



WORKERS ON THE MOVE 2

European migrant workers and health in the UK: A Review of the Issues

By Alex Collis, Neil Stott & Danielle Ross

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CONTENTS: “Workers on the Move 2”

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	Page
List of Tables	4
List of Figures	4
Foreword by Sheila Childerhouse (Chair of NHS Norfolk)	5
Chapter 1 Executive Summary	6
Chapter 2 Introduction	14
Chapter 2.1 Setting priorities for a national research agenda	16
Chapter 3 Migrant workers – the UK policy context	17
Chapter 4 Health at home	20
Chapter 4.1 Health systems and policies	21
Chapter 4.2 Key health issues	25
Chapter 4.2.1 Tobacco	26
Chapter 4.2.2 Alcohol	30
Chapter 4.2.3 Diet, nutrition and physical exercise	32
Chapter 4.3 Health promotion initiatives	39
Chapter 4.3.1 Smoking cessation and tobacco control (Poland)	43
Chapter 4.3.2 Quit & Win smoking cessation	44
Chapter 4.3.3 ‘Get the Best From Your Food’ (Portugal)	46
Chapter 4.3.4 Let’s Live Healthily and MURA Project (Slovenia)	47
Chapter 5 Health and migration in the UK	49
Chapter 5.1 Access to primary care services	51
Chapter 5.2 Information, interpreting and translation	52
Chapter 5.3 Expectations and cultural differences	53
Chapter 5.4 Other primary care issues	54
Chapter 5.5 Mental health and migration	55
Chapter 5.6 ‘Workers on the Move 3: Domestic Violence and Migration’	58
Chapter 6 Health and migration in Thetford and the East of England	61
Chapter 7 Primary research – the local context	63
Chapter 8 Bibliography	66
Chapter 9 References	72

List of Tables		Page
Table 1	Food intake and physical activity by country	35
Table 2	Prevalence of overweight and obesity in women and men depending on the region of Poland	35
Table 3	Major policy and legislative developments on health promotion and obesity prevention in sending countries	39-41
Table 4	Results from countries participating in the 2000 and 2002 international Quit & Win competitions	44
Table 5	Health data for clients to Keystone's META advice service (September 2009)	61

List of Figures		Page
Fig. 1	Prevalence of (all) smoking among adult populations of European countries	26
Fig. 2	Regular daily smokers (males) aged 15 years and over	27
Fig. 3	Regular daily smokers (females) aged 15 years and over	28
Fig. 4	Total alcohol consumption in European countries	30
Fig. 5	Prevalence of overweight among adults in European countries	33
Fig. 6	Prevalence of obesity among adults in European countries	34
Fig. 7	Prevalence of body mass index categories in 1993 – 1998 and 2003 – 2005 (by gender) in Portugal	36
Fig. 8	Factors and sub-factors affecting migrants' mental health and well-being	56

Foreword

European migrants play an important role in the Eastern region and beyond. Migrants provide local employers, including the NHS, with much needed workers as well as adding to the diversity of our communities. Norfolk NHS is attempting to better understand the needs and issues of our many communities – including European migrants – to ensure our services continue to be of the highest quality, relevant and responsive.

Workers on the Move 2 focuses on the health needs of migrants and summarises what is known about their experience in the UK. It is clear that it is an area that needs further work. While the report is the first step in a local study, it is also aimed at a national audience to inform and contribute to the health debate, as well as being a means to request further information from colleagues and academics.

I would like to thank the authors and team supporting them in this valuable work. NHS Norfolk is committed to listening and learning and I look forward to the local research study and responses to *Workers on the Move 2*. I would also like to thank Thetford Healthy Towns for supporting the project, funded through the Department of Health.

Sheila Childerhouse

Chair
Norfolk NHS



CHAPTER 1: Executive Summary

- 1.1. Migration is a key issue in the UK. European migrants provide much needed labour in many regions including the East of England. However there has been a general lack of consensus around the benefits of migration to the UK economy and the overall fiscal contribution of migrant workers. This debate has gained a new impetus during the recent economic downturn. Many of the concerns expressed around the negative impacts of migration have focused on the increased burden on public services such as education, health and housing.
- 1.2. The first volume in Keystone's 'Workers on the Move' series (Wiles et al. 2008) highlighted the issues around migration and housing. This second volume focuses on European migrants and health. It provides a review of current knowledge about migrant health issues in the UK, as well covering health issues and systems in home countries. Future volumes in the series will focus on other areas of public services such as education.
- 1.3. Keystone and META (Mobile Europeans Taking Action) have undertaken a considerable amount of work, supported by research, to better understand the needs of migrant workers arriving in the area. However, their health needs, concerns and issues are not yet well understood, nor is the potential impact of new arrivals on local services. Consequently, the health sector is failing to meet the needs of this group.
- 1.4. This research will aim to further our understanding of those needs, as well as migrant workers' experiences and perceptions of local health services. The project will also consider migrant workers' uptake of and attitudes towards health promotion activities, and will examine the relevance to this group of projects such as Change4Life and the Healthy Town programme – as well as exploring alternative ways of reaching these new communities.
- 1.5. This discussion paper, which represents the first stage of the research, is intended as a contribution to the literature and a means to gather feedback from academics, policy makers and practitioners across the UK.
- 1.6. Major concerns have been raised in the media - particularly since the accession, in May 2004, of eight new states to the European Union - about the potentially negative effects of increased immigration on the NHS. Scare stories about 'health tourism' are a regular occurrence. However, there is a lack of evidence to support such claims. Previous research has found that rather than representing a burden on services, migrant workers make an important contribution to the health care sector at both regional and national level, meeting key staff shortages and reducing cost pressures. The migrant worker population is also generally young and healthy, and is currently unlikely to make substantial demands on health care provision. There is also little evidence to suggest that the ready availability and high quality of healthcare in the UK acts as a major factor in migration decisions – in fact, many migrants prefer to access care in their home country.

- 1.7. Conversely, concerns have been expressed over the health inequalities experienced by some A8 migrants such as those with fewer language skills, who are unable to access employment which is sufficiently well-paid and secure to allow them to register on the WRS, thereby making them ineligible for medical assistance.
- 1.8. There is also a current debate around length of stay among migrant workers across the UK, and despite the publication of various research findings, the overall picture remains unclear. It should not be assumed that levels of demand for health care provision will remain low. This uncertainty makes estimating future levels of demand for services, and planning service provision particularly problematic.
- 1.9. Health (along with employment, education and housing) has been identified as a key indicator of integration. If migrant workers are planning to stay in the UK, even where their stay is temporary but long-term, it is essential that their health needs are routinely considered, along with projected levels of demand for and access to service provision.
- 1.10. The profile of the migrant population in our region is changing, with potential implications for health services, and there are indications of raised levels of demand in some areas. There is anecdotal evidence, for example, that health visitors are seeing a rise in the number of migrant worker *families* on their caseloads. More research will need to be done into the health needs, issues and concerns of migrant workers in order to plan more effectively for future levels of demand, and to enable local providers to respond more effectively to the needs of new arrivals – and to balance them against the needs of local communities. There is a delicate balance to be maintained between soothing the anxieties of local communities, which are often expressed as complaints about ‘health tourism’, and meeting the health needs of new arrivals.
- 1.11. Over the past two decades, health services in the majority of Central and Eastern European countries have been subject to some major reforms. Since healthcare reforms began in these countries, establishing a more equitable and efficient health system has been highlighted as a particular policy priority, and there has also been an increasing focus on health promotion. However the pace and scope of change in the different countries has been variable, and many still experience high levels of health inequalities.

- 1.12. Major differences remain between the organisation, funding and delivery of healthcare in sending countries and the UK system. The main *cultural* difference – and one which can cause problems for migrant workers living in the UK – is that, while the role of primary care providers has expanded, and there is more evidence of GPs acting as gatekeepers, most CEE countries retain the possibility of direct access to secondary and specialist care.
- 1.13. Several of the countries discussed here have comparatively high rates of smoking, often despite anti-smoking publicity campaigns and smoking cessation initiatives introduced by national governments. For example, 47.3% of Latvian men smoke, as do 42.1% of Lithuanian men, 41.1% of Slovakian men and 37.0% of Polish men. Many countries also have high levels of heavy (daily) smoking, particularly among those without health insurance who are less able to access medical care. Smoking among younger age groups has also been identified as a problem in a number of sending countries.
- 1.14. Research has highlighted a pattern of non help-seeking behaviour in relation to smoking cessation; a recent study also found that while 50% of Polish respondents were planning to quit smoking, *only 8% had sought medical advice on smoking cessation*. Any future research would need to investigate the possible reasons behind this trend, which could then be used to inform and develop smoking cessation initiatives both at home and in the UK.
- 1.15. High levels of alcohol consumption and patterns of 'risky' drinking have been identified as a major public health concern across Europe. While recorded consumption rates have dropped in several countries, levels of *unrecorded* consumption have either remained stable or risen. Within these overall patterns there are also significant differences according to a range of socioeconomic characteristics including age, ethnic group, education and income level.
- 1.16. Problem drinking has had severe economic and health consequences in a number of the countries discussed here, the long-term effects of which are still becoming apparent. For example, in Slovenia, the standardised death rate for liver cirrhosis is high, at 38.9 per 100,000 inhabitants over 15 years of age; rates of hospitalisation/absences from work due to the direct impact of alcohol are also high, and result in an estimated 'economic burden' of between 2 and 3% of national gross income.
- 1.17. There are indications that the obesity 'epidemic' previously identified in Western European countries is now beginning to 'migrate' eastwards. Poor diet, physical inactivity and a high prevalence of overweight and obesity – particularly among children and young people – along with associated health consequences, such as the negative effects on mortality rates and levels of associated morbidity (for example, increased levels of cardio-vascular disease), have been identified as significant problems in a number of sending countries.

- 1.18. Despite some improvements in nutritional habits (for instance, increases in consumption of vegetable fats rather than animal fats such as butter, lard and whole milk, and regular consumption of fresh fruit and vegetables), there are still significant differences between countries. There are also major *in-country* differences, particularly those relating to gender, educational level, geographical area and income group, with high prices often restricting the opportunity to make healthy food choices.
- 1.19. Even with the extensive reforms made to health systems in home countries, many are still focused on treatment rather than prevention. Policy has tended to focus on introducing new legislation and tightening up regulation, rather than actively promoting health. Moreover it has been suggested that health promotion is often seen as a low priority by health professionals such as GPs, who do not often give advice to overweight or obese patients on diet-related strategies to improve their health. The need to provide more lifestyle counselling has therefore been identified as a key priority for primary care training in several countries.
- 1.20. Despite extensive developments in health promotion in a number of sending countries, sustained political commitment to long-term funding and follow-up of projects can be patchy. Besides a range of implementation difficulties, such as the continued influence of powerful food and tobacco industries on policy-making, there is also evidence that health promotion initiatives are failing to bring about the desired behavioural changes among their target populations, many of whom are unaware of government campaigns.
- 1.21. One reason given for this lack of uptake is that health promotion is often seen as a question of personal responsibility, rather than the duty of health professionals. Neither legislative changes, nor the broadcasting of health-related information via the media, were seen as particularly successful in effecting behavioural change.
- 1.22. However, despite these apparently negative trends, a range of successful national and international campaigns have been implemented in sending countries. For instance, research has shown that anti-smoking initiatives in Poland (such as the annual quit smoking competition) are heavily promoted by the Ministry of Health, with high levels of awareness among Poles and reports of positive effects on smoking behaviour. Results from the 'Let's Live Healthily' project in Slovenia, which includes a number of food and exercise-related activities, also indicate a positive effect on health behaviours among participants, with approximately 90% making significant lifestyle changes.

- 1.23. Successful projects have adopted strategies to maximise participation, such as timing of programme activities and use of existing community groups and organisations such as the Catholic Church to publicise events, from which some useful lessons can be learned and applied to the Healthy Town project.
- 1.24. While there is currently little evidence on the health needs of migrant workers in the UK, existing research has identified a number of key issues; problems of access to primary care (including GPs, dentists, maternity and child health services and screening/immunisation programmes), access to information, interpreting and translation services, expectations of services and cultural differences in health provision between sending countries and the UK, and the effects of the migration experience on mental health.
- 1.25. Rather than coming to the UK as 'health tourists', research has shown that new arrivals often have little information on health services, and fewer still make use of them. Many migrants fail to register with a primary care provider, either through a lack of knowledge of what services are available, or more often because they do not perceive any need. However, despite concerns about migrant workers bypassing primary care provision altogether and putting an unnecessary strain on A&E departments, there is little evidence that this is actually happening.
- 1.26. The provision of language appropriate information is now widely recognised as good practice in provision of services to migrant workers, and is particularly relevant in health settings. Low levels of English language skills have been identified as a major barrier to accessing services. Studies have shown that migrants who received accessible information were more likely not only to have registered with a GP (54%) but to have actually used the service (51%).
- 1.27. Translation and interpreting services are a central part of facilitating access to health care among migrants who have fewer language skills. Where these services are not in place, migrants are often forced to rely on family and friends, which raises a number of confidentiality issues.
- 1.28. Evidence is emerging that migrant workers' expectations of health provision in the UK are often not fulfilled by their experiences, and that they are often highly critical of the level and quality of services available to them. This dissatisfaction can often be due to differences in the respective functions and coverage of primary and secondary care between the UK and a migrant's country of origin. Despite the recent expansion of primary care in sending countries, it is often not as established a feature as it is in the UK system and new arrivals are often confused about the gatekeeper function of GPs.

- 1.29. Consultations with migrant worker patients can raise further issues around cultural competence. Healthcare professionals are often unaware of how health systems in sending countries are organised. GPs may be unsure of patients' entitlements, or may find themselves under increased time pressure during appointments due to language issues. Once again, the evidence of this is largely anecdotal and should be investigated as part of the planned research.
- 1.30. Low rates of GP registration can have additional repercussions. For instance, if migrant workers are not registered with a GP it becomes more difficult for them to access preventative services such as screening programmes. The mobility of migrant populations means that these patients can easily be overlooked for regular health checks and health screening or immunisation programmes. Problems have also been highlighted with late presentation for antenatal care.
- 1.31. There is some evidence of increased pressure on maternity and child health services, although once again this evidence is mainly anecdotal. This should be followed up as part of the planned research, by talking to health visitors in the Thetford area. If migrant workers *are* beginning to settle in the UK and to bring up families, health visitors will play an important role in accessing migrant worker populations and building confidence in health services.
- 1.32. There is increasing recognition of the potential links between migration and mental ill-health. Migration can involve a range of stress factors including communication difficulties, unfamiliarity with a new environment and culture, work-related stress due to long hours and poor working conditions, practical stress such as high living expenses or accommodation costs, and social stress such as a lack of interaction.
- 1.33. However, the lack of systematically collected data means that our knowledge of migrants' mental health status remains limited, although there are initial indications of increased levels of mental health issues, including depression and anxiety caused by the strains and losses which are part of the migration experience. More work is needed in order to further our understanding of the mental health issues experienced by migrants, and to inform better service planning and provision. There may also be some reluctance among migrants to discuss any problems with a GP, partly as a result of cultural differences in understandings of mental health.

- 1.34. As yet, little is known about domestic violence issues among migrant workers. However there are initial indications that the particular stresses of migration discussed above have the potential to lead to increased levels of domestic violence incidents among this group. Migrant workers may also experience difficulty in accessing support services, either because of issues around cultural difference or language skills. This discussion paper will lead into the third volume of *Workers on the Move*, which will focus on domestic violence issues and the research team would welcome any thoughts or input at this stage from organisations working in this area.
- 1.35. Currently there are major gaps in the information base on health and migration in the East of England generally, and in Thetford in particular. Much of the evidence that *does* exist is anecdotal, and relatively little has been achieved so far in terms of sustained research into the health needs and experiences of migrant workers to the region.
- 1.36. Keystone's META advice team have recently begun to collate data on the health needs of clients, and are starting to build up an overall picture of access to services. We can draw two main conclusions from this initial data; firstly that levels of awareness of health services among migrant workers appear to be high. However, this data only covers those migrant workers who are more confident in accessing Keystone's advice service; it may equally be that there are other sections of the migrant community who are less confident in accessing advice and healthcare services.
- 1.37. Secondly, the data suggests that migrant workers in Thetford do not appear to be experiencing difficulties in registering with a GP. The planned research will explore whether there are any differences *between* groups of migrant workers in their experiences of accessing primary care services, and to identify any barriers experienced by particular groups of migrant workers (for example, those with fewer language skills or living in remote areas). The research will also consider reasons for non-registration with GPs, and whether this is as a result of barriers to access such as closed practice lists, or language difficulties – or whether it is simply because of a perceived lack of need.
- 1.38. Keystone's research team will carry out primary research to extend current knowledge of migrant workers' health needs and experiences/perceptions of healthcare services in the Thetford area. This will involve talking both to professionals (questionnaire and follow-up interviews) and to migrant workers (questionnaire, interviews and focus groups). There will be three broad areas of focus; access to and utilisation of health services (including barriers), migrant workers' health needs, issues and concerns, and their attitudes towards and uptake of health promotion initiatives (both at home and in the UK).

