towards broadening the availability and accessibility of funds in public hospitals which would be dedicated to assisting financially vulnerable patients. This would benefit all patients in financial need (regardless of background) and resources can be administered by social workers who are already assessing need and supporting patients. Currently, not all public hospitals have access to such funds and may be reliant on donations.

6. Promotion of the Irish Cancer Society Transport Service

The existing Irish Cancer Society Transport Service has supported immigrant patients in accessing services. ICS could conduct an internal assessment of the service, with an eye to accessibility to the needs of immigrants. Information from this research indicated that the provision of services in multiple languages and that promoting the service to known Direct Provision Centres would be helpful in increasing the visibility of the service amongst some marginalised immigrant communities.

7. Research into the Cost of Cancer Treatment

ICS is well placed to conduct or commission research on the cost of cancer treatments for immigrants. This research should incorporate information from all stakeholders, with special attention made to the secondary costs to the patient (e.g. prescription medications not reimbursed by PCRs, childcare, transportation, lost wages, etc.).

8. Extend Affordable Transportation Options

ICS to continue to liaise with the Department of Transport and local authorities to promote the extension of accessible and affordable public transport links to allow patients in rural areas to travel more easily to medical appointments. This may involve either public, or low cost private transport options.

ICS to continue to support expanding access to subsidised transportation services for cancer patients and other patients with chronic and long-term health conditions who may be unable to access public transport or for whom accessing public transport is a health risk.

9. Inclusive Implementation of Sláintecare

ICS needs to highlight the continued needs of immigrants in relation to the full implementation of Sláintecare. Specific challenges faced by immigrant communities, such as language barriers, cultural differences, financial constraints, and gaps in awareness of healthcare entitlements, must be addressed explicitly to ensure equitable access under this system.

ICS can play a pivotal role by advocating for immigrant-inclusive policies within Sláintecare and ensuring that healthcare reforms accommodate diverse needs. For example, Sláintecare's focus on integrated care pathways and community-based services offers opportunities to expand culturally sensitive programmes and interpreting services, which are critical for effective cancer care delivery.

Additionally, the ICS should engage in assessing how Sláintecare's implementation will affect its services, including psycho-oncology support and multilingual resources.

10. Promotion and Enforcement of Administrative Standards

ICS to encourage the HSE to require and enforce the use of administrative standards for collecting data on immigrant variables (e.g. ethnicity and language) in order to allow for comparisons of administrative healthcare databases to national trends. The use of standard demographic categories should also be utilised for all vulnerable groups as outlined by the Equal Status Acts.

11. Collaboration with Community Organisations

ICS to engage in collaborative efforts with immigrant and community organisations to gain insights into effective messaging campaigns.

These partnerships can strengthen outreach initiatives and support the creation of focused healthcare interventions.

Particular attention should be paid to organisations which are immigrant-led.

12. Policy Advocacy

ICS should advocate for cross-departmental policies that promote inclusive healthcare practices, eliminate barriers, and address the unique needs of immigrant populations. This may involve collaborating with policymakers to ensure that healthcare systems are responsive to diverse communities. Recognise that barriers to accessing healthcare cannot be addressed exclusively through healthcare policy. Efforts to alleviate these barriers must include areas such as social welfare, transport, immigration policy, housing, and childcare.

Various Government Departments and Other Organisations

13. Implementation of Unique Identifier

The Department of Health (DOH) and HSE need to put the necessary structures in place to fully deliver on the Individual Health Identifier, as introduced in the 2014 Health Identifiers Act. Having set standards and a mechanism for personal health information and individual level demographic variables, such as citizenship, would support health service provision.

14. Streamline Medical card and GP card applications

HSE to make IP applications for medical and GP visit cards more accessible, as had been provided for BOTPs: abbreviated length and multiple language versions.

15. Translation of Online and Offline Written Resources

The HSE, DSP and other relevant government bodies to ensure the availability of translated documents, equivalent to those available in English, to aid patients accessing information about services.

Application forms for social welfare, medical cards, and related supports should be shortened and written in plain English to ensure that all those who need to avail of these supports can do so. Some abbreviated forms already exist and should be made available to all, as at present these can only be utilised by specific populations. The existing availability of some translated materials on screening services is positive but should be expanded to a greater range of languages.

The provision of both English-language and translated resources should account for patients' literacy and numeracy needs by using a wide range of media, including written, audio, and video resources, providing captions and sign language interpreters where appropriate.

16. Cultural Competency Training

The HSE, in alignment with the HSE's National Cancer Control Programme to meet with stakeholders regarding the delivery of training in cultural competency to healthcare professionals, aiming to deepen their comprehension of diverse cultural backgrounds. Emphasise the importance of effective communication, fostering respect for cultural differences, and cultivating awareness of potential cultural barriers. Cultural issues surrounding cancer, such as fears or stigma, should be attended to. Training should also extend to navigating matters of end-of-life care and death in a manner that is culturally sensitive and respects patients' wishes, traditions, and cultural norms.

Addressing this recommendation would be in alignment with the combined promises of the HSE's Second Intercultural Health Strategy 2018-2023 as well as Sláintecare.

17. Regularisation of Undocumented Immigrants

The Department of Justice (DOJ) should assess the ease of access, efficacy and refusal rate of the Regularisation of Long Term Undocumented Migrants Scheme, with the goal of making future schemes available to immigrants already residing in Ireland.

18. Stability of Private Accommodation for those in Direct Provision

DCEDIY needs to stabilise accommodation for immigrants living in DP centres. The accommodation should be suitable to the needs of the individuals' circumstances and health status, rather than their country of origin.

19. Provision of Nutritious Food to those in Direct Provision

Where DP accommodation is deemed necessary, DCEDIY should ensure that catering attends to residents' cultural traditions and healthcare needs (e.g. food type, nutrient value and timing of meals). Where this is not possible, adequate and accessible self-catering facilities should be provided which allow residents to tend to their own nutritional needs.

20. Interpreter Services

The DOH should guarantee the presence of professional interpreter services in healthcare environments to enable adequate communication between healthcare providers and patients with limited English proficiency. This enhances the precision of diagnoses and treatments, supports informed consent, and reduces the use of informal interpreters. Interpreters should be trained to work in a healthcare setting and be garda vetted.

Cultural competency and sensitivity as well as patient preferences are also important to consider in the provision of interpreters. Those performing in an in-person capacity could thus also act as cultural liaisons/mediators between patients and healthcare workers to support the cultural competency training mentioned above.

Access to interpreters should be adequately funded by the government for all public health services.

21. Culturally Tailored Health Services and Information

The HSE should further develop and distribute health information materials that are culturally sensitive and linguistically appropriate, this information should not be left to community organisations to provide. Diverse cultural and ethnic groups have unique approaches to addressing matters of ill health. Providing culturally appropriate information and messaging tailored for each target group is essential to reducing stigma associated with some forms of illness, such as cancer. The use of cultural representatives/peers in the development of such materials would be the most appropriate and in alignment with HSE principles (see HSE, 2015).

22. Accessible and Inclusive Health Facilities

The DOH should ensure that all primary care and public health services are accessible and inclusive to the public, including immigrants. The HSE should guarantee the accessibility and inclusivity of public healthcare facilities by offering materials in multiple languages, catering to diverse dietary requirements, and establishing welcoming environments that honour cultural norms and practices. Where cultural norms are unable to be followed for scheduled procedures due to staff availability, patients should be notified in advance of attending the appointment and, as much as possible, supported in making alternative arrangements.

Accessible and inclusive primary care services should include healthcare professionals who have experience working with immigrants. Considering the current geographic spread of IP applicants and other vulnerable immigrants, time should be allocated to identify parts of the country which would benefit from specialised, low barrier services.

As demonstrated in the international literature and requested by patients interviewed in this study, cancer screening clinics could be set up specifically to cater to gender norms and preferences for target groups. Cervical and breast screening services in particular must be trauma-informed, operated by staff trained in supporting patients who have experienced sexual trauma and female genital mutilation (also see suggestion on Regular Health Screenings).

23. Expand the use of Community Health Workers

The Department of Health and the HSE should utilise community health workers or liaisons from immigrant communities to act as intermediaries connecting healthcare providers with immigrants. These individuals can play a crucial role in helping navigate the healthcare system, offering information, and providing essential support. Peer immigrant community health workers and liaisons can also aid in bridging the linguistic and cultural gaps and barriers which discourage and prohibit immigrants from accessing care.

24. Regular Health Screenings

The DOH and the National Screening Service should implement regular health screenings within immigrant communities (e.g. DP centres) to identify and address health issues at an early stage. For example, screening clinics set up at DP centres could be set up to promote general health supports and HSE funding programmes (e.g. smoking cessation), along with ICS community (e.g. nurses and Roadshow events) and online resources, to target groups.

This could also be done through hosting mobile clinics and health fairs at local community organisations and providing specific linguistic support.

25. Childcare services

The DOH should work alongside other government departments to allocate funds and other resources to support parents and legal guardians of dependents in attending medical appointments. Establishing childcare services within public hospitals would enable families to access essential healthcare, particularly for individuals with chronic conditions like cancer who require regular visits.

More broadly, research should be conducted on the feasibility of providing access to affordable childcare to all children under the age of 6. This initiative would help improve healthcare access for families, reduce missed appointments, and contribute to better health outcomes.

26. Mental Health Support

The DOH should prioritise the mental health needs of immigrants by recognizing and addressing the unique stressors they face, particularly those linked to migration and ill health. This involves investing in culturally competent mental health services that can address these specific challenges effectively. Mental health support for immigrants should also integrate smoking cessation and cancer prevention services, recognizing the link between stress, poor mental health, and habits like smoking. Additionally, the Department should consider cultural perspectives on cancer, as immigrant populations may experience this differently, necessitating targeted mental health support to improve overall well-being and healthcare outcomes.

27. Extension of the Patient Advocacy Service

The DOH should expand the remit of the Patient Advocacy Service to include primary care settings, such as GP clinics and community health centres. Currently, the service primarily supports patients in hospital settings, where it helps address concerns and ensures fair treatment. Expanding this support to primary care would give patients guidance early in their healthcare journey and provide needed assistance in navigating primary care services. This step would help improve health outcomes, promote patient-centred care, and strengthen feedback on service quality across all levels of healthcare.

These recommendations adopt a human rights-based approach, aiming to establish a healthcare environment in Ireland that is inclusive, accessible, and attuned to the varied needs of immigrants, thereby cultivating a healthier and more equitable society.

