Gypsy, Roma and Traveller Communities
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Summary

Gypsy, Roma and Traveller communities introduction

- Gypsies and Travellers are designated ethnic minorities. They numbered 604 (0.1%) people in Suffolk when first counted in the 2011 Census. Although the count was seen as progress in recognition for the communities, it underestimated the numbers as many, particular those living in houses, would not identify themselves for fear of discrimination.
- Estimates suggest there are about 1,500 Gypsies and Travellers living in Suffolk in either trailers or houses based on an average of four persons per unit.
- There are no transit sites in the County, but three permanent sites in West Meadows, Kessingland and Mildenhall.
- The Roma come from Central and Eastern Europe and recently arrived in the UK, mostly after 2004. An estimate from the Roma community suggests there are about 1,000 Romanian Roma and 100 Bulgarian Roma living in Ipswich.
- All three Gypsy groups have a history of suffering racism and discrimination. They have poor health, a life expectancy more than 10 years less than the general population and an attitude of fatalism to health and healthcare.
- Significant health problems include long-term illness, respiratory disease (asthma and bronchitis), chest pain, chronic cough, higher maternal and neonatal death rates, high smoking rates, and anxiety and depression.

Gypsy, Roma and Traveller communities key points

- Gypsies and Travellers can be very independent and distrustful of the wider population. The newly arrived Roma Gypsies, do not speak English and their own Romani tongue is not a written language. In South-Eastern Europe for example, only 18% of Roma attend secondary school compared with 75% of the majority community.
- Gypsies, Travellers and Roma have their own cultural health beliefs.
- The lifestyle of Gypsies and Travellers is dependent on adequate sites and pitches, both permanent and transit. This report notes that in 2013 in the UK there were 2,700 caravans in excess of the number of authorised public and privately-owned sites.
- Those who travel have overall better health than those on static sites.


This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.
• Roma people live in generally poor quality housing in Ipswich, and tend to have large families.
• There is a paucity of literature about Roma health.
• English Gypsy children receive little education; in the UK it is unusual for them to attend school beyond the age of 11 years. We were told the boys and girls after that age enter “apprenticeships” learning from older community members the skills necessary for gypsy manhood and womanhood. The Roma boys in Eastern Europe receive approximately four years of schooling, the girls none.
• Health beliefs developed during centuries in a relatively closed community are strongly held. Illness is to be avoided, so health screening is an anathema; immunisations are dangerous, fuelled by scaremongering about Measles Mumps and Rubella (MMR) vaccination; cancer and death are subjects of fear.
• The Wheel of Life is a Suffolk DVD in English and Romani produced by a Gypsy filmmaker in which community leaders speak of their positive experiences of the NHS and different professionals explained their services and how they could be contacted. The DVD has been widely distributed, a good example of self-help.
• Gypsies and Travellers spoke of positive experiences with GPs and health visitors who were culturally well-informed and sympathetic.
• The Norfolk and Suffolk Gypsy, Roma and Traveller Service (NSGRTS) provides a good liaison, to which the Health Outreach Project adds clinical and social work support.
• The community gave examples of when they had not received the help they sought from the statutory authorities; trust needs to be earned by both service providers and Gypsies and Travellers.
• Groups from the mainstream population making transient or trailer dwelling a lifestyle choice are not included in this Assessment. These include “New Travellers” and “New Age Travellers”.

Gypsy, Roma and Traveller recommendations

1. A strategy is needed to create a multiagency approach to supporting the health needs of GRT communities. Services should provide consistent advice and support. Smoking in pregnancy and refusal of immunisations and vaccinations are particular areas to be tackled.
2. Members of the Gypsy, Roma and Traveller groups could be trained as advocates to work alongside the Norfolk and Suffolk Gypsy, Roma and Traveller Service (NSGRTS) and The Health Outreach Project to build further bridges with
the community.

3. Cultural competency among health and social care workers is appreciated by gypsies and travellers and staff training should be developed and encouraged.

4. Appropriate information to encourage the use of NHS services should be available to increase understanding of waiting times, queuing procedures, referrals, signing-in at clinics and response to letters from NHS authorities on topics such as such screening and hospital appointments. However funding for English language and integration lessons stops September 2015 and opportunities to carry on this work need to be developed.

5. The Health Outreach Project should be supported to improve their monitoring and reporting of activity and outcomes and needs to record data about Gypsy, Roma and Travelling communities in real time.

6. Suffolk County Council may wish to include “New Travellers” and “New Age Travellers” in a future health needs assessment.

**Who are Gypsy, Roma and Traveller Communities and why is it important for Suffolk?**

The Gypsy, Roma, Traveller communities are distinct cultural entities who are at risk of inequalities in health status, service access and health outcomes. English Gypsies and Irish Travellers were recognised under the Race Relations Act 1976 (Matthew 2008) which was superseded by the Equality Act 2010, and were included in the 2011 census as an ethnic minority.

