

## Research paper

# The health promotion needs and preferences of Gypsy Travellers in Wales

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## ABSTRACT

Gypsy Travellers suffer high levels of racism, socio-economic deprivation, unemployment and illiteracy, the poorest life expectancy in Europe and poor access to health promotion. A study of the health promotion experiences, needs and preferences of Gypsy Travellers in Wales was undertaken obtaining data from five focus groups formed from a convenience sample of 18 Gypsy Travellers living on authorised caravan sites in Wales. Findings indicate that these Gypsy Travellers see improvement in socio-economic conditions as a primary need. Women were

more open to health promotion activities, and some wished to engage in their design and delivery. Participants preferred health promotion provided locally. Culturally competent health promotion practitioners who can be flexible and willing to work on Gypsy Travellers' terms are needed, as are changes in health and social policy to improve their socio-economic conditions and reduce health inequalities.

**Keywords:** cultural competence, Gypsy Travellers, health promotion

## Introduction

Gypsy Travellers in Britain today are a diverse constellation of different groups, including Romany Gypsies and English, Scottish, Welsh and Irish Travellers. Although there is no one culture common to all these groups, they share an ancient tradition of nomadism and an 'oral tradition' of passing on knowledge.

According to the Commission for Racial Equality (CRE) the Romany Gypsies have lived in Britain since the 16th century and were the earliest group of Gypsy Travellers in Britain (CRE, 2004). Because of their nomadic lifestyles and a lack of systematic ethnic monitoring, the number of Gypsy Travellers can only be estimated; in Britain there may be as many as 300 000 (CRE, 2004), although other estimates place this figure much lower at between 90 000 and 120 000 (Office of the Deputy Prime Minister, 2003). The number in Wales – where the study described in this paper took place – is unknown (Welsh Assembly Government, 2003). However, in July 2006 a caravan count showed that there were around 722 Gypsy and Traveller caravans in Wales located on 57 sites (excluding

Monmouthshire and Wrexham local authorities which did not participate in the count; Statistical Directorate, National Assembly for Wales, 2006).

Gypsy Travellers suffer gross health inequalities and have the lowest life expectancy levels of all Europeans (Krushelnyck, 2003). Crawley (2003) estimated that on average Gypsy and Traveller women in Britain live 12 years less and men 10 years less than the general population. A recent exploration of the health status and health needs of Gypsy Travellers in England concluded that:

'There is now little doubt that health inequality between ... Gypsy Traveller population in England and their non-Gypsy counterparts is striking, even when compared with other socially deprived or excluded groups ...' (Parry *et al*, 2004, p.9).

It is likely that such health inequalities also exist amongst Gypsy Travellers in Wales. Despite such glaring health inequalities there has been little research regarding the specific health problems and needs of

Gypsy Travellers, or the behaviours that may contribute to them (Aspinall, 2005).

The National Assembly for Wales, which was established in 1999 following devolution from British governance, and the Welsh Assembly Government, which is accountable to the National Assembly, are responsible for a number of policy areas that impact on the health of Gypsy Travellers. These include economic development, education and training, the environment, health and health services, highways, housing, social services and transport ([www.direct.gov.uk/en/Gtgl1/GuideToGovernment/DevolvedAndLocalGovernment/DG\\_4003265](http://www.direct.gov.uk/en/Gtgl1/GuideToGovernment/DevolvedAndLocalGovernment/DG_4003265)). The Welsh Assembly Government has a statutory duty to promote equality of opportunity, and Gypsy Travellers have the full protection of the Race Relations Act (Welsh Assembly Government 2003).

A major programme of reform and improvement to healthcare in Wales was outlined in 2001 in *Improving Health in Wales: a plan for the NHS with its partners* (Health Service Strategy Team, 2001). The Inequalities in Health Fund was also set up in 2001 to tackle inequalities in health and inequities in access to services (Health of Wales Information Service, 2004).

## The study and its aims

It was against this backdrop in 2002 that the Welsh Assembly Government's Health Promotion Division, Office of the Chief Medical Officer commissioned and funded the authors to undertake the Health ASERT Programme Wales study (Asylum Seekers, Ethnic minorities, Refugees and Travellers). This study aimed to ascertain the health promotion experiences, needs and preferences of Gypsy Travellers, new age travellers, minority ethnic groups and asylum seekers/refugees in Wales, to inform the commissioning body's policy and programme development and other Welsh Assembly Government departments. Only the findings relevant to Gypsy Travellers are discussed in this paper. Findings relating to the whole study group are available in the study report (Papadopoulos *et al.*, 2007).