6. REFERENCES

Alananzeh, I., Ramjan, L., Kwok, C., Levesque, J. V., & Everett, B. (2018). Arab-migrant Cancer Survivors' Experiences of Using Health-care Interpreters: A Qualitative Study. *Asia-Pacific Journal of Oncology Nursing*, *5*(4), 399-407. https://doi.org/10.4103/apjon.apjon_19_18

Alananzeh, I. M., Kwok, C., Ramjan, L., Levesque, J. V., & Everett, B. (2019). Information needs of Arab cancer survivors and caregivers: A mixed methods study. *Collegian*, *26*(1), 40-48. https://doi.org/https://doi.org/10.1016/j.colegn.2018.03.001

Anaman, J. A., Correa-Velez, I., & King, J. (2018). Knowledge Adequacy on Cervical Cancer Among African Refugee and Non-Refugee Women in Brisbane, Australia. *Journal of Cancer Education*, *33*(3), 716-723. https://doi.org/10.1007/s13187-016-1126-y

Anaman-Torgbor, J. A., King, J., & Correa-Velez, I. (2017). Barriers and facilitators of cervical cancer screening practices among African immigrant women living in Brisbane, Australia. *European Journal of Oncology Nursing*, *31*, 22-29. https://doi.org/10.1016/j.ejon.2017.09.005

Arnold, M., Razum, O., & Coebergh, J. W. (2010). Cancer risk diversity in non-western migrants to Europe: An overview of the literature. *Eur J Cancer*, *46*(14), 2647-2659. https://doi.org/10.1016/j.ejca.2010.07.050

Asylum Information Database. (2016). *Country Report: Ireland*. Retrieved 23 January 2023 from https://asylumineurope.org/wp-content/uploads/2017/03/report-download_aida_ie_update.v_final.pdf

Asylum information Database and European Council on Refugees and Exiles. (2024). *Types of Accommodation: Republic of Ireland*. Retrieved 1 November 2024 from https://asylumineurope.org/reports/country/republic-ireland/reception-conditions/housing/types-accommodation/

Barlow, P., Mohan, G., & Nolan, A. (2021). Use of healthcare services by adults in Ireland from different countries of origins. *Economic and Social Research Institute*. https://www.esri.ie/system/files/publications/RB202130.pdf

Barlow, P., Mohan, G., & Nolan, A. (2022). Utilisation of healthcare by immigrant adults relative to the host population: Evidence from Ireland. *Journal of Migration and Health*, *5*, 100076. https://doi.org/https://doi.org/10.1016/j.jmh.2021.100076

Barrett, A., & McCarthy, Y. (2007). Immigrants in a booming economy: analysing their earnings and welfare dependence. Labour, 21(4-5), 789-808.

Bhargava, S., Tsuruda, K., Moen, K., Bukholm, I., & Hofvind, S. (2018). Lower attendance rates in immigrant versus non-immigrant women in the Norwegian Breast Cancer Screening Programme. *Journal of Medical Screening*, *25*(3), 155-161. https://doi.org/10.1177/0969141317733771

Boyle, P. (2014). An assessment of cultural competence of community public health nursing in Liffeyside Health Service Area, Dublin (Doctoral dissertation, Middlesex University).

Brzoska, P., Aksakal, T., & Yilmaz-Aslan, Y. (2020). Utilization of cervical cancer screening among migrants and non-migrants in Germany: results from a large-scale population survey. *BMC Public Health*, *20*(1), 5. https://doi.org/10.1186/s12889-019-8006-4

Casolino, R., Inno, A., Cassandrini, P., Cirillo, M., Magarotto, R., Modena, A., . . . Gori, S. (2017). R20 Cancer care for migrant patients: the value of a dedicated service. *Annals of Oncology*, *28*. https://doi.org/10.1093/annonc/mdx434.019

Central Statistics Office. (2022a). *Census of Population 2022 - Summary Results - CSO - Central Statistics Office*. Retrieved 23 November 2024 from https://www.cso.ie/en/releasesandpublications/ep/pcpsr/censusofpopulation2022-summaryresults/migrationanddiversity/

Central Statistics Office. (2022b). *COVID-19 Vaccination Statistics Series 6 - CSO - Central Statistics Office.* Retrieved 23 January 2023 from *https://www.cso.ie/en/releasesandpublications/fp/fp-cvac/covid-19vaccinationstatisticsseries6/*

Central Statistics Office. (2022c). *Population and Migration Estimates - CSO - Central Statistics Office.* Retrieved 23 January 2023 from *https://www.cso.ie/en/releasesandpublications/ep/p-pme/populationandmigrationestimatesapril2022/*

Cha, E. Y., & Chun, H. (2021). Barriers and Challenges to Cervical Cancer Screening, Follow.Up, and Prevention Measures among Korean Immigrant Women in Hawaii. *Asia-Pacific Journal of Oncology Nursing*, *8*(2), 132-138. https://doi.org/https://doi.org/10.4103/2347-5625.308302

Chauhan, A., Walton, M., Manias, E., Walpola, R. L., Seale, H., Latanik, M., . . . Harrison, R. (2020). The safety of health care for ethnic minority patients: a systematic review. *International Journal for Equity in Health*, *19*(1), 118. https://doi.org/10.1186/s12939-020-01223-2

Chiang, Y.-C., Collins, A., Chopra, P., Lu, T., Tan, E.-S., & Couper, J. W. (2015). Understanding the experiences of Mandarin-speaking patients diagnosed with life-threatening cancer in Australia. *Palliative and Supportive Care*, *13*(5), 1317-1323. https://doi.org/10.1017/S1478951514001175

Chopra, S., & Vidya, R. (2021). Impact of Immigration on Breast Cancer in Migrant Population in the UK. *Indian Journal of Surgery*. https://doi.org/10.1007/s12262-021-03086-5

Collins, C., Pericin, I., Larkin, J. & *Diaz, E.* Self-rated health and quality of life among Syrian refugees in Ireland – data from a cross-sectional study.

BMC Public Health 22, 1202 (2022). https://doi.org/10.1186/s12889-022-13610-1

Collins, C., MacFarlane, A., O'Carroll, A., O'Donnell, P., O'Malley, M., Quilty, T., . . . Donnellan, T. (2020). *Refugees and protection applicants (asylum seekers) - Information for General Practitioners*. Retrieved 23 January 2023 from https://www.ul.ie/medicine/sites/default/files/Refugees%20and%20protection%20applicants%20-%20Information%20for%20GPs.pdf

Cork Cancer Action Network. (2017). *Establishing a community focused approach to cancer prevention in Cork City North West*. Retrieved 17 January 2023 from https://www.cancer.ie/sites/default/files/2019-11/cork_cancer_action_report_network_final.pdf

Cork Kerry Community Healthcare. (2022). *Cork Kerry Refugee Resettlement Initiative*. Retrieved 25 November 2022 from https://ahlan.ie/

Crawford, J., Ahmad, F., Beaton, D., & Bierman, A. S. (2016). Cancer screening behaviours among South Asian immigrants in the UK, US and Canada: a scoping study. *Health & Social Care in the Community*, *24*(2), 123-153. https://doi.org/https://doi.org/10.1111/hsc.12208

CrossCare. (2022). *Welfare and Health*. Retrieved 23 January 2023 from https://www.livinginireland.ie/welfare-health/

Cullerton, K., Gallegos, D., Ashley, E., Do, H., Voloschenko, A., Fleming, M., . . . Gould, T. (2016). Cancer screening education: can it change knowledge and attitudes among culturally and linguistically diverse communities in Queensland, Australia? *Health Promotion Journal of Australia*, *27*(2), 140-147. https://doi.org/https://doi.org/10.1071/HE15116

De Jesus, M., Rodrigue, C. M., Rahmani, S., & Balamou, C. (2021). Addressing Cancer Screening Inequities by Promoting Cancer Prevention Knowledge, Awareness, Self-Efficacy, and Screening Uptake Among Low-Income and Illiterate Immigrant Women in France.

International Journal of Public Health, *66*, 1604055. https://doi.org/10.3389/ijph.2021.1604055

Delon, C., Brown, K. F., Payne, N. W. S., Kotrotsios, Y., Vernon, S., & Shelton, J. (2022). Differences in cancer incidence by broad ethnic group in England, 2013–2017. *British Journal of Cancer*, *126*(12), 1765-1773. https://doi.org/10.1038/s41416-022-01718-5

Department of Children, Equality, Disability, Integration and Youth. (2023). *Ireland's 5th Periodic Report under Framework Convention for Protection of National Minorities submitted to Council of Europe.* https://www.gov.ie/en/press-release/340f8-irelands-5th-periodic-report-under-framework-convention-for-protection-of-national-minorities-submitted-to-council-of-europe/

Department of Health. (2017). *National Cancer Strategy 2017- 2026*. Retrieved 23 January 2023 from https://assets.gov.ie/9315/6f1592a09583421baa87de3a7e9cb619.pdf

Department of Health. (2021). *National cancer strategy: Implementation Report*. Retrieved from https://www.gov.ie/en/publication/f012d-national-cancer-strategy-2017-2026-implementation-report-2021/

Department of Justice. (2021). *Minister McEntee announces new landmark scheme to regularise long-term undocumented migrants*. [Press Release] Retrieved 23 January 2023 from https://www.gov.ie/en/press-release/bdd61-minister-mcentee-announces-new-landmark-scheme-to-regularise-long-term-undocumented-migrants/

European Cancer Information System. (2022a). *Estimates of cancer incidence and mortality in 2022, for all countries*. Retrieved 1 November 2024 from https://ecis.jrc.ec.europa.eu/explorer

European Cancer Information System. (2022b). *Estimates of survival, by country and cancer site*. Retrieved 23 January 2023 from https://ecis.jrc.ec.europa.eu/explorer

European Cancer Organisation. (2022a). *It can be done: beating inequalities in cancer care Action Report.* Retrieved 23 January 2023 from https://www.europeancancer.org/component/attachments/?task=download&id=366:Inequalities_Action-Report_final

European Cancer Organisation. (2022b). *The choice we must make: choosing against cancer inequality.* Retrieved 23 January 2023 from https://www.europeancancer.org/resources/268:the-choice-we-must-make-choosing-against-cancer-inequality.html

European Commission. (2022). *Europe's Beating Cancer Plan - Communication from the commission to the European Parliament and the Council*. Retrieved 23 January 2023 from https://health.ec.europa.eu/system/files/2022-02/eu_cancer-plan_en_0.pdf

European Website on Integration. (2019). *Cairde launches new website on Irish health services for migrants*. Retrieved 23 January 2023 from https://ec.europa.eu/migrant-integration/news/cairde-launches-new-website-irish-health-services-migrants_en

Faculty of Public Health Medicine. (2016). *Migrant Health - the Health of Asylum Seekers, Refugees and Relocated Individuals: A position paper from the faculty of public health medicine*. Retrieved 23 January 2023 from https://rcpi-live-cdn.s3.amazonaws.com/wp-content/uploads/2016/06/Migrant-Health-16062016.pdf

