

Public Health Team, Oxfordshire County
Council

East Timorese Population Health Needs Assessment for Oxfordshire

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August 2018

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With gratitude

This Health Needs Assessment would not have been possible without the accounts from all the professional stakeholders, community stakeholders, and members of the East Timor Working Group who offered their time, experience and wisdom to the project.

Executive Summary

There is an estimated population of 2500 residents from the Democratic Republic of Timor-Leste in Oxfordshire. This population of working-age labour migrants often live in more deprived areas of Oxford City and face multiple health and social needs. As most of this population originate from East Timor, but have Portuguese passports, demographic and health information on this group is hidden by their inclusion in the wider category of European Union citizens. This Health Needs Assessment (HNA) takes a primarily corporate approach to assessing the needs of this community.

Many of this community live in houses of multiple occupancy, that can be of variable quality. The community are typically economically productive, but may end up, due to language and other barriers, in low paid and sometimes low security employment in catering, domestic or factory work.

The health needs of the community include difficulties in access and use of healthcare due to language difficulties, high rates of TB and anecdotal reports of sexual health risk taking behaviour. Non-communicable disease risk factors, including smoking and alcohol use, may lead to future morbidity and mortality. Professional stakeholders reported a small, but very serious number of violent crime, social care and domestic abuse incidences.

The East Timor Working Group supports the identification of, and improved multi-agency response to, the culturally specific needs of Oxfordshire's East Timorese community. Despite this example of excellent practice, the East Timorese community face challenges to improving their health and wellbeing, including individual, community, health system and societal challenges.

Recommendations to address the community's needs include to use a coordinated prioritisation approach; explore the possibility of additional data collection; promote professional's education in cultural competence; promote opportunistic encouragement of GP and dentist registration; request Tetum interpreters when recommissioning translation services; start a programme of latent TB testing; encourage take up of English for speakers of other languages (ESOL) courses, ensure that safeguarding of vulnerable members of the community continues to be a priority; and prepare for the impact of Brexit upon the East Timorese community.

Oxfordshire East Timorese population at a glance*

East Timor

- Lower middle-income country in Maritime Southeast Asia
- Population of 1,185,000
- Ex Portuguese colony
- Official languages: Portuguese and Tetum, also regional languages including Fataluku
- Religion: Predominantly Catholic, some traditional animist beliefs

UK Population

- Principally labour migrants with Portuguese passports
- Population estimates between 7,000 – 20,000
- 90% male
- 60% single (unmarried)
- 75% < 30 years old on departure to UK

Oxfordshire Population

- Estimated population 2500
- Located in Oxford City (Blackbird Leys, Cowley, Headington, Littlemore)
- Small populations in Abingdon, Bicester, Witney
- Employment in restaurants/hotels, colleges, factories, often via agencies
- Often living in rented HMO accommodation

** These are based on best estimates from available data. Please see full report for data and methodology of estimates*

Introduction

There are an estimated population of 2500 residents originating from the Democratic Republic of Timor-Leste in Oxfordshire. Timor-Leste, also known as East Timor, is a former Portuguese colony in South Eastern Asia, which underwent a turbulent and violent period after the withdrawal of the Portuguese administration and the invasion by Indonesia in 1975. During Indonesia's twenty-four-year rule, it was estimated that the occupation was directly responsible for the deaths of more than 100,000 East Timorese, with many more persons displaced (CAVR 2005). Although the United Nations (UN) recognised East Timor as an independent country in 2002, violence continued to be widespread within the country, with the UN's peacekeeping mission ending at the end of 2012 (UN 2017).

The East Timorese population is a hidden population within Oxfordshire. Citizens born prior to Timor-Leste's independence in 2002 are entitled to apply for Portuguese citizenship, thus enabling movement to the UK through the European Union freedom of movement article. This means many of those from Timor-Leste are, if considered in local data, categorized as EU or Portuguese citizens, and in surveys of ethnicity are often included in a wider category of South Asian ethnicity (McWilliam 2015). The consequence of is that the health needs of this minority population can be obscured by the larger and varying categories assigned to them. This is problematic, as there is evidence that individuals in this specific population may have greater and differing needs than the wider population.

Aims and objectives

This health needs assessment (HNA) aims to explore the health needs of the East Timorese population in Oxfordshire.

The understanding of what constitutes a *health need* can vary, but this HNA uses Bradshaw's framework of the four ways that a need can be perceived. *Normative needs* are those that professionals' judge as required, such as an indication for a medical treatment, which can be ascertained through methods such as stakeholder analysis. *Felt needs* are those which are perceived by an individual, constituting their perceptions of their health. *Expressed needs* are those which the population demonstrate or express, typically through use of services or feedback on current services. Comparative needs are a judgement of the needs of a specific population relative to other populations, and can indicate inequalities in health needs (Bradshaw, 1972). The objectives of this HNA utilise Bradshaw's framework.

Objectives

1. Describe the East Timorese population in the United Kingdom (UK) and Oxfordshire and identify specific health needs for this population relative to the wider population (*comparative needs*)
2. Determine professional perspectives on the health and social needs of this population (*normative needs*)
3. Explore the *felt and expressed needs* of individuals in the East Timorese population
4. Form recommendations for how specific health needs for this population can be approached

The East Timorese population is an ethnic minority group located primarily in areas in East Oxford with high levels of deprivation. A focus on this population contributes towards one of the specific challenges outlined in Oxfordshire's Joint Health & Wellbeing Strategy 2015 – 2019 (Oxfordshire County Council, 2016), namely the persistence of small geographical areas of social disadvantage, which are often culturally diverse and contain ethnic minority groups with specific needs. It is also in accordance with Oxfordshire County Council's Equality Policy objective of placing importance on understanding the needs of individuals and communities (2012). Because of the importance of the community focus in these documents, this HNA takes a broad approach to health needs, including social determinants which may affect health and wellbeing, such as safe housing and secure employment.

Methods

A health needs assessment is “*a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities*” (Cavanagh 2005).

HNAs can be undertaken from different approaches, namely epidemiological, comparative and corporate (PHAST 2017). This report takes a primarily corporate approach, thus eliciting the views of stakeholders, both professional and community figures, to inform perspectives on normative and expressed needs of the population. As this is a population in which there is evidence that cultural, religious, and traditional beliefs may impact upon health beliefs and use of health services, the expressed needs of this population include relevant sociocultural perspectives.

Where feasible, epidemiological and comparative approaches have been used to corroborate or counter corporate perspectives. These approaches use epidemiological data to outline expressed needs for service provision, and illustrate comparative needs between the East Timor population and wider Oxfordshire population.

This HNA included the following steps:

1. A literature review of academic, government, and grey literature and data relating to the East Timorese population in the UK.
2. A qualitative stakeholder analysis, including professional and community figure perspectives. This was not limited to health and social care professionals, but included professionals with experience in areas related to wider determinants of health.
3. Gathering of existing epidemiological data for health needs identified from stakeholder interviews.
4. Design, distribution, and analysis of an online questionnaire to the East Timorese community (Appendix 1). This questionnaire was translated into Tetum and distributed to individuals via the East Timor Community Oxford Facebook page.
5. Recommendations for approaching and addressing specific health needs identified.
6. Distributed to stakeholders for comments, before production of final report.

Although these steps represent distinct phases of the project, this report is structured by theme (for example housing, tuberculosis), rather than by step. This allows the total sum of evidence and range of perspectives for each topic to be considered in turn.

Stakeholders

The organisations, departments and/or roles of the stakeholders who participated in this HNA are listed below. Stakeholders were identified by a local knowledge of Oxfordshire services, snowballing process from early stakeholders, and referrals from public health team members. Where organisations are listed, inclusion can be taken to mean that either a minimum of one individual within that department, organisation or with a described background has recounted their personal experiences, of working with, or being part of the community or that the organisation has provided quantitative data for the analysis. In such cases, the origin of the data is acknowledged.

1. East Timorese community figures (community leader, community worker, interpreter)
2. East Timor Working Group
3. Oxfordshire County Council (Children, Education and Families' Directorate)
4. Oxford City Council (Private Housing, Houses in Multiple Occupation, Community Services Teams)
5. Oxfordshire Clinical Commissioning Group
6. Oxford University Hospitals NHS Foundation Trust (Tuberculosis, Community Paediatrics)
7. Oxford Health NHS Foundation Trust (Health Visiting Team)
8. Thames Valley Police
9. Oxfordshire Domestic Abuse Services
10. Public Health England South East (Thames Valley Health Protection Team)
11. Solutions 4 health Oxfordshire
12. Open Door Oxford charity
13. Sacred Heart Church
14. Former specialist nurse educator in Dili, East Timor

Questionnaire

The brief, anonymous questionnaire (Appendix 1) was designed to gain further insight into the demographics of the population and access to health services. It was designed after the literature review and stakeholder analysis to allow prioritisation of areas in which there was insufficient data or knowledge. As the East Timorese community have been difficult to engage with, an important consideration for the questionnaire was to make it simple and quick to fill out. Therefore, the questionnaire was limited to fourteen closed questions because these could fit on one side of A4 paper (for the paper version) or was predicted to take less than five minutes to fill out (online version). The questionnaire covered four areas. These were population demographics (questions 1 to 5, 9), primary care and dentist registration (questions 6 to 7), self-reported health status and risk factors (questions 8, 13, 14), languages (questions 10,11) and health and social care difficulties experienced in the UK (question 12).

After consultation with community figures regarding languages and content, the questionnaire was published in English and Tetum, with a statement asking individuals to contact the author if they wanted the questionnaire in another language. This statement was translated into Fataluku, Bahasa Indonesian, and Portuguese to be accessible to the majority of the population. However, no requests for translation into another language were received. The questionnaire was primarily distributed online via key community figures posting the link and explanation on professional and community Facebook pages (Tetum Solution and East Timor Community Oxford). This was because Facebook was seen by community members to be the key method

of community wide communication. Paper copies were offered to stakeholders to distribute to increase reach of the questionnaire, but this offer did not lead to further return of questionnaires.

The questionnaire was published online on the Oxfordshire County Council consultations website on 4th December 2017. As it was aimed at a specific demographic group, it was not listed or searchable by the general public but accessed by a weblink. This weblink was shared with members of the East Timor Working Group, and the three community based leaders. In particular, the link was posted on two Facebook pages that were identified as being key online communities for the East Timor Population. On the 'Tetum Solution' Facebook page, the link and brief explanation was posted on the 6th December, where it received 43 'likes' and 12 'shares'. A reposting of the link on 11th December only received 1 'like'. It was posted on the East Timor Community Oxford Facebook page on 7th December where it received 8 'likes' and 1 'share'.

There were 16 online responses to the questionnaire, which was opened on 4th December 2017, of which 15 were complete and 1 only included basic demographic information. Although fewer individuals completed the questionnaire than 'liked' it, the date of responses to the questionnaire indicate that respondents saw the link and filled it out shortly after seeing this (Figure 1). The questionnaire closed on 31st December 2017 after more than a week with no further responses.

