Understanding the Health Needs of Central and Eastern European Migrants in Hertfordshire

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Understanding the Health Needs of Central and Eastern European Migrants in Hertfordshire

1. Executive Summary & Recommendations

One of the key priorities for NHS Hertfordshire is to understand the key health issues facing recent Central and Eastern European (CEE) migrant communities that have settled in Hertfordshire since the expansion of the European Union in 2004.

This report details the findings of a health needs assessment conducted in early 2011 to:

a) Determine the geographical distribution of Eastern European migrants within Hertfordshire.

b) Identify the major Eastern European migrant groups that reside the county.

c) Explore the main issues Eastern European migrants face in relation to health and/or accessing health-services in the UK and Hertfordshire.

d) Establish what particular health conditions the Eastern European migrant community is at risk of.

Central and Eastern European migrants are a challenging group with a diverse range of health needs. Currently, there is very limited quantitative data regarding the precise numbers, locations and health status of CEE migrants in Hertfordshire, and a distinct lack of established community groups through which to access this particular population. Analyses of National Insurance number allocation amongst CEE migrants, Worker Registration Scheme data and interviews with community development workers suggest that Welwyn Hatfield, Watford and Hertsmere are the three top districts in which high numbers of CEE migrants are likely to reside. Similar data indicates that migrants of Polish origin, of whom there are an estimated 10,000 resident in Hertfordshire, constitute the largest cohort of CEE migrants in each of the county’s ten districts. The remaining smaller but still significant CEE communities include several hundred migrants from Lithuania, Hungary, Romania and Slovakia as well as many from Bulgaria, Czech Republic and Latvia however it is not clear at present how large these communities are. The majority of Polish and Lithuanian migrants in Hertfordshire are thought to be young single men and women, or families with young children.

Discussions with community development workers in Hertfordshire who have an in-depth knowledge of their local CEE communities and a review of literature regarding the health of migrants across the United Kingdom (UK) identified a number of problems that are particularly prevalent amongst CEE migrant communities including:

- Difficulty accessing health services due to a poor understanding of the National Health Service (NHS) and their entitlement to healthcare.
- Significant language and cultural barriers as a result of lack of English language skills amongst some migrants and inconsistent provision of translation and interpreter services.
- An increased risk of mental health problems due to a combination of social isolation and lack of support, financial or employment difficulties and a lack of understanding or awareness of mental health and support services available to them.
- A higher risk of sexual health problems including sexually transmitted infections and an increased need for family planning services among CEE females.
- High rates of smoking and alcohol consumption as well as a lack of interest or time for exercise; risk factors known to increase the risk of developing conditions such as hypertension, ischaemic heart disease, cerebrovascular disease and respiratory tract malignancies to name a few.
Recommendations
In view of the findings of this report, the following recommendations have been put forward as ways to address the major issues identified and further our understanding of the health needs of CEE migrants in Hertfordshire:

1.1. Implement “Commissioning Framework for Language Support 2011”

1.2. Review CEE migrant-specific data once results of the 2011 National Census are available

1.3. Establish better links with CEE migrant communities to improve direct access to stakeholders and identify trusted leaders/role-models from within these communities

1.4. Deliver information services and health promotion events in local community settings which are more acceptable to migrants

1.5. Develop strategies with employment agencies to facilitate provision of adequate occupational health and sickness absence information

1.6. Assess STI rates and sexual health clinic attendance amongst CEE migrants in Hertfordshire since 2004 to better quantify need for sexual health services

1.7. Assess tuberculosis rates in Hertfordshire since 2004 and encourage use of the Health Protection Agency’s new online resource, “The Migrant Health Guide” - particularly in primary care
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2. Introduction
One of the core principals and values of the NHS is the concept of providing “a comprehensive service, available to all”. Following the launch of the modernisation programme in July 2000, the NHS also pledged to respond to the different needs of different populations, help to keep people healthy and to reduce health inequalities (The NHS Constitution for England, 2009); aims which have been further emphasised in the latest NHS White Paper, “Equity and excellence: Liberating the NHS”.

One of the key priorities for NHS Hertfordshire is therefore, to identify the main health issues facing traditionally under-served populations within the county such as migrant groups, understand the reasons for any discrepancies in health and establish recommendations to improve health promotion and aid better planning and provision of local health services for these groups.