Fang, C. Y., & Ragin, C. C. (2020). Addressing Disparities in Cancer Screening among U.S. Immigrants: Progress and Opportunities. *Cancer Prevention Research*, *13*(3), 253-260. https://doi.org/10.1158/1940-6207.CAPR-19-0249

Fernandes, A., & Miguel, J. e. (2009). Health and Migration in the European Union: Better Health for All in an Inclusive Society. *Instituto Nacional de Saúde Doutor Ricardo Jorge.* ISBN: 978-972-8643-41-6

Fiscella, K., Franks, P., Doescher, M. P., & Saver, B. G. (2002). Disparities in health care by race, ethnicity, and language among the insured: findings from a national sample. *Med Care*, *40*(1), 52-59. https://doi.org/10.1097/00005650-200201000-00007

Giusti, K., & Hamermesh, R. (2022). Reducing racial disparities in cancer outcomes. *Harvard Business Review.* https://hbr.org/2022/01/reducing-racial-disparities-in-cancer-outcomes

Hannigan, A., Basogomba, A., LeMaster, J., Nurse, D., O'Reilly, F., Roura, M., . . . MacFarlane, A. (2018). Ethnic Minority Health in Ireland-Co-creating knowledge (EMH-IC): a participatory health research protocol. *BMJ Open*, *8*(10), e026335. https://doi.org/10.1136/bmjopen-2018-026335

Hannigan, A., Villarroel, N., Roura, M., LeMaster, J., Basogomba, A., Bradley, C., & MacFarlane, A. (2019). Ethnicity recording in health and social care data collections in Ireland: where and how is it measured and what is it used for? *International journal for equity in health*, *19*(1), 2. https://doi.org/10.1186/s12939-019-1107-y

Health Equity. (2022). *Migrant Health*. Retrieved 4 October 2022 from https://www.healthequity.ie/migranthealth

Health Service Executive. (2009). *Health Services Intercultural Guide: Responding to the needs of diverse religious communities and cultures in healthcare settings*. Retrieved 23 January 2023 from https://www.lenus.ie/handle/10147/311962

Health Service Executive. (2015). Peer support workers: A guidance paper. Retrieved from https://www.hse.ie/eng/services/list/4/mental-health-services/mentalhealthengagement/peer-support-workers-a-guidance-paper.pdf

Health Service Executive. (2018). *Second National Intercultural Health Strategy 2018- 2023*. Retrieved 23 January 2023 from https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/second-national-intercultural-health-strategy.html

Health Service Executive. (2022a). *GPs who accept medical cards*. Retrieved 25 November 2022 from https://www2.hse.ie/services/schemes-allowances/medical-cards/about-the-medical-card/gps-who-accept-medical-cards/

Health Service Executive. (2022b). *Social Inclusion in Dun Laoghaire*. Retrieved 25 November 2022 from https://www.hse.ie/eng/services/list/1/lho/dunlaoghaire/social-inclusion/

Health Service Executive. (2024). *Medical card and GP visit card assessment guidelines*. Health Service Executive. Retrieved 1 November, 2024, from https://www.hse.ie/eng/staff/pcrs/medical-card-and-gp-visit-card-assessment-guidelines.pdf

Hirko, K. A., Rocque, G., Reasor, E., Taye, A., Daly, A., Cutress, R. I., . . . Park, Y. H. (2022). The impact of race and ethnicity in breast cancer—disparities and implications for precision oncology. *BMC Medicine*, *20*(1), 72. https://doi.org/10.1186/s12916-022-02260-0

Hjerkind, K. V., Larsen, I. K., Aaserud, S., Møller, B., & Ursin, G. (2020). Cancer incidence in non-immigrants and immigrants in Norway. *Acta Oncologica*, *59*(11), 1275-1283. https://doi.org/10.1080/0284186X.2020.1817549

Hoare, P. (2022). 'World first' initiative gives migrants in Ireland health support in their own language. *The Irish Examiner*. Retrieved 23 January 2023 from https://www.irishexaminer.com/news/arid-40904333.html

Holland, K., & Pollack, S. (2020). Concerns for undocumented migrants seeking medical care: Many fear being deported during coronavirus outbreak if they come forward.

The Irish Times. Retrieved 23 January 2023 from https://www.irishtimes.com/news/social-affairs/concerns-for-undocumented-migrants-seeking-medical-care-1.4202558

Huhmann, K. (2020). Barriers and Facilitators to Breast and Cervical Cancer Screening in Somali Immigrant Women: An Integrative Review. *Oncol Nurs Forum*, *47*(2), 177-186. https://doi.org/10.1188/20.onf.177-186

International Organisation for Migration Ireland. (2021). *Voices of Syrians: resettled refugees in Ireland. A report by IOM Ireland for the Irish Refugee Resettlement Programme.* Retrieved 23 January 2023 from https://ireland.iom.int/sites/g/files/tmzbdl826/files/documents/iomi-resettlement-study-document-english-final.pdf

International Protection Accommodation Services. (2022). *Collection - Statistics.* Retrieved 23 January 2023 from http://www.ipo.gov.ie/en/ipo/pages/statistics

Irish Cancer Society. (2019). The real cost of cancer: Research conducted by Kantar. Retrieved from https://www.cancer.ie/sites/default/files/2020-01/Real%20Cost%20of%20Cancer%202019%20report.pdf

Islam, N., & Patel, S. (2018). Best Practices for Partnering with Ethnic Minority-Serving Religious Organizations on Health Promotion and Prevention. *AMA Journal of Ethics, 20(7), 643-654*. https://doi.org/10.1001/amajethics.2018.643

Jaehn, P., Kaucher, S., Pikalova, L. V., Mazeina, S., Kajüter, H., Becher, H., . . . Winkler, V. (2019). A cross-national perspective of migration and cancer: incidence of five major cancer types among resettlers from the former Soviet Union in Germany and ethnic Germans in Russia. *BMC Cancer, 19(1), 869*. https://doi.org/10.1186/s12885-019-6058-6

Kildare Street. (2022). *Dail Debates - Written Answers Wednesday, 19 January 2022*. Retrieved 25 November 2022 from https://www.kildarestreet.com/wrans/?id=2022-01-19a.3031

Kizilkaya, M. C., Kilic, S. S., Bozkurt, M. A., Sibic, O., Ohri, N., Faggen, M., . . . Sayan, M. (2022). Breast cancer awareness among Afghan refugee women in Turkey. *EClinicalMedicine*, *49*, 101459. https://doi.org/10.1016/j.eclinm.2022.101459

Ku, L., & Waidmann, T. (2003). *How race/ ethnicity, immigration status and language affect health insurance coverage, access to care and quality of care among the low-income population*. Retrieved 23 January 2023 from https://www.kff.org/wp-content/uploads/2013/01/how-race-ethnicity-immigration-status-and-language-affect-health-insurance-coverage-access-to-and-quality-of-care-among-the-low-income-population.pdf

Kwok, C., White, K., & Roydhouse, J. K. (2011). Chinese-Australian Women's Knowledge, Facilitators and Barriers Related to Cervical Cancer Screening: A Qualitative Study. *Journal of Immigrant and Minority Health*, *13*(6), 1076-1083. https://doi.org/10.1007/s10903-011-9491-4

Lebano, A., Hamed, S., Bradby, H., Gil-Salmerón, A., Durá-Ferrandis, E., Garcés-Ferrer, J., . . . Linos, A. (2020). Migrants' and refugees' health status and healthcare in Europe: a scoping literature review. *BMC Public Health*, *20*(1), 1039. https://doi.org/10.1186/s12889-020-08749-8

Ledoux, C., Pilot, E., Diaz, E., & Krafft, T. (2018). Migrants' access to healthcare services within the European Union: a content analysis of policy documents in Ireland, Portugal and Spain. *Global Health*, *14*(1), 57. https://doi.org/10.1186/s12992-018-0373-6

Lei, F., Zheng, Y., & Lee, E. (2022). Interventions for cancer screening among Chinese Americans: A systematic review and meta-analysis. *PLOS ONE*, *17*(3), e0265201. https://doi.org/10.1371/journal.pone.0265201

MacFarlane, A., Glynn, L. G., Mosinkie, P. I., & et al. (2008). Responses to language barriers in consultations with refugees and asylum seekers: A telephone survey of Irish general practitioners. *BMC Family Practice, 9*, 68. https://doi.org/10.1186/1471-2296-9-68

MacFarlane, A., Ogoro, M., de Freitas, C., Niranjan, V., Severoni, S., & Waagensen, E. (2021). Migrants' involvement in health policy, service development and research in the WHO European Region: A narrative review of policy and practice. *Trop Med Int Health*, *26*(10), 1164-1176. https://doi.org/10.1111/tmi.13643

MacFarlane, A., Phelan, H., Papyan, A., Mohamed, A. H., & Garry, F. (2022). Research prioritization in migrant health in Ireland: toward a participatory arts-based paradigm for academic primary care. *The Annals of Family Medicine*, *20*(Supplement 1), 2727. https://doi.org/10.1370/afm.20.s1.2727

Mac Gabhann, K. (2012). Managing ethno-cultural differences in healthcare service delivery in hospital settings: the Irish experience (Doctoral dissertation, Université de Strasbourg).

March, S., Villalonga, B., Sanchez-Contador, C., Vidal, C., Mascaro, A., Bennasar, M. d. L., & Esteva, M. (2018). Barriers to and discourses about breast cancer prevention among immigrant women in Spain: a qualitative study. *BMJ Open*, *8*(11), e021425. https://doi.org/10.1136/bmjopen-2017-021425

Marques, P., Geraldes, M., Gama, A., Heleno, B., & Dias, S. (2022). Non-attendance in cervical cancer screening among migrant women in Portugal: A cross-sectional study. *Women's Health*, *18*, 174550572210930. https://doi.org/10.1177/17455057221093034

McCarthy, J., Cassidy, I., Graham, M. M., & Tuohy, D. (2013). Conversations through barriers of language and interpretation. *British Journal of Nursing, 22*(6), 335–339. https://doi.org/10.12968/bjon.2013.22.6.335

McDonald, J. T., Farnworth, M., & Liu, Z. (2017). Cancer and the healthy immigrant effect: a statistical analysis of cancer diagnosis using a linked Census-cancer registry administrative database. *BMC Public Health*, *17*(1). https://doi.org/10.1186/s12889-017-4190-2

Mental Health Reform, & Mental Health Commission. (2021). *Ethnic Minorities and Mental Health: Revised guidelines for mental health services and staff on working with people from ethnic minority communities*. Retrieved 23 January 2023 from https://www.mentalhealthreform.ie/wp-content/uploads/2021/12/mhr_revised_guidelines-10-03Dec.pdf

Migge, B., & Gilmartin, M. (2011). Migrants and healthcare: Investigating patient mobility among migrants in Ireland. *Health & Place*, *17*(5), 1144-1149. https://doi.org/https://doi.org/10.1016/j.healthplace.2011.05.002

Migration Data Portal. (2021). *Migration and Health*. Retrieved 23 January 2023 from https://www.migrationdataportal.org/

MIPEX Health Strand. (2020). *Country Report: Ireland*. Retrieved 1 November 2024 from https://www.mipex.eu/ireland

Mohan, G. (2021). Migrant background and children's use of healthcare services in Ireland. *ESRI Research Bulletin March 2021*. Retrieved 23 January 2023 from https://www.esri.ie/system/files/publications/RB202107.pdf

Moorkens, J., & Rocchi, M. (2020). Ethics in the translation industry. In K. Koskinen & N. K. Pokorn (Eds.), *The Routledge handbook of translation and ethics*. Routledge.

