Emerging Communities in Kirklees – Maternal and Family Health.

Background

Kirklees is a diverse community. Changes in the area's demographic profile are long standing. The district's economic and social history, from the Industrial revolution onwards, has drawn people to Kirklees. The textile, chemical and engineering industries drew people from Ireland, the Caribbean, India, and Pakistan in the twentieth century. More recently, the growth of the university has attracted international students and staff. Conflicts in the Balkans, Middle East and North Africa and EU expansion have drawn new entrants to the borough. Extended family members have moved to join relatives.

Recent years have seen significant rises in refugee and asylum seeker entrants, and increasing numbers of European economic migrants. A discussion at the Starting Well Communication and Community Engagement Group concerning new entrants' access to maternal health services and health behaviours suggested that this was an area worth further investigation: to see whether anecdotal information - about late booking, poor access to services, high smoking rates, significant use of alcohol, health inequalities related to poverty and its impact – were borne out in reality. There was also concern that these health circumstances might have potential to impact on low birth weight and infant mortality rates in Kirklees, which has seen a gradual declining trend in the past 5 years.

The Public Health Starting Well Communication and Community Engagement Group is a cross-sector, multi-agency group of people who are engaged in providing healthcare for women of child bearing age and their infants or have access to communities and neighbourhoods where our target groups are settled. It includes professionals from; midwifery, community engagement, primary care, housing, public health, children's services, communication services and physical activity, and share an interest in supporting improved health behaviours and access to services.

This paper sets out the information that has been gathered so far in the first phase of the work. It suggests some initial insights, and identifies areas that need further exploration. The first phase has focused on desktop research into data about new entrants to Kirklees, and meetings with professionals working in the community. Early in the process a decision was taken to initially focus on Eastern European economic migrants. Refugee and asylum seeker entrants are automatically linked into the health, housing and education system through Home office arrangements, and are consequently more likely to be supported to access appropriate services. Although there are some apparent issues concerning access to services further on in their stay, those needs may be the subject of a later piece of work.

At this stage the focus is on EU migrants who do not have automatic support. EU migrants' language skills, lack of information, limited communication with appropriate services and traditions and cultures from home countries can all have a separate and combined effect on their capacity to access services.

Participants:
People who have participated in the work so far have generously provided significant insight and experience. They are:

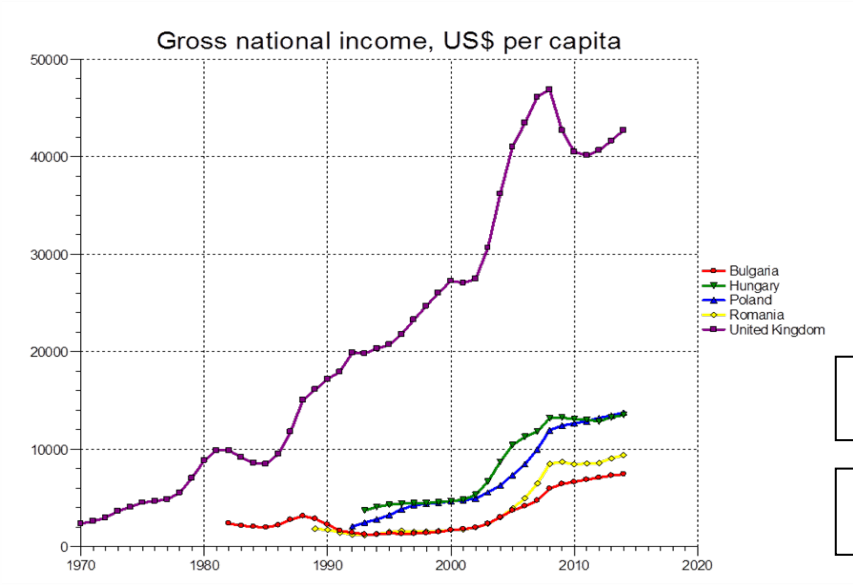
- Andy Shackleton – Research Officer, Kirklees Council - migration data and demographics
- Sarah Thurgood and Owen Richardson (Public Health Intelligence) – Health data
- Sarah Mitchell & Sarli Sardou Nana – Refugee & Asylum Seeker Support
- Una Crozier, Louise McConnell & Sadie Shaw – Health visitors
- Rebecca Breen & Carmen Taylor – Community Engagement Workers
- Emma Mills and Robeena Mir – Birkby Junior School Deputy Head & Family Worker
- Members of the Starting Well Communication and Community Engagement Group, representing a range of services and organisations including Kirklees council's Public Health, communities, Transformation & Change; Communications; Commissioning & Health Partnerships Services; Auntie Pam's; Mid Yorkshire Hospitals NHS Trust; Calderdale & Huddersfield Foundation Trust; Locala. (Gill Logan, Cheryl Beirne, Sara Javid, Cathy Munro, Dee Haigh, Mary White, Emma Boyes, Janine Grayson, Nargis Javaid, Lisa Akester, Ann- Marie Wilkins, Chris Chinnock, Sarah Thurgood, Kate Large, Penny Allison, Emma Dickens, Ann- Marie Wilkins, Noreen Abbas, Jayne Walker, Hannah Walker; Darren Wilson, Andrew Dolman)