## Health promotion

Health promotion is taken by the authors to be a complex concept beset with definitional and philosophical idiosyncrasies. However, we found Tannahill's (1985) model of health promotion, with its three interrelated and overlapping constructs of health education, health protection and disease prevention, to be a useful framework in guiding the study. Health education comprises activities aimed at the development of positive health attributes in individuals, such

as healthy eating and taking exercise and activities that encourage the uptake of disease prevention and health protection activities. Disease prevention includes measures such as immunisation, various health screening interventions, smoking cessation programmes and so on. Health protection includes policies such as clean air, seat belts, and water fluoridation. The overlapping domains of these three constructs emphasise their interrelatedness, and the many social and health agencies that need to work together to promote health.

## Methodology

A culturally competent approach to the study was adopted to ensure participants' cultural traditions were recognised and respected. As a group view of the areas under study was desired, and as their oral tradition required an oral data collection method, focus groups were used. A relationship of trust, empathy and respect is needed between researchers and participants (Papadopoulos, 2006), and as Gypsy Travellers often distrust authorities, focus group facilitators were used who were known to the participants and who understood their culture. This decision was taken following consultation with Gypsy Traveller leaders and local key health professionals. The focus groups were undertaken in the participants' own environment at times suitable to them. To maintain confidentiality the socio-demographic details of each participant were obtained individually prior to each focus group discussion.

The facilitators underwent rigorous training provided by the researchers to help reduce the potential effects of familiarity and the power imbalances between them, as well as informing them about the study.

Five focus group discussions were held in 2003 with a total of 18 Gypsy Traveller participants. These were tape recorded with their permission. Since all participants spoke fluent English all focus groups were conducted in English (see Box 1).

## Identifying and recruiting the participants

A convenience sample of Gypsy Traveller participants for the focus groups was identified and recruited by the focus group facilitators using a networking/snowball approach. This involved requesting people who had agreed to participate to enlist other suitable participants. To facilitate attendance at the focus groups, participants were paid expenses and provided with child care when needed.

**Box 1** Topic list for focus groups

The following focus group topic list was developed with the help of the advisory group to meet the aims of the study:

- participants' health-promotion needs
- access to and utilisation of health information
- problems accessing information
- health-promotion materials available to them
- health-promotion and information approaches they were aware of and/or preferred
- preferences regarding who should conduct health promotion with their communities and where
- suggestions for culturally appropriate health promotion.

**Table 1** Referencing system for focus group quotation

| Abbreviated quote reference | Name of group                      |
|-----------------------------|------------------------------------|
| WET1                        | Welsh English Travellers (group 1) |
| WET2                        | Welsh English Travellers (group 2) |
| IT                          | Irish Travellers                   |
| WT                          | Welsh Travellers                   |
| ET                          | English Travellers                 |

**Ethical considerations**

The researchers gained ethical approval from the University School of Health and Social Science Research Ethics Committee and the appropriate Welsh local research ethics committees.

Written information and verbal explanation, important for those who could not read, about the study were provided and their consent to participate was sought. Participants were assured of their anonymity and of the confidentiality of any information they provided; this is particularly important when researching marginalised groups who may distrust authorities.

**Data analysis and verification**

An initial analysis of the focus group data was performed by the group facilitators to elicit the main issues from their perspective. Audiotapes of the focus groups were transcribed in full and were analysed independently by two researchers. The researchers compared their analyses and reached a consensus on the final themes. These were analysed more fully using the NUD\*IST v4 qualitative data analysis package. This process of researcher triangulation assured the credibility of the findings. Further verification of the findings was achieved through comparisons with published literature and by asking the focus group facilitators to confirm whether the findings made sense to them, whether they represented what they understood to be the main issues, and that no important issues were omitted.

Table 1 illustrates the group identifiers used to mark the source of each quotation.