- 1.39. The results of this research will be used to improve local practice in meeting the health needs of migrant workers. The findings will be disseminated to a range of health providers in the area, as well as to META health advisers in order to enhance the service provided by Keystone.
- 1.40. Besides the improvements to local knowledge and practice, this project also has the potential to contribute to the development of a national research agenda. Keystone's research team therefore welcomes any comments and contributions from academics, policy makers and practitioners across the UK, in response to the themes and issues outlined in this discussion paper, as well as the planned research design.



CHAPTER 2: Introduction

Migration is a key issue in the UK. European migrants provide much needed labour in many regions including the east of England. Mobile workers are bringing a diversity and vibrancy to many communities who have not experienced much immigration as well as adding to the cultural mix in our cities. *Workers on the Move; Migrant workers, housing and growth in the Eastern region* (KDT 2008) highlighted the issues around housing and migration as well as reporting on primary research with European migrants. *Workers on the Move 2* focuses on European migrants and health. It provides a review of what is known about migrant health issues in the UK as well as home countries health systems and issues. *Workers on the Move 2* is part of a research project commissioned by the Thetford Healthy Town Project; it is intended as a contribution to the literature and a means to gather feedback from academics, policy makers and practitioners across the UK.

While considerable work has been undertaken through Keystone/META (Mobile Europeans Taking Action) to better understand the needs of migrant workers arriving in the area, their health needs, concerns and issues are not yet well understood – nor is the potential impact of new arrivals on local services. We believe that this is the case across the UK. The research will aim to further our understanding of those needs, as well as migrant workers' experiences and perceptions of local health services. The project will also consider migrant workers' uptake of and attitudes towards health promotion activities, and will examine the relevance to this group of projects such as Change4Life and the Healthy Town programme – as well as exploring alternative ways of reaching these new communities.

This discussion paper represents the first stage of the research; it will consider the existing research evidence and literature on migration and health including the health issues and problems which migrant workers in the UK might face, their utilisation of health services and any barriers to access – as well as covering issues around health promotion. Section 3 outlines the policy context of debates around migration and health; in it, we address the common claim that migrants come to the UK primarily because of the ready availability and high quality of health services, and consider the implications for community cohesion. The comparative lack of data to support these claims is also discussed, and contrasted with the health inequalities experienced by many migrant workers – particularly the negative effects of the severe deprivation experienced by those who are undocumented, without work or without recourse to public funds. The section concludes with a consideration of recent changes in patterns of migration to the UK – particularly the initial evidence suggesting that many migrant workers are returning home rather than settling – and the likely effect on levels of demand for health services, along with the difficulties this causes in service planning and delivery.

It has been suggested that migrant workers experience barriers to accessing and using health services in the UK because of cultural differences between the UK system and the system they have been used to at home – particularly with regard to the function of primary care provision. Section 4.1 therefore explores the development of healthcare systems in sending countries, and identifies a number of differences from the UK system which might affect migrant workers' experience of and attitudes towards provision in this country. Section 4.2 highlights some of the main health issues identified in sending countries, particularly those countries (Poland, Portugal and Lithuania) from which most migrants to the Thetford area originate. Levels and patterns of tobacco and alcohol consumption are discussed, as well as issues around diet, nutrition and physical exercise – along with the associated health risks/consequences. Information on a range of health promotion initiatives introduced in these countries is also included along with the results of any project evaluations, as well as any lessons which can be learnt around influencing health choices and behaviours, and which could be applied to the Healthy Town project.

Section 5 considers the health issues which might be experienced as a consequence of migration, and the potential implications for services in the UK. Despite concerns addressed in section 3, the initial indications are that the migrant worker population is relatively healthy and makes few demands on health services – indeed, it has been suggested that migrants often enjoy an initial health advantage over existing communities (known as the 'healthy migrant effect'). In this section we consider whether migrants are in fact *disadvantaged* health-wise, particularly with regard to access to primary care services, and also whether the stresses of migration can adversely affect their mental health. Section 6 then outlines the current state of knowledge on health and migration in Thetford (and, beyond that, the East of England), focusing in particular on the health-related data which the META advice service has begun to collect from clients. Finally, section 7 identifies a number of key issues to be explored and questions to be addressed. We welcome contributions from academics, policy makers and practitioners interested in European migration and health.

CHAPTER 2.1: Setting priorities for a national research agenda

The results of this research will be used to improve local practice in meeting the health needs of migrant workers. The findings will be disseminated to a range of health providers in the area, as well as to META health advisers in order to enhance the service provided by Keystone. However, besides the improvements to local knowledge and practice, this project also has the potential to contribute to the development of a national research agenda. Keystone's research team therefore welcomes any comments and contributions from academics, policy makers and practitioners across the UK, in response to the themes and issues outlined in this discussion paper, as well as the planned research design. A comprehensive literature review has been carried out as preparation for this discussion paper; *however, it would be helpful to know if there are any key studies which have been missed – or of similar research projects happening in other areas.*

Specifically, the research team would welcome responses to the following questions;

- Have others observed a 'healthy migrant effect', whereby new arrivals enjoy an initial health advantage over existing communities, or are migrant workers disadvantaged health-wise?
- What current knowledge is there in other regions of migrant workers' health needs, concerns and issues? Is data on migration and health being collected in other areas?
- Do different groups of migrant workers experience particular health inequalities?
- What level of knowledge of primary care services has been observed among migrant workers? Are migrant workers registering with primary care services such as GPs and dentists?
- Has accessing primary care been identified as a particular problem for migrant workers? What barriers to access have been identified? What evidence is there that migrant workers are bypassing primary care provision, and accessing acute care directly?
- What differences have been observed between health services in home countries and the UK? Have these differences in organisation and coverage caused any difficulty for migrant workers in accessing services here? Is meeting their expectations of services a problem?
- What knowledge is there of the major health issues in sending countries, in particular alcohol and tobacco consumption, or diet, physical exercise and levels of overweight/obesity – and the potential implications for migrant communities across the UK?
- What might the reasons be for migrant workers' apparent lack of uptake of health promotion initiatives, both at home and in the UK? Is there evidence of initiatives which have successfully targeted migrants?

CHAPTER 3: Migrant workers – the UK policy context

Major concerns have been raised in the media - particularly since the accession, in May 2004, of eight new states to the European Union – about the potentially negative effects of increased immigration on the NHS, and the ‘health implications of migration have become, quite literally, front page news’¹. Scare stories about ‘health tourism’ are an apparently regular occurrence; for example, in June 2004 an article published under the headline ‘Invasion of the Health Tourists’² warned that one in ten patients seen by GPs were not entitled to free medical treatment, and that further action was needed to ‘weed out the cheats and take the pressure off the overstretched Health Service’. Five years later, similar concerns were being raised over the proposed changes to the rules on medical care available to failed asylum seekers which could, it was warned, open the ‘floodgates’ to further health tourism³. The NHS, it was suggested, was being ‘routinely exploited’ by immigrants at a total annual cost of £200 million. While much of the media coverage has centred on asylum seekers or refugees, new arrivals from EU accession countries - despite the fact that they are entitled to free care - have also been seen as placing an increased strain on health services.

However, there is a lack of evidence to support such claims. Relatively little data is available on migrants’ use of UK health services, particularly from the viewpoint of migrants themselves, and this should be a priority for future research. Previous research has found that rather than representing a burden on the health service migrant workers are in fact ‘generally net contributors to public finances’ and to the health care sector⁴. In calling for a more informed, constructive debate on this issue, a recent IPPR report noted that ‘migrant health personnel have provided an important means to meet staff shortages and to *reduce cost pressures* within the health system’⁵. There is clear evidence of this contribution at a regional level; for example, a recent study of migrant working in the East of England found that both the NHS and private sector relied heavily on the employment of migrant workers in both qualified and unqualified nursing roles, with most care homes in the region employing between half a dozen and two dozen migrant workers as health care assistants⁶. The value of this contribution has also been recognised in other regions; in the North West, a Department of Health regional public health group report found that in 2006 approximately 6,200 accession nationals were registered as care workers across the UK⁷.

The contribution of migrant health professionals has also been acknowledged at central government level; recently the Department for Communities and Local Government recognised that migrants often play a 'key role in the delivery of public services', accounting for 17% of health care staff and 18% of social care staff⁸. The report also recognised that the migrant worker population, which is generally young and healthy, was currently unlikely to make substantial demands on health care provision. Nonetheless, ministers still sounded a warning that 'there is a balance to be struck between the long-standing NHS principle of free universal healthcare and considerations of fairness – and there have been some concerns about the possibility of 'health-tourism''⁹. Consequently, the government has stated its commitment to 'keep these rights of access under consideration'. The Institute for Community Cohesion also recently claimed that in fact the impact of increased migration on health services 'is increasing albeit from a low base'¹⁰. The potential effect on levels of community cohesion is a key consideration for policy makers. A recent study of the reception and integration of new communities found that health care usage could become a key flashpoint for tensions between new arrivals and established communities, and was 'noticeably acute in rural areas'¹¹ where there was a pre-existing strain. However, the report still found that 'current pressures do not reflect the magnitude of those reported in national and media discourse'¹².

Conversely, concerns have been voiced over the health inequalities experienced by some migrants – even those from accession countries who are entitled to free care, as long as they are registered on the Workers' Registration Scheme (WRS). A number of news stories have recently been published which highlight the destitution and subsequent health risks suffered by A8 migrants who have fewer English language skills and are unable to access employment which is sufficiently well-paid and secure to allow them to register on the WRS – thereby making them ineligible for medical assistance. For instance, one story highlighted the growing problem of TB among homeless A8 migrants¹³, arguing that 'a confusing and inflexible benefits system and exploitation by cash-in-hand bosses have condemned them to the squalor of a candle-lit, derelict garage – and a serious illness that could kill them and become a serious public health threat.'

Little is currently known about the health needs of migrants, and even less is known about those of migrant workers. Our level of knowledge of housing issues faced by migrant workers is growingⁱ, however this has not been matched by investment in research focusing on health needs and issues. Consequently, as a scoping report published recently by the East of England Regional Assembly (EERA) argues, the health sector is 'lagging behind other sectors in addressing the needs of this particular group'¹⁴. Moreover, the 'lack of strategic recognition of this agenda locally, regionally and nationally ... results in the issue not being addressed within mainstream health policy and service provision'¹⁵. It is therefore essential that further *sustained* research is carried out – not only to ascertain the facts of migrants' use of health services, in order to counteract allegations of health tourism and promote cohesion between existing communities and new arrivals, but also to better meet those new arrivals' particular health needs.

ⁱ See, for example, Wiles et al. (2008) and Robinson et al. (2007)

There is a current debate around length of stay among migrant workers across the UK, and despite the publication of various research findings, the overall picture remains unclear. A number of studies have suggested that rates of migration are slowing significantly, and that migrant workers are now less likely to stay in the UK long-term. For instance, in 2008 a report published by the Institute for Public Policy Research (IPPR)¹⁶ estimated that by December 2007 over half the migrant workers who arrived in the UK after May 2004 had left the country, either returning home or moving on to a different country, and that 30,000 fewer A8 migrants had arrived in the second half of 2007 as had in the second half of 2006. However, other reports such as the interim findings of the EEDA longitudinal study¹⁷ have revealed a more fluid and complex picture, with few migrant interviewees having fixed plans regarding length of stay. More often interviewees fluctuated between short-term and longer-term stays, which could be influenced by a wide range of factors; some reasons were economic, but social and personal reasons were also cited. Significantly, however, health was *not* cited as a major pull factor in deciding to come to the UK.

This uncertainty makes estimating future levels of demand for services, and planning service provision particularly problematic. There is a delicate balance to be maintained between soothing the anxieties of local communities – which can often find expression in complaints about ‘health tourism’ – and meeting the health needs of new arrivals. Moreover, it is vital to understand migrants’ health needs as soon after migration as possible, in order to minimise the inequalities of access described above. Health, along with employment, education and housing, has also been identified as ‘one of the four primary means and markers of integration’¹⁸. If migrant workers are planning to stay in the UK, even where their stay is temporary but long-term, it is essential that their health needs are routinely considered – along with projected levels of demand for and access to service provision.

CHAPTER 4: Health at home

Since their transition in the 1990s to a democratic system of government, health systems in the majority of sending countries in Central and Eastern Europe (CEE) have undergone extensive reforms, with wide-ranging changes to health care organisation, financing and delivery. Health systems in these countries were usually highly centralised, hierarchical state organisations which raised revenue through taxation. While the primary objective of these health systems was to ensure free access for all citizens to comprehensive care, by the early 1990s significant inequalities in health outcomes between different groups had started to emerge. Systems were usually supply-oriented, and often failed to meet the health needs of significant sectors of the population. During this period, many of the countries discussed here had particularly poor infant and adult mortality rates – a trend from which they are still recoveringⁱⁱ. Since healthcare reforms began in these countries, establishing a more equitable and efficient health system has been highlighted as a particular policy priority, and there has also been an increasing focus on health promotion. However, the pace and scope of change in the different countries has been variable¹⁹. Major differences remain between the organisation, funding and delivery of healthcare in sending countries and the UK system. The main *cultural* difference – and one which can cause problems for migrant workers living in the UK – is that, while the role of primary care providers has expanded, and there is more evidence of GPs acting as gatekeepers, most CEE countries retain the possibility of direct access to specialists (within hospital or outpatient settings).

The following section gives an overview of the organisation and delivery of health services in the sending countries as well as the implementation and progress of reform, and aims to give an idea of the wide-ranging differences in quality and coverage of healthcare available to their populations. There is also a particular focus on the countries from which the majority of Thetford's migrant population is drawn: Poland, Portugal and Lithuania, along with the Czech Republic and Slovakia. The Latvian and Estonian systems are also discussed briefly due to the relatively poor health outcomes and high levels of inequality among their populations.

ⁱⁱ See, for example, Georgieva et al. (2007), Hlavacka et al. (2004), Jakušovaitė et al. (2005), Koppel et al. (2008), Kuszewski and Gericke (2005), Rokosová and Havá (2005) and Tragakes (2008).

CHAPTER 4.1: Health systems and policies

Czech Republic²⁰

The Czech health system underwent extensive reforms in the 1990s, although the pace of change has slowed in recent years. Health services are based on a system of universal social insurance, with an element of co-payments and additional voluntary health insurance (VHI). There has been a particular focus on re-developing the primary care system, with four main groups of doctors as the first point of contact for Czech citizens: adult GPs, GPs for children and adolescents (paediatricians), ambulatory gynaecologists and stomatologists. As of 2005, Czech nationals were able to re-register with a primary care physician every three months, with no restrictions on choice of physician. In 1992, the Czech government also introduced a National Programme of Health Restoration and Health Promotion which included smoking cessation initiatives, and healthy diet projects, including a programme for healthy schools.

However, despite these improvements and innovations, significant criticisms have been made of the increasingly residualist nature of the Czech healthcare system²¹. For example, from January 2008 all patients must now pay a €1 fee for each visit to the doctor – with no exemptions for children or pensioners – as well as prescriptions for drugs, and each stay in the hospital. While this fee remains low, it has been seen as representative of a general trend away from universal provision.

Estonia²²

In 1993, the new government established a Ministry for Social Affairs which included a Department of Public Health to focus on health promotion and improving negative trends such as the relatively high mortality rate among working-age men. A number of health promotion initiatives have been launched since then, including the Heart Health Project and an Anti-Smoking Project. However, despite extensive structural change and initial evidence of the positive impact of new health programmes – for instance, life expectancy has increased and rates of certain diseases such as TB and STDs have dropped – there has been little sustained improvement across a range of health indicators, and there are still substantial inequalities in health outcomes. A 2002 study²³ also found a continued association between membership of a lower socio-economic group, lower life expectancy and lower levels of access to/utilisation of health care – as well as growing educational and ethnic differences (between native Estonians and Russians) across a range of health behaviours such as tobacco and alcohol consumption. Funding of health promotion initiatives has also remained static since 2001, and despite several high profile campaigns there has been little overall decrease in levels of tobacco and alcohol consumption.

Lithuania²⁴

The Lithuanian health care system has also gone through a period of major transformation since the early 1990s. While the overall aim has been to increase the efficiency of healthcare provision, Jakušovaite et al. (2005) argue that the changes needed to ensure this happens have not yet been fully implemented, with the result that there are still significant inequalities in access and outcomes. For example, the equality target outlined in the Lithuania Health Programme (1998) which stated that by 2010 socio-economic differences in access to healthcare – particularly differences between rural and urban areas – should be reduced by 25%, has not been met.

