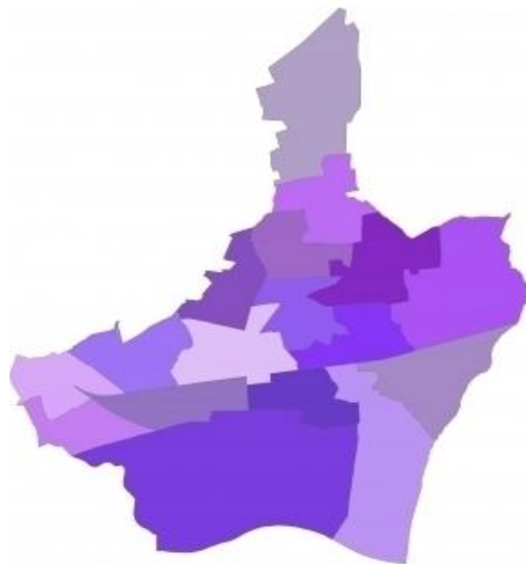
NHS
Barking and Dagenham

Health and Social Care Needs Assessment of Eastern European (including Roma) individuals living in Barking and Dagenham

Final Report



September 2010

UEL University of East London | INSTITUTE FOR HEALTH AND HUMAN DEVELOPMENT

Commissioned by

Barking and Dagenham

Prepared by

Authors

Patrick Tobi
Kevin Sheridan
Shahana Lais

Contributors

Ge Yu
Gail Barrow-Guevara
Faye Adams-Eaton

Collaborators

Shpresa Programme
Roma Support Group
Refugee and Migrant Forum of East London

Contact for information

Institute for Health and Human Development

University of East London

Suite 250, University House

Water Lane

London E15 4LZ

www.uel.ac.uk/ihhd

Preface

This project has been challenging. In covering the health and social care needs of four Eastern European communities in the London Borough of Barking and Dagenham, we have had to engage with communities that have definitely proved hard to reach, despite our experience of doing so in other communities all over London.

In doing this, we have encountered numerous hurdles, not least the near absence of voluntary and community organisations representing the target communities in Barking and Dagenham. Because of this we have had to increase our partnership with BME community organisations outside Barking and Dagenham. However, everywhere we have gone we have been greeted with hospitality, generosity, good will and enthusiasm. We thank all those people who have helped us in this onerous and challenging task, and hope that we have reflected their views as best we can.

Acknowledgements

First, we would like to thank members of our research team who have delivered commitment, perseverance, and resolution.

We would like to thank those Community Organisations and community fieldworkers who partnered with us and carried out the surveys, interviews, and focus groups in target community languages:

- Shpresa Programme without whom it would have been impossible to complete the survey of the Albanian community, and also helped with the Lithuanian survey.
- The Roma Support Group without whom it would have been impossible to complete the survey of the Roma community
- The Refugee and Migrant Forum of East London (RAMFEL) who put us in contact with the other organisations and tried to help us at every point when we were struggling.
- Marta Hurley, Karolina Pleban, interpreters and translators with Newham Language Shop, and Tetyana Vovyanko, independent fieldworker, without whom it would have been impossible to complete the survey of the Polish and Lithuanian communities

We would also like to thank all those at NHSBD & LBBD who offered us help and advice, especially Justin Varney.

Finally we would like to thank all those community members who took part in the questionnaire survey and qualitative interview survey.

Patrick Tobi & Kevin Sheridan

PLEASE NOTE: Appendices in separate file: Appendix 1: Health Profile; Appendix 2: Topic Guide; Appendix 3: Questionnaire Survey; Appendix 4: Ethics

© Institute for Health and Human Development 2010

Table of Contents

1 Background 6
1.1 National context 6
1.2 Local context 6
2 Purpose of the study 8
3 Methods 8
3.1 Overview 8
3.2 Study population 9
3.3 Community engagement and co-production 10
3.4 Data generation 10
3.4.1 Documentary/data review of existing evidence 10
3.4.2 Qualitative research 11
3.4.3 Questionnaire survey 12
3.5 Data analysis 12
3.6 Research ethics 13
4 Population and health profile of Barking and Dagenham 14
4.1 Population changes 14
4.2 Health profile 15
4.3 The Health of Eastern European nationals 15
4.4 Population estimates 16
5 Qualitative research 20
5.1 Understanding and accessing the health system 20
5.1.1 Language Issues 20
5.1.2 Lack of knowledge about system 22
5.1.3 Third Sector community organisations 24
5.2 Mental and Physical Conditions 25
5.2.1 Mental health 25
5.2.2 Physical health 26
5.3 Other Issues 27
5.4 Diversity issues within the communities 28
5.4.1 Disability 28
5.4.2 Mental Health 29
5.4.3 Attitudes towards homosexuality 30
6 Survey findings 32
6.1 Socio-demographic profile 32
6.2 Employment, income and benefit claims 33
6.3 Residency, family and social networks 33
6.4 Health behaviour and access 34
6.5 Service awareness and information seeking 35
7 Conclusions and recommendations 37
7.1 Introduction 37
7.2 Current estimates and projections 37
7.3 Access Issues 37
7.3.1 Language Barriers 37
7.3.2 Induction 37
7.3.3 Working with the third sector 37
7.3.4 Use of community newspapers and websites 38
7.3.5 Cultural Competency Training 38
7.3.6 Training and Supporting the Receptionists 38
7.3.7 GP Registrations 38
7.4 Different Experiences 38

7.4.1 Inequalities experienced by the Roma community ... 38
7.4.2 Understanding Albanians and Kosovans ... 38
7.5 Mental Health, Healthy Lifestyles, and Health Promotion ... 39
7.6 Diversity Issues ... 39
7.6.1 Mental Health & Disability ... 39
7.6.2 Homosexuality ... 39
Glossary ... 40
References ... 41

1 BACKGROUND

1.1 NATIONAL CONTEXT

On May 1, 2004, 8 new countries joined the European Union (EU) from Eastern Europe (the A8 countries).[1] In January 2007, a further two countries (A2)[2] became full EU members. Nationals from these 10 Accession states are free to live and, under certain conditions, work in the UK. Since then, an estimated 1.5 million predominantly young economic migrants have come to the UK from these states.[3,4] Not only have Central and Eastern Europeans made up about half of labour immigration in recent years; they also differ substantially from previous immigrant groups, for example representing a younger demographic group. As a result, over the last few years in the UK, migration has come to account for a greater proportion of population increase than natural change.

The substantial increase in international migration has presented challenges for the provision, funding and delivery of public services at the local level, where the resources to respond fully might not be available.[5] Local authorities now recognise that they need to understand the composition and needs of these groups among their local population in order to better plan and deliver services more effectively, and foster community cohesion. Consequently, there has been a growing body of research on new migrant populations as authorities attempt to understand the experiences and needs of these new and emerging communities.

However, the most recent data shows that net migration to the UK, as monitored by National Insurance (NINo) registrations, fell in 2009/10 to the lowest level since 2004 and reflects a decreasing trend since peaking in 2007/08 (although the proportion of all in-migrants coming to London appears to have risen). Registrations by Accession nationals decreased by 29% from 2008/09 to 2009/10 and seem largely as a result of increased out migration of Polish nationals. Although their numbers are falling, Poles continue to form the largest nationality within the Accession 8+2 group: 70 thousand NINo registrations were made to Polish citizens in 2009/10 (a 48% decrease from the previous year).

While migration is an important driver of population change, imperfect monitoring of people's entry into and exit from an area (unlike births and deaths) means that it is the most difficult of the population growth determinants to estimate.

1.2 LOCAL CONTEXT

As with many other areas in the country the London Borough of Barking and Dagenham (LBBD) has seen a substantial rise in population from the Accession States since 2004. The borough was among the top ten areas in the UK with the largest increases in NINo registrations for foreign nationals between 2007/08 and 2008/09 (Table 1). Six of the areas in the group were London boroughs (generally in the eastern half of the capital), demonstrating the attractiveness of London for immigrant communities.

---

[1] Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia (A8 countries).
[2] Bulgaria and Romania (A2 countries).
[3] Home Office UK Border Agency: Accession Monitoring Report. 2009. http://www.ukba.homeoffice.gov.uk Crown copyright.
[4] Centre for Research on Nationalism Ethnicity and Multiculturalism, University of Surrey. Polish migrants survey results. http://www.surrey.ac.uk/Arts/CRONEM/ Commissioned by BBC Newsnight.
[5] Green A, Owen D, Adam D (2008) A resource guide on local migration statistics. Warwick Institute for Employment Research (IER).

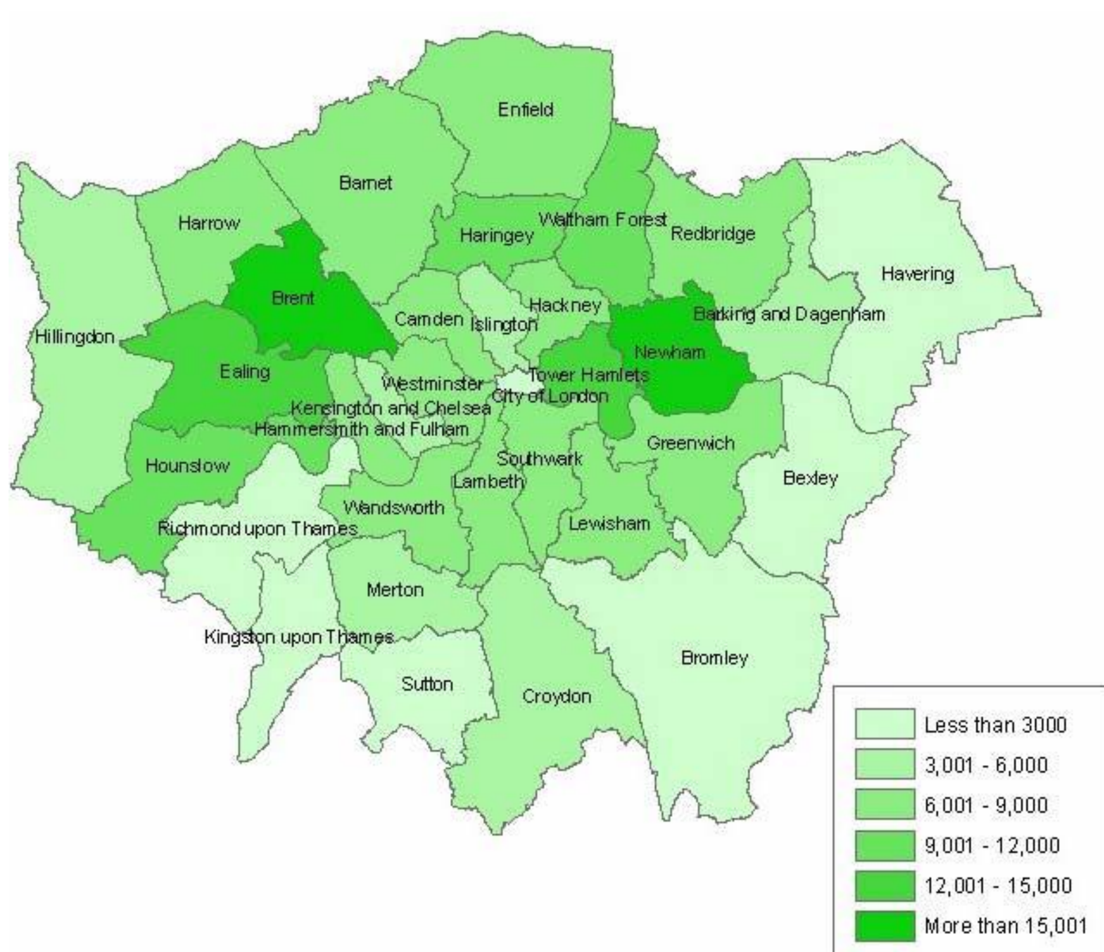
Table 1 Change in overseas NINO registrations, 2007/8 to 2008/9

Largest increases	*Number*	Largest declines	*Number*
1. Newham	1800	1. Doncaster	-490
2. Southwark	1250	2. Blackburn/Darwen	-500
3. Enfield	730	3. Swindon	-550
4. East Cambridgeshire	600	4. Barnet	-580
5. Barking & Dagenham	*590*	5. Manchester	-700
6. Lewisham	550	6. Slough	-720
7. Sheffield	530	7. Bristol	-870
8. Cambridge	450	8. Ealing	-1080
9. Welwyn Hatfield	430	9. Leicester	-1190
10. Islington	390	10. Leeds	-1350

Source: DWP. National Insurance Number Allocations to Adult Overseas Nationals entering the UK

But the picture in 2009/10 may have changed. Of the top 20 Local Authorities with the highest number of registrations in 2009/10, 16 were in London but did not include Barking and Dagenham (figure 1 below). This however is not an indication of the overall level of migration in each local authority since 2004.

