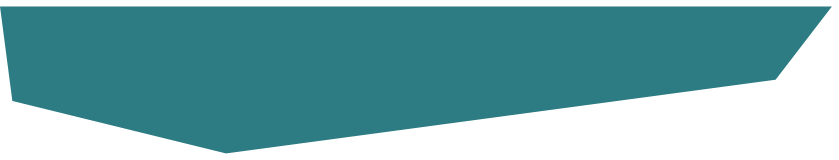
[](http://www.kpho.org.uk)

**Kent ‘Gypsy, Roma and Traveller Populations’ Joint Strategic Needs Assessment**

**June 2023**



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**|**

# 1. Executive Summary

**Overview:** It is recognised nationally that Gypsy, Roma and Traveller people have significantly poorer health outcomes than the general population of England and these inequalities in health are a result of interactions between adverse environments (living, working and social), lifestyle behaviours and poor access to health, social care and wider support services. Kent has a higher percentage of Gypsy and Traveller people than the England average and many Roma communities. Nationally there is a lack of focus on Gypsy, Roma and Traveller communities in Joint Strategic Needs Assessments which results in these communities being overlooked when planning services. In response to these issues Public Health in Kent County Council carried out a Gypsy, Roma and Travellers Health Needs Assessment (HNA) to update the previous HNA of 2015.

**Methods:** A mixed methods approach was used to describe the scale of health needs faced by Gypsy, Roma and Traveller communities in Kent. Stakeholders were interviewed to obtain views on the needs for health and social care services amongst Gypsy, Roma and Traveller communities, the extent to which these needs are currently being met and barriers faced. Stakeholders were from healthcare, Kent County Council, Voluntary Community Social Enterprise (VCSE) services, community advocates and other statutory services. Where possible stakeholder findings were triangulated with findings from other recent projects supporting Gypsy, Roma or Traveller communities in Kent.

The groups in scope for this HNA were the Romany Gypsies, Irish Travellers, and Roma groups. These are ethnically and culturally diverse groups although some share the tradition of a nomadic lifestyle. When referred to collectively in this paper, it is with the understanding that there are differences between communities which are recognised and acknowledged; equally, there are aspects of similar shared experiences which are also recognised.

**Findings:** Findings were in line with what is known about the health needs of these communities nationally. Stakeholders reported significantly poorer health outcomes across the life course for all Gypsy, Roma and Traveller groups. Poorer health outcomes included: high rates of childhood illness, predominance of non-communicable disease, poor mental health across the life course, unhealthy lifestyle behaviours e.g. high prevalence of smoking and obesity. Additional concerns for older community members included musculoskeletal issues, especially in men, and the care of individuals with dementia. All groups have a strong tradition of elder care which may deter help seeking for older relatives.

Poor mental health was reported across the life course, specifically perinatal mental health for Gypsy and Traveller mothers and bullying of children and young people in state schools. Stakeholders highlighted that the concept of mental health is unfamiliar amongst Roma communities which negatively impacts help seeking and treatment.

Members of the Gypsy, Roma and Traveller communities face multiple barriers to accessing healthcare, many of which are common across all communities. A major theme was a lack of trust resulting from experiences of discrimination and a lack of cultural awareness amongst healthcare providers. Stakeholders reported low levels of health literacy amongst some community members. This was partly attributable to general low literacy levels, language difficulties (for first generation Roma migrants) and on-going cultural beliefs/taboos of issues such as sexual health, mental health, and cancer. Barriers to healthcare result in low uptake of preventative and screening services across all communities. Uptake of antenatal and cancer screening services were of particular concern.

The barriers which Gypsy, Roma and Traveller people face revealed extremely high levels of poor health, precarious employment, poor engagement in the education system and socioeconomic deprivation.

**Recommendations:** The report makes several recommendations covering the following areas:

1. Instigating and monitoring Gypsy, Roma and Traveller ethnicity reporting in health, social care, and VCSE services across Kent.

2. Using policy levers and system leadership to develop a system-wide approach to addressing health needs.

3. Increasing joined up working between services and co-design with service users.

4. Investing in developing trust and culturally competent services.

5. Addressing health and mental health literacy through accessible information sources, peer support and adult education.

6. Training trusted individuals in Making Every Contact Count (MECC) to support healthy lifestyles and uptake of preventative services.

7. Identifying primary care champions, developing communities of practice, and promoting inclusion health audits.

8. Developing innovative solutions to support those living nomadic lifestyles to attend screening and routine appointments.

9. Investing in and training of community members to increase employment opportunities.

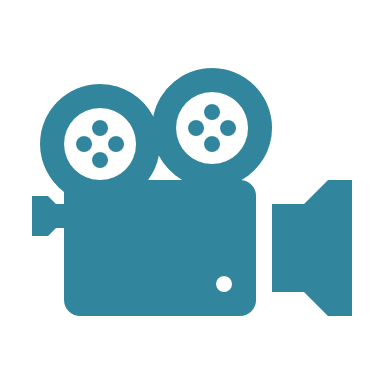
10. Developing granular understanding of community needs through further in-depth research with community members.

# | 2. Introduction

## Definitions

The terms Gypsy, Roma and Traveller are used to describe a range of ethnic groups, or those with nomadic ways of life who are not from a specific ethnicity. In the UK, it is common to differentiate between Gypsies (including English Gypsies, Scottish Gypsy/ Travellers, Welsh Gypsies, and other Romany people), Irish Travellers, who have specific Irish roots, and Roma, understood to be more recent migrants from Central and Eastern Europe.

The video below explains the history and origins of the Gypsy, Roma and Traveller population.

[](https://youtu.be/1bhBbMrF8Z0)

<https://youtu.be/1bhBbMrF8Z0>

Gypsy, Roma and Traveller communities have all been a part of British society for many centuries and share several cultural and lifestyle characteristics. The Traveller Movement describes these similarities as:

***“…the importance of family and/or community networks; the nomadic way of life, a tendency toward self-employment, experience of disadvantage, and having the poorest health outcomes in the United Kingdom.”***(Traveller movement n.d.)

The term Gypsy, Roma and Traveller is an umbrella term used to describe a wide variety of cultural and ethnic groups. The definition of individual Gypsy, Roma and Traveller communities and community members is complex because they are not one homogeneous group and the perceived identities of Gypsies, Roma and Travellers are affected by myths, stereotypes, and historical interactions between communities. The definitions of each group that have been utilised in this report are listed below:

**Romany Gypsies**

Gypsies, or more correctly, Romany Gypsies have been in Britain since at least 1515 after migrating from continental Europe during the Roma migration from India. Along the way they were defined (usually by others) as being ‘Egyptian’ referring in a generalist way to a foreign person with dark skin. This has become shortened to ‘Gypsy’. Romany is the word that Gypsy people in England and Wales apply to themselves, however this term is not used to describe more recent incomers to the UK from Central and Eastern Europe, generally described as Roma (see below).

**Source**: [Gypsy Roma and Traveller History and Culture | The Traveller Movement](https://travellermovement.org.uk/gypsy-roma-and-traveller-history-and-culture)

**Irish Travellers**

Traditionally, Irish Travellers are a nomadic group of people from Ireland but have a separate identity, heritage, and culture to the community in general. An Irish Traveller presence can be traced back to the 12th century Ireland, with migrations to Great Britain in the early 19th century. Some Travellers of Irish heritage identify as ‘Pavee’ or ‘Minceirs’, which are words from the Irish Traveller language, Shelta.

**Source**: [Gypsy Roma and Traveller History and Culture | The Traveller Movement](https://travellermovement.org.uk/gypsy-roma-and-traveller-history-and-culture)

**Scottish/Welsh Travellers**

There are other groups of Travellers who travel through Britain, such as Scottish and Welsh Travellers, many of whom can trace a nomadic heritage back for many generations and who may have married into or outside of more traditional Irish Traveller or Romany Gypsy families.

**Source**: [Gypsy Roma and Traveller History and Culture | The Traveller Movement](https://travellermovement.org.uk/gypsy-roma-and-traveller-history-and-culture)

**Roma**

In the UK ‘Roma’ is often used to describe migrant populations from Central and Eastern Europe that have arrived in the last half-century. The Roma first came to the UK as asylum seekers, and they are the largest ethnic minority in Europe. The Roma originate from Punjab and Rajasthan areas of India. Their ancestors emigrated from India approximately 1000 years ago and travelled through Asia to Europe and later to the Americas. For centuries they maintained a nomadic lifestyle but were forced to settle under the communist regimes of Eastern Europe.

Many Roma in Western Europe are migrants from countries such as Poland, Slovakia, the Czech Republic, Romania, Lithuania, and Latvia. Though frequently associated with English Gypsies and Irish Travellers, Roma in the UK face a unique set of challenges related to recent migration and past experience of discrimination. Many Roma speak one of the many Romani dialects as a first language, and they usually speak the language of their countries of origin as a second language (e.g., Polish, Slovak or Romanian).

More recent Roma migrants to the UK may have as much or more in common (in terms of their economic and social needs and their experience of discrimination) with other recent marginalised migrant communities, than with long-established British and Irish citizens from Gypsy and Travelling communities.

**Source:** [roma-info-leaflet.pdf (england.nhs.uk)](https://www.england.nhs.uk/wp-content/uploads/2016/07/roma-info-leaflet.pdf)

**All the above-described Gypsy, Roma and Traveller groups are protected under the Equality Act 2010, on the basis of their ethnicity, race and/or nationality.**

**Non-ethnically defined groups**

The term ‘traveller’ can also encompass other groups that travel, including but not limited to, New Travellers, Boaters, Bargees and Showpeople. These Travellers are not protected by equality legislation or have not tested their rights in court. While this wider group are not the primary focus of this assessment, it is acknowledged that much of the discussion regarding health inequalities, barriers to health access and subsequent recommendations will be applicable to these communities as well.

## Historical context

Gypsy and Traveller people have been present in England since at least the 16th Century and the first recorded mention of Gypsies in England can be found in a document from 1514 (Clark and Greenfields 2006). There is a misconception that Gypsies originated from Egypt, although records suggest they originally arrived from the Indian subcontinent (ibid.). Roma migrants from Eastern and Central Europe have tended to arrive much more recently, from the 1990s onwards (Poole 2010).

There are a variety of complex factors which affect the relationship Gypsy, Roma and Traveller communities have with statutory services, including health and social care. Much of this can be traced to an historical and political context. There is a legacy of Gypsy, Roma and Traveller persecution across Europe, with every modern EU state having anti-Gypsy laws at some point. In the sixteenth century a law was passed in England that allowed the state to imprison, execute or banish anyone that was perceived to be a Gypsy (Women and Equalities Committee 2019). During the Second World War, there was a genocide of Gypsy Roma and Traveller people– known in Romani as the ‘*Porrajmos’* – by Nazi Germany. The total number of Gypsy, Roma and Traveller victims has been estimated at between 220,000 and 1,500,000 across Europe (BASW 2022).

Between the 1970s and the 1990s Roma women experienced one of the most serious human rights violations, the practice of coercive sterilisation (European Roma Rights Centre 2016). The legally sanctioned Decree on Sterilisation gave public authorities free rein to systematically sterilise Roma women and women with disabilities without their consent as a means of birth control. In 1979, Czechoslovakia also introduced a programme of financial incentives, encouraging Roma women to undergo sterilisation motivated by the need ‘*to control the highly unhealthy Roma population through family planning and contraception’* (Public Defender of Rights 2006)*.* An investigation into the practices of involuntary sterilisation of Roma women estimated that since 1972, thousands of women may have been involuntary sterilised throughout the former Czechoslovakia (ibid.). Female sterilisations were state policy until 1993 when it was abolished (ibid.). However, the practice of sterilising Roma women and women with disabilities against their will did not end with the abolition of the legislation, but continued throughout the 1990s and 2000s, with the last known case occurring as recently as 2007 (European Roma Rights Centre 2016). Anecdotal evidence has suggested these practices are still happening. The pain and suffering of thousands of Roma women has consequently resulted in extreme distrust and fear of doctors and other hospital personnel (especially those accessing maternal services) (ibid.).

These histories are felt keenly by Gypsy, Roma and Traveller people and contribute to the lack of trust the communities have in the state and authorities today, including the police, local councils, and other statutory public bodies (such as health and social care services) (Parry et al 2004).

It has been noted in the literature that there is also a strong degree of mutual suspicion and hostility between some Gypsies and Travellers and the settled community. Parry et al (2004) found the following:

***“…prior experience and expectation of racism was closely associated with mistrust of non-Travellers in general, that leads to defensive hostile behaviours and avoidance of unnecessary encounters with non-Travellers.”***

Although the anti-Gypsy laws described above were repealed in the late 18th century, prejudice against Gypsy, Roma and Traveller communities has remained embedded in British society for centuries.

# | 3. Background information

## 3.1 National and local policy context

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the ‘Core20PLUS’ – and identifies ‘5’ clinical areas requiring accelerated improvement. The Gypsy, Roma and Traveller communities are considered to be [**inclusion health groups**](https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health)**.** Inclusion health is a ‘catch all’ term to describe people who are socially excluded. People in inclusion health groups typically experience multiple overlapping risk factors for poor health such as poverty, violence and complex trauma, experience stigma and discrimination and are not consistently accounted for in electronic records such as healthcare databases. People belonging to inclusion health groups frequently suffer from multiple health issues and have extremely poor health outcomes, often much worse than the general population. In addition, inclusion health groups, including Gypsy, Roma and Traveller people, are identified as a priority within the PLUS element of the NHS [CORE20PLUS5](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/#:~:text=Core20PLUS5%20is%20a%20national%20NHS,clinical%20areas%20requiring%20accelerated%20improvement.) framework approach which seeks to reduce healthcare inequalities.

The [NHS Long Term Plan](https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/) published in 2018, sets out the strategy for the NHS over the next ten years and includes ambitions for the NHS to increase its contribution to tackling some of the most significant causes of ill health, with a particular focus on the communities and groups of people most affected by these problems. Although there is no specific mention of the Gypsy, Roma and Traveller populations in the plan, there is a commitment to take a stronger action on tackling health inequalities, which includes setting out specific, measurable goals for narrowing inequalities through service improvements, as well as offering support to local planning and national programmes, to ensure they are also focused on health inequality reduction (Family Friends and Travellers 2019).

The Houses of Parliament Commons Select Women and Equalities Committee conducted an inquiry into tackling inequalities faced by Gypsy, Roma and Traveller communities (Women and Equalities Committee 2019). This assessed the impact and progress achieved from 28 commitments to tackling inequalities made by a 2012 ministerial working group (ibid.). It noted that there was a lack of focus on Gypsy, Roma and Traveller communities within Joint Strategic Needs Assessments (JSNAs) nationally and highlighted that this omission resulted in these communities being overlooked when planning services. Furthermore, the report identified a persistent failure by both national and local policymakers to tackle these inequalities in a sustained way which has led to services that are ill-equipped to support Gypsy, Roma and Traveller people to use services that they need and are indeed entitled to. The Committee stated this was unacceptable given the poor health outcomes faced by the Gypsy, Roma and Traveller communities.

While it was still a member of the EU, the UK was supposed to develop a specific strategy to promote Roma integration. Rather than developing this specific strategy, the UK government decided to use a mainstream legislation. However, the complex mechanisms of UK policymaking means that responsibility for integration is diffused. As a result of the devolved governmental systems and the often-localised agenda of Gypsy Roma Traveller populations, these communities often find that they are subject to different forms of inclusion and exclusion depending on their specific geopolitical location (Lane and Smith 2019).

## Health inequalities

Health inequalities are unfair and avoidable differences in health across the population and between different groups within society which lead to poorer outcomes, shorter, unhealthier lives, and additional burdens on the NHS (Williams et al 2022). It is widely recognised that our health is influenced by several factors, including where we live, who we are, our lifestyles and behaviours and our access to health services. Whitehead and Dahlgren’s seminal diagram below maps the relationship between the individual, their environment and health. It highlights the layers of influences on health, such as individual lifestyle factors, community influences, living and working conditions, and more general social circumstances. Several studies have acknowledged the importance of these factors, and evidence from the King’s Fund shows that the biggest contributor to health inequalities is the wide bundle of factors wrapped up in the phrase ‘*wider determinants of health*’ (Buck and Maguire 2015).

**Figure 1: Dahlgren and Whitehead’s model depicting the wider determinants of health** (Baker et al 2017).

A diagram showing Dahlgren and Whiteheads model of the wider determinants of health. Which includes information on the individual, social and environmental factors which influence the health of the population and impact on health inequalities.


In regards of health and health inequality, Gypsy, Roma and Traveller communities experience some of the most extreme health disparities in our society. These are explored within this Health Needs Assessment.

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# 4.

# Rationale of the Health Needs Assessment

## 4.1 Overall approach

The purpose of this health needs assessment is to describe the health needs of Gypsy, Roma and Traveller communities in Kent and to assess the extent to which they are currently being met, and to make recommendations for future service developments and improvements.

## Aims

The assessment seeks to:

* Identify the health needs (including wider determinants) and barriers of the Gypsy Roma Traveller communities in Kent, recognising the diversity of needs across these communities and differentiating them accordingly.
* Describe services and support in place to address these needs.
* Identify gaps in meeting health needs, and opportunities for future interventions, using evidence-based or best practice approaches.
* Make recommendations to address these gaps/opportunities focusing on reducing health inequalities and enabling Gypsy, Roma and Traveller communities to make informed decisions to improve their health and wellbeing.
* Support decision-makers across statutory services within Kent to improve health outcomes and reduce health inequalities for Gypsy, Roma and Traveller communities.

**|**

# 5.

# Gypsy, Roma and Traveller Groups in scope

For the purpose of this Kent County Council Health Needs Assessment the groups in scope are the Romany Gypsies, Irish Travellers and Roma groups.

Gypsy, Roma and Traveller communities in the UK are a diverse group, and although there is not one commonly shared culture amongst these groups, many share the tradition of a nomadic lifestyle. The ‘grouping together’ of Gypsy, Roma and Traveller communities as an undifferentiated and unitary group, in the acronym “GRT” will purposely be avoided in this document. When referred to collectively in this paper, it is with the understanding that there are differences between these communities which are recognised and acknowledged; equally, there are aspects of similar shared experiences which are also recognised.