We are concerned to address the needs of those most likely to experience the greatest health inequalities. It is recognised that the focus on engaging people who are working with those in greatest need gives the information that we hear a bias – both from staff perception and from the particular circumstances of the most disadvantaged and disengaged EU migrants. We are concerned to address the needs of those most likely to experience the greatest health inequalities.

Data / context
New entrants to Kirklees include: refugees and asylum seekers; economic migrants; international students; family members joining those with leave to remain. Data from Migration Yorkshire shows that, in 2014, there were 2700 new long term entrants (i.e. 12 months +) and 880 new short term entrants. Migration Yorkshire data on National Insurance Number Registrations between 2002 – 2014 shows NI numbers issued in Kirklees to new entrants. NI numbers are issued to adults who are working or seeking work and receiving benefit. For Eastern European entrants to Kirklees, the picture is:

Country	**2002 – 2015**	**2014**	**2015**
Poland	4793	416	423
Hungary	1439	229	127
Lithuania	552		
Slovakia	385		
Romania	370	336	287
All Eastern European entrants	**8455**		
Total – all countries	**24,458**		

Although this data is more current and "live" than census data, nationally it is recognised that NINR do not reflect the actual economic migrant figures, as many workers arrive without official registration, so numbers are likely to be much higher than officially recorded.
There are clearly economic drivers to come to the UK, where incomes are (despite austerity) 6 – 7 times what they are in home nations.

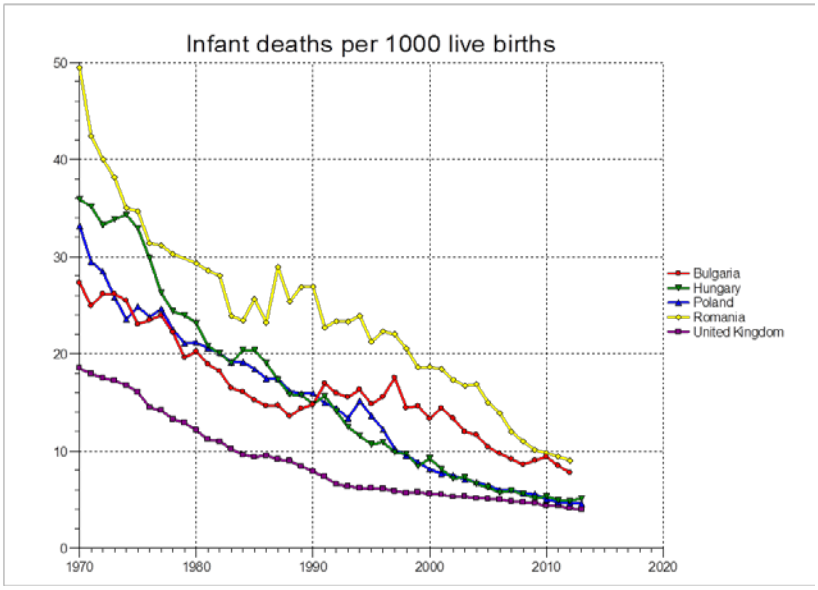


$48000 = £ 36500 approx
$7000 = £5300 approx

WHO data comparing UK, Poland, Hungary, Romania, Bulgaria.