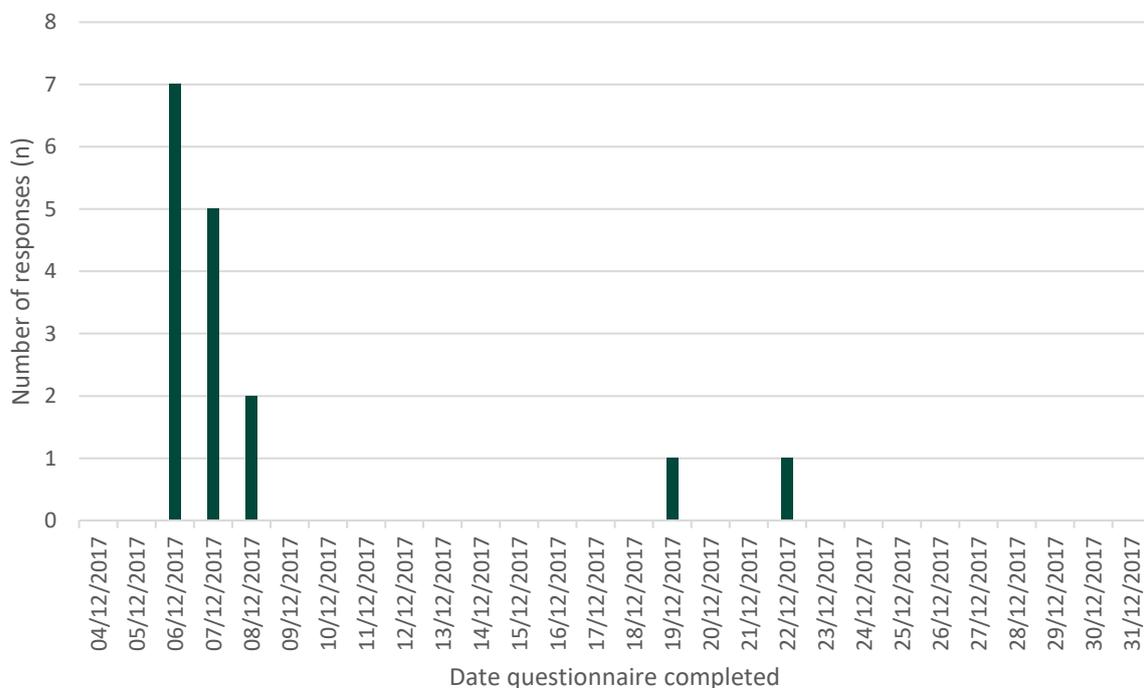


Figure 1: Responses to online questionnaire by date, December 2017

Limitations

There are key limitations to assessing the health needs of a migrant population, including lack of epidemiological data, language barriers to communication with individuals, and engagement difficulties due to mistrust between communities and public organisations. Despite this, migrant communities often face an inequitably high level of health needs and social deprivation (Suphanchaimat et al. 2015).

In the Oxfordshire East Timorese population, the problem of acquiring accurate demographic and health data was a principle limitation. There was very little published academic literature on this population, necessitating use of grey literature that has not been subject to peer review. The potential bias introduced by this literature, which included that by respected academics but that is in prepublication, was judged to be less important than the knowledge gained from it in a difficult to research community.

There was very little existing demographic or healthcare data about this population in the UK or Oxfordshire. This was because, with the noteworthy exception of Public Health England South East, records did not commonly include country of birth or recent residence. In some instances, this left a reliance on professional stakeholders to manually identify cases in their practice that involved the East Timorese population, a solution that is both time consuming and subject to error. However, identification of these cases allowed insight into the expressed needs in the East Timorese population.

A further difficulty was assessing the comparative needs of the East Timorese population, without a validated estimate of population size. For example, to compare whether there is more tuberculosis in the East Timorese population than the rest of the Oxfordshire population requires looking at the number of cases compared to the size of the population (*incidence or prevalence rates*). Without an accurate population size, these relative measures of health risk a biased conclusion to the comparative need of the population, for example overstating the need in the East Timorese population. To mitigate this risk, a thorough justification of the population size is included (under 'Oxfordshire Population') and the absolute numbers are given alongside the rate estimates.

As the questionnaire was only answered by 16 individuals from the community, it captured a small and biased sample. The sample is likely to be biased as those that answered online needed to be literate in either English or Tetum, have internet access, and be a member of one of the community Facebook groups. This may exclude the less educated and those without an established network. Equally, as the East Timorese community is known to be mobile within the UK and internationally, it may be that individuals filled it out that were no longer living in Oxford. Despite these very significant limitations, it has worth as one of the only questionnaires targeting this population. It has value in describing the characteristics of that sample, even if these are not generalizable to the wider East Timorese population. Finally, the risk of

drawing biased conclusions can be minimised through comparing questionnaire data to other data on this population, to identify outlying results.

Ethics and governance

The East Timor population in Oxford can be characterised as a vulnerable population as this population group have “*an identifiably increased likelihood of incurring additional or greater wrong*” (Hurst 2008). Characteristics identified that indicated this during project scoping include that this a minority ethnic population who speak English as a secondary language and appear to have high levels of deprivation. These characteristics are known to be associated with poorer health and social outcomes. Understanding the population as vulnerable guided the approach to this HNA. Before undertaking any community engagement, the project was discussed with the engagement team at Oxfordshire County Council to guide the approach and ensure that guidance regarding community engagement was followed.

Two key ethical issues were identified and mitigated before undertaking this HNA. Firstly, the need to maintain confidentiality of professional stakeholders and community members who participated in or whose data was utilised in the assessment. This was especially true due to the small size of the population. This risk is mitigated by not naming individual stakeholders, but only the type of organisation they worked for or belonged to (public sector worker, community member or third sector worker). There were two reasons to withhold identities of professional stakeholders. Firstly, for professionals working with a small number of high risk individuals, identifying the professional risked identifying their patients or service users. Secondly, it helped reduce the risk that honest accounts of experiences could impair existing relationships between professionals and the community. Confidentiality of community members was maintained by anonymization of accounts and avoiding publishing small number events unless the data was already in the public domain, for example for housing prosecutions.

The second risk was that reliance on qualitative accounts of experiences could lead to unjust and stigmatizing generalisations about the population. This is a risk pertinent to the qualitative stakeholder analysis, as by nature of their jobs professionals in health, social care, and other public sector will encounter individuals who have needs, rather than those who do not. This is addressed in two ways. Firstly, via corroboration of issues raised with different independent stakeholder perspectives. Where the issue raised has been done so by more than one professional stakeholder, care has been taken to ascertain that these views do not represent contamination of knowledge gained at shared events, for example at the East Timor Working Group, but accounts personally experienced by the individual or their team. Where possible, quantitative data and questionnaire responses have been used to confirm the qualitative account. However, despite this process it is important to emphasise that this HNA indicates that

some individuals in the population have these needs, not that these needs are a necessarily a characteristic of the population.

East Timor demographic and health profile

East Timor is a lower-middle income country¹ in Maritime Southeast Asia (Figure 2). The country has an unusually young age profile, with a median age of 17 years, and 46% of its 1,185,000-population aged under 15 years (WHO 2015). The official languages of East Timor are Portuguese and Tetum, and the dominant religion is Christianity, predominantly the Roman Catholic Church. However, animist or traditional rituals are observed by some groups, sometimes in addition to Catholic practices (McWilliam 2015).

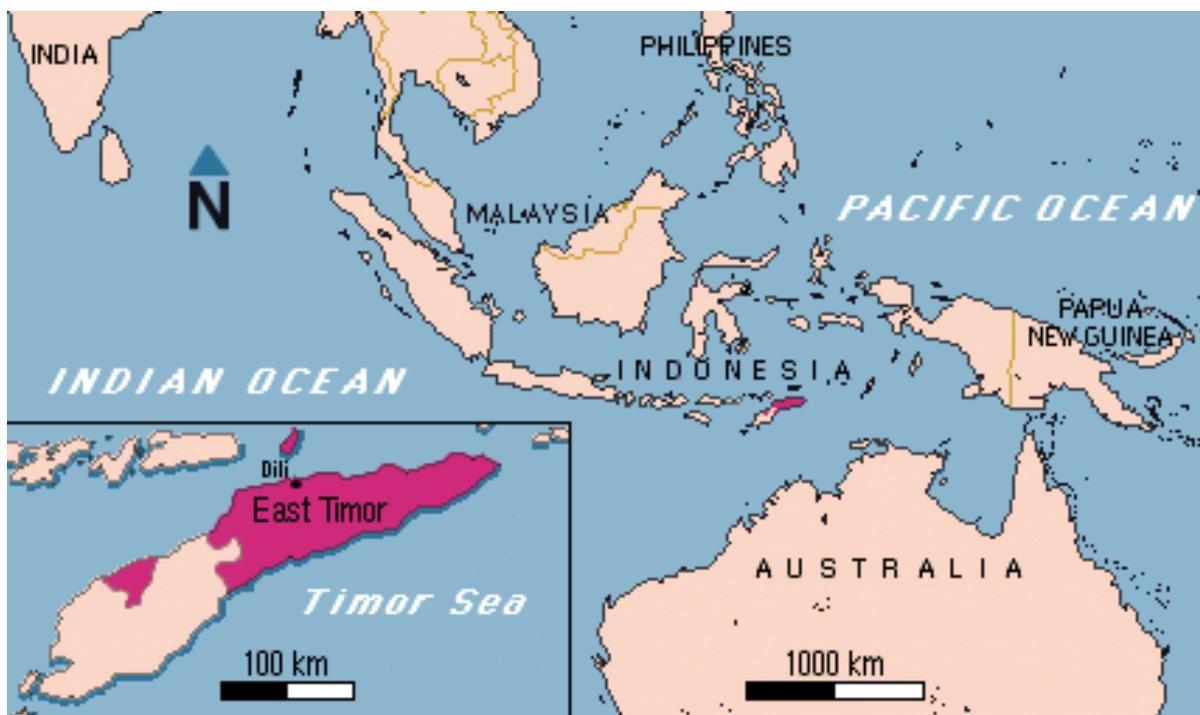


Figure 2: East Timor and surrounding countries (reproduced from ETAN.org, 2017)

The 2015 life expectancy from birth in East Timor was 67 years in men and 70 years in women. The most common causes of death in 2012 were tuberculosis, lower respiratory infections, ischaemic heart disease, and stroke, but high maternal and child mortality rates also remain a key concern (WHO 2015). Important causes of morbidity in East Timor include child malnutrition; other communicable diseases (including malaria); parasitic infections (including filarial lymphoedema and soil-transmitted helminth infections); and mental health conditions and domestic abuse concerns

1. World Bank 2017 classification.

(including post-traumatic stress disorder and explosive anger) post conflict (WHO 2015, Silove 2014a, Silove 2014b, Rees 2016, Martins 2012)

Although the health conditions and risk factors East Timorese individuals face in the UK will be different to those in East Timor, migrants who have spent their childhood and/or parts of their adulthood in East Timor may have a higher prevalence of certain risk factors than the UK population. This could be due to prior exposure to risk factors, such migrants who may have been exposed to tuberculosis in East Timor, or different norms of behaviour, such as higher rates of male smoking.