This paper will present Gypsies and Traveller communities together and separately from the Roma communities as they are often studied in this way.

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# 6. Methodology

This Health Needs Assessment will use an epidemiological and corporate approach described by Stevens and Rafferty (1994) to:

* Describe, and where possible quantify, the scale of health needs faced by Gypsy Roma and Traveller communities across the life-course (epidemiological).
* Obtain stakeholder views on the needs for health and care services amongst Gypsy Roma and Traveller communities and elicit views on the extent to which these needs are currently being met and barriers faced (corporate).
* Map current community, health, and care services available to Gypsy Roma and Traveller communities against evidence-based/best practice standards to make an assessment of met and unmet need.

## 6.1 Desktop research

Desktop research has consisted of a literature review to evidence the health needs and barriers faced by these communities and identify evidence-based and best practice interventions to meet these. This has predominantly been achieved via nationally available research and academia.

Kent County Council Public Health Observatory’s librarian conducted a literature review search which included an exploration of relevant databases (Social Care Online, Trip database, LGA case studies, Cochrane library), screening reference lists and searching organisations’ websites for evidence on health inequalities in Gypsy Roma and Traveller communities, as well as current initiatives and best practice to tackle these. Documents reviewed were from 2017 – 2023. There was acknowledgement of a general lack of up to date and accurate data on the health status of these communities and hence, drawing on robust and reliable data is a significant challenge for reasons such as notably poor data recording and the nature of the transient population.

A literature review had also been conducted by the UK Health Security Agency on behalf of public health colleagues elsewhere in the country, and this also was of relevance to this assessment. Search scope included the mental health and physical health needs and outcomes for Gypsy, Roma and Traveller residents. Documents reviewed were from 2017 onwards. This review included 27 grey literature documents and 59 published journal articles.

## 6.2 Data collection

Kent County Council Public Heath Observatory (KPHO) were responsible for scoping, analysing, and narrating the quantitative data for this health needs assessment. The KPHO team examined a number of data sources available, however have noted the lacking and inaccurate recording of data for the Gypsy Roma and Traveller communities.

To understand the Gypsy and Traveller communities in Kent, site liaison managers at seven Kent County Council owned Gypsy and Traveller sites undertook a brief mapping exercise and completed a snapshot survey of these authorised sites. KCC site liaison managers, who are a part of the Gypsy and Traveller Resident Service team, completed a Microsoft Forms survey which explored demographic profiles of each site and some basic health needs within these communities. The Microsoft Forms survey can be found in [here](https://forms.office.com/Pages/DesignPageV2.aspx?subpage=design&FormId=DaJTMjXH_kuotz5qs39fkFqP0x4USpNMioLeL6-V1wJUMEpYTDNWU1RSNUVFSTJDTldTUDNFT0VKQS4u&Token=fa19792f1c3344c6af9d2fd0e7743be8). Findings from the survey are presented later in this paper.

Most data collection exercises have focused on obtaining qualitative data from stakeholders who presented views of the health needs and barriers of accessing health services for the Gypsy Roma and Traveller communities. The methodology was as follows:

**Recruitment**

Snowball sampling took place in early January 2023 to identify key stakeholders who currently or previously worked with these groups (e.g. previous job role or funded project) and could provide insight into the day-to-day culture of the Gypsy, Roma and Traveller communities and obtained significant insight around the health needs and barriers. Stakeholder interviewees came from a variety of backgrounds, including health, education, Kent County Council and the third sector, with all having good working knowledge of Gypsy Roma and Traveller communities.

As this was a short, time-limited project, contact with the stakeholders was limited to recruitment (email and short MS Teams call to establish whether knowledge was sufficient), the interview and a brief follow-up post interview (via email).

**Interviews**

Semi-structured interviews were thought to be most beneficial when engaging with stakeholders as they offer some structure during the interview process, allowing an understanding of what data needs to be collected, but also provides movement for new concepts to emerge. Using this approach to collect data for this research allowed for participant-driven data, giving the participants space to discuss such issues. Lamarche et al (2012) suggest that taking a qualitative approach ensures opportunity to gain a more in-depth understanding which is often missed when using quantitative research.

Fifteen semi-structured interviews took place during mid-February 2023, for two weeks. The interview schedule was approved by the Gypsy Roma Traveller Steering Group which can be found in appendix A. All interviews lasted between 45 minutes to an hour and were conducted using Microsoft Teams. Prior to the interviews, the interviewer discussed the main objectives and answered any questions arising from the stakeholder. The interviewer then gained consent for the interview to be transcribed (using function on MS Teams). All interviews were recorded using the transcription function and the interviewer also noted anything of particular interest.

**Analysis**

Firstly, to meet Data Protection Act guidelines, all data was stored on a personal password protected laptop and all data has been deleted following analysis. Stakeholder names have been omitted within the results section to ensure anonymity, as well as any information considered potentially identifiable.

The appropriate method of analysis for this research was to undertake a thematic analysis. As the interviews took place on MS Teams, they were automatically transcribed with the participants’ consent. The data was re-read several times to ensure correct understanding and to obtain ‘repeated reading’ as Braun and Clarke (2006) suggest, which is imperative for the researcher to ‘immerse themselves’ in the data and to begin building initial ideas resulting in the coding phase.

All key initial codes that were judged relevant were placed into themes and grouping was conducted on an Excel Spreadsheet. Any themes that did not have enough data or were outlying themes of no relevance were omitted here. The themes were named and defined, to certify the overall findings within the data. The research has taken direct quotations from the transcripts to demonstrate the aspects of the specific themes, acknowledging experiences and meaning explored by the participants.

Where applicable, findings from the stakeholder engagement have been triangulated with other recent work exploring the health needs of the Gypsy Roma and Traveller communities in Kent. The assessment also evidences best-practice examples in Kent included in the findings section.

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# 7. Literature review of Gypsy and Traveller health

## 7.1 Health Status and beliefs of Gypsies and Travellers

Established research evidence demonstrates that Gypsies and Travellers have poorer health experiences and outcomes than non-Travellers.

**Life expectancy and mortality:**

* Life expectancy is 10 to 12 years less than that of the non-Traveller population (Traveller Movement 2012). One study in 2005 (Baker 2005) found that only 3% of Gypsy and Travellers in Leeds were aged over 60, although the life expectancy of the general population in Leeds was 78 years.
* A report published by the Equality and Human Rights Commission (2009) (EHRC) suggested that amongst Gypsies and Travellers with access to secure council or private owned sites, and who had access to adequate medical care, life expectancy may be closer to that of the general population (Cemlyn et al 2009). The report also found evidence to suggest that Irish Travellers may have a lower life expectancy than English Gypsies as these populations often have ‘poorer health status and an increased tendency to reside on unauthorised sites or in housing.’
* The EHRC report found anecdotal reporting of premature deaths among young Gypsies and Travellers because of road traffic accidents, often associated with alcohol use and high-speed driving (ibid.).

**Poorer health outcomes across the life course:**

**Maternal and early years:**

* Research has shown poor birth outcomes and maternal health, with an excess prevalence of miscarriages, stillbirths, neonatal deaths, and infant mortality in these communities (Parry el al 2004) (Aspinall 2014). One in five Gypsy and Traveller mothers will experience the loss of a child, compared to one in a hundred in the non-Traveller community (Ormiston Children and Families Trust 2008).
* A 2018 study (McFadden et al 2018) focussing on maternity and early years found that many mothers from the community described pregnancy complications, such as anaemia, gestational diabetes, difficult and/or long labours, caesarean sections, and haemorrhage.

**Children and Young People**

**Immunisations:**

* Childhood immunisation uptake is considerably lower in the Gypsy and Traveller community in comparison to the general population (Parry et al 2004).
* Lower child immunisation rates are associated with elevated rates of measles, whooping cough, and other infections in comparison to the general population (Aspinall 2014).
* However, a literature review investigating the beliefs and attitudes of under-vaccinated populations (Fournet et al 2018) reported that in a 2007 measles outbreak among Irish Travellers in London, the Irish Traveller community responded favourably to interventions, with many non-vaccinated contacts being given the MMR vaccine (Lovoll et al 2007). Muscat (2011) suggested that the low vaccination coverage among the Gypsy and Traveller community is explained by: the poor access to health care, because of population mobility; inequalities in registration with GP surgeries; health illiteracy and a lack of services that are culturally sensitive regarding the needs of these communities.

**Adults:**

* The health status of Gypsies and Travellers is much poorer than that of the general population with higher rates of limiting long-term illness, even when controlling for other factors, such as variable socio-economic status and/or ethnicity (Matthews 2008).
* The Office for National Statistics (ONS) recently undertook research (ONS 2022) exploring the lived experiences of Gypsy and Traveller communities relating to health. It found that participants from the Gypsy and Traveller communities described experiencing a range of health difficulties, including chronic obstructive pulmonary disease (COPD), asthma, diabetes, bladder problems, cancer (“the c-word”) and mental health difficulties.
* A seminal study conducted by Parry et al (2004) commissioned by the Department of Health found that Gypsies and Travellers had significantly higher rates of arthritis, asthma, or chest pain/discomfort than in the comparison group.
* Gypsy and Travellers are three times more likely to have a chronic cough or bronchitis even after smoking status had been considered (ibid.).
* There are higher reported rates of diabetes in the Gypsy and Irish Traveller population (Aspinall 2014).
* 42% of English Gypsies are affected by a long-term condition, as opposed to 18% of the general population (Royal College of General Practitioners 2013).
* Gypsy or Traveller men were 12.4 times as likely to suffer from two or more physical health conditions than white British men (Goodier 2023); higher figures than for any other ethnicity.

**Mental health:**

* An All-Ireland study found that suicide prevalence is six times higher for Irish Traveller women than women in the general population, and seven times higher for Traveller men (Safa el al 2010).
* Gypsies and Travellers are nearly three times more likely to be anxious than average and just over twice as likely to be depressed (Parry et al 2004).
* A recent small-scale study (Darragh 2020) has revealed that Irish Travellers are a distinct group who endure specific stress that is extraneous to the stress faced by the general population of Ireland, particularly in relation to issues around identity concealment and bereavement/loss.

**Older adults:**

* Mobility problems were reported by 25% of Gypsies and Travellers compared with 15% seen in their counterparts (Parry et al 2004).
* Family, Friends, and Travellers organisation undertook research (Rattigan and Sweeney 2018) around dementia in Gypsy and Traveller communities and found that 80% of participants knew someone in the community who had been diagnosed with dementia.

**Dental Health**

* Accounts of poor dental health are documented within the literature (Parry et al 2004); research has found that child dental health problems seem to be common, including dental decay, misaligned teeth and apparently high rates of treatment needed for extractions, mass extractions and fillings.

**Behavioural/lifestyle factors**

* Parry et al (2004) found the proportion of the Gypsy and Traveller population that were smokers was considerably higher (57%) than matched comparators (21.5%).
* Alcohol consumption is often used as a coping strategy, and drug use among Traveller young people is widely reported and feared by Traveller elders (Matthews 2008). Although some research has been carried out on the extent of substance misuse within Travelling communities in Europe, there is little research into this subject in the UK.
* Limited research around Gypsy and Travellers lifestyles have identified high rates of obesity, and limited awareness of healthy eating patterns (Saunders 2007).
* Traditionally Gypsy and Travellers had very active lifestyles often working in the outdoors, usually in agriculture. Farmers would often have long-standing, entrusted relationships with these communities and would provide manual labour on farms throughout the year (Friends, Families and Travellers n.d.). However, increasing legal restrictions on Gypsies’ and Travellers’ ability to travel, coupled with alternative sources of cheap labour (such as migrant workers from other parts of Europe) have seen a decline in this traditional way of life. Nowadays, much agricultural employment has been replaced amongst Gypsy and Traveller men by work such as market trading, scrap metal dealing, gardening, building, laying tarmac, buying and selling electrical goods and used car trading (OPM 2010). It is thought that the change from high levels of active living and ‘eating from the land’, to a more sedentary lifestyle and consumption of processed convenience foods witnessed today, has had a disproportionate impact on Gypsy and Traveller communities’ health (Greenfields 2009).

**Health beliefs**

* Gypsy and Traveller communities have strong cultural beliefs and attitudes that underpin their health-related behaviour, and these are influenced by previous health experiences (Cleemput et al 2007).
* There is a reported tendency towards a fatalistic acceptance of ill health and disease and a view that illness is an inevitable and natural process of reaching middle age and therefore medical interventions are not always considered appropriate nor necessary (Parry et al 2004).
* The EHRC report (Cemlyn et al 2009) highlights that Gypsies and Travellers have a holistic concept of health that emphasises social and environmental factors as key drivers of health, rather than a medical model rooted in concepts of disease and medication.
* Research has highlighted a deep-rooted fear of cancer and other diagnoses that are perceived as terminal. Condon et al facilitated (Berlin et al 2018) peer interviews and focus groups in Gypsy and Traveller communities and found:
  + Cancer is often considered a ‘taboo’ and evil disease. Participants would not talk about cancer because they saw this as invoking bad luck, as bringing forth painful memories of family members who have suffered or died from the disease and as causing their families too much worry. Cancer was referred to as *‘that old cover’, ‘that old thing’, ‘that disease’ ‘the C word’* (ibid.)*.*
  + Not all individuals considered cancer a ‘death sentence’ and there was awareness of the possibility of a cure if diagnosed early and treated effectively.
  + Those participants who engaged in interviews said that although they attended screening themselves, they knew of other community members who were unlikely to; the younger generation were more likely to attend than the older generation.
  + Variable cultural beliefs about cancer and lower levels of knowledge about the purpose of preventative cancer services act as a barrier when accessing cancer-related health services.
  + There is strong sentiment within Gypsy and Traveller communities that information about cancer should not be forced upon them.
  + Male stoicism was noted, which may contribute to nonattendance of medical appointments.
* Amongst Gypsy and Traveller communities significantly more trust is placed in family carers, rather than professional care, especially concerning end of life care. A systematic review (Dixton et al 2021) study looking at palliative and end of life care found:
* Strong family and community values include a preference for healthcare to be provided from within the community, duty to demonstrate respect by attending the bedside and illness as a community problem, with decision-making extending beyond the patient.
* Additional research conducted by Fuller and Sweeney (2019) found that extended family is crucial especially in illness or crisis, with family members staying with their loved one while in hospital and taking meals into hospital if their loved one will not eat hospital food.
* There are distinct health beliefs regarding superstitions around illness, personal care, death rituals and bereavement. Traditions around death and bereavement include taking the body home; keeping a vigil over the body by family members; Irish Travellers will often light candles near the bed of the dying person and the candles will be kept lit under after the funeral; after a death there will be a continued flow of visitors to pay their respects to the family (ibid.).

**Access to Healthcare**

Research has defined health care access as the ‘*opportunity to identify health care needs, to seek healthcare services, to reach, to obtain or use heath care services and to have the need for services fulfilled’* (Levesque et al 2013).

Gypsy and Traveller communities face multiple issues in relation to access of healthcare, meaning heath issues often get dealt with when they become urgent, and people aren’t accessing routine screenings and appointments. The reasons are multiple, complex, and interlinked and they exist at an individual, provider, health system and national level (Siebelt et al 2017).

Levesque et al (2013) have suggested five dimensions of *approachability, acceptability, availability, affordability and appropriateness.* Research evidence has suggested that Gypsy and Traveller communities are disadvantaged across these domains as described below.

**Approachability**

*Approachable services are visible to the populations they serve and are recognised by potential service users that they can be reached and will have an impact on their health.*

* Gypsy and Traveller communities have limited awareness of services. According to research conducted by the Family, Friends, and Travellers (FFT 2020) organisation, over one third of Gypsies and Travellers reported that they find information from health professionals hard to understand. Over 45% of FFTs service users have low or no literacy so without the correct support may find it difficult to read medical letters, get registered and understand information given by health professionals.
* A lack of trust in health care services because of fear and experiences of discrimination impacts on service approachability. The FFT organisation (ibid.) reports that due to longstanding experiences of discrimination, it can often take time to build trust with members of the Gypsy and Traveller communities. Community members might not be aware a service is available, might not be sure if they will be welcomed or may not feel confident that it will be delivered in a culturally appropriate way.
* Treise and Shepherd (2006) identify several reasons why Gypsies and Travellers are reluctant to access services including personal or perhaps a friend or relative’s negative experience of a service (e.g. with a receptionist or GP), low expectation on the part of the health professional and fear of hostility or prejudice (Honer and Hoppie 2004).

**Acceptability/appropriateness**

*Acceptable services are culturally and socially appropriate to the populations they serve and are judged so by potential service users.*

* A lack of training in delivering culturally appropriate care amongst health care professionals has a negative impact on acceptable access amongst Gypsy and Traveller communities (Friends, Families and Travellers 2022).
* There are historically low immunisation uptake rates amongst Gypsy and Traveller communities. Research findings suggest that this may be due to structural barriers that make it difficult to access mainstream immunisation programmes. A study conducted by UNITING (Jackson et al 2015) found that Traveller communities were largely supportive of immunisations, especially in younger generations. The authors concluded that whilst awareness and motivation may be issues for some Travellers, for others, it is a failure of a culturally competent system to provide the opportunity to access immunisations (Mytton et al 2021).

**Availability**

*Available services, either physical space or those working in health care roles, can be reached and in a timely manner.*

There is a large body of literature that documents how health care services are unavailable to Gypsy and Traveller communities.