Latvia

During the process of decentralisation, the main focus in Latvia was on establishing a network of primary care providers – before that point care had generally been provided in acute settings. Healthcare is now provided through a tax-funded social insurance system (the Government has experimented with a variety of social insurance models). Over recent years since the introduction of additional user charges the private share of healthcare spending through voluntary health insurance (VHI) has increased. While the current system is seen as better than the centralised model of provision that preceded it, and there is – in theory at least – a commitment to universal entitlement, concerns have been expressed about continued and significant inequalities in health outcomes between different sections of the population, with those in higher income brackets able to purchase shorter waiting times and better quality care. Consequently Latvia has the highest level of income-related health inequality – certainly among the Baltic states – with significant numbers of Latvians unable to access the necessary care²⁵.

While the number of GPs and dentists practicing in Latvia has risen since the 1990s, the overall number of doctors, as well as midwives and nurses has steadily declined – Tragakes (2008) has suggested that this is due to the fact that salaries remain comparatively low, and medicine is not seen as a particularly prestigious profession.

Poland

At the beginning of the 1990s, the Polish health care system was 'over-centralised, over-specialised and costly'²⁶, as well as being poorly managed. Levels of public dissatisfaction with healthcare provision were particularly high, and the issue of health service reform became a policy priority. This period marked a 'radical shift to a decentralised, insurance-based system' under the Strategy for Health programme (1994)²⁷. There were also major changes in the coverage and function of primary care with GPs – or 'family doctors' – taking on more of a gatekeeping role. In 1999 a new obligatory health insurance system was introduced, which operated through 16 regional 'sickness' funds. However, there were a number of concerns about the efficiency of this system and in 2003 it was abolished; health insurance is now administered by the regional branches of the National Health Fund (NHF).

While many positive changes were made during this period of transition, and key reforms implemented, progress towards more equitable provision and outcomes has been 'slow and piecemeal'²⁸. Consequently, despite the increased emphasis on primary care provision and family medicine, the number of specialists still exceeds the number of GPs – possibly because of the relatively low pay that GPs receive²⁹. There is still a high level of private spending on health care (27.5%), with the result that those groups which are less able to purchase higher quality services are at risk of experiencing poorer health outcomes and limited access³⁰.

Particular criticism has also been levelled at what is seen as a serious under-investment in public health and preventative services³¹. The Polish Chamber of Physicians warned in 2004 that if levels of pay and working conditions did not improve, there would be an 'exodus' of Polish doctors to Western Europe after accession to the EU; an opinion survey conducted at the time found that almost a third of doctors planned to work abroad in Western European countries³². Over recent years the Polish health care system has become increasingly destabilised; for example, there has been a series of strikes by health care providers in protest at low levels of pay and the underfunding of services (with Poland spending one of the lowest amounts in Europe on health care as a % of GDP).

Portugal

Portugal has a national health service (NHS), managed by the Ministry of Health³³, with the aim of providing a guaranteed universal right to health care which is (mostly) free at the point of use, although there is an element of co-payments and co-insurance for things such as medicines. The NHS also overlaps with a number of 'health subsystems' providing special public and private insurance schemes for certain professions.

Primary health care is mainly delivered through publicly funded and managed health centres (HCs), each of which covers an average of 28,000 patients – although this can vary widely between fewer than 5,000 and more than 100,000 patients. HCs have an average of 80 staff each, although again this can vary widely from over 200 staff to just one³⁴. Care is usually delivered by GPs and nurses, although some centres offer specialised care. Patients can choose between providers in a geographical area and, while the majority register with a GP in their residential area, some register

with a GP near to their place of work. As in the UK, GPs operate on the basis of patient lists, which are on average approximately 1,500 patients. However, concerns have been raised that – despite the relatively comprehensive coverage of primary care services – many Portuguese residents prefer to access secondary and specialist care directly, leading to an excessive burden on emergency departments³⁵. There are also a number of issues with equality of access for poorer and geographically isolated sections of the population, and there are also indications that the population has a generally low opinion of the quality of primary care provisionⁱⁱⁱ.

There have been some recent reforms of the primary care system to improve quality of and access to care, such as the implementation (since 2006) of a system of Family Health Units (FHUs) which are voluntarily formed multidisciplinary primary care teams. However, Barros and de Almeida Simões (2007) note that despite the focus on primary care the role of hospitals as the centre point of health care delivery has remained unchanged, with many Portuguese residents accessing emergency care rather than visiting a primary care provider. The apparent underfunding of primary care provision has been heavily criticised, and barriers to access for some sections of the population have been noted; for example, an estimated 750,000 Portuguese residents (representing approximately 7% of the population) have no GP³⁶.

ⁱⁱⁱ Bentes et al. (2004) reported findings which indicated that 30% thought provision was of poor quality.

Slovakia

As with most of the other countries discussed here, Slovakia's health system has undergone a process of decentralisation, although progress has been rather slower than in other countries³⁷. Within the primary care system there are four 'types' of doctor; GPs for adults, GPs for children and adolescents (paediatricians), gynaecologists and dentists. All of these act as gatekeepers to specialist services, although patients can self-refer to ophthalmologists in cases of eye injury and for spectacles. In some cases, patients can also go directly to psychiatrists, geneticists and specialists in sexually transmitted diseases. Patients with a chronic condition who are registered with a specialist clinic also have direct access to the relevant specialist provision, and do not need to be re-referred by their GP. Slovakian residents also have the right to change their primary health care physician every six months.

Since 1995 there has been an increased focus on health education and promotion³⁸, and in 2000 a new State Health Policy was published which aimed to incorporate the WHO 'Health for All' objectives³⁹. However, a lack of clear lines of responsibility for funding and implementing programmes has meant that progress in improving public health outcomes has been mixed⁴⁰.

CHAPTER 4.2: Key health issues

This section will highlight some of the main health issues identified in sending countries, focusing in detail on areas prioritised within the Change4Life and Healthy Town initiatives such as levels and patterns of tobacco and alcohol consumption, as well as issues around diet, nutrition and physical exercise – along with the associated health risks/consequences. Information on a range of health promotion initiatives introduced in these countries is also included along with the results of any project evaluations, as well as any lessons which can be learnt around influencing health choices and behaviours, and which could be applied to the Healthy Town project.

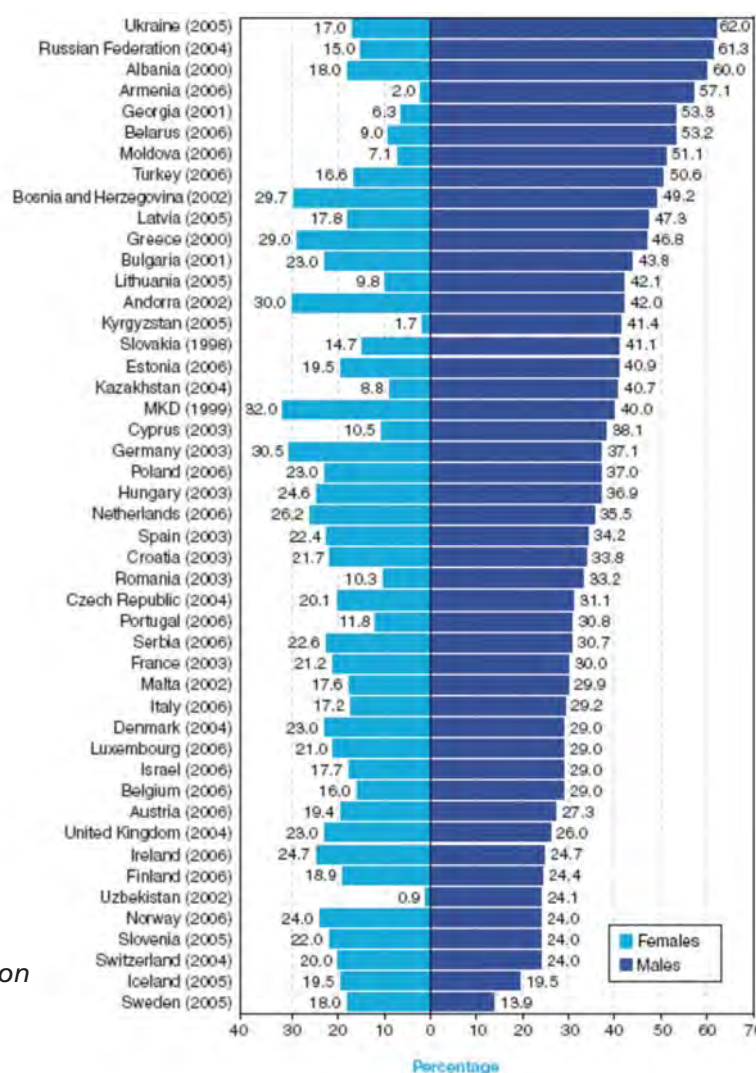


CHAPTER 4.2.1: Tobacco

Several of the countries discussed here have comparatively high rates of smoking, often despite anti-smoking publicity campaigns and smoking cessation initiatives introduced by national governments^{iv}. The chart below (Fig. 1), which uses data collected by the International Labour Organisation (ILO), shows smoking prevalence in a range of European countries. While rates in CEE countries are not as high as those in some of the former Soviet Republics they are still higher than the European average, with particularly high rates among female populations, among whom smoking rates are generally lower. For instance, at 22.0% the prevalence of smoking among adult

women in Slovenia is almost equal to the prevalence of smoking among men (24.0%). Poland (23.0%), Bulgaria (23.0%) and Hungary (24.6%) also have relatively high rates of smoking among women. Rates of smoking among men are high in many of the countries: for example, 47.3% of Latvian men smoke, as do 42.1% of Lithuanian men, 41.1% of Slovakian men, 40.9% of Estonians and 37.0% of Polish men. Similarly, a report published by the Estonian National Institute for Health Development⁴¹ showed high levels of daily smoking among males of all age groups – for example, 51.1% of 25 to 34 year olds and 52.5% of 35 to 44 year olds.

Fig. 1: Prevalence of (all) smoking among adult populations of European countries



Source: World Health Organisation (2008: 93)

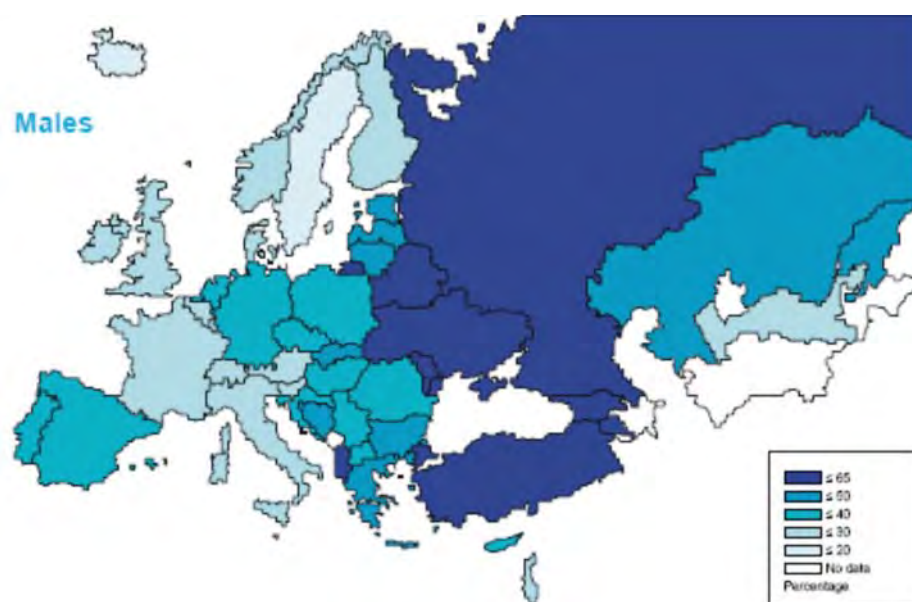
^{iv} There are important differences between countries as well – for example, a study of smoking in Baltic countries by Pomerleau et al. (1999) found that rates of daily smoking (as opposed to overall smoking) were higher in Estonia than Latvia and Lithuania.

Levels were lower among women, but were still high – particularly among slightly older women, with just 19.5% of 25 to 34 year olds identified as daily smokers compared with 27.2% of 35 to 44 year olds and 23.6% of 45 to 54 year olds. Daily smokers were also disproportionately represented among those who had no health insurance, and might therefore be less able to access appropriate medical care when needed.

Previously, levels of tobacco consumption in Portugal were comparatively low – indeed, Portugal had the lowest smoking rate in the Eur-A group⁴². This is due partly to the country's comparatively early introduction of strict bans on smoking on public transport and in public facilities, as well as tight controls on tobacco advertising. However, rates have now caught up to some extent. Consequently, while smoking is still relatively uncommon among girls and young women, it is increasing.

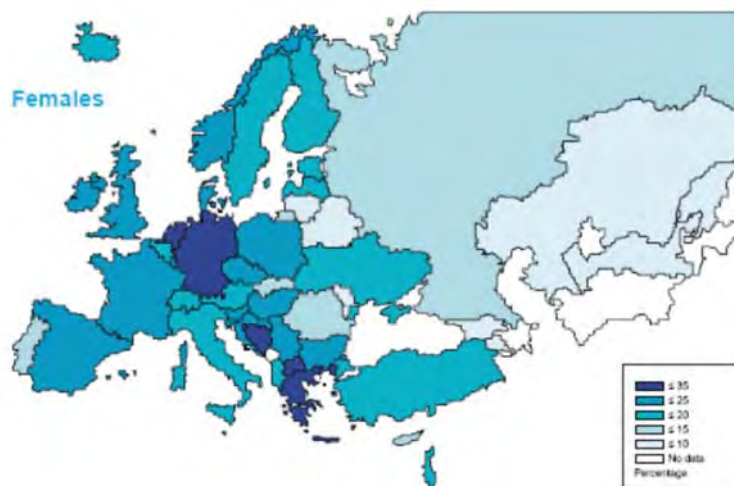
The two maps below (Fig. 2 and Fig. 3) also show that patterns of heavy (daily) smoking are fairly high in several sending countries, although there are significant inter-country differences, and intra-country differences between patterns of male and female smoking. Smoking rates among men in Estonia, Latvia and Lithuania fall into the second highest bracket, yet the second map shows that the rate of regular, heavy smoking among Lithuanian women is one of the lowest, and that smoking among Romanian women is also relatively rare – compared with Germany, for example, where the rate of smoking among adult women is particularly high.

Fig. 2: Regular daily smokers (males) aged 15 years and over



Source: World Health Organisation (2008: 93)

Fig. 3: Regular daily smokers (females) aged 15 years and over



Source: World Health Organisation (2008: 93)

Smoking among younger age groups has also been identified as a problem in a number of sending countries. For example, a study of tobacco use in Lithuania found that since 1994^v the prevalence of smoking among teenagers (aged 11 to 15) and adult women had increased significantly⁴³. Rates of (all) smoking among Lithuanian women also rose dramatically between 1994 and 2002 from 6.3% to 12.8%, with a particular increase among young women from 4.3% to 14.3% - although if we refer to the maps above, the prevalence of *heavy* smoking remains comparatively low. The number of boys smoking at least once in the previous month rose from 11.3% to 23.6%, with a particularly steep increase among 15 year old boys among whom smoking rates rose from 23.0% to 46.8%, while there was an equivalent increase among girls of the same age from 7.7% to 30.3%. The European School Survey Project on Alcohol and Other Drugs (ESPAD)⁴⁴ reported similar findings on tobacco use among students; particularly high rates were noted in Bulgaria, where 40% of students reported having smoked in the past 30 days, the Czech Republic (41%) and Latvia (41%) – compared with a study average of 29%. Conversely, rates were *lower* than average in Portugal, where just 19% of students smoked.

Policy-makers and researchers have consistently raised concerns about the high prevalence of tobacco use in Poland, particularly among *daily* smokers – in the 1980s it was estimated that after Hungary Poland had the highest rates of lung cancer in Europe while the rate of lung cancer among middle aged Polish men in particular was one of the highest in the world⁴⁵. It has been suggested that under the totalitarian regime information on the tobacco-related health issues was heavily censored and that public awareness of the health risks around smoking was fairly low^{vi}. Despite some improvements in the 1980s, the situation deteriorated further in the early 1990s; political change and the introduction of free market principles had the effect of making a wider range of cigarettes more readily available, meaning that their consumer appeal rose. A tobacco marketing drive halted the slight decline in rates of smoking that had been achieved during the 1980s and tobacco use became *more* prevalent, with a particular increase in the numbers of young smokers (such as those aged between 11 and 15). Towards the end of the decade, however, policy-makers began to focus on the health risks of tobacco use and to discourage smoking. The Polish government adopted various EU standards and recommendations on tobacco advertising and marketing, such as the publication of health warnings, and also

^v For this study, smoking rates were measured in 1994, 1998 and 2002.

^{vi} Zatonski argues that there was real difficulty in mounting successful information campaigns, due to the fact that large sections of the media were closely controlled by government.

recognised the need for regular collection of data on smoking patterns as well as public education on the health risks and development of smoking cessation support initiatives.