UK Population

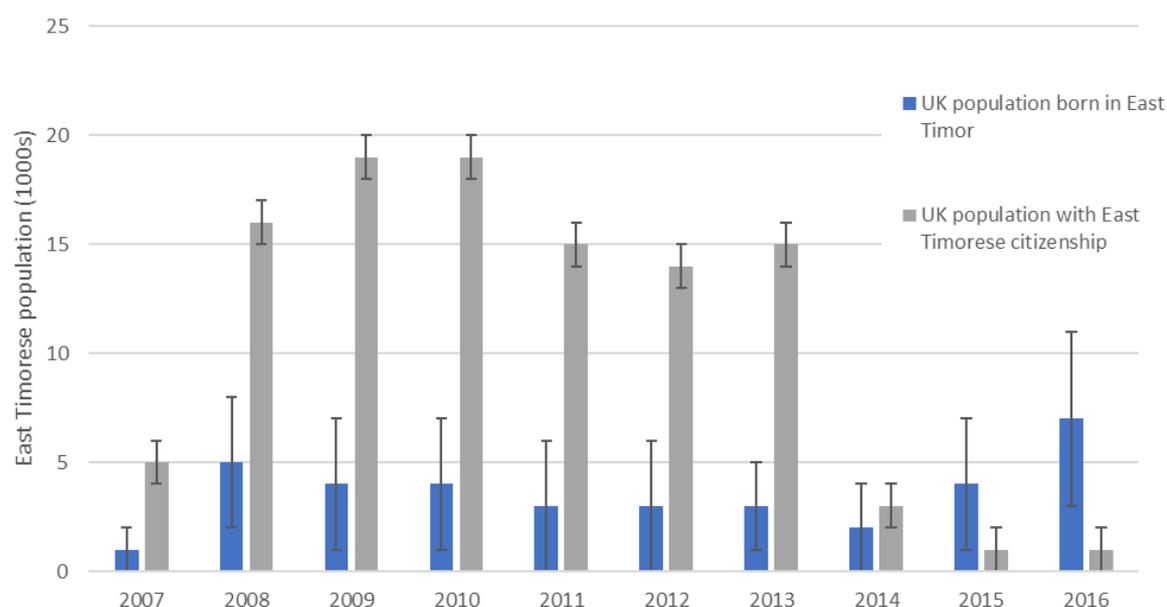
There are multiple estimates of the size of the East Timorese population in the UK (Table 1). These range from 1000 East Timorese citizens (Office of National Statistics, ONS) to over 20,000 persons from East Timor, but primarily with Portuguese citizenship (Embassy of Timor-Leste in London). Differences in these estimates can be attributed to methodological differences and estimates of being a citizen of, or born in, East Timor. For the purposes of this HNA, estimates of those born in, or previously living in, East Timor are of more use than those with East Timorese citizenship. This is because exposure to health risk factors in East Timor may be independent of current citizenship status, especially if most individuals apply for Portuguese passports from East Timor with the express purpose of travelling to the UK, rather than immigration after residence in (McWilliam 2017). Including only estimates of those born, or previously living, in East Timor, a median population estimate is 7000 persons (ONS, 2016).

Figure 3 displays the change in population estimates between 2007 and 2016, using ONS data. It shows an apparent increase in those born in East Timor between 2011 to 2016 contrasted with a large decrease in those with East Timorese citizenship in 2014. However, it is unclear whether this is a true change, or can be attributed to classification error or bias. Whilst country of birth cannot change, nationality can change and is captured by that stated by the respondent. It is unknown whether the East Timorese population surveyed would have stated their nationality as Portuguese, as this forms the basis of their right to be in the UK, or East Timorese, as this would be the place where the majority of migrants previously resided, as Portugal and East Timor both allow you to hold dual citizenship.

Table 1: Estimated number of persons from East Timor in the UK

Estimate (95% CI)	Geographical Region	Year	Source	Methodology	Potential for error or bias
5345	Europe, excluding Portugal	2015	National Census for East Timor	Survey of family members in East Timor asking them to about family members living abroad	<ul style="list-style-type: none"> • Reduced likelihood of bias, as censuses tend to be more representative of the population. • Higher potential for with secondary reporting by family members • This method could underestimate the population if entire families has moved to the UK leaving no one to respond to the census. • It could overestimate the population, as it includes all European countries excluding Portugal. However, the vast majority of these migrants are theorised to live in the UK (McWilliam 2017).²
7000 (3000 – 11000)	United Kingdom	2016	UK Office of National Statistics	Annual Population Survey in the UK - data by country of birth	<ul style="list-style-type: none"> • A broadly representative sample • For smaller minority populations in the UK, the limited sample size these estimates are imprecise.
1000 (0 - 1000)	United Kingdom	2016	UK Office of National Statistics	Annual Population Survey in the UK - data by citizenship	<ul style="list-style-type: none"> • As above • Unclear how many of those from East Timor have dual citizenship, and how many of these self-identify as East Timorese or Portuguese
>20,000	United Kingdom	2017	Embassy of Timor-Leste in London	Unknown	<ul style="list-style-type: none"> • As this estimate is of unknown methodology, it has a large potential for error or bias. • However, the embassy is one of the stakeholders with most interest in East Timorese citizens in the UK, it may be that they obtained a reliable estimate

2. After Indonesia, the UK is identified as the most populous place for Timorese expatriates (McWilliam 2017).



[Source: Office of National Statistics 'Population by country of birth and nationality underlying datasets']

Figure 3: Estimated East Timorese population in the UK between 2007 and 2016, with 95% confidence intervals

Oxfordshire population

Given the difficulties estimating the UK population from East Timor, it is unsurprising that the same difficulties exist for the Oxfordshire population. There is no ONS data or other official data regarding the East Timorese population in Oxfordshire. Local perspectives may give further insight into the Oxfordshire population, but must be treated with caution as they are not based on systematic data collection (Table 2). For the purposes of this HNA, an estimate of 2000-3000 persons in Oxfordshire is used, with a figure of 2500 as a denominator for calculating rates. This figure is chosen as it is close to the median estimate for the Oxford City population, where most the population reside, but makes allowance for a small population outside Oxford City, as reported by community sources.³ This includes communities in Abingdon, Bicester, and small groups in Witney and Banbury.

Depending on which UK population estimate is used, the estimated Oxfordshire population appears to comprise a large proportion of the UK East Timorese population. This could be explained by population clustering in centres around the UK, including Oxford, but also Peterborough, Liverpool, London and Bristol in England, and Dungannon and Portodown in Northern Ireland. These population centres are theorized to exist because of historical reasons, with origins in student activists

3. Although the figure of 2500 persons is a best estimate, some community members have unofficially estimated that the figure may be much higher, as much as 6000 persons.

travelling to them escaping police and military repression in East Timor, and cemented by family and friendship ties facilitating travel, initial accommodation, and information regarding the availability of work (McWilliam 2017). The strong links within this community are suggested through the local survey data that indicated that 60% of respondents (n=7) know more than 50 persons from East Timor in Oxfordshire, with 27% (n=4) suggested they knew more than 200 persons.

Table 2: Estimated number of persons from East Timor in Oxfordshire

Estimate	Geographical Region	Year	Source	Methodology
2500	Cowley, Headington and Blackbird Leys	2017 (Unknown, but estimate currently used)	Thames Valley Police	Estimate from a local contact
1331	Oxford City	2017	East Timor Community Oxford Facebook page	Number of followers of social media community page
1610	Oxfordshire – but unclear	2017	Tetum Solution	Number of followers of prominent interpreting and tutoring business based in Banbury
2000	Oxford City	2015	McWilliam (academic)	Estimate from local contacts
3000	Oxford City	2014	Unknown	Bar chart acquired by community figure of unknown origin
1615	Oxford City	2011	2011 UK Census	Other South-East Asia, excluding Philippines
50 - 100	Blackbird Leys	2010	Oxford Mail (Allen)	Estimate from prominent community worker
300	Oxford City	2009	Oxford Mail (Walker)	Unknown

Population Characteristics

As East Timor is a culturally and linguistically diverse country made up of twelve municipalities, migrants in Oxfordshire may have diverse backgrounds and characteristics. A subpopulation of particular note is Fataluku speakers from the far Eastern and rural district of Lautém, because it is estimated that up to 30% of UK based migrants are Fataluku speakers (McWilliam 2017).

Two recent surveys undertaken in East Timor that asked households about family members working in the UK, aid in understanding the Oxfordshire migrant population alongside the local questionnaire (Table 3). Even though these external surveys are primarily of Fataluku households regarding familial migration to all the UK, some generalisations may be made to the wider East Timorese migrant population in the UK, because of the large proportion of Fataluku migrants in this population and their concordance with the local questionnaire. Collectively these surveys provide evidence that the UK, and Oxfordshire, population is likely to be predominantly male, young, single and recent immigrants. The rate of prior unemployment shown in the two external surveys is unsurprising, given high rates of unemployment in East Timor and unemployment or inferior employment being a motivation for seeking employment as a labour migrant.

Table 3: Characteristics of the UK East Timorese migrant population

Characteristic	Lautem and Dili Survey (McWilliam and Dos Santos Monteiro 2017) *	Asia Foundation Survey (Reis et al. 2017) *	Local questionnaire
Number surveyed	54 households	357 households	16 individuals**
Gender	90.5% male	89.1% male	88% male
Age	75.6% under thirty years on departure for the UK	-	81% 19 – 40 years
Marital status	59.2% single	60.6% single	-
Time in UK	51.8% departed to UK between 2011 and 2016	86.9% departed to UK between 2008 and 2014	53% in UK 1-5 years 47% in UK for 5+ years
Previous employment in East Timor	40.5% unemployed 16.7% employed 35.7% student/graduate	66.6% unemployed 9.4% agriculture work 17.2% students	-

* Table summarised and reproduced from McWilliam and Dos Santos Monteiro, 2017. Please note that this a pre-publication article by a reputable academic in the field, but has not yet been subject to peer review.

** Of 16 questionnaires answered 15 were complete and 1 provided only basic demographic information

Even though East Timorese migrants with Portuguese passports should not face immigration problems, individuals can run into difficulties when their Portuguese passports expire. This can make it difficult to prove their right to remain in the UK. However, costs associated with passport renewal, including travel to a Portuguese consulate and fees, can be a significant expense. The ability to seek help from the Portuguese consulate can also be delayed if an individual has not registered with the consulate in advance, and made more difficult if the individual does not speak Portuguese (community member).