**Wrongful registration refusal in primary care.**

* Between 2018 and 2019, Friends, Families and Travellers (FFT) conducted a mystery shopping exercise in 50 General Practices (GPs) in England and found that, despite no regulatory requirement to provide proof of address or identification to register at a GP practice, almost half of all GP practices contacted refused registration on this basis (Sweeney and Worrall 2019).
* During the Covid-19 response, FFT’s casework team flagged a notable shift towards digital-first processes for registration which resulted in additional barriers to health care. To understand this further, FFT conducted a second mystery shopping exercise in 100 GPs in England between March and April 2021, and found:
* 74 GP surgeries broke NHS England guidance and refused to register the mystery shopper because they were unable to provide proof of identity, proof of fixed address, register online or another reason.
* 17 GP surgeries did not answer the phone despite receiving phone calls on three different dates and times from the mystery shopper.
* 2 GP surgeries who otherwise agreed to register the mystery shopper refused to give help with form filling.
* The report concluded for patients experiencing multiple disadvantages, with no address or form of identification, and who also have low or no literacy, only 6 out of 100 GP surgeries would have allowed them to register. Inequalities in GP registration for people living nomadically has significantly worsened since FFT published their last report exploring this back in 2019 (Friends, Families and Travellers 2022).
* Practices often only register patients without a fixed address as ‘temporary patients,’ despite 2015 guidance stating that GP practices are free to permanently register patients outside practice boundaries (NHS n.d.). Temporary registration results in patients not being invited for a range of preventative care interventions, including cancer screening programmes and immunisations, further perpetuating health inequalities in these communities.

**Digital exclusion and accessible information**

* Research has shown that people within the Gypsy and Traveller communities are more likely to experience digital exclusion. In 2018 FFT interviewed 50 individuals from Gypsy and Traveller communities across the UK to explore this. Findings included:
  + Over half of participants said that they did not feel confident using digital technology by themselves.
  + 38% of Gypsy and Traveller people (33% if housed) had a household internet connection, compared to 86% of the general population (Scadding and Sweeney 2018).
  + It is estimated that around 40% of Friends, Family and Travellers service users have low or no literacy which worsens digital exclusion. An increase in the delivery of remote healthcare consultations and online registration forms resulting from the Covid-19 pandemic response, has further exacerbated barriers to healthcare services for this population.

**Waiting list inequalities for nomadic travellers**

* Friends, Families and Travellers report (Friends, Families and Travellers 2022) that people living nomadically have experienced disadvantage on NHS waiting lists. Nomadic people often have to start from scratch when moving to a new area and many have been removed from waiting lists when travelling; meaning health needs are not addressed or treated until they have reached a more severe stage.
* The Government’s plans to tackle the backlog in elective care waiting lists has been termed ‘*the biggest catch-up programme in the NHS’s history’* (GOV 2021)*.* Without a system in place to support nomadic patients to maintain their position on waiting lists, there is a risk that pre-existing inequalities will increase during this recovery.

**Affordability**

*Reflects the economic capacity for people to spend resources and time to use the appropriate services.*

Although not explicitly mentioning any concern around affordability contributing to the barriers of access to health care, the wider determinants and social factors demonstrate high levels of unemployment and socio-economic deprivation, which in turn can act as a further barrier, as individuals may be less likely to take time off work or afford travel or parking expenses.

**Wider determinants**

Gypsy and Traveller communities experience chronic exclusion across the wider determinants of health, with many individuals facing multiple inequalities including deprivation, difficulty accessing adequate accommodation, inequalities in education and barriers to employment.

**Deprivation**

* Children from Irish Traveller families are over 3 times as likely to be eligible for Free School Meals than White British children (Dept of Education 2018).
* Very limited information is available on receipt of benefits and tax credits by Gypsies and Travellers; 2011 Census data suggests higher levels of need among the Gypsy and Traveller community compared with the population as a whole (BASW 2017).
* A recent study (Goodier 2023) found that Gypsy and Traveller groups are less likely to be in the highest occupational positions and also had high rates of financial difficulties and benefit receipts.

**Accommodation**

* Many Gypsies and Travellers now live in settled accommodation and do not travel, or do not travel all of the time, but nonetheless still consider travelling to be part of their identity. In the 2011 Census, the majority (76%) of Gypsies and Travellers in England and Wales lived in bricks-and-mortar accommodation.
* A report by the Traveller Movement found that living conditions on sites significantly contribute to Gypsies’ and Travellers’ physical and mental health (GOV 2016).
* Van Cleemput el al (2007) found that settled Travellers can experience high levels of depression, linked to loss of their traditional lifestyle.
* 10,000 Gypsies and Travellers have no place to stop as a result of a chronic national shortage of sites (GOV 2019).
* Whilst over 1696 households are currently on waiting lists for pitches, there are just 59 permanent and 42 transit pitches available nationwide (Friends Families and Travellers 2021).
* 3,000 families without a permitted stopping place have limited or no access to basic water and sanitation (ibid.).
* The shortage of permanent and transient Gypsy and Traveller sites results in unauthorised encampments, weakened community cohesion and local authority expenditure on eviction and clearing up illegal sites (BASW 2017).
* The criminalisation of ‘travelling’ and the shortage of authorised private or council owned sites has been described by some Travellers as a ‘crisis in the community’ (The Traveller Movement n.d.).

**Education**

* Children from Gypsy and Traveller communities attain and progress significantly below the national average throughout compulsory education. 60% of Gypsies and Travellers have no formal qualification (ibid.).
* Children leave school at a much earlier age than children in other ethnic groups and they have worse attainment standards than any other ethnic group from early years onwards (GOV 2023).
* Levels of both temporary and permanent exclusion are high and in the school year of 2019 to 2020 the suspension rate was 15.28% for Gypsy students and 10.12% for Traveller pupils – the highest rates out of all ethnic groups (GOV 2022). The highest permanent exclusion rates were among Gypsy pupils.
* In the autumn term of the 2020 to 2021 school year, 52.6% of Gypsy pupils and 56.7% of Traveller pupils were persistently absent from school. Pupils from these ethnic groups had the highest rates of overall absence and persistent absence (ibid.).
* In the 2018 to 2019 school year, 19% of Gypsy pupils and 26% of Traveller pupils met the expected standard in key stage 2 reading, writing and maths; these were the lowest percentages out of all ethnic groups (ibid.).
* In the 2019-2020 school year, 20% of pupils from Irish Traveller background and 8% from Gypsy background attained 5 GCSEs (or equivalent) at grades A\* - C; this was the lowest percentage of all ethnic groups. Gypsy and Traveller pupils were the least likely to stay in education after GCSEs, however, they were likely to go into employment, although it is not possible to draw firm conclusions about these groups, given the small number of pupils in key stage 4 (ibid.).
* Parental literacy skills and cultural expectations within the Travelling community can act as a barrier to young people engaging in education. There is a cultural norm and expectation that domestic and child-rearing responsibilities lie with girls and for boys, starting work and cultural attributes unconnected with traditional education achievement may be more important (Friends Families and Travellers n.d.).
* In addition, consistent experiences or racial harassment and bulling are also linked to poor educational attainment and achievement for these communities (ibid.).

**Employment**

* A recent study (Goodier 2023) found Gypsy and Traveller people were among the least likely of ethnic groups to be in employment, and when they did have jobs during the Covid-19 pandemic, they were the most likely to be in precarious employment. After adjusting for age, 85% of Gypsy or Traveller men were in precarious employment, compared with 19% of white British men.
* When compared with the general population, double the percentage of Gypsies and Travellers were in elementary employment (construction, sales or service) (Traveller Movement 2018).
* The 2011 Census found that Gypsy and Travellers as an ethnic group had the lowest employment rates and highest levels of economic inactivity. The Gypsy and Traveller group had the highest percentage (31.2%) of people who declared that they ‘never worked or were long-term unemployed’ (GOV 2022). The most common reason for not working was looking after the home or family (27% for Gypsy and Travellers; 11% England average). The second most common reason was being long term sick or disabled (26%), the highest proportion out of all ethnic groups (ibid.).
* The EHRC (Cemlyn et al 2009) reported data collected via accommodation needs assessments, that married women with school-aged children are starting to enter employment in low but increasing numbers. This is often in unskilled labour, such as cleaning. The report also noted an increasing interest amongst younger Gypsy and Traveller women in entering health and beauty-related vocations, despite some cultural resistance from older relatives.
* The EHRC report also highlighted some of the barriers faced by these communities into mainstream employment, including racism, lack of settled address, lack of bank account, poor literacy and low skill level and qualifications (ibid.).

**Cultural beliefs**

* Families are organised according to strict hierarchies and gender roles, with women being expected to look after the household, childrearing, cooking and cleaning and men being responsible for supporting the household financially. There is a strong emphasis throughout the culture, but especially for men, on self-sufficiency and against help seeking (financial, emotional etc) (Parry et al 2004).
* There are strong cultural beliefs and rules regarding cleanliness and pollution within the Gypsy and Traveller culture. Having a clean home is considered as imperative and for women, keeping the home clean is an important social role (ibid.).
* Gypsy and Traveller people hold strong beliefs regarding pollution, which can manifest in concerns around additives, unnatural foods, medications, and some vaccinations (ibid.).

**Discrimination**

* An unprecedented survey conducted by the Evidence of Equality National Survey of Ethnic and Religious Minorities found that 62% of Gypsy and Traveller people had experienced a racial assault (Goodier 2023). The percentage exceeded that for any other ethnic minority group. One in three Gypsy and Traveller people had experienced a physical racist attack.

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# 8. Literature review of Roma health

## 8.1 Health Status and beliefs of Roma groups

Established research evidence demonstrates that Roma communities have poorer health experiences and outcomes than non-Roma communities.

**Life expectancy and mortality:**

* The Roma community is still one of the most disadvantaged ethnic groups in the UK today (Roma Support Group n.d.).
* According to the Roma health and early childhood development report, there is consistent evidence demonstrating that the Roma population has considerably shorter life expectancy compared to the non-Roma population. Roma life expectancy is reported to be up to 10 years lower compared to non-Roma communities in the UK.
* Roma child mortality rates are between two and six times higher than the general population of Europe (EPHA 2018).

**Poorer health outcomes across the life course:**

**Maternal and early years:**

* Some researchers estimate that infant mortality rates and health levels are similar to that of the majority population in the 1970s (Langhamrova et al 2003).
* It is acknowledged in the literature that persistent poverty, weak access to pre-and post- natal care, intolerable housing and unsafe environments, poor nutrition and unhealthy lifestyles seriously influence the general health levels of Roma infants (ibid.).
* Barriers to women receiving antenatal and postnatal care are grounded in Roma taboos and traditions around childbirth, which are associated with cultural conceptions of cleanliness and purity, known as the ‘purity period’ (Roma Support Group n.d.).
* There is also a linguistic taboo around using words like ‘breast’ in breast feeding, showing pictures of genitals or touching areas of the body viewed as sexual (ibid.).
* The historical practice of coercive sterilisation of some Roma women in their home country exacerbates mistrust and fear of professionals regarding maternal health care (European Roma Rights Centre 2016).

**Children and Young People**

**Immunisations:**

* Data on immunisation uptake suggests in general that the Roma population is more likely to be below the level required for herd immunity than the non-Roma population (EPHA 2018).
* A little over half of the Roma population in Slovakia had received some sort of vaccination, compared to up to 99% in the majority population (ibid.).
* Lower vaccination rates may be due to children being born abroad and therefore not receiving standard childhood immunisations in their country of origin and a lack of health records once they arrive in the UK (ibid.).

**Adults:**

* Local health needs assessments have demonstrated common health conditions in the Roma community which are often lifestyle related, including cardiovascular disease, diabetes, obstructive airways diseases (e.g. COPD), pneumonia and lung cancer (Tobi et al 2010).
* One study in Manchester found among Central and Eastern European immigrants including Roma, 40% of respondents said they would not have the Covid-19 vaccine (Europia 2021).
* Other studies suggest that Roma groups are at much higher risk of suffering from ‘communicable and non-communicable diseases’ compared to the rest of the population (ibid.).
* Roma men were five times as likely to suffer from two or more physical health conditions than white British men (Goodier 2023); higher figures than for any other ethnicity.

**Mental health:**

* High reported rates of anxiety and depression noted (Roma Support Group 2021).
* According to data shared by the EU Fundamental Rights Agency (FRA 2016), the Roma population tend to have higher rates of illnesses associated with poor diet and stress.
* Some Roma experience anxiety because of traumatic experiences from the wars in the Balkan region, leading to mental health problems and psychosomatic complaints (ibid.).
* Mental health problems for Roma communities may also be intensified further by social exclusion, such as experiencing discrimination, stigma, or racism (Roma Support Group 2016).
* Victims of rape and domestic violence within Roma communities are often stigmatised, they rarely discuss their traumas (ibid.).

**Older adults:**

* Given the socio-economic disadvantage and lower life expectancy common in Roma communities, many Roma patients will be at a higher risk of frailty (Garrett et al 2020).
* Although there is very little national level data on Roma health, especially regarding the elderly, a previous study identified high rates of long-term conditions observed in Roma communities (Tobi et al 2010).

**Dental Health:**

* There is a high frequency of dental problems reported in the Roma community, which can be attributed to the poor diet experienced by these groups (FRA 2016).

**Behavioural/lifestyle factors**

* Lung cancer is of particular concern in the Roma community due to the high levels of smoking. One study found that 67% of Roma individuals were current smokers (Bailey 2019).
* There are contrasting trends in relation to alcohol consumption, with most studies suggesting the Roma population consume less than non-Roma populations (EPHA 2018).
* Dietary habits are poor, with Roma generally having a poor diet, likely as a result of poverty and consuming more processed, high sugar and fast food. A Sheffield needs assessment (Willis 2016) reported a greater proportion of Roma men and women between 18-55 with an obesity diagnosis than their counterparts in non-Roma populations.

**Health beliefs:**

* Roma patients were less likely to attend cancer screening than non-Roma counterparts (ibid.). There is a lack of awareness and misconception about cancer symptoms and treatment that can lead to a delay in discussing symptoms or seeking help, for example, some Roma Support Group clients believe that cancer will ‘get angry’ and develop faster if touched by surgery, chemotherapy, or other treatment (Smolinska-Poffley et al 2015).
* In addition, some Roma women may be reluctant to discuss gynaecological problems or take up preventive cervical cancer screening with their GP, especially with a male doctor. Anderassen et al’s (2018) study into the participation of Roma women in a national cervical screening programme found that providers attributed low uptake to a lack of knowledge, negligence, low education, and health beliefs. Cultural sensitivity is crucial as mentioning intimate parts of the body, which include breasts and anything below the waist, are significant cultural taboos for this community (ibid.).
* Talking about mental health is a greater taboo than any other health issue, although attitudes do seem to be changing amongst the younger generations. Roma communities believe that mental health problems are genetic and run in the family, so they are rarely discussed for fear of damaging the family’s reputation (Roma Support Group n.d.).
* There is fear of health professionals and hence, individuals may not seek help with mental health problems for fear they will be institutionalised or perhaps have their children removed (ibid.).

**Access to Healthcare**

Like Gypsy and Traveller communities, Roma communities face multiple issues in relation to access to healthcare and many struggle to access health and care, meaning heath issues often get dealt with when they become urgent, and people aren’t accessing routine screenings and appointments. The reasons are multiple, complex, and interlinked and they exist at an individual, provider, health system and national level (Siebelt et al 2017).

As per the Gypsy and Traveller review, issues are presented across the following domains of access to health care: *approachability, acceptability, availability, affordability and appropriateness* (Levesque et al 2013).

**Approachability**

*Approachable services are visible to the populations they serve and are recognised by potential service users that they can be reached and will have an impact on their health.*

* Some Roma are relatively recent arrivals into the UK and are therefore unfamiliar with how the NHS works and their right to healthcare (Roma Support Group n.d.). In other countries, individuals can self-refer to elective care without consulting a GP, hence Roma individuals may be confused about care pathways and delay seeking treatment, which can consequently lead to untreated conditions and late diagnoses (ibid.).
* A lack of trust in health care services impacts on service approachability. Frontline health practitioners are often unaware that their patients are Roma or know very little about the Roma ethnicity. Sometimes this can result in culturally insensitive practices amongst health care staff and can also result in Roma patients feeling professionals do not take their needs seriously (ibid.).
* Language and literacy levels act as a barrier for Roma communities as often their first language is not English and thus, Roma community members often require an interpreter or health advocate to attend appointments (ibid.). Roma people have often received limited education in their countries of origin, and many have low literacy levels or do not understand medical terms, even in their first language. Many have difficulties reading a formal letter or written material in English which can often lead to appointments being missed (ibid.).

**Acceptability/appropriateness**

*Acceptable services are culturally and socially appropriate to the populations they serve and are judged so by potential service users*.

* There is often a lack of knowledge from health and care professionals, and many are insufficiently aware of the Roma as a distinct ethnic group and of the communities’ healthcare needs, their historical context and the health barriers and inequalities faced by these communities.
* In Roma culture, health is traditionally considered an ‘unclean’ or taboo subject not to be discussed. There are unwritten rules about discussing health with other Roma people of the opposite gender or in a different age group (Roma Support Group 2016). Conversations about specific health issues should happen with a medical professional of the same gender and similar age where possible. For example:
* Anything related to female sexual or gynaecological health is considered an unclean subject/object and is to be discussed only amongst females.
* Health related issues are not traditionally discussed in groups of Roma where the age gap is greater than 10 years.
* An older Roma man will often feel embarrassed to talk about his personal health conditions, for example, urological or gastrointestinal conditions through a younger interpreter of any gender.

**Availability**

*Available services, either physical space or those working in health care roles, are those that can be reached and in a timely manner.*

There is a large body of literature that documents how health care services are unavailable to Roma communities.

**Immigration status**

* Most Roma are citizens of an EU country and the requirement to prove they are entitled to healthcare has changed after the end of freedom movements in the UK. EU citizens living in the UK who do not have settled or pre-settled status under the EU Settlement Scheme and/or have not yet applied for status, will no longer be entitled to free secondary healthcare until they make a valid application (Roma Support Group n.d.).

**GP registration**

* Similar to the Gypsy and Traveller communities, Roma groups often have difficulties registering with a GP due to lacking ID documents or proof of address, or lacking proof of previous childhood immunisations in the case of registering children (ibid.).

**Digital exclusion and accessible information**

* Many Roma, especially older individuals, do not have technology devices or internet access to use digital services. They often lack skills to use online booking and video appointments. Research (Mellana 2020) conducted into digital exclusion found most people in Roma communities do not own a tablet or laptop, nor do they have a valid personal email address.
* Language is a problem in discussing health matters, and NHS England guidance recommends an offer of the provision of a registered interpreter when available. However, as there are very few professional interpreters who work in Romanes, therefore, communication often takes place in the patients second language (often Slovak or Czech) which can lead to confusion, misunderstandings and withholding information for fear and distrust of the interpreter (Roma Support Group n.d.).