**Findings****Socio-demographic characteristics of the study participants**

Fifteen female and three male ( $n = 18$ ) Gypsy Travellers took part in the study. The youngest participant was aged 18 years and the oldest was 45 years. All female participants were housewives, with the exception of a 24-year-old factory worker; all males were unemployed. They all reported to be Christian. Their school attendance ranged from 'never' (two participants) to attending until aged 17 years (one participant). The average school-leaving age was 12 years. All participants were living on authorised Gypsy sites in Wales. The majority ( $n = 16$ ) reported that they were born in England and two in Wales. They defined their ethnicity using a number of terms including 'Romany Welsh Traveller' ( $n = 3$ ), 'Welsh Gypsy' ( $n = 1$ ), 'Welsh' ( $n = 2$ ), 'English' ( $n = 5$ ), 'Romany English Traveller' ( $n = 1$ ), 'English Gypsy' ( $n = 1$ ), 'English Traveller' ( $n = 1$ ), 'Irish Traveller' ( $n = 3$ ) and 'Tinker' ( $n = 1$ ).

The findings have been synthesised under three main themes: (1) health promotion needs; (2) barriers to health promotion; and (3) preferred health promotion practices.

**Health-promotion needs*****Related to socio-economic factors***

Poverty was identified as contributing towards participants' ill health. Some said they could not afford basic household amenities, such as a washing machine.

Homes being damp and in a bad state of repair were also described as potentially health damaging:

‘Well for one thing I need a carpet, I can’t afford one and as I said my little girl is disabled, and there is nails there so she might hurt.’ (WT)

Only one participant reported to be in paid employment. Difficulty finding employment was felt to be due to discrimination against them based on a perception of them as thieves and therefore as untrustworthy. Since employment is a determinant of health, such discrimination does not promote health.

Gypsy Travellers’ unemployment rates, although not systematically measured in Britain, are reported to be high (CRE, 2004), as they are for Roma across Europe (European Commission, 2004). However, they often prefer to work for themselves than be employed (Parry *et al*, 2004).

### *Related to environmental factors*

Participants reported that accidents, particularly among their children, were common and that lack of safe play areas on sites was thought to be a reason for this, as an Irish Traveller described:

‘... there is always accidents on the site because the kids play on top of the caravans.’ (IT)

Living on sites that were not lit and not having safe access to amenities and facilities, such as shops, were felt to increase their risk of road accidents and assault, as illustrated by the following discussion:

‘I think they should put something there, either traffic lights or a zebra crossing.’

‘Yeah.’

‘That might stop a few getting killed.’

‘Exactly.’

‘... we should also have street lights ‘cause there ain’t any street lights.’

‘And it’s dangerous to go walking up and down the road anyway.’ (WET2)

Asthma was reported to be a common illness among children in their community. Transmissible diseases such as diarrhoea, vomiting and measles were said to spread quickly among them.

Poor sanitation and lack of water on some sites (Hennink *et al*, 1993; Welsh Assembly Government, 2003), and low uptake of immunisation (Feder *et al*, 1993, cited in Aspinall, 2005) are likely to contribute to the transmission of diseases.

### *Related to lifestyle*

Although men in their community were described as being ‘good eaters’ they were said not to eat ‘... much salads and things like that’ (ET). They agreed their diet

was not good, and an Irish Traveller explained the link between this and their early death:

‘Get back to the question about how come Travellers die so much quicker than settled people do, because of their food. Travellers like to eat plenty of pots of food, but there ain’t no good in it. It’s always like fries, fast food ...’ (IT)

Gender difference in alcohol consumption was indicated by a female participant in our study who said:

‘... we’re all good Christians, but the men like a drink now and again’. (WET1)

However, they did not raise heavy alcohol consumption or illicit drug use as a concern.

An Irish participant in our study commented that ‘everyone smokes’. Another said they did not smoke because it is bad for health. The policy of non-smoking in public places was praised by another.

Aspinall’s (2005) review of the literature relating to Gypsy Travellers and health promotion identified few studies that had explored their alcohol consumption. One study he cited (Macreadie and Taylor, 1995) found 54% of Gypsy Travellers stating that drinking alcohol caused them some difficulties. Parry *et al* (2004) reported that recreational alcohol use was acceptable among young Gypsy Traveller males in England, but not females.

Although there are no official statistics on drug use among Gypsy Traveller communities, there is anecdotal evidence that it is a growing problem (Parry *et al*, 2004).