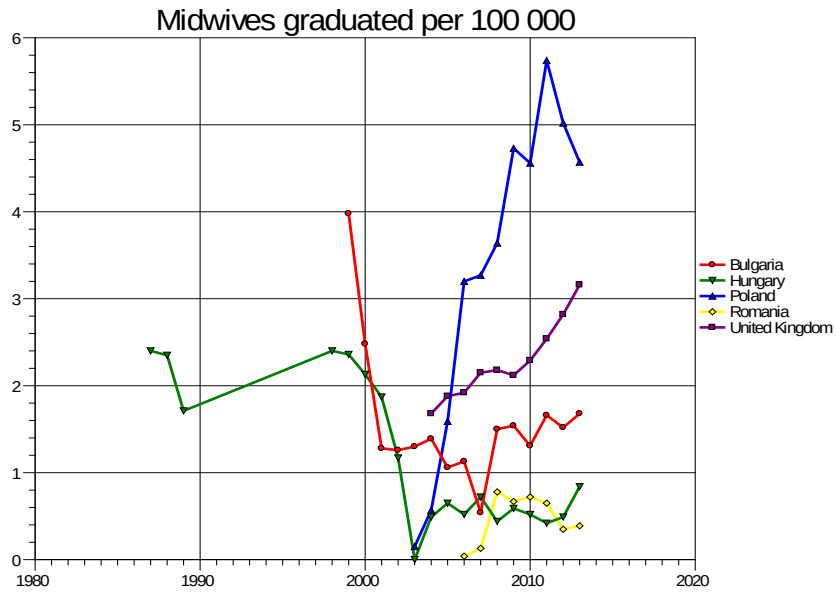
There may also be advantages from the UK benefit system over countries of origin systems, which currently enables European Union members to transfer benefits to home countries – this may well change on exit from the Union.

Early research on health systems from "home" countries (such as Poland, Hungary, Bulgaria, Romania) suggest that provision differs from country to country. For some, government and global drivers have in some respects supported better outcomes for pregnant women and babies. However economic, political/ governmental and social forces play a crucial part in many countries as to the range of services available – for example;