Gypsies and Travellers are defined as:

*Persons of a nomadic habit of life, whatever their race or origin, including such persons who on grounds only of their own or their family’s or dependants’ educational or health needs or old age have ceased to travel temporarily or permanently, and all other persons with a cultural tradition of nomadism and/or caravan dwelling.* (Gypsy and Traveller Strategy 2012).

The definition excludes travelling show people because they are not an ethnic group and “rarely camp illegally”.

Within the collective definition, the distinct groups are:

- English Gypsies (either travelling or on permanent encampments)
- Irish Travellers

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• European Roma Gypsies who are a distinct ethnic and cultural group, with their own language and lifestyles, whose nomadic traditions were made illegal in their countries of origin about 40 years ago.

However, different studies use different terminologies for groups, sometimes using terms generically ("gypsies" to include travellers or "gypsies and travellers" to include all ethnic minority groups with a transient lifestyle whatever their heritage).

The Gypsy, Roma, Traveller community is used to opposition and discrimination. This forms a constant refrain in the literature and in interviews with individuals. They feel different and ostracised and this has an effect on health. This alienation is closely linked to the placement of trailers on unauthorised sites and so the availability of transit and permanent sites is very important and is a health determinant. Successive Government policies have encouraged Gypsies and Travellers to purchase their own land but they still have to apply for planning permission; when they do, permission is often refused (Lane, Spencer and Jones 2014).

There is no national policy on integration for these groups; mainstream policy and legal mechanisms are intended to deliver inclusion. However Lane et al (2014) found that “mainstream polices in the areas of discrimination, accommodation, education, employment and health have consistently failed Gypsies and Travellers in the past”. Lane et al conclude citing an “urgent need for changes in policies in all these areas to address inequalities and promote integration”.

The aims of the Government in respect of Traveller sites are that local planning authorities should make their own assessment of need for the purposes of planning and that local planning authorities, working collaboratively, develop fair and effective strategies to meet need through the identification of land for sites (DCLG 2012). Government policy is that sites should be provided to meet the accommodation needs of Gypsies and Travellers.

This is very much needed, since in 2011, there were 18,383 Gypsy and Traveller caravans in the UK. That figure rose to 18,730 by January 2013. In 2011, there were 6,942 caravans on authorised public sites and 8,332 on authorised privately-owned sites; in 2013, the figure for public sites had barely changed at 6,930 (indeed decreased, albeit only by 12), but there were 9,100 caravans on private sites (an increase of 768). This leaves 2,700 caravans without a designated place to pull off the road.

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2 Since 2006, all local authorities with housing responsibilities have been legally required to conduct Gypsy Traveller accommodation and associated needs assessments (GTANAs)
Inclusion and exclusion criteria

Included in the topic are English (Romany) Gypsies, Irish Travellers and European Roma. The Gypsies and Travellers have been in Britain for about 500 years. The Roma are present in many Central and Eastern European countries, where they have experienced harassment and racial discrimination. Some arrived as refugees in the UK from about 1999. Since 2004, when a large bloc of Eastern European countries was admitted to the European Union, many more have arrived. In the UK, they settle in permanent brick-built accommodation. There are also ‘New’ Travellers or ‘New Age’ Travellers, who started to take to the road about 30 years ago. Most New Travellers are from settled communities, although some children may have been born into a Traveller lifestyle. There is a settlement of New Travellers on a private site in Rendlesham Forest; they are not an ethnic minority, but have chosen a distinct way of life.

This needs assessment does not include New Travellers or travelling showmen and circuses. Terms used here are for English Gypsies (or “gypsies”), Travellers and Roma. “Gypsies and Travellers” is a reference to a combination of the first two of the three groups; comments may be related to either of the two. “Romani” is the language, closely related to Hindi, spoken by the Eastern European Roma, who are believed to have emanated originally from India and spread across central and Eastern European countries. Where other writers have used different terms, or made different combinations (such as Parry), this has been indicated.

A topic for Suffolk

Suffolk is an attractive county for both travelling and non-travelling Gypsies. Currently there is no transit site in the County, so Gypsies moving in this part of the East of England will either pass through Suffolk to transit sites in Essex or Norfolk, or use unauthorised (“roadside”) encampments, this can exacerbate prejudice and discrimination against the Traveller community from local permanent residents. There are a number of permanent sites in Suffolk and a significant Gypsy population.

Health of the Gypsy, Roma and Traveller community

Members of these communities have a life expectancy of less than 90% that of the general population; a recent study stated that the general population to live up to 50% longer than Gypsies and Travellers (DCLG/MWG 2012). However whilst studies show that life expectancy is low across the group, life expectancy can vary within the Gypsy and Traveller
communities.