**Navigating to scheduled appointments**

* Roma individuals are often unable to navigate the public transport system due to language barriers and unfamiliarity with this, which puts a further strain on their time and finances (ibid.).

**Affordability**

*Reflects the economic capacity for people to spend resources and time to use the appropriate services.*

* The Roma Support Group highlights the often long working hours experienced by the Roma community (ibid.). Thus, it is likely that taking time off work, as well as travelling to attend health appointments act as a further challenge for this community, due to financial constraints and working commitments.
* EU citizens living in the UK who do not have settled or pre-settled status under the EU Settlement Scheme and have not yet applied for status under the scheme, are no longer entitled to free secondary healthcare until they make a valid application (Roma Support Group n.d.). This could act as an additional barrier to accessing healthcare for this community, although it is not known how many Roma individuals have not applied for settled status. This issue is discussed in more detail in the [‘current services’](#_10.1_Health) section in this assessment.

**Wider determinants**

Roma communities experience chronic exclusion across the wider determinants of health, with many individuals facing multiple inequalities including deprivation, difficulty accessing adequate accommodation, inequalities in education and barriers to employment.

**Deprivation**

* The European Union Agency for Fundamental Rights (2022) found in Europe 80% of Roma individuals are living below the poverty line.
* The research (ibid.) shows that 7% of Roma surveyed in Europe live in a household in which at least one person regularly went to bed hungry in the preceding month.
* A recent study (Goodier 2023) found that Roma groups are less likely to be in the highest occupational positions and also had high rates of financial difficulties and benefit receipts.

**Accommodation**

* A third of Roma European households do not have tap water, just over half have an indoor flush toilet or shower and 78% live in overcrowded households (ibid.).
* 43% of Roma experience discrimination when trying to buy or rent housing in Europe (ibid.).
* Research conducted in the City of Westminster (Felja et al 2016) found there to be 1,388 Romanian rough sleepers in 2015, representing 18.7% of all rough sleepers in Greater London, second only to UK nationals. The data also shows a sharp rise in the number and percentage of Romanian rough sleepers thought to be of Roma ethnicity. In addition, the research conducted interviews with a total of 64 Roma rough sleepers and found none had any knowledge of the UK welfare system and 87% of interviewees reported that they had had limited interaction with homelessness services and struggled to communicate with staff (ibid.).

**Education**

* Roma communities often suffer from low levels of education, with international experts saying this has created a form of inter-generational poverty (VOA news 2017). In 2018 to 2019 19% of Roma pupils met the expected standard in key stage 2 reading, writing and maths – the lowest percentage out of all ethnic groups (GOV 2022).
* In the 2019 to 2020 school year, 8.1% of Roma pupils got grade 5 or above in GCSE English and Maths, the lowest percentage of all ethnic groups (ibid.).
* Roma (58%) pupils were the least likely to stay in education after GCSEs (ibid.).
* The highest permanent exclusion rates were among Roma pupils (ibid.).
* In the autumn term of 2020 to 2021 school year, 52.2% of Roma pupils were persistently absent from school; pupils from these ethnic groups had the highest rates of overall absence and persistent absence (ibid.).
* Many Roma adults are also illiterate – making written communication inappropriate for Roma community members (Roma Support Group 2016).

**Employment**

* A European-wide study suggests only 43% of Roma are in a form of paid employment (FRA 2026).
* An additional study in 2021 found that during the Covid-19 pandemic many Roma individuals faced job loss, financial difficulties and reported borrowing money and using food banks (Roma Support Group 2021).
* A recent study (Goodier 2023) found Roma people were among the least likely of ethnic groups to be in employment, and when they did have jobs during the Covid-19 pandemic, they were the most likely to be in precarious employment. After adjusting for age, 65% of Roma men were in precarious employment, compared with 19% of white British men.

**Discrimination**

* An unprecedented survey conducted by the Evidence of Equality National Survey of Ethnic and Religious Minorities found that 47% of Roma people had experienced a racial assault, while 35% has been physically attacked. (Goodier 2023).

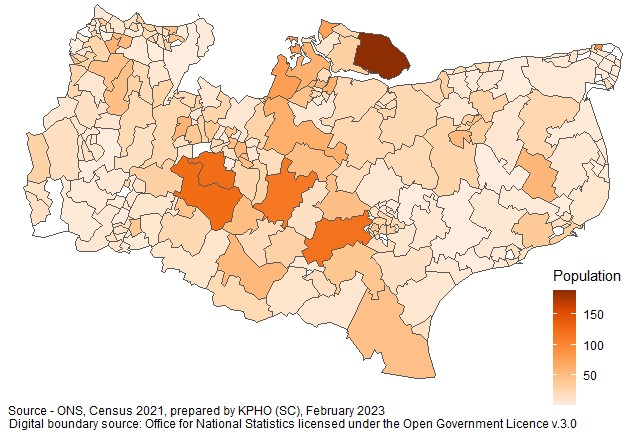
**|**

# 9. Findings

## 9.1 Kent population data - Gypsy and Irish Traveller

The 2021 Census recorded that 5,405 people in Kent (0.3%) identified themselves as being from Gypsy and Irish Traveller ethnic groups, while the corresponding figure for England was 60,073 people (0.1%). The data also shows that Maidstone, Swale and Ashford rank in the top five of England local authority districts with the highest proportion of people from the Gypsy or Irish Traveller ethnic group (0.6%, 0.6% and 0.5% respectively).

These numbers may be lower than the true population size as it is recognised that people from Gypsy or Irish Traveller ethnic groups are often reluctant to disclose their ethnicity for fear of discrimination. Additionally, the mobile nature of these communities can mean that counts taken at snapshots data may be less stable in their accuracy compared to other populations. It should also be noted that the 2021 Census was recorded during the COVID-19 pandemic when many people were displaced from their usual place of residence.

**Figure 2: Gypsy and Irish Traveller Population in Kent; Population numbers within Kent wards, 2021**

**Table 1: Kent wards with the largest Gypsy and Irish Traveller Populations; Population numbers taken from the 2021 Census**

|  |  |
| --- | --- |
| **Ward** | **Gypsy and Irish Traveller Population** |

|  |  |
| --- | --- |
|  |  |
| Sheppey East (Swale) | 189 |
| Marden and Yalding (Maidstone) | 125 |
| Coxheath and Hunton (Maidstone) | 123 |
| Weald Central (Ashford) | 120 |
| Headcorn (Maidstone) | 114 |

Within Swale there are three distinct areas with high populations of Gypsy and Irish Traveller communities: Meresborough, Upchurch and the Isle of Sheppey (all of which are settled communities) (11.1%, 8.7% and 8.2% of residents are Gypsy or Irish Traveller respectively).

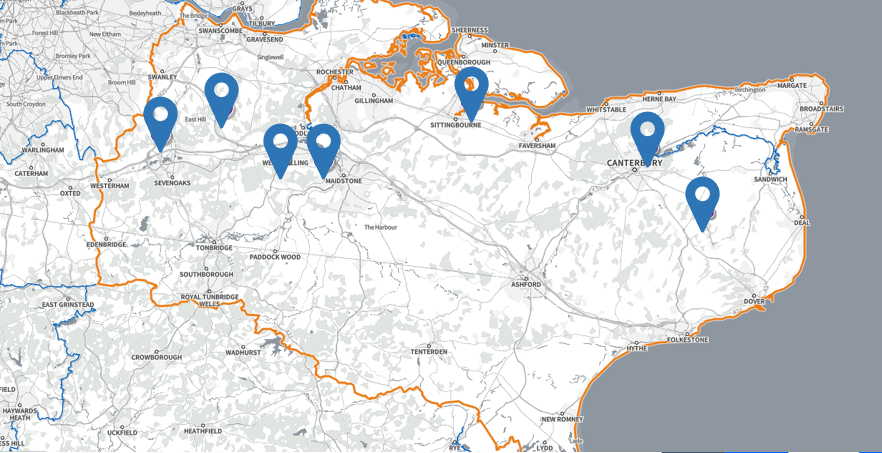
Within Maidstone, Linton, Hunton and Ulcombe have high populations of Gypsy and Irish Travellers communities; (11.6%, 9.2% and 8.1% of residents respectively).

Other areas in Kent where Gypsy and Traveller communities are located include near the Dartford Bypass, near Shadoxhurst, Ashford and near South Alkam, Dover (10.7%, 14.5% and 8.5% respectively).

Kent County Council owns and manages seven sites designated for Gypsy and Traveller accommodation. These include:

* Dover
* Sevenoaks
* Aylesford
* Canterbury
* Polhill
* Sittingbourne
* West Malling

**Figure 3: Kent County Council owned Gypsy Roma Traveller accommodation sites.**



In the UK, around 3/4 Gypsy and Travellers now live in bricks and mortar settled accommodation, and 1/4 live in caravans or mobile structures, either residing on private and public (council) caravan sites or on unauthorised encampments (FFT 2020).

**Table 2: Local authority authorised site provision in Kent, Caravan Count, July 2022**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **District** | **Site name and location** | **No. pitches (of which transit)** | **Caravan capacity** | **Date opened** | **Date of last site changes** |
| Ashford | Chilmington, Chart Road | 23 (0) | 32 | 1985 | Not known |
| Dartford | Claywood Lane, Bean | 12 (0) | 12 | 1972 | 2012 |
| Dover | Snowdown Caravan Site, Aylesham | 14 (0) | 14 | 1985 | 2002 |
| Gravesham | Denton Caravan site, Gravesend | 8 (0) | 16 | 1977 | 1984 |
| Maidstone | Stilebridge Lane Caravan Site, Marden | 23 (0) | 23 | Not known | Not known |
| Maidstone | Water Lane Caravan Site, Ulcombe | 20 (0) | 20 | Not known | Not known |
| Sevenoaks | Barnfield Park, Ash | 35 (0) | 35 | 1999 | 1999 |
| Sevenoaks | Hever Road, Edenbridge | 16 (0) | 16 | 1993 | 2013 |
| Sevenoaks | Polhill, Dunton Green | 7 (0) | 7 | 1993 | Not known |
| Swale | Silverspot, Old Ferry Road | 1 (0) | 1 | 1990 | Not known |
| Swale | Three Lakes Park, Swale Way | 14 (0) | 22 | 1990 | Not known |
| Tonbridge and Malling | Coldharbour Caravan Site, Aylesford | 33 (0) | 52 | 1982 | 2013 |
| Tonbridge and Malling | Windmill Lane, West Malling | 14 (0) | 14 | 1969 | Not known |
| Tunbridge Wells | Cinderhill Wood, Five Wents | 8 (2) | 8 | 1988 | 2007 |
| Tunbridge Wells | Heartenoak, Hawkhurst | 5 (2) | 5 | 1978 | 1978 |
| **TOTAL** |  | **233 (4)** | **277** |  |  |

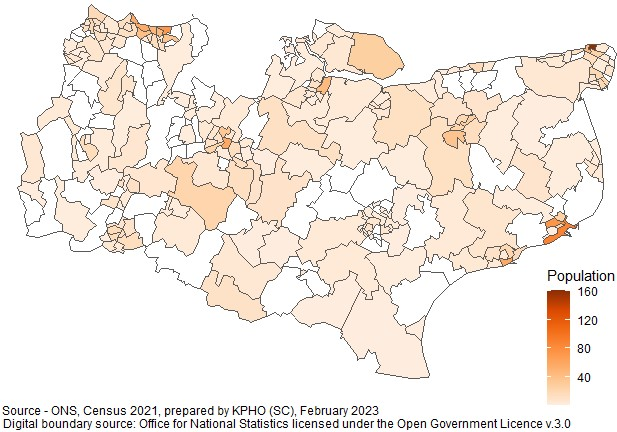
## 9.2 Kent population data – Roma

Most Roma migrants are from Central and Eastern Europe. The Roma population is estimated (by Salford University) to be at least 200,000 and to be growing nationally (Brown et al 2013). In Kent, there are Romanian, Slovak and Czech Roma individuals. Anecdotal evidence has suggested that Kent’s Roma communities have increased over recent years, however much like the Gypsy and Traveller population, data around the exact numbers of Roma populations in Kent is unknown.

The 2021 Census recorded that 2,255 people in Kent (0.1%) identified themselves being from the Roma ethnic group, while the corresponding figure for England was 99,138 people (0.2%). The 2011 census data found a Roma **national** population (total for England and Wales) of 730 via write-in responses (GOV 2022).

Anecdotal evidence suggests that the majority of Roma population are living in housed accommodations and include 2nd and 3rd generation family members. The map below shows areas in Kent that have higher populations of resident Roma individuals.

**Figure 4: Roma Population in Kent; Population numbers within Kent wards, 2021**



Stakeholder engagement and information provided via the Southeast Strategic Partnership for Migration identified Dover, Thanet, Folkestone, Gravesend, Maidstone, and Medway as areas where higher populations of Roma live. This is borne out by the 2021 Census data.

**Table 3: Kent wards with the largest Roma Populations; Population numbers taken from the 2021 Census**

|  |  |
| --- | --- |
| **Ward** | **Roma population** |

|  |  |
| --- | --- |
|  |  |
| Cliftonville West (Thanet) | 161 |
| Town & Castle (Dover) | 89 |
| St Radigunds (Dover) | 75 |
| Riverside (Gravesham) | 73 |

There are further ‘pockets’ of higher populations of the Roma community. In Thanet, 5.9% of the population in Cliftonville East identify as Roma as do 8.4% in Dover West. Medway has a high number of resident Roma individuals (Census count 469 people); In Kent Sevenoaks has the fewest Roma residents (Census count 72 individuals).

## 9.3 Education Data

There is no separate ethnic group for Roma pupils so education data for all Gypsy, Roma and Irish Traveller pupils is given below.

### School Pupil Population

Table 4: Percentage of school pupils across the Kent districts

Spring 2022

|  |  |  |
| --- | --- | --- |
| **District** | **Number of Gypsy, Roma and Traveller of Irish Heritage pupils** | **Percentage of Gypsy, Roma and Traveller of Irish Heritage pupils** |
| Maidstone | 432 | 1.8 |
| Swale | 268 | 1.2 |
| Sevenoaks | 210 | 1.4 |
| Ashford | 207 | 1.1 |
| Dover | 189 | 1.3 |
| Thanet | 168 | 0.9 |
| Gravesham | 158 | 1.0 |
| Tunbridge Wells | 140 | 0.9 |
| Canterbury | 121 | 0.7 |
| Tonbridge and Malling | 119 | 0.6 |
| Dartford | 118 | 0.7 |
| Folkestone & Hythe | 60 | 0.4 |
| **Total** | **2,256** (includes 66 undeclared) | **1.1** |

The school census suggests that the Gypsy, Roma and Irish Traveller population in Kent is larger than the 2021 Census states (0.4%), although some of the discrepancy could be due to larger family sizes within the communities.

## 9.4 Data limitations

There are two main concerns regarding the use of data related to Gypsy, Roma and Irish Traveller groups: under-recording and inconsistency of recording.

### Under-recording

Gypsy, Roma and Irish Traveller people may be reluctant to self-identify for fear of discrimination and mistrust of organisations and authorities.

According to the Census in 2021, there are a total of 7,660 people living in Kent from one of these communities. Yet searches of primary care health records return less than 1,000 patients recorded by General Practices. This can be partly explained by differences in the likelihood of being registered with a GP and by data completeness issues. Overall, about 70% of registered patients in Kent have a valid ethnicity recorded in their primary care health record. There is a concern that these ethnic groups are less likely to be recorded than others.

### Inconsistency

The 2021 Census recorded data on those who identified themselves as ‘Gypsy or Irish Traveller’ category and a new ‘Roma’ category. Multi-variate level data is not yet available for the 2021 Census (as of March 2023). This is data that has more than one piece of information measured or observed at the same time. For example, the number of individuals who identify as Roma with long-term health problems.

The ethnic group ‘Gypsy or Irish Traveller’ ethnic group was first introduced in the 2011 Census. This was not intended for people who identify as Roma because they are a distinct group with different needs. People who identified as Roma in 2011 were allocated to the ‘White Other group’. The separate category ‘Roma’ was introduced in the 2021 Census.

Where ethnicity is recorded by public sector organisations it is common to group Gypsy, Roma and Irish Traveller communities with other white minority groups. For example, the NHS Data Dictionary, used by treatment providers, has the groups ‘White British’, ‘White Irish’ and ‘Any other white background’. This is also adopted by Stop Smoking services. This approach is based on 2001 Census classifications.

The Department for Education groups children as ‘Gypsy/Roma’ and ‘Travellers of Irish Heritage’.

The Race Disparity Unit (RDU) has committed to working with government departments to maintain a harmonised approach to collecting data about Gypsy, Roma and Traveller people using the GSS (Government Statistical Service) harmonised classification. The GSS harmonisation team workplan recommend using the questions in the 2021 Census for data collection for ethnic groups at present.

The RDU has identified working with the Department of Health and Social Care and NHS Digital colleagues as a priority; the NHS classification is based on 2001 Census classifications and does not capture information on any of the Gypsy Roma Traveller groups separately (they were categorised as ‘White Other’ in the 2001 Census).

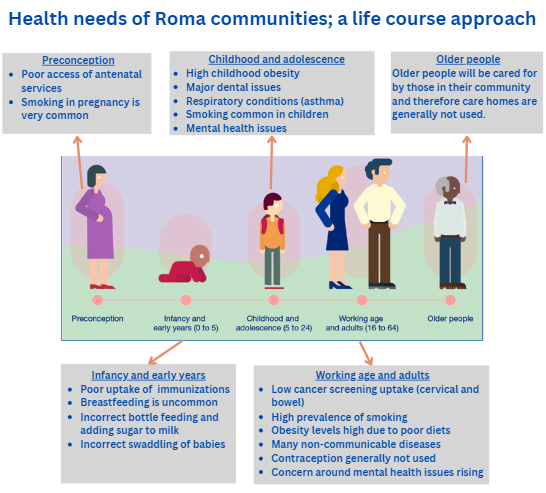
## 9.5 Stakeholder engagement findings

These are several key themes that have been developed throughout the interview process and the thematic analysis conducted. The findings are split into two; focusing firstly on Roma communities, followed by Gypsy and Traveller communities.