Employment

The Lautem and Dili Survey (McWilliam and Dos Santos Monteiro 2017) summarized the common types of employment for East Timorese migrants in the UK (Table 4). Whilst this suggests that the most common jobs for East Timorese migrants are in factories, restaurants and hotels/pubs, the dominance of factory based jobs is not necessarily true in Oxfordshire. Data recorded by Public Health England South East for notified cases of tuberculosis between 2011 and 2016 included occupation, and provides some insight into Oxfordshire jobs. Of these patients, the most common jobs were in areas of catering/restaurant/bar/shop work, followed by those working in domestic settings (e.g. as cleaners), factories or manual labouring, and with just under a quarter not in employment. It must be noted that this data was taken from a specific patient population and may not be representative of the wider East Timorese migrant population. For instance, in this patient population the high unemployment rate could be due to symptoms of tuberculosis.

Table 4: Employment in the UK

Lautem and Dili Survey (McWilliam and Dos Santos Monteiro 2017)	Public Health England South East (2017)
n = 54 Fataluku households in East Timor	n = 31 East Timorese TB patients in Oxfordshire 2011-2016
46.3% factory 29.6% restaurant 13% hotel/pub	45.2% catering/restaurant/bar/shop 32.3% domestic work/factory/labourer * 22.6% not in employment**

* Diverse occupations with large manual labour elements have been categorised together to protect patient confidentiality, due to the small sample size

** Includes those that defining themselves as unemployed or as a housewife/househusband

However, the reduction in factory employment in Oxfordshire was corroborated by community stakeholders, and is concordant with the employment opportunities available in Oxfordshire, especially those which would not require fluency in English, a barrier to many new immigrants. Whilst this includes some factory jobs, (BMW UK Manufacturing Ltd, Unipart Group of Companies, Milton Business Park companies, Countax Tractors in Great Haseley), Oxfordshire also has large hospitality and public sectors. Restaurants, particularly those serving East Asian food, and hotels (Travel Lodge, Jury Inn, Four Pillars Hotel) were perceived as common employers (community members). In the public sector, freedom of Information requests sent to major employers identified University of Oxford Colleges as significant employers (51 employees: 30 men, 11 women, 10 unknown /transgender gender), with employees often working as domestic staff, kitchen staff or porters. Although, there was stakeholder perception of high numbers of employees in other public sector organisations such as the hospitals, Oxford University Hospitals NHS Foundation

Trust had less than 11 employees (<5 men, 6 women) and no employees from East Timor were known to work at Oxford Brookes University or Oxford Health NHS Foundation Trust.

This HNA only identified a fraction of the estimated working East Timorese population. This was due to the difficulty gaining information from large private employers and the difficulties faced by some public organisations in identifying those from East Timor but with Portuguese citizenship. Some private and public sector employees were also known to employ East Timorese staff through agencies (for example BMW recruitment through Rudolph and Hellmann Automotive Oxford Agency, and colleges using cleaning agencies for domestic staff).

Employers often had East Timorese employees working in low skill and low paid jobs, primarily due to language barriers (community members, public sector workers). For example, all the East Timorese staff working at Oxford University Hospitals NHS Foundation Trust were employed at a salary grade of between £15,404 and £18,157 per annum full time equivalent. Other types of work included shift work to work multiple jobs, zero-hour contracts, and reports of cash-in-hand payments. There is a risk that some of these employment statuses may leave individuals open to exploitation, and unable to access employment benefits, such as sick pay or protection against unfair dismissal. Although there were cases and opportunities for East Timorese workers to advance in jobs, including from kitchen porter to chef, and from factory line worker to supervisor, there seemed to be a ceiling to further advancement, for example to management positions. A part of this could be access to education needed to advance or secure higher quality employment, as a minority of local survey respondents (33%, n=5) reported difficulties in accessing education.

A community figure described a typical pattern of employment for new arrivals to the UK. Most individuals manage to find employment within a period of a couple of weeks. This initial employment is commonly short term, casual employment, paying a wage less than the minimum wage. An individual may do several of these short-term jobs, often moving around the country to do so, before finding long term work. These employment opportunities were often gained through an informal network of East Timorese migrants around the UK highlighting opportunities in their locality to others, often via Facebook. This could explain the response in the questionnaire, where only 13% (n=2) of respondents indicated they had difficulty finding work: quality, not quantity of work is a key issue.

Sending remittances back to East Timor is demonstrated to be a common practice amongst labour migrants in research literature, including the Schuaib survey (2008), Asia Foundation Survey (Reis et al. 2016), and Lautem and Dili Survey (McWilliam and Dos Santos Monteiro 2017). This can lead to migrants, even in poorly paid UK jobs, sending home much more money than they could have earned in East Timor. In 2015, USD 18,700,227 was sent via Western Union cash transfers from the UK to

East Timor (Reis et al 2016). Using an estimate of 7000 persons in the UK, this would equate to approximately USD 2670 per person. Although Western Union transfer account for approximately 98% of official transfers, other money is known to be taken in undeclared cash by migrants, relatives and friends travelling between the countries (McWilliam 2017). This practice may mean that some community members in the UK only retain a very modest amount of money for living expenses. Although sending remittances home was confirmed by community figures for Oxfordshire, there was also a noted difference between individuals focused on sending money home, and others who spent large amounts of disposable income on high risk leisure activities, including at bookmakers, on alcohol, and engaging sex workers.

Housing

Oxford has been designated as one the UK's least affordable cities for housing (Lloyds Bank 2017). In the local questionnaire, 27% (n=4) of respondents indicated that they had difficulty finding housing. Stakeholders (public sector workers, community members) reported that many East Timorese service users live in privately rented houses of multiple occupation (HMOs). These are commonly in the more deprived areas of Oxford City, including Cowley and Blackbird Leys. Although living in a well-regulated HMO can provide an affordable community and support network for residents, the HMO Enforcement Team at Oxford City Council has found that in recent years the team is seeing more of this population living in unregulated and poor condition HMOs.

Since 2013, there have been three successful prosecutions and one threatened prosecution involving members of the East Timorese community in Oxford City for housing offences.⁴ These have affected a total of 21 tenants and two landlords from East Timor. One of these cases included 12 persons, including three children, living in a three-bedroom maisonette with no fire measures, damp and mouldy conditions, and a heavy cockroach infestation (Oxford Mail 2014).

Although this is a small number of cases, successful prosecutions represent the more severe cases for the HMO enforcement team, with a ratio of service requests to prosecutions and cautions of over 50:1 (Coney 2015). The qualitative experiences of professional stakeholders working in the community outlined both similarities and differences in conditions in these HMOs. All accounts (public sector workers) indicated that this population displays low material wealth in housing. However, conditions ranged from HMOs where individuals have few possessions, for example mattresses on the floor instead of beds, but spotless kitchens, and communal cooking (public sector worker), to reports of severely crowded houses, shift sleeping, pest and waste disposal problems, poor security and safety concerns (second public sector worker).

4. Failures in managing or licensing HMOs under the Housing Act 2004 or breaches of the Management of Houses in Multiple Occupation (England) Regulations 2006. Please see https://www.oxford.gov.uk/info/20104/private_housing/378/enforcing_private_rented_housing/4

There is also a shared perception amongst stakeholders that some in the community, particularly new arrivals, may be a hidden homeless population who are 'sofa surfing' around multiple houses with East Timorese tenants.

A problem identified by the HMO enforcement team in cases involving the East Timorese community, is when individuals in a perceived poor quality or unlicensed HMO self-identify as a family. This may not be seen as a family under HMO regulatory definitions, but may be a family under East Timorese societal definitions, in which the extended family, for example distant cousins, are considered as 'brothers' and 'sisters' (community figure). As families are not subject to HMO enforcement regulations, this leaves the HMO enforcement team without power to effect change in poor conditions. This leaves a tension between the HMO enforcement team and the community. On one hand, if these households do not meet the regulatory definition of family, they are treated as HMOs.⁵ The advantage of this is that this gives the HMO team power to enforce standards to prevent overcrowding, unsafe and exploitative HMOs. On the other hand, there is a risk of imposing British definitions of a family upon a community whom it may not be culturally appropriate to do so. For community members that are satisfied with their living arrangements, some feel that council involvement, for example, to reduce overcrowding, can be an unwarranted interference into their family life and risk that individuals are forced to move into less crowded and thus often more unaffordable accommodation (community figure). This can affect health, as it may mean individuals are reluctant to disclose their address and household contacts to authorities (community figure).

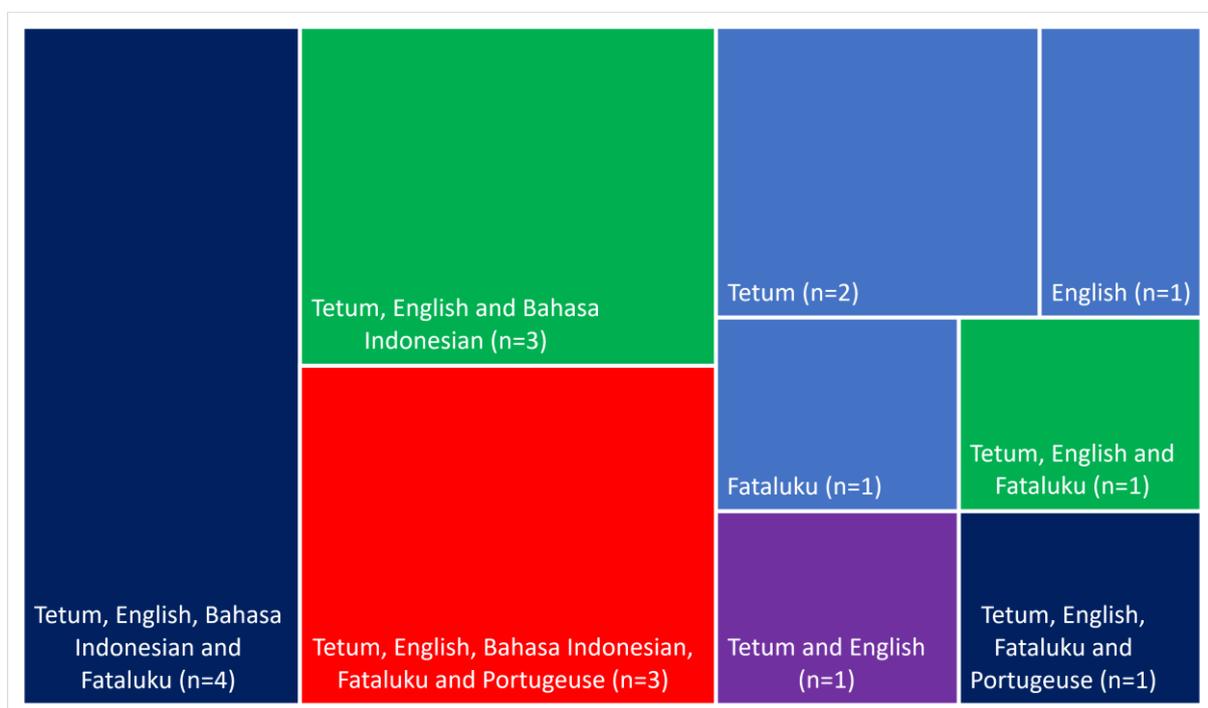
Access to healthcare

Professional and community stakeholders reported low community access to and use of healthcare, particularly primary care. For example, the tuberculosis team saw multiple patients that presented via A&E or were brought to tuberculosis services by a community figure, but were not yet registered with a general practitioner (GP). A community stakeholder reported that whilst most families with children were likely to be registered with a GP, a high proportion of the young single population will not be. These observations are consistent with an Oxfordshire Primary Care Trust survey of GPs in 2011 to 2012, that found only 98 patients registered in ten practices, despite eight out of the ten practices being in areas (East Oxford, Blackbird Leys and Headington) in which the population resides (Oxfordshire PCT 2011). In the local questionnaire, the majority of respondents (60%, n=9) were registered with a GP, but only a minority were registered with a dentist (33%, n=5). Respondents also reported difficulties with access to healthcare and dentistry, with nearly half the respondents (47%, n=7) saying they had difficulty accessing healthcare and a quarter had difficulty accessing a dentist (27%, n=4).