Parry et al (2004) used the term “Gypsy Travellers” to include “Gypsies, Travellers, Romanies or the Roma people”. Parry studied these as a generic group, making specific empirical comparison between Gypsies and Travellers when necessary. The groups included those who travelled all year round, or were summer, rare or never Travellers. Whether they travelled, were living on permanent sites, or in houses, the need for secure housing is as important to the Gypsy Roma Traveller communities as to others in the wider population. “Poor living conditions are the most influential contributing factors to the poor health status of Gypsies and Travellers, and poor quality or inappropriate accommodation as a result of forced movement inevitably exacerbates existing health conditions as well as leading to new problems” (Lane, Spencer, Jones, 2014). Insecure housing is a recognised health risk particularly to mental health.

Particular health problems which were mentioned in a number of studies and in focus groups were chest pain, chronic cough, bronchi
tis and asthma. The prevalence of anxiety and depression were significantly higher in Gypsy women than Gypsy men, and in both genders they were significantly higher than the wider population (Parry et al 2004) (Table 1). Gypsies and Travellers reporting poorer health status for the last year were significantly more likely to have a long-term illness, health problem or disability, which limited daily activities or work. They also had more difficulty with mobility, self-care, usual activities, pain or discomfort and anxiety or depression as assessed using the EuroQol-5D health utility measure. There was a higher overall prevalence of reported chest pain, respiratory problems, arthritis, miscarriage and death in childhood. No inequality was reported in diabetes, stroke or cancer (Parry 2007).

Where accommodation types and travelling patterns were accounted for, there were significantly higher anxiety symptoms among those living in houses rather than in trailers. Travelling patterns showed a high correlation with health, those travelling rarely reporting long term illness, chronic cough, or depression. But there is no indication whether these conditions prevent travelling, or whether static living has a negative effect on health. In overall terms, the Gypsies and Travellers experienced poorer health compared with other ethnic minority groups and also compared with their white counterparts in deprived inner city

3 ‘if you have somewhere to live all the rest seems to fall into place to be honest, your health gets better.’ Gypsy: England (Lane, Spencer, Jones 2014)
or rural locations, with the exception of self-reporting of long term limiting illness. They also demonstrated much less formal education, larger family size and higher smoking rates.

Table 1 shows differences in health experience between the Gypsy and/or Traveller populations, measured against age- and sex-matched comparators, even after controlling for socio-economic status and other marginalised groups.

**Table 1: Comparisons in health between Gypsy/Travellers and the wider population.**

<table>
<thead>
<tr>
<th></th>
<th>Gypsy /Traveller</th>
<th>General population</th>
<th>Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long term illness</td>
<td>39%</td>
<td>29%</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>22%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>Chest pain</td>
<td>34%</td>
<td>22%</td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>X3 over general population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>X2 over general population</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscarriage/</td>
<td>29%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Maternal death</td>
<td>“Possibly the highest maternal death rates among all ethnic groups”(^4)</td>
<td>During pregnancy or shortly after childbirth.</td>
<td></td>
</tr>
<tr>
<td>Caesarean Section</td>
<td>22%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Life expectancy Female</td>
<td>-12 years</td>
<td>Lower than general population</td>
<td></td>
</tr>
<tr>
<td>Life expectancy Male</td>
<td>-10 years</td>
<td>Lower than general population</td>
<td></td>
</tr>
</tbody>
</table>


All of these studies relate to Gypsies and Travellers. Hagioff and McKee (2000) reviewed published literature on the health of the Roma people, whom they said “originated in northern India and have been known in Europe for nearly a thousand years. For much of that time they have been the subjects of discrimination and oppression”. They found few references, and these focused on communicable disease and reproductive health, suggesting to the authors a greater concern for the populations amongst whom the Roma lived than with the community’s own health. More research was recommended.

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\(^4\) Lewis and Drife (2001). The authors acknowledge the difficulty of establishing ethnicity.
A low level of general education and literacy also affects health, understanding of health-promoting practices, recognition of poor health and symptoms of ill-health and acceptance of the value of medical intervention. Gypsy children are poor attenders at school and may have frequent changes of school when travelling. Racism and anti-social behaviour in the settled community may further alienate Gypsy and Traveller children who rarely attend beyond the age of eleven (Van Cleemput 2009).

Use of health services
Traditionally, gypsies and travellers have pursued their own health care using traditional herbs and treatment methods. Although they now use modern health services more, there are still cultural differences to the approach taken. Although the gypsies we spoke to us that their babies had received all vaccinations, there are many who do not participate in these programmes. Treatment within the community is preferred to outside support. Men are less likely to take up treatment than women (as for the settled population), but women also are slow to attend, preferring to take advice from neighbours than health care professionals. Consultation of these will be sought only when the symptoms are advanced. A stay in hospital is likely to attract large numbers of family members in attendance and especially when there is a death. However these occasions would be rare as “hospitals are seen as polluted, places of death and disease” (Okely, 1983), to be used only as a last resort.