*Please note: this section presents verbatim quotes from interviews. They have not been attributed to maintain anonymity. Often the word ‘they’ is used to describe community members which may sound dismissive. This is not the intention of informants or this HNA which seeks to be sensitive to Gypsy, Roma and Traveller communities throughout.*

### 9.5.1 Roma findings

Stakeholder interviews identified the health needs faced by Roma communities; they are demonstrated using the infographic below, which takes a life course approach to health issues.

**Figure 5: Health needs of Roma communities in Kent; a life course approach – Kent County Council Public Health findings from stakeholder engagement qualitative interviews** 

**Poorer health outcomes across the life course:**

**Maternal and early years:**

* Stakeholders highlighted the poor access and late presentation to antenatal services.
* Smoking is a significant problem in pregnant women and stakeholders discussed that there are few women who will stop smoking when they are pregnant.
* There is a lack of uptake of contraception, resulting in women opting for abortions as a last resort. Some Roma women will return to their own country to have a termination.
* Breastfeeding is not common within Roma communities and often viewed as taboo.
* Stakeholders discussed inappropriate use of bottle feeding and the belief ‘sugar is good for the bones’ (often mothers will put sugar in formula milk).
* Incorrect swaddling of babies was acknowledged and concern regarding the lack of education around safe sleeping in babies (one stakeholder reported a case of sudden infant death which may have been linked to overheating).

**Children and Young People**

**Immunisations:**

* Low immunisation uptake in children and young people, often as a result of misinformation spread throughout the community (e.g., beliefs around autism as a side effect).
* Some children are smoking as young as 12 years old. One stakeholder highlighted that the children they work with have now quit smoking but have started to vape.
* Asthma was a common problem discussed and so was the severity of asthma attacks (presenting to A&E with asthma attacks); thought to be as a result of incorrect management of condition (e.g., stakeholders noted incorrect inhalation techniques) and perhaps as a result of second-hand smoking / smoking themselves.
* Childhood obesity was a frequent stakeholder finding; poor diet and consumption of sweets and sugar being a common occurrence.
* Dental issues in children were apparent, with stakeholders discussing children with rotting teeth at three or four years old; stakeholders reported a poor understanding of good oral hygiene and children often having high sugar diets.
* Constipation was a concern, attributed to poor diets and children not being correctly toilet trained and not emptying their bowels properly.

**Adults:**

* There was a general consensus that there is a low uptake of screening in Roma communities; particularly cervical screening uptake as this is taboo in their culture.
* Lack of knowledge or uptake of contraception; often responsibility will fall onto the women, which sometimes results in women opting for abortions as a last resort.
* Engagement with vaccination programmes: stakeholders discussed the concern amongst community members around the flu vaccine and highlighted that the Covid vaccine was a ‘*whole other thing’*; the HPV vaccine is also deemed inappropriate and unnecessary due to being a taboo.
* High prevalence of non-communicable diseases (e.g., heart attacks, high blood pressure, strokes, diabetes).
* Issues regarding respiratory conditions, for example asthma, COPD and breathing difficulties were recorded.
* Chronic pain was highlighted; often problems with back pain or legs, perhaps from manual labour.

**Mental Health:**

* Roma communities do not have a word to mean mental health and they find it difficult to distinguish between mental health and physical brain conditions.
* There was concern around young men’s mental health in particular and the number of young men in mental health hospitals is thought to be rising.
* Stakeholders acknowledged women’s mental health and how they are often the ones who experience isolation as they have little independence within this culture.

**Older Adults:**

* Roma elderly often have multiple co-morbidities.
* Stakeholders emphasised the importance of the Roma family and caring for their elders; it is unlikely that a Roma elder will be placed in a care home.

**Behavioural/lifestyle factors**:

* Smoking is prevalent in these communities. Stakeholders noted the traditional and deep-rooted habits (e.g. morning routine of coffee and a cigarette being the norm for majority of Roma adults).
* Many Roma individuals are overweight or obese which was attributed to a poor diet; many have lifestyle related illnesses, e.g. high blood pressure, heart attacks, strokes.
* Very few Roma individuals exercise; one stakeholder acknowledged this issue disproportionately affected women, which may be a result of cultural beliefs about physical appearance. Although not reported, not taking part in formal exercise may also be a result of Roma women not having access to resources (e.g. independent transport or disposable income, which have been discussed as common issues).
* Stakeholders reported alcohol use disorders in some adults, but acknowledged this was not as big an issue as smoking. Drugs not were not recognised as a significant concern but there was acknowledgement that this is probably well hidden in the community; one stakeholder did highlight marijuana use in young men.

**Health beliefs:**

* Engagement with preventative health care is low as Roma individuals do not consider this a priority.
* The Roma community can be fearful of going to the doctors from fear of finding something sinister and not returning back home (e.g. going into hospital for a long period).
* Roma communities will often take their cues from information sources in their country of origin (this was especially of concern when Covid-19 restrictions were different in the UK).
* Individuals may opt to return to their home country for medical treatment (e.g. long-term cancer treatment).
* Misinformation and side effects of vaccinations is widely spread, particularly if an individual within the community has experienced a negative reaction (e.g. developed a cold after receiving a dose of vaccine).
* There is significant cultural taboo surrounding sexual health, contraception, or anything to do with intimate parts of the body (e.g. breastfeeding, cervical screening). One stakeholder stated that ‘*nobody ever talks about sexual health*.’
* Mental health is not recognised within the community, and there is not a word to mean ‘mental health’. Stakeholders also recognised concerns around children not being diagnosed with neurodivergent disorders as parents would not present for testing for fear of discrimination.

**Barriers to accessing health care for Roma communities.**

Using the Levesque et al (2013) model of the five dimensions to health care (*approachability, acceptability and appropriateness, availability and affordability)*, stakeholders’ views of Roma individuals’ access to health care services are presented below.

Additionally, stakeholders suggested successful interventions and engagement with Roma communities, which are described in boxes corresponding to each theme.

**Approachability**

*Approachable services are visible to the populations they serve and are recognised by potential service users that they can be reached and will have an impact on their health.*

**Theme 1: Trust** - The lack of trust was the most dominant theme throughout the interviews, very much in line with national research. Stakeholders acknowledged the real concern amongst the Roma community regarding social services and children being removed due to engaging with professionals.

*“Roma only trust Roma.”*

*“Within Roma communities they are really, really, really scared of their kids being taken away.”*

*“They’re not used to professional involvement because in their country it means they’re gonna take their children away (…) I had one Mum, and she wanted her child to have his dry skin looked at and its quite chronic and she said, ‘if I take him to the doctors will social services be called and will I lose him?’ and I thought, how brave are you that you came here thinking that was an actual possibility.”*

**Intervention 1: Taking the time to build trust.**

Stakeholders acknowledged the importance of understanding that this is not an overnight quick fix, especially because of the scale of mistrust of professionals amongst the Roma community. Trust must be built in a sustainable, patient-focused environment and working sensitively on messaging or activities that have specific relevance to this community will help break down barriers and reduce the perceived vulnerability.

*“We must allow ourselves the headroom and space to work this out, we are too focused on numbers and meeting targets.”*

*“Take your time and build the trust with them, because once you have that trust, you’re in, the door is open.”*

*“A lot is short sharp burst pilots that’s taken away. If you want this community to trust you, that is what they’ll be used to, so it needs to be a sustainable continued process.”*

**Theme 2: Language** *-* Language was noted as a significant barrier discussed by all stakeholders. There was concern around basic information not being offered in the correct language.

*“How can they be expected to book an appointment when they don’t even have an option in their own language?”*

An additional concern around language is the availability of suitable translators; stakeholders highlight that these are either offered in the incorrect language or they add an additional layer of mistrust.

*“And sometimes when they do go to the GP and the GP is providing a translator, they will usually receive Slovakian or Czech Republic, which is OK for some Roma, but not all Roma because they do not understand Slovak or Czech languages. We do not have Roma translators and then it’s the mistrust not just of the doctor but also of the translators because they’re not speaking the same language.”*

*“It’s difficult, should we call patient champions in each surgery who speak different languages, that’s really tricky because the Roma community are close knit, and everyone knows someone and so from a data protection point of view its difficult and they are less likely to trust the translator if it’s their friend’s cousin’s sister.”*

Participants discussed issues around children being used as translators by their parents at GP appointments, which is inappropriate particularly for some medical concerns and appointments.

*“Children as young as six are explaining things to the doctor for Mum, things they shouldn’t even know about, but they can speak English and then of course, things can get lost in translation and the incorrect information might get said back to Mum.”*

“*There was one young girl translating for her Mum and the doctor said that Mum would have to go to the hospital for treatment, but the daughter didn’t translate this as she didn’t want her Mum to leave her and go to the hospital.”*

**Intervention 2: Accessible information.**

A key finding was the need for accessible information to be used. There was discussion around the issue of accessibility of health information that is written in English. Suggestions around improvements consisted of visual information, minimal wording, using videos and ensuring language preferences are available (e.g., Romani). Face to face information sharing was always stated as the ultimate engagement tool for these communities.

It is essential that information is received from a credible source, relayed in an appropriate way for the audience and is relevant in the setting in which these communities are living their lives.

*“Face to face is a must, and you’re also building the trust, it needs to be delivered in an acceptable way to the audience and it’s about taking the time to explain things.”*

*“How we’re getting around some of this, especially with the cervical screening, we do visual leaflets, which sounds horrible, but visuals are so much better as you don’t need different leaflets for different languages.”*

*“It could be videos, like a video of a GP surgery, there’s a GP surgery doing this in Thanet, filming a tour of the surgery, this is what happens when you come in, here is where you go and sign in for your appointment and it’s in their language, not English.”*

**Acceptability/appropriateness**

*Acceptable services are culturally and socially appropriate to the populations they serve and are judged so by potential service users.*

**Theme 3: Navigating the system -** Stakeholders emphasised the issues around the complexity of navigating the NHS system, especially regarding onward referrals and waiting times. The participants also discussed how Roma communities may access health services, like the GP or A&E. However preventative services are unlikely to be accessed.

*“They don’t understand why you aren’t seen by one person for everything, the referral system doesn’t make sense to them, the waiting times are alien, anything that would need an onward referral would become challenging.”*

*“I do think they are a bit more open to the GP if there is a problem but in terms of screening and things like that, they are still on the back burner for them very much.”*

*“They might take their child who has a cold and temperature to the hospital, which is obviously an inappropriate pathway, but they know they can just turn up and be seen there.”*

**Intervention 3: Use existing engagement.**

Most stakeholders highlighted the importance of using already established relationships and trusted individuals in the community, whilst taking a proactive approach to reach into these communities by offering engagement events to build trust and increase knowledge of the system (e.g. what services are available to them). Building on previous asset-based work is required but it must also be noted that there may be reluctance to engage if activities don’t have the backing of trusted or influential individuals.

*“You must piggyback on other stuff that’s happening with established relationships.”*

*“They are not going to come to us, they’re not sitting there waiting for us to come and talk to them. It’s up to us to go and meet that community and seek out what they need.”*

*“We held a family day event last year and had some health checks there as well, and we were offering blood pressure checks and they were like ‘oh I’m here so may as well get checked’, so having things that are appealing family events and then health is just also ‘there’.”*

**Theme 4: Cultural taboos -** The stakeholders noted that there are certain medical conditions that are not deemed ‘appropriate’ to discuss within their culture. Sexual health and mental health were all extreme taboos acknowledged in the Roma communities.

*“I once discussed sexual health and contraception and one family just got up and left.”*

*“Some of the ladies have got pregnant and they would go home for a termination and that’s really really sad. And of course, then we looked at getting these ladies the access here, if that’s the choice they want then we need to support them to have it here, and they don’t discuss this with their husband.”*

*“When it comes to mental health, people really don’t want to recognise it, they literally haven’t got a word to mean mental health.”*

Moreover, due to certain medical conditions being viewed as taboo within these communities and not discussed in this tight knit community, individuals can subsequently experience devastating isolation (possibly a young person) when diagnosed or requiring medical help for one of these conditions.

**Intervention 4: Workforce training**

Stakeholders discussed the need for staff who are working with the Roma community to have the appropriate cultural training, to ensure there is understanding about historical experiences, to reduce discrimination and prejudice and understand cultural differences (e.g. taboos that exist).

*“I just wish there was more training I guess for us and more understanding and having empathy for that group, it would be beneficial to have training in different professions but definitely for GPs and receptionist staff.”*

*“So maybe like a workshop about Roma culture and understanding of how they have been treated in their country, some history you know about their behaviours and stuff like that so they can have more understanding about who they are dealing with.”*

In addition, several stakeholders also mentioned the importance of recruiting from these communities.

*“Recruit from these communities – if you can recruit from these communities, you’re halfway there.”*

**Availability**

*Available services, either physical space or those working in health care roles, can be reached and in a timely manner.*

**Theme 5: Logistical barriers -**The availability of accessing health services was highlighted, especially regarding when travel is required to access appointments, resulting in individuals not attending their appointments because of this.

*“I had a lady the other week that wanted an abortion and you know, there’s nowhere local that does that, so she has got to travel to Maidstone, she doesn’t speak English, doesn’t drive, and she won’t understand the correct after care and support etc.”*

*“The majority of middle-aged ladies don’t drive and so it means that the man or uncle has to take them to the hospital and many times I would write them down bus numbers and describe the routes of where they should get off but no, they just wouldn’t go by public transport and so it means their options are very limited and they DNA appointments often because of this.”*

The concern of digital exclusion and accessible information was discussed by participants.

*“It’s quite embarrassing to come out and ask for help with form filling and things, and not understanding something, they might need things read to them or explained in a different way.”*

*“Often they have no laptops or computers therefore can’t access things online like bookings appointments.”*

**Intervention 5: A joined-up approach.**

Stakeholders considered the importance of partnership working and stakeholders understanding local populations through collaborative working. There should be consideration regarding utilising the relationships and experience that the voluntary sector and grassroot organisations also have.

*“I think it helps the community because we're all the local stakeholders and we are kind of fitting together now. We've all got a component that helps support this community.”*

*“The PCNs, the children centres, the local authorities need to look after their patch and once that is done, you can then draw into a much systemwide approach, because if you do it too big, it's not gonna work. Each demographic will have different needs and a lot of the time, this group don't know actually that they do need something until we tell them, until we show them.”*

*“We should realise the people who are ‘gold dust’, our voluntary organisations and those who have those ‘ins’ with the communities.”*

**Affordability**

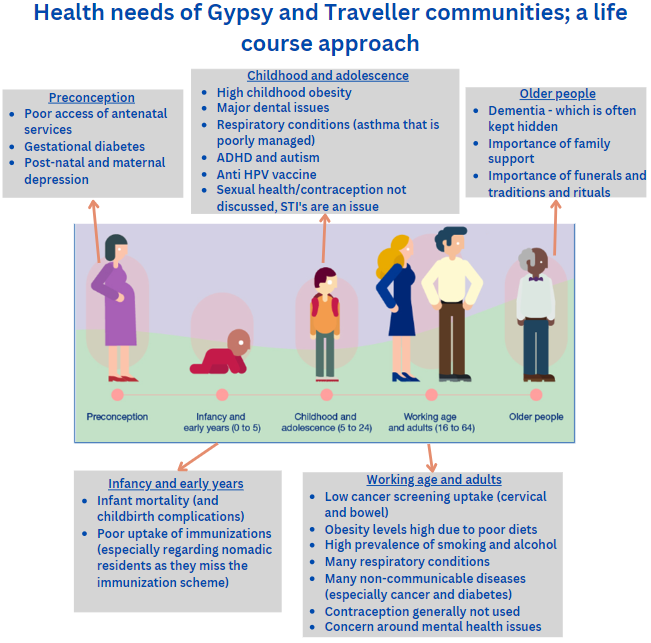
Despite stakeholders not explicitly mentioning any concern around affordability contributing to the barriers of access to healthcare, the wider determinants and social factors discussed by the stakeholders acknowledged the low levels of employment. Low levels of employment and poverty are likely to act as a barrier to health care, as individuals are less likely to be able to take time off from work or afford travel or parking expenses to attend an appointment.

### 9.5.2 Wider determinants

* Low levels of employment recognised within the stakeholder interviews.
* Low attainment and achievement levels in education, although language is improving in the younger generations; many middle-aged individuals are partially illiterate and are relying on younger generations (see the [education section](#_School_attendance) of the Gypsy and Traveller findings for Gypsy, Roma and Traveller school attendance and attainment combined).
* There is a distinct hierarchy within the community and cultural traditions regarding men being dominant and responsible for bringing in money, whereas women are responsible for child-rearing and household responsibilities and no more.
* Stakeholders discussed a significant concern around poverty and housing issues and insecurity (and a lack of understanding within this community regarding what they are entitled to in terms of help and support) as well as overcrowded living conditions and poor hygiene.

### 9.5.3 Gypsy and Traveller findings

Stakeholder interviews identified the health needs faced by Gypsy and Traveller communities in Kent; shown in the infographic below, which takes a life course approach to health issues.

**Figure 6: Health needs of Gypsy and Traveller communities in Kent; a life course approach – Kent County Council Public Health findings from stakeholder engagement qualitative interviews** 

**Stakeholders reported poorer health outcomes across the life course:**

**Maternal and early years:**

* Stakeholders highlighted that Gypsy and Traveller mothers had poor access to antenatal services and subsequently presented late. During discussions stakeholders spoke of the difficulty in accessing maternity care when individuals are living nomadic lifestyles.
* There was anecdotal reporting of cases of infant mortality seen on Gypsy and Traveller sites. This was thought to be a result of childbirth issues and non-detection of abnormalities that might have been diagnosed through antenatal services and screening. Stakeholders spoke of babies born with deformities and attributed this to these not being picked up due to lack of attendance at antenatal services.
* Gestational diabetes was discussed as an issue for Gypsy and Traveller pregnant women.
* Post natal depression was acknowledged as a concern, for which few women are accessing help and support.