5. It is thought that some households have been instructed to say they are a family to avoid council notice. This view has not been corroborated, but it is possible that fear of eviction from even low-quality HMOs would encourage this perspective.

Language was identified as a key barrier to using health services. East Timor residents in Oxfordshire speak a variety of languages, but not all are fluent in English. Most speak Tetum and many will have learnt Indonesian during the occupation. For some, Indonesian may be objectionable to speak, as it is the language of East Timor ‘oppression’ (public sector worker), though this perspective was not seen by all (community figure). Some of those who had education in East Timor, either before the start or after the end of the Indonesian occupation (those less than twelve years or greater than fifty years) speak Portuguese, but this is often limited to those of higher socioeconomic status (community figure). Of the small number of respondents to the local survey, an impressive number of languages were spoken, with most respondents bi-, tri-, or multi-lingual (Figure 4).

Figure 4: Languages spoken by respondents (colour indicates number of languages spoken)

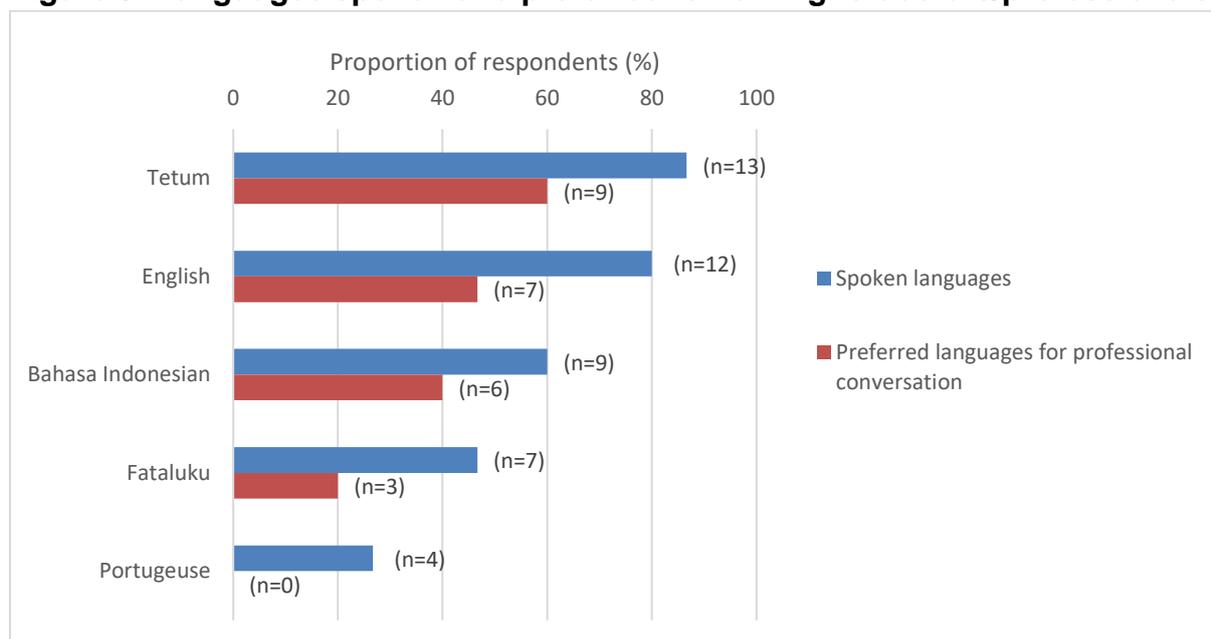


Oxfordshire CCG currently provides and funds interpreting services for primary care e.g. to GP practices and NHS dentists. Interpreting services in secondary care are funded by Oxford University Hospitals NHS Foundation Trust, Oxford Health NHS Foundation Trust and South Central Ambulance Service NHS Foundation Trust in Oxfordshire. This is for telephony, face-to-face and deaf interpreting. GPs are encouraged to use telephony interpreting, as there are more interpreters and these can be rapidly accessed within a couple of minutes, with face-to-face interpreting used for complex secondary care interactions. To access telephony interpreting, GP patients need to book a double appointment to allow for the extra time it takes. The

CCG also provides cards that patients can take with them documenting their main and secondary languages. The current provider of telephone interpreting for Oxfordshire is Language Line. Language Line classifies Tetum as a rare language, and Fataluku does not appear on Language Line listings, so no interpreters are available for either language.

The lack of Tetum and Fataluku interpretation in primary care may discourage GP attendance, particularly in those who do not speak conversational English. Interpreters for Bahasa Indonesian are available, but a stakeholder reported sometimes waiting for twenty minutes for an interpreter during an appointment (public sector worker). Interpreters for Bahasa Indonesian sometimes are Bahasa Malaysian interpreters, as these languages are mutually intelligible. However, the accent and colloquial differences can make it harder for those already speaking Bahasa Indonesian as a secondary language to understand (community member). These stakeholder perspectives corroborate the limited data from the survey: There was a disparity between languages spoken by the community and preferred languages for professional conversations, including with doctors. Only approximately half of respondents of this group preferred to speak to a professional in English.

Figure 5: Languages spoken and preferred for talking to doctors/professionals



Interpretation data from GP surgeries, dentists and optometrists in Oxfordshire demonstrate these difficulties. In a twelve-month period from 2016 to 2017, there were just 10 calls with an Indonesian interpreter and 206 calls with a Portuguese interpreter. Only a small minority of Portuguese calls are likely to be for East Timorese patients. This means, as community figures confirmed, that a significant proportion of the East Timorese population may not be registered with GPs, may be registered but

infrequently attending GPs, or may be accessing GPs without an interpreter, even when this would improve the quality of, and mutual understanding in a consultation. Although a predominantly young, male population are known to have lower primary care needs and access, the increased levels of deprivation in this population are likely to mean that this group have higher needs than others of this age and sex demographic.

In addition to language barriers, traditional beliefs about disease causation may reduce GP attendance or impair communication in consultations (community member, third sector worker). In academic literature, McWilliam describes the use of herbal remedies '*humere*' for healing alongside spells and mantras '*mamunu ho fulumé*' in the Fataluku population (McWilliam, 2008). In Oxfordshire, a community member described individuals using traditional remedies bought from East Timor as a first choice, with the decision to seek medical attention from British healthcare taken only if an illness worsened. Beliefs that may hinder GP attendance include the understanding that when a doctor gives a diagnosis, that this may be brought about by that doctor, rather than the identification of something already present in that person (community member). Ill health is sometimes perceived to be caused by the actions of one's ancestors. For example, a moral wrong done by their ancestors, such as murder, might cause an individual to suffer bad health in this life (community member). Whilst it is not clear to the extent that these beliefs are held, a degree of cultural sensitivity may be needed by healthcare professionals when communicating with individuals who may hold these beliefs.

Tuberculosis

In the 2016 Public Health England Tuberculosis Health Needs Assessment for Oxfordshire, it was identified that a high number of tuberculosis cases were notified in those born in East Timor (PHE 2016). Between 2014 to 2016, there were 163 cases of tuberculosis in Oxfordshire, of which 12.3% (20 cases) were in individuals born in East Timor.⁶ This equates to a crude tuberculosis incidence of 267 per 100,000 in the East Timorese population.⁷ Even though this is a small patient population, this is significantly higher than the incidence in all of Oxfordshire (8 per 100,000 per year) and the incidence in the non-UK born population (56 per 100,000) (PHE 2017a, PHE 2017b). The higher rate in the East Timorese population reflects background risk from East Timor, which has a tuberculosis incidence of 498 per 100,000 in East Timor (2015 figure, WHO 2015). Although the UK has a programme of pre-entry TB screening for migrants from high risk countries (Public Health England, 2006), which would include East Timor, most UK residents from East Timor would not be included in this. This is because high risk migrants are identified when they apply for visas, but East Timorese migrants with Portuguese passports do not need visas.

6. Total number of cases on PHE fingertips tool (n=163) differs slightly from number of cases reported in Thames Valley TB Cohort Reviews for same years in Table 6 (n=165).

7. This is based on the assumption of the population being and remaining stable at 2500 persons.

Oxfordshire tuberculosis patients from East Timor are predominantly living in Oxford City, are male, young and have been in the UK for a median of two years (Table 6). These characteristics are similar to the known characteristics of the East Timorese population in the UK (McWilliam and Dos Santos Monteiro 2017, Reis et al. 2017).

Despite the high incidence in the East Timorese population, there are some encouraging findings relating to treatment of this population. A key indicator for tuberculosis is the proportion of pulmonary tuberculosis cases that start treatment within two months of symptom onset. Between 2014 to 2016, it is positive that there was no significant difference between the proportions starting treatment within the East Timor-born patients (31%) and overall Oxfordshire patients (33%) (PHE 2017a), even though there are improvements that can be made to this target.⁸ A second positive finding that once patients were in treatment, there were no significant differences between East Timor-born patients, non UK-born patients, and UK-born patients in Oxfordshire who completed treatment (Table 6). All the East Timor patients that remained in the local area completed treatment, with those that did not moving out of area or back to East Timor (20%). There were no confirmed cases of multi-drug resistant tuberculosis in this population from 2014 to 2016.

However, two key areas of concern were identified from either qualitative or quantitative evidence. Stakeholders reported that there is a tendency for individuals to present for health or social care when in crisis or when extremely unwell with TB, rather than when problems are less severe (public sector workers, community members). Whilst it was difficult to quantify this, it may be suggestive that half (50%) of East Timor-born patients required a hospital admission, as patients presenting with more advanced illness may be more likely to be admitted. This was significantly higher than the other non-UK born patients, but not than the UK born patients. This may warrant investigation of presentation delay and admission rationale between groups.

It appears that contact tracing has been difficult in this community, with 43% of contacts refusing or not attending screening appointments (Table 6). This is significantly higher than the refusal rates in other non UK-born patients (6%) and UK-born patients (7%). This is particularly concerning as the rate of latent TB found in those who took up screening was again significantly higher than other non UK-born patients and UK-born patients (46% vs 16% vs 11% respectively). This is likely to indicate that screening is identifying those who have contracted latent TB from their recent contact with a case, but also those who may have been contracted TB at an earlier time. This could indicate a need for a wider latent TB screening programme in this community beyond contact tracing.