A recent study of tobacco use among Polish migrants living in Dublin⁴⁶ found a higher smoking rate among migrants than Irish residents which contradicts the idea of a 'healthy migrant effect' (see section 5). Higher rates of smoking were found particularly among those migrants who were employed, had only primary level education and had been overseas for a period longer than two years. At 50.9%, the study predicted higher levels of tobacco use among men rather than women - although the rate was still comparatively high among female migrants at 39.8%. Rates were particularly high among 19 – 40 years olds, with almost 20% of Polish men aged under 20 identifying themselves as smokers. Furthermore, Polish migrants were more likely to be heavy smokers^{vii} (20%) than Irish nationals (10%).

Perhaps most significantly, the study found that while 50% of Polish respondents were planning to quit smoking, *only 8% had sought medical advice on smoking cessation*. Any future research would need to investigate this further, and examine the possible reasons for this non-help seeking behaviour – which could then be used to inform and develop smoking cessation initiatives. Decisions about smoking among Polish respondents in this study were influenced by a wide range of factors *besides* receiving information about the negative health effects.

In contrast to the Irish smokers surveyed, migrant smokers were relatively well educated and usually employed, often with high incomes. The authors of the study argued that changes in migrants' economic situation after Poland's accession to the EU, which meant that many had higher levels of disposable income, could equally influence tobacco use. They also talk about something called the 'bargain effect'; the ease of travel between Ireland and Poland, where cigarettes are relatively cheap^{viii}, could also act as an inducement to smoke. If, as has previously been suggested, migrant workers are adopting increasingly transnational lifestyles (see section 3), this trend may become more marked and it would be useful for the planned research to explore this issue further and assess the potential implications for smoking cessation initiatives.

^{vii} Defined by the study as smoking 20+ cigarettes per day.

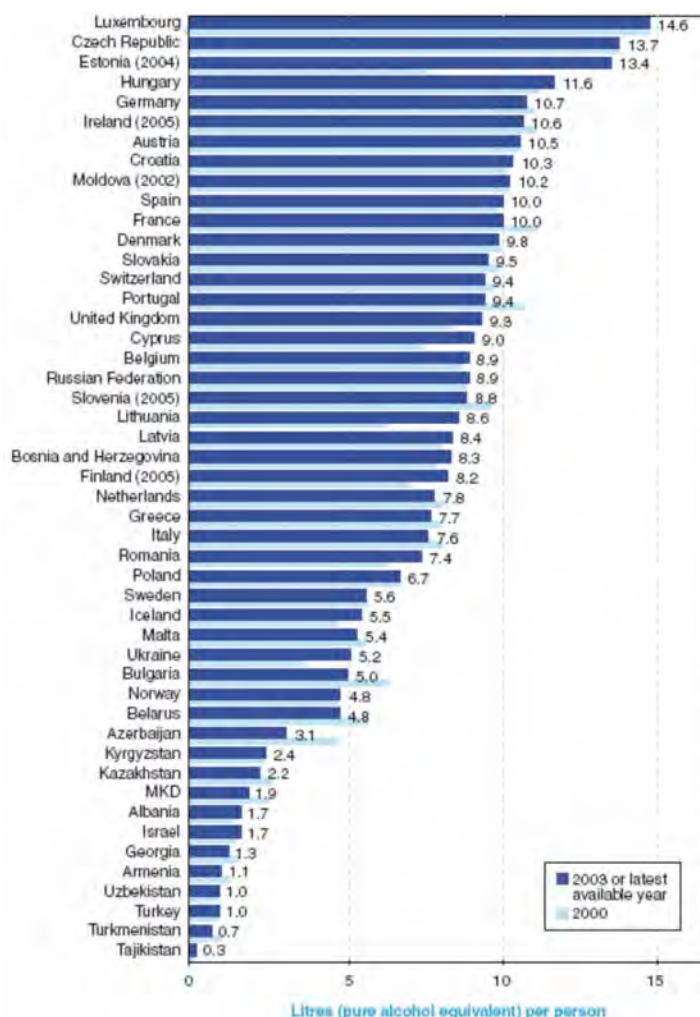
^{viii} This is particularly pertinent given the recognition in recent research (e.g. Eade et al. 2006; Vertovec 2007; Schneider and Holman 2009) that many migrants are leading increasingly transnational and mobile lives.

CHAPTER 4.2.2: Alcohol

High levels of alcohol consumption and drinking patterns have also been identified as a major public health concern across Europe. The chart below (Fig. 4) sets out data on total alcohol consumption, with particularly high levels in several sending

countries such as the Czech Republic, Estonia and Hungary. Moreover in some of the countries – for example, Lithuania and Estonia – levels of alcohol consumption rose between 2000 and 2003.

Fig. 4: Total alcohol consumption in European countries



Concerns have been raised around particularly high levels of alcohol consumption in the Baltic Republics of Latvia, Lithuania and Estonia; for example, one study found that Estonia had a particularly high rate of *heavy* drinking (over 80g per day) especially among men, with one in ten identified as a heavy drinker⁴⁷. Research has found that a high percentage of Latvians consume particularly strong

varieties of alcohol and that the country has raised levels of binge drinking, particularly among adult men, 23.7% of whom reported drinking to excess (a slight rise from 22% in 2004)⁴⁸. Figures published by the World Health Organisation (WHO) also indicate that while levels of alcohol consumption in Portugal are decreasing they still remain significantly higher than the Eur-A average^{ix}. An investigation into alcohol

^{ix} The WHO Highlights on Health Series divides countries up into different reference groups. The Eur-A group comprises those European countries with very low child mortality and very low adult mortality rates. Currently there are 27 countries in this group - Andorra, Austria, Belgium, Croatia, Cyprus, the Czech Republic, Denmark, Germany, Greece, Finland, France, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, the Netherlands, Norway, Portugal, San Marino, Slovenia, Spain, Sweden, Switzerland and the United Kingdom.

use and associated harm in Slovenia found that between 1982 and 2002 there had been an overall decrease in annual alcohol consumption per capita from 11.5 litres to just 9.8 (representing a 15.1% drop), although the rate of decrease had slowed dramatically since 1991⁴⁹. Despite this apparent improvement, the authors of this study argue that rates of consumption remain high compared with other European countries, and these findings were replicated in a subsequent study which found that Slovenia was third overall in the WHO group of countries with rates of alcohol consumption over 10 litres per person (which also included Lithuania, Portugal and the Czech Republic)⁵⁰. This research also identified one third of adult male Slovenians and one in ten adult women as 'risky' drinkers, with between 10 and 15% of all adults identified as alcoholics.

It is important to recognise that within these overall patterns there are significant differences according to a range of socioeconomic characteristics including age, ethnic group, education and income level. For example, in all three Baltic Republics rates of alcohol consumption decreased significantly with age, with fewer than one in twelve women over 50 identified as heavy drinkers⁵¹. In Lithuania, there has been a particularly steep rise in levels of alcohol consumption among children and adolescents^x. Hence studies have shown that in 2002 13.4% of boys and 6.5% of girls reported consuming alcohol on a regular basis – rates which increase rapidly with age, so that rates among 15 year olds were significantly higher (27.3% of boys and 12.9% of girls). The ESPAD study⁵² reported similar findings while also highlighting major differences between countries. In Bulgaria, although the proportion of students who reported drinking in the past 12 months was around the European average, at 45% the proportion who had been *drunk* was higher. Latvian students were above study averages

for both tobacco and alcohol consumption; Polish students, however, reported levels of drunkenness (31%) *lower* than the ESPAD mean. Students in Portugal were also less likely to report having been drunk (26%). Romania in particular was identified as a 'very low prevalence' country, with only 26% of students reporting being drunk, and those who did drink only drinking comparatively low volumes of alcohol. Data on problem drinking in Estonia indicates significant and growing differences between ethnic groups, with Estonians reporting higher rates than Russian nationals; in Lithuania, however, levels were higher among Russians than Lithuanians⁵³.

Problem drinking has had particularly marked health consequences in a number of the countries discussed here, the long-term effects of which are still becoming apparent. For example, between 1990 and 1995 deaths from cirrhosis of the liver *doubled* in both Estonia and Latvia (with a 50% increase in Lithuania)⁵⁴. In 2000 there were 170 alcohol-related deaths per 100,000 population in Lithuania, 172 per 100,000 in Estonia and 180 per 100,000 in Latvia, rates which were *triple* the EU-15 average. Similarly in Hungary there were 160 alcohol-related deaths per 100,000 population, which was double the EU-15 average⁵⁵. Furthermore, while recorded consumption rates have dropped in several countries, levels of *unrecorded* consumption have either remained stable or risen.

In Slovenia, the standardised death rate for liver cirrhosis is high, at 38.9 per 100,000 inhabitants over 15 years of age; rates of hospitalisation/absences from work due to the direct impact of alcohol are also high, and result in an estimated 'economic burden' of between 2 and 3% of national gross income⁵⁶. While *overall* there has been a decrease in alcohol-related mortality in Slovenia, this is still an issue for concern and is subject to 'substantial yearly oscillations'⁵⁷.

^x This was also highlighted as an issue in Slovenia by Susic et al. (2006).

CHAPTER 4.2.3: Diet, nutrition and physical exercise

Poor diet, physical inactivity and prevalence of overweight and obesity are significant issues in a number of sending countries. There are indications that the obesity 'epidemic' identified in Western European countries is now beginning to 'migrate' eastwards^{xi}, and that poor diet and the associated health consequences – such as the effects on mortality rates, and levels of associated morbidity (such as increased levels of cardio-vascular disease) – is becoming an increasingly prevalent problem in a number of CEE countries.

In many of these countries there has been a 'dramatic decrease' in rates of physical activity, along with significant changes in eating habits^{xi}. For example, the number of Hungarians who are obese (with a body mass index (BMI) over 35) has doubled since 1989, while 75% of men in the Czech Republic and 80% of Latvian are overweight (with a BMI over 25). Similarly, 56% of Bulgarians and almost 50% of the Slovakian population are overweight. According to Spitzer (2004), this is partly a legacy of food policies introduced under the previous

political regime which were geared towards the production and consumption of large amounts of meat and fat.

As the two charts below (Fig. 5 and Fig. 6) indicate, there is a high prevalence of overweight and obesity in several of the countries considered here. However, it should also be noted that these patterns are far from simple and uniform across the countries discussed in this report, and that there are key differences *within* countries across a range of socio-economic factors^{xii}. A relatively high proportion of adult Hungarian women in Hungary are overweight (49.5%), with similar patterns identified in Lithuania (48.9%) and the Czech Republic (47.4%), compared with other European countries such as Norway (34%) and Switzerland (29.3%). The variation is less marked among men, although a number of sending countries have high proportions of overweight men such as Hungary (58.9%), Slovakia (57.8%) and Lithuania (56.3%), while others such as Latvia (42.0%) and Estonia (45.7%) have *lower* proportions.

^{xi} For example, the increased availability and consumption of junk food.

^{xii} In-country differences will be discussed separately below.

Fig. 5: Prevalence of overweight among adults in European countries (latest available year for the period 2000 – 2006)

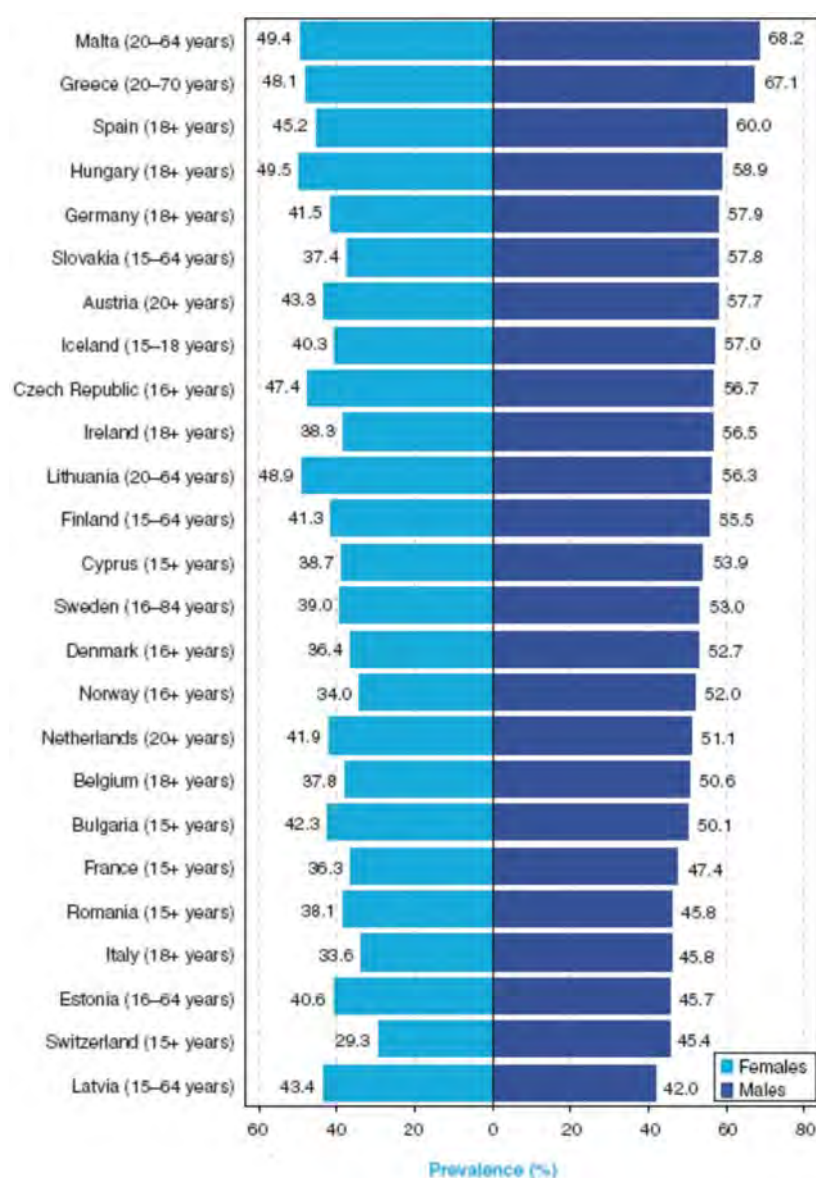
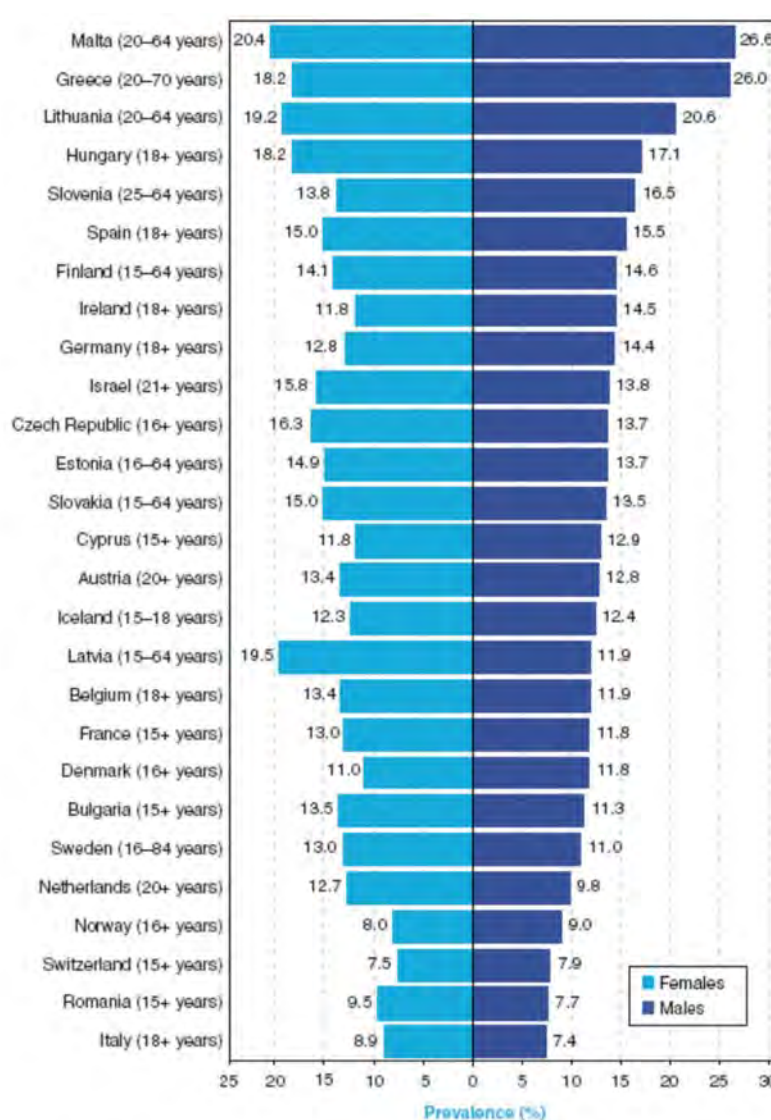


Fig. 6: Prevalence of obesity among adults in European countries (latest available year for the period 2000 – 2006)



When we look at the data for levels of obesity below, it is possible to observe similar patterns. For example, the prevalence of obesity is particularly high among Lithuanian and Latvian women at 19.2% and 19.5% respectively, compared with just 8.0% in Norway and 7.5% in Switzerland. Interestingly, prevalence of both overweight and obesity are relatively low in Romania *and* (to a lesser extent) Bulgaria.