3. Aims & Objectives
The purpose of this health needs assessment (HNA) is to:

- Determine the geographical distribution of Eastern European migrants within Hertfordshire.
- Identify the major Eastern European migrant groups that reside the county (with the exception of Polish migrants, for whom a HNA has recently been conducted in late 2010).
- Explore the main issues Eastern European migrants face in relation to health and/or accessing health-services in the UK and Hertfordshire.
- Establish what particular health conditions the Eastern European migrant community is at risk of.

4. Background
Hertfordshire is one of the most densely populated shire counties in England, with an estimated population of 1,095,500 in 2009 (Hertfordshire Observatory); a figure that has been projected to increase by a further 20.6% over the next 25 years (National Office for Statistics, mid-year population estimates).

Minority ethnic groups form a significant proportion of Hertfordshire’s population. Estimates from the National Office for Statistics (NOS) suggest that in mid-2007 minority ethnic groups represented 16% of Hertfordshire’s population, compared to just 11% at the time of the 2001 National Census. Between mid-2007 and mid-2008 the estimated increase in Hertfordshire’s population that was due to migration (and other changes) was also noted to be higher than that due to natural change (births minus deaths) for the first time in ten years. During this time, 38% of the estimated net in-migration to Hertfordshire was due to the arrival of migrants from overseas.

Part of this change in Hertfordshire’s demographics is likely to be attributable to the expansion of the European Union (EU) in May 2004. The expansion saw the simultaneous accessions of ten new member states - eight of which (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia and Slovenia) are within Central and Eastern Europe and are often referred to as the “Accession 8” (A8) countries. This represented the largest single enlargement of the EU to date and was closely followed by the accession of two more Eastern European countries (Bulgaria and Romania, often described as the A2 countries) in 2007, which has further facilitated the large influx of Eastern European migrants in particular, into the UK and into Hertfordshire.
5. Defining the Population
This report focuses on relatively recent migrants originating from Eastern Europe (but not Poland) who reside within the county of Hertfordshire.

The term “migrant” refers to a person who travels from one region (their country of birth) to another to seek employment or educational opportunities, join other family members or to escape persecution in their home country (asylum seekers and refugees).

The definition of Eastern Europe can vary depending upon the cultural, political, historical and geographical criteria employed. For the purpose of this report the EU definition, which relies predominantly upon geographical location to define countries as part of either Central and Eastern Europe (CEE), or Southern Europe, has been used. The Baltic States (Estonia, Latvia and Lithuania) are considered separate but may also be included within the definition of Eastern Europe due to their former political affiliations and current EU member status.

Image 1. Map of Central & Eastern Europe

Table 1. Central & Eastern Europe Countries

<table>
<thead>
<tr>
<th>Country</th>
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<tbody>
<tr>
<td>Albania</td>
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<tr>
<td>Armenia</td>
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<tr>
<td>Azerbaijan</td>
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<tr>
<td>Belarus</td>
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<tr>
<td>Bosnia &amp; Herzegovina</td>
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<tr>
<td>Bulgaria</td>
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<tr>
<td>Croatia</td>
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<tr>
<td>Czech Republic</td>
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<tr>
<td>Estonia</td>
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<tr>
<td>Republic of Macedonia</td>
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<tr>
<td>Hungary</td>
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<tr>
<td>Georgia</td>
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<tr>
<td>Kosovo</td>
</tr>
<tr>
<td>Latvia</td>
</tr>
<tr>
<td>Lithuania</td>
</tr>
<tr>
<td>Moldova</td>
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<tr>
<td>Montenegro</td>
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<tr>
<td>Poland*</td>
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<tr>
<td>Romania</td>
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<tr>
<td>Russia</td>
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<tr>
<td>Serbia</td>
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<tr>
<td>Slovenia</td>
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<tr>
<td>Ukraine</td>
</tr>
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</table>

*Recent HNA completed December 2010

6. Methodology
There is very limited data available regarding the numbers, locations and health status of migrants and particularly CEE migrants in Hertfordshire. Results from the 2001 National Census are also significantly outdated and likely to be inaccurate by now so should be interpreted with caution. The small numbers of Eastern Europeans other than Polish migrants and the lack of any well-established community groups or forums have also meant that it has not been possible to access stakeholders directly during the course of this exercise.