8. P value is insignificant (>0.5) for pair-wise comparison between the East Timorese patients vs. Oxfordshire patients, including correcting for overlap between samples (Hayes and Berry, 2006). Data not available for

Education about tuberculosis may be important for addressing these concerns. Stakeholder perspectives suggested that individuals are likely to give a low prioritisation for testing and treatment for latent tuberculosis when they feel well (community member). Conversely, as tuberculosis is a common and often fatal disease in East Timor, individuals may avoid presenting to medical services despite recognising they are unwell with tuberculosis symptoms, because they believe that treatment is futile. A community member reported a harrowing story of someone trying to fly home to East Timor rather than go to the hospital when severely ill, because they believed that they were going to die and didn't want their family to have to pay to have their body repatriated. Fortunately, they were stopped from getting on the flight by authorities, taken to hospital, and survived the incident. This story, however, illustrates how lack of health education can lead to much greater risk.

Table 6: Characteristics of tuberculosis patient population in Oxfordshire 2014-2016, by patients born in East Timor, other non-UK born, and UK born.

Demographics	Born in East Timor (n=20)	Other non UK-born (n=95)	UK-born (n=45)
Sex (% male)	90	54*	56*
Age (years) ¹	30 (22-42)	36 (10 - 78)	40* (3 - 86)
Time between UK entry year to symptom onset (years) ²	2 (0 - 2)	Not available	Not applicable
Time between symptom onset and first presentation to any health professional (days) ²	38 (19 - 70)	Not available	Not available
Time between first presentation to any health professional and treatment (days) ²	20 (4-59)	Not available	Not available
Proportion of patients admitted to hospital (%)	50	20*	42
Proportion of patients completing treatment (%)	80	91	82
Clinical details			
Pulmonary disease (%)	65	46	71
Previous tuberculosis diagnosis (%)	5	2	4
Contacts			
Screening contacts identified per patient ^{1,3}	4.9 (0 - 11)	3.5 (0 - 14)	4.8 (0 - 15)
Proportion of contacts identified who refused screening/failed to attend appointment (%; total number contacts identified)	43 (98)	6** (n=316)	7** (n= 91)
Proportion of contacts screened with latent tuberculosis infection (%; total number of contacts screened)	46 (56)	16* (n=287)	11* (n=174)

1 Normally distributed data presented as mean (range)

2 Skewed data presented as median (interquartile range)

3 Large scale incidents (>15 contacts) excluded as these likely represent large work-placed screening rather than household contacts.

* Statistically significant difference ($p < 0.05$) between value and value for East Timorese population on pair-wise comparison.

** Highly statistically significant difference ($p < 0.001$) between value and value for East Timorese population on pair-wise comparison.

Source: Thames Valley TB Cohort Reviews 2014-2016, Public Health England South East.

Methods: Significance testing was conducted using pair-wise comparisons of the East Timorese patients with other non-UK born cohort, and East Timorese patients with UK born patients, using T test for difference in means and Chi² for difference in proportions. Universal tests between the three groups were not conducted (i.e. via ANOVA and Chi²) because the focus on this HNA is on differences between the East Timorese population and other Oxfordshire populations, rather than differences between all three populations.

Data period: Between 2011 and 2016 there were 31 cases in total in the East Timor born group. The analysis in Table 6 was limited to those between 2014 to 2016 because data for comparative was only available for these years. The data for East Timor-born patients from 2011 to 2016 can be seen in Appendix 1.

Sexual health

There is very little recent evidence for background risk of HIV and other sexually transmitted infections in East Timor (WHO 2015). A small cross-sectional survey in 2003 demonstrated a low HIV prevalence of 3% amongst female sex workers, 0.9% amongst men who have sex with men, and no cases in a group of soldiers and taxi drivers. There was also very low condom use and lack of education about sexual health (Pisani 2006). Lack of education around sexual health may have influenced the low number of respondents to the local survey that reported they had a difficulty getting contraception or sexual health advice (n=2, 13%). From this limited data sexual health cannot be identified as a *felt* need by the population, but still may a *normative* need seen by professionals.

Reports given to Thames Valley Police and to the Sex Workers' Intervention Panel suggest that East Timorese men provide a proportion of female sex workers' custom. A minority of the community engaging with sex workers was confirmed by community stakeholders. This behaviour was associated with groups of men drinking alcohol and spending time in betting shops, before seeking sex workers when these shops shut (community member). The men's behaviour towards sex workers has been reported to include refusal to use barrier contraception, verbally aggressive behaviour to drive down prices, and practices of inviting a sex worker to visit multiple clientele in one HMO (public sector workers, community members). Although it was not feasible to gain quantitative data to support these qualitative reports, the reports raise sexual health, health protection and safeguarding concerns.

Unprotected sex is a high-risk behaviour for contracting or transmitting sexually transmitted infections. This is especially the case when interacting with a high risk and vulnerable group of on-street female sex workers in Oxford. Although there were no reports of intravenous drug use, a risk factor for transmitting blood borne viruses, in the East Timorese community, this is a risk factor known to be present in the sex worker population (public sector workers). The refusal to wear condoms amongst this group is a significant health risk to the East Timorese men, the sex workers, and their wider sexual networks. This includes East Timorese women in relationships with East Timorese men. According to community figures, it is highly unlikely that this group of young men will be accessing sexual health services. There are also health protection issues and safeguarding concerns for the female sex workers interacting with the East Timorese men. If some sex workers are consenting to unprotected sex, there is a risk that this could lead to a communicable disease outbreak amongst their sexual contacts. There are safeguarding concerns, because it is not established that this group are voluntarily consenting to unprotected sex. These risks need further investigation, and are likely to require a multi-agency approach to address.

Amongst the East Timorese population, beliefs and attitudes around sexual health and gender equality may impact upon behaviours. It is important to note that despite East Timor being a predominantly Catholic country, community members thought it was unlikely that a Catholic prohibition on condoms was a relevant barrier to using these. An example of a health belief that would lead to high risk behaviour was recounted by a community member, who suggests that men may think if they have a sufficient wash in a shower or bath after sex, that will clean and protect them from infections. A community member described a subculture of a minority of young single men being proud of drinking alcohol and engaging sex workers as signs of manliness.

Domestic abuse

Concerns over domestic abuse in the community were raised by a domestic abuse worker, health visitor, and social services team member, all who had encountered service users who were female victims of domestic abuse in heterosexual East Timorese couples. Like for other risks, this may reflect a background risk in East Timor, in which domestic abuse continues to be a significant issue. The East Timorese Demography and Health Survey 2009-2010, although 10 years old, provides some of the most comprehensive data on domestic abuse in East Timor. It found that 36% of married women have experienced physical, sexual, or emotional violence by a husband or partner, and that 86% of women and 80% of men believed that a husband is justified in beating his wife for neglecting her duties⁹ (NSD, 2010). Bride prices are still paid in many families, and some hold beliefs that wives belong to their husbands (public sector workers, community member). These may reflect the cultural norms of violence in a patriarchal society which East Timorese migrants may have experienced growing up. This violence may have been seen or experienced both in intimate relationships and during the conflict (public sector workers, third sector worker).

There were challenges identified in trying to help women in situations of domestic abuse. These included less women being present in the public sphere, and women emphasising the importance of their community. A risk to women in removing themselves from a domestic abuse situation by leaving their partner could mean risking being ostracized from community and church (public sector worker, community member). Violence within intimate partner relationships is often solved in East Timor by families coming together to discuss it. In the UK, some family protection may be lessened by distance, but women may still be encouraged to stay with partners by their families (public sector workers, third sector worker).

Even when women wanted to leave their partner, there were sometimes economic and social constraints to doing so: Low paying jobs, length of stay requirements for

9. Neglect of duties in this survey included burning the food, women refusing to have intercourse with her husband, or neglect of children.

benefits, and bureaucratic and language barriers to accessing help, meant it could be economically prohibitive to leave partners (public sector workers). However, a community figure emphasised that women in the community with secure jobs may be more empowered than initial perceptions show. Even though there may be an initial family disapproval associated with marriage breakdown, the ability of a women to support herself and send remittances back to her family can be seen favourably (community member).

Child health, maternal health and safeguarding

The proportion of families including women and children in the Oxfordshire East Timorese population is unknown, but thought to be growing, although demonstrably less than the number of single men. In the local survey 33% (n=5) of both male and female respondents reported they had children, but with these limited numbers the figure could be biased by just one couple with children both filling out the survey.

Women with children were perceived to be more likely to be registered with a GP (community members), but stakeholders reported difficulties with providing women with high quality antenatal and postnatal care. Women would present late to antenatal care, thus missing out on early health and preventative care (public sector worker, community member). There were reports of individuals working long hours until very late pregnancy and restarting work less than two months' post-partum, which could make it harder to access healthcare (public sector worker). Women were also lost to the system when they moved cities during pregnancy because of employment opportunities (community figure). A community figure described the split between women who chose to remain in the UK and access free healthcare when giving birth here, and those that chose to fly back to East Timor to have traditional births with their families.

Child health and safeguarding concerns were noted in this community, but it is unclear that these are more than would be expected for a small population in a deprived urban area. In November 2017, there were less than ten families who were involved with the Family Solutions Service in Oxford City, including four children with child protection plans or were looked after children. Concerns raised over safeguarding included alcohol use in fathers as a factor in violent behaviour and children witnessing of domestic abuse towards their mother, antenatal violence and (threatened) physical chastisement of children (public sector workers).

Social services in Oxfordshire did have access to an in-person Tetum interpreter for planned meetings. In a 12-month period between 2016 and 2017, social services made 43 bookings (mean 3.6 per month) for Tetum interpreters, commonly using a

single interpreter.¹⁰ As high-risk families have multiple meetings, this interpretation data would be in accordance with the small number of families with social service involvement. Even though access to an interpreter was available, there were difficulties noted with translation. The complex vocabulary of safeguarding did not always have a direct translation into Tetum, which meant that the interpreter had to both translate into Tetum and explain concepts, a time-consuming process (public sector worker, community member). Some professionals raised concerns that because the East Timorese community was relatively small with close links, that individuals may be unwilling to disclose to an interpreter that was also part of that same community (public sector workers).

There were cultural differences in childcare norms, with children often looked after by multiple informal carers (public sector worker). This became problematic if these other carers are known by social services to be unsuitable from other case work (public sector worker). Many residents also had children back in East Timor, with sending remittances back to East Timor sometimes causing increases in material poverty for the mother and any children in the UK. It could also mean that although some pregnant women in the UK may have previous children, it could not be assumed that they are experienced mothers, as someone else may have raised their previous children (public sector worker).