Smoking is reported to be common with as many as 70% of Gypsy Travellers smoking tobacco (Aspinall, 2005).

### *Related to lack of information and poor access to healthcare*

In our study a participant who consulted a general practitioner (GP) about her depression reported receiving little information about it and implied a lack of attention to its causes:

‘When I had depression I didn’t get a lot of information, only the depressed tablets and was told to see you later. I was really down for six months ... I tried to commit suicide, I drunk three Reefs and 20 antidepressants and just slept it off ... it was horrible.’ (WET1)

A young woman in our study described pulling out her own rotting teeth and implied that this was commonly done in her community, due to their difficulties in finding accessible dental care.

In his review of the literature on the oral health of Gypsy Travellers, Aspinall (2005) found it to be extremely poor. Their use of and registration with dental services was low, and was related to their mobility and insecure tenure on sites.

Mental illness is a stigmatising condition to Gypsy Travellers (Parry *et al*, 2004). This is of some concern as the same authors also found that Gypsy Travellers, particularly females, are more likely to suffer from anxiety and depression than comparison groups.

### ***Culturally related health promotion needs***

Female participants in our study reported being protected from knowledge about reproduction until after they were married:

'You have to be pure to get married and we're not allowed to know anything. I knew nothing 'til I got married, I didn't know about virgins ... We don't talk about pregnancy ...' (IT)

Conversely, some female participants implied that Gypsy Traveller males were permitted sexual freedom before marriage.

This double standard on what is perceived to be acceptable sexual behaviour between the sexes was also identified in an ethnographic study of Gypsy Travellers in Bulgaria and Hungary (Kelly *et al*, 2004). They found that men have sexual freedom before and during marriage; that they have unprotected sex with both their primary and multiple external partners; and that women are expected to remain virgins until marriage and then be sexually exclusive to their husbands. They also found that condom use was not the norm.

## **Barriers to health promotion**

### ***Poor access to health promotion***

Participants described poor access to health promotion not only through difficulties finding GPs willing to see them, but also through a lack of accessible, culturally appropriate health promotion activities and materials. For example, their high rates of illiteracy were not always considered:

'Well nobody bothers about Travellers, sometimes you get the paper leaflets, but if you can't read them you throw them in the bin ...' (IT)

Some also disliked having to consult unfamiliar healthcare practitioners to receive health promotion.

Aspinall (2005) cites studies that identified GPs' negative perceptions of Gypsy Travellers such as being disruptive in the surgery and not complying with advice and treatment, while others referred to issues around reimbursement and concerns about safety when visiting caravan sites; all these factors are reported to deter GPs from delivering their service to Gypsy Travellers.

### ***Racial discrimination***

An Irish Traveller in our study described his perception of racism thus:

'The government don't care about Travellers. We wish they would care ... Travellers are like black-listed. Nobody wants to know them. Nobody wants to deal with them.' (IT)

Many others also complained that their voices were not heard.

This perception was extended to health professionals when a participant reported that getting attention for their own health was difficult but that when this was forthcoming it was mainly a consequence of having children. When an English Traveller was asked if anyone (health practitioners) visited her, she said:

'No. Sometimes they come to visit me sister. Not us, 'cause we ain't got no children like other people.' (ET)

Some participants perceived that the location of authorised sites in Wales was discriminatory:

'They say they build more sites, but where do they build them? In the wilderness 20 miles from a shop or anything! ... You wouldn't walk 20 miles to a shop would you?' (WET2)

Health-promotion services and events were also reported to be too distant and difficult to get to without private transport.

There is compelling evidence that the lack of culturally appropriate healthcare and the existence of institutional racism are barriers affecting the health of minority ethnic groups, including Gypsy Travellers (Nazroo, 1997). Despite attempts to address institutional racism in Britain, particularly since the passing of the Race Relations Amendment Act (2000), it continues to affect the provision of services to Gypsy Travellers. For example, a review of the location of English residential local authority Gypsy Traveller sites in 2003 indicated that they were indeed often located at some distance from public services. Sixty-eight percent of sites were more than 1 km from a primary school and over a third (38%) more than 1 km from public transport (Office of the Deputy Prime Minister, 2003). Glele-Ahanhanzo (2004) reported that the Roma – and by extension the Gypsy Travellers – are probably the most marginalised and discriminated against ethnic minority group globally.

