Worldwide there are more than 100 groups of Gypsies and Travellers who collectively form part of a wider Romani population, estimated at 12 million people. The Gypsies and Travellers in this study comprise English and Welsh Gypsies, Irish Travellers and Scottish Gypsy Travellers. English and Welsh Gypsies and Irish Travellers form an estimated population of 300,000 in England and Wales. Nomadism and caravan (trailer) dwelling, although not defining them, are features of their cultural heritage rather than a lifestyle choice; many live in houses and others live on authorised or non-authorised residential caravan sites. They are among the UK’s most socially excluded groups despite legal protection as a result of their ethnic minority status.

There are many previous studies of health meanings, values and practices among different cultural groups, and studies concerning beliefs and views about specific health problems. However, there seem to be little information concerning general views and perceptions of health and influences on the health of Gypsies and Travellers.

This was not a comparative or theoretically informed study, but a descriptive qualitative strand of an applied policy mixed methods study designed to estimate the current health status of Gypsies and Travellers. The key finding from the health methods study designed to estimate the current health status of Gypsies and Travellers was that an estimated population of 300,000 in England and Wales. Nomadism and caravan (trailer) dwelling, although not defining them, are features of their cultural heritage rather than a lifestyle choice; many live in houses and others live on authorised or non-authorised residential caravan sites. They are among the UK’s most socially excluded groups despite legal protection as a result of their ethnic minority status.

METHODS

Participants and setting

The sampling frame comprised 269 Gypsies and Travellers participating in a parallel study of their health status conducted at five English locations: the survey sample was itself constructed to include quotas of men and women, Irish and British, across roadside, official, private and housed accommodation. Within this frame, anyone who reported a recent or current health problem and therefore had cause to access health services was eligible for inclusion in the qualitative study (ie, intensity sampling). Maximum variation purposive sampling was also used across the study localities to ensure a representative final sample (table 1). A variety of health problems or unidentified symptoms were reported among the final sample (appendix A). Interviews were distributed over a 12-month period to capture any seasonal variation in mood and health states.

Research governance approval (including multicentre research ethics committee ethical review) was obtained with secondary approval from primary care trusts and local research ethics committees in each location where health visitors worked.

Interviews

Data were collected by individual in-depth semistructured interviews with participants in their own homes or at a venue of their choice. The interviews were carried out within 2–3 weeks of completion of the Health Survey Questionnaire. A topic guide was developed from five sources: personal practitioner experience; previous pilot study; other published evidence; advice from the project advisory team, which included Gypsy Travellers; and initial pilot interviews. Non-directive interview questions allowed the exploration of
standing was developed using the framework method. This is
sation and retrieval of data. A thematically organised under-
Scientific Software Development, Berlin) was used for organi-
tment.
areas and describes the four major emergent themes relating
health experience, access and use of health services, approaches to preventive healthcare, health knowledge, effect of lifestyle on health and health beliefs. The interviews were long and detailed; this paper focuses on the last two topic
of each stage was also reviewed by the third author (KT).

To test our interpretation of the data and to check for
they were not selected by health status. A total of 55 attended
results varied as intended across the specified range of personal
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illness, this group referred directly to the effect of a travelling
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experienced as a result of the limited accommodation options
open to Gypsies and Travellers. These issues were often described in terms of perceived benefits and disadvantages of the travelling lifestyle.

Participants perceived many health-related benefits from
the travelling way” including freedom, choice and ability to
live among extended family. Often the first benefit mentioned
was “fresh air” associated with being outdoors, with strong
regret expressed at the loss of this perceived benefit if a move to
housing was deemed necessary.

A focus on accommodation difficulties and the threat to the
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“The travelling way … I don’t know what it is, but it never leaves you, never leaves you, no.”

Only one participant referred to the economic necessity of travelling.