Obesity among children and young people has also been identified as a particular policy priority at European level⁵⁹, with concerns raised around recent increases in levels of physical inactivity, including the increasing amount of time spent engaged in sedentary

activities such as watching television and using computers^{xiii}. Significantly, some of the countries on which this report focuses have *lower* rates of adolescent overweight and obesity – for instance, fewer young people in Lithuania and Latvia are overweight (5.1% and 5.9% respectively) while very small proportions are obese (0.4% and 0.5%). Rates are also fairly low in Poland, where 7.4% of young people are overweight and 1.1% are obese, Estonia (6.5% overweight and 1.0% obese) and the Czech Republic (9.1% overweight and 1.0% obese). However, rates are much higher in South-West European countries including Portugal^{xiv}, where 15.0% of young people are overweight and 3.0% are obese (see Table 1 opposite).

^{xi} Interestingly, this study – which compared prevalence of overweight and obesity among school-aged youth in 34 countries – found no direct link to diet, and consumption of fruit and vegetables.

^{xii} This is also the case in North American countries – and Great Britain.

Poland

There are indications that obesity is a growing problem in Poland, with a number of associated health risks; for example, rates of cardiovascular disease are the leading cause of death in Poland (accounting for 56% of all deaths). Among Poles aged 15 and older, 10% of males and 11% of females are clinically obese. For males in this age group the average BMI is 25.2, meaning

that the average Polish man is overweight^{xv}, and a total of 31% of the adult population is reported to be physically inactive⁶⁰. A recent study identified a particular increase in obesity among adult women in the Lower Silesian region between 1993 and 2003 from 8.9% to 15.0%, while the proportion of women who were overweight also rose from 30.7% to 34.0%⁶¹.

Table 1: Food intake and physical activity by country

Source: Janssen et al. (2005: 128)

Country	High fruit intake*	High vegetable intake*	High sweets intake*	High soft drink intake*	Physically active [∞]	High TV viewers	High computer users
Czech Republic	42.5	27.9	25.2	28.6	42.4	47.0	26.1
England	27.1	28.6	31.6	38.1	41.8	51.9	37.2
Estonia	20.1	15.4	28.4	9.8	25.2	63.0	32.4
Hungary	31.7	15.1	34.1	32.5	29.3	39.1	22.8
Latvia	24.0	28.7	27.6	15.6	30.1	62.6	26.7
Lithuania	22.2	30.1	18.9	10.2	42.7	57.3	23.3
Poland	46.1	36.3	36.4	25.4	35.3	52.5	31.8
Portugal	48.8	26.9	22.5	33.5	25.4	52.8	25.4
Scotland	34.2	33.4	45.1	46.9	39.9	50.1	38.8
Slovenia	39.0	25.7	26.4	39.6	40.8	39.6	22.7
Wales	23.0	21.1	26.7	36.5	36.5	53.0	32.8

However, over the same period the proportion of men who were overweight fell sharply from 44.2% to 24.0%. There are also significant regional variations in

prevalence of overweight and obesity, with particularly high rates in the eastern part of the country (see Table 2 below).

Table 2: Prevalence of overweight and obesity in women and men depending on the region of Poland

Source: Milewicz et al. (2005: 114)

	Women		Men	
	Overweight (%)	Obesity (%)	Overweight (%)	Obesity (%)
Lower Silesia	45.0	22.5	39.0	15.75
Upper Silesia	35.0	25.0	45.0	20.0
Lublin	32.9	36.1	39.6	23.6

The same study also found that young people in Poland were less likely to be overweight or

obese, while rates were particularly high among the 40 to 60 age group.

^{xv} The corresponding figure for women is 24.4.

* percentage of study participants who reported consuming food item once per day or more often

[∞] percentage of study participants who reported participating in 60 minutes or more cumulative physical activity on 5 or more days per week (ave. of last week and typical week)

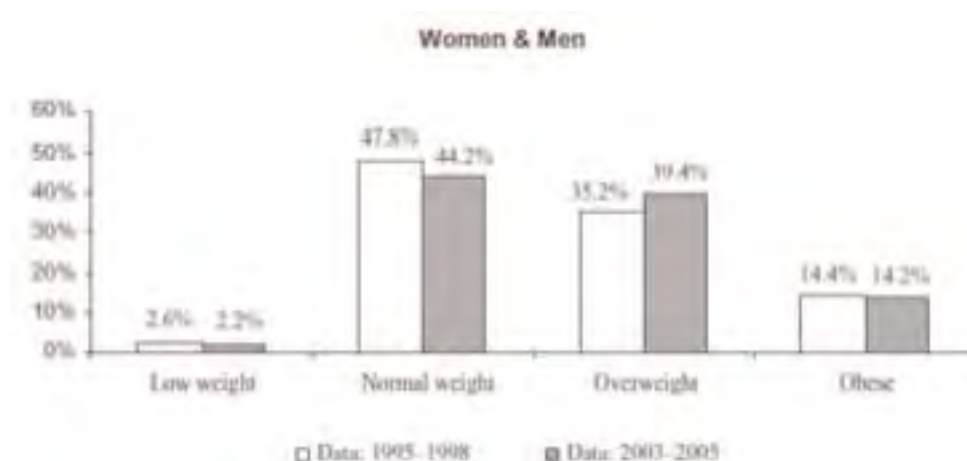
Portugal

Since the first nationally representative survey was undertaken between 1995 and 1998, data has consistently indicated a high prevalence of overweight and obesity in Portugal⁶². As shown in the graph below (Fig. 7), the overall proportion of Portuguese who are either overweight or obese has also risen significantly from 49.6% (1995 to 1998) to 53.6% (in the 2003 to 2005 survey). The results for 2003 to 2005 indicate that 38.6% of adults (between 18 and 64 years) are overweight, while a further 13.8% are obese⁶³. More men (60.2%) than women (47.8%) are

overweight or obese, and older adults are more likely to have a weight issue⁶⁴. Levels of obesity among children and young people have also been highlighted as a significant problem, with 31.5% of 7 to 9 year olds identified as either overweight or obese which is a particularly high rate compared with other European countries, and is second only to Italy (36%)⁶⁵. Similarly, data published by the World Health Organisation indicates that 15% of boys and 6% of girls in Portugal are 'pre-obese', figures which are considerably higher than the Eur-A average⁶⁶.

Fig. 7: Prevalence of body mass index categories in 1995-1998 and in 2003-2005 (by gender) in Portugal

Source: do Carmo et al. (2007: 15)



There is also an apparent link between the prevalence of overweight/obesity and educational or income level, although caution must be exercised in drawing any firm conclusions about causality. Nonetheless, it has been found that the chance of being overweight or obese decreases with the level of education; 45.1% of Portuguese women with 'low' levels of education were identified as obese, compared with 37.9% of women in the 'medium-low' bracket, 31.1% with a 'medium-high' level of education and just 25.9% of women who had the highest level of education⁶⁷.

There are a number of heightened health risks associated with these overall trends. For example, 45.6% of the sample in one of the studies mentioned here⁶⁸ suffered from various weight-related illnesses and conditions such as cardio-vascular disease, with 22.2% at very high risk of becoming ill. The costs of treating weight-related illnesses have been estimated as making up 3.5% of the country's total expenditure on health⁶⁹. However, despite the fact that prevalence of overweight and obesity has been recognised as a significant problem in Portugal for the past ten years, policy responses have had little apparent effect⁷⁰.

Lithuania

There is a sizeable body of research looking at diet and nutrition in the three Baltic republics, which has indicated generally high levels of overweight and obesity, comparatively low levels of fruit and vegetable consumption and a worrying association with major health problems such as cardio-vascular disease and a range of cancers⁷¹. The mean fat intake among Latvians, Lithuanians and Estonians remains high and has often exceeded recommended levels, comprising between 15 and 30% of the dietary energy of people in those countries⁷².

In Lithuania, the prevalence of overweight and obesity has increased significantly in recent years. According to data collected by the FINBALT survey, in 2002 49.1% of all Lithuanians were overweight, while 16% were obese⁷³. More men (57.4%) than women (42.4%) were overweight and, while levels of obesity among men rose from 10.6% in 1994 to 16.2% in 2002, there was a slight^{xvi} decrease among women from 18.9% (1994) to 15.8% (2002). Nonetheless, levels of obesity among Lithuanian women remain high compared with other European countries. Levels of obesity also increased sharply with age; research has identified 0% of men aged between 20 and 24 as obese compared with 30.1% of those aged between 55 and 64, while among women levels rose from 2.6% of those aged between 20 and 24 to 29.7% of 55 to 64 year olds. Moreover, the overall population is also relatively sedentary; among Lithuanians aged between 19 and 65, only 64% of men and 57% of women are physically inactive⁷⁴.

A number of positive trends have been observed in the nutritional habits of Lithuanians. For example, consumption of vegetable fat rather than animal fats such as butter, lard and whole milk has increased, as has consumption of dark bread, fresh fruit and vegetables⁷⁵. Between 1994 and 2002, the proportion of Lithuanians using vegetable oil in their cooking rose from 31.3% to 83.2% of men and from 47.7% to 92.6% of women⁷⁶ while use of lard and butter decreased over the same period from 46.2% to 11.2% of men and from 30.8% to 4.8% of women. Regular consumption of fresh fruit and vegetables (on a minimum of three days per week) increased from 18.1% of men and 24.8% of women in 1996, to 45.7% of men and 55.8% of women in 2002. Lithuania scores highly on this indicator compared with Latvia and Estonia; in 1999 it was reported that 70% of Lithuanians consumed fresh fruit and vegetables daily compared with 43% of Latvians and just 34% of Estonians⁷⁷.

However, beneath this superficial improvement there are several important differences, particularly relating to gender, educational level and income group – particularly with high prices restricting the opportunity to make healthy food choices. Lithuanian women are more likely to consume fresh fruit and vegetables, fish and cereals, and to use vegetable oil rather than animal fats in their cooking. Research has also shown that Lithuanians who are better educated have healthier dietary habits, such as consumption of fish, fruit and vegetables, and use of vegetable oil for cooking, and are more likely to be physically active⁷⁸. Men and women with lower levels of education have been found to consume more whole milk, while higher educated women consume meat less often; hence the odds of eating meat daily are 41% lower among women educated to university level. However, a higher level of education does not always influence healthier dietary habits. For example, Lithuanians with a higher level of

^{xvi} i.e. not statistically significant

education were more likely to consume butter rather than margarine with bread – and better educated Lithuanian men have also been found to consume more cheese⁷⁹.

Lithuanians living in cities have been found to eat fresh fruit and vegetables more regularly; for example, 53% of men and 61% of women living in cities eat fresh vegetables on at least three days per week compared with 36% of men and 42% of women living in villages⁸⁰. Conversely, men

and women living in rural areas were more likely to favour ‘heavy’ foods with high fat and sugar contents⁸¹, and less likely to consume fresh fruits or berries at least three times per week at 12% of men and 18% of women, compared with overall consumption rates of 36% (men) and 44% (women)⁸². The nutritional deficiencies discussed above have serious health implications, and are responsible for a significant proportion of the country’s disease burden.

Latvia and Estonia

Among Latvians over 15 years of age, 9.5% of men and 17% of women (almost 14% of the overall population) are identified as clinically obese⁸³, while 41% of men and 33% of women are pre-obese. In all, an estimated 50% of the adult population is overweight. Levels of physical activity are relatively low; among respondents in a recent study, only 38.2% of men and 29.8% of women engaged in a minimum of 30 minutes of exercise causing mild breathlessness at least 2-3 times per week⁸⁴. Similarly an earlier piece of research found that high proportions of respondents from the Baltic region – particularly Lithuanians (60%), but also 52% of Latvians – only took part in sedentary leisure activities such as reading or watching television⁸⁵. Only 8% of Latvian respondents engaged in physical activity, such as jogging or cycling, which caused them to break into a sweat. The overall prevalence of overweight and obesity among Estonians is slightly lower than in Latvia and Lithuania; among the population aged 19 and over, 10% of men and 6% of women are clinically obese, while 32% of men and 24% of women (28% of the overall population) are pre-obese. In all, 35% of the adult population is overweight⁸⁶.

A range of poor dietary habits has been identified in both countries; for example, higher proportions of Estonians in one study reported cooking with butter rather than

vegetable oil⁸⁷. Reported levels of salt consumption were also disproportionately high; in Latvia, 78% of men and 59% of women used salt regularly. Rates were slightly lower in Lithuania (63% of men and 44% of women) and Estonia (57% of men and 48% of women) yet were still relatively high, and one in nine men overall reported always adding salt to their food *before* tasting it^{xvii}. However, there are indicators of several positive changes in dietary habits^{xviii}. For example, a study conducted by the National Institute for Health Development in Estonia⁸⁸ found that overall Estonians were;

- using less animal fat (24.4% of men and 40.0% of women)
- using more vegetable fat (20.5% of men and 32.8% of women)
- eating more vegetables (22.2% of men and 37.5% of women)
- consuming less sugar (19.6% of men and 33.1% of women)
- consuming less salt (18.7% of men and 27.4% of women)

However, behind this overall trend, there are important differences according to a range of socio-economic variables. For example, Estonians living in major cities such as Tallinn rather than rural areas, those in higher income brackets or with higher levels of education, or those with health insurance coverage were significantly more likely to change their dietary habits.

^{xvii} However, respondents also showed high levels of awareness of the potential health risks.

^{xviii} See, for example, Polluste et al. (2005).

CHAPTER 4.3: Health promotion initiatives

Even with the extensive reforms highlighted above (see section 4.1), many of the new health systems are still focused on treatment rather than prevention⁸⁹. Policy making has tended to focus on introducing new legislation and tightening up regulation, rather than actively promoting health. The low level of physical activity among Latvians has been attributed partly to the low priority it is given as a health promotion strategy among health professionals⁹⁰. Similarly it has been suggested that few Lithuanian GPs give advice to overweight or obese patients on diet-related strategies to improve their health⁹¹, although there is a relative lack of

data to support this conclusion. Data published by the WHO in 2002 showed that only 13% of Lithuanian smokers were advised to stop smoking by their GP, and only one in five women and one in ten men received advice on changing their dietary habits.

Certainly the need to provide more lifestyle counselling has been identified as a key priority for primary care training in several countries. The table below gives an overview of the major policy and legislative developments in each of the sending countries;

Table 3: Major policy and legislative developments on health promotion and obesity prevention in sending countries⁹²

Bulgaria	• Action Plan for 2005 – 2010 (launched in 2004) to enhance the health of the population by improving nutrition and reducing the risk of diet-related chronic diseases • introduction of new standards for the nutritional content, marketing and labelling of foods, and incentives to encourage the production and sale of healthy foods • launch of a new information and education campaign by the National Centre of Public Health Protection to publicise principles of healthy nutrition • promotion of physical activity among children through initiatives such as Education Through Sport (2004) and Sport at School (2006)
Czech Republic	• National Council for Obesity established as a permanent advisory body to Department of Health to implement the national action plan, based on WHO recommendations. This has working groups on issues including nutrition and food, community programmes and education, child obesity, physical activity and the treatment of obesity • new dietary guidelines established in 2005 • National Cycling Strategy introduced in 2004 • introduction of the 'Keep it Balanced' campaign (2006) focusing on healthy diet and physical activity. This initiative is organised by the Ministry of Health with support from the National Public Health Institute, along with a range of commercial and health insurance providers
Estonia	• adoption in 2002 of the Healthy Nutrition Action Plan (2002-2007), which highlights a number of areas for action including food accessibility, local food for local consumption, food safety, nutrition in specific population groups, and the links between overweight/obesity and chronic diseases • introduction of the National Strategy for the Prevention of Cardio-Vascular Disease (2005 – 2020) in 2005 which aims to enhance healthy lifestyles and choices by developing a comprehensive system of health education • introduction of various health promotion projects such as the Healthy Heart and Anti-Smoking schemes • provision of rye bread and fruit in school meals since 2006 • Sport for All scheme (2006-2010) introduced in 2006 to promote physical activity