Links to other PHAST health needs assessments in Suffolk
It is possible that health problems experienced by the Roma group are common with asylum seekers and refugees, and with Eastern Europeans, except they often lived in substandard conditions, which contributes to their poorer health, as well as experiencing additional discrimination and harassment having been the only visible minority in their countries of origin. The Roma are different from the other Gypsy /Traveller groups included here, and have their own health experience, lifestyle and culture.

Why this is an important public health problem
Gypsies and Travellers have a long history in the UK but are not integrated. They retain a distinct way of life, culture and relationships, have poor health experience. They are looking for a better way life, integration and an end to racism, discrimination, poverty and social exclusion, but not for assimilation (Lane, Spencer, Jones 2014).

“Gypsies/Travellers have low rates of GP registration, poorer general health and high rates of limiting long term illness, substantially elevated smoking rates, poor birth outcomes and maternal health, and low child immunisation rates and commensurate elevated rates of measles, whooping cough, and other infections” Aspinell (2014).
The health status of the Roma is also poor. They generally do not speak English, adding stress to their life in the UK, are often illiterate in their mother tongue, and in their culture the role of women is to continue to produce children as long as they are able. Amongst the Roma in Ipswich, up to twelve children in a family is not unusual, with the consequent toll on the mother, the costs and a reduced standard of living in the family.

**What is the local picture?**

Romany Gypsies and Irish Travellers were included as ethnic minority groups in the 2011 census for the first time. The census for Suffolk recorded 604 in the joint category. This was 0.1% of the population, the same proportion as in England and Wales. There is a risk of underestimation as members of a frequently targeted ethnic minority group may decline to identify themselves as such.

The Norfolk and Suffolk Gypsy, Roma and Traveller Liaison Service (NSGRTS) is funded by Norfolk and Suffolk County Councils and undertakes welfare assessments on unauthorised encampments. The service estimates there are around 1,500 Gypsies and Travellers living in Suffolk. This is based on 215 pitches across the County, with an average of four people per pitch, approximately 860 people, and increasing by 50% to account for Gypsies and Travellers who now live in brick houses, giving 1,500 people.

The Department of Health does not have a code for Gypsies and Travellers in ethnicity monitoring so they are not identifiable in health datasets.

It is estimated that there are 197,000 Roma migrants in the UK from all countries in Central and Eastern Europe (Brown et al 2013). Roma people in Ipswich generally occupy houses. For some years, there had been 10 to 13 Romanian Roma families living in the Ipswich area. By 2011, there were 56 families, with an average household size of approximately 9.5 persons. However, national research suggests that actual numbers are generally around three times the identified number. These numbers are likely to increase.

In 2015, the Roma community suggested that there are 1000 Romanian Roma and about 100 Bulgarian Roma in Ipswich, which is the centre of habitation for these families in Suffolk. Currently few Gypsies and Travellers pass through the County owing to the limited possibility of stopping. However the District and Borough Councils have a duty to provide temporary encampments locations for Travellers to avoid unauthorised roadside stopping. Suffolk Travellers currently stop in Thetford Forest, Norfolk. Lack of places to stop, poor conditions...
on sites, anxiety and fear of being moved on, adverse reaction by local people to
unauthorised parking and allied racism and hate crimes by neighbours are all health risk
factors.

The health of Gypsies and Travellers is notoriously poor. Those over the age of 50 are
considered elderly.

Many factors feed into the communities’ poor health. Studies indicate high infant mortality
and perinatal death rates, low birth weight, low immunisation uptake and high child accident
rates. In adults there is late consultation on health issues, poor food and exercise, little
education, for women many pregnancies and for men a rough outdoor life. The communities
also have health beliefs not allied to the scientific base of the health services. They are
fiercely independent and unlikely to attend for screening; cancer is a taboo subject which
gives rise to fear and fatalism. When medical advice is sought, the visit will be postponed as
long as possible. There is also a lack of divulgence between men and women. The belief is
that medical services have nothing to offer and are not to be trusted. Gypsies and Travellers
would consult family and friends of the same sex before health professionals.

The community approach means that if a Gypsy or Traveller is seriously ill and needs
hospitalisation and especially if death is approaching, the whole extended family wishes to
remain with the person. This can be difficult to accommodate in a hospital, although locally
stories were told of NHS staff working hard to arrange for family members to remain with the
patient.

**What is the evidence base for interventions? What is best practice?**
The Gypsy Roma Traveller communities can benefit from best practice interventions which
are available to the whole population. However the minority groups often benefit less as they
have limited access. This has been recognised at Government level in the “Tackling
Inequalities” literature which cites the aim “to improve the health of the poorest fastest”
(PHOF, 2013, Marmot 2013).