Figure 1 NINo registrations to adult overseas nationals for LA's within London Government Office Region – 2009/10



Source: DWP, Aug 2010

2 Purpose of the study

This health and social care needs assessment (HNA) was commissioned by NHS Barking and Dagenham (NHSBD) to better understand the changing make up of the borough, and patterns of health and social care access by Eastern European nationals. By focusing on another minority demographic group, it complements a population health needs assessment carried out in the borough in 2006 among Black and Minority Ethnic (BME) residents.[6] The assessment is intended to guide the PCT in improving strategic planning of service delivery and effective targeting of resources until after the national census in 2011 when more robust intelligence will become available.

The HNA had three key objectives:

- To obtain best estimates and projections of the population of Eastern European nationals living in the borough from a review of existing intelligence
- To understand their particular health and social care needs
- To estimate the future demand for services.

3 Methods

3.1 Overview

The study design relied on a combination of quantitative and qualitative methods to collect and analyse information. The use of mixed methods is consistent with standard research strategy in migration studies generally and with the differing questions asked in this study which are best addressed in different ways. The main methods used were a) documentary review of relevant literature and statistical data, b) questionnaire survey, c) focus groups/group interviews and d) one to one interviews. Their relationship to the study objectives is shown in Table 2.

Table 2 Study objectives and data collection methods

Study objectives	Data collection methods			
	Document and data review	Focus group /group interview	1-1 interview	Survey
To obtain best estimates and projections of the Eastern European population in B&D.	Y			Y
To understand their particular health and social care needs.	Y	Y	Y	Y
To estimate the future demand for services.		Y	Y	Y

[6] Acaye C (2006) Black & Minority Ethnic Population Health Needs Assessment in Barking & Dagenham. Public Health Report No: Dph 185. Health Improvement Directorate, Barking & Dagenham Primary Care Trust

The multimethods approach was useful at two levels: a) it enabled investigation of a study objective by more than one method thus allowing for broader insights and data triangulation, and b) it gave the research team the flexibility to select the methods that were most appropriate for the circumstances of specific nationalities (for instance the use of world café and focus group methods with groups who had local community organisation representation and one-to-one interviews with those who didn't).

The study was commissioned in December 2009 and followed with an inception meeting with NHSBD in January 2010. Table 3 outlines the main phases, activities and timelines of the study.

Table 3 Study phases, key activities and timeframe

Study phase	Key activities	Timeframe
• Project inception	• Study objectives, primary target groups, data collection methods, work plan and deliverables agreed with NHSBD • Research ethics application submitted • Refinement of data collection methods	January 2010
• Documentary and data review	• Identification and collation of relevant documents and statistical data. • Initial population estimates and projections • Desk-based literature review of health related conditions and behaviours of target groups • Preliminary mapping of existing evidence of need and estimation of projected burden of need	February - May
• Community engagement	• Identification and engagement with local community groups – relationship-building, snowballing network of contacts. • Contracting with local partners to recruit and train fieldworkers • Qualitative interviewing – focus groups, 1-1 and group interviews	February – May July - September
• Survey	• Interviewer-administered questionnaire survey among target groups	June - September
• Data analysis	• Data inputting, cleaning, validation and analysis • 'Within method' and 'within group' analyses to identify specific features • Estimation of service demand.	September
• Knowledge synthesis and write up	• Data analysis 'across methods' and 'across groups' to identify common themes • Adjusted population estimates and projections inputting community consultation intelligence	September

3.2 Study Population

Although the study looked at Eastern European nationals generally, four nationalities – Polish, Lithuanians, Albanians (including Kosovans) and Roma – were the main focus of attention. The first three were selected in conjunction with NHSBD based on existing intelligence indicating that they comprised among the largest Eastern European groups living in the borough. The Roma were included because they are known to disproportionately suffer worse health and social inequalities. As an incentive for taking part in the survey and qualitative research, all participants received a £10 shopping voucher as compensation for their time.

3.3 Community engagement and co-production

It was intended that for each nationality, an established community organisation within B&D would be identified in order to co-lead the process of community engagement, inputting their expertise and local knowledge into this component of the research. Each group was invited to a fieldworker training session at the University of East London where the survey process and the questionnaire were discussed in detail. The training was interactive and encouraged feedback regarding the questionnaire translation, cultural appropriateness of each question, etc.[7]

For the Albanian/Kosovan group, Shpresa Programme was identified as an active organisation, based in B&D promoting the Albanian community. Three fieldworkers from Shpresa were involved in the data collection. The Roma Support Group (RSG) was identified as a prominent organisation based in Newham but with a strong client base throughout East London as the main contact for the Roma group. One fieldworker was recruited from the Roma Support Group. Although there is a large Polish/Lithuanian presence in B&D, we found no locally based organisations representing them. The absence of organised community structures meant that we were not able to work in partnership with a representative group, so Polish and Lithuanian/Russian speaking fieldworkers (1 per group) were eventually identified and recruited from the Newham Language Shop.

3.4 Data generation

Primary and secondary intelligence about B&D's Eastern Europeans was generated from four main sources:

- Documentary/data review of existing evidence
- Qualitative research
- Questionnaire survey

3.4.1 Documentary/data review of existing evidence

A desk-based rapid review of the literature on the target populations took place over the first three months, and then intermittently throughout the remaining period of the study as new information came to light. A wide variety of information was accessed including scientific and grey literature, and statistical data from government and other sources. Local, London region and UK migration and service utilisation literature was reviewed as well as country specific literature and statistics on health care services, burden of ill health and deaths, and health seeking behaviour of the target nationalities.

3.4.1.1 Statistical data sources

There is no single statistical data source that comprehensively captures international migrant flows or numbers of migrants in the UK. Consequently, international migration is estimated using information from surveys designed for different purposes; both on their own and in combination with administrative data. Differences in the methodology and focus of the different published estimates further complicate understanding of international migration statistics.[8]

ONS national statistics on international migration come from four main sources: Labour Force Survey (LFS), Annual Population Survey (APS), International Passenger Survey (IPS) and Long-Term International Migration (LTIM, previously known as Total International Migration (TIM)). The data sources are broadly split into two groups: those that provide information on the flow (movement) of migrants into and out of

[7] An important outcome of the feedback was that question items related to individual and community perceptions about diversity (such as sexual orientation and gender identity minorities) were discussed instead at one-to-one interviews.

[8] Ker D, Zumpe J, Blake A (2009). Estimating International Migration: An exploration of the definitional differences between the Labour Force Survey, Annual Population Survey, International Passenger Survey and Long-Term International Migration. Office for National Statistics. http://www.statistics.gov.uk/downloads/theme_population/International_migration_data_differences.pdf

the country (IPS and LTIM) and those that estimate the stock (number) of non-UK born or non-British nationality people living in the UK (LFS and APS).

Migration related data also comes from administrative sources, primarily:

- Patient registers
- Asylum seekers, grants of settlement and worker applications from Central and Eastern Europe EU accession countries (also known as the Worker Registration Scheme or WRS) from the Home Office
- School census data from the Department for Education and Skills
- National Insurance numbers (NINos) allocated to adult overseas nationals from the Department for Work and Pensions

It is recognised that national level data can conceal significant local variations, and for this reason our preference in the first instance was for data that reported at local level. Accordingly, NINo and school census data were used in this exercise. They further had the advantage of being actual counts rather than estimates from samples of the target population. It should be noted however that ONS has recently undertaken work on reconciling administrative sources (WRS, NINos and patient register data) and a combination of short- and long-term migration estimates.[9]

3.4.2 QUALITATIVE RESEARCH

Qualitative information was collected using group-based and individual methods. The choice of method was dictated by considerations of the circumstances of each target group and the research team's field assessment of the most appropriate method.

3.4.2.1 WORLD CAFÉ, FOCUS GROUPS AND GROUP INTERVIEWS

The world café methodology was used with the Albanian/ Kosovan group.[10] Twelve participants took part (2 groups of 6 participants) with a total of 9 females and 3 males. Discussions were conducted in Albanian, with the partner organisations moderating the event and taking detailed notes. The discussion themes addressed four key areas – need, barriers, enablers and improvement (see Appendix 2 for topic guide in separate document). For the Roma community, 2 focus groups took place, one for the Polish-Roma (8 participants, 4 male, 4 female) and one for the Romanian-Roma (5 participants, 3 male and 2 female).

3.4.2.2 ONE TO ONE INTERVIEWS

Due to the absence of local organisations representing the Polish and Lithuanian communities, it was logistically easier to use one-to-one techniques with them rather than group-based approaches. Eight interviews each were held with Polish (4 male, 4 female) and Lithuanian (3 male, 5 females) participants. Each interview lasted around 30 minutes and was based on the same questions asked in the focus groups. Separate one to one interviews were also used to elicit information on community perceptions about diversity..

[9] Reconciliation of ONS estimates: Comparison of combined IPS (short- and long-term migration) estimates with administrative sources: http://www.statistics.gov.uk/about/data/methodology/specific/population/future/imps/updates/downloads/Reconciliation_Exercise.pdf

[10] World Café events are based on whole systems thinking and originated in the developing world as a creative vehicle for engaging excluded groups and generating a shared understanding of key issues amongst diverse stakeholders. It is important that café conversations allow every voice and view to be heard equally and in this respect initial presentations or input to stimulate discussion is not advised since this privileges some perspectives above others. Café events which focus on the key question and allow a free, open discussion usually generate critical insights and ideas which are often overlooked if the conversation has been directed. Experience shows that this method can generate a lot of new privileged data.

3.4.3 Questionnaire survey

One hundred and twenty residents (30 from each target nationality) participated in an interviewer-administered survey. Respondents were recruited through snowball sampling.[11] The survey asked wide ranging questions about health beliefs, needs and practices, health and social care utilisation and barriers to access, and community cohesion experiences. The questionnaire consisted of 71 items grouped in 9 sections: i) socio-demographic; ii) current employment; iii) previous employment in home country; iv) long term intentions; v) accommodation and household; vi) family and social networks; vii) experience of exclusion and discrimination; viii) awareness of social services; and ix) health behaviour and access to healthcare (See Appendix 3 Questionnaire Survey). Altogether, 161 participants were interviewed.

Table 4 summarises the methods used for each group.

Table 4 Data collection methods

Target groups	Data collection methods*				
	Document review	World café	Focus group	1-1 interview	Survey
Polish	Y			Y (8)	Y (30)
Lithuanian	Y			Y (8)	Y (30)
Albanian/ Kosovan	Y	Y (12)			Y (30)
Roma	Y		Y (13)		Y (30)

Number of respondents in brackets.

