Living in Limbo

“I once told my daughter that what keeps the Earth turning are the thousands of immigrants walking to new destinations every day, pushing the planet around and around with their millions of footsteps.” (Anonymous) (1)

Introduction

French artist Bruno Catalano has created an eye-catching series of bronze sculptures called “Les Voyageurs”. The sculptures were put on display in Marseilles to celebrate its position as the 2013 European Capital of Culture and in Venice in 2019.

Born in 1960 to a Sicilian family living in Morocco and raised in France, Bruno Catalano became a sailor in his twenties. He describes how his travels left him feeling that a part of him was gone and would never come back. His sculptures, especially Les Voyageurs show this influence. They explore the themes of migration, home, belonging and loss – are they missing something, or is it something that these “voyagers” have simply left behind? The suitcase is the focus in each statue, weighing them down, but also serving as their only means of support.

In recent years, there has been an increase in the number of migrants coming to Ireland through resettlement and relocation programmes, seeking international protection, of which there are two types (2):

- refugee status, and
- subsidiary protection
A refugee is a person who cannot return to their own country for fear of persecution based on their race, religion, nationality, political opinion, or because they belong to a particular social group (for example, due to their sexual orientation). (2)

Subsidiary protection is granted for those seeking asylum who did not qualify for refugee status. People applying for such status are often called asylum seekers. (2)

A person who is eligible for subsidiary protection is not a refugee but does face a real risk of suffering serious harm if returned to their own country.

On 10 September 2015, the Government set up the Irish Refugee Protection Programme (IRPP). This was part of Ireland’s response to the migration crisis in central and southern Europe. (2)

Under this programme, the Government committed to accepting up to 4,000 people into the State. They would do this through a combination of the:

1. UNHCR-led refugee Resettlement Programme
2. EU Relocation Programme,

Between 2015 and 2018, more than 2,000 people had arrived in Ireland under the IRPP:

- 1,130 programme refugees under the UNHCR led Resettlement Programme. (Our original commitment was 1,040, and the Minister pledged to accept a further 945 between 2018 and 2019. 855 people under this section of the IRPP are expected to arrive by the end of October 2019.)

- 1,022 asylum seekers arrived in the State under the EU Relocation Programme, which ended in March 2018. (2)

3,673 new applications for international protection were received in 2018. (3) The top 5 countries of application were: Albania (459), Georgia (450), Syria (333), Zimbabwe (282), Nigeria (251). (3)

By the end of 2018, there were 6,252 applicants for international protection living in State provided accommodation centres. These centres are funded by the Reception and Integration Agency (RIA). More than 700 people had already been granted some form of status, but they continued to live in State-provided accommodation while they looked for private accommodation. Another 226 people had deportation orders requiring that they leave the State. (2,3)

At the end of November 2018, the RIA accommodation portfolio was comprised of a total of 39 centres throughout 17 counties, with a contracted capacity of 6007. In addition to this almost 1,400 people are being accommodated in hotels and B&Bs. The average length of time people spent in State-provided accommodation centres has
been reduced. In 2015, the average was 38 months. By the end of 2018, it was 24 months.

On 1st July 2018, the EU (recast) Reception Conditions Directive became law in Ireland. This allowed international protection applicants to get a job or be self-employed (access the labour market’). An applicant must be waiting on a decision on their protection application for nine months or more to be eligible to work or be self-employed. Following the introduction of labour market access for International Protection applicants in June 2018, 2,889 applications were received, of which 1,965 were approved.

Wicklow

In November 2018 the Grand Hotel in Wicklow was contracted as a direct provision centre with a capacity for 100 persons who are seeking international protection. This occurred while I was on placement in Wicklow as a 3rd year GP Registrar (HSE Dublin Mid Leinster).

At the time I was commuting from Dublin to Wicklow. I would listen to local and national news. There was much coverage of the proposed opening of the direct provision centre which was met with negativity from the residents of Wicklow Town. The news covered the angry exchanges at a public meeting in the local GAA grounds. Over 200 people attended to voice their opposition to the move. One man was worried his 27 year old son could be attacked on the way home from socialising "He goes out at the weekend with his friends and has a few drinks. If he can't get a taxi he walks home. He's walking past the Grand Hotel some night and these people are there and they try to take his wallet off him...maybe he could get knifed." Meanwhile, one woman was worried for young girls who she said "were scantily enough dressed". She went on to say that some people "are just going to be worried about those girls". Another lady claimed “These countries that they're coming from - they do not respect women. Every woman in this town as far as I know is scared for themselves, their daughters and also their sons." I struggled with the news portraying the asylum in such a way, with no balance being offered..

I first became aware of the health care of the asylum seekers relocating to Wicklow at an evening meeting between local GPs and a HSE representative. Ninety asylum seekers had been relocated with no plans made for their health needs. We had many questions around the provision of health care in general practices already bursting at the seams and financially stretched. There was concern about access to patient records and clinical tests and availability of support services.

I didn’t hear anymore about this for about 4 weeks, the radio reports grumbled on - "you have no idea of what’s coming , they're not the same culture , they don’t integrate." I was quite disheartened until one night in out of hours I met a wonderful couple from the DR Congo. They had met in University and fled to Ireland approximately 6 months prior to our meeting. She was complaining of abdominal pain, nausea and vomiting for a week. Was she on a contraceptive? When she had been in DR Congo but not since she came to Ireland. Did she have a GP? No. Did she have any idea what you be the cause for this?
She mentioned possibly the food in the direct provision centre, but also that her period was late. She was HCG positive. Fortunately they had the support of each other. Unfortunately I had to explain in an out of hours setting that she was pregnant and I was concerned that she had an ectopic pregnancy. I arranged an ambulance and transferred her to Dublin. Would they have known or had transport to Dublin if I had not arranged an ambulance for her? I thought about how this situation would have been different if she had a GP – there were many different scenarios, but all would have been better.