There are Government commitments to:

- reduce barriers and increase accessibility of services, specifically to the Gypsy Roma
  Traveller population (DCLG, MWG 2012)
- question the insistence of GPs for proof of identity and of a permanent address
- support health and wellbeing boards to ensure Joint Strategic Needs Assessments
  reflect the needs of Gypsies and Travellers with the worst health outcomes

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on behalf of Suffolk County Council.
• work with other institutions to include the needs of Gypsies and Travellers in the commissioning of health services, by
  o lowering mortality and increasing immunisation rates
  o identifying gaps in data and research, and
  o seeking specific interventions that produce positive health outcomes for this group.

This is a major national policy development increasing the visibility and the importance of Gypsies and Travellers and their health needs.

Best practice recommended by the Royal College of General Practitioners (Gill et al 2013) includes:

• “Outreach: helps to establish a connection to local communities, in order to build the initial relationship and raise awareness among Travellers on the range of services available.

• Mobile units and clinics: whilst bringing services directly to sites might be a way to establish some rapport, it does not ultimately help integration in mainstream services. Community building and health education are positive alternatives.

• Patient access: due to the high mobility of these patients, accessible records and interoperability of care records software will be of great benefit to the continuity of care.

• Peer-education: is a valuable means to get access to strong communities. Gaining the trust of community leaders and role models can be very beneficial to reach out to the wider group, and gradually challenge some health beliefs and behaviours.”

The Faculty for Homeless and Inclusion Health (2013) emphasise that Gypsies and Travellers who are now living in settled housing do not cease to be Gypsies or Travellers and in either situation they have a legal right to access NHS and social care services. Best practice also includes care of where the Gypsies and Travellers will live since if there are insufficient sites, they “may find themselves living in irregular locations, (for instance, under motorways or next to sewage works) so they may face unusual hazards for example, lack of sewage disposal and limited access to water”. If they are not literate, information about treatment and appointments may need to be explained. Finally, because of the high level of unmet need, fast-tracking to preventive services should be considered. The Faculty also recommends peer or community health promotion workers.
A good example of a peer intervention is the recent Suffolk production of *The Wheel of Life* (Bowers 2015), a DVD produced in both English and Romani of health experiences of Gypsies and Travellers, and interviews with local NHS staff – a GP, psychologist, cancer consultant, and midwife among others – speaking about how they can help. For each speaker, a phone number is spoken and shown on the screen. This DVD circumvents poor literacy, is of high quality, interspersed throughout with interviews of high profile members of the community recommending the services. It was made by a Gypsy journalist and filmmaker supported by Community Development Workers from Voiceability, part of Suffolk Wellbeing Service with lottery funding.

**What is the pattern of services in Suffolk at present?**

**Community care: Gypsies and Travellers**

The Norfolk and Suffolk Gypsy Roma Traveller Service (NSGRT) works with partners to help Gypsies and Travellers to get the help and advice they need for good health. In the Gypsy population there is a clear division of labour. Men and boys do outdoor work, dealing in scrap metal or laying tarmac for drives or felling trees, work not so easily available in the modern economy, while women and girls work in the trailer. The women interviewed for this needs assessment were independent, often with the partner elsewhere, so to an extent living their lives as single mothers although with female ‘significant others’ in the community.

Support workers have spent a number of years getting to know the communities, building trust, supporting wherever possible and providing links to statutory services. These support workers also liaise closely with The Health Outreach Team for marginalised and vulnerable adults.

Outreach and preventive work is provided by The Health Outreach Team which works at all stages of the prevention, treatment and care pathway, with a prime purpose of providing treatment, information and advice on health related issues and facilitating access to GPs and other mainstream health and social services. There is more information on The Health Outreach Team in the Homelessness Needs Assessment.

The Health Outreach Team can also act in an intermediary role, of which evidence was seen in the case of a seriously ill Gypsy child whose consultant and GP had recommended should be rehoused as her condition worsened, but for whom housing was not available. The case was complicated but, for relationships to improve between the community and the statutory authorities, the community need to know that they are heard and that due attention is given
to their needs as they define them. In this instance they were sure that refusal was based on their cultural background. The Health Outreach was the only organisation able to intervene. This is an example of the need for different services to work in closer collaboration towards mutually defined and agreed evidence-driven measurable ends, as knowledge about this child was only shared as a result of interviews for this needs assessment.

Collaboration is also needed in West Meadows where fly tipping is an issue. It is uncertain who is responsible, but site members are certain it includes those from the settled community (non-gypsies). Fly tipping encourages the breeding of rats such that one young mother was fearful to let her child play outside the trailer. The heap had been cleared but was restarted the next day. Managers of the site continue to try and resolve this ongoing concern.

**Community care: Roma**

The Health Outreach Team has few set clinics. It offers a “low threshold open access service”: when people arrive, they are seen. Any who did not fit the acceptance criteria would be unlikely to attend The Health Outreach Team; if any did, they would be re-directed. Many of the specific groups and clinics are not generally advertised but are focussed on those target populations.

