

**Exploration
of the health needs
of people who have arrived in
Newcastle upon Tyne
from
central and eastern European
countries**

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Many thanks to everyone who gave their time to this health needs assessment

1 Executive Summary

Newcastle upon Tyne public health team commissioned this health needs assessment to inform service development and reduce inequalities (Race Equality Foundation 2013, Salway et al. 2013, Rose et al. 2011).

45 people from Poland, the Czech Republic and Slovakia¹ took part in group discussions and interviews, January to March 2014. The age range was 16 to 50s:

- 9 women and 6 men from the Polish community
- 8 women and 7 men from the Czech community
- 7 women and 8 men from the Slovakian community.

28 practitioners shared their experience of working with people from Poland, Czech Republic, Slovakia and Romania. They work in the following areas of service provision:

- Youth work
- Primary care, including interpreting support
- Community care, including school nursing, health visiting, midwifery and dental health
- Mental health care
- Local authority, including education and community safety
- Voluntary sector community health development and family support
- Employment support.

Participants across central European communities and practitioner groups highlighted the stress, and consequent undermining of physical and emotional wellbeing, of encountering difficulties in:

- Settling in to a new place
- Finding good quality accommodation
- Securing employment with a living wage
- Developing trust and understanding with service providers.

Community members and practitioners identified the potential of family/social networks to undermine, as well as promote, wellbeing and health. They illustrated this by referring to:

- Resources and strengths with which people arrive
- Ways in which networks can open up/constrain opportunities

Across interviews and group discussions there was reference to the importance of access, including good quality language support as needed, to gain information about:

- How to use the NHS effectively
- Support to improve health and wellbeing.

¹ The European Union Regional Development Fund defines Poland, Czech Republic, Slovakia, Slovenia and Hungary as central European countries (www.central2013.eu, accessed 7 April 2014). Lithuania, Latvia and Estonia are Baltic states (www.latlit.eu, accessed 7 April 2014). These countries joined the European Union as part of the 2004 expansion. Romania and Bulgaria are in south-eastern Europe and joined the European Union in 2007.

2 Background to the health needs assessment

Newcastle's changing population profile

Newcastle is similar to Sheffield in being a city with a long history of the arrival of relatively small numbers of people from a diverse range of countries (Robinson et al. 2007). A report for Newcastle City Council (Foggie 2014) describes a population shift over the last ten years, as a result of the enlargement of the European Union and the national policy of dispersal of people who arrive seeking asylum. 14.7% of people living in Newcastle who completed a 2011 census form described themselves as other than white, compared to 6.9% in 2001, and 13.4% reported that they were not born in the UK. 25% of people aged 25 to 34 identified their birthplace as outside of the UK. A census profile produced by Krausova and Vargos-Silva (2013) identified Newcastle as the North East local authority with the highest number and proportionate share of residents born in countries other than the UK (35,579 in 2011).

Census data are a snapshot, already out of date by the time they have been analysed and presented, and they imperfectly capture the dynamic process of migration that is shaping Newcastle's population profile. Apart from the national census, there is no single source of information about the backgrounds of people living in the city, and even within Newcastle City Council there are different systems across departments for producing monitoring data about service user' identities.

Stapley (2008) referred to people from Poland, Slovakia and Lithuania making up the largest migrant groups in the North East and Cumbria at that point in time. Underwood's 2011 report, to Newcastle Local Authority's Children's and Young People's Overview and Scrutiny Panel, identified Polish as sixth on the list of first languages other than English spoken by students in Newcastle schools. His report in 2012, to the Newcastle Migrant Task Group, suggested that approximately 3000 people of Roma background, the majority of whom had moved from the Czech Republic and Slovakia, were living in Newcastle at that point, predominantly housed in the west end of the city.

Recent analysis of 2011 census data by Newcastle Council Central Policy Unit showed that 3792 people who completed a census form in the city identified themselves as having been born in a central or eastern European country. The spread across wards is reflected in the following numbers (wards with under 100 people are not shown): Elswick (573); Benwell and Scotswood (475); Wingrove (385); Byker (334); Westgate (306); Ouseburn (193); Kenton (180); Walker (135); South Heaton (129); South Jesmond (125). The manager of a general practice in west Newcastle shared monitoring data, showing that English is at the top of a list of first languages of people registered with the practice, followed by (next six languages in descending order) Bengali, Punjabi, Urdu, Czech, Slovakian and Polish.