**Children and Young People**

**Immunisations:**

* Stakeholders reported widely held beliefs against immunisation amongst Gypsy and Traveller community members and there is reported low immunisation uptake in children and young people. One stakeholder acknowledged one community member saying, *‘immunisations are not in our culture’*. There are also issues around misinformation spreading throughout the community (e.g. beliefs around autism as a side effect). Nomadic living (especially those living on unauthorised sites) and not having a fixed address contributes to low immunisation uptake as community members do not receive invitations to the childhood immunisation programme and miss health promotion messages.
* The HPV vaccine is viewed by some as inappropriate and unnecessary due to sexual health issues being a taboo. For example, one stakeholder reported a mother stating her daughter will not need the HPV vaccine as she is not ‘promiscuous’.

**Prevalence and management of childhood illnesses**

* Stakeholders observed a high prevalence of childhood illnesses in general, and asthma, childhood obesity and poor dental health in particular.
* This was due in part to progression to more severe illness and a view amongst stakeholders that conditions were not being adequately managed, due to low levels of health literacy being a contributing factor. A high prevalence of severe asthma attacks, often presenting to A&E, were cited as an example and one stakeholder discussed how children would incorrectly inhale their asthma pumps, leading to unmanaged condition and worsening symptoms.
* Early symptoms of childhood illness can go unrecognised which leads to late presentations and more entrenched chronic disease.
* Poor diets and a high consumption of sweets and sugar were highlighted as being common to many Gypsy and Traveller children.

**Mental Health in Children and Young People**

* Autism and ADHD in children were also discussed as concerns, as was relatively high levels of dyslexia.
* Young people’s mental health, in particular high rates of anxiety and depression, was highlighted as a concern. Teenagers, particularly young boys, were thought to be at risk. One stakeholder acknowledged how attending a state school can often exacerbate feelings of isolation, anxiety and depression in Gypsy and Traveller young people.

**Adults:**

**General Health**

There was a general consensus amongst stakeholders that within Gypsy and Traveller communities:

* There is a low uptake of cancer screening, particularly cervical screening uptake which was attributed to cultural taboos. Stakeholders noted that most women had never attended for cervical screening.
* Cancers are often diagnosed at a later stage (thought to be due to a lack of understanding of symptoms and presenting late to clinical settings for diagnosis). In some cases, individuals were being diagnosed with cancer at a younger age.
* There was a high prevalence of non-communicable diseases (e.g. heart attacks, cardiac arrests, high blood pressure, strokes).
* There are issues with many respiratory conditions, such as COPD and asthma; one stakeholder mentioned that many Gypsy and Traveller residents attribute this to the environment in which they live in and the poor air quality. Complications with long-covid and breathing problems were highlighted.
* There are high rates of type 1 and type 2 diabetes. One stakeholder discussed how they have known of individuals to die or become seriously ill due to the incorrect management of their condition.
* One stakeholder highlighted issues with urinary tract infections in women, as they are unable to fully sit down on the toilets due to the unsanitary conditions on sites, subsequently meaning they cannot fully empty their bladder.
* Haemophilia, an inherited blood clotting disorder, was discussed; stakeholders highlighted the risk of serious outcomes for affected individuals living on site or carrying out manual labour should accidents or incidents occur.
* Chronic pain was highlighted; often problems with back pain, perhaps from manual labour.

**Sexual Health**

* There is significant cultural taboo surrounding sexual health and contraception, attributed to religious beliefs. Anything related to intimate parts of the body is not discussed (there is a very low uptake of cervical screening in these communities and low uptake of HPV vaccine).
* There is a lack of contraception used in teenagers or not using contraception in the correct way as they have not been taught. One stakeholder acknowledged that they often do not use contraception as it is against their religion.

**Engagement with preventative services**

* Engagement with preventative health care was reported to be a low priority; one stakeholder described a conversation with a community member who said they would not seek medical help unless ‘*they were literally on deaths door’*.
* Stakeholders discussed the resistance amongst community members around the Covid vaccine, noting that they believe what they see on social media and fake news.

**Mental health in Adults:**

* There was concern around mental health and the unmet need for support within these communities. One stakeholder stated that many individuals in the community have been affected by suicide (often being bereaved by suicide). Another stakeholder noted that they often see individuals at crisis stage and at breakdown rather than attempting to prevent and improve mental health and wellbeing.
* Mental health is not a topic of discussion within the community, although some stakeholders did record a noticeable shift in younger generations being more forthcoming about discussing anxiety and depression.
* Post-natal and maternal depression was discussed; one stakeholder raised concern that as the women are often left at home, with no work or independence, they suffer generally with poorer mental health.
* Men are unlikely to discuss mental health problems; one stakeholder highlighted an overreliance on Diazepam for mental health issues that would be better treated or accompanied with talking therapies.

**Older Adults:**

* Gypsy and Traveller elders often have multiple co-morbidities.
* There is a lack of dementia care planning which was attributed to not seeking medical care or help. There are potential on-site risks to vulnerable adults with dementia, and those who care for them, which could be addressed through care planning.
* Stakeholders emphasised the importance of Gypsy and Traveller families caring for their elders.
* The importance of funerals was discussed, and the rituals and traditions that this includes for these communities; often funerals are attended in large numbers, and often individuals will travel across the country to attend, perhaps being away for weeks or longer. Stakeholders noted how this can impact on accessing appointments, as often individuals want to access health services in their local area and due to not understanding the three DNA discharge rule, many will remain undiagnosed and untreated as they are discharged back into primary care.

**Behavioural/lifestyle factors**:

Many stakeholders highlighted the following:

* High prevalence of overweight and obese individuals, attributed to a poor diet and consumption of highly processed foods (often takeaways and fast food) and diets high in sugar and salt.
* High proportion of smokers within the community, often children second-hand smoking.
* High levels of alcohol consumption, especially in men.

**Health beliefs:**

* A reluctance to seek professional help alongside a cultural element of ‘brushing off’ symptoms and thinking a doctor will not be able to help.
* There is a sense of feeling judged with negatively held preconceptions about Gypsy and Roma traveller communities.
* Culturally there are differences in documentation, for example, quite often stakeholders highlighted that individuals in the Gypsy and Traveller community will not know their own date of birth date nor have such documents (which consequently acts as a barrier when accessing health services).
* Another cultural difference is their concept of time; stakeholders acknowledged their lack of using calendars and diaries in the same way the general population would do so; again, posing an issue when booking future appointments.
* Gypsy and Traveller communities will often take their health cues from social media which gives inaccurate information that spreads rapidly throughout the community; negative experiences of healthcare quickly travel around the community (e.g. developed a cold after receiving a dose of vaccine).
* There are deep-rooted beliefs of looking after ‘their own,’ especially when a family member is sick. There are matriarchs of sites who hold much of the knowledge regarding health and interventions (which may or may not be appropriate).
* Mental health is not recognised well within the community. One stakeholder acknowledged there had been times when suicide and depression had been particularly bad on site, however, could not determine how common mental health issues are; noting this might be due to not disclosing such problems due to the cultural taboo, or individuals not disclosing due to being unaware of what they are experiencing.

**Barriers to accessing health care for Gypsy and Traveller communities.**

The Levesque et al (2013) model of the five dimensions to health care (*approachability, acceptability and appropriateness, availability and affordability)* is used to discuss Gypsy and Traveller communities access to health care services.

Additionally, stakeholders suggested successful interventions and engagement with Gypsy and Traveller communities, which are described in boxes corresponding to each theme.

**Approachability**

*Approachable services are visible to the populations they serve and are recognised by potential service users that they can be reached and will have an impact on their health.*

**Theme 1: Trust** - The lack of trust was the most dominant theme throughout the interviews, very much in line with national research. Stakeholders discussed the issue of racism and discrimination further exacerbating the lack of trust in authoritative figures.

*“Many professionals don’t treat as an individual; they judge and have preconceptions about the community.”*

*“I am from the Romany Gypsy community, and I have never filled out a census and said, ‘Romany Gypsy’ I say, ‘White British’ – I don’t want to declare for fear of being mistreated.”*

*“Racism is a massive reason why it might deter people, they are not treated the same, they end up having to hide themselves and their identity, in fear of being treated a certain way.*

**Intervention 1: Taking the time to build trust.**

Stakeholders acknowledged the importance of understanding that this is not an overnight quick fix, especially because of the scale of mistrust of professionals amongst the Gypsy and Traveller community. Trust must be built in a sustainable, patient-focused environment and working sensitively on messaging or activities that have specific relevance to this community will help break down barriers and reduce the perceived vulnerability.

*“As I say, it’s going to be trying to get to know them on a personal level then building that trust up, possibly through a GP, you know a GP might gain that trust.”*

*“Them speaking to a trusted professional, someone they have seen regularly, they might come and say, what do you think about say the Covid vaccine for example, and they’re coming to you because you’ve built such a rapport and relationship with them, and they think you have all this knowledge and it does sort of change their thought process slightly.”*

*“It’s a slowly slowly catchy monkey approach, it’s not an overnight fix, it’s going to take time and resource.”*

There was also discussion around the significance of ensuring the community were aware that the system is there for them, not against them.

“*We need to make it clear that we have an eye on them, and in the right way, we want to ensure that they have equality with the rest of our communities, and they are not being stigmatised or left out.”*

**Theme 2: Literacy levels –** The issue of literacy levels was discussed by stakeholders, and the barrier this causes in terms of accessing health services. In addition, stakeholders also highlighted the need for more education and awareness raising around certain health conditions, which need to be appropriately adapted to meet literacy needs in this community.

*“Simple stuff you know, completing forms, registering them with a GP and dental service what have you, can be really tricky.”*

*“Because actually if you just get a letter a lot of them can’t read or write anyway so letters are irrelevant and then trying to find out where they are living on top of that because they are moving around makes contact difficult.”*

*“And because of the literacy levels, or the lack of literacy levels, you have to explain things in a sort of layman’s term without making them feel stupid and for them to understand and make an informed choice. And I think the most important thing is giving them time, which is what we don’t have in general practice.”*

*“There sometimes isn’t the knowledge around symptoms and diseases to understand what symptoms might indicate something more serious.”*

**Theme 3: Misinformation –** Stakeholders highlighted the barrier of misinformation, as inaccurate and harmful content spreads rapidly throughout these communities, as well as there being deep rooted beliefs concerning certain health conditions and services.

*“Information spreads like wildfire and they will talk and scaremonger.”*

*“They would rather take on board the media influence and what the media is saying, like fake news, rather than maybe a professional. They cannot filter out fake news and what’s true, they take whatever is said in the community as gospel rather than looking at an official research article.”*

*“I had a lady who’s forty, fifty maybe, and she didn’t get her son the MMR jab, and then he subsequently died of rubella and that was a massive thing, but even now she doesn’t regret not giving him the vaccine because she believes its linked to autism.”*

*“There are a lot of beliefs around immunisation, and you know the flu jab and Covid jab and it being linked to autism and ADHD and things like that, it’s getting better but it does still worry them.”*

There was concern regarding a lack of knowledge around symptoms and diseases and the need for the community to understand that certain symptoms might indicate something more serious which needs clinical attention.

**Intervention 2: Accessible information.**

A key finding was the need for accessible information to be used when engaging with this community. There were concerns discussed around the issues of accessibility of health information due to literacy levels. Suggestions around improvements consisted of having more visual information and minimal wording, using trusted individuals to spread messaging, and identifying key platforms for awareness raising.

It is essential that information is received from a credible source, relayed in an appropriate way for the audience and is relevant in the setting in which these communities are living their lives.

*“And we’ve managed to get some of the younger women in for screening which before they’ve never had a screening but a lot if it is having the time to sit down with them and explain to them why it is important to have a smear.”*

*“There was a Give Blood donation advert tailored towards ethnic minorities because they needed more blood from those groups, and I think health things that are more tailored towards them, warning about things like cancer etc, especially for them would work.”*

*“Leaflet dropping could work and information and education and awareness raising but you have to spend 5 or so minutes with them to explain what this means, if things get worse call this number and signposting for further help and support. You can’t just give them a leaflet and go.”*

**Acceptability and appropriateness**

*Acceptable services are culturally and socially appropriate to the populations they serve and are judged so by potential service users.*

**Theme 4: Navigating the system -** All stakeholders highlighted the issues around the complexity of navigating the NHS system, especially regarding accessing appointments, onward referrals and the complexity of nomadic communities.

“*Their concept of time is totally different to ours; they don’t use calendars or diaries. Giving someone an appointment in two months’ time, they’re unlikely to attend. That’s why they need to be reminded, via a phone call on the day of appointment, and where they need to go, when and how to get there.”*

*“A real issue is when they do move around and being able to access prescriptions and medications.”*

*“We did have an issue when we had 40 families pitch up near our surgery and they were coming in to register and there was confusion as our receptionist said ‘I can’t register you as you don’t have a fixed address’. We subsequently put their address as the surgery, and they are now registered patients with us.”*

Conversely, some participants did note that many Gypsies and Travellers are well integrated and would have no problem accessing and navigating the system.

*“Only a small amount of Travellers are still nomadic and aren’t able to access health care.”*

*“Many Romany Gypsies are well integrated.”*

Additionally, it was also noted *how* the Gypsy and Traveller communities use the health care system, and that there are beliefs within the community of only accessing help and support when vital.

“*They won’t go (to the doctor) unless they are literally on deaths door, I was having a conversation recently and he was saying ‘we don’t go to hospital, we don’t go to the doctors unless we really have to go.”*

*“Their culture is very much they don’t need to go to the doctors unless it’s an absolute crisis hence many end up in A&E.”*

**Intervention 3: Use existing engagement.**

Most stakeholders highlighted the importance of using already established relationships and trusted individuals in the community, whilst taking a proactive approach to reach into these communities by offering engagement events to build trust and increase knowledge of the system (e.g. what services are available to them). Building on previous asset-based work is required but it must also be noted that there may be reluctance to engage if activities don’t have the backing of trusted or influential individuals.

*“On Facebook there is a community and word travels very fast, especially if it’s a positive message about helping them or what they can access, they will share that quite fast.”*

*“The elder in the Gypsy and Traveller community will help as they offer advice and support to the community so if you get in there the information will be shared.”*

*“Them speaking to a trusted professional, someone they have seen regularly, they might come and say, what do you think about ‘X’ and they’re coming to you because you’ve built such a rapport and relationship with them, and they think you have all of this knowledge, and it does sort of change their though process slightly.”*

**Theme 5: Cultural taboos -** The stakeholders noted that simply, there are certain medical conditions that are not deemed appropriate to discuss within that culture. Sexual health and mental health were all extreme taboos in the Gypsy and Traveller communities.

*“They don’t believe in contraception, they are Catholic. I went in and one of the nurses mentioned contraception to a 16-year-old and the mother literally flew at her saying she’s not married.”*

*“Very few girls will get the HPV vaccine, they’re very against it. I had one mother saying that her daughter is not going to be promiscuous and all sorts of things.”*

*“I was once being asked all sorts by these two young girls, all about menstruation and rape and I was sat there thinking I shouldn’t be talking to them about the because their families would be horrified but I was answering in a matter-of-fact way. They couldn’t get their questions out fast enough and they had really distorted ideas about a few things.”*

*“A few times suicide and depression has been really bad in the community, losing multiple family members within a short amount of time (to suicide), I’m not too sure how prevalent it is because they just don’t speak about it.”*

Moreover, due to certain medical conditions being viewed as taboo within these communities and hence not discussed in this tight knit community, individuals can subsequently experience devastating isolation (possibly a young person) when diagnosed or requiring medical help for one of these conditions.

**Intervention 4: Workforce training**

Stakeholders discussed the need for staff who are working with the Gypsy and Traveller community to have the appropriate cultural training, to ensure there is understanding about historical experiences, to reduce discrimination and prejudice and understand cultural differences (e.g. taboos that exist).

*“People just need a bit more education and a bit more awareness.”*

*“There needs to be training for all members of health services to understand the gypsy culture and traditions and norms as well as the discrimination faced by this community on a day-to-day basis.”*

*“As a surgery we had a meeting about how we’re going to deal with this population because it’s really important to basically see them and get rid of the prejudices. Because even within the receptionist teams you know, we all have prejudices. We have our own opinions of this community so it’s trying to be completely non-judgemental to make them feel more comfortable.*

In addition, several stakeholders also mentioned the importance of recruiting from these communities.

*“The thing that I think works in this community is to have somebody from that community themselves.”*

**Availability**

*Available services, either physical space or those working in health care roles, can be reached and in a timely manner.*

**Theme 6: Negative experiences -** Stakeholders discussed the significance of negative experiences which may result in Gypsy and Travellers ceasing engagement with a particular service. In addition to this, many Gypsies and Travellers will attend the same GP surgery, health services or schools as they feel safe in the knowledge that their community is also present there and having a positive experience.

*“There just needs to be one experience, just one and it could be a minor experience of an encounter with someone in uniform and that one experience will stay with them and be concreted in their beliefs.”*

*“Where there has been a serious medical condition or even a death in the family, they will all be at the hospital, around the bed, this is tradition and normal however can sometimes be met with aggression from staff as they think ‘haven’t you got nothing better to do’.”*

*“You will find that Gypsy and Traveller families tend to congregate if you like, or use the same schools etc.”*

**Theme 7: Generational differences** - Several stakeholders recognised the importance of hierarchy within the communities and how identifying a trusted and respected individual can act as an opportunity for engagement.

*“If you can identify the ‘elder’ in the Gypsy and Traveller community, this will help as this is a well-respected and valued individual who holds information and offers advice and support to the rest of the community.”*

Another noteworthy finding was discussion around a generational shift, in terms of the younger generations ability to engage and build knowledge around health conditions and services they can access.