Violence and crime

Between January 2013 and September 2017 there were 60 detentions (approximately 1 detention per month) in those of East Timorese nationality by Thames Valley Police in Oxfordshire. The vast majority of these detainees were male (n=58, 97%). Compared to the rate of detentions in men excluding the East Timorese community, East Timorese men have a much lower estimated detention rate of 578 per 100,000 persons compared to 2410 per 100,000 in the rest of the Oxfordshire population.¹¹

Cases of serious crimes reported by stakeholders or in the press included a domestic murder, where both the male victim and convicted male perpetrator were East Timorese, and a reported multiple rape of a female sex worker by East Timorese men. Reports of fighting within the community occurred by two different mechanisms: Instigated fights as a form of informal conflict resolution and spontaneous fights during alcohol-fuelled celebrations such as birthdays or baptism (public sector workers, third sector worker). A factor relevant to past intercommunity divides was suggested to be

10. 63 bookings were also made for Portuguese interpreters, and 5 bookings for Indonesian interpreters, but it is thought most of the East Timorese population will have opted for a Tetum translator.

11. This is based on an average rate per year between 2011 to 2016. The denominator for the Oxfordshire population includes the total male population for each year minus the estimated number of East Timorese men. The denominator for East Timorese men was estimated to be 2250 per year or 90% of the estimated East Timorese Oxfordshire population and was assumed to be constant over the four years.

rural (Fataluku speakers) vs urban (Tetum speakers, often previously Dili resident) dwellers from when previously living in East Timor (public sector worker, third sector worker), but this divide was thought be of less importance in recent years (community member).

Violence and crime has public health implications because of the physical injuries and mental wellbeing problems associated with it. The difference between the qualitative reports of frequent violence and quantitative evidence of a low rate of detentions could be caused by multiple reasons. It is unclear how nationality is defined by Thames Valley Police, and how it classifies persons that may have dual citizenship, so the real number of detentions could be higher. Detentions do not equate to crimes, and not all incidents are reported to the police, particularly if contained within community. Equally stakeholders could be reporting just a few notable incidents that do not represent a pattern. Therefore, given this uncertainty, and to reduce the risk of stigmatizing a community, it must be concluded there is no evidence for increased crime in this community.

Noncommunicable disease

Given the young age of most East Timorese migrants, non-communicable disease is not a significant current health issue for the community. Indeed, there is evidence of high levels of physical activity for some, as there is a large community tradition of football. Men from this community previously fielded up to 10 football teams in Oxfordshire (community member). However, risk behaviours including smoking and alcohol use may lead to future elevated risk.

Stakeholders (community members, public sector worker, third sector worker) reported seeing that a lot of men smoke, with a community member stating that “*nearly all*” men smoke. This reflects a background risk in East Timor that suggests that smoking prevalence amongst men is more than 55% (Ng 2014). Women are not commonly seen to smoke (community member, public sector workers). Solutions 4 Health, the current Oxfordshire provider of smoking cessation services is aware of interest in their services from the East Timorese community. Although in the local survey only 13% (n=2) respondents reported smoking, the small number of respondents and risk of social desirability bias mean that this survey data is of limited value.

Problematic alcohol use, or problematic consequences of alcohol use, in men was reported by multiple stakeholders (community members, public sector workers). Although a 2010 WHO report on harmful alcohol use in men in East Timor only showed a 2.4% prevalence of harmful alcohol use, migrants to the UK may be adopting the increased alcohol use seen in their new country, with 16.3% of the entire male UK population having alcohol use disorders (WHO 2014). In the local survey, 53% (n=8)

reported drinking alcohol occasionally or sometimes, but no respondents reported drinking most or every day. This again may be subject to social desirability and other biases.

Stakeholders also reported links between young single men who drank alcohol, went to bookmakers, and were more likely to be involved in intercommunity violence and high risk sexual behaviour (community members, public sector workers). The link between alcohol use, interpersonal violence and problematic gambling reported in this community, is supported by academic evidence in other settings and communities (WHO 2006, Dowling et al. 2017).

A consequence of gambling was reported by a community member. They observed that some men spend considerable amounts on gambling to the detriment of their health and social wellbeing. This included financial difficulty in paying rent, buying food, meeting basic needs, or being able to afford to return to East Timor.

Current Services

Current health and public health service provision for the East Timorese community is contained within the NHS universal healthcare and local authority public health provisions and programmes, as for any resident. However, this HNA has demonstrated that there may be areas where the East Timorese population are not adequately accessing universal healthcare. Consideration of the broader needs of this specific community are currently coordinated through the East Timor Working Group, which set up in summer 2016 to support the identification of, and improved multi-agency response to, the culturally specific needs of Oxfordshire's East Timorese community. Although this encompasses broader aims than public health, some of the work and events the group has initiated has included health topics, for example education by a tuberculosis nurse at an event.

Targeting of the East Timorese community prior to the working group has primarily been via a series of events, organised ad hoc by different groups and agencies (Table 9). This is an area where high quality work has been done, in consultation with community figures, to engage with the community, but prior to the 2016 start of the East Timor Working Group, this appears to be somewhat sporadic in nature. The focus of these events has primarily been on education, but with a difficult to define group, it is hard to quantify if these events have reached those with the greatest needs or the effects of education on the groups that have received it. However, these events have helped establish links between the community and public sector, with community members reporting that they feel their community receives a lot of attention.

Table 9: Events targeting the East Timorese population

Date	Event	Organiser	Details
January 2013	Community event to raise awareness and improve access to health and social care services	Oxfordshire Primary Care Trust	At Blackbird Leys Community Centre, 11 men and 7 women, one with a baby attended. Invited attendees included immunisations, tuberculosis screening, C&SH Services, Smoking Cessation, Bowel Screening, Housing, Domestic abuse Team, Mind, Health visitors.
November 2015	Community event	Thames Valley Police	Partnered with housing, health and other services.
May 2017	United Oxford Cup Football tournament	Partners included Oxfordshire Mind, Asylum Welcome, Refugee Resource and East Oxford United Football Club	Football tournament which united asylum seekers, refugees and migrants in Oxford. The East Timor team won the tournament.
August 2017	Community event, linked in with East Timor Day event	East Timor Working Group, funded by Oxford Safer Communities Partnership	Football match, followed by dinner, talks and stalls. Stakeholders included were community Emergency Foodbank, tuberculosis nurse, Thames Valley Police
September 2017	English for speakers of other languages (ESOL) course	Family Learning at Abingdon and Witney College	Originally just for East Timor community, but opened to other nationalities due to low uptake (<5 attendees). However, those that did attend signed up for a further ESOL course.
Awaiting start date	Community drop-in session	President of the East Timor Community Association, supported by Oxford City Council	Mutual support and information provision for community members, including regarding law, social services, housing, and access to healthcare.

Challenges to health and wellbeing improvements

Through the stakeholder analysis, potential challenges to improved health and wellbeing were identified in different contexts. Challenges identified have been synthesised and categorised into those relating to individual factors, community factors within the Oxfordshire East Timorese population, health system factors, and societal factors within Oxfordshire or the UK (Table 7). These reflect understandings of the wider determinants of health seen in the Dahlgren-Whitehead rainbow in which health can be understood on micro, meso, and macro levels. The purpose of this categorisation is not to assign responsibility by level, for instance for community members to take responsibility for individual or micro level challenges, but to identify where challenges are located and enable better targeting of interventions.

Table 7: Challenges to improved health and wellbeing in the East Timorese population

Challenge		Relevant to	Explanation
Individual	Language	All issues of health and wellbeing	Language barriers, whether in a healthcare or another context were universally spoken about. Written and spoken English may prevent individuals registering with, and attending a GP. Communication with all professionals is more complicated, and some therapies, e.g. counselling of domestic abuse victims, may be infeasible.
	Knowledge	All issues of health and wellbeing	New arrivals, and those with limited contact outside their community, may not understand their entitlement to health or social care in the UK, employment law, and the importance of registering with a GP and dentist.
	Migrant plans	All issues of health and wellbeing	For labour migrants who plan to return to East Timor, there is little incentive to integrate outside their community or improve their English, especially if they have been able to secure a job without English fluency.
	Time prioritisation	All issues of health and wellbeing	The priority for the young working population is work, rather than health: Many individuals work long shifts and/or have long commuting times and will not be, or do not believe they will be, paid if miss a shift for sickness or a GP visit during the working day.
	Health beliefs	Health	Some community members hold traditional beliefs regarding disease causation and sexual health, which may reduce willingness to access healthcare.
	Health traditions	Health	Preference may be given for traditional remedies, prior to accessing British healthcare.
Community	Patriarchal culture	Women's health, domestic abuse	Women are a less visible minority of the East Timorese population. Traditional practices such as bride prices mean that attitudes may still exist that wives <i>belong</i> to their husbands. Women's attendance at public sector events targeted at the East Timorese population has previously been low.
	Libertarianism	Housing, sexual health	Some issues, such as housing, are perceived as personal business, and individuals do not want authorities, or even community figures, interfering in these.
	Importance of community	Domestic abuse, child safeguarding, mental wellbeing	The importance of the East Timorese community means that social interventions that may take an individual away from their community or church, such as domestic abuse shelters, are unlikely to be successful.

Community	Informal dispute resolution	Domestic abuse, crime, safeguarding	Disputes within communities, for example in domestic situations, are often solved by families coming together to resolve these informally. This can involve physical alterations, and means that the community may be less likely to contact authorities for problems.
	Experience of violence	Mental wellbeing, domestic abuse, crime	Individuals in their thirties will have grown up in East Timor during the conflict, and many will have seen or experienced violence and sexual violence. These can have lasting impacts on mental wellbeing and behavioural patterns.
Health system	Lack of interpreters	Health services	Absence of telephony Tetum interpreters primary care, dentistry and optometrists in Oxfordshire
	Proof of address for GP registration	Primary care	There were reported difficulties in individuals registering with a GP if they did not have proof of permanent address.
	Pre-entry tuberculosis screening	Tuberculosis	As most of the East Timorese population have Portuguese passports, they are exempt from the UK's system of pre-entry TB screening for individuals from high risk countries that would apply to them if they were applying for visas from East Timor.
Societal	Insecure housing	Mental wellbeing, environmental health, tuberculosis	Good quality rented housing in Oxford can be prohibitively expensive, especially upfront costs of deposits for recent immigrants. The availability of low cost, low quality and sometimes unlicensed HMOs, leaves individuals in unsafe and overcrowded housing, sometimes with little recourse against unfair eviction.
	Insecure employment	Mental wellbeing, occupational health	Employment opportunities in Oxfordshire that do not require English fluency are generally low pay, can be irregular hours or zero-hour contracts, and are sometimes unregulated cash-in-hand jobs. This can mean employees do not have a living wage or employment protections.
	Insecure legal status	Access to medical care and benefits	Expiration of Portuguese passports, which need renewing every five years, leaves citizens vulnerable if they cannot afford to renew it, because this can make it harder to prove their right to remain in the UK.
	Economic hardship	Domestic abuse	Low pay coupled with language and bureaucratic barriers to apply for benefits mean that it may be economically prohibitive to for some individuals to leave abusive partners.

Building on the strengths of a changing community

As well as the challenges to improved health and wellbeing, it is important to note the many unique strengths of the community that can be built upon moving forward.