This is the case for the Roma population. There are two clinic half days, one mixed and one for women, when an interpreter is present. She is a member of the Roma community who has been resident in the UK for about 12 years and has very good understanding of the language, the nature and structure of services, and of the people who use The Health Outreach. The clinics are staffed by health, social workers and support staff and deal with any issue the women bring.

The needs of the Roma women are great. The men may be in basic work, gathering and selling scrap metal for example, and the families are large. Management and decision-making seems to rest on the women. For newly arrived immigrants with no understanding of English and often no literacy skills in their own language, it is challenging to negotiate the education, health, welfare, financial and other systems.

A shortage of social housing may force members of these communities into expensive private rented accommodation, although migrants from the European Economic Area (EEA) are unlikely to be eligible for social housing, even if it was available. Irish Travellers who cease to travel are documented as having worse health experience compared with the rest
of the community. Does this effect occur also with the Roma people? A Scottish Traveller was quoted: “I am from a travelling background and I get very ill when I am static and I really would prefer to be in a caravan with other people of my ethnicity around”. For Roma people, this effect is multiplied as Roma families from Eastern Europe were forcibly prevented from travelling by having the wheels taken off their vans and being required to settle, in the 1970s. In view of the life expectancy of Roma people, this happened a generation ago.

The Health Outreach has also identified a number of clients with learning disabilities and specifically in the Roma community, a growing number of genetic conditions which also present with a learning disability.

The Health Outreach Team carries out health checks on those aged over forty years and this has been useful, yielding broader benefits over those provided in the general population and indicating where additional help may be needed. With anticipated additional numbers of Roma families moving into the area, demand is set to grow.

A report on one afternoon at the women’s clinic is included in the Appendix A.

**Primary care: Gypsies and Travellers**

For primary care, the Gypsies and Travellers use a single GP practice which is effective in providing for their needs as relationship and trust has grown. The West Meadow site is permanent, with a few spare pitches for people to pull off the road but this may be only when others are away. A report of conversations with the residents detailing compliance with vaccinations, antenatal care and health visiting services is included in Appendix A. Most of the residents smoked, did not use a dentist and had many children. Very young mothers (<19 years) are visited fortnightly by the Family Nurse Partnership during pregnancy and until the child is two years when the health visiting service takes over. The relationship is valued and improves antenatal and child health, and the life-course of the mother, helping with planning the next pregnancy, returning to education and finding employment. However in this matriarchal society the gypsy mothers who gave interviews smoked in pregnancy, were wary of immunisations and vaccinations and lacked the security of a constant male partner.
Primary care: Roma

Roma women are supported in GP registration by The Health Outreach. If double appointments are made, the GPs will use language line for translation; sometimes they ask patients to bring a family member for translation or ask The Health Outreach to provide help.

Secondary care: Gypsies and Travellers

Secondary care is provided as for the general population. It is not possible to track use of health services by this group as the NHS has no codes for Gypsies and Travellers. Even if it had, not all would divulge this owing to negative experiences of discrimination. Health beliefs of the communities affected the use of NHS secondary care. If a gypsy is hospitalised the wish to be present all the time, especially if death is imminent can be difficult for hospital services that are concerned about infection control and want to limit the number of visitors to a bed. However one Gypsy matriarch reported how understanding a hospital had been in allowing constant presence in a recent case.

The commitment to mobility and travelling seems to be a positive health benefit to this community. However, where there are insufficient transit sites they are liable to be moved on, generally an unpleasant experience to both travellers and the settled people around them. In that situation, they also have little opportunity of a consistent relationship with a GP, or opportunity to be followed up for medical investigations, or for antenatal care. The literature demonstrates many instances of healthcare being disrupted by the need to travel either by eviction or as a desire and need on the part of the community5.

Secondary care: Roma

Secondary Care for Roma patients is not freely available but is as per overseas visitor charging regulations 2015.

What additional information is needed?

- Further information should be sought on availability of primary care services willing and able to serve this community as demand is high, and is increasing. One GP commented, “I would like to see the service work with these communities to encourage English lessons and integration lessons”. This will also apply as it is understood that Suffolk County Council will be consulting on the need for transit sites for the Traveller population passing through Suffolk. However, ESOL provision in Suffolk is diminishing.

5 'My aunt missed an important appointment about a kidney operation because she had to move before it was sorted' (Lane, Spencer Jones 2014)
The Norfolk and Suffolk Gypsy, Roma and Traveller Liaison Service (NSGRTS), working closely with The Health Outreach, provides a valuable link with the communities through their liaison role, the “trusted friend”. A review of the wider network of services including Suffolk Wellbeing Service and VoiceAbility would identify the strength and consistency of the health messages and how these link to strategic public health targets.

Recommendations elsewhere (Homelessness Needs Assessment) have been made on data collection by The Health Outreach.