National Cancer Control Programme. (2022). *National Survey on Cancer Awareness and Attitudes: September 2022*. Retrieved 23 January 2023 from https://www.hse.ie/eng/services/list/5/cancer/prevention/nccp-national-survey-on-cancer-awareness-and-attitudes-report.pdf

National Cancer Registry Ireland. (2022). *Data Dictionary 2022*. Retrieved 23 January 2023 from https://www.ncri.ie/sites/ncri/files/documents/Data%20Dictionary%20Report%20-%20Final.pdf

National Cancer Registry Ireland. (2023). *Cancer in Ireland 1994-2021 – Annual Statistical Report 2023*. https://www.ncri.ie/sites/ncri/files/pubs/NCRI_AnnualStatisticalReport_2023.pdf

National Economic and Social Council. (2021). Secretariat Covid-19 Working Paper Series: The Impacts of Covid-19 on Ethnic Minority and Migrant Groups in Ireland. *NESC Research Series, Paper 18.* Retrieved 23 January 2023 from http://files.nesc.ie/nesc_research_series/research_series_paper_18_Covid19Migrants.pdf

Nnorom, O., Sappong-Kumankumah, A., Olaiya, O. R., Burnett, M., Akor, N., Shi, N., . . . Lofters, A. (2021). Afrocentric screening program for breast, colorectal, and cervical cancer among immigrant patients in Ontario. *Can Fam Physician*, *67*(11), 843-849. https://doi.org/10.46747/cfp.6711843

Nowak, A. C., Namer, Y., & Hornberg, C. (2022). Health Care for Refugees in Europe: A Scoping Review. *Int J Environ Res Public Health*, *19*(3). https://doi.org/10.3390/ijerph19031278

OECD/ European Observatory on Health Systems and Policies. (2021). *Ireland: Country Health Profile 2021, State of Health in the EU*. https://doi.org/10.1787/4f7fb3b8-en.

Office for the Promotion of Migrant Integration. (2019). *The Migrant Integration Strategy 2017-2020: Progress Report to Government*. Retrieved 23 January 2023 from https://www.gov.ie/pdf/?file=https://assets.gov.ie/137896/4bb8ad84-a471-45ed-94f5-f4a3fc3f9581.pdf#page=null

Ogunsiji, O. O., Kwok, C., & Fan, L. C. (2017). Breast cancer screening practices of African migrant women in Australia: a descriptive cross-sectional study. *BMC Women's Health*, *17*(1), 32. https://doi.org/10.1186/s12905-017-0384-0

O'Hara, J., McPhee, C., Dodson, S., Cooper, A., Wildey, C., Hawkins, M., ... & Beauchamp, A. (2018). Barriers to breast cancer screening among diverse cultural groups in Melbourne, Australia. International journal of environmental research and public health, 15(8), 1677.

Oireachtas. (2023a). *Written answers – Social Welfare Payments.* Retrieved from https://www.oireachtas.ie/en/debates/question/2023-06-13/931/

Oireachtas. (2023b). *Written answers – Social Welfare Payments.* Retrieved from https://www.oireachtas.ie/en/debates/question/2023-09-20/688/

Ornelas, I. J., Ho, K., Jackson, J. C., Moo-Young, J., Le, A., Do, H. H., Lor, B., Magarati, M., Zhang, Y., & Taylor, V. M. (2018). Results From a Pilot Video Intervention to Increase Cervical Cancer Screening in Refugee Women. *Health education & Behavior: The Official Publication of the Society for Public Health Education*, *45*(4), 559–568. https://doi.org/10.1177/1090198117742153

O'Hara, J., McPhee, C., Dodson, S., Cooper, A., Wildey, C., Hawkins, M., Fulton, A., Pridmore, V., Cuevas, V., Scanlon, M., Livingston, P. M., Osborne, R. H., & Beauchamp, A. (2018). Barriers to Breast Cancer Screening among Diverse Cultural Groups in Melbourne, Australia. *International journal of environmental research and public health*, *15*(8), 1677. https://doi.org/10.3390/ijerph15081677

Polakowski, M., & Quinn, E. (2022). Responses to irregularly staying migrants in Ireland. *ESRI Research Series 140, Dublin: ESRI and EMN Ireland*. https://doi.org/10.26504/rs140

Puthoopparambil, S. J., Phelan, M., & MacFarlane, A. (2021). Migrant health and language barriers:

Uncovering macro level influences on the implementation of trained interpreters in healthcare settings. *Health Policy*, *125*(8), 1085-1091. https://doi.org/https://doi.org/10.1016/j.healthpol.2021.05.018

Quaresma, M., Carpenter, J. R., Turculet, A., & Rachet, B. (2022). Variation in colon cancer survival for patients living and receiving care in London, 2006-2013: does where you live matter? *J Epidemiol Community Health*, *76*(2), 196-205. https://doi.org/10.1136/jech-2021-217043

Qureshi, S. A., Gele, A., Kour, P., Møen, K. A., Kumar, B., & Diaz, E. (2019). A community-based intervention to increase participation in cervical cancer screening among immigrants in Norway. *BMC Medical Research Methodology*, *19*(1), 147. https://doi.org/10.1186/s12874-019-0795-8

Rechel, B., Mladovsky, P., Deville, W., Rijks, B., Petrova-Benedict, R., & Mckee, M. E. (2011). Migration and Health in the European Union. *McGraw Hill: Open University Press. eISBN: 978-0-33-524568-0* https://www.euro.who.int/__data/assets/pdf_file/0019/161560/e96458.pdf

Republic of Ireland Living Wage. (2023). *Living Wage Update 2023/24.* https://www.livingwage.ie/download/pdf/living_wage_2023-24.pdf

Richard, L., Furler, J., Densley, K., Haggerty, J., Russell, G., Levesque, J. F., & Gunn, J. (2016). Equity of access to primary healthcare for vulnerable populations: the IMPACT international online survey of innovations. *Int J Equity Health*, *15*, 64. https://doi.org/10.1186/s12939-016-0351-7

Robotin, M. C., Porwal, M., Hopwood, M., Nguyen, D., Sze, M., Treloar, C., & George, J. (2017). Listening to the consumer voice: developing multilingual cancer information resources for people affected by liver cancer [https://doi.org/10.1111/hex.12449]. *Health Expectations*, *20*(1), 171-182. https://doi.org/https://doi.org/10.1111/hex.12449

Roura, M., Bradley, C., Hannigan, A., Basogomba, A., Adshead, M., LeMaster, J., . . . MacFarlane, A. (2018). 2.3-O3

Unveiling participation of ethnic minorities and other stakeholders in health research decision-making in Ireland. *European Journal of Public Health*, *28*(suppl_1), cky047.056. https://doi.org/10.1093/eurpub/cky047.056

Roura, M., Dias, S., LeMaster, J. W., & MacFarlane, A. (2021). Participatory health research with migrants: Opportunities, challenges, and way forwards. *Health Expect*, *24*(2), 188-197. https://doi.org/10.1111/hex.13201

Roura, M., Lemaster, J. W., Hannigan, A., Papyan, A., McCarthy, S., Nurse, D., . . . Macfarlane, A. (2021). 'If relevant, yes; if not, no': General practitioner (GP) users and GP perceptions about asking ethnicity questions in Irish general practice: A qualitative analysis using Normalization Process Theory. *PLOS ONE*, *16*(5), e0251192. https://doi.org/10.1371/journal.pone.0251192

Rowland, C., Mullers, S., Kirkham, C., Ritchie, R., & Malone, F. D. (2021). Irish maternity: a changing ethnic landscape. *Irish Medical Journal, 114*(2), 265-272.

Scanlon, B., Brough, M., Wyld, D., & Durham, J. (2021). Equity across the cancer care continuum for culturally and linguistically diverse migrants living in Australia: a scoping review. *Globalization and Health*, *17*(1), 87. https://doi.org/10.1186/s12992-021-00737-w

Seay, J. S., Carrasquillo, O., Campos, N. G., McCann, S., Amofah, A., Pierre, L., & Kobetz, E. (2015).

Cancer Screening Utilization Among Immigrant Women in Miami, Florida. *Prog Community Health Partnersh*, *9 Suppl*, 11-20. https://doi.org/10.1353/cpr.2015.0029

Social Welfare Appeals Office. (2022). *Social Welfare Appeals Office Annual Report 2022*. https://www.gov.ie/pdf/?file=https://assets.gov.ie/267678/fa47277b-b0f6-42cd-b9f9-7844d552961c.pdf#page=null

Stan, S. (2015). Transnational healthcare practices of Romanian migrants in Ireland: Inequalities of access and the privatisation of healthcare services in Europe. *Social Science & Medicine*, *124*, 346-355. https://doi.org/https://doi.org/10.1016/j.socscimed.2014.04.013

Sullivan, R., Shamieh, O., Kutluk, T., Daoud, A., & Coutts, A. P. (2019). IARC Scientific Publications - Inequality and cancer: the conflict ecosystem and refugees. In S. Vaccarella, J. Lortet-Tieulent, R. Saracci, D. I. Conway, K. Straif, & C. P. Wild (Eds.), Reducing social inequalities in cancer: evidence and priorities for research. *International Agency for Research on Cancer*. Retrieved 23 January 2023 from https://www.ncbi.nlm.nih.gov/books/NBK566174/

Suwankhong, D., & Liamputtong, P. (2018). Early Detection of Breast Cancer and Barrier to Screening Programmes amongst Thai Migrant Women in Australia: A Qualitative Study. *Asian Pac J Cancer Prev*, *19*(4), 1089-1097. https://doi.org/10.22034/apjcp.2018.19.4.1089

Sze, M., Butow, P., Bell, M., Vaccaro, L., Dong, S., Eisenbruch, M., . . . Goldstein, D. (2015). Migrant health in cancer: outcome disparities and the determinant role of migrant-specific variables. *Oncologist*, *20*(5), 523-531. https://doi.org/10.1634/theoncologist.2014-0274