3.5 Data analysis

The qualitative data was analysed thematically within the context of the discussion themes in the topic guide. Thematic analysis is a strategy for identifying, coding, analysing, and reporting patterns (themes) within data. It minimally organizes and describes a dataset in rich detail.[12] Analysis of the interview data obtained from each participant can be done independently or across the whole group or defined subsets (cross-case analysis). The latter approach was considered more appropriate for the purposes of this study.

The survey data was entered into Epidata (EpiData Software http://www.epidata.dk/links.htm) and analysed with SPSS Version 15.0 for Windows (SPSS, Inc., Chicago, IL). Simple frequency tables and graphs were used to describe the dataset in terms of central tendency and dispersion, and cross-tabulations performed to highlight relationships of interest. The non-probabilistic method of sampling and relatively small size of the dataset did not permit statistical testing to be performed. It also means that the results should be interpreted as a snapshot of perceptions from segments of the target groups and not definitively representative of the populations from which they are drawn.

[11] Snowball sampling is a non-probabilistic form of chain referral. Recent progress on the theory of chain-referral sampling has led to Respondent Driven Sampling (RDS), a rigorous chain-referral method which allows unbiased estimates of the target population. RDS is good at surveying 'hidden' populations who are not listed on electoral registers or in other official documents. A modified version of the RDS was originally proposed for the whole survey (it was successfully used in sampling the Albanian population) but dropped for the full survey because the sample size specified in the service level agreement was insufficient to ensure accurate calculation. Furthermore, it proved awkward to administer without local community organisation support.

[12] Some of the advantages of thematic analysis include flexibility, relatively easy and quick to use in summarising key features of a large body of data, the results are accessible to the lay public, and it is a useful method for working with participants as collaborators. In addition, it can generate unanticipated insights and is useful for producing qualitative analyses suited to informing policy development.

3.6 RESEARCH ETHICS

Approval to carry out the research was obtained from the University of East London's Research Ethics Committee. Information about the study was provided to each participant and written/verbal consent obtained before they were interviewed (see Appendix 4 in separate document for details).

4 POPULATION AND HEALTH PROFILE OF BARKING AND DAGENHAM

4.1 POPULATION CHANGES

Although approximately 77% of the population of Barking and Dagenham is White (compared to 71% in London as a whole), the borough is evolving from being a traditionally white, working class community to a much more diverse population. The borough has historically experienced a relatively high rate of migration from Indian and Pakistani nationals, but more recent years has witnessed a significant increase in the number of Nigerian and Eastern European nationals moving into the area. The growing diversity is particularly noticeable in the local schools where nearly 50% of pupils are from minority ethnic backgrounds.[13]

The borough's population is estimated on an annual basis by the Office for National Statistics (ONS) using the Mid Year Estimate (MYE). From a Census figure of 165,279 in 2001, the population in 2005 was estimated to be 167,218 while the most recent estimate for 2011 was 178,049. The figure is projected to increase to 225,000 by 2024. Corresponding lower end estimates by the Greater London Authority Review of London Plan (GLA, RLP - Low) are 166,000 (2001), 167,000 (2006), 178,000 (2011) and 219,000 (2024). The upper end estimates differ by several thousands. GLA population projections for London are generally considered by London PCTs to be more robust than those of the ONS.[14]

Compared to London and national profiles, the population is comparatively young with nearly a quarter of residents under the age of 16. The birth rate is high and expected to remain so. Population projections show sustained growth in most age groups especially those under 15 (22% rise), those aged 50 to 60 (35% increase) and the over 90s (50% rise). The ONS does not record figures for the number of people of Eastern European origin who now live in the borough, although anecdotal and migrant data evidence indicates that these figures are rising. Of those borough residents born in Eastern Europe, the 2001 census identified that approximately 50% were of Christian faith and 50% were of Muslim faith.

In recent years migration has accounted for a greater proportion of population increase than natural change at the national level. With economic reasons as the main driving factor, the majority of in-migrants to the UK are young adults. At the borough level, migration figures for 2006/07 show that the number of migrants coming into Barking and Dagenham was 10,690, compared to 12,130 who left, leaving a net decrease of 1,450. The number of international migrants coming in was 1,240, with 640 leaving, a net increase of 600 people. Additionally, 210 asylum seekers came into the Borough, whilst 120 left, leaving a net figure of 90.[15]

---

[13] Lewis S (2009). Barking and Dagenham Joint Strategic Needs Assessment. http://www.barkingdagenham.nhs.uk/PDF/Joint%20strategic%20needs%20assessment%20May%2009.pdf

[14] There are two sources of population estimates for London PCTs/Boroughs: the Greater London Authority (GLA) and the Office for National Statistics (ONS). Both sets of estimates are based on the census data (2001) but projection methods and data sources differ resulting in different estimates. GLA population projections are considered more robust as projection methods used by ONS may underestimate the population of London Boroughs because of a higher rate of migration and population churn in London compared to national trends. GLA projections in particular make use of housing capacity and household projections as key determinants of population growth. GLA recommend that for longer-term population estimates, it is advisable to use the RLP (High) projections, but that in the short-term, the RLP (Low) projection may be closer to changes that have occurred since 2001.

[15] Lewis S (2009). Barking and Dagenham Joint Strategic Needs Assessment.

4.2 HEALTH PROFILE

Barking and Dagenham's Joint Strategic Needs Assessment (JSNA) in 2009 provides information on the borough's health profile.[16] Life expectancy is significantly below the national and London average for both men and women. Cancer and cardiovascular disease are responsible for much of the burden of death and ill health. Unhealthy lifestyles are a contributory factor with a greater than average proportion of people estimated to smoke, and eat unhealthily.

The leading causes of death overall are circulatory disease (coronary heart disease and heart failure), cancer, chronic obstructive airways disease (COPD) and pneumonia. Lung cancer was the major cancer contributor in both men and women. Digestive diseases (including ulcers), accidents unrelated to road traffic, genitourinary and infectious diseases also make small but significant contributions.

4.3 THE HEALTH OF EASTERN EUROPEAN NATIONALS

A wide range of scientific and grey literature on the four target Eastern European groups was reviewed to gain insights into their health care services, the burden of death and ill health, social determinants of disease and health seeking behaviour. Full details of the review can be found in **Appendix 1**, but in general, while measures of health show that the health of EU populations continues to improve, there are however considerable differences across countries in terms of life expectancy, infant mortality and avoidable mortality. Life expectancy at birth has increased in all countries, and women on average continue to live longer than men. The two most recent countries to join the EU, Bulgaria and Romania, lag behind EU averages in most mortality and morbidity indicators.

Chronic diseases account for the main burden of death in the EU including the CEE countries. The most significant chronic diseases are heart disease, cerebrovascular disease and cancer. The most common cardiovascular disease (CVD) is ischaemic heart disease (IHD), which is the leading cause of death in Europe. There is a considerable gender gap in death rates from heart disease in all countries, and deaths are considerably higher in CEE than in Western Europe, especially among men.

The health profile of Poland illustrates some of the country level factors that influence mortality and morbidity patterns. In recent years, the health-care system in Poland has undergone many reforms and is currently based on an obligatory public health insurance system. Patients can take advantage of free access to hospital care based on a referral from a general practitioner. Patients also have the right to choose a doctor, nurse, midwife, and hospital from all available public (mainly hospitals) and private (individual or group medical practices) health-care providers.

Cancer is a leading cause of death in the country (in particular lung and prostate cancers) and death rates are driven in part by behavioural factors (both social and health seeking). The percentage of people undergoing medical treatment during the very early stages of cancer is still very low (20%) and is mainly due to the widespread promotion of methods of complementary and alternative medicine.

In 2006, the incident rates of all cancer types (excluding stomach cancer) among women were slightly higher in Poland and in the EU than in 2002, but lung cancer started to be more of a health hazard for women in Poland, with a doubled incident rate at 28.6 in 2006 compared with an incident rate equal to 14.6 in 2002. Polish women also continued to have the highest mortality rate due to lung cancer in 2006.

Health literature on Albanian and Roma people on the other hand strongly emphasises mental health issues. Many Albanians are refugees/asylum seekers from the Kosovo crisis and this has had a lasting impact. A central theme that runs through most health issues related to the Roma is the pervasive impact of experiencing racism and discrimination throughout an entire lifespan and in employment, social and

[16] Lewis S (2009). Barking and Dagenham Joint Strategic Needs Assessment.

public contexts. The body of evidence on Roma health highlights high rates of anxiety, depression and at times self-destructive behaviour (for example, suicide and / or substance abuse).

4.4 POPULATION ESTIMATES

The number of Eastern European nationals in the borough based on adult national registrations for employment (NINo) is reported in Table 5 and Figure 2. Data from previous years is included to allow comparison of changes in the size of the groups over time. Whole borough figures are also provided to enable analysis of rates of change.

The following features are illustrated by the data:

- Since 2002-03, a total of 27,530 adult nationals, including 7,670 from the Accession states and Albania, have registered for employment in the borough.

- 7,670 would represent the high end estimate for the number of Eastern European nationals living in the borough *assuming that all migrants have not emigrated or moved outside since registration.*

- The proportion of foreign nationals within the adult working population has steadily grown from 21 per 1000 (2002-03) to 47 per 1000 (2009-10). Similarly, the proportion of Eastern European nationals has increased from 2 per 1000 (2002-03) to 16 per 1000 (2009-10).

- Eastern European nationals accounted for 19% of all foreign registrations in 2004-05 and 28% in 2009-10.

- Lithuanian, Polish, Bulgarian, Romanian and Albanian nationals are the top 5 largest groups and together represent 92% of all Eastern European registrations.

- Lithuanians are the only major nationality where registrations rose in 2009-10.

- However, *while the overall number of foreign nationals has increased, the rate of increase has slowed since 2007-08*. The drop owes mainly to Eastern Europeans among whom actual number of registrations has fallen in the last year.

- The borough pattern of declining Eastern European registrations is consistent with the national picture.

Table 5 NINo registrations by nationality in Barking and Dagenham, 2002 - 10

Year	Borough Population (MYE)[a]	NINo registrations															
		All	Rate/1000 working age pop	Accession nationalities (plus Albania[b])													
				All	Rate/1000 working age pop	Poland	Lithuania	Albania	Roma[c]	Czech	Estonia	Hungary	Latvia	Slovak Rep	Slovenia	Bulgaria	Romania
2002-03	101,529	2,110	21	**170**	**2**	20	60	20	-	-	-	-	-	-	10	40	20
2003-04	101,971	2,350	23	**270**	**3**	40	130	20	-	-	-	-	10	-	10	40	20
2004-05	102,442	2,530	25	**490**	**5**	110	230	20	-	10	-	-	10	20	30	40	20
2005-06	103,091	3,160	31	**830**	**8**	250	420	20	-	30	10	10	40	20	10	10	10
2006-07	103,853	3,080	30	**850**	**8**	320	350	20	-	20	-	10	20	30	10	50	20
2007-08	104,505	4,290	41	**1,530**	**15**	400	400	30	-	10	10	20	10	20	-	320	310
2008-09	106,090	4,880	46	**1,810**	**17**	600	480	30	-	10	10	30	30	20	-	280	320
2009-10	108,609	5,130	47	**1,720**	**16**	580	620	-	-	10	10	30	80	20	10	160	200
Totals		**27,530**		**7,670**		**2,320**	**2,690**	**160**		**90**	**40**	**100**	**200**	**130**	**80**	**940**	**920**