*“The youngsters now, I think are sort of finding out you know because of the internet and phones and things, I think they are a bit more with it, with what’s going on in the world.”*

*“A couple of Mums I spoke to said they were very anti-immunisations for their children and said it’s not in their culture. But I’ve now spent a lot of time with them, explaining the benefits and I have a few new Mums now who have babies and they’re having them vaccinated. I think its trust, education and perhaps a generation thing too.”*

**Intervention 5: A joined-up approach.**

Stakeholders considered the importance of partnership working and stakeholders understanding local populations through collaborative working. There should be consideration regarding utilising the relationships and experience that the voluntary sector and grassroot organisations also have.

*“We need to make it clear that we have an eye on them, and in the right way, we want to ensure that they have equality with the rest of the community, and they are not being stigmatised or left out.”*

*“Any professional that is going to be working or engaging with this community needs education on this community and understanding from the start why there is mistrust and about the intriguing parts of their culture because this shifts their thoughts on professionals too.”*

There may be opportunity to undertake family focused work to assist learning across generations and help mitigate some of the adverse effects of cultural norms and beliefs.

*“The majority of the time, the people who are younger, maybe 35 and younger, tend to be a little better integrated generally and that positively impacts accessing health services.”*

**Affordability**

Despite stakeholders not explicitly mentioning any concern around affordability contributing to the barriers of access to healthcare, the wider determinants and social factors discussed by the stakeholders acknowledged the low levels of employment. Low levels of employment and poverty are likely to act as a barrier to health care, as individuals are less likely to be able to take time off from work or afford travel or parking expenses to attend an appointment.

### 9.5.4 Wider determinants

**Education**

* Low attainment and achievement levels in education; bullying and discrimination still occur although some improvements have been observed. One stakeholder highlighted that for some Gypsy and Traveller students the best thing for them is to be with their community and people they identify with, rather than being in mainstream education where they feel isolated and experience poor mental health and wellbeing.

### School attendance

The absence rate for Gypsy, Roma and Irish Traveller pupils in the Autumn 21 and Spring 22 terms was significantly higher than the Kent average at 17.5% compared to 7.7% (note: education data is collected for Gypsy, Roma and Irish Traveller children and young people combined).

Figure 7: Kent school pupil attendance rates

Autumn 21 and Spring 22 terms

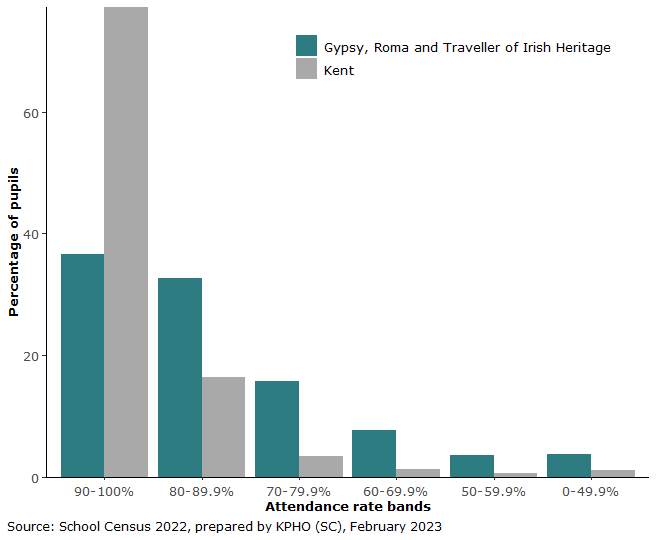


Figure 7 shows that over 3/4 of Kent school pupils have over 90% attendance, in comparison to just over 1/3 of Gypsy, Roma and Irish Traveller pupils.

There was evidence that Gypsy, Roma and Irish Traveller pupils had significantly lower attendance than the Kent average.

### Elective Home Education

There was a higher percentage of Gypsy, Roma and Traveller children and young people, recorded as educated at home between 6th September 2021 and 31st August 2022 when compared to the pupil population: 8.2% compared to 1.1% respectively.

### Students removed from roll

In the 2020/21 academic year, 37.7% and 33.3% of students identifying as a Traveller of Irish heritage were removed from the school admission register (referred to as being ‘removed from roll’) in the R-6- and 7–11-year groups respectively, this compares to 1.4% at the Kent level in both year groups.

In the Autumn 2021 and Spring 2022 term there were 1,525 Gypsy, Roma and Irish Traveller pupils listed as attending primary school and 657 attending secondary school. This is a 70/30 split which compares with a 59/41 split at the Kent level. These numbers suggests that higher than average numbers of Gypsy, Roma and Irish Traveller children attending primary school may not go on to enrol at secondary school.

### School exclusions

In the Autumn 2021 and Spring 2022 terms 7.5% of Gypsy, Roma and Irish Traveller pupils were excluded from school compared with 2% for the whole of Kent.

### Percentage of pupils meeting the expected standard KS2 in reading, writing and maths

The percentage of pupils meeting the expected standard KS2 in reading, writing and maths is significantly lower for Gypsy-Roma and Traveller of Irish Heritage children and young people at 14.9% compared with the Kent pupil population at 59% (2021).

**Living conditions**

* There was concern highlighted around site conditions: poor water sanitation, high levels of pollution and air quality, as sites are often near motorways, issues of contaminated land and the suitability and safety of sites in the height of winter and summer. Unsafe environments for children was also acknowledged. Overcrowding of living conditions was discussed, as was the issue of individuals not being aware of benefits and support they might be entitled to.
* Stakeholders also discussed that this community are often active as they engage in manual labour and are therefore outdoors often, which should be further explored to understand more about health and wellbeing in this community, as this is deep-rooted in their history and culture and something they very much enjoy.

The case studies below exemplify how services should work together to address issues and intervene early to support health and wellbeing and improve the life chances of community members.

**Case study 1:**

*One Mum in Swanley with mental health issues had 3 young primary age children.  She was a lovely mum and had a good relationship with the school. But, on some occasions she was unable to get out of bed and get the children ready for school. On those days, when the children were young, they would miss school.  As the children grew a little older, the oldest sibling would try to get the younger ones ready herself and leave home to walk to school alone.  They would be leaving home late so the roads were emptier. They learned to avoid being home to get away from the rows and mum’s low mood. Risk taking behaviours became more common, out on the streets, spending time in the park with older children and smoking. Their persistent low attendance affected their progress and achievement, relationships with others in the school as they missed so much of what was going on and general attitude to education.*

**Case study 2:**

*A family living just inside the boundary of Bromley but going to school in Kent. The children had terrible school attendance. They lived in a trailer and could not afford the heating. It was wet at night-time, the children became ill, there was domestic abuse. One of children became a school refuser as he was so frightened of leaving his mum alone.  It was terrible trying to access services for the child because they lived in Bromley, but the child was at school in Kent.*

## **Microsoft Forms snapshot survey of Kent County Council sites**

To gain a better understanding and insight into the Gypsy and Traveller communities, Kent County Council Gypsy and Traveller sites were invited to undertake a brief mapping exercise via a snapshot survey. KCC site liaison managers completed a Microsoft Forms survey which explored demographic profiles of each site and basic health needs within these communities. The results are as follows.

**Figure 8: Demographic profiles of KCC owned sites; completed via Microsoft Forms**

|  |  |  |  |
| --- | --- | --- | --- |
| **KCC site** | **Est individuals on site (including unauthoritsed individuals)** | **Average age of people on site** | **Approximate number of children (aged under 18)** |
| Aylesham | 32 | Evenly split | 13 |
| Aylesford | 76 | Evenly split | 32 |
| West Malling | 35 | Young - mostly > 30 | 15 |
| Canterbury | 37 | Mid-age - mostly 30-60 | 12 |
| Sittingbourne | 47 | Evenly split | 20 |
| Barnfield Park | 150 | Mid-age - mostly 30-60 | 30 |
| Polhill | 27 | Evenly split | 10 |

The gender split of each site was also obtained through data collection. In four KCC owned sites, the site liaison managers noted there were mostly women living there. The other sites had an even split of gender.

It was important for the research to establish what communities live on KCC sites. Within the KCC sites the community most dominant were the Romany Gypsies. ‘*Other’* refers to the sites that had a mixture of Romany Gypsies and Irish Travellers.

**Figure 9: Dominant community of KCC owned sites; completed via Microsoft Forms**

It was of significance to understand how many residents on site were registered with a GP surgery, as this is often noted as a concern throughout the literature and national research.

Within the KCC sites, site liaison managers acknowledged that more than half of the individuals living on site were registered with a GP surgery (figure 10), and this was observed in most sites.

**Figure 10: Individuals on site registered with a GP practice, completed via Microsoft Forms**

Regarding health needs, the survey asked site liaison managers *to the best of their knowledge, do health visitors (HV) attend their site and if so, approximately how often*. Some responses highlighted that health visitors had attended sites, but this was often a rare occurrence and for a specific reason, others could not respond as they were unsure whether they had seen health visitors on site before.

*“Yes, I have seen HV attend site but mainly in the early days of birth, I also understand there are sometimes barriers with HV attending site due to not understanding the community or fearful of attending site.”*

*“As far as we know, visits are rare and only for specific reasons, i.e., new-born babies, seeing mothers who have recently given birth.”*

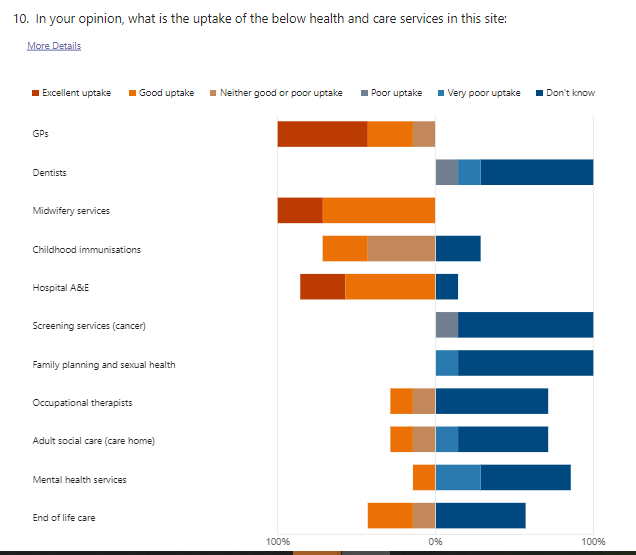
The survey also explored whether there is a member of staff on site who can signpost to relevant health services and/or has basic knowledge of what is available regarding health and wellbeing promotion and prevention. All responses highlighted that the site liaison managers are often the first port of call for these communities and therefore, they often provide a basic level of health information.

*“There are no live in members of staff, but the KCC site managers can signpost to basic health services if needed.”*

*“Myself and the other site managers always give basic advice on the importance of attending health services but not in detail.”*

Site managers were also asked, in their opinion, *what is the uptake of specific health and care services in their site*. This was of interest as much of the literature highlights that the Gypsy and Traveller communities are unlikely to access particular health and care services for a multitude of reasons. Figure 11 demonstrates that residents living on KCC sites have a good uptake of GP services, hospital A&E services and midwifery services. On the contrary, poor uptake has been noted in dentists, screening services, family planning, sexual health and mental health services.

**Figure 11: Uptake of health and care services, completed via Microsoft Forms**

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Finally, the site liaison managers were asked to categorize how their sites would find out about health services available to them, health messaging and other information. Most responses selected ‘*other’* which referred to a mixture of the listed options below.

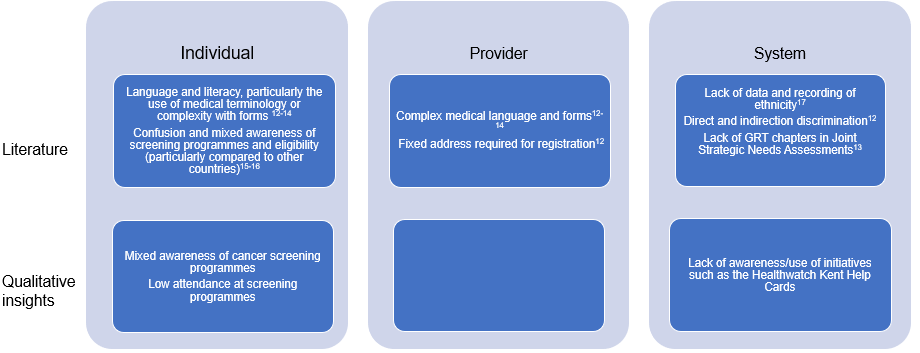
**Figure 12: Information sharing; completed via Microsoft Forms**

## 9.6 Triangulation of evidence

In this section, findings from this needs assessment have been triangulated with existing evidence on health needs and barriers experienced by Gypsy, Roma and Traveller communities in Kent. Recommendations made from previous work are assessed against the suggested interventions recommended from stakeholder findings.

**Cancer**

* The Kent and Medway Cancer Alliance developed a cancer inequalities toolkit (2022), and one chapter focuses specifically on cancer in inclusion health groups.
* Although the NHS does not record information on cancer diagnoses by Gypsy, Roma or Traveller groups, NHS Kent and Medway data taken from an analysis of national GP Survey data shows a high proportion of Gypsy and Traveller respondents reporting a cancer diagnosis compared to other groups (noting a lack of confidence intervals). This aligns with stakeholder findings reporting cancer as an issue in these communities.
* A paper-based survey was administered across Kent County Council Gypsy and Traveller sites and found the below:
  + All respondents (10/10) were registered with a GP and reported accessing GP services, and 3 also reported using A&E and 111.
  + 6/9 responded they would feel comfortable/able to go to a GP if they had a worrying symptom.
  + All respondents (10/10) were not aware of HealthWatch Kent Help cards. The cards developed by *Healthwatch Kent* allow patients to discreetly indicate that they may need additional help at their appointments, such as form-filling. There is a general version and also a bespoke card for the traveller community.
  + 5/9 respondents were aware of cancer screening programmes.
  + 5/9 would want to attend screening.
  + 2/9 reported having previously attended screening programmes (1 of which was breast). One participant responded that more information would help individuals attend screening.
  + 5/9 participants do not regularly check their body for changes.
* The research also explored qualitative insights into the lifestyle of Gypsy, Roma and Traveller communities. It found the following:
* 4/8 reported that they currently smoke or use tobacco.
* All 4 smokers were not interested in stopping or reducing the amount they smoke.
* 6 reported no alcohol consumption.
* Barriers were identified at an individual, provider and system level in accessing cancer services in Kent, as demonstrated by the figure below.

**Figure 13: Kent and Medway Cancer Alliance, Cancer Inequalities toolkit: key barriers**

Recommendations included:

* Provider recommendations: use an asset-based approach and build trust over time; use simple language; provide support with form filling; provide translated materials; ensure services do not disadvantage digitally excluded.
* System recommendations: ensure people from a Gypsy Roma and Traveller background are registered with a GP which would allow screening to be offered; training of staff in primary care to understand the health and access needs of this community; ensure local authority JSNAs have a Gypsy Roma and Traveller section; improved recording of individuals ethnicity.

**Triangulation with stakeholder findings**

The Kent and Medway Cancer Alliance findings are in line with the stakeholder findings, particularly issues around:

* Lack of knowledge and awareness around cancer symptoms.
* Lack of uptake of screening services.
* High prevalence of smoking.

The Kent and Medway Cancer Alliance recommendations also corresponded with the interventions recommended from stakeholder findings in this needs assessment:

* Build sustainable trust.
* Use relevant information in an appropriate format.
* Invest into workforce training.
* Develop a joined-up approach.

**Covid-19 vaccine**

* Research was undertaken in 2021 by Compas Charity, on behalf of Kent County Council, to provide insight into whether Roma people living in Kent are at risk of lower uptake of the Covid-19 vaccine and why.
* Insight from 70 Roma volunteers was gathered, with age ranges from 18-65 years old. Findings include:
  + At the time of conducting the interviews, only 15 out of 70 people had at least one dose of the vaccine, which equates to only 21.4% of all respondents. The UK average equates to 91.6% for over 40s receiving one does of the vaccine in May 2021.
  + For individuals aged 18-25 none were vaccinated, in the age group 26-40 five participants were vaccinated and in the age group 41-60, seven were vaccinated. The research does highlight however, that at the time of conducting the research, not all age groups had access to the vaccine and with this in mind, the number of participants now vaccinated may differ from the date of the interviews.
* The research explored what would change attitudes amongst Roma communities about getting the Covid-19 vaccinations and what public authorities could do more of. Findings included:
  + Most individuals said they needed more information in their own language.
  + Reassurance was required regarding the vaccine not causing any harm but also providing more information and education about any possible health risks caused by the vaccine.
  + Stopping the spread of fake news.

Recommendations included:

* Awareness raising - translated information resources and Covid-19 vaccine ambassadors.
* Engagement with influential people and other stakeholders within the community: several influential and trusted community leaders were identified during the research who play a vital role in providing health messages to this community.
* Accessible services**:** one of the biggest barriers was the low command of English and ability to work on a computer, hence there needed to be well-advertised and accessible walk-in clinics to increase vaccination uptake.

**Triangulation with stakeholder findings**

The Covid-19 insight work findings are in line with the stakeholder findings, particularly issues around:

* Lack of uptake of vaccinations.
* Lack of knowledge regarding vaccinations due to language barriers.
* Issue of widely spread misinformation regarding vaccine side effects.

The Covid-19 insight work recommendations also corresponded with interventions recommended from stakeholder findings in this needs assessment:

* Use relevant information in an appropriate format.
* Use existing engagement.

**Maternal health**

* During the summer of 2022, NHS Kent and Medway undertook research with focus on people from Black, Asian and minority ethnic communities and those living in neighbourhoods with high levels of deprivation, about their experiences of Kent maternity services.
* As the research focused on Black, Asian and minority ethnic communities, for the purpose of this health needs assessment, only findings from the Gypsy, Roma Traveller community will be used. The research obtained views from Roma women, aged 22 to 54 years. Findings included:
  + Overall, many people were satisfied with the maternity services and said they had received caring support from midwives and other staff before, during or after the birth - *“The care was above standard. In my opinion, all was right regarding my pregnancy. I had not anything to complain about. My midwife explained all to me, provided me with a lot of information and contacts to where to turn for help if needed or in the case of any complications.”*
  + More help and education was required – *“After birthing my baby, no-one helped me. Not show me well feeding the baby.”* And *“Not understanding only little English. Did not understand what induction and C-section is, no pain relief.”*
  + Accessible information needed to support mothers before, during and after birth – *“On the internet in Czech language, the brochures were only in English. I prefer it in my language.”* There was also mention of wanting information about childhood diseases in their mother tongue.