Hungary	• introduction of the National Public Health Programme (2003 – 2013) including a National Nutrition Policy Framework (2005) and National Food Safety Programme (2005) • work in schools including the regular distribution of a healthy eating newsletter to 5th grade students, and the introduction of a National Healthy School Canteen Programme (2005) • an information campaign run across stores in a major supermarket chain which highlights healthy foods, drinks and sports equipment. Customers are able to access advice on lifestyle, and have their blood pressure, sugar levels and body weight measured
Latvia	• introduction of the national Healthy Nutrition plan (2003-2013) to encourage consumption of fruit and vegetables, legumes, and berries and to keep the public informed on issues such as healthy nutrition and lifestyles, physical activity and food hygiene • formulation of specific dietary guidelines for certain groups (such as 0 to 2 year olds, or 2 to 18 year olds) • establishing a Nutrition Council (2006) • moves to regulate the marketing of food/drink which is of low nutritional value such as soft drinks, sweets and salty snacks
Lithuania	• introduction in 2004 of a state food and nutrition strategy/action plan (2003-2010) • moves to regulate/control food labelling, marketing and advertising • attention has also been paid to reducing the prevalence of chronic diseases related to poor nutrition • promotion of sport in schools and communities
Poland	• revision of the 1990s National Health Programme for the period from 2006 to 2015 • introduction of a National Programme for the Prevention of Overweight, Obesity and Non-Communicable Diseases through Diet and Improved Physical Activity 2007–2016 • creation of a National Centre for the Promotion of Healthy Diet focusing on, amongst other things, the improvement of diet and physical activity among primary and secondary schoolchildren • introduction of a national information initiative 'Food, Nutrition, Health' under National Food and Nutrition Institute to encourage healthy choices • a joint initiative between the Ministries of Health and Sport to promote physical activity • 'Put Your Heart on Its Feet' campaign to promote the benefits of increased physical activity
Portugal	• introduction of a National Health Plan (2004-2010) including a National Programme Against Obesity • introduction of the 'Move It' campaign to promote physical activity
Romania	• organisation of a 'Day of The Heart' (September 2002) with a range of activities including blood pressure and blood sugar measurements for the general public, staff employed at government offices and workplaces (e.g. the timber industry) • introduction of campaigns aimed at prevention of cardio-vascular disease such as 'A memorable day: the day you quit smoking', 'Take Care of Your Heart' and 'Your health is up to you'
Slovakia	• implementation of the Health State Policy (updated 2006) and National Health Promotion Programme, with a focus on the promotion of healthy lifestyles and reduction of non-communicable diseases • introduction of the National Programme for Sport Development (2001) and 'Move It' campaign • proposals for a National Obesity Prevention Programme

Slovenia	• introduction of a National Nutrition Policy Programme with three major strands; food safety, sustainable food supply and balanced/preventative nutrition • drafting of a National Plan for Physical Activity (2006) • introduction of various local level initiatives such as 'Let's Live Healthily' and the Mura programme (see below) • setting up of the 'That's Me' web site for young people to give information on nutrition and physical activity • introduction of a Healthy Nutrition and Physical Activity for Secondary School Teachers Programme (2004-2005) to promote the inclusion of health and nutrition issues in the curriculum • introduction of National Institute for Public Health standards for healthy nutrition in schools • introduction of the Body Weight for Adolescents and Getting Active plan (2004-2006) which monitors body weight and physical activity among 13 to 16 year olds through systematic checks • introduction of tighter controls on the sale of alcohol such as a prohibition on the sale of distilled alcohol before 10.00 a.m. and the appointment of a Council for Alcohol Policy (2003) within the Ministry of Health
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Despite these extensive policy developments, political commitment to long-term funding and follow-up of projects can be patchy. For example, in Estonia between 0.5% and 1% of the health insurance budget is earmarked by government for health promotion work – however, the government has been slow to increase this budget despite evidence of significant and continued health inequalities⁹³. Projects have generally focused on raising individual awareness and changing individual attitudes rather than addressing some of the underlying socio-economic issues behind poor health. As critics have noted, despite a number of campaigns around alcohol and tobacco consumption and some evidence of positive impacts, this remains limited and overall progress has been 'unremarkable'⁹⁴.

The authors of an article discussing measures targeting problem drinking in Slovenia note that there are few *sustained* public information campaigns in place⁹⁵. National alcohol policy is criticised as both poorly coordinated and targeted, with the majority of campaigns being both localised and short-term, and as comparing unfavourably with approaches in other countries. At the time

when the article was written (2006) there was still no national alcohol action plan. Controversially the ban on alcohol advertising was lifted and alcohol consumption continued to be shown as a positive lifestyle choice; as the authors note, popular media figures in Slovenia have often been portrayed as consumers of alcohol. Much of Hungarian health promotion has focused on issues around food in schools, and has involved measures including the proposed regulation of school canteens and vending machines⁹⁶. However, policies have been difficult to enact due to the powerful influence of the food industry lobby, and rather than implementing the compulsory directive which was their initial plan, the government have allowed the industry to continue to self-regulate.

In addition to these implementation difficulties, there is also evidence that health promotion initiatives are failing to bring about the desired behavioural changes among their target populations. For instance, while there has been a growth in the overall numbers of Latvians expressing a willingness to give up smoking⁹⁷ - which would suggest that smoking cessation campaigns have enjoyed an element of success – this has not always translated into action. Research has shown that many Latvians were unaware of health promotion campaigns; just 26.1% of men and 31.3% of women surveyed for a recent study had heard of the Healthy Heart campaign, while a mere 13.8% of men and 16.6% of women had heard of Family Health Week. Relatively few had any knowledge of the Healthy Food promotion scheme introduced by the Health Promotion Agency (just 27.1% of men and 30.8% of women), or the Iodine Salt campaign (17.9% of men and 19.7% of women). Awareness of anti-smoking campaigns such as Quit & Win (see section 4.3.2 below) was slightly higher (49.6% of men and 52.0% of women)⁹⁸. However, levels of participation in such initiatives remained low (just 11.9% of men and 9.3% of women surveyed)^{xix}. The reasons behind this type of non help-seeking behaviour are extremely complex, although the authors of the Latvian research indicated that it was at least partially due to the fact that the majority of respondents (78.8% of men and 78.1% of women) thought of health promotion as a question of personal responsibility, rather than education providers or health professionals. Neither legislative changes, nor the broadcasting of health-related information via the media, were seen as particularly successful in effecting behavioural change. However, despite such apparently negative trends, it has nonetheless been possible to identify a number of apparently successful health promotion projects which have been introduced by sending countries.

^{xix} The potential motives for this type of non-participation are too complex to discuss in great depth here, but any planned research would certainly need to consider this theme.

CHAPTER 4.3.1: Smoking cessation and tobacco control (Poland)

As already discussed, rates of tobacco consumption are high in Poland (see section 4.2.1) and have been identified as a particular policy priority by the Polish government. With the recent introduction of a Health Promotion Foundation (HPF), a number of smoking cessation programmes have been implemented. For example, an annual competition has been held in Poland for those participants who quit smoking since the beginning of the year. Entrants submitted a postcard to the HPF talking about their experience, and the successful entrant won a one week trip to Rome which included an audience with the Pope. The Ministry of Health has also worked with other agencies to promote the benefits of smoking cessation. For instance, the Catholic Church has acted as sponsor of an annual anti-smoking campaign. Schools are also heavily involved in smoking-related health promotion projects, and target both pupils and parents^{xx}.

Smoking cessation initiatives are heavily publicised, and are well recognised among Poles; according to one study, between 80 and 90% were aware of these initiatives⁹⁹. Levels of public and media support for the postcard competition were particularly high, with television coverage of the winner's trip to Rome. There have been reports of positive effects on smoking behaviour, and an associated fall in the associated mortality rate. Hence the total Polish mortality rate fell by 10% between 1991 and 2000, with roughly one third of that drop attributed to a reduction in levels of cigarette consumption¹⁰⁰.

However, despite these ostensibly positive results it is also acknowledged that smoking cessation remains a policy priority and that further action is needed to reduce overall smoking rates.

^{xx} However, these health promotion initiatives have run in parallel with a number of legislative changes and tighter regulation of the marketing and selling of tobacco such as the complete ban on tobacco advertising introduced in the late 1990s and the ban on selling cigarettes to under 18s.

CHAPTER 4.3.2: Quit & Win Smoking Cessation

'Quit & Win' is an international smoking cessation initiative organised as part of the WHO Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme^{xxi}, which began in 1994 – since then, the National Public Health Institute (KTL) in Finland has also coordinated international Quit & Win competitions. In 2002, the competition involved around 660,000 smokers from 77 countries worldwide with all 27 CINDI countries organising their own Quit & Win competitions, and a further 15 CINDI countries running an optional competition for health professionals to get them to quit smoking and recognise their value as role models for their patients. The table below (Table 4) shows results from some of the participating CINDI countries, which include all of the A10 countries as well as Portugal¹⁰¹: The United Kingdom has also participated.

The competitions have been more successful in some countries than in others; for example, the one year abstinence rate for Poland after the 2000 competition is particularly high at 43%, compared with relatively low figures for Latvia (9.4%) and Romania (7.2%). Other countries, such as Bulgaria, Hungary and Poland, have been more successful at recruiting health professionals – and in 2002 the prize for the optional health professional contest went to Lithuania. In 2002, all countries organised Quit & Win smoking cessation competitions, with related events. For example, in the Czech Republic a climb of the country's highest mountain, Mt. Snezka, was organised for World No Smoking Day with politicians and prominent doctors taking part. In Hungary five smoking cessation competitions were organised throughout the year with over 4200 adults and 358 14 to 17 year olds taking part.

Table 4: Results from countries participating in the 2000 and 2002 international Quit & Win competitions

Source: adapted from World Health Organisation (2002: 33)

Country	2000 Participants	2001 One year abstinence rate %	2002 Participants	2002 Health professional participants
Bulgaria	3601	26.0	4162	867
Czech Republic	2024	15.4	1518	34
Estonia	481	19.3	318	-
Hungary	7831	12.3	4205	986
Latvia	824	14.3	234	16
Lithuania	911	9.4	522	87
Poland	3730	43.0	6000	575
Portugal	1215	-	1764	-
Romania	1323	7.2	1412	160
Slovakia	1657	13.6	626	60
Slovenia	700	-	1416	74

^{xxi} CINDI also organises the FINBALT health monitor mentioned earlier.

Peer educators were also trained to deliver 15 anti-smoking and 9 anti-alcohol programmes in secondary schools. The Lithuanian health ministry gave particular priority to smoking cessation initiatives targeted at children and adolescents after a 2001 survey revealed that almost 50% of boys and 25% of girls aged 12 to 18 were regular smokers. In Kaunas an anti-smoking campaign 'Don't start and win – quit and win' was launched, and around 2300 children registered as participants. Smokers were asked to stop smoking for a minimum of one month, and others had to commit to not starting to smoke for the same period. Over 50 winners received a trip to a water park in Poland. Other campaigns were organised to publicise the risks associated with passive smoking, such as the 'I was born a non-smoker' campaign which was introduced for No Smoking Day (31st May), with all newborns receiving campaign t-shirts. As part of a further campaign, 'Let Me Grow Up Healthy', hundreds of children's shoes were arranged on the pavement outside the Lithuanian Parliament to symbolise the risks to which passive smoking exposed them.

CHAPTER 4.3.3: ‘Get the Best from Your Food’ (Portugal)^{xxii}

The ‘Get the Best from Your Food’ scheme was introduced as part of the Portuguese Health and Food Programme in September 1997, which aimed to provide education and information on health and nutrition. ‘Get the Best from Your Food’ was launched in schools by the Ministry of Education, and targeted pupils aged between 6 and 16 years. Pupils aged between 6 and 10 years were presented with leaflets containing games and stories, as well as a poster about ‘Ideas to flavour your life’ which was designed like a Christmas advent calendar, and had windows which pupils could open to uncover information on a variety of

health/nutrition topics. The poster format was aimed at allowing teachers to talk to their classes about a different topic or theme each day for a month; each morning the topic window was opened and then the theme for that day’s lessons was developed by the whole class^{xxiii}. Examples of topics included the benefits of water, the importance of sharing meals with friends and family, and the value of getting enough sleep; not only were topics nutrition related, but students were encouraged to make links between nutrition and their general well-being as well as social life/interaction.



^{xxii} See <http://www.fao.org/DOCREP/X2650T/x2650t07.htm>

^{xxiii} Teachers also received a guide containing information on each theme, with suggestions for appropriate related activities to help them structure sessions.

CHAPTER 4.3.4: Let's Live Healthily and MURA Project (Slovenia)

In 2007, the Slovenian government introduced a National Health Enhancing Physical Activity Programme (2007-2012) with the central goal of improving nutrition and levels of regular physical activity among the general population¹⁰² as well as reducing rates of obesity and associated health risks. Under this policy a number of new health promotion programmes have been introduced or existing projects expanded, including the Let's Live Healthily and MURA projects. Both projects run in the Pomurje region of the country which has the lowest level of GDP per capita as well as the highest percentage of long-term unemployed, and the lowest level of educational attainment. Pomurje also has the lowest life expectancy in Slovenia, the highest number of years of life lost per 1000 people under 65 and a particularly high incidence of heart and coronary disease and tumours¹⁰³.

The MURA programme originally operated in eight communities in the Beltinci municipality (in 2001) but now runs in over 50 communities. MURA's central aim is to enable inhabitants of rural communities to take a more active role in health promotion, and it incorporates a range of activities such as the incorporation of healthy lifestyle topics into a life/social skills programme for young people who have dropped out of school, and the setting up in 2004 of a consortium of fruit and vegetable producers to run organic farming centres. The programme also promotes Nordic walking as both a tourist activity *and* a way for locals to get fit. Initial results from the programme are encouraging; for example, the National CINDI Health Monitor Survey for 2001-2004 showed some positive changes in nutritional habits in the region such as higher rates of consumption of fresh fruit and vegetables, as well as good fats like olive oil, as well as lower rates of consumption of animal fats, fried foods, sugar and added salt.

'Let's Live Healthily' also targets adults in rural communities within the Pomurje region, and encourages communities to take an active part in health promotion. The programme incorporates a wide range of activities such as weekly walking and cycling events, food events including pumpkin and bean holidays^{xxiv}, where residents are shown how to prepare the same traditional foods but in healthier ways, and the creation of demonstration gardens where local residents can learn how to grow their own food. There is a basic programme of thirteen workshops on a range of topics including physical activity and health, nutrition (using the food pyramid and healthy plate), self-supply with vegetables and growing herbs, and demonstrations of healthy food preparation. Participants are also able to access blood pressure testing and lifestyle counselling before meetings.

Every effort is made to ensure these events are as accessible as possible; for instance many are held in the early evening when working adults are better able to attend. Health topics are explained to participants in the relevant dialect where appropriate, and care is taken to recruit local programme coordinators who are familiar with the lifestyle and culture of the community. Let's Live Healthily' is also implemented through a partnership approach which incorporates local authorities, health providers, schools and kindergartens, pharmacies, community groups and local churches. Announcements about events are often made during church services and priests are frequently involved in running them.

^{xxiv} For example, on Pumpkin Day in Lipovci a competition is held for amateur cooks who are invited to submit recipes for healthy pumpkin dishes.

Initial evaluations of the project have reported positive changes in health behaviours among participants. Approximately 90% of participants changed their lifestyles significantly after completing the basic programme, by changing their eating habits and becoming more physically active. 70% of participants were reported to be consuming less animal fat and almost two thirds reported eating more fresh fruit and vegetables, while roughly half had increased their levels of physical activity. The weekly walks in the Razkrižje municipality, which were reported to regularly attract between 50 and 100 participants, were found not only to increase levels of physical activity but also to promote social interaction.

Summary:

The development of healthcare provision in sending countries has been highly variable, both in the pace and scope of change, and migrant workers in the UK will have experience of a wide range of systems. Significantly, some migrant workers may be less familiar with the gatekeeping role of general practitioners, which could affect their use, expectations and experiences of primary care in the UK. Some migrants may also have experienced significant inequality of access to services in their home country, and as a result may have additional health needs.

Many of the countries from which migrant workers come to the UK have identified similar public health concerns to those addressed by the Healthy Town Project – in particular high levels of tobacco and alcohol use, and issues around diet, obesity and physical activity. Even with the extensive reforms to healthcare systems in sending countries, many remain focused on treatment rather than prevention, and the priority which national governments have given to health promotion has been variable. Nonetheless, a number of health promotion initiatives in sending countries have been identified which have enjoyed varying degrees of success – for example, public awareness of some projects has remained low, and projects are sometimes undermined by the lack of priority given to health promotion by healthcare professionals. Other projects have adopted strategies to maximise participation, such as timing of activities and use of existing community groups to publicise events, from which some useful lessons can be learned and applied to the Healthy Town Project.

CHAPTER 5: Health and migration in the UK

We are starting to learn more about migrant workers' use of and access to public services in the UK, such as housing – and the likely demands new arrivals are likely to make on those services. The first volume in Keystone's 'Workers on the Move' research series, published in 2008¹⁰⁴, explored migrant workers' housing needs and experiences. Results from the primary research highlighted a number of key issues around exploitation in employment and housing, and potential problems with neighbourhood tensions and community cohesion – as well as potential effects on migrant workers' physical and mental health. The main findings of this piece of research were that despite concerns that migrant workers would begin to place an increasing burden on the already overstretched public housing sector, the majority lived in private rented accommodation and made few demands on affordable housing provision. The report also uncovered evidence of significant 'overcrowding, insecurity and exploitation'¹⁰⁵, all of which are likely to directly affect both physical and mental health of migrant workers. For example, overcrowding in houses in multiple occupation (HMOs) may put occupants at an increased risk of contracting communicable diseases, while other issues such as damp could also affect the respiratory system. The additional stress from living in unsuitable conditions or from the threat of eviction which is a very real fear for many migrant workers as their accommodation is often tied to their employment, could lead to serious mental health issues.