Teunissen, E., Gravenhorst, K., Dowrick, C., Van Weel-Baumgarten, E., Van Den Driessen Mareeuw, F., De Brún, T., . . . Macfarlane, A. (2017). Implementing guidelines and training initiatives to improve cross-cultural communication in primary care consultations: a qualitative participatory European study. *International Journal for Equity in Health*, *16*(1). https://doi.org/10.1186/s12939-017-0525-y

The Guardian. (2018). *Home Office prevented asylum seeker's urgent cancer treatment.* Retrieved 23 January 2023 from https://www.theguardian.com/politics/2019/sep/19/asylum-seeker-denied-cancer-treatment-nhs-home-office-hostile-environment

The Lancet Editorial. (2021). Racial disparities in cancer care: can we close the gap? *22*, 1643. https://doi.org/10.1016/S1470-2045(21)00669-0

Tong, M., Hill, L., & Artiga, S. (2022). *Racial disparities in cancer outcomes, screening and treatment.* Retrieved 23 January 2023 from https://www.kff.org/racial-equity-and-health-policy/issue-brief/racial-disparities-in-cancer-outcomes-screening-and-treatment/

University of Limerick. (2021). *The Irish World Music Cafe*. Retrieved 29 November 2022 from https://www.ul.ie/medicine/news/irish-world-music-cafe

van Loenen, T., van den Muijsenbergh, M., Hofmeester, M., Dowrick, C., van Ginneken, N., Mechili, E. A., . . . Lionis, C. (2018). Primary care for refugees and newly arrived migrants in Europe: a qualitative study on health needs, barriers and wishes. *European Journal of Public Health*, *28*(1), 82-87. https://doi.org/10.1093/eurpub/ckx210

Vanthomme, K., Rosskamp, M., De Schutter, H., & Vandenheede, H. (2021). Lung cancer incidence differences in migrant men in Belgium, 2004–2013: histology-specific analyses. *BMC Cancer*, *21*. https://doi.org/10.1186/s12885-021-08038-6

Villarroel, N., Hannigan, A., Severoni, S., Puthoopparambil, S., & MacFarlane, A. (2019). Migrant health research in the Republic of Ireland: a scoping review. *BMC Public Health*, *19*(1), 324. https://doi.org/10.1186/s12889-019-6651-2

Walker, P. F., Settgast, A. M., & DeSilva, M. B. (2022). Cancer Screening in Refugees and Immigrants: A Global Perspective. *The American Journal of Tropical Medicine and Hygiene*, *106*(6), 1593-1600. https://doi.org/10.4269/ajtmh.21-0692

Wilson, J. (2021). Migrants face barriers to accessing health and social services, committee hears. *The Irish Times*. Retrieved 23 January 2023 from https://www.irishtimes.com/news/ireland/irish-news/migrants-face-barriers-to-accessing-health-and-social-services-committee-hears-1.4730611

Zavala, V. A., Bracci, P. M., Carethers, J. M., Carvajal-Carmona, L., Coggins, N. B., Cruz-Correa, M. R., . . . Fejerman, L. (2021). Cancer health disparities in racial/ethnic minorities in the United States. *British Journal of Cancer*, *124*(2), 315-332. https://doi.org/10.1038/s41416-020-01038-6

7. APPENDICES

Appendix 1. Research Contributions

Table A 1. Research contributors, location and type of contribution

Organisation	Location	Type
Akidwa	Dublin	facilitated survey
Ballyhoura Development CLG	Limerick	facilitated survey; interview
Cairde	Dublin	facilitated survey
Catholic Church	Various	interview
Community Pharmacy	Various	interview
Dublin City Community Co-operative	Dublin	facilitated survey
Family Carers Ireland	Various	interview
Gort Family Resource Centre	Galway	interview
General Practitioner Surgery	Various	interview
Health Service Executive	Various	interview
Nasc	Cork	interview
National Maternity Hospital	Dublin	interview
Northside Family Resource Centre	Limerick	interview
Patient Advocacy Service	Various	interview
Ruhama	Various	interview

Safetynet Primary Care	Various	interview
Summerhill Primary Care Centre	Dublin	interview
The Sexual Health Centre	Limerick	interview
Tiglin	Wicklow	interview
University Hospital Waterford	Waterford	interview

Appendix 2 - Study Limitations and Ethical Considerations

Limitations

Balancing Depth and breadth: Research questions in the survey and interviews were designed to fill in the gaps and add clarity to the information available in the literature.

Bias and Interpretation Challenges: The research team documented their own biases and assumptions in order to minimise their effect. In addition, where the data available showed biases, these were noted in the report.

Our participant pool is not representative of all immigrant communities in Ireland. Firstly, none of our participants identified themselves as being undocumented. While this does not necessarily mean that we did not have any undocumented participants - as some may have been undocumented but chose not to disclose this - it limits the insight our findings can provide into the experience of undocumented immigrants. Some interviewed service providers had worked with undocumented clients and so could speak to their experiences. Whilst very informative and insightful, these are not first-hand accounts and thus cannot fully capture the experience of being an undocumented immigrant.

Secondly, a comparatively small number of men participated in our research. Only 51 of the 242 patient survey respondents, two of the 10 interviewed patients, and four of the 20 interviewed service providers were male. In total, this amounts to 21% of the participant pool being male. Thirdly, the nationalities of our participants were not reflective of the general immigrant population of Ireland. For example, at 34.5% (N=81), Ukraine was the most represented country of birth among patient survey respondents, while only 3.4% (N=8) were born in Poland, despite Poland being the second most common country of birth among non-Irish nationals living in Ireland after the UK.

In addition, a very small proportion of our participants discussed undergoing cancer treatment, limiting the insight we could gain into the first-hand experiences of immigrants undergoing cancer treatment in Ireland. Although this data was supplemented by reports from service providers, as with the experiences of undocumented immigrants, these were not first-hand accounts.

Ethical Considerations

Participant information sheets were provided in multiple languages (i.e. English, Ukrainian, Brazilian Portuguese, Spanish, French, Arabic, and Mandarin) to explain all aspects of the research projects to patients. Information sheets were made available on the TASC website.

Informed Consent: Participants were provided with a clear explanation of the study's purpose, their role in the research, how their contributions would be used, and how their data will be handled prior to the interview or focus group. Any support which an individual might need to participate in the research were considered and catered for.

Data protection and anonymity: Only essential information which was essential to research aims were collected during interviews or focus groups. Names, addresses or specific locations and exact dates were not to be collected unless absolutely essential. In the case of this research, this was particularly important as participants may have had ongoing asylum claims and be identifiable as part of only a small cohort of their nationality or culture present in the country.

Prevention of harm: The purpose of the research was explained to participants, allowing them to prepare themselves in advance for what would be discussed. A protocol was put in place for monitoring the participant for signs of distress during the interview and a plan put in place in the event that psychological support was needed. When necessary, the researcher called for a halt or a break. In the case of working with asylum seekers and refugees, was important to work to ensure research subjects are not retraumatised through the research process. Details of the nature of a participant's grounds for asylum or experience of passage to Ireland were never sought.

Position of the research: Explanation of the goals of the research and the position of the researcher was important to conducting an external evaluation. It was important that the researcher remained independent so that the evaluation was as unbiased as possible. This allowed for participants to feel free to express their views and talk about their experiences without concerns.

Appendix 3 - Survey type completion data

Table A 2. Breakdown of survey responses by survey type and language.

Type	Language	n
Facilitated	N/A	**96**
General	Ukrainian	72
	English	64
	Chinese (Mandarin)	5
	Arabic	2

	Brazilian Portuguese	2
	French	1
	Total general	**146**
Overall total		**242**

Appendix 4 - Age & gender

Table A 3. Age & gender of survey participants (N=242) compared to the total adult population of Ireland.

	n	**%[15]**	**% of 18+ population[16]**
Gender			
Female	184	76%	48.9%
Male	51	21.1%	51.1%
Non-binary/genderfluid	3	1.2%	Unknown
Prefer not to say	2	0.8%	N/A
Prefer to describe[17]	1	0.4%	Unknown
NA[18]	1	0.4%	N/A
Age (years)			

---

[15] Percentages may not add to 100% due to rounding.

[16] The 2022 census included a "sex" (rather than "gender") question and offered only two possible answers: male and female. "Invalid" answers (e.g. those who checked both boxes, or neither) were categorised as male or female by the CSO. Comparative figures for the other categories are therefore unavailable.

[17] Description: "Gay"

[18] In all tables, "NA" denotes the number of participants who did not respond to the question.

18-24	13	5.4%	11.2%
25-34	73	30.2%	16%
35-54	125	51.7%	38.4%
55-59	10	4.1%	7.8%
60-64	11	4.5%	6.9%
65-69	7	2.9%	6.1%
70-74	2	0.8%	5.2%
75+	1	0.4%	8.5%

Source: TASC, 2025; CSO, 2022.

Appendix 5 - Country/region of birth

Table A 4. Participants' country/region of birth by EU/EEA/UK and non-EU/EEA/UK and compared to the general population of Ireland, not including those born in Ireland (N=7) and unknown (N=11).

EU/EEA/UK				Non-EU/EEA/UK			
Country/region	**n**	**%[19]**	**% of non-Irish population[20]**	**Country/region**	**n**	**%[6]**	**% of non-Irish population**
Bulgaria	1	0.4%	0.5%	Afghanistan	1	0.4%	0.3%
France	3	1.3%	1.5%	Albania	1	0.4%	0.2%
Greece	1	0.4%	0.2%	Algeria	1	0.4%	0.2%
Hungary	1	0.4%	0.8%	Angola	1	0.4%	0.1%

---

[19] Percentage of participants born outside of Ireland who stated their country/region of birth (N=224).

[20] Data on the country of birth of specifically the adult population of Ireland is unavailable. As such, comparative population data is based on the total number of residents of Ireland born in each named country (regardless of age) as a percentage of the overall total number of residents in Ireland born outside of Ireland.