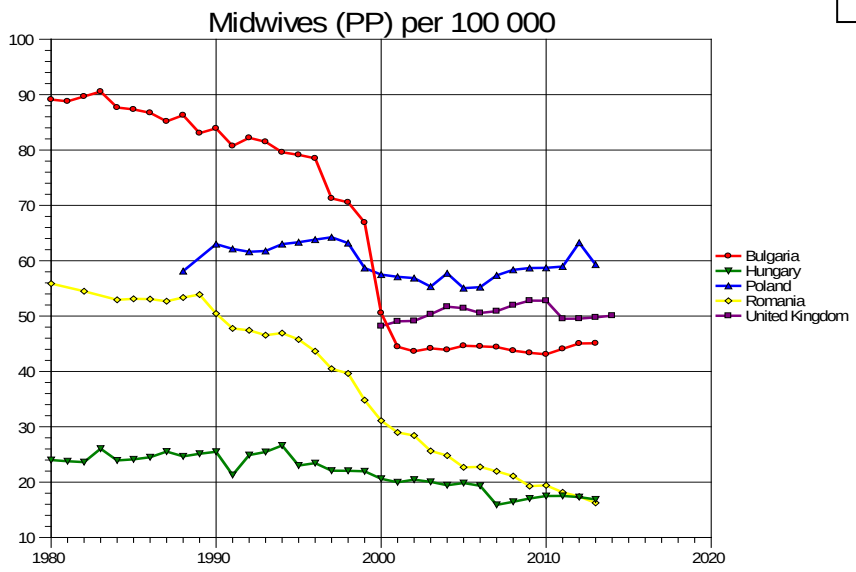


Infant death is measured as the number of infants who die before their first birthday, per 1000 live births.
Note the radical drop in IM rates in the last 45 years. For most countries this is due to improved clinical interventions during pregnancy and birth. However as with our own recent high rates in the last decade, health behaviours and lifestyle choices are of more significant impact on rates.

WHO data comparing UK, Poland, Hungary, Romania, Bulgaria.



WHO data comparing UK, Poland, Hungary, Romania, Bulgaria.



We are told by health professionals here through conversation with residents that in some of these countries, midwives and maternity professionals are held in low esteem by the population, perhaps the tradition of a clinical based maternal provision is not as robust as in the UK.
There also seems to be a variation between countries about what is deemed to be a public health service, but where payments to particular professionals through care pathways are expected for some services – this renders the notion of a free service to those in poverty or low paid employment inaccessible for many.

The following evidence review from ***A Targeted Health Needs Assessment of the Eastern European Population in Warrington Final Report*** *October 2014 (**Hannah Madden, Jane Harris, Beccy Harrison, Dr Hannah Timpson)*** offers an overview that resonates with similar Kirklees populations;

The national evidence on the health of Eastern European communities living in the UK is mainly focused on epidemiology, rates of illnesses and language issues. Little research has focussed on the experiences of these communities in relation to public health and what would encourage more healthy behaviour.
The national evidence base shows that, when compared to the UK-national population, Eastern European populations have: poorer mental health; higher mortality dues to heart attacks and stroke; higher levels of obesity; increased risk of sexual ill-health; higher smoking rates and higher lung cancer prevalence. Evidence is mixed on rates of alcohol and drug use in this population. These health inequalities are compounded by poor or insecure housing, low pay, isolation, unemployment or underutilisation of skills and prejudice.
Barriers to accessing health services included language problems, not understanding the UK health systems and lack of money, as well as cultural differences such as differing prescribing practices and frustration with the GP referral model (as opposed to directly accessing specialist care). There are very few published evaluated interventions aimed at Eastern European populations.

Kirklees Top 10 births by country of Mother
Jan 2012 to Jun 2015, from ONS births file

	Birth date							
Country of mother	Jan-Dec 2012		Jan-Dec 2013		Jan-Dec 2014		Jan-Jun 2015	
England	4387	76.2%	4320	76.0%	4152	75.2%	1943	74.0%
Pakistan	636	11.0%	614	10.8%	563	10.2%	273	10.4%
Poland	106	1.8%	125	2.2%	130	2.4%	72	2.7%
India	116	2.0%	119	2.1%	106	1.9%	45	1.7%
Iraq	41	0.7%	46	0.8%	56	1.0%	26	1.0%
Hungary	32	0.6%	33	0.6%	47	0.9%	24	0.9%
Scotland	39	0.7%	32	0.6%	44	0.8%	17	0.6%
Libya	27	0.5%	28	0.5%	24	0.4%	17	0.6%
Germany	23	0.4%	22	0.4%	23	0.4%	12	0.5%
Wales	23	0.4%	18	0.3%	26	0.5%	11	0.4%
Other	329	5.7%	328	5.8%	353	6.4%	184	7.0%
Grand Total	5759	100.0%	5685	100.0%	5524	100.0%	2624	100.0%

Place and Language
Eastern European migrants are spread throughout the borough. Some settle near to, or accommodated by, their new workplace. Many new migrants chose to live near friends and family who have already come to the area, creating small concentrations of people from the same countries of origin. For example, there is a concentration of Hungarian families in Birkby Fartown and Ravensthorpe.