Are accessible records available so Travellers can continue to receive care? This would be for health immunisations and vaccinations and maternity care, but also for example, drug lists for people with diabetes or other long-term conditions who may need to ask for prescriptions elsewhere whilst travelling. Many travel in the summer, and for the horse fairs.

The desire of one GP to supply information to this needs assessment suggests that an audit of GP input to these communities should be carried out to see how primary care can be supported, and other GPs encouraged to offer services to Gypsies, Roma, and Travellers. Again this is an area where The Health Outreach has been instrumental in developing relations with, and supporting primary care for the benefit of marginalised adults.

Further research may be needed on why there are poor maternal and infant health outcomes in this community.

What can be concluded?

The needs of the Gypsies and Travellers are different from those of the Roma. The latter are new migrants who have suffered discrimination, racism and rejection in the Eastern European countries from which they have come, with all the needs of people moving into a new community but with the additional culture of their Roma heritage. The former have a history of British discrimination and alienation behind them.

The most pressing health need of this group is to develop trust with the settled community and with health service providers. GPs and health visitors who were perceived to be culturally well-informed and sympathetic were highly valued. But instances were also cited where trust was threatened, for example where a child who needed rehousing and the family thought the denial, in the face of representation from hospital and GP, was because they were Gypsies. Similarly there was evidence of a serious rat infestation at a Gypsy site which was subject
to fly tipping. This had been cleared but immediately more rubbish was left. So the problem was seen as intractable and the children could not play outside the trailer because of the rats. Gypsies needed to know they had the support of the authorities as much as the settled community.

- Health determinants of secure housing, education, strong relationships, lack of discrimination, and availability of good food, exercise and avoidance of smoking are as important to the Gypsy Roma Traveller communities as to the general population.
- The Family Nurse Partnership was very much appreciated with potential to contribute to the Marmot indicator of every child getting a good start in life.
- The Norfolk and Suffolk Gypsy, Roma and Traveller Liaison Service, the first line of communication, and The Health Outreach work well on the front line with the communities.
- On peer education Suffolk has taken a lead with the production of the DVD, *The Wheel of Life*. This was a great example, the idea of the community, produced within the community, and indicating links to health services with community members discussing how their own needs had been met.
- Best practice indicated that Health and Wellbeing Boards should ensure that the needs of Gypsies and Travellers with the worst health outcomes are better reflected in needs assessments and joint health and wellbeing strategies. There is evidence of this working well in Suffolk but should develop with the increasing size of the populations.

**References**


This needs assessment was prepared in July 2015 by the Public Health Action Support Team on behalf of Suffolk County Council.
Research Initiative Project 121/7500. Sheffield: University of Sheffield.  
https://www.sheffield.ac.uk/scharr/research/publications/travellers  Last accessed 10/06/15  
West Meadows Traveller site. Accompanied by a support worker from NSGRTS

1. **Female aged 19**
   - Not originally Gypsy but has a partner who is. She is 21 years, with a child of 15 months and a second due in 3 months. She is permanent at West Meadows and will not travel.
   - Registered with GP at Chesterfield surgery.
   - All immunisations and vaccinations complete
   - No need of GP or hospital – generally well, only for pregnancies.
   - Is visited by the Family Nurse Partnership fortnightly which gives extra support to teenage mothers.
   - The community midwife also visits and sees her in the trailer.
   - She does not see a dentist, not does her child.
   - She smokes and has thought about giving up but finds she needs a cigarette to calm her down.
   - Her health concern is the rats on the site. The children cannot go out to play. There is a huge amount of rubbish and the site is subject to fly-tipping. It has been cleared but it reappears, so there is no possibility of getting the rats cleared.

2. **Female aged is 21, part Irish traveller and part English Gypsy, but considers herself Irish traveller.**
   - She has moved round, about every two years. But sees herself as being settled at West Meadows. She has a child of three and is pregnant with twins. She has never visited a dentist nor has her child. The HV visits the child and the midwife also visits at home.

3. **Female a Romany Gypsy age 37**
   - Has 7 boys
   - Registered with the GP at Chesterfield
   - Is a summer traveller.
   - She goes round visiting sites where her boys might live when they take a wife.
• Her 11 year old is still at school – unusual for children at the site. She says they are home tutored. The boys take an apprenticeship with their older brothers, in tree work etc.

• The girls do not go to school – they are home schooled in washing, cooking, care of the van etc. – training for Gypsy womanhood.

• Men do not seek medical help until it is very urgent.

• Women will be accompanied to hospital by other women.

• They do have dental care.

4. *Husband, wife and adult daughter (who has a 4 year old girl)*

• It is ten years since this couple travelled. They now have some stability and comfort but feel it has come at a very high price. They are grandparents and share the trailer with their daughter and her family with two children.