Migrant health and wellbeing

Social determinants of health

Jayaweera (2010) discussed the health, and access to health care, of migrants in a Race Equality Foundation Briefing Paper. The briefing cited evidence of structural barriers to good health for people who migrate to the UK, and suggested that social determinants of

health are significant in explaining health outcomes for migrants. Barriers to good health included those identified by participants in this health needs assessment:

- Low income and poverty, leading to difficulty in maintaining wellbeing
- Sub-standard accommodation in local areas of socio-economic deprivation
- Inadequate information on how to access services
- Inadequate language support in health care settings.

UK work experiences of people who migrate from central and eastern European countries, including low pay, have been shown to have a significant effect on their lives, illustrating that health needs cannot be assessed in isolation from the job market (Spencer et al. 2007). Hemon (2011) highlighted the risk for migrants of insecure employment, and exploitation in the private housing sector. People from Czech and Slovak Roma communities living in Newcastle upon Tyne have shared experiences of poor quality accommodation (HealthWORKS 2009a). White (2011) referred to a body of research showing that people who move to the UK from the European Union can experience social exclusion, despite their relatively privileged status in comparison with other migrants.

Language support issues and information gaps

A paper, prepared by Newcastle City Council about the experiences of international migrants, identified 'language barriers' as a challenge for people arriving from the European Union (Gates 2009). Several research reports, exploring experiences of migrants living in different parts of the UK, have identified language support issues, as well as lack of information about how the NHS works, as barriers to effective use of health services (White 2011, Scullion and Morris 2010, Collis and Stallabrass 2009, Scullion and Morris 2009, Scullion, Morris and Steele 2009). Spencer et al. (2007) referred to a gap in systematic provision of accessible information to people on their arrival in the UK. Current anecdotal evidence suggests that access to language classes for migrants continues to be restrictive.

Health improvement areas

McKee and Shkolnikov (2001) showed smoking to be a significant factor in the premature death of men in central and eastern European Europe. A paper on migrant health in north east England (Rodgers and Chappel 2008) identified high smoking prevalence in some migrant groups, as well as poor dental health as a known health issue for all migrants, and emphasised the need for health improvement work to ensure appropriate provision for people in migrant communities. A 2011 needs assessment of people from Poland who had migrated to Hertfordshire (Coakley) highlighted future needs in relation to hypertension, ischaemic heart disease, and lung and gastrointestinal cancers, linked to high rates of smoking, and also future needs in relation to support for mental ill-health.

Locally, Donnelly (2009) reported low uptake of sexual health information and services, in a health needs assessment of people from eastern and central European Roma communities living in Newcastle. Del Amo (2011) identified the need for work with people from central and eastern European countries around age, gender and power in the context of negotiating sexual relationships, an issue relevant across majority and minority ethnic communities, as illustrated in literature produced during the national Teenage Pregnancy Strategy (Swann et al. 2003).

Pregnancy and maternity care

Low uptake of antenatal and maternity care was identified in a 2009 health needs assessment of people from eastern and central European Roma communities living in Newcastle, an issue similarly mentioned by Collis and Stallabrass (2009) and Coakley (2011).

The process of the health needs assessment

A multi-agency group (community and voluntary sector, NHS and local authority), led by Newcastle public health team, steered the health needs assessment. Before each group discussion and interview there was a recap with participants of the aim of the piece of work, namely to inform Newcastle upon Tyne public health team's commissioning, so that services meet the needs of everyone living in the city. Language support was available in interviews and group discussions, as needed.

The participants

45 people talked about their experience of moving from a central European country and settling in to life in Newcastle. Their accounts illustrate the ethnic, social class, economic and cultural diversity of the parts of Europe from which people have migrated, a point emphasised by the former central Europe correspondent of the BBC's World Service (Glenny 1990).

Some people described themselves as well networked at the time of arrival, because they moved to take up a professional post with a good level of proficiency in the English language. Some, of Roma² background, arrived seeking asylum during the 1990s, having become particularly vulnerable in the economic restructuring that followed the collapse of Communist regimes (European Commission 2010). Some moved to Newcastle when their countries of origin acceded to the European Union. Several people said that they "no longer feel like migrants", because they have a home and a job in Newcastle, their children are settled in school, and they have a sense of having established themselves here.

28 people, whose job is to support people across Newcastle communities, talked about what they know from their work experience and illustrated the challenges and rewards of working in an increasingly ethnically diverse city.