A number of other sources have therefore been utilised to gain information about the Hertfordshire’s CEE migrant community including:
a) A literature review of the health needs of Eastern European migrants (both in Hertfordshire and elsewhere within the United Kingdom).
b) Interviews with several community development workers working specifically with CEE migrant groups around Hertfordshire.
c) World Health Organisation (WHO) data regarding the major causes of morbidity and mortality in the home countries of CEE migrants.
7. Results & Discussion

7.1. Geographical distribution of Hertfordshire’s CEE migrant population

There is currently very limited data regarding the specific numbers and locations of CEE migrants in Hertfordshire. Communities of CEE are often all classed as simply “White: other white” ethnic groups, or incorrectly categorised because of language difficulties.

7.1.1. 2001 National Census Data

A household analysis by mosaic groups using data from the 2001 National Census was performed (Table 2). Mosaic groups G (young, well-educated city dwellers), I (lower income workers in urban terraces in often diverse areas) and N (young people renting flats in high density social housing) signify the top three groups that are likely to have residents from an Eastern European background, which helped indicate the districts within Hertfordshire that have the greatest proportion of East European migrants residing within them. The results indicate that Watford, St Albans and Welwyn Hatfield are the top three districts likely to have residents of an Eastern European background. As these results are based on data which is largely outdated by now, they are indicative only and should be reviewed once results from the 2011 National Census are available.

<table>
<thead>
<tr>
<th>District/Borough</th>
<th>Total Mosaic Households</th>
<th>Households in Mosaic Groups G, I &amp; N</th>
<th>% of Households in Mosaic Groups G, N &amp; I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watford</td>
<td>36097</td>
<td>11303</td>
<td>31.3%</td>
</tr>
<tr>
<td>St Albans</td>
<td>57445</td>
<td>8101</td>
<td>14.1%</td>
</tr>
<tr>
<td>Welwyn Hatfield</td>
<td>47306</td>
<td>4839</td>
<td>10.2%</td>
</tr>
<tr>
<td>Stevenage</td>
<td>35199</td>
<td>3295</td>
<td>9.4%</td>
</tr>
<tr>
<td>Dacorum</td>
<td>60547</td>
<td>4473</td>
<td>7.4%</td>
</tr>
<tr>
<td>Hertsmere</td>
<td>41058</td>
<td>2493</td>
<td>6.1%</td>
</tr>
<tr>
<td>Three Rivers</td>
<td>36038</td>
<td>1940</td>
<td>5.4%</td>
</tr>
<tr>
<td>East Hertfordshire</td>
<td>57466</td>
<td>2861</td>
<td>5.0%</td>
</tr>
<tr>
<td>North Hertfordshire</td>
<td>54880</td>
<td>2721</td>
<td>5.0%</td>
</tr>
<tr>
<td>Broxbourne</td>
<td>38861</td>
<td>1700</td>
<td>4.4%</td>
</tr>
</tbody>
</table>

7.1.2. 2007-2009 National Insurance Number Allocation Data

More recent data regarding the allocation of national insurance (NI) numbers from 2007-2009 in Hertfordshire shows that Welwyn Hatfield, Watford and Hertsmere had the highest numbers of NI numbers allocated to CEE migrants, suggesting that these districts are more likely to have residents of CEE origin.

Chart 1.
NI Number Allocation to CEE migrants in Hertfordshire (2007-2009)
7.2. Hertfordshire’s main CEE communities

7.2.1. 2008 Joint Strategic Needs Assessment Data
Data from the 2008 Joint Strategic Needs Assessment shows that Polish migrants form the largest cohort of non-UK nationals in each of the ten Local Authority areas in Hertfordshire.

<table>
<thead>
<tr>
<th>Table 3. Largest Non-UK National Populations by Local Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broxbourne</td>
</tr>
<tr>
<td>Dacorum</td>
</tr>
<tr>
<td>East Hertfordshire</td>
</tr>
<tr>
<td>Hertsmere</td>
</tr>
<tr>
<td>North Hertfordshire</td>
</tr>
</tbody>
</table>

Further information regarding the other major CEE migrant groups however is not as readily accessible. Discussions with community development workers who have an in-depth knowledge of their local communities revealed that there is general consensus on the fact that the Polish community form the largest contingency within the CEE community in Hertfordshire, and recent estimates suggest that there are as many as 10,000 Polish migrants currently resident in Hertfordshire.