### ***Cultural barriers to health promotion***

Our study suggests that Gypsy Travellers may hold contradictory beliefs in themselves as fundamentally healthy despite recognising their tendency to die young, as a male participant described:

'I told yer I'm fit and healthy. I don't need anything for me.'

[Interviewer]: 'What about when you get older?'

'Gypsies don't get old.' (WET2)

A certain level of determinism and fatalism also appears to demotivate Gypsy Travellers from seeking health-care or health promotion. For example, a woman reported that she would be happy for her children to receive health promotion, but not the adults as '... we are too old to change' (ET). When asked why she did not access healthcare, a young woman replied, 'You have to die of something' (WET1).

Self-imposed cultural barriers such as their strong desire to minimise the influence of 'outsiders' on their way of life was also reported: 'We likes teaching Gypsy children in our own ways, not mixing like' (ET). This was given as a reason for their lack of attendance at health promotion events for adults too, but lack of knowledge about events was another significant reason for non-attendance.

Parents reported not consenting to their children receiving sex education in schools, and young women said they were closely monitored:

'I can read a bit and I see pictures in magazines but my mammy doesn't like me having magazines because they have boys in them and I'm not allowed to talk to them unless they're in my family.' (IT)

A nomadic lifestyle was seen to be a barrier to their community receiving medical care, such as immunisations:

'Sometimes you get the injections as well. Sometimes they go on in the clinic and sometimes [name of health visitor] comes here, but if you're travelling you miss them.' (IT)

Although there were reports of immunisations being accepted, some also said they were not liked, or were disapproved of:

'I didn't have none of mine [immunisations]. Anyway me mammy doesn't agree with injections. I'm scared of them.' (IT)

However, there was some suggestion that some mothers would have their children immunised if other mothers in their community were to have theirs immunised too.

Other studies have also found that cultural factors impact on Gypsy Travellers' access to and consumption of health promotion. For example, Hawes (1997) and Parry *et al* (2004) reported that Gypsy Traveller men do not to seek health advice until they are really ill. Parry *et al* (2004) also found that many Gypsy Travellers feel that God's will determines their destiny.

## Preferred health promotion solutions

The Gypsy Travellers in our study perceived health promotion primarily in terms of improvements to

their socio-economic and environmental conditions: the health protection and prevention aspects of Tannahill's model (1985) rather than health education aspects of it. Their preferences for health promotion relate to the location of its delivery, the media used, and their preferences regarding who should deliver health promotion to them.

### *Location of health promotion*

Perhaps because of difficulties travelling to and accessing mainstream health provision, their difficulties finding child care, and their preference not to mix with the majority culture, many participants wanted health promotion services to come to them, such as via mobile health and dental services. Some expressed a wish for community centres specifically for their community within their locality, in which health promotion (as well as other activities) could take place.

### *Health-promotion media*

Although leaflets may not be appropriate for all, they were still thought to be beneficial to those with low levels of literacy, as an Irish Traveller explained:

'... most of them can read a bit and even passing out the leaflets, because they can help the others if one can read, then the other can pass the message onto the others ... then that rumour will carry on and on ...' (IT)

Some liked health education leaflets because they could be stored and referred to as needed, but a dislike for 'big words' and medical jargon was expressed. Pictures in health promotion materials were thought to be helpful for those who had literacy problems, providing they were culturally sensitive. Some female participants wished to be involved in the design of health promotion materials.

Information about health promotion events, activities and services was wanted verbally as well as in writing to ensure they did not miss out. Some participants were keen to get health information and advice via videos and television, but the internet was not reported to be used, nor was NHS Direct (a nurse-led telephone and internet health advice service). Word of mouth appeared to be a powerful mode of communication with Gypsy Travellers. Consequently, health events and talks on health and disease were generally viewed positively by the few participants who had attended them.

### *Health-promotion delivery*

Health visitors seem to have been the most significant professional source of health promotion for many of the women with children. Some reported building a trusting relationship with them:

'I tell her [health visitor] everything.'

[Interviewer] 'Is there anyone apart from [name of health visitor] you could talk to anywhere else?'