Each of the 73 accounts is inevitably limited by individual perspective. However, together they offer insight in to lived experiences and health needs. One interviewee referred to a lecture given by the author Chimamanda Adichie in 2009, in which she asked her audience to think about how our lives and cultures are composed of many overlapping stories, and warned against 'a single story' about any group of people. A recent authoritative memo from the European Commission (2014) makes the same point, specifically in relation to the depiction of mobile European Union citizens as 'not working and abusing social benefits schemes'. Single stories flatten the range of experiences, resources and aspirations within and across communities, and create stereotypes that can lead to discrimination.

² 'Roma' refers to groups of people with similar cultural characteristics and a shared history of marginalisation in European societies. There is economic, social and cultural diversity within Roma communities (European Commission 2010).

3 Themes from participants' accounts

Quotes by practitioners are identified in the text. All other quotes are from people who have migrated from a central European country.

3.1 Stress, and consequent undermining of wellbeing

Participants across central European communities and practitioner groups highlighted the stress of encountering difficulties in:

- Settling in to a new place
- Finding good quality accommodation
- Securing employment with a living wage
- Developing trust and understanding with service providers, because of the language barrier and inconsistent quality of communication support, and (for some) because of previous experience of discrimination.

They referred to the risk of people trying to manage feelings of stress, anxiety and depression through coping mechanisms that undermine health and wellbeing e.g. smoking, drinking described as “hard”, use of drugs, and eating “the wrong things”.

Difficulties settling in to a new place

A significant number of participants referred to stress linked to settling in to a new and unfamiliar place:

- Depression's an issue for new arrivals, because they think everything will be good and there'll be no waiting time for jobs, and it's a big shock (practitioner)
- I have struggled from the beginning. My emotions were all over the place, especially seeing my kids have a hard time. They waited four months for a school place
- Things were hard at the beginning when I moved here and I felt bad most of the time
- I felt homesick and didn't know about any places to go and it was hard to adapt
- School featured highly as a source of stress in a workshop with young men, because they didn't understand things like course work (practitioner).

Difficulties in finding good quality accommodation

Reference was made to people being at risk of exploitation in the private rented accommodation sector, because of lack of knowledge of the housing sector and tenants' rights and responsibilities and, for some, their level of English language skill:

- People often sign up for a tenancy without much money and without the language needed to understand what's in the contract (practitioner)
- For newcomers it is the biggest problem to find good quality accommodation. My partner is a doctor so we're not representative. Quite a lot of Polish doctors work in the RVI and the Freeman Hospital and live in Gosforth and Benton. Income-wise and rent-wise many people don't have a lot of choice and can be exploited
- People have no other accommodation opportunities so they live in awful conditions (practitioner).

Securing a tenancy can be just the first 'hurdle', as illustrated by the following quotes:

- Trying to get repairs done is a nightmare because landlords ignore requests
- People clean and decorate, replace flooring and carpet. They care a lot about how they live and landlords know that they can leave places in very poor condition and people will clean up.

One person's access to good quality accommodation followed an upward employment and income trajectory:

- My journey started in a caravan park, then I had a really terrible house, with damp and mould, then I got a decent house because I got a good job.

Participants highlighted the impact of poor quality privately rented sector accommodation on people's health, particularly the effect of cold and dampness resulting in mould. The health effects mentioned most frequently were respiratory conditions, with particular concern expressed about chest infections and asthma in children, and mental distress:

- There is pressure, low mood and stress because of poor housing (practitioner)
- There is a lot of dampness because the heating doesn't work properly and then there's mould and that affects children's health
- Damp accommodation has a massive impact on people's health. People have chest infections and asthma, particularly children (practitioner).

The correlation between poor housing and ill health, including respiratory problems and anxiety and depression, was identified in a 1999 Scottish Office summary of research evidence (Wilkinson). Although several people acknowledged the difficulty of speaking up about poor quality accommodation in the private rented sector, others wanted to know: "Where do we ask for help?". The Public Health and Housing team at Newcastle City Council confirmed that people in domestic dwellings, including in the privately rented sector, are protected by a range of legislation (Housing Act 2004, Environmental Protection Act 1990, Building Act 1984, Public Health Acts of 1936 and 1961). In all cases of legitimate complaint a formal notice is given by the council with a timescale within which specified work must be completed by the agent or landlord. Anyone wishing to make a complaint can contact the Public Health and Housing team via the council's switchboard: 0191 2787878.