The other smaller but still significant CEE groups include migrants from Lithuania, Slovakia and Czech Republic as well as some from Hungary, Latvia and Romania. Estimates regarding the sizes of these populations were not possible at this time however provisional data from the Worker Registration Scheme suggests that Polish, Lithuanian and Hungarian migrants form a substantial component of Hertfordshire’s newer CEE population.

7.2.2. Worker Registration Scheme (WRS) Data
The WRS was initially established to monitor the participation of workers from the A8 countries in the UK labour market, and data from October 2008 to September 2010 show that Polish, Lithuanian and Hungarian migrants accounted for approximately 83% of all successful (first-time) workers registrations applications in Hertfordshire during this period (see Chart 2 below).

This data does not take into account self-employed or unemployed migrants and those whose applications have been unsuccessful and so may underestimate the sizes of the various CEE migrant groups shown. Given that many migrants will also have undoubtedly moved during the early months of their arrival within the UK for better employment or housing opportunities, details regarding country of origin and current place of work will need to be reviewed and updated following completion of the 2011 National Census.
7.2.3. National Insurance (NI) Number Allocation Data

Between 2007 and 2009 a total of 9720 NI numbers were allocated to CEE migrants in Hertfordshire. These accounted for 35% (i.e. over a third) of all NI number allocations to migrants in Hertfordshire during this time. Almost two thirds of these were allocated to those of Polish origin, and several hundred were also allocated to migrants of Slovakian, Romanian, Hungarian and Czech Republic origin, suggesting that significant numbers of these migrant groups are likely to currently reside within Hertfordshire.

7.3. Demographics of the CEE community

A recent HNA of Hertfordshire’s Polish community identified that the majority of Polish migrants who have arrived since the year 2000, are young single men and women aged 25-40 years or young families with parents aged 25-40 years and children under ten.

Direct discussions with a number of community development workers and a stakeholder within the Lithuanian community revealed that the majority of Lithuanian migrants are also men and women aged 20-35 years with young families, or migrants aged 35-50 years but not much older.

Demographic information regarding migrants from the other major CEE countries represented in Hertfordshire was not known at this time.
7.4. Health issues identified amongst CEE migrants

Discussions with community development workers in Hertfordshire and a review of literature regarding the health of migrants across the United Kingdom (UK) have helped identify a number of problems that are particularly prevalent amongst CEE migrant communities. The extent of these problems and their impact on the health and well-being of migrants are discussed below.

7.4.1. Difficulties accessing health services

One of the main issues that have been repeatedly highlighted with regards to migrant health is the difficulty they face with accessing relevant healthcare services. This is due to a multitude of reasons including a poor understanding of the organisation of the National Health Service (NHS) in the UK, confusion regarding their entitlement to health care (particularly about occupational health regulations and sickness absence) and a lack of awareness about the services and support that are available to them. The majority of these problems all stem from an underlying lack of adequate English language skills and a failure to address the subsequent language barrier that migrants frequently face in the NHS.

7.4.2. Language and cultural barrier

Language difficulties and differences in culture appear to be the most significant challenge experienced by CEE migrants, and are likely to govern not only how well migrants integrate into the community but how well they seek out and use information and NHS services. As such, the General Medical Council (GMC) stipulates that where practical, arrangements should be made to meet patients’ language and communication needs.

A UK-wide study conducted just before and after the enlargement of the EU in 2004 helps demonstrate the importance of language in relation to health. Results of a survey and over 600 in-depth interviews with CEE migrants in the UK found that one-third of respondents described their English language skills as “basic or none” and only a third of migrants surveyed knew how to register with a GP but these migrants were twice as likely to have registered as migrants lacking this vital information (Spencer S et al., 2007). Adequate provision of information and language support are thus essential aspects of improving the health of CEE migrants.

The inability to convey and understand information is also seen as a considerable source of frustration and embarrassment for many migrants, and often results in the omission of important details during the consultation process and frequent misunderstandings. As such, data regarding the use of interpreters across the West Hertfordshire Hospitals NHS Trust showed a 35% increase in the number of CEE interpreters assigned in 2010/2011 compared to 2009/10, as well a greater variety of CEE languages amongst patients (13 different CEE languages in 2010/11 compared with just six CEE languages in 2009/10).