While the evidence base on the effects and implications of increased migration to the UK in general (and the East of England in particular) is undoubtedly growing, there is a clear gap in our knowledge about the health issues faced by migrant workers and their use of health care services. The initial indications are that migrant workers make relatively few demands on services, and that accessing healthcare is not a major motivation for those

who come to the UK¹⁰⁶. Research has consistently indicated that the majority of migrant workers coming to the UK are young, single and in relatively good health and are therefore unlikely to make substantial demands on health services¹⁰⁷. New evidence¹⁰⁸ has also shown that health reasons can often cause migrants to return home temporarily in order to access services, *rather* than accessing health care provision in the UK. However, the profile of the migrant population in our region is changing, with potential implications for health services, and there are indications of raised levels of demand in some areas. There is anecdotal evidence, for example, that health visitors are seeing a rise in the number of migrant worker *families* on their caseloads. More research will need to be done into the health needs, issues and concerns of migrant workers in order to plan more effectively for future levels of demand, and to enable local providers to respond more effectively to the needs of new arrivals – and to balance them against the needs of local communities.

Several studies in both the UK and other countries such as Canada have also discussed what is known as the 'healthy migrant effect'. According to this theory, while migrants *on arrival* have an initial health advantage over the native population – which would tally with the research evidence in the UK of a young, healthy migrant worker demographic – their health can deteriorate with length of their stay in a country. For example, while migrant women in the USA – particularly Hispanic mothers – were found to be initially less likely to experience premature births or to have low birthweight babies, they gradually lost this relative health 'advantage'¹⁰⁹. Similarly research on immigrants living in Canada found that they were initially less likely to be overweight or obese, but that the likelihood of them becoming overweight or obese changed with their length of residence, eventually converging with levels among native Canadians.

This has implications not only for health care providers (in terms of increased levels of demand for services) but also for health promotion initiatives which should be designed with the needs of the migrant population in mind. For example, a study of women who had recently migrated to Canada¹¹⁰ found that while they were initially less likely than Canadian women to engage in health risk behaviours or be overweight, immigrants who had lived in the country for ten years or more experienced a similar prevalence of chronic conditions and long-term disability. Their engagement in high risk health behaviours – such as the consumption of a high fat diet, or tobacco/alcohol use – also increased with length of residence. Recent immigrants were also less likely to attend screening appointments for cervical and breast cancer, and to participate in regular physical activity.

It is widely argued that migrant workers from CEE countries only see their stay in the UK as a temporary one, and that increasing numbers are leaving either to return home, or move to a third country – particularly with the recent economic downturn. A recent study from the Institute of Public Policy

Research (IPPR)¹¹¹ estimated that over half the migrant workers who arrived in the UK after May 2004 had left by December 2007 and that the rate of new arrivals has slowed significantly, with 30,000 fewer migrants arriving in the second half of 2007 compared with the same period twelve months earlier¹¹². If these trends persist, then it is unlikely that demands on health services will increase significantly. However, the evidence regarding length of stay among migrant workers to the UK is far from clear, and it should not be assumed that levels of demand for health care provision will remain low. Recent evidence published by EEDA on migration to the East of England^{xxv} has shown that migrants' intentions regarding length of stay are both flexible and contingent on a wide range of factors and can change frequently; health provision will need to be sufficiently flexible to be able to respond to any fluctuations in the migrant worker population.

The following sections map the current evidence base on the health needs and outcomes of migrants, and set the agenda for the issues which the proposed research will investigate.

^{xxv} Schneider and Holman (2009).

CHAPTER 5.1: Access to primary care services

Several research studies have considered access to and uptake of primary care services among migrant workers, and the overall conclusion is often that comparatively few are registered with a GP - either through a lack of knowledge of how to register, or usually because they do not see the need to register. For example, a study of South Lincolnshire¹¹³ found that rather than coming to the UK as 'health tourists', new arrivals often had little information on health services and fewer still had made use of them. Only 53.3% of migrant workers in this study were registered with a GP, while only 11.9% were registered with a dentist. Only 11.6% of those surveyed had telephoned NHS Direct, while just 40.2% were aware of the 999 number for emergencies^{xxvi}. The study found evidence of some migrant workers who had been in the UK for up to 5 years who were still unaware of the services available to them, and who did not know how to contact NHS Direct - in some cases going directly to accident and emergency departments for medical care.

Similarly another report, *Migrants' Lives Beyond the Workplace*¹¹⁴ found that only 33% of migrant workers surveyed knew how to register with a GP, and only 19% were aware of how the health system works - with those who spoke fluent English more likely to know how to access this information. 77% of those with no English, and 74% of those with only a basic level of English, had received no information on how to register. Overall, fewer than 10% had used an accident and emergency department (which again belies the accusations that migrants are 'swamping' the health service), only 3% had been a hospital inpatient (the majority of whom were mothers giving birth) and only 12% had accessed dental treatment.

In the North West, while significant pressures on GP registrations have been noted in some areas - mainly in large urban centres such as Liverpool - the overall pressures on the NHS have been 'minimal'¹¹⁵. Another study based in Edinburgh¹¹⁶ found that most respondents regarded themselves as healthy, and over half knew how to access the necessary services although few were registered with a GP, mainly because they did not see the need to register. Similarly in Glasgow, demand on primary care services had remained limited with only 58% of migrant workers registered with a GP¹¹⁷. Recent research in the Eastern region found that 23% of respondents had experienced difficulties in accessing healthcare services¹¹⁸.

However, despite the apparent difficulties in accessing primary care clearly experienced by many migrant workers, there is little concrete evidence to justify heightened concerns about the inappropriate use of secondary and acute care as an alternative.

^{xxvi} The authors also noted that those who responded to the survey were likely to have better language skills, have better links to information sources, and be more proactive - and might therefore have better health outcomes; those with fewer language skills might encounter greater difficulties in locating and accessing health services. This was also offered as an explanation for the unusually high rates of GP registration (85%) found by Bell et al. in their 2004 study *Migrant Workers in Northern Ireland* (Institute for Conflict Research).

CHAPTER 5.2: Information, interpreting and translation

A range of factors have been identified which might inhibit migrant workers' knowledge of or access to primary care services, perhaps the most significant of which is a lack of English language skills.

The provision of language appropriate information is now widely recognised as good practice in provision of services to migrant workers, and is particularly relevant in health settings. Research has shown that migrants who had received comprehensive and accessible information were more likely not only to have registered with a GP (54%) but to have actually *used* the service (51%) compared with those who had not received any information, only 26% of whom registered with GP, while just 24% had actually visited their GP¹¹⁹. Preliminary findings from the ongoing EEDA longitudinal study have also indicated a link between poor self-reported health and lower levels of English language competency¹²⁰.

The provision of translation and interpreting services is a central part of facilitating access to health care among migrants who have fewer language skills. Where these services are not in place, migrants are often forced to rely on family, friends – and sometimes community 'gatekeepers' – which raises a number of confidentiality concerns. Currently there is a lack of rigorous data collection on access to translation and interpretation services in health settings^{xxvii}, it would be particularly important for any future research to collect this information by talking both to migrants accessing services and to healthcare professionals about their experiences of using interpreters during consultations^{xxviii}.

^{xxvii} However, there is a certain amount of *anecdotal* evidence.

^{xxviii} This should also consider the difficulties faced by health professionals in building relationships with their clients when they have to communicate via an interpreter or translator.

CHAPTER 5.3: Expectations and cultural differences

Evidence is emerging that migrants' expectations of health provision in the UK often remain unsatisfied. Migrant workers in the Lincolnshire research study mentioned earlier frequently expressed 'deep disappointment' with the level and quality of services available to them¹²¹. Similarly Spencer et al. (2007) reported that migrants were often highly critical of healthcare provision. Yet again, a survey of health needs among migrant workers in Dumfries and Galloway found that a high proportion of respondents identified health services in general, and access to GPs and dentists in particular, as the 'worst' aspect of living in the UK¹²². This dissatisfaction can often be due to differences in the respective functions and coverage of primary and secondary care between the UK and a migrant's country of origin.

While the majority of countries have developed and extended the role of primary care providers over recent years (see section 4.1), it is often not as established a feature as it is in the UK and is 'unusual in a global setting'¹²³. Consequently there is often an element of confusion among new arrivals regarding the 'concept and role of the GP and their gatekeeper function in making referrals to secondary care'¹²⁴.

Again, there is currently little consistent and rigorous data collection on migrant workers' attitudes towards health services. However, there *have* been a number of small-scale local studies which indicate that migrants often expect onward referrals at an early stage, or to be able to directly access specialist provision. Sometimes migrants arrive at individual appointments with multiple family members, or expect nurses and GPs to be able to provide help with other matters such as completing benefit claims¹²⁵. Conversely, healthcare professionals are themselves often unaware of how health systems in sending countries are organised, or of differences in prescribing patterns¹²⁶. Appointments with migrant workers can raise a range of other issues around cultural competence – for example, GPs might lack confidence in their knowledge of patients' entitlements or find themselves under increased time pressure during appointments due to language issues. However, yet again the evidence here is either small-scale or anecdotal, and it would be a priority for future research to investigate these issues further.

CHAPTER 5.4: Other primary care issues: screening and immunisation, maternity and child health services

Low rates of GP registration can have additional repercussions. For instance, if migrant workers are not registered with a GP it becomes more difficult for them to access preventative services such as screening programmes. The mobility of migrant populations also makes arranging follow-up appointments particularly problematic. For example, certain regular child health checks such as neonatal audiology screening, primary and catch-up immunisations, or scheduled developmental checks can easily be missed¹²⁷. Problems have also been highlighted with late presentation for antenatal care. While there

is some evidence of increased pressure on maternity and child health services¹²⁸, this is again mainly anecdotal and it would be interesting to follow this up as part of any future research by talking to health visitors in the Thetford area. If migrant workers are beginning to settle in the UK and to bring up families – even where their stay is temporary though long-term – health visitors will play an important role in accessing migrant worker populations and building confidence in health services.

CHAPTER 5.5: Mental health and migration

There is increasing recognition of the potential links between migration and mental ill-health. This was recently identified as a key priority for action at EU level during the Portuguese presidency which took health as its theme, and acknowledged that 'migration is in itself a risk factor, thus it is not surprising that migrants have high rates of alcoholism, drug addiction and suicide, among others'^{129xxix}. However, there has been extensive criticism of the general dearth of research and 'severe lack of monitoring' reported on mental health services for migrant groups¹³⁰. The lack of systematically collected data means that our knowledge of migrants' mental health status remains limited, although there are initial indications of increased levels of mental health issues, including depression and anxiety caused by the strains and losses which are part of the migration experience¹³¹. At a regional level, a recent report into migrant health needs in the East of England made the point that it is both 'difficult and dangerous' to make generalisations on this issue; while mental health difficulties are not an inevitable consequence of migration, where they *do* occur the consequences can be severe¹³². Consequently, more work needs to be done in order to further our understanding of the mental health issues experienced by migrants, and to inform better service planning and provision^{xxx}.

While there is an extensive literature discussing the specific mental health difficulties faced by asylum seekers and refugees, much less is known about the experiences of migrant workers. However, some initial evidence is beginning to emerge; stakeholder interviews in a report on migrant working in the East of England found that there was a growing perception that migrant workers 'did not necessarily cope leading to mental health problems caused by stress

('they struggle the best they can')'¹³³. More recent research has also suggested that while many migrant workers had not experienced particular stresses, the small number of questionnaire respondents who reported that they were coping 'badly' (4%) or 'fairly well' (31%) 'might be at risk of experiencing situations which may affect their mental health, aspirations and length of stay'¹³⁴.

Research into the consequences of migration for A8 nationals in Scotland found that migrant workers - particularly those in manual or low skilled employment - often experienced significant levels of stress, with potentially negative consequences for their physical and psychological health¹³⁵. This evidence, the author argued, directly contradicts the idea of the 'healthy migrant' effect^{xxxi} which leads to 'the assumption that migrant workers are likely to be particularly healthy, resilient and resourceful'¹³⁶.

The key stress factors identified were:

- *communication difficulties* (many of those interviewed for the research arrived with very little English, which limited their opportunities for social interaction)
- *unfamiliarity with the new environment and culture*
- *work-related stress* (including initial uncertainty about whether they would find employment, low wages and lack of overtime pay, poor working conditions, high workloads and long/unsociable hours leading to 'burn out', split shifts, night shifts, and working in positions for which they were considerably overqualified)
- *practical stress* (such as continued financial hardship, high living expenses and accommodation costs)
- *social stress* (e.g. loss of social contact and interaction)

^{xxix} Others' includes disorders such as anxiety, dermatitis, sleep-related problems, hypochondria and paranoia.

^{xxx} Mental health was also identified as a key priority in a recent health needs assessment exercise in Wisbech (Sergeant 2005).

^{xxxi} See also Pernice et al. (2009), who argued that mental health among immigrants during the initial post-arrival period was no better than that of native-born Canadians - often as a result of underemployment, occupational stress or dissatisfaction and wider stresses relating to the migration process.

Interviewees also reported that they were often unable to rely on networks of co-nationals for both practical and emotional support, as has been previously suggested. Rather this study found that often migrants came to the UK with high expectations and 'took advantage' of those already living here; interviewees described the expectation that they would support fellow Poles - who, they argued, were interested only in money and work, rather than genuine friendships - as particularly 'onerous'.

Consequently 'competition, envy and a lack of cooperation and loyalty were seen as

common features of the Polish migrant community'¹³⁷. The article concludes by arguing that these 'high acculturative demands' and migrant workers' 'increased vulnerability' makes them a 'specific target group for health promotion, prevention and health care'¹³⁸, and calls for a holistic response to their needs which considers not only their physical health, but also the relevant psychological and social factors^{xxxii}.

The following chart (Fig. 8) summarises the range of complex and overlapping factors which could potentially impact on migrants' mental wellbeing;

Fig 8: Factors and sub-factors affecting migrants' mental health and well-being

Source: adapted from World Health Organisation (2002: 33)¹³⁹



Findings from research carried out in other countries may also have some relevance here. For instance, a study of Romanian immigrants in Bologna found that many exhibited 'a high prevalence of distress and psychotic symptoms, related to health problems' – and also linked to other issues such as poor housing, reduced opportunities for social interaction and low levels of integration¹⁴⁰. Another study of Thai migrant workers in Israel¹⁴¹ also identified a clear association between migration stressors and symptoms of psychological distress, with respondents who had poor relationships with other Thai co-workers or were particularly homesick reporting particularly high levels of psychological problems - which suggests that the support

of fellow migrants can be a key protective factor. A review of research into the health of migrants in the US found that overall migrant women often had lower rates of mental health problems than American women – a trend which is indicative of a healthy migrant effect. Where worse mental health outcomes were identified, this was usually among older migrants. However, the study also found that some groups of migrants in fact experienced worse mental health outcomes than the native population – for example, Hispanic immigrants were found to be more likely to experience symptoms of depression – again reminding us of the difficulty of making generalisations about the links between migration, stress and mental ill health.

^{xxxii} Another key priority identified in this study is the need for more longitudinal studies to investigate the relationship between migration and mental health outcomes, rather than relying on cross-sectional or snap-shot data.

Research carried out in Dumfries and Galloway¹⁴² identified a range of strategies employed by migrants to counteract such stresses, including taking opportunities for social interaction (for example, smiling was seen as a form of protection against mental ill health), taking physical exercise, early rising/not sleeping too much, relaxation, planning for the future and giving/receiving respect. When asked about the advice they would give to friends, family or colleagues suffering from depression, respondents advocated taking an active rather than a passive approach and mentioned taking a holiday, talking with friends, or going home for a holiday. Few would recommend going to a GP to discuss their problems, partly as a result of cultural differences in understandings of mental health;

‘In Poland nobody would go to the doctor or to mental health services if they were depressed. It is a fear of what other people might think – they would be seen as a freak if they were using mental health services so they will not use those services here either. You would have to be really hearing voices or something before anyone would go.¹⁴³’

These conclusions largely correspond with the findings of studies which have considered the links between migration and mental health among other ethnic groups, and in other national contexts. A study of mental health issues experienced by recent Chinese immigrants to the UK found that over 60% of questionnaire respondents reported symptoms of poor mental health¹⁴⁴. Many respondents had limited opportunities for leisure and social contact, often due to long working hours, and this social isolation was seen as directly affecting their mental health - for example, although the result was not statistically significant, a link was drawn between having more interaction with British friends and better mental health. Respondents also indicated

that where there was a significant ‘discrepancy between expectations and initial experiences’¹⁴⁵ of migration, mental health outcomes could also be negatively affected. As with many migrant groups, a significant number of respondents expressed specific concerns around accessing help, with 63.4% experiencing moderate or extreme difficulties in using health services.

Summary:

There are major gaps in our knowledge of the health needs and experiences of migrant workers. While concerns have been raised – in political debates and in the media – about the additional burden new arrivals might place on already overstretched public services, research so far has generally shown that migrant workers make few demands on healthcare services and in fact make a significant contribution to the NHS as a significant proportion of its workforce. There is little evidence to suggest that the ready availability and high quality of healthcare in the UK acts as a major factor in migration decisions – in fact, migrants often prefer to access care in their home country.