Difficulties in securing employment with a living wage

A significant number of participants from central European countries talked about not being able to get work in the UK that matches their skills and experience, to a significant extent because of their level of proficiency in the English language. This mismatch can lead to feelings of disappointment, uselessness, anxiety and depression, as well as financial difficulty:

- It seems as though people can't access jobs they are qualified for and end up in low paid, menial jobs. Some men are skilled mechanics, decorators and waiters and end up doing low level cleaning jobs. This causes a lot of stress, worry and depression
- Some people like me who speak good English can change situation very quickly through getting a good job. People who struggle with learning English get stuck and their health is affected for longer
- People arrive without a functional level of English, apart from those who've worked in England before. In central Europe young people tend to pick German to learn at school, not English (practitioner).

Difficulties in getting secure and well paid employment result, initially for some and in the longer term for others (depending on access to language lessons), in a “hand to mouth existence”:

- There is stress because of low pay, and some people experience poverty because of their level of income.

Perceptions of participants from Czech and Slovak Roma background, that they are disadvantaged because of experience of discrimination, are supported by international research, for example several studies in Slovakia show that residential segregation has had a negative effect on Roma’ access to the labour market (European Commission 2010). The theme of lack of equal chances is mirrored in reports about people of Roma background who have migrated to Germany (Grunau 2013) as well as the UK (Brown et al. 2013).

There was particular reference to issues for children who arrive in the UK shortly before or at the point of moving to secondary education, who leave school without the skills needed for employment:

- There are barriers to opportunity for young people who arrived here and went straight in to secondary school without much English, who are now leaving full-time education with no qualifications (practitioner).

Difficulties in developing trust and understanding with service providers

Participants highlighted the importance of people and practitioners being able to develop an adequate level of understanding of their different cultural backgrounds, to build trust. Several people made the point that everyone has a ‘culture’, whether in a personal or professional/organisational context. Looking for points of overlapping experience can be helpful in breaking down barriers:

- Culture ‘speaks’ and is behind the way that people act. I grew up not far from where a lot of Roma lived and I was friends with Roma children and didn’t see them as different. I have experience of discrimination myself because of my religious background and so I had some understanding of the things affecting them
- With some families I feel as though I’m picking on them and I don’t mean to be. There’s a need for perseverance and for building trust (practitioner).
- If a level of trust is built up, then people start to learn about things like the importance of making changes.

Language barrier: Practitioners identified communication as key to developing relationships of trust and maximising the effectiveness of health care. Their quotes below highlight the importance of people having opportunities to develop English language skills, and consistent use of high quality interpreting support when needed:

- In the maternity department women say they are treated very kindly as individual human beings, though sometimes, because of the language barrier, they can’t explain the skills they already have as mothers and the way they do things, like swaddling their babies³

³ A systematic review (van Sleuwen 2007) showed that swaddling has been used by people across many cultures and in many ways. It concluded that swaddling can be used safely when supported by advice about sleeping position, amount of clothing and bedding, and tightness of the swaddling around chest, hips and knees.

- Things that could be explained through a good interpreter are really important, for example when people move house without Health Visitors knowing how to stay in contact with them, which can set off an alarm. Some people are more mobile than others and this can be difficult practically. The language barrier gets in the way of regular contact and clear communication
- Using good quality interpreting is key to avoiding a 'clash of culture' and what can seem like a clumsy response to things like a communal approach to living, within which people share childcare. There are different family shapes and support networks across all communities
- Without adequate interpreting support it is impossible to get informed consent for immunisations
- Good quality interpreting is key to the management of the whole situation in health consultations. When interpreting works well professionals can deal with the situation on the appropriate level. Poor interpreting undermines that and then there is no way of building up trust and people can't engage with professionals and professionals aren't able to understand people's cultural and religious backgrounds.
- The change of provider has broken up something that was functioning really well. The previous provider would send the most experienced people to complex consultations. Now some interpreters don't even turn up
- The language barrier adds another layer of complexity to the sort of multi-layered health issues we see in other people living in the west end of the city. For example, a working age man in his 50s who's a life long smoker with severe peripheral vascular disease causing him leg pain, and back pain from a mining accident back home.