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Box 1 The travelling way

“I was happy if I was in a caravan … freedom and all that … you know, fresh air. I’m used to plenty of fresh air.” (M5)

“It used to be different because maybe you’d get two or three weeks in one place and you’d be with all different families and just nice … I find it terrible, you miss out, and you miss it. You miss it for the children as well because the children really enjoy it, they like meeting all different people and living in all different places.” (F13)

“So in other words you just couldn’t stop anywhere, making you go out of the area. How can I go out of the area? If I go up that motorway and something happens to my wife, what am I going to do, stuck in the middle of the motorway? I don’t know … if you were ill you wouldn’t want the police to come and say right, ‘you’ve got to move out of your house,’ That’s what they’re basically saying to you you’ve got to get back in the motor and drive. Don’t stay in our area because we’re going to come and move you again.” (M4)

“I blame moving there caused my health … I mean it’s a health hazard down there … that’s when my health started to go wrong. See I’m right against the motorway, then the tip and then the sewerage.” (F2)

“The house is like toilets, baths, warmth, comfort that I didn’t have in the caravan. I could handle the caravan before I was sick but there when I got unwell I couldn’t, it was just getting too much for me … because you’d have to move every day basically. Police would move you on … so that weren’t helping, not at all … I wish I had my health back because I imagine I wouldn’t be here. I don’t know (sighs). It’s just the way you’re reared up isn’t it.” (F1)

“We had a house in X, but we couldn’t live in it … the people on the housing estate, they were hurting the kids and one thing and another. They were big women fighting me 11-year-old daughter… and when the kids were going to school and getting bullied ‘you’re only Gypsies’ and all the names under the sun.” (F6)

Perceived benefits of a travelling lifestyle also included proximity to extended family members in an otherwise hostile “world”. This was felt to be important, both psychologically and in terms of practical support and security. Travelling also allowed the possibility of moving away from potential trouble. Some participants described how they had returned to living in a trailer in order to escape hostility or victimisation from housed neighbours.

However, those trying to maintain a travelling lifestyle also described negative effects. Travelling was seen as potentially hazardous because of the diminishing choice of safe stopping places. Lack of basic amenities, such as running water, on unauthorised camping sites or poorly serviced transit sites, and difficulties in accessing services such as education and healthcare were other perceived disadvantages that sometimes precipitated a decision to seek a settled base. Health-related concerns about the conditions on official rented sites and the surrounding environment were also commonly reported. In addition to health risks from hazardous environments, psychological effects were also described, such as a feeling of “imprisonment” on a rented site related to the loss of freedom to travel.

For some participants, current poor health had precipitated a move into housing, although many felt coerced into this decision by additional circumstances, particularly the stress arising from being forcibly moved on from unofficial sites.

Elderly participants suggested that the wet and damp endured during years of living on the road in all weathers had had a detrimental effect on their health, with many blaming these conditions for their arthritis and chest complaints. Although health reasons were commonly cited for a move into housing, the psychological effect and “culture shock” of giving up a travelling lifestyle was perceived to counteract this benefit.

Among all age groups, a valued travelling lifestyle that was possible in the past was seen as increasingly denied and unattainable. Current adverse conditions, such as a lack of choice in accommodation and often intolerable conditions on existing sites, were described not only in terms of their direct effect but just as forcibly as an indication of the negative way in which society views Travellers and the travelling lifestyle. A perceived policy of social assimilation via accommodation and education was seen by many as a threat to their culture and identity as Gypsies and Travellers:

“We haven’t asked anybody to change their ways. Do you know what I mean? Why should they ask us to change ours? See what I’m saying. And that’s what the government’s trying to do. They’re trying to make you change your ways.” (M4)

Low expectations of health

An acceptance and expectation of ill health was pervasive, and some participants gave a long list of complaints suffered without considering themselves to be particularly unhealthy as a result. Many described their state of health, irrespective of its severity or extent, in terms of restrictions on their ability to perform daily tasks, and appeared to accept chronic ill health as long as day-to-day management of symptoms could be readily achieved.

The apparent acceptance of ill health and associated symptoms is consistent with an inverse relationship of access to healthcare in relation to need, although a lack of knowledge and understanding about the relevance of some symptoms was also evident. The inability to obtain relief for unmanageable symptoms was described, as was resignation and low expectations of improvement. Many Gypsies and Travellers who came to the presentations of the preliminary health survey findings were genuinely amazed that their overall state of health compared so unfavourably to other matched groups.

Self-reliance and staying in control

Stoicism and self-reliance were specific beliefs that were described as intrinsic for Gypsies and Travellers, arising from their experience of adversity and portrayed as necessary for survival. They were associated with the understatement of chronic ill health, commonly expressed as being tough and not admitting or succumbing to minor health complaints. Men in particular appeared to dismiss such complaints as insignificant.