'No, I wouldn't trust them. I know [name] for 10 years since I had my first born and [name of other health visitor] she's been helpful too.' (WT)

However, they were cautious of others unknown to them, as an Irish Traveller explained:

'... we listens to you [health visitor], but sometimes you bring people and we don't trust them and you have to be careful who you talks to.' (IT)

Some were clear that they would prefer health advice and information to come from their own community:

'Us Travellers never do listen ... [if] I was working for the Travellers they would listen to me more ... because it's coming from a Traveller.' (IT)

Some females expressed willingness to be involved in helping promote health, as an Irish Traveller explained:

'... if I was working in the community I could read all that information out to the community on the site, they trust me because I am a Traveller.' (IT)

Regarding advocacy, some felt that a 'Gypsy spokesperson' would be more effective in advocating for their health promotion needs than a non-Gypsy, as a Welsh/English Traveller explained:

'For Gypsies, if they don't know Gypsies they don't think our way. They don't think what we need. They think what they think we need. You know what I mean?' (WET2)

Their own life experience and the experiences of others regarding health and illness were valued.

The Gypsy Travellers' concern for their children appeared to be a strong motivating factor in their willingness to 'let in' mainstream healthcare workers. More care and attention from health services to Gypsy Traveller children was felt to be a way of gaining access to the wider Traveller community:

'If there was something more done for children then, and the families, they [the Gypsy Travellers] would listen more.' (IT)

Parry *et al* (2004) found that trusted members of health staff are highly valued by Gypsy Travellers, who will make an effort to maintain continuity with that person. Being treated with respect and empathy was reported to be the most important factor influencing the outcome of health service encounters

## Discussion

Tannahill's (1985) health promotion model is consistent with the *Ottawa Charter for Health Promotion*

(World Health Organization (WHO), 1986) and its follow-up, the *Jakarta Declaration on Leading Health into the 21st Century* (WHO, 1997). The Ottawa principles included equity, empowerment, the achievement of participating communities, the reorientation of the health services towards the total needs of the individual as a whole person, and a greater emphasis on promoting health. The *Jakarta Declaration* added the principles of increased investment and a more secure infrastructure for health promotion, the promotion of social capital and social responsibility for health, and the expansion of partnerships for health promotion. The findings of our study are, to a large degree, in accordance with these principles.

In our study, Gypsy Travellers perceived health promotion as meaning access to clean water, a clean environment, good sanitation, decent homes, safe areas for children to play, freedom from stress, and access to healthcare when ill.

The need for health screening and preventative interventions, such as engaging in physical exercise, or even immunisation, appeared not to be highly prioritised by them.

Gender differences in beliefs about health promotion needs were apparent, whereby males tended to perceive themselves as healthy, despite acknowledging that they tend to die young. However, women with children appeared to be more positive about health promotion, in that they recognised its potential value for their children, providing it was culturally relevant and easily accessible. Women, therefore, may be more likely to be instrumental in helping shape future services.

Our findings suggest that while action is needed to address the inadequacy of health promotion for Gypsy Travellers, and its frequent lack of cultural competence, there is, as in the case of other marginalised groups, an equally pressing need to address the socio-economic inequalities and discrimination they endure. Tones (2001) suggests that to address these needs, changes in policy are needed to create legislation, economic and fiscal measures, and various forms of social and environmental engineering in order to make the healthy choice the easy choice. The Welsh Assembly has fully embraced the need for such changes within its overarching health strategy *Designed for Life* (Welsh Assembly Government, 2005). This aims to 'improve health, reduce and where possible, eliminate inequalities in health for all disadvantaged groups, including Gypsies and Travellers'. This study, along with others (e.g. Parry *et al*, 2004) has informed how health promotion can be fashioned to better contribute to the aims of this agenda.

Within the European Union, initiatives to address the plight of Gypsy Travellers will follow as a result of the recent adoption by the European Parliament (2005) of the resolution which calls for member states to

tackle a raft of exclusion and racial discrimination issues facing Roma peoples. Wales has been pro-active in developing policies that will help eradicate the social conditions that create the health inequalities they endure.