Previous experience of discrimination: People who identified themselves as Roma talked about the complex issue of discrimination in their countries of origin, and the impact this has on their opportunities in the places to which they migrate. Brueggemann (2011) highlighted the impact on Roma people of regime change in many central and southeastern European countries from 1999. An increase in unemployment followed the shift from centrally planned to market economies, and a competitive job market resulted in many Roma being first to lose jobs. Brueggemann's report presented analysis of Roma children's educational opportunities in central European countries, showing the proportion of Roma students attending ethnically segregated schools to be above 30% in Slovakia and over 20% in Romania, and the share of Roma children and young people attending special schools to be over 10% in both the Czech Republic and Slovakia.

One practitioner interviewee referred to the endorsement and enactment of persecution of Roma communities by state organisations in central European countries, and suggested that feeling wary of people in positions of authority is a reasonable response by people with this experience (similarly documented by Gates 2009 and HealthWORKS 2009b).

This highlights the importance of service providers having some level of understanding of the history of migrant communities, to break down misunderstandings that can develop when practitioners are working with an increasingly diverse population, sometimes without adequate preparation and training, in a context of reduced funding and increased demand:

- People forget the journey these people have taken and who they are (practitioner).

Participants of Roma background expressed enthusiasm for opportunities in the UK, assessing Newcastle as 'better' than other potential places of settlement, despite difficulties in accessing good accommodation and jobs, and related stress:

- There is stress, though our experience in Newcastle is better than in other places and we see the UK as a safe place
- We want to live here and to be part of what's going on, and for people to know us as we are.

Sagar (2014) captures this positive embrace of a new place in a collection of accounts by people from Slovakia and the Czech Republic living in Newcastle who describe discrimination, and in some cases violence, against themselves and family members, and nevertheless express pleasure in being able to live here. People who arrived in the early 2000s seeking asylum similarly highlighted the advantages of living in Newcastle, including educational opportunities, friendly people and the beauty of the city, despite experiencing violence motivated by racism, including vandalism of property and physical attack (Grabham 2004).

3.2 Social networks and their potential to undermine/promote wellbeing and health

Informal support within networks of family and friends was one of the resources and strengths mentioned in many of the interviews and group discussions, by people who have arrived from central European countries and by practitioners who have had time to get to know some of them well. A sense of pride linked to identity, and aspirations for children's futures, also emerged as themes in people's accounts. These assets could be said to be held across all Newcastle communities to varying degrees:

- They are proud of who they are. They want to be listened to as human beings and sometimes people don't listen to them (practitioner)
- Children are highly valued and there is great hope for children who are born and brought up here.

The following quotes illustrate the value of networks for people who have migrated to the UK:

- Extended communities are a resource for people because they feel safer and they have a source of information (practitioner)
- There are informal networks of care, and there's a lot of pooling of help and of things people need. There is solidarity and a level of confidence from that (practitioner).

Social and family networks can be a source of information:

- I think that many are unaware of services until others in the community pass the word on. For example, one Czech speaking parent joined the breakfast club and then others came (practitioner).

Family assets play a significant part in determining social mobility. Brook (2005) highlighted the importance of people's networks as routes to jobs, with reference to the idea of social capital conceived by Pierre Bourdieu⁴ (1986) i.e. that people's contacts shape their access to resources. The value of social and family networks, however, depends on the status, experience, knowledge and connectedness of the people within them. Participants

⁴ Bourdieu, unlike Putnam (another social capital theorist), explicitly covers issues of power related to social position.

gave examples of the limitations of networks of family and friends whose own experience is only of insecure, low paid jobs:

- For some people employment is by word of mouth within their communities, through which they access low paid jobs such as cleaning, working in recycling plants and car-washing, despite having high level skill in areas such as joinery.

People's opportunities can be opened up by spending time with others from different communities, in English-speaking environments, and constrained by staying mainly within tight-knit family and community groups. Gates (2009) highlighted the risk of wider social isolation for people who move from a country in the European Union to live in Newcastle, who socialise only/mainly with people who speak their first language. There is evidence that the larger and more diverse a person's social network, the greater the benefits for health and wellbeing (Fee et al. 1999):

- There is a fantastic opportunity currently for socialising with people from different cultural backgrounds and finding out about how culture and religion plays a part in daily life. And people can develop language skills more quickly if they meet up with others
- I struggled at the beginning with the language when I came to England, but I started working straight away in the hospital and made English friends at work, so I'm doing OK, the same as my children
- I was stressed because I didn't know the language. I lost confidence because I couldn't do anything on my own. The I joined a women's group and met other women, and everybody was so open and down to earth, and things changed. I started having friends and did an ESOL class and slowly started getting my confidence back. Things are going well for my children at school and things have turned out good for us
- There have been really positive experiences for young people who've taken part in groups meeting in (young person's service), because they've been able to make friends outside of their own community, and their English has improved hugely, and they've grown in confidence (practitioner)
- Some young people don't socialise outside of their (first language) community very much and so aren't exposed to different opportunities (practitioner)
- Over half of the young men who took part in an event were from central and eastern European countries. But it's difficult to do in-depth issues based work without a particular level of English - you only get so far (practitioner).