![Chart 4. Interpreters in WHHT April 2010-March 2011](chart_image.jpg)
Despite the increasing need for CEE interpreters, interviews with stakeholders from the Lithuanian community revealed there is often no or inadequate provision of translation and interpretation services. As a result, informal interpreters such as family members (including children) or friends are often used during consultations which compromise both patients’ confidentiality and understanding of their health problems. Discussions with a community development worker who works closely with much of the Lithuanian community in Broxbourne, Hoddesdon, Waltham Cross in the south-east of Hertfordshire also highlighted the inconsistent provision of formal interpreters amongst primary care services in particular as a major barrier to promoting equal access to health services.

Inadequate language support is not a problem unique to Hertfordshire. A report published by the South East Migrant Health Study Group in October 2010 also found that delivery of vital interpreting and translation services across South East England was often inconsistent due to differences in staff knowledge and the additional costs associated with translating literature and providing suitably qualified interpreters.

7.4.3. Mental health risks

Particular concern has been raised by a number of groups about the frequency of mental health problems amongst migrant groups. These may range from mild forms of mental distress such as poor self-esteem and confidence to more severe illnesses such as depression, anxiety disorders and an increased risk of suicide.

Migrants (particularly asylum seekers and refugees) are at a higher risk of developing mental health illness because of greater exposure to multiple stressors such as trauma or persecution in their home countries, bereavement and separation from family and friends, as well as financial difficulties, poor housing conditions and social isolation upon arrival in the UK. Stakeholders within the Lithuanian community for instance, described issues such as “culture shock”, isolation and financial, employment or accommodation worries as the major contributing factors to poor mental health following migration. Many CEE migrants are also reluctant to seek help via mainstream services because they fear the social stigma that is often related to mental illness, which demonstrates poor understanding of mental health and a lack of awareness of community support that is available.

It is important to recognise that many migrants are in fact quite resilient and do not necessarily go on to develop mental health illness or require mental health services. It is nevertheless, essential to ensure the appropriate provision of information about where they can seek advice or help if necessary. Migrants’ understanding of mental wellbeing and awareness of the availability of mental health community teams should also be improved through better provision of translated literature and locally-based health education programmes. Promotional events lead by health care workers and medical professionals fluent in both English and common CEE languages would also encourage attendance and allow stakeholders to engage with speakers.

7.4.4. Sexual and reproductive health risks

The majority of migrants are young, sexually active individuals who frequently migrate without their primary partner. Migration itself, is also a recognised risk factor for high-risk sexual behaviour independent of marital and cohabitation status or social background. These factors significantly increase the risk of sexually transmitted infections (STIs) amongst CEE migrants.
Results of a six-year study assessing the use of sexual health services in London noted significantly increased attendances of people of Eastern European origin between June 2001 and April 2007 (Burns et al., 2009).

Collection and analysis of KC60 data detailing all new attendances at two clinics showed that by the sixth year of the study (May 2006-April 2007), CEE women accounted for 7.9% of all female attendances and CEE men for 2.5% of all male attendances. Men of CEE origin were also more likely to be diagnosed with syphilis than males of other nationalities, whilst family planning services were more likely to be required for CEE women than those born elsewhere. Clinic attendance data also highlighted high proportions of CEE women attending the female sex worker clinic sessions and larger proportions of CEE men that were homosexual or bisexual, suggesting the presence of at least two high-risk populations amongst CEE migrants in London.

It is unclear to what extent these results can be extrapolated to Hertfordshire’s CEE migrant population however the increased risk of STIs and unplanned pregnancies amongst CEE migrants should be taken into account when commissioning services for Hertfordshire’s migrant population.

7.4.5. Major causes of morbidity and mortality amongst CEEs (WHO statistics)
Statistics from the WHO indicate that the leading causes of morbidity and mortality in CEE countries are non-communicable diseases (NCDs) and lifestyle-related risk factors similar to those experienced in the UK.

Diseases of the circulatory system (including ischaemic heart disease and cerebrovascular disease) accounted for the highest proportion of deaths in all major CEE countries. This was followed by malignancies and external causes of injury such as road traffic accidents and violence. Lung cancer and colorectal cancer were the most common types of malignancy diagnosed amongst males in many CEE countries, whilst breast cancer followed by colorectal cancer were most common in females. Cancers of the respiratory tract are also increasing among women in some CEE countries such as Hungary. Latvia was noted to have a high proportion of neglected cervical cancers with 46.6% of cases diagnosed during the late stage of disease.

Lifestyle-related risk factors including increasing rates of smoking (especially amongst young people and women), alcohol consumption and obesity due to poor diet and/or lack of exercise are also extremely prevalent throughout all major CEE countries.