As regards the health education aspect of health promotion, our study participants indicated that it would best be delivered by people trusted by them – including their own community members – in locations accessible to them and in formats that were culturally appropriate, bearing in mind their frequent poor literacy. This supports Hawes' assertion that improving the level and quality of health promotion that Gypsy Travellers receive is dependent on the principle that their needs should be met on their terms: 'It will require adaptation by the services rather than the Travellers if progress is to be made in terms of social justice in healthcare' (Hawes, 1997, p.32).

### Partnerships with Gypsy Travellers

The Welsh Assembly has a statutory duty to consult its citizens on service planning and operation and in the development of proposals for changes. Hence, those involved in planning, delivering and evaluating health-promotion services need to have sustained and active working partnerships with Gypsy Travellers. Our study highlights the need for those responsible for developing such partnerships to ascertain, through consultation with Gypsy Travellers, how this can best be facilitated to ensure the methods used are culturally appropriate. For example, health professionals will need to accommodate Gypsy Travellers' low levels of literacy, lack of experience in formal bureaucratic structures and processes, their lack of trust in outsiders and authority, and in some cases their choice to avoid involvement in the affairs of the non-Gypsy community and government (Welsh Assembly Government, 2003). Professionals may need to meet with them less formally outside of offices and formal buildings, and maybe on Gypsy sites. Also, Gypsy culture is egalitarian, and the notion of a Gypsy representative speaking on behalf of all may be problematic (National Council of Women, 2002).

The *Review of Service Provision for Gypsies and Travellers* (Welsh Assembly Government, 2003) identified some barriers to representation which included: the diversity between groups in terms of their culture, traditions, attitudes and background; their respect for traditional roles and representation by elders; and the conflicts which sometimes exist between family groups. There are no easy solutions to these challenges, but raising awareness of Gypsy Traveller cultures among health promotion professionals is an important initial step, as is developing Gypsy Travellers' capacity to self-advocate. Tones (2001) states that helping people to

gain control over their lives is both a prime goal in its own right and a major means of achieving equity.

Both practitioners and policy makers require appropriate skills and knowledge to enable them to develop and deliver health promotion in partnership with Gypsy Travellers. They need to respect Gypsy Travellers' preferred self-care practices, and accept their preferences and priorities. They also need to understand how to help counter the discrimination Gypsy Travellers face. Such skills and knowledge will be enhanced through partnerships, as well as by formal cultural competence training.

To date, community nurses, health visitors and midwives in Britain have been key workers in the delivery of health promotion to Gypsy Travellers. However, consistent with Gypsy Travellers' beliefs in self-reliance and autonomy, some female participants in our study were themselves willing to be involved in the design and delivery of educational aspects of health promotion. Their involvement could result in more culturally appropriate and therefore more effective health promotion. These measures reflect the sentiment of the 'citizens at the centre' approach advocated by the Welsh Assembly in *Making the Connections* (Welsh Assembly Government, 2004) and the vision that services should be provided in a manner that suits the needs of the user rather than the convenience of the provider.

### Limitations of the study

Although the data for this study were obtained from a relatively small number of participants and particularly few males, the findings closely match those of other larger non-Wales based studies, such as that by Parry *et al* (2004).

It could be argued that as a result of having a female bias in the sample, the completeness of the information revealed to the 'outsider' focus group facilitators may be questioned. The Refugee Women's Resource Project and Asylum Aid (2002) reported a tendency for Roma women to ally with the males to protect the community as a whole from external aggressors, and to maintain family honour and family cohesion. Further, our study was conducted with Gypsy Travellers in Wales living only on authorised sites where access to amenities and services is better than on unauthorised sites. Those who live on unauthorised sites who face frequent eviction are likely to suffer even greater health inequalities and problems with accessing health promotion.

### Conclusion

Despite the study's limitations, the findings have helped illuminate the nature of the health promotion



needs and problems faced by this highly marginalised group. It has also contributed some culturally appropriate solutions to alleviating the health promotion barriers faced by them. We believe that some of the knowledge gained from this study is applicable to other gypsy traveller groups throughout the UK and beyond.

Much more research is needed, not only into specific health promotion needs, but also to explore how the preferences of Gypsy Travellers and their suggested approaches to health promotion delivery could work. Any such research should involve them from the planning stage, thus encouraging their ownership and active collaboration, fostering research *with or by* Gypsy Travellers, a view shared by the Welsh Assembly in relation to policy development.

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#### CONFLICTS OF INTEREST

None.

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