Despite the fact that individuals took pride in self-reliance and in not “putting each other out” unless really necessary, most spoke of their responsibility to share care for their sick or elderly parents and extended family members. The idea of a relative going into a care home was particularly deplored.
“I don’t feel top twenty like, but I feel fine.” (Man with breathing, digestive and kidney problems, headaches and hypertension—M2)

“I don’t think it’s nothing too major … I haven’t had it forever, I think it’s this last four or five months.” (21-year-old man who coughed persistently through the interview—M2)

“I suffers with asthma and I had, must be getting on two years ago, I had about like, four or five mini strokes. Well I just took me tablets now for it [frozen shoulder] and that so I got tablets really to control that…arthritis, I got that and …. Like I can’t um, like … I can bounce about the place and just dust and do what I can reach and that, but there’s like, clean windows, can’t do anything like that … so I still got this stuff … when I starts walking and I finds I’m getting a little pain or a bit breathless, I just takes that. So I’m very happy …” (Woman with angina, frozen shoulder, arthritis, asthma and several “mini strokes”—F17)

“My health is perfect, lovely … I only have a bad back all the time — that’s since I was 15.” (Woman with chronic back complaint, a history of severe allergies and skin complaint—F5)

“I get tired, moody, restless but that’s, I’ve been like that most of my life but it’s got worse now. … I don’t know. But apart from that, not too bad really, but like I say I used to have stacks of energy. I’d clean and do and clean and do all the time but I can’t be bothered now. It’s. If I have a good day today … then tomorrow I just haven’t got the strength to do it… I think just you feel run down all the time.” (Woman with symptoms but apparent acceptance of depression—F9)

“I don’t bother with it [offered investigation for coeliac disease]. No I don’t bother with it that much, but I’d a very bad colour I’d be anaemic. It’s partly over that. I has um iron injections most of the times. But then it drops back down again you see… there’s not much they can do is there, just keep giving me the injections and bring it back up.” (Woman with a history of childhood coeliac disease and severe anaemia—F13)

Self-reliance was also associated with a strong need to retain control, with high levels of stress arising from any inability to do so. One of the hardships often described by the respondents in this study was the lack of perceived control over their destiny, in the light of policies that were felt to restrict their self-determination and authorities that exclude them in various ways. The impotence felt by such unequal power relationships results in despair for some respondents, whereas others resisted domination and fought hard to achieve as much control as possible.

A strong sense was expressed of living within a society that is hostile, and has been for many generations, which seemed to reinforce the belief that they should be wary, and slow to invest their trust in outsiders, until convinced otherwise. A lack of trust in others, with resulting low expectations, was sometimes manifested as stoicism and increased self-reliance.

Fatalism, fear of death, avoidance

While participants often expressed fatalism with regard to health problems, there was no evidence of any acceptance of life-threatening diagnoses or the experience of dying.

Fears around death and dying were strongly associated with a dread of a diagnosis of cancer, which was seen as an inevitable “death sentence”, and this seemed to be confirmed by experience for most respondents. People therefore avoided any possibility of hearing that diagnosis. The fatalistic attitude that “nothing can be done” for cancer was frequently described, which in turn is likely to increase the chances of a terminal prognosis.

This finding, of an exceptionally strong and specific aversion to discussing cancer, was reinforced at one of our respondent validation sessions. There was a marked reduction of participation when cancer was mentioned; a lively and talkative group suddenly became uneasily silent, and showed little desire for discussing this aspect of the findings in a large forum.

Bereavement was also deeply feared and the intensity of grief related to bereavement described was severe and prolonged in all cases, with several stories of relatives “never getting over the
death”. The prolonged and extreme grief reactions described might appear surprising in the light of the close and supportive extended family that rally round when someone has died. However, there are several aspects to family involvement that appeared to give conflicting benefits. Close family members will ensure that the bereaved relatives are never left alone after the death. This would seem to be particularly important for Gypsy and Traveller families, as it would be so unusual in their experience to have ever been alone, and it adds further to the acute sense of loss experienced when a death occurs. Family members therefore experienced added grief on witnessing the grief of close relatives.

The grief of bereavement was perceived as a cause of illness and often as an indirect cause of death. Certain strategies people used to try to cope with bereavement and depression were recognised as an added cause of ill health, most notably, substance and alcohol misuse.