Polish families are more widely distributed. Huddersfield has an established Polish community, who entered the UK before and during the Second World War and settled and integrated here. Faith – especially connections created to local people and institutions through the Catholic churches and attending Catholic schools – was a positive influence on integrating with the wider community. Since Polish accession to the EU, there has been a new wave of Polish migrants, perhaps more likely to focus on work than on wider community integration. Church attendance has decreased significantly for both the British and (to a lesser extent) the Polish. There is some anecdotal evidence from community workers' observations of some tensions between the 'old' and 'new' Polish communities. In recent years an improvement in the Polish economy suggests there might be less urgency to migrate to the UK in search of work, or that they are transient between the two countries.

For Roma families (whose country of origin include Hungary, Bulgaria and Romania), their Roma identity is possibly of greater cultural influence than their nationality, and their social connections reflect this. Many Roma families record experiences of economic and social exclusion as well as prejudice in their home country and in the UK because of their background and heritage.

The greater representation of Polish and Hungarian families is reflected in requests to the local authority Community languages service for translators in a 12 month period 2015 - 2016. For Eastern Europe, the greatest number of requests was for Polish (538); Hungarian (414); Romanian (67); Albanian (22) Lithuanian (17) and Russian (16). Further work will be undertaken to see what requests are made from other translation providers, including the NHS.

Where language barriers exist, people and services use different methods to try to overcome them. We found examples of schools and GPs using internet based translation services. These enable people to access services, but there may be concerns about the quality of the translation. They are also less useful for people with limited literacy skills.

Access to translation effects people's capacity to engage with services. For example, Locala no longer have funding for all of the translation services that they have had previously (e.g. funding for a Hungarian translator supporting a Mums' group in Ravensthorpe ceased in December 2016, with the consequence that attendance has fallen and it is difficult to engage new mums). Health Visitors have also voiced concerns that the new phone-based translation service means that they are not always certain that they are talking to the right person.

Friends and family members are sometimes used to breach the gap in professional translation services' availability. While this can be useful and enable many people to better access services, it can also be problematic in terms of confidentiality, accuracy and hearing the genuine voice of the service user, rather than the translator's views and interpretation.

There is some anecdotal evidence of lower take up of English language classes by Eastern European women compared to men. This needs to be verified. It may be that men have more need of English as they are more likely to be in the workplace.

Housing & Poverty
Many East European economic migrant families live in overcrowded houses, whether they are official HMOs or otherwise. The private rented sector provides most of the housing, so the condition of houses varies enormously. Professionals' commonly described observing lots of beds in living areas and overcrowded bedrooms. In some cases, there is a mix of genders, ages, and unrelated occupants in the same accommodation. It can be difficult to tell the size and shape of some families and households, or relationships between different household members. Household members may avoid being open about who is there as they don't know how the information may be used or shared. This has resulted in some low level safeguarding concerns about who may have access to children (or vulnerable adults) in the household. There are also some real positives about extended families providing practical and emotional support for each other.

Health Visitors report that the most frequent requests for help to access services are for housing services and benefits advice. There is some limited evidence that access to health care (as well as education) can be a pull towards the UK for some Roma families. A health visitor reported the frequency of requests for help to access Personal Independence Payments from Roma families. The top 5 topics that a Ravensthorpe Health visitor reports migrant clients as wanting help with: money, benefits, child benefit, terminating pregnancy and housing.

Some individuals, families and households move around frequently, with implications for continuity of care.

Many families come to the UK for work. In practice, many may end up in low waged, zero-hours contracts, meaning that incomes are not predictable and it can be difficult to plan ahead when work may call. This has an effect on the ability to make and keep appointments and to be available when services call.

Birkby Juniors have experienced some children coming to school hungry and needing breakfast. School has also helped to supply clothing.

Health status and access to health care.
There is some evidence that the status of health workers, including midwives, is very low in some Eastern European countries (such as Hungary), which has an influence on how services may be regarded in the UK. We need to do more research about the availability and status of health care in migrants' home countries, and the impact that that may have on their views and use of UK NHS services. Any (lack of) access to the types and ways that services are accessed 'at home', and the costs associated with them may shape how people go about caring for themselves, each other, and interacting with health professionals and the NHS.