There is also a lack of systematically collected evidence on the health needs of migrants, making it difficult for service providers to plan adequately for the requirements of new arrivals. This section provided an overview of the existing evidence on health needs from research carried out in other areas of the UK, and highlighted areas of potential need identified in the international literature on health and migration. This has also helped to shape the research agenda for this project; Keystone’s research team will not only map migrant workers’ health needs – particularly in relation to primary care, translation and interpreting services, maternity care and mental health – but also explore their use of and attitudes towards healthcare services.

CHAPTER 5.6: ‘Workers on the Move 3: Domestic violence and migration’

What is domestic violence?

The Government defines domestic violence [or domestic abuse] as ‘Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners or family members, regardless of gender or sexuality.’¹⁴⁶ According to a recent report, domestic violence accounts for 16% of all violent crime with 77% of the victims being women¹⁴⁷. The report also states that, on average every week, two women are killed by a current or former male partner.

The costs of domestic violence

Aside from the costs of human suffering, there are quantifiable economic costs attributable to the role of domestic violence in society. A 2004 study estimated that domestic violence creates an annual cost of £1 billion, to the criminal justice system, representing one quarter of the criminal justice budget for violent crime¹⁴⁸. The cost to social services is estimated to be £0.25 billion and housing costs £0.16 billion. With regard to financial implications to the healthcare system, the cost of physical healthcare treatment resulting from domestic violence is thought to be £1,220,247,000 and the cost of treating mental illness and distress is £176,000,000¹⁴⁹. The charity Woman’s Aid have suggested that this amount is a significant underestimate, as public services do not collect specific data on the extent to which services are used as a result of domestic violence¹⁵⁰. The figures also exclude the cost of support given by the voluntary sector.

Health implications

As the above statistics suggest, experiences of domestic violence can have a significant and adverse effect on women’s health. For example, the World Health Organisation reports that women who suffer domestic violence are significantly more likely to report poor or very poor health than women who have never experienced such abuse¹⁵¹. They also report that victims of abuse are more likely to experience difficulties walking and carrying out daily activities, pain, memory loss and dizziness.

Further to the more obvious physical effects of domestic violence, women suffering such abuse may also suffer from additional mental health issues. A 1999 study states that a meta-analysis of 18 studies found that those subjected to domestic violence had a rate of depression of 48% and a suicide rate of 18%¹⁵². The study also reported an average rate of post-traumatic stress disorder among victimised women of 64%. The psychological impact of domestic violence and its link to women remaining in abusive relationships is explored at some length by Lenore Walker’s theory of the ‘Battered Woman Syndrome’¹⁵³.

The issues for abused women

The 'Battered Woman Syndrome' is a controversial model with some commentators arguing that it is the '...lack of socio-economic alternatives for women rather than "learned helplessness" that makes leaving violent men so difficult'¹⁵⁴. It is true that there are a number of practical rather than psychological factors that point to why women remain in abusive relationships, for example, lack of economic resources and access to low cost housing or women's refuges. A study by the charity Shelter found that domestic violence was the most quoted reason for becoming homeless, with 40% of all homeless women naming it as contributing to their homelessness¹⁵⁵. Sanghvi & Nicolson argue that many women do attempt to seek help to escape but the response from state institutions is 'woefully inadequate'¹⁵⁶. Such problems are further exacerbated in situations involving children and further compounded by concerns surrounding taking children away from their father or even losing them in a custody battle.

The problem does not necessarily end when violence is reported. In the UK a man charged with domestic violence can be released on bail and even if he is subject to an injunction, practically speaking, he is not prevented from returning to the victim¹⁵⁷. He would not be subject to sanctions until the police are made aware of breach of an injunction or bail conditions, or worse, a further incident. It seems some women feel that attempting to leave their partners is futile as he will always find them. This is supported to some degree by the fact that on average, two women per week are killed by a male partner or *former* partner¹⁵⁸. A report published by the Home Office states that 7% of women said the worst incidence of violence occurred after they had stopped living with their abusive partner, demonstrating that '[f]or a small but significant minority, leaving the relationship is the most dangerous time of all'¹⁵⁹. In a report by Women's Aid, 76% of separated women reported suffering post-separation

violence¹⁶⁰. The Law Commission agree that evidence shows '[m]any abused women learn that if they attempt to leave, they will be followed and forced to return, to face even greater hostility and more serious violence'¹⁶¹.

The issues for migrant women

The private nature of domestic violence makes it likely that many incidents of abuse remain unreported or undiscovered. This secrecy intensifies the potential of prejudice for women as it perpetuates the notion that it is a taboo subject, or that women are somehow to blame for the abuse. Society often fails to acknowledge that shame and isolation play a large part in women remaining with their abusive partners and in many cases keeping the violence a secret. There is little doubt that geographical or emotional isolation from friends and family plays a significant part in the problem for women of all races and social backgrounds and it is not difficult to see how such factors are exacerbated for migrant women in the UK, presenting additional difficulties in seeking out and receiving services and support.

The Law Commission report that during their discussions with psychiatrists, it was commented that many cases of violence are not simply a matter of the physical abuse inflicted, but also the man's wish to exercise dominance and control over the woman¹⁶². Once again, for migrant women, the man's ability to exert dominance and control is heightened by the potential isolation of migrant women, but also by the fact they are often dependant on their working partner or family members for housing and income^{xxxiii}. Migrant women who do not work outside the family home are likely to face additional barriers in forming independent social support networks, developing language skills, gaining knowledge of their legal and welfare rights or having any kind of financial independence; all socio-economic factors that potentially impact on a woman leaving an abusive situation.

xxxiii This situation is particularly relevant to those women from A2 and A8 countries.

Language barriers present an obvious problem for migrant women wishing to receive assistance, for example communicating with police and witness support and also in gaining basic knowledge of services available to them. However, discussion with local service providers suggests that the issues preventing many women successfully escaping abusive situations penetrate deeper than this. In the first instance it is an issue of building trust with migrant women, especially between them, the police and witness support services, in order to encourage them to initially report the crime, but also to pursue prosecution of the perpetrator. There is also suggestion from service providers that in certain cases, where women are entirely financially dependant on their spouse, they are reluctant for them to be removed from the family home as it effectively constitutes the removal of the 'bread winner'. With this in mind it would seem then that the issue is not simply one of isolation or fear of reporting the violence, but the necessity to live and provide for themselves and their families. It is in this area that there appears to be a lack of services able to meet such women's needs. This is especially true where women have no recourse to public funds.

Women with no recourse to public funds

One of the most concerning issues is those women who have little recourse to public funds due to their immigration status. European migrants originating from the accession countries (also known as the A8 Countries) must work, as a 'registered worker' under the Worker Registration Scheme continuously for 12 months before they are entitled to certain welfare benefits, such as income support and housing benefit. Therefore when women are not able to fulfil these requirements, they are often left in a situation with little or no support and without the practical assistance of facilities such as emergency housing.

Preliminary conclusions

On the whole, there is relatively little specific national information available regarding European migrants and domestic violence in England and Wales. This does not however, mean it is not an issue. Discussions and work by local and national services providers highlight the fact that it is a very real concern, especially in cases of those with no recourse to public funds^{xxxiv}. It will be interesting to note the developments of both research and policy surrounding this area in the coming months.

Domestic violence and the migrant community will be the subject matter of the next 'Workers on the Move' publication.

^{xxxiv} See, for example, http://www.islington.gov.uk/DownloadableDocuments/HealthandSocialCare/Pdf/duties_to_support_manchester_conference_report.pdf

CHAPTER 6: Information on health and migration in Thetford and the East of England

Currently there are major gaps in the information base on health and migration in the East of England generally, and in Thetford in particular. Much of the evidence that *does* exist is anecdotal, and relatively little has been achieved so far in terms of sustained research into the health needs and experiences of

migrant workers to the region. Keystone's META advice team have recently begun to collate data on the health needs of clients, and are starting to build up an overall picture of access to services. The data collected for the month of September 2009 is summarised in table 5 below:

Table 5: Health data for clients to Keystone's META advice service (September 2009)

Aware of health services	56
Not aware of health services	7
Registered with GP	37
Not registered with GP	8

There are two main key conclusions which we can draw from this data, the first of which is that levels of awareness of health services among migrant workers appear high. This may well be a result of the overall improvements in information provision about services which have been achieved regionally, particularly the provision of language-appropriate information. It would, however, still be interesting to explore further how and where migrant workers access information and whether this is through services such as those provided through Keystone, via word of mouth in the migrant community – or whether migrant workers research and access services independently. However, it should be noted that this data only covers those migrant workers who are more confident in accessing Keystone's advice service; it may equally be that there are other sections of the migrant community who are less confident in accessing advice – and healthcare provision. The planned research should also look at barriers to seeking help and advice, particularly in relation to health, and identify any improvements which could be made.

The second conclusion which we can draw from the available data is that migrant workers in Thetford do not appear to be experiencing difficulties in registering with a GP. This conclusion is certainly supported by the experiences of both the Polish and Portuguese advice workers at Keystone, who have reported that the majority of clients have little difficulty in registering with GPs, although they *have* reported clients experiencing difficulties in making appointments with opticians and dentists. The planned research would need to explore whether there are any differences *between* groups of migrant workers in their experiences of accessing primary care services, and to identify any barriers experienced by particular sections of the migrant community. It may be, for instance, that those living in remote areas (rather than in the more central parts of the town) find it more difficult to access services.

It would also be interesting to explore the various reasons for non-registration with a GP among the minority who have not registered, and to assess whether this is due to barriers such as closed practice lists, or language difficulties – or whether migrant workers do not register with a GP simply because they do not feel they need to. Any survey carried out for this project would also need to explore migrant workers' views and experiences of primary care provision, including negative views (as discussed above), as well what alternative sources of health care those who are not registered might use – for example, whether they go back home to access treatment.

EERA's recent scoping report on migrant health in the region, which sits within a larger project led by the Department of Health that aims to improve our understanding of migrants' health needs and experiences, also highlighted these knowledge gaps and identified a range of areas where new arrivals are likely to experience problems and where our knowledge needs to be improved and extended¹⁶³;

• **Access to primary care services:**

Many migrants fail to register with General Practices either because of their own perceptions of their needs or misunderstandings about how health services work or because of barriers faced when trying to do so. This might result in failure to access health promotion and screening services, a range of unmet needs and late presentation for care in other health service areas.

• **Translation and interpreting:**

The biggest barrier to care identified by GPs, other service providers and patients themselves is the failure to utilise quality translation and interpreting services, without which access to care and thus positive health outcomes is effectively denied and risks around incorrect diagnosis and inappropriate care are increased.

• **Maternity care:**

A significant increase in the numbers of births to mothers born outside the UK combined with difficulties in accessing primary care, the mobility of migrant families, the lack of support networks and complexities around domestic abuse and trafficking raise important issues to be considered in the commissioning and delivery of maternity and child health services.

• **Mental health services:**

Whilst migration generally and seeking asylum in particular can create a wide variety of stressors, mental illness is not an inevitable consequence. However, where mental distress does occur the limited capacity of primary care mental health services for the population generally are compounded with particular access issues for migrants, especially around cultural understandings of mental distress and effective communication.

• **Data Collection, Health Needs Assessments and Commissioning**

Robust and comprehensive data regarding new migrant communities is limited, creating difficulties in the completion of meaningful Joint Strategic Needs Assessments and with the inclusion of needs into Local Area Agreements and the commissioning of health services.

Broadly speaking, these themes match up with the issues highlighted in the literature review carried out as preparation for this discussion paper. In order to gain a better understanding of the health issues experienced by migrant workers in the region, it will be important for the planned research to link up with EERA's work – and also to avoid duplicating it. The scoping report makes a number of recommendations, including the facilitation of a migrant health e-network to share information and best practice and to enable collective work, and again it would be important for the planned research to feed into this.

CHAPTER 7: Primary research – the local context

The primary research stage of this project, which will run between November 2009 and February 2010, will involve a series of linked research tasks:

Research with professionals:

- An email questionnaire to be distributed to a range of health professionals and ancillary staff in Thetford and the surrounding area. This questionnaire will be used to pinpoint broad trends in migrants' use of health services, and to identify key themes and issues to be explored more closely in the subsequent interviews.
- Interviews with key health providers, both those operating at a strategic level and those involved in front line service delivery. The interview schedules will be developed from an exploration of the available literature, and initial analysis of the questionnaire data.

Research with migrant workers:

- A short questionnaire completed by META clients. Migrant workers accessing the information service will be supported by META health advisers and Keystone's research manager in completing this form, which will be translated into Polish, Portuguese and Lithuanian. Questionnaire respondents will also be asked if they would be willing to take part in the next stage of the research.
- Individual interviews and focus groups with migrant workers. Again, the interview schedules and topic guides will be developed from the main themes identified in the literature on health and migration, as well as an initial analysis of findings from the migrant questionnaire. The interview/focus group samples will be purposive; participants will be selected according to specific questionnaire

answers – for example, those respondents who report difficulties in registering with a GP, or those who are heavy smokers.

This review of the existing evidence and literature on health and migration has identified a number of key issues and questions to be addressed by the primary research. These can be divided into the following broad areas:

Access to and utilisation of health services

- As already discussed in the preceding sections, little is currently known about migrant workers' use of health services and the likely level of demand for services among new arrivals. Consequently, a central part of this research will be to piece together a fuller picture of the current migrant community's knowledge and use of healthcare services. For example, a questionnaire^{xxxv} could be filled in by clients of the META advice service giving information on whether they are registered with a GP or dentist, whether they have had contact with other practitioners such as midwives and health visitors, and whether they have used other services such as NHS Direct or the out of hours service. Respondents could also be asked about their use of acute services – for example, whether they had accessed emergency care rather than going to a GP.
- Migrants' perceptions of the available services, and how this compares with provision in their home country would also need to be explored – for example the suggestion, in some research, that many are disappointed in the quality and availability of services and prefer to access care at home instead.

^{xxxv} This could then be followed up by a smaller number of in depth interviews.

- It will be important to explore any barriers to accessing primary care services, particularly the issues around availability and quality of interpreting services, and the provision of language-appropriate information. Differences between groups of migrants, for example in relation to nationality, area, gender or age, could also be a factor here and the research would also need to explore these issues.
- In order to provide a balanced picture, researchers would also need to investigate health service professionals' experiences of treating migrant workers, and their attitudes towards and perceptions of this group of patients. A questionnaire distributed to professionals would need to include questions on their knowledge of migrants' entitlements, or their experiences of using interpreting and translation services. Any barriers they have experienced in treating migrants, such as expectations and cultural differences – possibly around the gatekeeping role of GPs in the UK – would also need to be considered.
- A significant amount of research has been carried out into the mental health needs of other migrant groups, such as asylum seekers and refugees; little, however, is known about the mental health needs of migrant workers. Emerging evidence suggests that migrant workers are experiencing increasing levels of stress, sometimes leading to serious mental health difficulties. This research would begin to explore these issues, and to consider the various coping mechanisms migrant workers might adopt in order to deal with the stress of living and working in the UK.
- There is a wide range of reasons why migrants may not access health services or seek help with their health problems; this may be because of a lack of information or language skills, or because of migrants' perception of the quality of provision; it may also be because of previous negative experiences – or simply because they do not perceive any need. Sometimes migrants may access health services at home, or they may prefer to deal with problems independently. The research will also consider the various reasons for non-help seeking behaviours, and identify any potential improvements to provision which could address these issues.

Health needs, issues and concerns

- Another main aim of this research will be to gain a fuller understanding of the health needs and issues of migrant workers. It has often been assumed that new arrivals to a country enjoy a health advantage over the native population (the 'healthy migrant effect'), and certainly the *initial* evidence gathered on migrant workers coming to the UK would suggest that they are comparatively young and healthy. This research will explore more fully how migrant workers to the area perceive their own health, along with any health problems they might experience, including any deterioration in their health which has occurred since arriving in the UK.

Health promotion

- A range of health promotion initiatives introduced in sending countries has been identified; the planned research will investigate migrant workers' awareness of these campaigns and what effect – if any – they have had on migrants' smoking, dietary or exercise habits. Any lessons which can be drawn from these campaigns and applied to the Healthy Town initiative will be highlighted.
- Research in other countries has emphasised the lack of priority given to health promotion by primary care practitioners, and the fact that health is seen as an issue of personal responsibility; the attitude of research participants towards taking dietary or lifestyle advice from primary care providers would also be an interesting area to explore.
- The research will also explore migrant workers' awareness of and response to health promotion initiatives in the UK, such as Healthy Town and Change4Life. Any reasons for lack of engagement will need to be explored, as well as any barriers to participation in these projects (for example, timing and targeting of events), and the findings used to enhance service provision. It will also be useful to explore migrant workers' responses to specific health promotion campaigns such as smoking cessation initiatives.

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