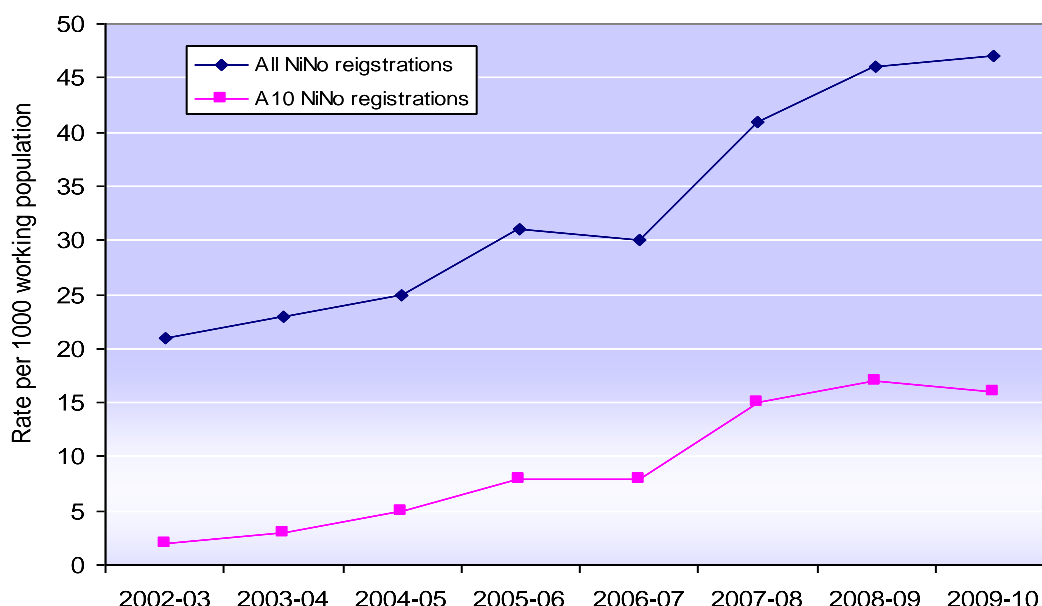
Data sources: DWP, ONS, GLA 2008 Round Ward Population Projections – Low

[a] MYE - Working age (16-59/64) mid year population estimate.

[b] Albania is not an A10 country but included based on indications from local informants that it has among the largest number of Eastern European nationals living in the borough

[c] Members of the Roma community belong to different nationalities so have no individual figures recorded.

Figure 2 NINo registrations in Barking and Dagenham for all foreign and Eastern European nationals, 2002-10



Information on the child population in the borough was derived from school census pupil data which is collected in January of each year (Table 6 Pupils in schools in LBBD as at annual January School Census). Ethnicity information for Eastern European children is hidden within the aggregate category of 'White Other' but sub-analysis is still possible as the census also collects information on first language (or native tongue) from which nationality can be ascertained with reasonable accuracy.

Table 6 Pupils in schools in LBBD as at annual January School Census

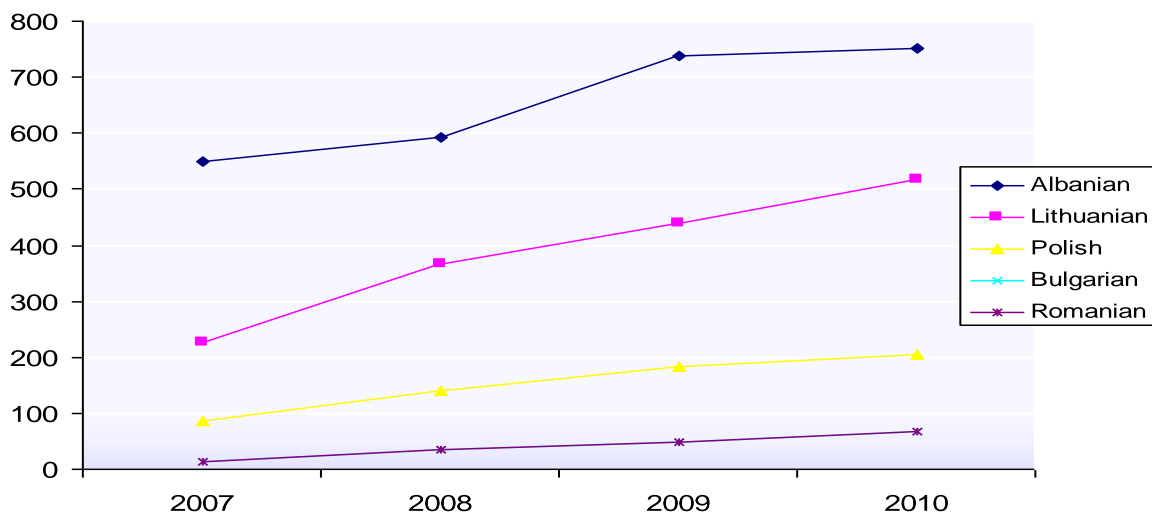
Language	2010		2009		2008		2007	
	No. of pupils	% of total	No. of pupils	% of total	No. of pupils	% of total	No. of pupils	% of total
Polish	204	0.61	182	0.56	141	0.44	86	0.27
Lithuanian	518	1.54	438	1.34	365	1.14	226	0.72
Albanian/Shqip	752	2.24	737	2.25	593	1.85	549	1.74
Czech	19	0.06	20	0.06	15	0.05	10	0.03
Estonian	2	0.01	1	0.00	-	-	-	-
Hungarian	10	0.03	9	0.03	8	0.03	3	0.01
Latvian	9	0.03	5	0.02	4	0.01	2	0.01
Slovak	15	0.04	15	0.05	5	0.02	5	0.02
Slovenian	1	0.00	-	-	2	0.01	-	-
Bulgarian	67	0.20	49	0.15	35	0.11	14	0.04
Romanian	67	0.20	49	0.15	35	0.11	14	0.04
Romani (International)	5	0.01	3	0.01	2	0.01	2	0.01
Romany/English Romanies	4	0.01	6	0.02	-	-	1	0.00
All White Other	2608	7.76	2331	8.94	2058	6.43	1730	5.48
English	21092	62.76	21362	65.35	22441	70.16	23492	74.41
Total on roll	33605		32688		31984		31573	

Data for 2010 shows that there were 33,605 children in schools in LBBD, 63% of who were classified as English (speaking) and 7.8% as White Other. Eastern European nationals fall within the latter category. Among Eastern European nationals, the top largest groups for native languages spoken were Albanian (752, 2.2%), Lithuanians (518, 1.5%), Polish (204, 0.6%), Bulgarian and Romanian (67, 0.2% each). Figure 3 shows how numbers for the top 5 nationalities have increased over time. The following features are illustrated:

- The rate of increase is highest for Lithuanians and Albanians, but while the slope for Albanians reduced between 2009 and 2010, as it did for Poles, that of the Lithuanians remained constant.

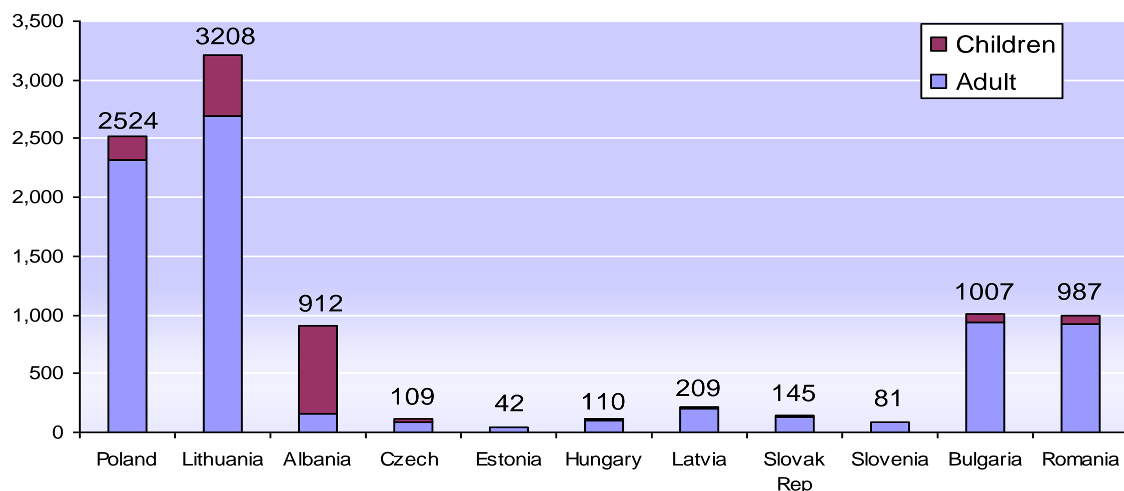
- The sustained increase in the number of Lithuanian children parallels that of adult Lithuanians who are the only nationality among the top 5 where NINo registrations rose in 2009-10

Figure 3 Number of pupils enrolled in schools in LBBD, 2007-10



By combining the 2010 adult and children's data, current population figures for each of the Eastern European nationalities were derived. This is shown in Table 4. The total population figure is 9,334 (based on the assumption that no emigration has taken place. This is supported by the survey findings which indicated that the majority of people intended to remain in the borough).

Figure 4 Population of Eastern European nationals in LBBD - High



5 Qualitative research

Respondents in all four target communities were asked the same questions (see below). Answers were thematically analysed and the main results are presented below under thematic headings. For details of the methodology see section 3.4.2.

The four questions respondents were asked were as follows:

- HEALTH NEEDS: What do you think are the main health and social care problems in your community?
- BARRIERS: What problems have you experienced in trying to use health and social services?
- ENABLERS: What things have made it easier for you to use these services?
- IMPROVEMENTS: What can the authorities do to improve health and social services for you?

5.1 Understanding and accessing the health system

5.1.1 Language Issues

"I am convinced that all health and social problems of Lithuanian community in the UKmainly due to poor English"

Lithuanian community Member

Respondents from all four targeted communities highlighted the issue of language as a major contributing barrier to access to services.

"When I go to see GP I never have an interpreter. This is a big problem for us." (everyone present agreed with this point)

Roma community member

Levels of proficiency in English language usage among BME community members in both spoken and written forms profoundly influence the facility with which communications within day-to-day social transactions and interactions with services take place. But they also influence these communities' understanding of how the system works. Among the community members and those working with them that we interviewed, language (including issues of translation and interpretation) was consistently identified as a major barrier to accessing services. This barrier was strongly linked to other identified barriers; a lack of understanding of the system (see 5.1.2 below for further detail) and a lack of representative statutory sector workforce.

Problems with language skills have cumulative effects. They reinforce, and are reinforced by, a lack of cultural understanding between BME community members and those working within the NHS and its services. BME community members may often have a limited knowledge of the culture of the British system, its history, its processes, its mechanisms; and at the same time many of those working to plan or provide services may often have a limited knowledge of the cultures, manners, customs and sensitivities of the BME communities who they deal with in the course of their work. This can engender a lack of trust.

Service access and use: Put bluntly, in order to access services BME community members need to know they exist. Leaflets and other advertising are often not available in people's first languages, and so are dismissed.

"We do not understand the system and find it difficult to communicate. When we receive letters we do not understand what they mean"

Roma community member

"I have picked one leaflet at my GP about healthy eating but it is in English. Good job that it is mainly pictures plus I have translated the leaflet into Polish with some help from my dictionary but I would much prefer to have it in Polish. I think more people would be interested to have some more health information in Polish"

Polish community member

If they know services exist, they have to be willing to contact them and then when they seek to access services they may not know how to go about it.

When they succeed in accessing a service, they can't explain their needs or understand how things will proceed, and they may be discouraged from proceeding by their experience of contact.

"When approaching GP to register, they are reluctant and they turn you away because of the language difficulties you may have. Interpreting is often not provided"

Albanian community member

"Always the receptionist tells me that I need to bring somebody who can speak English as they do not have an interpreter. If I need to go and see my doctor I have to ask my friend's daughter who is 14 to come with me and pay my friend or buy her something for that."

Polish community Member

If they do speak the language they may not understand the terminology.