• The man has arthritis and depression and anxiety and is forgetful. His wife cares for him. He is concerned not to let the community know about his mental state. He has received advice and care through the wellbeing service and NSFT.

• The granddaughter has a serious kidney complaint which is worsening. They have been advised that she should be living in a house for management of the frequent infections and warmth. They have to leave the van for frequent visits to the toilet in a separate building and this includes night visits and in winter. The child tries not to go which also worsens the condition. Many representations to the housing department on the part of medical professionals has brought no result and the appeals have been continuing for a long time. This was referred to the MVA to see if they could help.

• The opinion was expressed that no help was forthcoming as the child is in the Gypsy community. This was a strongly held belief.
Roma women. Accompanied by an interpreter who works with The Health Outreach.
Interviews at Health Outreach Project 20/05/15

The Clinic
This was a clinic run at the Health Outreach, St Helen’s Street (MVA), for Roma women. The clinic was extremely busy, with 15 – 20 clients and many children waiting when I arrived. The clinic was staffed by a social worker and an education engagement officer, but clinical staff were also available in the building if there were physical or mental health queries. Probably the main attraction of the clinic was the Roma interpreter who has lived in the UK for many years.

Social care
A number of the queries concerned obtaining school places for children. The interpreter stated that Roma women continue to have children “until their bodies pack up”, and a number of the queries I witnessed concerned families with between 6 and 12 children. Through the interpreter one woman with 12 children described her very small accommodation. Another who had seven of her own children, was seeking school places for an additional four boys whom she had adopted as a result of family tragedy. It was explained that she needed to provide passports, and proof of adoption and of the presence of the children in the UK. In seeking school places families naturally wanted the children together. Places in two different schools had been offered to one mother, the schools in different directions from her home. Opposite her home was another school but that had no places at all. She was advised to accept the place for the older child, then wait for a place to become available in the same school for the younger child. She was concerned about being in trouble for not sending the younger one to school but was assured that as long as the school engagement officer was dealing with it, there would be no problem.

The women were generally illiterate so they received letters at home and had to attend the clinic to find out what they were about. The interpreter was teaching them to recognise logos, for the Borough Council, the NHS, and the Department of Work and Pensions so they would know where the letter had come from.

One woman was proud of her children’s grasp of English and she had been helped to get into an English for Speakers of Other Languages (ESOL) class. She brought a Council Tax bill in arrears of some thousands of pounds. She was advised how to pace the payments to
avoid further measures against her. Another had a claim for payment of health charges which required information relating to her husband’s self-employed scrap metal business. The interpreter herself was able to deal with most of these queries as she was experienced by her attendance at the clinic.

**Accessing health services**

There was evidence of poor understanding of how to deal with services. A woman arrived when the waiting area was very full but she just wanted her blood pressure to be checked. She was not willing to wait. The interpreter spent quite a few minutes explaining to her the need to take her turn, but the conversation was prolonged as the woman argued. The interpreter afterwards explained that it is the same in Romania; people do not want to wait to be seen.

Another woman had attended as requested, for a cervical smear at the GP surgery. She arrived and sat in the waiting room but she had not booked in and so was not called and missed the appointment. Again, although she had got herself that far, she did not understand that she needed to let the receptionist know that she was there. For another woman who appeared quite unwell, an appointment was made the following day for her to attend her GP.

Most are now registered with the GP and can use language line at appointments (a double appointment is needed when booking). But getting registered is difficult as they have no English, and a member of the MVA staff must accompany them to the surgery to make the registration. After that language line is available. GPs often ask other organisations to provide the interpreter or ask the patient to bring someone with them. If this is their children it is inappropriate and would be quite unacceptable to the women.

The obverse problems occur once the Roma people start to trust and then may become dependent on services put in place to help them to become independent.

It was acknowledged that there is a higher prevalence of hepatitis B and tuberculosis.

The view of the Interpreter – culture of the Roma.

Following the clinic which ran over time by about two hours, the interpreter explained the situation for these families. They derived originally from India but had experienced discrimination in the Eastern European countries from which they now came. As Roma
gypsies they had always travelled. There was no contraception and having children was the sole aim of the women. They had come with many years of neglect of their health. Minor problems would be managed within the community; big fears included cancer. The women are very private in health matters; if they are ill they would go to the doctor but not tell their husband or children. In the UK they accept vaccination for babies and children but would not have done in Romania. Illness was generally dealt with only when it was a last minute emergency. In Romania they would buy antibiotics over the counter and self-medicate, or share round a medication which had helped one person and so was recommended for all. They would not follow through in taking medication if they felt better. Even in the UK some do not attend for antenatal care. An example was given of a pregnant woman working in agriculture for 12 hours a day and would have been unable to attend any sort of medical appointment.

About 90% of the women were illiterate. Before they came to the UK, boys would achieve maybe 3 – 4 years education; girls would not go to school but be trained in doing what their mothers did in running the house and family.