Keeping children "at home for as long as possible" was mentioned as something that some families perceive as the best thing to do, because they are not aware of the advantages of pre-school activity:

- Some women feel ashamed if they let their children go to nursery, because they think "I'm not a good mother"
- Women want to keep their children with them and so they lose out on the advantages of going to nursery (practitioner)
- People will start to see the benefits I think. Their children will make friends and be more confident and get a good level of English, which they'll need for school (practitioner).

In many European countries, including the Czech Republic, Slovakia and Romania, children do not go to school before the age of six. In Poland the mandatory age for starting school will become six from 1 September 2014 (previously seven), and since 2011 it has

been mandatory for children to attend kindergarten from the age of five⁵. There is a body of UK research (for example Sylva et al. 2004) showing the benefit of pre-school opportunities for all children living in socio-economically disadvantaged areas, especially when there is a mix of children from different social backgrounds.

3.3 Access to information and services

Across interviews and group discussions there was reference to the importance of access to information about:

- How to use the NHS effectively
- Support to improve health and wellbeing.

Community members and practitioners highlighted the importance of people having opportunities to develop English language skills, and consistent use of high quality interpreting support when needed. so that they can easily access information and services. They shared their experiences of difficulties in language support in medical consultations, particularly in relation to unreliable attendance of interpreters, inappropriate allocation of male/female interpreters, and inconsistent interpreter' attitude and level of skill:

- I asked for a female interpreter because I was seeing a woman and it was a sensitive issue, and it was a male interpreter and it was impossible to take a history (practitioner)
- I had asked for a male interpreter but a female came and I was embarrassed in front of her explaining what was wrong with me
- I am very happy that there is an interpreting service, however some interpreters struggle with medical vocabulary and if it is something complicated they can't convey it and this affects diagnosis because the doctor doesn't get the full information
- Some interpreters say directly to the doctor that they have no medical background though they have good English. There is a need for more training for interpreters.
- The standard of interpreting varies massively. Some do a good job. Some have a positive attitude towards people and some are rude
- Poor quality interpreting means that there isn't a good channel of communication and people can't engage (practitioner).

How to use the NHS effectively

Lack of knowledge about how the NHS works, and how primary and secondary care connect via GP referral, was identified by community members and practitioners in over half of the interviews and group discussions as a barrier to effective health care for some people:

- In general people access primary care well but some don't understand the system and what you're expected to self-manage (practitioner)
- We need information about how appointments work
- It's difficult to explain that some things get done at primary care level before referral if necessary. People don't understand the process of assessment in primary care to get to a referral point if appropriate (practitioner)

⁵ www.nfor.ac.uk (accessed 19 May 2014), European Commission information network on education in Europe.

- I think that many people are unaware of services like pharmacies until others in their community pass the word on
- Language can be a big barrier, for example if people don't know what the words 'prescription' and 'pharmacy' mean.

A small number of participants from central and eastern European countries talked about working in the NHS and/or having family links with people who work in the NHS, from whom they learn how to find their way easily around the system.

While some people talked about eventually getting to know how to negotiate the system through using it, several referred to initial misinformation and misuse:

- Some people come in and ask for an emergency appointment, because they've been told that that's how to get an appointment, and it isn't an emergency. It's difficult to explain how the system is trying to work for everyone (practitioner)
- I was told by a friend to go to A and E if I had any problems getting to see my GP and unfortunately I was using that system for a while.

Confusion about how things work can lead to a breakdown of trust in the NHS, illustrated by a small number of people from Poland and the Czech Republic who referred to waiting until they go back to their country of origin to seek health care, travelling specifically for health care, and/or to consulting with doctors from their countries of origin working in other parts of the UK e.g. Manchester. Having said this, participants who have a sense of how the NHS works said that they greatly appreciate the fact that it is a universal service that discriminates only in terms of prioritising need via appointment and referral systems.