"My main problem was poor English so it was difficult obtain any information. It was pretty hard to understand differences between A&E, GP, NHS and NHS walk-in centres etc"

Lithuanian community Member

These problems are exacerbated by difficulties experienced by some in accessing interpreters and by the non-representativeness of the service provision workforce.

"Main problem is language barrier as there are difficulties in explaining symptoms"

Lithuanian community Member

Those providing services, as well as those accessing them, feel the consequences of language barriers. There are knock-on effects on staffs' ability to offer appropriate and efficient services and may have a profound effect on individuals accessing appropriate and timely health treatment or advice.

"The voice message on the phone that takes you from one option to another is not suitable for people with language barriers and often people, despite the need, can not travel to go and make the appointment in person and they leave things for too late."

Albanian community member

"As a mother of a young child with health issues I found it very stressful when I need to go to see a doctor or go to the hospital for some test or examinations and I am not able to do so as my English is no good enough. When I was having our daughter all my antenatal appointments I attended with my husband, who speaks very good English but we were never told that there was anything wrong with the pregnancy. But there were some complications during the labour but because there was no interpreter, myself and my husband, did not fully understand what the problems were and our daughter is now mildly disabled as a result of these complications. But we are not suing the hospital for damages as other people would have done. "

Polish community member

"Borough should make more efforts to provide English classes for Polish people. Then they could deal with GP appointments etc by themselves with no need to rely on others for translation."

Polish community member

5.1.2 Lack of knowledge about system

"It is really difficult to access services. The first problem is that we do not know much about any of the services here."

Roma community member

5.1.2.1 Where do I get help?

Many respondents spoke about their lack of knowledge about the system, what help was available, and where to seek it.

"The main barrier for me is the fact that I do not know where to go for help. I do not want to speak to my friends about it as I do not want them to know about my personal problems. I do not have a GP in B & D because of the language barrier and lack of knowledge about the changing over process. My old GP will not see me no more because is out of borough, they have told me to find another one where I live but I do not know how or where and what do I need to do. I am not sure who runs the AA meeting and where they are? Even if I knew how will I go there when my English is good enough for the building site but not the therapy session. The whole situation is very difficult but I do not know where to start. And that is also a contributory reason for my drinking - frustration."

Polish community member

Many people from the Eastern European BME Communities have obviously arrived with different language skills, knowledge, contacts and cultural awareness. It is in the interest of new arrivals that they are able to understand their rights, entitlements and obligations. It is also in their interest, and the interest of the wider community, for them to be able to communicate effectively. The sooner new arrivals can gain access to and negotiate the mechanisms of the society, the better for all concerned. With this in mind the key concept becomes communication. Once new arrivals 'present themselves' it would be useful if they could participate in a form of 'induction'.

"We need information about different services. What is available for disabled people and how to access mental health services."

Roma community member

This could include things such as; how to sign on with a Doctor, how to gain access to emergency services, how to report crime, the legal system, employment opportunities, translation services and language classes, the roles of the State and Government, information on the political system and how to register to vote, information on the role of the NHS and Local Authority, how to enrol children into school, how to enrol in adult education and training, vehicle licensing, postal services, and so on.

This would all need to be carried out while recognising the wide diversity of the entrants, not just in terms of cultural background, but also in their level of preparedness and expectation. A one-size-fits-all approach might not be effective.

"Many Roma have problems with reading so it would be good we could find in GP practices and other public places simple comprehensive information, leaflets in community languages."

Roma community member

General and specific information on each service could be provided, in appropriate languages, and in appropriate media, to explain, in the first place, how it all works. This might include websites, leaflets, video, CDs or audiotapes, distributed or lent through front line service offices, libraries, community organisations or outreach teams, or it might be regular ongoing training presentations in the local community in various languages, by or with community organisations or own language outreach teams.

"Perhaps authorities could create an information package for Roma and other migrants about the services available to them, how they work and how to access them. It would be good if the information was written in simple language and translated into Romanian so people can understand it."

Roma community member

"Information about heath services and social care needs to be translated and materials and information can be explained to people in details by community groups – so more involvement of NHS or GP with the third sector"

Albanian community member

"Can advertise health messages in two Albanian newspapers and on their website"

Albanian community member

As Barking & Dagenham is set to continue to be a destination for migrants, one can envisage that this could be a continuing resource adapting to new groups as they present themselves, and cost of certain media could be shared between services and indeed between boroughs.

Any information needs to be honest. It needs to tell it straight - not to raise expectations – explain when a service is limited, and why, explain waiting lists, and times people might wait for housing or health for instance, and how decisions are made. For this reason, induction information needs to be updateable.

"If there is someone nice who takes interest and explains things it helps"

Roma community member

"I think the main problem is lack of information about services and their accessibility in various aspect of everyday life. The system is very different in the UK than in Poland and many people who come to live here even temporary need help and advice but there is nowhere to go for that in B & D. All of the Polish people I know work and pay taxes so it is only fair that some of that money is put back to help the people who are making them. I understand that sometimes people do not want to be helped but sometimes is necessary to make it more approachable and accessible for them. I know many people who do not even know about the basic services like GP in this country."

Polish community member

5.1.2.2 Lack of knowledge about medical conditions

Further, many Roma people have very little knowledge and understanding of different medical conditions or know much about healthy diets. Many Roma did not know what was wrong with them or what treatment they should receive. Generally the Roma community don't like talking about ill health.

5.1.2.3 Registering with services

Respondents from all communities, but particularly Roma and Lithuanians, spoke about their difficulties in registering with GPs and other services. The main reason was due to inability to show proof of address, often compounded by uncooperative private landlords.

Respondents complained that when they tried to register or use a service, they met with so many obstacles that it became impossible. Most could not afford separate accommodation so they often lived with relatives or friends and paid rent communally but usually only one person in the household held the proof of address.

"There are some difficulties to register with GP as the requirements are to provide certain documents. Many of people I know personally cannot provide any utility bills or other documents due to following reasons. Some of them rent only one room or even bed and landlords are not willing to show up they have tenants as houses are overcrowded. Some people

work as cleaners for private clients and have not any pay slips. Some people work illegally or employer employs people illegally not paying any taxes. Consequently people do not receive any medical help."

Lithuanian community Member

"The most inexplicable and disappointed situation was refuse in registration within GP. I just came to the UK; I was not working these times and could not provide any pay slips or utility bills."

Lithuanian community Member

"When I lived in France I was staying at a caravan site. There were other people like me. We all could register with doctor's surgeries and use health services, there was special provision and it was possible to use the caravan site address. But over here in Barking and Dagenham people living with friends or relatives in their houses virtually cannot access many of the services including GP surgeries."

Roma community member

5.1.2.4 CULTURALLY SPECIFIC SERVICES

"Health advocates in hospital are needed not only for interpreting but because of cultural differences."

Albanian community member

The lack of provision of culturally sensitive services was seen as another barrier to community members accessing services. This applied to particularly the Roma and to a lesser degree Albanian/Kosovan communities. Culturally specific norms and taboos about such subjects as sexual health, homosexuality, domestic violence, drug and alcohol abuse, disability and mental health means that it is often difficult to discuss these issues openly in front of other community or family members. It can also be inappropriate for women to discuss certain sexual health issues with male health staff. This can lead to these issues being hidden and not dealt with until too late.

The solution to this from respondents was to provide more culturally sensitive services, employ advocates who understood Roma or Albanian culture, to educate service providers more fully about culturally sensitive issues, and to begin to broach these issues with the community through third sector organisations.

"Mental health is a taboo – so more information/awareness on mental health is required"

Albanian community member

"Roma adults need education about mental health and disabilities. It cannot be done overnight and authorities must realise that health and especially mental health, learning and other disabilities are taboo subjects amongst Roma. Authorities should be aware that those subjects are very sensitive and if they want to change things they should provide culturally appropriate support for Roma with mental health problems, learning difficulties and other disabilities and for their families. There should be support centres open for Roma with staff aware of the Roma culture."

Roma community member

5.1.3 THIRD SECTOR COMMUNITY ORGANISATIONS

There was only one community organisation in Barking and Dagenham amongst our four targeted communities – Shpresa, an Albanian community organisation. The Roma Support Group (RSG) is located in Newham and works with the Roma community in several surrounding boroughs but until this survey had seldom worked in Barking and Dagenham. We found no groups representing Poles or Lithuanians.

The lack of advocacy and formalised social networks creates a situation where the issues highlighted elsewhere in this section arise e.g. lack of knowledge about services or lack of cultural understanding by service providers.

Health advocacy was seen by respondents as an important unmet need of their communities and by making it available, it was felt that access to health services would improve.

Shpresa is a good example of health advocacy. For instance, Shpresa members are taken to the hospital for cervical screening in a group by Shpresa team members after Albanian women did not respond to letters from GPs as they thought "it was nothing to do with them". A similar approach could be taken for other screening programmes.

Shpresa (http://www.shpresaprogramme.com/) currently is a small organisation offering a variety of services that promote the development, education, health and well-being of the Albanian and Kosovan community.

The Roma Support Group (http://www.romasupportgroup.org.uk/) based in Newham runs a mental health project and a health advocacy project.

It was felt that many in Social services and GPs were not aware of these third sector organisations and did not refer people to them, and that there was a need to have representatives on different health community panels.

> *"I do not know where to ask for help in my area, the only place I know of which is helping us (Roma) is the office (RSG office). Roma office (RSG office) is making it easier for us to use services. If we do not have help from that office, there is nobody to help."*
>
> Roma community member

5.2 MENTAL AND PHYSICAL CONDITIONS

Respondents described the types of medical issues, both mental and physical, that they felt were prevalent within their communities.

5.2.1 MENTAL HEALTH

The stresses and anxieties carried from home countries, combined with new stresses related to immigration and adaptation to their new environment in the UK surfaced quickly within the focus groups and interviews. All communities spoke about high levels of stress, depression and poor mental health.

The reasons for these high levels of stress, depression and poor mental health were partially surfaced and revealed some community differences. Amongst Roma and Albanians/Kosovans, in particular, discussion of mental health issues openly is taboo and so conversations were limited.

Many from the Roma community worried about their residential status in this country. Asylum cases meant they could not work, made life very difficult and lead to widespread stress and depression.

For Albanians/Kosovans, the perceived factors were the trauma that people went through before coming to the UK - war in Kosovo, problems in Albania, having to leave everything behind including their family, community, way of life, support networks and belongings. Women have been traumatised and raped, and people had witnessed genocide. There were also issues with domestic violence, and fears about their residential status in the UK.