**DISCUSSION**

This study was limited by practical difficulties in accessing and interviewing members of this marginalised minority group. This particular subgroup was purposely selected as a group with health problems, and therefore the emergent themes from analysis of the individual interviews would not necessarily be applicable to all Gypsies and Travellers. However, these themes were presented to groups of Gypsies and Travellers, who endorsed them, recognised them as meaningful and amplified them. Consultations with stakeholders on the advisory group endorsed them, recognised them as meaningful and amplified them in the health status survey. Ill health was imposed by a hostile and racist society.

**What is already known on this topic**

- Our survey of health status (see companion paper) showed an excess burden of ill health among Gypsies and Travellers in England.
- Ill health among Gypsies and Travellers exceeds that seen in other ethnic minorities and socially disadvantaged groups.
- Socioeconomic position and cultural beliefs influence health and health-seeking behaviour.

**What this study adds**

- Coherent cultural beliefs and attitudes underpin health-related behaviours among Gypsies and Travellers, combining low expectations, normalisation of ill health, stoicism, fatalism, ignorance and fear.
- Adverse social experiences and distressing perceptions of hostility and racism are also pervasively linked to ill health by respondents.
- Culturally appropriate and sensitive services are required to improve the health experience of Gypsies and Travellers.

To the distress that these cause in terms of their social meanings. For example, considerable distress was linked to the feeling of being “confined” and the erosion of freedom on a site, and isolation from extended family and the wider Gypsy Traveller culture arising from house dwelling. Great distress was reported from the perception that these hardships are imposed by a hostile and racist society.

There was an overriding perception of negative social attitudes and social exclusion as damaging to health, particularly mental health, but equal dismay at the prospect of social assimilation. These findings replicate those reported in an Irish study of

**Policy implications**

- We expect improvements in the policy response to the needs of this neglected minority in the light of these findings. Those responsible for public health policy and planning cannot assume that the health needs of Gypsies and Travellers are met by existing policy in relation to other ethnic minorities and socially disadvantaged groups.
- Strong ethnic identity and coherent cultural beliefs and attitudes underpin health-related behaviour in this group, and health experiences need to be understood in this context, alongside the specific effect of social and economic hardship and social exclusion.
- Health data are important in monitoring health and evaluating the effects of health interventions, and Gypsies and Travellers should be included in routine ethnic monitoring.
- The provision of effective healthcare and improvement of poor health in Gypsies and Travellers requires multi-agency awareness and joint working to deal with the negative effects of both adverse social experiences and attitudinal barriers to health.
Traveller health, the only other study that links epidemiological and qualitative findings. Although this qualitative study is unable to show causes of ill health among participants, the effect of both social adversity and personal health beliefs (such as “fatalism”) on health outcomes is well evidenced—for example, in chronic diseases such as asthma, diabetes and in mental illness. The link between health outcomes and the perception of both social adversity and personal health beliefs (such as inability to show causes of ill health among participants, the effect of initial symptoms, making it easier to tolerate conditions if symptoms are manageable. The combination of a lack of knowledge, low expectations and fear reduces the likelihood of seeking early treatment, particularly for those conditions (e.g., cancer and heart disease) where early detection has the greatest effect on prognosis.

Studies of health attitudes of other disadvantaged or disempowered groups, such as working class women and ethnic minorities, have also found a functional concept of health, fatalism and stoicism.

However, these features do not account for all our findings, and others must be attributed to the particular culture of Gypsies and Travellers and associated adverse social experiences. The evidence in this study, showing the particular beliefs and circumstances that Gypsies and Travellers relate to their health experience, need to be taken account of and understood in the design of services aimed at improving their health.

APPENDIX A

REFERENCES


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APPENDIX A

SELF-REPORTED HEALTH PROBLEMS OF THE INTERVIEWEES

Mental health problems
Depression, anxiety, schizophrenia, “nervous disability” attributed to drug misuse

Chronic physical problems
Arthritis, hypertension, diabetes, angina, asthma, chronic back pain, chronic cough, anaemia and coeliac disease, diverticulitis, gastric ulcer, mild stroke

Less well-defined problems
Pregnancy with complications, “bladder problems”, postoperative complications after bowel surgery, “kidney problems”, chronic disability from connective tissue disease, investigations for cancer

Problems associated with trauma
Fractured vertebrae after a road traffic accident, laceration trauma to the leg

Problems related to caring for close relatives with serious health problems
Child with cerebral palsy, child with congenital syndrome
Health-related beliefs and experiences of Gypsies and Travellers: a qualitative study

Patrice Van Cleemput, Glenys Parry, Kate Thomas, Jean Peters and Cindy Cooper

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