Italy	1	0.4%	1.5%
Latvia	21	9.4%	2%
Lithuania	2	0.9%	3.4%
Netherlands	1	0.4%	0.5%
Poland	8	3.6%	10.4%
Portugal	1	0.4%	0.6%
Romania	17	7.6%	4.2%
Slovakia	2	0.9%	0.9%
Spain	2	0.9%	1.8%
United Kingdom	3	1.3%	28.4%
Botswana	1	0.4%	0.1%
Brazil	3	1.3%	3.9%
Cameroon	1	0.4%	0.1%
China	9	4.0%	1.6%
Congo	2	0.9%	0.3%
Eritrea	1	0.4%	-[21]
Gambia	1	0.4%	-
India	1	0.4%	5.6%
Iran	1	0.4%	0.2%
Iraq	2	0.9%	0.2%
Israel	1	0.4%	0.1%
Kenya	4	1.8%	0.1%
Kosovo	1	0.4%	0.1%
Lesotho	1	0.4%	-
Mauritius	1	0.4%	0.2%
Moldova	3	1.3%	1.6%
Morocco	1	0.4%	0.1%
Namibia	1	0.4%	-
Nigeria	10	4.5%	2%
Pakistan	1	0.4%	1.5%
Palestine	1	0.4%	-
Russia	2	0.9%	0.8%
Saudi Arabia	1	0.4%	0.3%
Sierra Leone	1	0.4%	0.04%
Somalia	2	0.9%	0.2%

---

[21] Population figures for some countries are unavailable as the CSO aggregates these into larger “other” categories, e.g. “other Africa”, “other Asia”, “other America”.

		South Africa	1	0.4%	1.6%
		Sri Lanka	1	0.4%	0.1%
		Sudan	1	0.4%	0.2%
		Tanzania	1	0.4%	0.04%
		Turkey	1	0.4%	0.4%
		Uganda	1	0.4%	0.1%
		Ukraine	81	36.2%	1.5%
		United States	2	0.9%	3.4%
		Uzbekistan	3	1.3%	0.03%
		Venezuela	2	0.9%	0.2%
		Zambia	1	0.4%	0.1%
		Zimbabwe	5	2.2%	0.5%
		Other African	3	1.3%	Unknown
Total EU/EEA/UK	**64**	**Total non-EU/EEA/UK**			**160**

Source: TASC, 2025; CSO, 2022.

Appendix 6 - Year of taking up residence in Ireland

Table A 5. Year of taking up residence in Ireland among survey participants (N=242).

Year	n	%
1995	2	0.8%
1996	1	0.4%
1997	1	0.4%
1998	1	0.4%

1999	1	0.4%
2000	3	1.2%
2001	3	1.2%
2002	5	2.1%
2003	4	1.7%
2004	5	2.1%
2005	5	2.1%
2006	7	2.9%
2007	8	3.3%
2008	3	1.2%
2009	5	2.1%
2010	4	1.7%
2011	3	1.2%
2012	5	2.1%
2013	4	1.7%
2014	1	0.4%
2015	9	3.7%
2016	7	2.9%
2017	7	2.9%
2018	14	5.8%
2019	11	4.5%
2020	6	2.5%
2021	13	5.4%
2022	76	31.4%
2023	23	9.5%
NA	5	2.1%

Source: TASC, 2025.

Appendix 7 - Citizenship

Table A 6. Citizenship of survey participants (N=242) compared to the general population of Ireland.

Citizenship	n[22]	%	% of total 15+ population[23]
Afghanistan	1	0.4%	0.03%
Albania	1	0.4%	Unknown
Angola	1	0.4%	0.005%
Botswana	1	0.4%	0.01%
Brazil	1	0.4%	0.6%
Cameroon	1	0.4%	0.01%
China	6	2.5%	0.3%
Congo	1	0.4%	Unknown
DRC Congo	2	0.8%	Unknown
Eritrea	1	0.4%	Unknown
Ethiopia	1	0.4%	0.01%
Gambia	1	0.4%	Unknown
India	1	0.4%	0.9%
Iran	1	0.4%	0.02%
Iraq	1	0.4%	0.02%
Ireland	46	19.0%	83.1%
Israel	1	0.4%	0.01%
Kenya	2	0.8%	0.01%

---

[22] Multiple answers were possible for this question. In total, 25 people had dual citizenship and one person had triple citizenship.

[23] Figures for the 18+ population are unavailable. Where the figure is entered as "Unknown", this is either due to disaggregated figures for the country not being available, or due to lack of clarity about participants' answers and/or CSO figures, e.g. "Congo" vs. "DRC" vs. "Republic of Congo".

Kosovo	1	0.4%	0.004%
Latvia	1	0.4%	0.4%
Mauritius	1	0.4%	0.04%
Namibia	1	0.4%	Unknown
Nigeria	5	2.1%	0.3%
Other EU country	69	28.5%	Unknown
Pakistan	1	0.4%	0.3%
Romania	2	0.8%	1.0%
Russian Federation	2	0.8%	0.06%
Saudi Arabia	1	0.4%	0.02%
Sierra Leone	1	0.4%	Unknown
Somalia	1	0.4%	0.03%
South Africa	3	1.2%	0.2%
Sri Lanka	1	0.4%	0.01%
Sudan	1	0.4%	0.04%
Sweden	1	0.4%	0.05%
Syria	2	0.8%	0.06%
Tanzania	1	0.4%	Unknown
Turkey	2	0.8%	0.07%
Uganda	1	0.4%	Unknown
United Kingdom	3	1.2%	2.6%
Ukraine	70	28.9%	0.2%
United States	2	0.8%	0.9%
Zambia	1	0.4%	Unknown
Zimbabwe	2	0.8%	0.06%
Do not want to state	1	0.4%	N/A
Unknown	2	0.8%	N/A
NA	20	8.3%	N/A

Source:

TASC, 2025;

CSO, 2022.

Appendix 8 - Ethnicity

Table A 7. Ethnic background of survey participants (N=242) compared to the general population of Ireland.

Ethnicity	n	%	% of total population
Afghanistan	1	0.4%	Unknown[24]
African	40	16.5%	1.3%[25]
Amazigh (Berber)	1	0.4%	Unknown
Any other Asian background (including British or Caribbean)	1	0.4%	0.9%
Any other Black background (including British or Caribbean)	1	0.4%	0.2%
Any other White background (including British)	116	47.9%	9.8%
Arab	11	4.5%	0.4%
Black Irish	4	1.7%	Unknown
Chinese	9	3.7%	0.5%
Crimea Tatar	2	0.8%	Unknown
Eastern European	1	0.4%	Unknown
Hispanic or Latinx/Latino/Latina	6	2.5%	Unknown

---

[24] All "Unknown" population figures are due to the specific ethnicity not featuring on the Census 2022. Some may have been included in the "Other including mixed background" category, which constituted 1.3% of the population.

[25] This figure is based on the "Black or Black Irish - African" ethnic category in Census 2022.

Indian/Pakistani/Bangladeshi[26]	3	1.2%	1.8%
Irish Traveller	1	0.4%	0.6%
Middle Eastern	1	0.4%	Unknown
Mixed	3	1.2%	Unknown
Roma	17	7.0%	0.3%[27]
Slavic	2	0.8%	Unknown
Ukrainian	3	1.2%	Unknown
White Irish	7	2.9%	75.6%
White Ukrainian	1	0.4%	Unknown
NA	13	5.4%	6.1%

Source: TASC, 2025; CSO, 2022.

Appendix 9 - Language

Table A 8. Survey participants' (N=242) responses to questions concerning language use and preferences.

Question	n	%
Is English your first language?		
Yes	21	8.7%
No	220	9.9%

---

[26] This figure is based on the "Asian or Asian Irish - Indian/Pakistani/Bangladeshi" ethnic category in Census 2022.

[27] This figure is based on the "White Roma" ethnic category in Census 2022.

NA	1	0.4%
Are you comfortable speaking with health and social care staff in English?		
Yes	152	62.8%
No	88	36.4%
NA	2	0.8%
If no, then what language would be best for you to communicate?		
Arabic	2	0,8%
Chinese	4	1,7%
Dinka	1	0,4%
English (Plain English/with supports)	7	2,9%
French	4	1,7%
Latvian	3	1,2%
Moldavian	2	0,8%
Polish	2	0,8%
Portuguese	1	0,4%
Romanian	10	4,1%
Russian	18	7,4%
Albanian	1	0,4%
Serbian	1	0,4%
Somali	1	0,4%
Swahili	1	0,4%
Ukrainian	39	16,1%
Crimean Tatar	1	0,4%
Unknown	2	0,8%
NA	155	64,0%
Do you feel that you need an interpreter present when attending appointments with health services?		

Yes, for all appointments	56	23.1%
Sometimes	79	32.6%
No	106	43.8%
NA	1	0.4%

Source: TASC, 2025.

Appendix 10 - Religion

Table A 9. Survey participants' religion (N=242)

Religion	n	%	% of 20+ population[28]
Agnostic	6	2.5%	0.07%
Baptist	1	0.4%	0.07%
Buddhism	2	0.8%	0.21%
Catholic (unspecified)	1	0.4%	Unknown
Christian (unspecified)	1	0.4%	0.71%
Church of Ireland	2	0.8%	2.39%
Greek Catholic	1	0.4%	Unknown[29]
Himba (Holy Fire Believer)	1	0.4%	Unknown

---

[28] Census 2022 data on religion are divided into age brackets which do not allow for the analysis of data specifically pertaining to people aged 18 or older. People aged 18 or 19 are included in a 15-19 years bracket, thus including people under the age of 18. As such, comparison figures look at those aged 20 or older.

[29] Within the Census 2022 data, data on Russian, Coptic, and Greek Orthodox faiths are aggregated. The percentage of the 20+ population of Ireland who identify with one of these categories is 1.97%.

Hinduism	3	1.2%	0.67%
Islam	26	10.7%	1.31%
Jehovah's Witness	1	0.4%	0.13%
Judaism	1	0.4%	Unknown
Lutheran	2	0.8%	0.07%
Methodist	1	0.4%	0.11%
No religion	58	24%	15.15%
Orthodox Christian	83	34.3%	Unknown
Pentecostal	5	2.1%	0.21%
Presbyterian	1	0.4%	0.46%
Roman Catholic	38	15.7%	67.7%
Unknown	3	1.2%	N/A
NA	5	2.1%	N/A

Source: TASC, 2025.

Appendix 11 - Highest level of education

Table A 10. Survey participants' (N=242) highest level of education compared to the general 15≤ years old population of Ireland.

Level of education	n	%	% of 15+ population of Ireland
Doctorate (PhD) or higher	5	2.1%	1.1%
Postgraduate/Master's Degree	28	11.6%	11.2%

Bachelor's Degree	58	24.0%	21.4%
Technical or Vocational College	55	22.7%	7.5%
Advanced certificate/completed Apprenticeship	10	4.1%	5.6%
Higher certificate	33	13.6%	5.5%
Upper Secondary Education	17	7.0%	18.1%
Lower Secondary Education	12	5.0%	13.2%
Primary Education	15	6.2%	7.4%
No Formal Education	6	2.5%	2.4%
NA	3	1.2%	6.5%

Source: TASC, 2025; CSO, 2022.

Appendix 12 - Occupation

Table A 11. Survey participants' (N=242) occupation.