5.2.2 Physical health

Community	Identified Health Issues	Notes
Roma	• Diabetes • Depression • Asthma • Cancer • TB • Heart problems	In fact, in their own opinion, the Roma have so many problems that *"every other person is depressed"*. Illnesses amongst the Roma in Barking & Dagenham are often related to poor working and living conditions and poor diet. Anecdotal evidence from fieldworkers spoke of some respondents living in appalling conditions – in rat infested (rented) squats in the middle of industrial estates – and fieldworkers also observed several untreated injuries and conditions. Respondents spoke of many community members dying young and of many families having disabled children, and finding it difficult to cope with the fact that their children are disabled. They often do not seek help but try to hide the problem from other community members. This is caused by fear of stigma and branding which would have impact on their life and standing in the community. Roma do not want to talk about problems such as mental health or disability; it is a taboo subject.
Albanian/ Kosovan	• Lower back pain	People have had to start work from a young age in factories and in the field and these involved lifting heavy weights. They also "have been beaten" or have had accidents.
	• Arthritis, Sciatica, Spondylitis and Rheumatism	Have been health issues for generations in the community.
	• Asthma and bronchitis	Respondents felt this was due to poor housing and living conditions even in UK, and this was also affecting young children.
	• Type B diabetes	Seen as due to the poor nutrition and unhealthy diets.
	• High blood pressure and heart attacks	Seen as due to extreme stress
	• Kidneys complaints	May be due to high salt intake
	• Stomach problems such as ulcer or dyspepsia	Feedback from doctors says that the stomach problems were related to stress and poor nutrition.
	• Migraine and sinus	Continuous headaches associated with stress, eating habits
	• Epilepsy	Respondents said more people have been diagnosed

	• Cancer • Overweight and obesity • High levels of stress • Breast cancer	and died from cancer in the last 10 years
Lithuanian	• High blood pressure • High levels of stress • Heart problems	
Polish	• Poor eating habits • Drug problems • Heavy drinking and smoking, particularly amongst the men.	Seen as due to busy lifestyles. *"I think the main problem for Polish people living in B & D is not looking after themselves for whatever reason. People are not paying too much attention what they are eating. They are buying processed food what they will never do in Poland but in here they just live on fast food rather then cooking."* *"Since we came to live in B&D 2 years ago we have put so much weight on and if you look around the town centre there are only fast food shops and nothing else. I know that we do not have to go to them but it the convenience and lack of other better food shops."* *"People do things here which they would not do if there were in their own towns back in Poland because of the risk that somebody may know them but here they do not care."* *"I think the main problem for Polish people living in B & D is alcohol abuse (especially amongst men) and lack of facilities helping to overcome this problem. Many Polish people here are single people who work long hours and after hard day at work reach for a few beers or a bottle of vodka. After that there is often more alcohol and the problem starts. People are lonely so when they meet to keep each other company they also drink… They miss the families they have left in Poland when they came here to the UK to earn money."*

5.3 Other Issues

Interviews and focus groups raised many opinions on the experience of using the health services in Barking and Dagenham. Some were negative, and some positive, the latter especially amongst the Lithuanians.

Below are listed some of the more frequent issues raised:

- All communities felt they had to wait to long for services, including appointments, specialists, referrals and test results. This particularly affected those at work.

- Reception staff were criticised for being rude, uncaring and unhelpful.
- The "one appointment, one problem" rule was seen as unreasonable.
- The over-prescription of paracetamol was criticised. *"It is outrageous to prescribe paracetamol for every single occasion. I would say that Eastern European nationals are more knowledgeable about health and remedy."*
- Many used private doctors from their own communities when they could afford it, as they felt they weren't getting good enough treatment elsewhere. *"Sometimes I think that if people would not go to private Polish doctors they would never get treated."*
- The Roma felt that NHS staff needed cultural training to understand cultural sensitivity of their community.

5.4 Diversity issues within the communities

5.4.1 Disability

5.4.1.1 Roma

Within the Roma community, disability, both physical and mental, is described as "shameful". Both physical and mental disability is taboo. Those disabled are unlikely to participate in community life. Having a disabled child was described as a difficult issue for parents. The community has little understanding of the causes or roots of disability. Health beliefs consider it to be passed on genetically. Thus it can jeopardise the marriage chances of siblings, and because of this belief, disability is hidden away.

Parents will talk discretely about their difficulties but not in front of other community members for reasons given above. It is changing slightly as younger people and more progressive community members come in contact with Western attitudes. The younger are more open but would still have difficulty talking within family.

Many don't know what help to get, what help is available or how to get it. When some sort of access is achieved, they get frightened and confused by the amount of information thrown at them by the authorities. They feel the process and procedures are not explained – why this assessment, that assessment? What's its purpose? Authorities need to work slowly, taking them step by step else they are likely to withdraw.

Because of past experiences, the Roma are very suspicious of authorities especially around child assessment cases. They fear that their children will be taken away and locked up.

Health promotion about disability needs one-to-one support with clients to build trust. Working with clients must be culturally sensitive i.e. not broadcast in the community.

5.4.1.2 Albanians

Like the Roma, disability is seen as a problem within families and they don't like to talk about it. Health beliefs see it as genetic, perhaps affecting marriage chances of other siblings, and thus it is hidden. Often the disabled are not allowed out. Attitudes are changing as people are coming more in contact with western attitudes and services. Change in attitudes may be accelerated through awareness of services, through community media, schools, and GPs.

5.4.2 Mental Health

5.4.2.1 Roma[17]

Mental Health is treated as a taboo amongst the Roma community. It is not discussed amongst the Roma. If it is, Roma talk about being sad, feeling down and having a specific problem in their life; in situations like that it is acceptable to say that someone is depressed. Some people will not be reluctant to talk about mental health in front of others but usually not in front of other Roma. They also describe their mental health problems as problems “with the head” or “being crazy” rather than recognising and naming specific mental health conditions.

Drug addiction is one of the greatest taboos amongst the Roma who deny that drug addiction exists amongst their community, clan, tribe, or family. Another huge taboo is rape and the mental health problems suffered by the victims. Victims rarely talk about their problems. Problems such as alcohol abuse are treated as a social activity and most of the time not treated as an addiction. The situation is changing amongst the young people who are more aware of various mental health problems but still reluctant to discuss them.

There is strong belief that mental health problems can be passed on genetically which can jeopardise the prospect of marriage for the sufferer as well as other family members making mental health one of the most hidden and shameful issues in their community.

Seeking Help: Roma try to hide the fact that they are suffering from mental health problems from their family and other community members. Once the family knows, they will endeavour to hide the problem from others. This often creates a long delay in seeking medical help. In some cases health professionals are approached only when the situation is completely out of control and the family members can not cope with the situation.

Barriers in Accessing Health Services: Discrimination faced by the Roma in accessing health services in the countries of origins, and the branding of Roma children as having learning difficulties or mental health problems when none existed, has created deep distrust towards general and mental health professionals. Roma find it difficult to trust doctors and to talk about sensitive issues such as mental health problems, fearing negative consequences.

Another barrier is often created by language problems; non-Roma interpreters might not be aware of the language limitations of the Roma patient and misunderstand or mistranslate the subject discussed. Also there is an element of distrust between Roma and non-Roma interpreters. However, if a Roma interpreter is present the Roma patient might be reluctant to discuss their mental health issues. Even when the Roma patient speaks good English they might need an interpreter to explain their medical and emotional problems since they may not know the relevant vocabulary. Therefore, it is important to be sensitive about the patient/interpreter relationship.

For the above reasons as well as low self-esteem, lack of knowledge about the help available and their rights, it often means that Roma find it difficult to voice concerns about their mental health problems, describe them or to get referred to a mental health professional.

Contact with Health Professionals: A relationship of trust and respect between the health professional and the Roma patient is necessary for the Roma to talk about all the sensitive issues related to their health and especially to talk about their mental health problems.

---

[17] Much of this section is taken from “The Roma Community: An Information Leaflet for Health Professionals and Especially Mental Health Professionals” by the Roma Support Group.

- Friendly and respectful body language displayed by the health professional helps Roma to trust them.
- Eye contact while talking is one of the most important things for the Roma patient, (they find it offensive if the doctor looks at the computer or his notes while talking to them).
- Roma do not like what they call difficult questions, these are personal questions asked before trust and understanding with a health professional is established. If a difficult question is asked too soon it may undermine the future relationship with patient.
- Older doctors are trusted more than younger ones. For many Roma continuity with the same doctor is extremely important.

5.4.3 Attitudes towards homosexuality

Attitudes towards homosexuality in Eastern and Western Europe differ somewhat. In Eastern Europe, homosexuality is seen as a taboo subject, hidden from the public realm. The National Pew Global Attitudes Survey (2007)[18] highlighted this difference. In western, secular nations, there is a belief that homosexuality should be accepted. However this level of tolerance is not echoed by Eastern European regions where attitudes are more mixed. Among Eastern Europeans, opinions towards homosexuality tend to be rather diverse. Czechs and Slovaks adopt the view that homosexuality should be seen as a lifestyle choice and is acceptable; Poles and Bulgarians are divided on this issue and contrastingly Russians and Ukrainians strongly oppose it. There seems to be a pattern in terms of age, with 54% of younger (18-39) Bulgarians stating that homosexuality should be accepted compared to 31% of older (40+) Bulgarians. This perhaps suggests a change in attitudes through the generations.

Membership to the European Union requires countries to repeal any anti-homosexuality legislation and although the Accession states have adopted such laws, societal attitudes are still negative. This is demonstrated by the violence and discrimination targeted towards gays and lesbians and anti homosexual sentiments propagated by the government. It could be said that some of these societies were kept in a social deep-freeze for 4 decades and are only now going through the cultural changes that the Western nations went through in the 1950s. In line with this view, which presumes a belief in "stages" of social and cultural evolution, the social revolutions seen in the West in the 1960s are yet to take place in Eastern Europe[19]. Recently, a man declaring his homosexuality on Albania's version of Big Brother was forced to seek asylum after mass demonstrations.

These attitudes are reflected in interviews with Eastern European community organisations, although not held by the interviewees themselves. Within both the Albanian and Roma communities where we were able to gauge attitudes to homosexuality, the subject was totally taboo. It is "unacceptable" and community members refuse to talk about it. Even raising the subject informally is likely to lead to respondents withdrawing, and we were advised to leave homosexual referencing questions out of the survey.

Interviewees told us that no one would dare to identify themselves as homosexual. This would lead to a rejection by their families and exclusion from their communities and support networks. Within the Roma community, this would even have a knock on affect onto their families. It would lead to feelings of shame for the entire family, ostracism and ridicule.

Certain issues were taboo, or embarrassing. These included domestic violence, drugs but especially homosexuality as well as being uncomfortable about talking about individual health problems. So homosexuality remains a hidden subject. We were advised that the Roma were "not ready" to tackle it.

Whilst no anecdotal stories were given of violence against homosexuals, there was some evidence, although small, of self harm, even suicide. Basically, attitudes as mentioned above within these

[18] The Pew Global Attitudes Survey (2007). Pew Global

[19] Stroehlein, A, (1999) A Queer Taboo. Central European Review, Issue no: 7

communities are akin to pre-1950s western attitudes. It is unlikely that someone from these communities who is indeed homosexual or lesbian would know where to get help or advice and is likely to keep their feelings and desires suppressed.

Within the Lithuanian, Polish, and Albanian/Kosovan communities there may be an opportunity to advertise services or helplines for homosexuals within larger community newspapers. Local community organisations might feel compromised, even where sympathetic, in advertising helplines etc. Amongst the Roma community, there was presently little opportunity in any way to raise these issues. Perhaps, as the community slowly integrates itself, understandings and opportunities for dialogue on this issue will arise, and health services should continue to look for such opportunities.

6 SURVEY FINDINGS

One hundred and twenty respondents (30 from each of the four target groups) participated in a questionnaire survey conducted by fieldworkers drawn from their local community and fluent in their native language. The purpose was to gain insight into people's perceptions, attitudes and practices in relation to their health and social care experiences. Information was also elicited on family and community life and long term residency intentions.

6.1 SOCIO-DEMOGRAPHIC PROFILE

Participants ranged in age from 16 to 76 years with a mean age of 36.3 years. Two thirds of them (67%) were women and almost half (47%) were married. Moslems made up about 1 in 5 people surveyed and were all of Albanian/Kosovan nationality. The proportion of those who had completed post-secondary education was highest among the Albanians/Kosovan (63%) and lowest among the Roma (10%). Thirty nine percent rated their spoken English as excellent or good. The proportion fell to 27% for written English. In both instances, Roma and Polish people had the lowest rates. Overall, Roma individuals have the lowest qualifications and language skills and this is an issue that has been highlighted in the qualitative research as posing a significant barrier to accessing services.