I swiftly moved on to my next patient who was a 50 year old man from the direct provision centre who was ‘just’ attending for his blood pressure prescription (an ACE inhibitor). He had the pill box with him. He had not had his medication in over 4 weeks because he had been relocated; he didn’t have a GP in Wicklow and indeed didn’t even know how to go about arranging a GP. He was unsure when his blood pressure had last been checked – possibly when he had started the tablet some 6 months ago. And for his last bloods? Possibly his screening bloods on arrival.

Finally that evening a young woman in her 20s from Somalia, who had Insulin Dependent Diabetes Mellitus, complaining of numbness on one side of her body for 6 weeks, maybe longer. As our 12 minute allocated consultation unfolded it became apparent that she had endured unimaginable violence at the hands of state agents before she came to Ireland. What support or follow up could I suggest or offer in out of hours?

The next day after discussion with the practice team, including my trainer, we invited as many of the asylum seekers as possible that we could safely take care of to join our practice – including all the patients I had met the evening before. We initially had 30 patients. None of them had full medical cards. We offered 30 minute initial assessments to everyone. The Congolese couple came for their first antenatal appointment.

**Issues identified during initial assessment:**

Of the 30 patients there were 10 children (4 born in Ireland into direct provision) and their age ranged from 6 weeks to 62 years old. There were 12 males and 18 females. Our new patients originated from South Africa (8), Albania(6), DR Congo(2), Nigeria(2), Zimbabwe(4), Somalia (2), Algeria (1), and other (5).

**Difficulties experienced by asylum seekers in engaging with the health system.**

A. It can be very difficult to find a GP in a position after years of cutbacks and FEMPI to take on new patients in Ireland. Therefore asylum seekers often have no choice but to seek medical care in the after-hours facilities, which are not designed for this type of medical care

B. Without a GP a patient cannot apply for a medical card.

C. There is a lack of knowledge as to how the health system works in Ireland.

D. There are language and cultural barriers.

**Follow up appointments.**

1. Patients can miss important appointments due to:
a. Lack of transport – no/few family supports available.
b. Lack of childcare – frequently provided by other residents.
c. Patients attending education courses are afraid to miss classes to attend appointments as they fear it may impact negatively on their asylum claim.
d. Patients who have commenced work fear taking time out of employment for medical appointments.
e. Cultural issues: referral and appointment system does not allow for specification of female only physicians for appointments/procedures.
f. Cultural issues around time and punctuality.

Screening
1. Many residents are unscreened – it is a voluntary process

2. Of those who are screened:
   a. only some have a copy of their results
   b. it can be difficult to know who/where to contact to get results
   c. people are afraid screening will impact on their claim for asylum and withhold information out of fear
   d. screening may result in life altering diagnosis – there is little psychological support for patient, especially when they are moved from centre to centre within the RIA and at a distance from their original medical care givers.

Medical issues in an asylum seeking population
1. Biological
   a. Vitamin D deficiency (20% of patients screened).
   b. HIV – new diagnosis (One patient, who was subsequently diagnosed with CIN III and underwent LLETZ).
   d. One patient presented for his 1st consultation one week post STEMI – he attended to have medication transcribed to GMS script. He had no GP prior to this.
   e. Two women registered for Maternity and Infant Care Scheme.
   f. Five children needed catch up vaccinations (not including primary vaccinations of children born in Ireland).
   g. Request for cultural and religious circumcision.
   h. Two patients with Insulin Dependent Diabetes Mellitus registered with the Diabetes Cycle of Care.
   i. Two patients attended for Medico Legal reports.

2. Psychological
   a. Arising from prior experience
      At least five patients admitted to experiencing violence in their country of origin, this included torture and organized violence and sexual violence.
One patient subsequently admitted to have experienced child sexual assault.
One patient had been raped on arrival to Ireland and subsequently had a termination of pregnancy.
One 18 year old had been separated from his sister who was living in Dublin – his only listed next of kin.
Two patients presented with suicidal ideation (one as a result of a deportation order).

b. Issues arriving from current situation
– Living in direct provision (significant racial discrimination within the centre), moving from centre to centre.

c. Psychological issues and assessments to bolster asylum claims

The narrative has now changed. The headlines are more positive and opinions have changed: ‘Direct provision group to raise funds for Wicklow Cancer Support’, “Many of the residents have been spending a lot of their free time volunteering,” says Emma Kitson, one of Wicklow Welcomes’ organisers. “[They have been] working in the charity shops, working with volunteering Ireland, helping out around the hotel. ‘Residents of direct provision aid tidy towns On St Patrick’s Day, eleven residents of the centre served as stewards in the town’s parade for the first time.’ Two of these people were our patients and had told me how much they had enjoyed being ‘included’. They knew much about St Patrick’s Day as it is celebrated internationally, not least by Irish emigrants.

They asked me about that saying, Cead Mile Failte – I told them the meaning; ‘One Hundred Thousand Welcomes’.

References

1. General Practice Care for Asylum Seekers and Refugees. Information Pack for GP’s in Galway.
2. Immigration in Ireland Annual Review 2018, Department of Justice and Equality.

Useful resources

1. General Practice Care for Asylum Seekers and Refugees. Information Pack for GP’s in Galway.
2. Communicable Disease Screening for Asylum Seekers and Refugees in Ireland: A Mapping Study, October 2010 (Updated February 2011). RCSI.

Dr Louise Fitzgerald, GP Trainee