There is some anecdotal evidence of higher rates than usual of using A&E to access health care. Further enquiry and access to data is needed to verify this.

Health visitors reported some difficulty in getting people to attend appointments in surgeries or clinics. They also report that some families have medicine sent over to the UK for them, perhaps indicating a habit of self-medicating, with its potential consequences. It may be that this enables access to drugs that would not usually be available (at least over the counter) in the UK. It poses the

question about whether there is a consequent informal trade in medicines and drugs. Some home remedies (giving the baby a shot of whisky to calm it down) are cause for concern – but we have no way to assess how widespread, or not, such practices are from talking to local professionals. We need to engage with families to build a clearer picture.

Midwives report higher levels of maternal smoking and late booking into maternal health services.

Given the issues with poor access to health care and transient families, there may be a case to be made to connect women with future services before they are discharged after birth.

Midwives, health visitors and family support workers all report very high rates of smoking among men and women. Smoking is normal, including around children in enclosed indoor spaces. In addition to the usual range of poor health consequences, this can result in stigma for the children who come to school smelling of stale tobacco.

In some families and households, men are gatekeepers – answering the door and phone and questioning workers about who they want to see, why they want to see them and what they want to do or say. This has implications for women's privacy and autonomous access to health care.

Dental health seems to be poor in some families. Birkby Juniors reported instances of 9 year old Hungarian and Bosnian children with black and rotten teeth, who had never seen a dentist. Again, we need to find out more about dental care and attitudes towards it to help discover what might improve access to services.

Other snippets

Many families use Lebara Sim cards, which give cheap calls to their home country and free communication to other Lebara users within the UK.

The cost of translation is a barrier to understanding needs and delivering services.

In conversation with a sex workers support service, a number of factors were highlighted about women in this business locally. In reality, numbers from Eastern European countries are still fairly small, with about 1/3 of local sex workers with European nationality. As many women had already been trading as sex workers in their home country, they are more likely to view this as a business. This means in general they take better care of their health, access health services frequently and often need support for GP registration, school and nursery access. There seem to be other women within communities who are linked to sex workers but are not in the trade themselves. These may be family or friends who support with childcare, or are supported by their sex working friends to live here. These women may also experience poor housing, poor health and have no employment. Many women will not have worked in employment long enough to have access to benefits.

For families with school age children, school may be a good way to access families and services, as the family often has an established relationship with the school and is more likely to trust and accept services offered via this route. Birkby's experience is that families prefer one to one support, and do not tend to access drop in offers.

Children often don't start school until the age of 5 or 6 in many Eastern European countries – so there can be some resistance to regular, punctual school attendance for young children in the UK.

There is some evidence (again, anecdotal) of compliance culture – i.e. people saying what they think you would like them to say, rather than telling it how it is. This has implications for how we set the context of interactions with people – ''it's OK to say whatever you want to say''

Next Steps

This piece of work has implications and connections across a range of services and organisations. Although the target numbers for these communities may be relatively small in comparison to the total Kirklees population, by the significant issues of poor access and health behaviours, there should be cause for concern. In particular, women and children are highlighted as having poverty of choices for improved health and well-being, and local providers should aim to improve choices and outcomes through collaborative provision and support.

Things to consider;

- Share information with Public health colleagues, wider council colleagues and health colleagues to invite their input into how this work could progress.
- Further research into the types, availability, cost and status of health services in EU countries to assess how this may shape perceptions, experiences and access to healthcare.
- Research women's access to English Language classes.
- Research PIP payments to see if there is evidence of increased uptake (and therefore potential connections to emerging communities)
- Further research into use of A & E services as first point of contact
- Secure appropriate translation services to enable conversations with women and families from the target communities

It should also be considered who might be best placed to take this work further, as it does not neatly fit into the remit of just one service.

Dee Haigh Health Improvement Practitioner Specialist
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