Occupation	n	%
Retired and on state pension	10	4,1%
Farmer of less than 50 acres	1	0,4%

High managerial, administrative or professional (for example, doctor, lawyer, company director (50+ people), judge, surgeon or school headmaster)	18	7,4%
Intermediate managerial, administrative or professional (for example, school teacher, office manager, junior doctor, bank manager, police inspector or accountant)	44	18,2%
Supervisor, clerical, junior managerial, administrative or professional (for example, policeman, nurse, secretary, clerk or self-employed (5+ people))	35	14,5%

Skilled manual worker (for example, mechanic, plumber, electrician, lorry driver or train driver)	26	10,7%
Semi-skilled or unskilled manual worker (for example, baggage handler, waiter, factory worker, receptionist, labourer or gardener)	31	12,8%
Student – Third level	6	2,5%
Student – Second level	1	0,4%
Managing the household	7	2,9%
Unemployed	61	25,2%
NA	2	0,8%

Source: TASC,2025.

Appendix 13 - Income

Table A 12. Participants' sources of income in the past 12 months.

Social welfare income						Other income					
Type	**Yes**	**No**	**Don't know**	**Prefer not to say**	**NA**	**Type/region**	**Yes**	**No**	**Don't know**	**Prefer not to say**	**NA**
Child, family or care allowance/benefit	65	102	1	10	64	Wages (excl. self-employment)	102	83	3	7	47
Unemployment benefit	57	55	1	2	31	Self-employment/ farming	21	131	3	7	80
Disability benefit/pension	13	135	2	9	83	Retirement pension	9	143	0	7	83
Additional needs payment	34	127	2	9	70	Money transferred from relatives	26	129	1	10	76
Housing, rent, or heating benefit	47	117	1	9	68	Sick pay entitlements[30]	7	133	2	9	91
Direct provision payment	17	133	2	9	81	Living at home support	1	136	2	9	94
Illness benefit	9	133	1	9	90	Other income	14	126	2	9	91
Invalidity pension	4	136	2	8	92						

---

[30] Usually 70% of salary paid by employer to employees who are on sick leave, normally up to a specified maximum number of days per calendar year and only following a certain period of employment (e.g. after an employee passes their probationary period).

Supplementary welfare allowance	21	129	1	9	82
Disability allowance	10	133	1	9	89
Medical card entitlement	52	109	0	9	72
Carers' allowance	4	136	3	9	90
Domiciliary care allowance	1	137	2	9	93
Other social welfare	28	127	2	9	76

Source: TASC, 2025.

Appendix 14 - Healthcare entitlements

Table A 13. Survey participants' (N=242) healthcare entitlements.

Type	n	%	% of (18+) population of Ireland
GP visit card	44	18.2%	6.3%
Medical card	153	63.2%	31.1%
Private health insurance	34	14.0%	47.4%
None of the above	36	14.9%	Unknown

NA	4	1.7%	N/A

Source: TASC, 2025; GP Agreement, 2023; CSO, 2022; Health Insurance Authority, 2023.

Note: Data on the number of GP Visit and medical card holders by age group is sourced from the GP Agreement 2023. The corresponding percentages are calculated based on a 18+ population of 3,930,572, as per the 2022 Census. Data on the percentage of the population who have private health insurance is in respect of the general population (not only 18+) and is sourced from the Health Insurance Authority.

Appendix 15 - General practitioner care

Table A 14. Summary of survey participants' (N=242) answers to questions concerning GP access.

Question	n	%
When you arrived in Ireland, did someone recommend or give you contact information for a general practitioner (GP)?		
Yes	100	41.3%
No	125	51.7%
I don't remember	14	5.8%
NA	3	1.2%
Are you registered with a GP?		
Yes	207	85.5%
No	34	14.0%
NA	1	0.4%
Why are you not registered with a GP?[31]		

---

[31] Percentage figures based on the number of participants who said they are not registered with a GP (N=34), as only they were asked this question.

Difficulties providing proof of address	1	2.9%
Awaiting answer from GP	1	2.9%
Lack of/awaiting information	4	11.8%
I don't trust the services	1	2.9%
I have never tried to register with a GP	9	26.5%
Language barrier	1	2.9%
I visit a GP in another country, when needed	5	14.7%
Too expensive to access	1	2.9%
Local GP practices are not accepting new patients	11	32.4%
Not yet assigned	1	2.9%
I access healthcare elsewhere (e.g. online doctor), when needed	2	5.9%
Have you needed to access a GP in the past year?[32]		
Yes	19	8.7%
No	15	6.2%
NA	206	85.1%

---

[32] As above.

Since you are not registered with a GP in Ireland, where in Ireland do you go when you have healthcare needs?[33]		
Alternative medicine	3	8.8%
Community nurse	3	8.8%
Hospital	12	35.3%
I travel back to my home country	3	8.8%
Landlord	1	2.9%
I do not receive medical care from anyone	2	5.9%
I treat the issue with medications that are available	1	2.9%
Pharmacist	9	26.5%
Online doctors	1	2.9%
Friends	1	2.9%
NA	6	17.6%
Did you have any challenges in registering with a GP?[34]		
No	115	55.6%

---

[33] Percentage figures based on the number of participants who said they are not registered with a GP (N=34), as only they were asked this question.

[34] Percentage figures based on the number of participants who said they are registered with a GP (N=207), as only they were asked this question.

Yes – I could not understand the person over the phone/the person on the phone could not understand me	32	15.5%
Yes – Other challenges	24	11.6%
Yes – I had to try a few GPs before registering	56	27.1%
Yes – I was told there was a waiting period of more than 2 weeks	31	15.0%
Yes – the GP would not provide me with an interpreter	24	11.6%
Yes – the time the GP was available did not work for my schedule	9	4.3%
NA	1	0.5%
Have you had any difficulty in making an appointment with your GP in the past year?		
Yes	69	28.5%
No	138	57.0%
NA	35	14.5%

How many kilometres is your journey from home to your GP?[35]		
Less than 1 km	44	21.3%
1-10 km	120	58.0%
11-30 km	32	15.5%
31-50 km	5	2.4%
I don’t know	5	2.4%
NA	1	0.5%
How do you usually travel from your home to GP appointments?[36]		
Bicycle	7	3.4%
Bus, minibus or coach	52	25.1%
Driving a car or van	43	20.8%
On foot	85	41.1%
Passenger in a car or van	14	6.8%
Taxi	2	1.0%
Train, DART or LUAS	5	2.4%

Source: TASC, 2025.

---

[35] Percentage figures based on the number of participants who said they are registered with a GP (N=207), as only they were asked this question.

[36] As above.

Appendix 16 - Confidence in accessing healthcare

Table A 15. Survey participants' (N=242) answers to questions concerning confidence in accessing healthcare.

Question	n	%
How confident are you that you can access the health services you need at this current time?		
Very confident	5	2.1%
Confident	41	16.9%
Neutral	61	25.2%
Not very confident	69	28.5%
Not at all confident	65	26.9%
NA	1	0.4%
What type of services are you not confident in accessing?		
Access Accident and Emergency	89	36.8%
Diagnostic tests (e.g. MRI scan or colonoscopy)	104	43.0%
Dermatologist	1	0.4%
Gynecologist	3	1.2%
Infertility treatment	1	0.4%

Adult assessment for neurodevelopmental disorders	1	0.4%
Medical supports in the community (e.g. physiotherapy, GP)	80	33.1%
Non-medical supports in the community (e.g. psychologist)	71	29.3%
Non-medical treatment in a public hospital (e.g. psychologist)	73	30.2%
Treated in a public hospital for a disease (e.g. chemotherapy)	65	26.9%
Ultrasound examination	1	0.4%
I don't know	66	27.3%
NA	24	9.9%

Source: TASC, 2025.

Appendix 17 - Emergency room

Table A 16. Survey participants' (N=242) answers to questions concerning emergency room visits.

Question	n	%

Did you ever have to visit an emergency room when you felt ill?		
No	130	53.7%
Yes – but it was an emergency	45	18.6%
Yes – I couldn't get an appointment with my GP	10	4.1%
Yes – I did not know where else to go	12	5.0%
Yes – I was referred by my GP	38	15.7%
Yes – my illness came on suddenly	44	18.2%
NA	2	0.8%

Source: TASC, 2025.

Appendix 18 - Missed appointments

Table A 17. Summary of survey participants' (N=242) answers to questions concerning missing healthcare appointments.

Question	n	%

In the last year, have you ever needed to attend a scheduled hospital appointment for diagnostics or treatment in person, for your own healthcare, but did not attend?		
Yes	31	12.8%
No	210	86.8%
NA	1	0.4%
Why did you not attend?		
Couldn’t get an appointment in person	3	N/A
Fear of not being understood	1	N/A
Hospital cancellation or postponement	11	N/A
I didn't have an appointment	1	N/A
I didn't have anyone to support me with childcare	1	N/A
I didn’t feel safe, so I cancelled	1	N/A
I didn’t think it was serious enough, so I decided to wait	1	N/A
I was afraid of what I might find out	1	N/A
I was sick	1	N/A

I was very afraid of contracting COVID-19 so I did not attend	1	N/A
Language is a barrier to me attending	9	N/A
The cost of the Hospital appointment	5	N/A
The cost of travelling/distance to the appointment	5	N/A
I forgot about my appointment	1	N/A
In the last year, have you ever needed to attend a scheduled GP appointment in person, for your own healthcare, but did not attend?		
Yes	41	16.9%
No	166	68.6%
NA	35	14.5%
Why did you not attend?[37]		
Anxiety surrounding communicating with medical staff	3	7.3%

---

[37] Percentage figures based on the number of participants who answered "Yes" to the previous question (N=41), as only they were asked this question.

Unsuitable appointment time (e.g. due to to work, college)	2	4,9%
Couldn’t get an appointment in person	8	19,5%
Hospital cancellation or postponement	8	19,5%
I didn’t feel safe, so I cancelled	4	9,8%
I didn’t think it was serious enough, so I decided to wait	7	17,1%
I was concerned that I would not receive the help I need (e.g. I would be dismissed by the medical staff)	3	7,3%
I was afraid of what I might find out.	1	2,4%
I was very afraid of contracting COVID-19 so I did not attend	2	4,9%
I was denied admission without an interpreter	1	2,4%
Language is a barrier to me attending	13	31,7%
Long wait for appointment	4	9,8%
I forgot about my appointment	1	2,4%

My Irish friend who takes me for appointments was unavailable	1	2,4%
The cost of the hospital appointment	4	9,8%
Barriers surrounding travelling to the appointment (e.g. cost, lack of transport)	10	24,4%
NA	2	4,9%

Source: TASC, 2025.

Appendix 19 - Smoking

Table A 18. Summary of survey participants' (N=242) answers to questions concerning smoking.