Table 7 Socio-demographic profile by nationality

Socio-demographic	Lithuanian		Polish		Albanian		Roma		Total	
variable	n	%	n	%	n	%	n	%	n	%
Age (years)										
Mean	38.0		33.1		35.9		38.4		36.3	
Range	18-65		18-56		23-55		16-76		16-76	
Gender										
Male	10	*33.7*	8	*26.7*	6	*20.0*	15	*51.7*	39	*32.8*
Female	20	*66.7*	22	*73.3*	24	*80.0*	14	*48.3*	80	*67.2*
Marital status										
Single	11	*37.7*	10	*33.3*	8	*26.7*	5	*16.7*	34	*28.3*
Married	12	*40.0*	14	*46.7*	12	*40.0*	19	*63.3*	57	*47.5*
Other	7	*23.3*	6	*20.0*	10	*33.3*	23	*20.0*	29	*24.2*
Religion										
Christian	26	*100.0*	26	*96.3*	0	-	30	*100.0*	64	*62.7*
Moslem	0	-	0	-	19	*100.0*	0	-	19	*18.6*
Education & communication										
Post-secondary Education completed	16	*53.3*	14	*46.7*	19	*63.3*	3	*10.0*	52	*43.4*
Self rated spoken English fluent/good[20]	11	*36.7*	10	*33.3*	17	*56.7*	9	*30.0*	47	*39.2*
Self rated written English excellent/good[21]	9	*30.0*	5	*16.6*	14	*46.7*	5	*16.6*	33	*27.5*

[20] It is necessary to emphasise that English language skills were self-reported and therefore may not be fully reliable.
[21] See above

6.2 EMPLOYMENT, INCOME AND BENEFIT CLAIMS

The proportion of people in current employment was highest for Lithuanians and Poles and lowest for Albanians/Kosovans and Roma people. Among those in employment, the commonest sectors worked in were construction (30%) and hospitality/catering (14%), (data not shown). The attraction of the construction sector owes to the job opportunities created by the 2012 Olympic Games that is transforming the landscape of East London. Another contributor may be the Thames Gateway development, one of the largest regeneration programmes in Europe. But it is instructive to note that the construction and manufacturing sector tends to shrink in times of economic strain. This likely explains the declining NINo registrations reported in section 4.4

Despite their relatively high levels of education, Eastern Europeans received relatively low levels of pay. The pattern of experiencing worse inequalities is again demonstrated in Roma individuals among whom more than 7 in 10 earned less than £870 a month compared to less than 1 in 5 for the whole cohort. Consequently, benefit claims were high especially for housing (39% of people), council tax (30%) and income support (19%).

Table 8 Employment, income and benefit claims by nationality

Variable	Lithuanian		Polish		Albanian		Roma		Total	
	n	%	n	%	n	%	n	%	n	%
In paid employment	24	*82.8*	20	*66.7*	6	*20.7*	10	*35.7*	60	*51.7*
Average monthly income less than £870	11	*39.3*	14	*58.3*	4	*15.4*	17	*73.9*	46	*45.6*
Current work at lower level than in home country	10	*41.6*	10	*47.6*	5	*38.5*	3	*23.1*	28	*39.4*
Living costs better than in home country	16	*57.1*	17	*68.0*	8	*33.3*	17	*80.9*	58	*78.9*
Receiving benefits:										
- Housing	5	*21.7*	10	*40.0*	18	*62.1*	9	*30.0*	42	*39.3*
- Council tax	3	*12.5*	8	*32.0*	18	*60.0*	4	*13.3*	33	*30.3*
- Income support	1	*4.2*	2	*8.0*	13	*43.3*	5	*16.7*	21	*19.3*
- Job seekers allow.	0	-	0	-	3	*10.0*	3	*10.0*	6	*5.5*
- Child support	4	*16.7*	1	*4.0*	3	*10.0*	3	*10.0*	11	*10.1*
- Disability/carers	0	-	1	*4.0*	1	*4.0*	3	*10.0*	5	*4.6*

6.3 RESIDENCY, FAMILY AND SOCIAL NETWORKS

Understanding the long term intentions of Eastern Europeans and the nature of their family networks is crucial in modelling the trajectories of their population growth. Two thirds of respondents indicated that they intended to reside permanently in the UK, a factor that supports accepting higher end estimates of their population growth. On the other hand, most respondents (74%) did not financially support anyone back in their home country nor were they planning to bring any family members to the UK to live with them (80%). This finding leans towards more conservative rates, together with data that shows increasing rates of emigration driven by the global economic downturn.

6.4 HEALTH BEHAVIOUR AND ACCESS

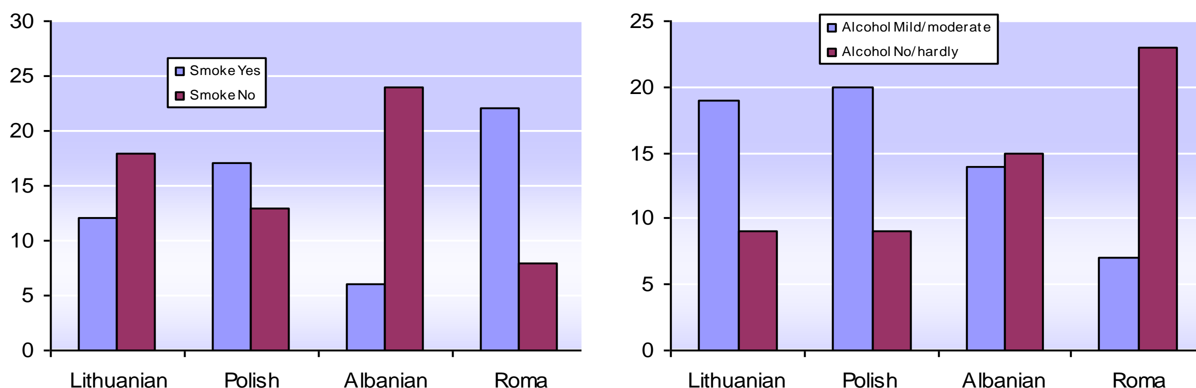
Seventy one percent of people rated their overall health status positively (i.e. as very good, 27% or fairly good, 44%). Rates varied across the groups and were highest for Polish nationals (83%) and Roma people (53%).

Most people (58%) went first to the GP for their health problems. the rate was highest among Albanians/Kosovans (93%) and lowest among Lithuanians and Poles (40%). Otherwise, people accessed pharmacies (19%) or A&E (11%). Other sources such as NHS Direct, NHS Walk in centres, self care and complementary medicine were the first ports of call for 12% of the group.

Forty eight percent of respondents smoked with the highest rates among the Roma (74%) and lowest in the Albanians/Kosovans (20%). With alcohol consumption, 51% admitted to mild or moderate drinking and rates were highest among Polish (69%) and Lithuanian people (68%).

From qualitative research with third sector organisations, we were told that the Roma smoke a lot. They start young, and there were now many cases of cancer. The Roma relate smoking to a relief of stress or stressful situations; and the practice has become cultural. The Roma Support Group (RSG) advise that cessation has to be promoted slowly, beginning with raising awareness especially amongst young people. The best places for health promotion are at "fun events" or community events such as RSG's AGM, where people will go for a get together. The Roma are unlikely to turn up at health promotion specific events. Health promotion materials need to include culturally sensitive visuals i.e. of Roma men, but not women, as smoking amongst women is considered taboo. According to Albanian community organisation, Shpresa, smoking in Albania is mostly by men, not women. It's a cultural activity. Although, in the UK, they reported that smoking among women, boys and girls was on the increase. Shpresa expressed the need for awareness raising projects. Presently, Shpresa do not specifically implement a smoking cessation service. This was due to lack of funding and capacity due to the many demands on small organisations.

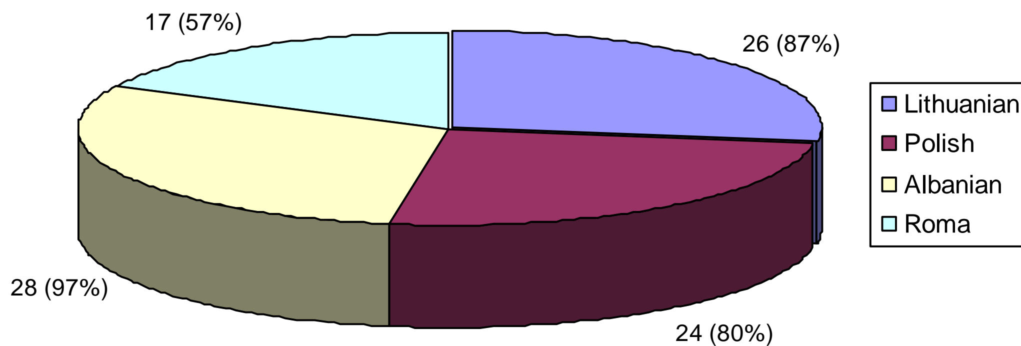
Figure 5 Smoking and drinking patterns by nationality



Many people expressed a desire to eat more healthily but cited cost, lack of time and not liking the taste as their main reasons for not doing so. From qualitative research, we were told that healthy eating has been promoted by the RSG through cooking sessions where a nutritionist is involved. The Roma like cooking and practical information but they prefer very visual info due to poor literacy.

8 in 10 people were registered with a GP but the figure varied across the groups. Whereas 97% of Albanians/Kosovans were registered, only 57% of Roma had done so. People who were not registered mentioned ignorance of the process (36%), never tried/bothered to (32%) and language barriers (20%) as the main obstacles.

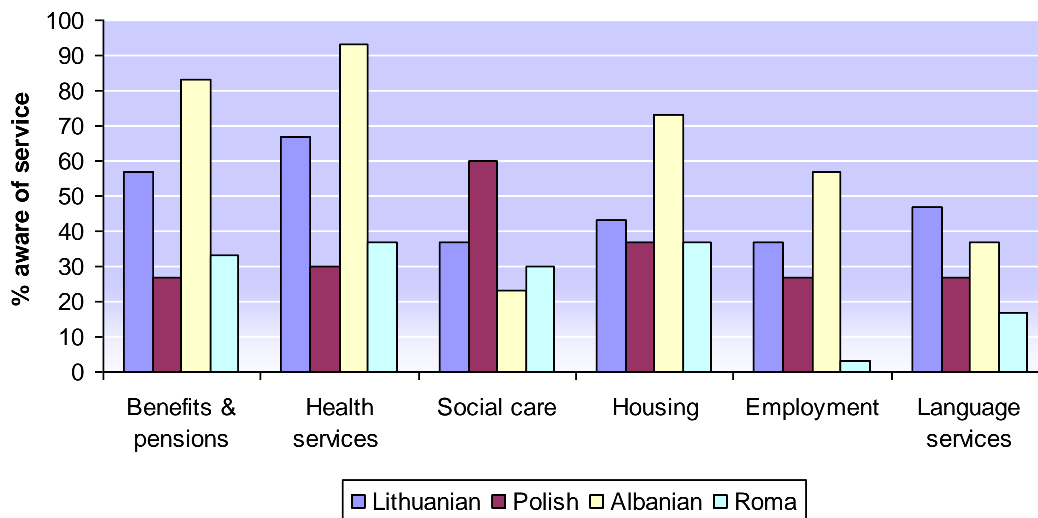
Figure 6 GP registration by nationality



6.5 SERVICE AWARENESS AND INFORMATION SEEKING

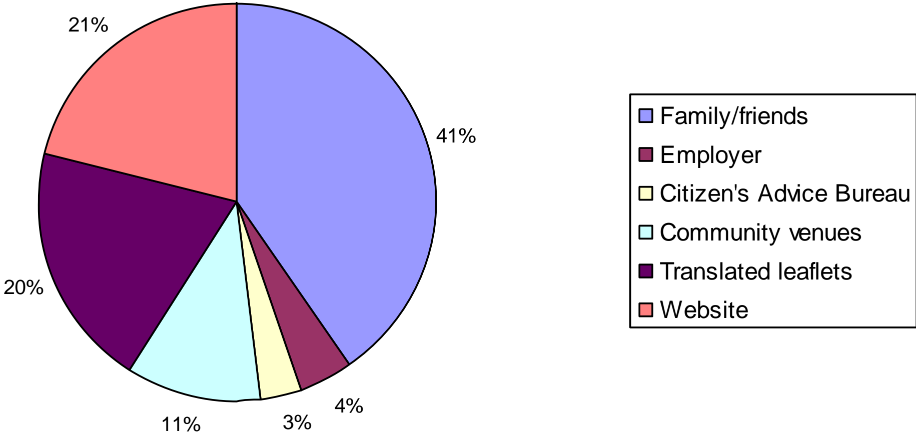
Survey respondents were asked about their knowledge of the health and social services available to them. While there were variations across the groups and across services, generally, Albanians/Kosovans and Lithuanians were more aware of services than the other groups. The Roma were particularly ignorant of employment and language services. An understanding of what services and support exist locally may be a strong explanatory factor in people's use of services.