Poland has one of the highest rates of tobacco consumption in Europe with 29% of people over the age of 15 years being regular smokers. Excessive alcohol intake is also a leading cause of liver cirrhosis in many CEE countries and consumption rates are likely to be higher than reported. Obesity and physical inactivity are also of particular concern in Hungary (66% of males and 50% of women considered overweight or obese) and Poland (52% of males and 29% of females considered overweight or obese).

Discussions with community development workers reveal that many of these risk factors are evident in Hertfordshire’s CEE migrant population, but that a lack of interest and time because of long or unsociable working hours means migrants are often unable to change these established patterns of behaviour. In view of this, further efforts to challenge lifestyle-related risk factors amongst CEE migrants are necessary to reduce the burden of NCDs in years to come.
The majority of CEE countries have low rates of communicable diseases. It should be noted however, that the risk of infections such as tuberculosis is generally higher amongst migrants from CEE countries. Four CEE countries (Bulgaria, Latvia, Lithuania and Romania) are considered by the WHO and Health Protection Agency (HPA) to have high rates of tuberculosis incidence (≥40/100,000 population). Three other recent CEE member states including Estonia, Poland and Hungary, although not considered to have a high incidence of tuberculosis, have rates higher than that of the UK (>12/100,000 population). High rates of co-infection with HIV and tuberculosis or MDR-tuberculosis are also reported in isolated pockets of Central and Eastern Europe such as Latvia.

Migrants originating from these particular countries are thus more likely to have undiagnosed latent tuberculosis which health professionals in the UK need to be aware of – particularly when dealing with high-risk groups. The launch of the HPA’s new online resource “The Migrant Health Guide” in January 2011 is very encouraging and will be an excellent tool to support GPs and nurses in managing the health of migrant patients.

8. Conclusion & limitations
Central and Eastern European migrants are a challenging group with a diverse range of health needs and there is at present, very limited quantitative data regarding their health status and service requirements, particularly within Hertfordshire. The lack of any established community groups or forums through which to directly access stakeholders also prevented the collection of primary data and poses problems when considering how best to disseminate information to CEE migrants.

Discussions with community development workers who have a strong understanding of their populations however, highlighted a number of health-related problems faced by CEE migrants including:
- Significant language and cultural barriers due to inadequate provision of language support
- Poor understanding of the healthcare system in the UK and their rights to healthcare or sick pay
- An increased risk of mental health problems and lack of awareness of mental well-being and the support services available to them
- Difficulty engaging CEE migrant communities or establishing sustainable community associations due to lack of interest, time and leaders from within the community itself

Literature reviews regarding the health of CEE migrants elsewhere in the UK also revealed an increased risk of sexually transmitted infections and reproductive morbidity as a particular health concern amongst CEE migrants. Further assessment of the sexual health of CEE migrants in Hertfordshire is warranted to better quantify the need for screening programmes and genitourinary medicine (GUM) services for the migrant population.

High rates of lifestyle-related risk factors including smoking, alcohol, obesity, poor diet and lack of exercise are recognised amongst people of CEE origin and put them at greater risk of developing problems such as hypertension, ischaemic heart disease, cerebrovascular disease and respiratory tract malignancies in the future. Targeted efforts to educate CEE migrants, support healthier lifestyle choices and screen for associated disease will need to be implemented to reduce this risk.

Review of the 2011 National Census results will be particularly important to ensure accurate and up-to-date information regarding the size and distribution of Hertfordshire’s CEE population so that effective resource allocation and planning of services can be achieved.
9. **Acknowledgements**

Thank you to all contributors who have made this report possible including Michal Siewniak (Strategic Development Officer, Hertfordshire), Monika Wodecka (Community Development Worker, East Hertfordshire), Azra Dautovic (Community Development Worker, Bosnia Herzegovina Community Association Hertfordshire)

Special thanks go to Peter Wright (Public Health Partnership Manager) at NHS Hertfordshire for his guidance throughout this report and Stephen Paul (Information Intelligence Analyst) of Hertfordshire County Council for all his help with the data analysis.

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- **East of England Strategic Migration Partnership** ([www.eera.gov.uk](http://www.eera.gov.uk))

- **Hertfordshire Observatory** ([www.hertfordshireobservatory.org/](http://www.hertfordshireobservatory.org/))

- **World Health Organisation** ([www.who.int/en/](http://www.who.int/en/))