Question	n	%
Do you or have you ever smoked cigarettes, rolled tobacco or e-cigarettes?		
No – I have never smoked	155	64.0%
Yes – I currently smoke	33	13.6%

Yes – I used to smoke in the past	53	21.9%
NA	1	0.4%
Have you ever planned to quit smoking?[38]		
Yes	19	57.6%
No	14	42.4%
Are you aware of any supports to quit smoking?		
Yes	2	10.5%
No	17	89.5%
If yes, what smoking cessation supports do you know?[39]		
HSE campaigns	1	50%
quit.ie web site	1	50%
Did you access healthcare supports to quit smoking?[40]		

---

[38] Percentage figures are expressed as a percentage of the participants who said they currently smoke (N=33).

[39] Percentage figures are expressed as a percentage of the participants who replied “Yes” to the previous question (N=2).

[40] Percentage figures are expressed as a percentage of the participants who said they currently smoke or have smoked in the past (N=86).

Yes	2	2.3%
No	52	60.5%
NA	32	37.2%
Which supports for quitting smoking did you use?[41]		
We Can Quit course	4	N/A[42]
Book (e.g. self-help)	2	N/A
Medication (unspecified)	1	N/A
GP support	4	N/A
Pregnancy and children	2	N/A
Nicotine replacement therapy[43]	2	N/A
None	17	N/A
NA	211	N/A

Source: TASC, 2025.

---

[41] This question offered participants the option to write in their own answers. For this reason, some of the answers listed are not strictly healthcare supports.

[42] Percentage values not provided as some participants answered "No" to the previous questions, but checked or typed in answers for this question.

[43] Specifically, Niquitin and Tabex.

Appendix 20 - Screening

Table A 19. Summary of survey participants' (N=242) answers to questions concerning cancer screening.

Question	n	%
Which of the following cancer screening services have you heard of?		
"BreastCheck"	118	48.8%
"CervicalCheck"	147	60.7%
"BowelScreen"	63	26.0%
None	74	30.6%
NA	1	0.4%
Which of the following cancer screening services have you used in the past 5 years?		
"BreastCheck"	43	17.8%
"CervicalCheck"	71	29.3%
"BowelScreen"	13	5.4%
None	141	58.3%
NA	1	0.4%
If you were aware of a cancer screening service and are eligible to be screened but did not attend, why not?		

Could not find an appointment time which worked for me	6	2.5%
Did the checks in my home country	1	0.4%
I was unaware of the services and/or how to register	6	2.5%
Fear of potential discomfort	2	0.8%
I did attend	36	14.9%
I didn't know services are available for men too	1	0.4%
I do not want to go	18	7.4%
Belief in good health (no perceived need)	2	0.8%
I had a negative experience the last time	6	2.5%
I have not registered	56	23.1%
I have not yet been invited even though I have registered	15	6.2%
I was afraid of finding out I was ill	17	7.0%
I was too embarrassed to do the screening	6	2.5%

It's not easy to book an appointment	22	9.1%
Language barrier	2	0.8%
Negative experience with the system	4	1.7%
Not eligible or applicable to me	50	20.7%
No female screener available for Breast/CervicalCheck	2	0.8%
NA	47	19.4%

Source: TASC, 2025.

Appendix 21 - Cancer

Table A 20. Summary of survey participants' (N=242) answers to questions concerning cancer diagnosis & treatment.

Question	n	%
Have you ever been diagnosed with cancer?		
Yes	18	7.4%
No	224	92.6%
Did you receive treatment for cancer		

while you were residing in Ireland?[44]		
Yes	14	77.8%
No	4	22.2%
In what year were you most recently diagnosed?		
2015	2	11.1%
2017	1	5.6%
2019	3	16.7%
2020	4	22.2%
2022	2	11.1%
2023	1	5.6%
NA	5	27.8%
How were you diagnosed?		
Biopsy after OGP/gastroscopy	1	5.6%
Biopsy following colonoscopy	4	22.2%
Biopsy following mammogram	2	11.1%
Blood test	7	38.9%

---

[44] For this question and all following questions in this table, percentage figures are expressed as a percentage of the participants who have been diagnosed with cancer (N=18), as these questions are only applicable to those participants.

Diagnostic imaging (for example, X-Ray, MRI, ultrasound, CT scan)	9	50.0%
I can't remember	5	27.8%
Malignant Melanoma (skin) biopsy	1	5.6%
Kidney Biopsy	1	5.6%
Within what timeframe were you offered an appointment for your diagnostic test?		
1-7 days	6	33.3%
8-14 days	3	16.7%
21-28 days	1	5.6%
29-60 days	2	11.1%
91-365 days	1	5.6%
I can't remember	1	5.6%
NA	4	22.2%
Which pathway did you use to access a diagnosis?		
Private	2	11.1%
Public	12	66.7%
NA	4	22.2%
Which pathway did you use to access treatment?		

Private	1	5.6%
Public	13	72.2%
NA	4	22.2%
What was your most recent treatment?		
Chemotherapy	5	27.8%
Immunotherapy	1	5.6%
Surgery	7	38.9%
Radiotherapy	1	5.6%
NA	4	22.2%
Approximately, how far do you live from the hospital in which you receive your treatment for cancer?		
1-10 km	5	27.8%
11-30 km	4	22.2%
31-50 km	1	5.6%
51-70 km	3	16.7%
101-150 km	1	5.6%
NA	4	22.2%
On average, how many times a month do you make a round trip to visit the hospital in which you received		

your treatment for cancer?		
Less than 1 time a month	4	22.2%
1 time a month	5	27.8%
2 times a month	2	11.1%
4 times a month	2	11.1%
NA	5	27.8%
What method of travel would you use to attend treatments at a hospital?		
Bus, minibus or coach	4	22.2%
Driving a car or van	3	16.7%
Irish Cancer Society Volunteer Driver Service	1	5.6%
Passenger in a car or van	6	33.3%
NA	4	22.2%

Source: TASC, 2025.

Appendix 22 - Access and travel to hospital and treatment

Table A 21. Summary of survey participants' (N=242) answers to questions concerning access and travel to hospitals and healthcare treatment.

Question	n	%
Did you have to attend hospital for any of the following tests? (select all that apply)		
Biopsy	1	0.4%
Biopsy following colonoscopy	7	2.9%
Biopsy following cystoscopy	1	0.4%
Biopsy following mammogram	10	4.1%
Blood test	113	46.7%
Cervical biopsy	1	0.4%
Cervical check	1	0.4%
Colposcopy after positive smear	1	0.4%
Diagnostic imaging, (for example, X-Ray, MRI, ultrasound, CT scan)	87	36.0%
I can't remember	24	9.9%
No test	39	16.1%
Stress test	1	0.4%
NA	37	15.3%
How many days did you have to wait before an appointment for your diagnostic test?		
0 days	34	14.0%
1-7 days	32	13.2%
8-14 days	21	8.7%
15-20 days	6	2.5%
15-21 days	3	1.2%
21-28 days	9	3.7%
29-60 days	31	12.8%

61-90 days	9	3.7%
91-365 days	14	5.8%
366 days or more	7	2.9%
I can't remember	34	14.0%
NA	42	17.4%
Which pathway did you use to access a diagnosis?		
Private	36	14.9%
Public	148	61.2%
NA	58	24.0%
What method of travel would you use to attend treatments?		
Ambulance	1	0.4%
Bicycle	11	4.5%
Bus, minibus or coach	57	23.6%
Driving a car or van	51	21.1%
Irish Cancer Society Volunteer Driver Service	4	1.7%
Not applicable	3	1.2%
On foot	47	19.4%
Passenger in a car or van	26	10.7%
Plane travel (I visit doctors outside the country)	1	0.4%
Taxi	2	0.8%
Train, DART or LUAS	9	3.7%
NA	30	12.4%
Approximately, how far do you live from the closest hospital?		
Less than 1 km	11	4.5%
1-10 km	93	38.4%
11-30 km	64	26.4%
31-50 km	32	13.2%

51-70 km	5	2.1%
71-100 km	3	1.2%
101-150 km	1	0.4%
More than 201 km	1	0.4%
Not applicable	3	1.2%
I don't know	10	4.1%
NA	19	7.9%

Source: TASC, 2025.

Appendix 23 - Sources of information on health

Table A 22. Survey participants' (N=242) main sources of information on health.

Source	n	%
Advertising	1	0.4%
Experience/training as a healthcare worker	1	0.4%
Books	2	0.8%
Chinese social media/platforms	4	1.7%
Facebook	9	3.7%
GP or nurse	71	29.3%
Health Service Executive (HSE) website	36	14.9%
Instagram	5	2.1%
Internet (e.g. through Google)	9	3.7%

Irish Cancer Society (for example, website/Support Line/Your Health Matters Roadshow/Other)	2	0.8%
Online consultations with doctors outside of Ireland	1	0.4%
Other	1	0.4%
Other community organisation	14	5.8%
Public posters	7	2.9%
Radio	1	0.4%
Religious community	7	2.9%
Research	1	0.4%
Scientific papers and newsletters	2	0.8%
Television	9	3.7%
Twitter	2	0.8%
WhatsApp/Telegram/Signal/other private messaging app	23	9.5%
Word of mouth/family and friends	39	16.1%
NA	6	2.5%

Source: TASC, 2025.

Appendix 24 - Awareness of Irish Cancer Society services

Table A 23. List of Irish Cancer Society services known to survey participants (N=242).

Service	n	%
Children's Fund	22	9.1%
Daffodil Day	1	0.4%
Charity shops	1	0.4%
I am not aware of any	51	21.1%
Information & resources	1	0.4%
Social media	2	0.8%
Irish Cancer Society	2	0.8%
Not applicable	2	0.8%
Night Nursing	8	3.3%
Signposting	1	0.4%
Support Line/Nurse Line	28	11.6%
Volunteer Driver Service	14	5.8%
Your Health Matters Roadshow	14	5.8%
NA	114	47.1%

Source: TASC, 2025.

Appendix 25 - Frequency of codes

Table A 24. List of codes extracted from qualitative data and their frequencies.

Code/Factor	**Survey responses**	**Provider interviews**	**Patient interviews**	**Total**
Access to General Practitioners	35	10	4	**49**
Autonomy and preferences	11	3	5	**19**
Awareness and access to information	45	17	7	**69**
Fear	27	7	-	**34**
Finances	18	16	7	**41**
Geographic location and transport	15	11	1	**27**
Housing circumstances	2	11	2	**15**
Immigration status and PPS numbers	-	9	2	**11**
Language and communication	30	20	4	**54**

Quality of healthcare (system)	17	9	8	**34**
Resources and wait times	87	10	9	**106**
Service provider factors	38	15	7	**60**

TASC receives support under the Scheme to support National Organisations (SSNO) which is funded by the Government of Ireland through the Department of Rural and Community Development.