A key strength of the community currently includes its leadership. Having community leaders who are actively involved in bringing this community together, via organising events, working with the public and charity sectors, and running community social media pages transforms this disparate population into a community. It is through these individuals that public-sector engagement with the community has been enabled.

As well the organisation of the community around leaders, the informal network for East Timorese migrants in Oxfordshire, and more widely in the UK, provides opportunities for health improvements. Local connections and social media use mean that a network of communication stretches around the community in the UK (community figures). This means that information and teaching given to key individuals can have a wider reach. Although there are negative aspects to the network, for example that false health myths can be propagated, the network acts as support for employment and housing, and with the potential for health support. The local community in Oxfordshire also provide physical and practical support for each other. If an individual is unwell and can't work, for example with TB, the household and local community will gather around them and ensure the person is looked after (public sector worker, community member).

Despite having high reported levels of deprivation, the East Timorese community can also be understood as a dynamic, hardworking, and economically productive population in Oxfordshire. Community figures suggest that the population is changing: It started out as a labour migrant community, but is shifting towards a settled community with more families and children. This shift may lead to new health and social improvements and challenges. As the families with children become more common, relationships between the community and public sector may be built upon via contact with maternity care, nurseries and schools. As children grow and learn English in schools, their parents may have more opportunities and motivation to improve their own English.

Recommendations

Recommendation	Rationale	Applicable to	Date for review	Actions
1. To use a coordinated prioritisation approach to address the health and social needs of the East Timor community	To ensure that challenges are prioritised, the community are not overwhelmed with agency contact, and expressed needs of the community are included	East Timor Working Group	May 2018	Tabled at East Timor Working Group May 2018 with plan to find health/social chairs and themed meetings for priorities
2. To explore the possibility of additional data collection to ensure country of birth is recorded by service providers.	To allow quantitative assessment of the health and social needs of minority groups including the East Timor community	All health and social agencies / service providers in Oxfordshire	July 2019	Tabled at East Timor Working Group May 2018. To speak to public service providers about possibility
3. To promote education in cultural awareness and competence amongst professionals who may have contact with this group	To uphold that the importance of cultural perspectives, language barriers and other challenges is known by professionals who may encounter this community.	East Timor Working Group	July 2018	To provide weblink to HNA for inclusion in existing learning resource developed by the East Timor Working Group for access to more in depth information
4. To promote opportunistic encouragement of GP and dentist registration	To take advantage of existing contact between community members and any agency to encourage registration	All service providers and Oxfordshire CCG	Ongoing	To propose the existing, but outdated, CCG leaflets explaining GP registration are updated and can be disseminated to key staff or key locations
5. To continue to request and declare a need for Tetum speakers when recommissioning interpreting services	This is an area in which external private services are unlikely to change unless they perceive a demand and actively recruit	All commissioners of interpretation services within Oxfordshire	July 2019	To remind commissioners and external agencies when recommissioning services

6. To start a programme of latent TB testing for this community in Oxfordshire	There is clear evidence of normative need and the HNA has identified sociocultural factors of relevance to addressing this need	Oxfordshire CCG	July 2018	To link in with the newly appointed latent TB Project Manager at Oxfordshire CCG
7. To promote opportunities for English for Speakers of Other Languages (ESOL) classes for members of the community	To enable individuals in East Timor community to take up low cost or free courses, e.g. as provided by <u>Abingdon and Witney College</u>	All public-sector services with direct contact with population	Ongoing	To ensure that up-to-date information is provided to members of the East Timor Working Group for dissemination to colleagues
8. To ensure that safeguarding of vulnerable members of the community continues to be a priority	Stakeholders for this HNA have reported anecdotal evidence for a small number of very serious events in areas of housing, child protection and crime	All public-sector services with direct contact with population	Ongoing	To raise awareness of this area via dissemination of HNA
9. To prepare for the impact of Brexit upon the East Timorese community	As this community face language barriers and are mostly resident in the UK via Portuguese citizenship, Brexit is likely to be an area of key concern.	East Timor Working Group	March 2019	For the working group to keep an awareness of the impact and needs of community as Brexit negotiations process

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Appendix 1:

Characteristics of East Timor-born tuberculosis patient population in Oxfordshire 2014-2016, (n=31)

Demographics	
Sex (% male)	87
Age (years) ¹	30 (22 - 42)
Time between UK entry year to symptom onset (years) ²	2 (0 – 3)
Referral and treatment timeline	
Time between symptom onset and first presentation to any health professional (days) ²	23 (5 – 59)
Time between first presentation to any health professional and treatment (days) ²	32 (4 – 85)
Proportion of patients admitted to hospital (%)	48
Proportion of patients completing treatment (%)	84
Clinical details	
Pulmonary disease (%)	55
Previous tuberculosis diagnosis (%)	13
Contacts	
Screening contacts identified per patient ¹	3.9 (0 - 13)
Proportion of contacts identified who refused screening/failed to attend appointment (n = 121 contacts) (%)	42
Proportion of contacts screened with latent tuberculosis infection (n = 60 contacts) (%)	48

* Normally distributed data presented as mean (range)

** Otherwise data presented as median (interquartile range)

Source: Source: Thames Valley TB Cohort Reviews 2014-2016, Public Health England South East.

This questionnaire is to help the public health team at Oxfordshire County Council learn about the health needs of the East Timorese community in Oxfordshire (i.e. Oxford, Banbury, Bicester, Abingdon, Didcot, Witney and the surrounding countryside). All responses are anonymous and will not be traced back to you. Please tick answers or answer online at https://consultations.oxfordshire.gov.uk/consult.ti/ET_HealthQu/answerQuestionnaire?qid=4872419

1. Are you?

- Male Female Other / prefer not to say

2. How old are you?

- Under 18
 19 – 40
 41 – 60
 Over 60

3. Are you a parent/carer to any children under 18 years living in Oxfordshire?

- Yes – 1 child
 Yes – 2 or more children
 No

4. How long have you lived in the UK?

- Less than one year
 1 to 5 years
 Over 5 years

5. How long do you plan to live in the UK?

- Permanently
 Less than five years
 More than five years

6. Are you registered with a GP in Oxfordshire?

- Yes
 No

7. Are you registered with a NHS dentist in Oxfordshire?

- Yes
 No

8. How is your health in general?

- Very good
 Good
 Fair
 Bad
 Very bad

9. How many people from East Timor do you know living in Oxfordshire?

- Less than 50
 50 – 200
 200 – 500
 Over 500

10. Which language(s) do you speak?

- English
 Tetum
 Fataluku
 Portuguese
 Indonesian
 Other _____

11. What language(s) would you prefer to talk to a doctor / professional in?

- English
 Tetum
 Fataluku
 Portuguese
 Indonesian
 Other _____

12. In Oxfordshire, it is/has been difficult for me to:

- Access healthcare (e.g. a GP)
 Access a dentist
 Get contraception/sexual health advice
 Find out about benefits
 Access education (e.g. English lessons)
 Talk to professionals (e.g. doctors)
 Find housing
 Find work
 Afford enough food
 Other _____
 None of these have been difficult

13. Do you smoke?

- Yes
 No

14. How often do you drink alcohol?

- Every day
 Most days
 Sometimes
 Occasionally
 I don't drink alcohol

Thank-you for filling out this questionnaire. If you have any questions, comments or concerns, please contact Frances Butcher on 07747564277 or at frances.butcher@oxfordshire.gov.uk

Jika anda membutuhkan kuestioner ini di dalam bahasa lain, mohon hubungi Frances Butcher di nomor telepon 07747564277 atau ke email frances.butcher@oxfordshire.gov.uk

Se gostaria de receber o questionário num outro idioma por favor contate Frances Butcher no número 07747564277 ou através do email frances.butcher@oxfordshire.gov.uk.

Kestionáriu Saúde ba Komunitade Timorese

Kestionáriu ida ne'e atu ajuda ekipa saúde publiku Konsellu Munisipiu Oxfordshire nian atu hatene kona ba nesesidade saúde komunitade Timorese iha Oxfordshire (hanesan Oxford, Banbury, Bicester, Abingdon, Didcot, Witney no area haleu nia zona rural). Resposta hotu sai anónimu no sei la iha esforsu atu buka hatene ita boot. Favor tau vistu ba resposta sira.

1. Ita nia jéneru?

- Mane Feto Seluk / prefere atu la fo sai

2. Ita nia idade?

- Seidauk to'o tinan 18
 tinan 19–40
 tinan 41–60
 Liu tinan 60

3. Ita nudar aman-inan ida/hakiak na'in ba labarik ho idade nebe sei dauk to'o 18 nebe hela iha area Oxfordshire?

- Los – labarik 1
 Los – labarik 2 ka liu
 Lae

4. Tempu hira ona mak ita hela iha UK?

- Seidauk to'o tinan ida
 Tinan 1 até tinan 5
 Liu tinan 5

5. Tempu hira ita planu atu hela iha UK?

- Ba nafatin
 La to'o tinan lima
 Liu tinan lima

6. Ita rejistu ho médiku familia nian (GP) iha Oxfordshire?

- Los
 Lae

7. Ita rejistu ho dentist NHS ida iha Oxfordshire?

- Los
 Lae

8. Jeralmente oinsa ita nia saúde?

- Diak liu
 Diak
 natoon
 Aat
 Aat liu

9. Ema nain hira husi Timor Leste nebe iha Oxfordshire mak ita hatene?

- La to'o 50
 50 – 200
 200 – 500
 Liu 500

10. Ita kualia lian saida (deit)?

- Inglesh
 Tetum
 Fataluku
 Portuguese
 Bahasa Indonesia
 Seluk _____

11. Ita prefere atu kualia iha lian saida ho médiku/profesional sira?

- Inglesh
 Tetum
 Fataluku
 Portuguese
 Bahasa Indonesia
 Seluk _____

12. Iha Oxfordshire ida ne'e, hau hetan ona difikuldade atu:

- Asesu ba asistensia saúde (ezemplu GP)
 Asesu ba dentista
 Hetan konsellu/informasaun kona ba kontrasepsaun/saúde seksual
 Hatene liu tan kona ba benefisiu sira
 Asesu ba edukasaun (ezemplu Kursu Inglesh)
 Kualia ba profesional sira (hanesan médiku sira)
 Hetan uma
 Hetan servisu
 Bele atu sosa aihan
 Seluk _____
 Laiha ida husi ne'e mak sai ona defisil ba hau

13. Ita fuma?

- Los
 Lae

14. Oinsa frekuénsia ita hemu alkohol?

- Lor-loron
 Kuaze lor-loron
 La'os lor-loron
 Dala ruma
 Hau la hemu alkohol

Obrigadu tamba kompleta ona kestonáriu ida ne'e. Se ita iha pergunta, komentariu ka preokupasun ruma, favour kontaktu Frances Butcher iha 07747564277 ka iha frances.butcher@oxfordshire.gov.uk

Se a eluhe tu kestonáriu en la'an em luku-lukun itelira na'e nara Frances Butcher i telefone 07747564277 e horuluku ali i email frances.butcher@oxfordshire.gov.uk e hau kere-kere.