Support to improve health and wellbeing

Participants from the different central European communities and practitioner groups identified the need for access, by young people and adults, to accurate information about appropriate forms of support in the following areas:

Mental health: The need for support around stress and feelings of anxiety and depression was outlined in section 3.1. Practitioners referred to the risk of people trying to manage mental distress through coping mechanisms that undermine health and wellbeing e.g. smoking, drinking described as "hard", use of drugs, and eating "the wrong things".

A practitioner commented that their community mental health team has had no referrals in relation to people from central and eastern European communities. This is interesting and needs further exploration to see whether people are presenting with stress-related anxiety and depression that might be defined as 'low level' and being managed in primary care.

Smoking: Appropriate support to stop smoking was the health need identified in almost all interviews and group discussions with both community members and practitioners. People across communities referred to a 'culture' of smoking within their community, and a significant number talked about smoking more, and/or finding it difficult to think about stopping smoking, because of stress:

- If lots of people are smoking it doesn't encourage you to stop
- People, men and women, smoke more because of stress. If you are in debt or have financial worries then it is difficult to change your smoking
- I smoke too much because of my situation, so I think it affects my health
- When I arrived I was stressing too much and I even started smoking.

There was appreciation of outreach with information about the risks of smoking, as well as acknowledgement that people might need time to feel ready to stop:

- I smoke so much that sometimes my chest hurts. I am trying to give up
- People are definitely starting to get the message through positive outreach, though they aren't going to stop straight away because there's a culture where everyone smokes (practitioner)
- It's about understanding what smoking means to people in terms of support and comfort (practitioner).

Weight management: There was reference to the need for people to have easy access to the most up-to-date information about 'eating less and moving more', and the risks of being overweight:

- There are people who are overweight, including young people, and that's probably down to inactivity, and sometimes misunderstanding information that's given or advice that's ambiguous, for example I suggested to one person that they could eat more fish and then I found out they were buying fish and chips (practitioner).
- There's a lot of pop and sweets. It would be good to get more information to children in schools.

One interviewee illustrated the impact of economic/social position on exercise opportunities:

- There's a very big difference between certain areas of the city. You see people jogging in Gosforth and Jesmond and round the Town Moor, but not in Benwell and Scotswood.

Concerns were expressed by some people about the quality of food available at school, and the influence of fast food on children and young people:

- We cook, we don't buy ready meals, we buy everything fresh and cook from scratch. Our children are being influenced by fast food
- Children from economically weaker families get fed at school and then they want that sort of food (practitioner).

Some practitioners highlighted ways of doing things, supported by family and community networks, that contribute to good health. For example, breastfeeding and family cooking were mentioned as assets to build on:

- There is a high level of breast feeding in these communities
- There are big pans of stew, cooked with fresh ingredients, so that's a positive resource to build on (the practitioner who mentioned this referred to the potential for changing some ingredients e.g. to leaner meat to a vegetable based stew)
- Generally women are very interested in the idea of healthy cooking and they ask "How do you cook that?"

There was reference to a community led dance group in a venue in west Newcastle and the potential for more physical activities, though the issue of sustainability was raised:

- The dance group is funded by ward committee money at present, for facilitator costs, and that funding's half way through.

Dental health: The importance of people getting information and support they need to improve the health of their teeth was highlighted. Several practitioners talked about the relationships of trust they have been able to build with people with the greatest need, which is a good platform for support around dental health, as well as a way in to broader health improvement work:

- We can accompany people to their first appointment if that's what they need to get there
- We do a lot around children's dental health and give tools to people via community groups
- It's useful if GPs think broadly and ask if they can check people's teeth, whatever they come in with, and then signpost them to dental care as needed. Some people have very poor dental health.

Sexual health: Unsurprisingly sexual health, as an area that is potentially sensitive for people to discuss, was mentioned in fewer than half of the interviews and group discussions. It was highlighted as an area needing more exploration, including by some of the young people who participated in interviews.

Care in pregnancy and birth: Practitioners referred to some women having no knowledge of their entitlement to antenatal support, and no easy access to information about the importance of care during pregnancy. The mobility of some family groups, referred to above, was mentioned as a potential barrier to consistent contact:

- Staff need to understand more about that, what people's movement is and why, so that they can accommodate what the women need (practitioner)
- The new maternity book is only available in English (practitioner).

Use of alcohol perceived as problematic: Community members highlighted issues around alcohol use for some people, particularly adult men. Some referred to use of alcohol as a way of managing stress:

- There are alcohol-related problems like family break-up and then people are ashamed
- You can feel on the edge if you're in financial difficulty and get in to hard drinking, mainly spirits.