Figure 7 Awareness of services by nationality



It is not sufficient for services to be available in a place. Users need to know about them. On this premise, we were interested to know how people accessed information. The results are presented in Figure 8. The main sources of information were from family and friends (41%), dedicated websites (21%) and translated leaflets (20%). Another key source was community venues (11%). It is vital for authorities to understand how the populations they serve access information as thousands of pounds can be inappropriately spent with little value for money achieved.

Figure 8 Sources of information about health and social services



7 Conclusions and recommendations

7.1 Introduction

Since the entry of the Accession states into the EU in 2004, the UK has witnessed an influx by nationals from these A10 countries that has significantly transformed the demographic landscape of the parts of the country where they have settled. The London Borough of Barking and Dagenham is one of such areas that has attracted in-migration particularly because of the availability of jobs in the construction sector occasioned by building for the 2012 Olympic Games, and to a lesser extent, the Thames Gateway regeneration programme.

However, like other areas, LBBD has had to rely on dated figures from the 2001 Census to derive estimates of its local Eastern European population. These figures have not taken account of the impact of post-2001 drivers of population movements such as the expansion of the EU and, more recently, the global economic downturn. As a consequence, there has been an increased growth in migration research as planning authorities endeavour to understand the experiences and needs of these new and emerging communities.

The health and social care needs assessment employed a mix of methods to gain insights into current population numbers and experiences of LBBD's Eastern European communities. Key learning from the study is summarised below:

7.2 Current estimates and projections

- The current population of Eastern European nationals in the borough is estimated to be 9,334. The figure includes both adults and children. The methodology used was based on the assumption that all those who registered for employment in the borough over the years have remained and not moved out. This therefore represents a *high* estimate.
- National trends since 2007-08 indicate that the rate of in-migration is slowing. Analysis of trends in B&D suggest that the national pattern is also being replicated locally.
- The main driver of emigration seems to be the global economic crisis which has made the UK (and B&D) a less attractive economic location of Eastern Europeans than it hitherto was.
- Accordingly, some downward adjustment needs to be made to the population estimates to account for this.
- Two thirds of survey respondents indicated that they intended to reside permanently in the UK.

7.3 Access Issues

7.3.1 Language Barriers

Language barriers, combined with a lack of understanding of the system and a lack of representative statutory sector workforce is (the) major barrier to accessing services.

7.3.2 Induction

As Barking & Dagenham is set to continue to be a destination for migrants, and the majority already settled have expressed their ambition to remain, some form of induction aimed at introducing newcomers to the system and how to navigate it would be a continuous useful resource.

7.3.3 Working with the third sector

Migrants' misunderstandings and lack of knowledge of the health system and how to navigate it, combined with service providers' misunderstandings and lack of knowledge of target communities'

cultural sensitivities can have knock-on effects on staffs' ability to offer appropriate and efficient services and may have a profound effect on individuals accessing appropriate and timely health treatment or advice. Working with (in partnership) and supporting appropriate third sector organisations from target communities should improve dialogue and work towards more efficient targeting and delivery. This may include helping to set up organisations in communities where no representation currently exists.

7.3.4 Use of community newspapers and websites

It may be useful to use community newspapers and websites, and other forms of social marketing to promote awareness of access and services as well as health promotion/improvement messages.

7.3.5 Cultural Competency Training

There is a need to train NHS staff in terms of cultural sensitivities of various communities, so that staff has an understanding of how to deal with and overcome sensitivities around certain health issues within certain communities, e.g. mental health, disability, LBGT (see 7.6 below). There is a need to work closely with third sector organisations around these sensitive issues and to help the third sector organisations to approach these issues. This will be a slow process but nevertheless needs broaching.

7.3.6 Training and Supporting the Receptionists

Respondents from all communities complained about the attitudes of receptionists. Receptionists are the meeting point of the community with the services. Misunderstandings and mistrust may be fermented at this point. Receptionists may often be the least qualified and least supported of staff. Getting it right at this "meeting" point may reduce other problems down the line.

7.3.7 GP Registrations

GP registrations appear to be a problem for all communities, especially the Roma. The issue is around the documentation that is needed to register.

7.4 Different Experiences

7.4.1 Inequalities experienced by the Roma community

Different data analysed highlighted the differential experience of Roma people (from both Poland and Romania) in B&D, particularly in respect of:

- Employment rates
- Low income levels
- Education and language skills
- Registration with a GP

The unique situation of the Eastern European Roma needs to be recognised as this is a community that suffers from levels of deprivation unmatched by other groups – a legacy of long history of discrimination and persecution in Europe. This experience may have built a wall of distrust that reinforces internal norms and customs against the outside world.

The Roma Support Group in Newham – the largest community organisation among the Roma in London - needs to be recognised as a vital asset for NHSBD. It has a proven capacity to deliver health services, health promotion and community development among the Roma community and has been been commissioned in the past by other local authorities and organisations.

7.4.2 Understanding Albanians and Kosovans

Albanians, particularly from Kosovo, have experienced extreme trauma including witnessing attempted genocide and rape. It is worth noting that the Albanian community have more children than Poles or Lithuanians and that a great number of them are on benefits. Albanians/Kosovans have come here as refugees, going through considerable trauma. Resettlement has been a long process for them, and when

granted leave to remain they express a greater likelihood to stay in the UK compared to Lithuanians and Poles on working visas, without children, and with a choice to stay here or return home.

Shpresa (Hope) Programme in Barking and Dagenham works closely with the Albanian and Kosovan community. This organisation is another third sector resource that can be commissioned to deliver health services, health promotion and community development among Albanians and Kosovans in Barking and Dagenham in partnership with NHSBD.

7.5 Mental Health, Healthy Lifestyles, and Health Promotion

Respondents from all communities spoke about depression and mental health problems, and several spoke about drug and alcohol abuse. Maintaining healthy lifestyles was raised as an issue across communities, particularly in relation to healthy diets e.g. large salt intakes by Albanians/Kosovans, weight gain, and use of fast food outlets. NHSBD may want to consider promoting healthier lifestyles to the target communities. Developing health champions and health trainers may prove useful as word of mouth messages were identified as the largest way that the communities received information, but also the use of community newspapers and websites, and by working in partnership with third sector organisations.

For example of good practice initiatives see Well London (http://www.london.gov.uk/welllondon/)
For case studies see http://www.london.gov.uk/welllondon/casestudies/
For healthy eating, also see Sustain (http://www.sustainweb.org/)

There are high rates of smoking amongst all communities, especially Roma, and anecdotal evidence that smoking is on the increase within the Albanian community, with both women, boys, and girls taking up the habit. These Eastern European groups have brought with them cultural habits and beliefs from their home countries that lapse considerably behind the UK's health promotion priorities of recent decades.

7.6 Diversity Issues

7.6.1 Mental Health & Disability

Both mental health and disability are taboo issues amongst the Roma and Albanian communities. Both are seen as shameful and are seen as having a negative effect on the marriage prospects of children and siblings and are thus hidden. Working with community organisations, and using some form of social marketing, for instance, through community newsletters and websites may encourage better access to services for some, but these health beliefs are entrenched and NHS practitioners will need to take a careful, sensitive and persevering approach to tackle these issues.

7.6.2 Homosexuality

Attitudes towards homosexuality amongst the target communities can be characterised as at the very least prejudiced. In some communities, notably amongst the Roma and Albanians/Kosovans, the subject is taboo. In order to offer necessary services to the LBGT community within these communities, creative methods will be needed.

GLOSSARY

A2	'Accession 2' countries which entered the EU in January 2007- Bulgaria and Romania
A8	'Accession 8' – the Central & Eastern European countries which joined the EU in May 2004: Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia
APS	Annual Population Survey
CEE	Central and Eastern Europe
DWP	Department for Work and Pensions
EU	European Union - Austria, Belgium, Bulgaria, Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the United Kingdom
GLA	Greater London Authority
GP	General Practitioner
IPS	International Passenger Survey
JSNA	Joint Strategic Needs Assessment
LBBD	London Borough of Barking and Dagenham
LFS	Labour Force Survey
LTIM	Long Term International Migration (formerly Total International Migration)
MYE	Mid Year Estimate
NHS	National Health Service
NHSBD	NHS Barking and Dagenham
NINo	National Insurance Number
ONS	Office for National Statistics
PCT	Primary Care Trust
PLASC	Pupil Level Annual School Census
RDS	Respondent Driven Sampling
RSG	Roma Support Group
SHPRESA	Shpresa Programme - active organisation promoting the Albanian community
TIM	Total International Migration
WRS	Worker Registration Scheme

REFERENCES

Acaye, C.J (2006) Black and Minority Ethnic Population Health Needs Assessment in Barking and Dagenham. Public Health Report No: DPH 185. Health Improvement Directorate. Barking and Dagenham Primary Care Trust.

Anderson, B; Ruhs, M; Rogaly, B; Spencer, S (2006). Fair Enough? Central and Eastern European migrants in low wage employment in the UK. Joseph Rowntree Foundation, York Publishing.

Centre for Research on Nationalism, Ethnicity and Multiculturalism 2007). Polish Migrants Survey Results. University of Surrey. Commissioned by BBC Newsnight.

Department for Work and Pensions (2009) National Insurance Number Allocations to Adult Overseas Nationals Entering the UK

DfE: Schools, Pupils and their Characteristics: January 2010
http://www.dcsf.gov.uk/rsgateway/DB/SFR/s000925/index.shtml

GLA Intelligence Update (2010) The London Plan: Ethnic Group Population Projections. DMAG Demography Team.

Green A, Owen D, Adam D (2008) A resource guide on local migration statistics. University of Warwick, Institute for Employment Research (IER).

Home Office UK Border Agency: Accession Monitoring Report. 2009. http://www.ukba.homeoffice.gov.uk Crown copyright.

Ker D, Zumpe J, Blake A (2009). Estimating International Migration: An exploration of the definitional differences between the Labour Force Survey, Annual Population Survey, International Passenger Survey and Long-Term International Migration. Office for National Statistics

Lewis S (2009). Barking and Dagenham Joint Strategic Needs Assessment.
http://www.barkingdagenham.nhs.uk/PDF/Joint%20strategic%20needs%20assessment%20May%2009.pdf

Office for National Statistics (2008) Migration Statistics 2008, Annual Report.
ONS and GLA population estimates. NHS Islington

Roma Support Group (Undated). The Roma Community: An Information Leaflet for Health Professionals and Especially Mental Health Professionals

Stroehlein, A (1999) A Queer Taboo. Central Europe Review, Issue 7.

The Pew Global Attitudes Survey (2007). Pew Global.

Tindell, G (2007) Current GLA population and employment projections. Thames Gateway London Partnership.