Use of illegal substances: Use of illegal substances was mentioned in relation to concern about young people, and as a response to stress, for some people:

- People don't know where to go to get help with addictions and the problem seems to be much bigger here than in Poland
- Young people's needs around drugs are becoming apparent, now that we've been able to get to know them and do some work (practitioner).

4 Next steps

Migration is dynamic (Rose et al. 2011) and it is important to understand the changing demography of the local population to commission services effectively. Research exploring the experiences of people from central and eastern European countries living in the UK has identified an inadequate understanding of the size of this migrant population and the diversity within it, as well as of the issues that significantly affect migrants from central and eastern Europe.

The purpose of this piece of work was to explore the health needs of these migrant communities with the aim of informing the commissioning and development of services. The public health focus was deliberately wide and included exploration of the impact of employment opportunities; quality of housing; access to education and training; discrimination; level of knowledge of local health care system and most efficient ways of using it; and level of cultural understanding. This approach was taken because it is well-documented that reducing health inequalities and achieving tangible improvements in health outcomes depends on a wide spectrum of action, just one of which is development of the delivery of services.

The three key issues identified by participants were:

- Stress and undermining of wellbeing
- Importance and potential of social networks
- Access to information and services

Each of these issues relates broadly to the support available for people who have moved to Newcastle from central and eastern Europe. Also significant are:

- The capacity of communities, commissioners and practitioners to exploit existing resources, and to share and strengthen existing good practice. This includes recognising the assets within, and the potential of, family and social networks
- The capacity of communities, commission, service providers and practitioners to work together to continually develop ways of working in response to need.

Suggestions for action are therefore presented in 4.1 in relation to these two themes.

In relation to 'action', it is important to report that before the findings of this needs assessment had been produced and shared, practitioners were already responding to identified need, as illustrated here:

- A group of young people identified their need to find out about sources of support, including where to go to get information about relationships and sexual health. A practitioner from a bilingual community development in health team arranged for them to visit a city centre service for young people, to get to know the workers and hear about the range of services available
- A primary care team health care assistant shared her experience of working with people across a wide range of backgrounds, and talked about wanting to be able to respond more effectively to people's need for opportunities to learn about healthy eating and exercise. She was linked up with the local Change4Life coordinator.

4.1 Exploiting existing resources and developing ways of working

Professionals providing a service in the east and west ends of Newcastle upon Tyne are experienced in responding to the needs of people living on low incomes, for whom there are structural barriers to educational and employment opportunities. In the west end there is a particular body of knowledge and experience from working with earlier migrants e.g. from Pakistan and Bangladesh. This was highlighted as a resource:

- Use knowledge from working with other migrant communities that are now established, and the resources that have been developed. Recognise this is a long term project with some quick wins along the way. Keep thinking “Who can I network with?” (practitioner).

Several voluntary and community sector organisations, with a history of working proactively with people through several waves of migration, were identified as a vital resource by both people who have migrated to Newcastle and a range of practitioners. Interviewees identified their skill in building relationships with people and checking out what they need to be able to take part in meetings, events and activities. This is an invaluable platform for planning outreach to address issues identified in the health needs assessment.

It is clear that there is scope to develop ways of working in partnership, building on past success.

4.2 Suggestions for action

Strategic

Establishment of a time limited multi-agency working group to plan ways of addressing identified issues. For example, the group could include the local authority Public Health and Housing team for strategic discussion about ways of improving the quality of housing options. The outcomes of the group would be relevant to practice across the city, and particularly in socio-economically disadvantaged areas. The group could exploit the combined knowledge and resources of members to plan ways of working towards:

- A living wage in Newcastle, using the experience of organisations within the community and voluntary sector that have made a commitment to this
- A range of good quality housing options
- Easy access to English language learning
- Consistent quality in language support provision
- Continuing development of ways of working, e.g. in mental health care, pregnancy care, health improvement support, and early years provision. This could happen via partnership learning events, for sharing knowledge and experience.

Operational

Production and circulation of information, with people in central European countries, e.g. about how to use the NHS effectively⁶, and about benefits of pre-school opportunities

Health improvement outreach work, planned and designed with people in target communities.

⁶ A leaflet ‘Our NHS: Use it well’ is currently being piloted by primary care teams in Newcastle, and there is a draft follow-up leaflet: ‘Our NHS: Where to go when’.

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