Recommendations included:

* Improving communication with families – especially where there are barriers to communicating.
* Focus on creating consistent person-centred care.
* Create a culture where racism and discrimination are not tolerated. Example quotes from Roma women *“Please be good to me and my culture.” “Treat me the same as an English woman.”*
* All maternity staff to understand cultural diversity and can act on needs and values of diverse cultures.
* Make every effort to recruit more staff from diverse backgrounds.
* Focus on improving care and support after birth.
* Encourage feedback, create a safe space for those from diverse backgrounds to share their experiences and demonstrate accountability when things go wrong.

**Triangulation with stakeholder findings**

The NHS Kent and Medway Perinatal work findings are in line with the stakeholder findings, particularly issues around:

* Lack of knowledge and education during birth (e.g. birthing options and pain treatment).
* Lack of knowledge and education post birth (e.g. breastfeeding / childhood diseases).
* Fear of being discriminated against and mistrust of professionals.

The Kent and Medway Perinatal work recommendations also corresponded with the interventions recommended from stakeholder findings in this needs assessment:

* Build sustainable trust.
* Use relevant information in an appropriate format.
* Invest into workforce training.
* Develop a joined-up approach.

**Lifestyle behaviours – healthy eating**

* This research was commissioned by University of Greenwich Natural Resources Institute as part of the UKCRF and was based on objectives of Kent and Medway Partnership for enterprise, food and health recommendations.
* Research was undertaken in 2022 to support the drive to reduce diet-related inequality and create a long-term shift in food culture. The research sought to understand the barriers and facilitators of eating for health by members of ethnic minority communities and how the trajectory of obesity can be changed through healthy eating.
* As the research focused on minority ethnic communities only findings from the Gypsy and Traveller communities are presented here. The research obtained views from Gypsy and Traveller community groups conducted via focus groups with seven adults living in authorised KCC sites. Some qualitative insights taken from the thematic analysis are below:
  + The study found that there is mostly adequate knowledge in ethnic minority groups on the impact of food on their health, although **significantly less so** within the Gypsy, Roma and Traveller community - *“No, I don’t know what foods are healthy. I can’t read you see. I have to eat what is available.”*
  + Affordability of foods was an issue for Gypsy, Roma and Traveller communities - *“I go by the price.”*
  + Factors identified from the study (including the wider ethnic groups) as influencing food eaten for health are affordability, age, availability, cultural influences, and knowledge and awareness.

Recommendations included:

* Design education techniques to build essential knowledge, including more visual information rather than written communication and non-English versions.
* Bring smaller community organisations delivering smaller projects together for better service provision and to reduce duplication of effort.
* Develop multifaceted community spaces that can offer a variety of facilities (e.g. developing cooking skills, community shop).

**Triangulation with stakeholder findings**

The Ethnic Minority Healthy Eating work findings are in line with the stakeholder findings, particularly issues around:

* Poor diets consisting of highly processed foods and high in sugar and salt are common within this community.
* Lack of knowledge around what constitutes healthy eating.
* Literacy levels acting as a barrier to information and education.

The Ethnic Minority Healthy Eating work recommendations also corresponded with the interventions recommended from stakeholder findings in this needs assessment:

* Use relevant information in an appropriate format.
* Develop a joined-up approach.
* Use existing engagement.

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# 10. Current services working to meet the needs of the Gypsy, Roma and Traveller communities

## 10.1 Health

Gypsy, Roma and Traveller communities who are British citizens are entitled to all NHS services free of charge, although as demonstrated throughout this document there are evident barriers in accessing health care services for these communities. The situation is more complex for Roma individuals who have migrated into the UK, even if they have been resident in the UK for several years. This is because many Roma are citizens of an EU country, and the requirement to prove they are entitled to healthcare changed after the end of freedom of movement in the UK. EU citizens living in the UK who do not have settled or pre-settled status under [the EU Settlement Scheme](https://www.gov.uk/settled-status-eu-citizens-families), and have not yet applied for status under the scheme, are **no longer entitled to free secondary healthcare** until they make a valid application (Roma Support Group n.d.). This could act as an additional barrier to accessing healthcare for this community, although it is not known how many Roma individuals have not applied for settled status. Roma people who have recently arrived in the UK may also not be aware NHS healthcare is free at the point of access for most people. Everyone, regardless of immigration status, has the right to access free primary care from a GP, urgent care centres and walk-in centres (GOV 2022).

The initiatives described below came to light through stakeholder engagement and are unlikely to be a complete list of all activity seeking to meet the health needs of the Gypsy, Roma and Traveller communities in Kent.

**The Dunkirk Women and Family Hub**

There is a current project running in Dunkirk Village Hall, seeking to encourage individuals from a nearby caravan site near Canterbury and Faversham to attend a drop-in heath session and checks, aimed predominantly at women and children but appropriate for all. The information leaflet also highlights where the village hall is located in comparison to the caravan site, ensuring ease of access for individuals.

**Are you ready for parenthood? Leaflet**

The Southeast Regional Maternity Team have created a Gypsy, Roma and Traveller community version leaflet of tips, advice and support for new parents. The information can be accessed [here](https://www.southeastclinicalnetworks.nhs.uk/wp-content/uploads/2023/01/ReadyforParenthood-GRT-community-booklet.pdf). The leaflet aims to educate around health of the new-born baby (e.g. vaccinations) and the health of the mother (e.g. looking after mental health and stopping smoking). The leaflet is created in an accessible manner with limited wording and uses images to educate and convey public health messaging. The document also consists of further useful links so individuals can find out in more detail about topics covered in the booklet.

**One You Lifestyle Advisor**

One You Kent has several advisors to support and advise on health prevention and health changes (weight loss, physical activity, smoke free, health checks). The Gypsy, Roma and Traveller community can access such services, and from stakeholder engagement research, intel has shown there are a small number of Roma patients currently accessing the Smoke Free service; it was highlighted that although the figures are incredibly small for those accessing the Smoke Free service, there are Roma patients currently engaged in the service, with the majority remaining smoke free after the 26 week follow up.

**Here 2 Help**

Social Enterprise Kent CIC has awarded [Compas](https://compas.org.uk/current-projects) (Roma charity) funding to tackle health inequalities. Here 2 Help is a new project that will aim to improve access to health, to increase awareness of health services in Thanet and enable people to gain more confidence in accessing such services. Here 2 Help aims to create a bridge between those communities and health provisions. Focus includes:

* Focus groups at centres on Northdown Road, Margate, covering various topics, including obesity, diabetes, stroke, maternity provisions, cancer, substance misuse, sexual health etc.
* Cooperation with schools and colleges with higher number of Roma pupils to increase awareness of healthy eating, obesity, and other important topics.
* Advice provision and translation for people struggling to get medical help.
* Targeted marketing and dissemination of information via social media and other means.

## 10.2 Best practice in Kent

‘Best practice’ has been derived from the triangulated recommendations from stakeholder engagement and previous work undertaken in Kent to understand health needs and barriers faced by the Gypsy, Roma and Traveller communities. This includes:

* **Building trust** with the communities in a sustainable and proactive way.
* **Offering relevant information** and ensuring information is relayed in an appropriate format for the audience.
* **Using already established relationships** and existing engagement.
* **Investing in workforce training** to ensure there is understanding about cultural differences and experiences.
* **Offering a joined-up approach** and exploring partnership working; utilising all contact with these communities where appropriate.

**Best practice 1 – KCHFT healthy communities project Kent**

* Delivered by Kent Community Health Foundation Trust (KCHFT) which ran between 2018 – 2020.
* Created a bespoke cohesive team that worked solely with migrant communities.
* Employed from the migrant workforce and trained the employee to be a One You lifestyle advisor, gaining access to the target communities, building trust and educating local clinicians and making information sharing easier.
* Once trained, the One You lifestyle advisor worked within their own communities, helping with a variety of issues: alcohol; healthy eating; registering with a GP and dentist; benefits; housing queries and domestic abuse.

Key outputs and areas of best practice included:

* Workforce: Employed from the migrant workforce and invested in training. The One You lifestyle facilitator saw 314 new clients from the Roma community over the course of the project.
* Accessible and appropriate information: Health visitors created ‘grab packs’- translated versions of leaflets already in use – for core services to pick up and grab before visiting a family.
* Offering a joined-up approach: Public health messages were delivered (including on dental health, healthy eating and immunisations) to children and adults though assemblies, classes and talks at community hubs.
* Workforce training: 24 cultural awareness training courses were delivered across the county in addition to 1 ‘train the trainer’ course to support the project legacy.

**Best practice 2 – Breastfeeding uptake in Roma communities**

* Undertaken as part of a Darzi Fellowship and following on from the individual’s previous role as a health visitor, it was identified that breastfeeding in Roma women in southeast Kent were particularly low. Also well-established bottle-feeding belief within the community.
* The project focused on relationship building and collaboration and invited Roma mothers to discuss their experience of breastfeeding, in whichever language they felt most comfortable with.
* The film was co-produced with the Roma women, acting as a vehicle to give the Roma women more confidence in themselves and to support new mothers to breastfeed, whilst also acting as a launch pad for delivering services together in the future. The [video on Roma women discussing breastfeeding can be accessed here](https://youtu.be/Edn6Dy5ZLHk).

Key outputs and areas of best practice included:

* Building trust with the community: Offering an opportunity to co-produce a project which will be beneficial to both those involved and future expectant mothers.
* Accessible and appropriate information: Increasing awareness and knowledge within the community regarding breastfeeding in an accessible and appropriate way (e.g. Roma women discussing in Roma on video).
* Using existing relationships: As the project lead was an ex-health visitor, there was already a level of engagement and relationship with some of the women prior to the project commencing.

**Best practice 3 – Ramsgate GP Surgery working with local Gypsy and Traveller community.**

* A community of Travellers moved in close by to the GP surgery and there was an initial issue regarding registration at the surgery, as the receptionist identified they had no fixed address and mistakenly thought they could not become registered patients.
* The team subsequently met and decided how best to support this community; recording the individuals’ address as the surgery’s address enabling them to become registered patients.
* Proactively engaged with the community and undertook a scoping visit in 2021 to understand the level of need in the population. Outreach work continued (e.g. blood pressure checks, vaccination uptake).
* Surgery staff now have regular contact with this community and there are now over 40 families registered at this GP surgery.

Key outputs and areas of best practice included:

* Building trust with the community: Have worked to build sustained trust and relationships with the communities (e.g. proactively reaching out to the communities, offering longer appointments often at the end of the day to ensure complex needs are being met).
* Accessible and appropriate information: Provided education and awareness in appropriate manner (usually face to face) regarding areas where there is a lack of uptake of services (e.g. cervical screening, immunisations in children, antenatal services) and have subsequently seen an increase in access and uptake.
* Offering a joined-up approach: Working in partnership with other service providers and stakeholders to understand and further support the community (e.g. working with Thanet district council to explore improvements to site conditions).
* Workforce training: Staff at the surgery have undertaken cultural awareness training (provided by a community member) to ensure surgery staff are aware of cultural differences and historical backgrounds. Basic knowledge of how the population lives and subsequently, offering additional help and support to ensure they can access services (e.g. phone call reminder on day of appointment, help with booking referral appointments/form-filling).

**Best practice 4 – Margate GP Surgery working with local Roma community.**

* A GP surgery has spent the last couple of years understanding their local population health needs and have undertaken asset-mapping to develop plans which focus on the Roma community and improving health needs.
* They have worked extensively to build trust and engage with Roma patients (using full engagement events in local community centres and proactively reaching out to the Roma communities).

Key outputs and areas of best practice included:

* Building trust with the community: Building trust and proactively engaging with the community through events (monthly outreach into the community).
* Offering a joined-up approach: Working with partners to offer a joined-up approach to support and there is now a local core group established, meeting fortnightly to raise concerns and discuss action. Other partnership working includes working with KCHFT regarding outreach clinics for child immunisation catch up programme; attending breakfast clubs in three local schools to offer health promotion or answering queries.
* Accessible and appropriate information: Regular outreach clinics with an outreach care coordinator who speaks four different languages, translating literature into relevant languages. Also disseminating health information in known locations e.g. Polish grocery shops. Provided education and awareness in appropriate manner (e.g. provided step-by-step visual ‘how to use’ guide for e-consult in five different languages, raised awareness of Covid vaccine and dispelling myths via a myth busting campaign, a paediatric nurse in school teaching correct asthma inhaler techniques).
* Workforce training: Delivering training for surgery administration staff around conflict resolution and understanding that not ‘one-size-fits-all’.

## 10.3 Wider determinants service provision

**Education**

**GTRSB pledge**

There is a [new national pledge](https://www.bucks.ac.uk/sites/default/files/2023-03/GTRSB%20Pledge%20for%20Schools%20Report%202023_FINAL.pdf) for education settings which seeks to improve access, retention and outcomes in education for Romany Gypsies, Travellers, Roma, Showmen and Boaters (GTRSB). The GTRSB school’s pledge consists of a firm commitment by education settings (schools, colleges, universities) to undertake certain steps to support the education of these pupils. The pledge is designed to support best practice in ensuring the monitoring of data, inclusion practice and the development of widening participation practice of GTRSB pupils, potential pupils and their families.

Schools must commit to working towards creating the most appropriate and welcoming environment and conditions in which GTRSB pupils can stay resilient and thrive academically and personally.

**Housing**

**Kent County Council -** [**Gypsy and Traveller Site Pitch Allocations Policy**](https://letstalk.kent.gov.uk/pitch-allocations-policy)

KCC are updating their Site Pitch Allocations Policy, changes are being proposed to ensure that pitches are allocated in a fair, transparent, and consistent way. The current Gypsy and Traveller Site Pitch Allocation Policy was last updated in 2012 and it sets out how KCC establishes an applicant’s need for a pitch on a site the council owns and how vacant plots will be allocated.

The proposed changes will only impact on future people applying to live on KCC owned sites. This will not impact current site residents unless they have children who are looking to apply for a pitch of their own when they reach 18 years old. The main changes that are being proposed are:

* Requesting supporting documents at application stage
* More robust verification and background checks
* Introduction of a deposit for each pitch
* Excluding applications from those who set up an unauthorised encampment on KCC land (including highways).

The consultation has now closed, and a subsequent consultation report will be produced, summarising the feedback the team have received.

**Kent County Council – Gypsy and Traveller Service; Energy Voucher Scheme**

Kent County Council (KCC) Gypsy, Roma Traveller Resident Service has been supporting residents on KCC owned and managed sites, and those residing on the Maidstone Borough Council owned sites, with accessing the Household Support Fund Energy Voucher Scheme through the Professional Referral Energy Voucher Scheme being administered by KCC.

Funded by the UK government, the Household Support Fund scheme supports vulnerable Kent households in need of help with significantly rising living costs. As one element of support, KCC set up a scheme for professionals to refer people into and the KCC Gypsy and Traveller Resident Service ensured that as many residents as possible from Gypsy, Roma Traveller communities on KCC managed sites benefitted from this.

Referrals have been made at every available opportunity and have provided significant financial contribution towards rising energy costs, in some cases providing a timely relief from worrying about costs and how energy would be sourced.

**Maidstone Borough Council –** [**Maidstone Gypsy, Traveller and Travelling Showpeople DPD**](https://localplan.maidstone.gov.uk/home/gypsy-traveller-development-plan-document)

Maidstone Borough Council is undertaking a Gypsy, Traveller and Traveller Showpeople Development Plan Document (DPD) and will form part of the Development Plan, in addition to the emerging Local Plan Review and Design and Sustainability DPD. Maidstone has noted it is committed to meeting the housing needs of the Borough’s Gypsy, Traveller and Travelling Showpeople communities in a sustainable way. This includes promoting an integrated co-existence between existing and future sites and wider local communities, balancing the needs of all communities whilst protecting the natural and built environment.

The plan is asking for views on these matters and are particularly keen to hear ideas on how to best meet the needs of the gypsy, traveller and travelling show people communities and what planning matters the policies should address.

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# 11. Gaps and recommendations

Although these communities have often been labelled ‘hard to reach’ this health needs assessment uncovered examples of systemic shortcomings that make it much more difficult for community members to access services.

**Gap 1: Invisibility in datasets**

There is inadequate routine data around the needs of the Gypsy, Roma and Traveller communities, including data as simple as quantifying the number of Gypsy, Roma and Traveller’s living in the UK, let alone Kent. Currently NHS services are not required to record Gypsy, Roma or Traveller ethnic status and consequently individuals from these communities are invisible in datasets used to support healthcare planning, quality monitoring, evaluation and health equity assessments. Consequently, the health needs of these communities are under-recognised and inadequately met, as evidenced by the high reported rates of poor health outcomes found in this review.

**Recommendations:**

* NHS Kent and Medway ICB and Kent County Council Public Health department should work collaboratively with the district and borough councils, as well as other key stakeholders (police, housing associations, hospitals, schools, GP surgeries) to develop a consistent approach to ethnic monitoring of the Gypsy, Roma and Traveller community in Kent. This should also be consistent with the categories used within the 2021 Census to ensure consistent data collection. Ethnicity recording is poor across the system, and this should be taken forward as a priority.
* Kent County Council to consider working with local voluntary care sector and grassroot led organisations to develop a wide-ranging campaign to explain the importance of collecting such data and encourage self-disclosure within these communities, as there remains mistrust and fear of disclosing their ethnicity.
* NHS Kent and Medway ICB to explore other ad hoc solutions to data capture in the meantime, for example stakeholder intelligence collected in primary care to enable richer understanding or establishing an inclusion health group flagging system to enable thorough acknowledgment of patients’ ethnicities throughout all health services.

**Gap 2: A lack of system-wide approach**

This health needs assessment highlighted areas of good practice, but these were often the result of individual practitioners and/or services recognising a need and subsequently addressing this. Currently there is no system-wide approach to address the health inequalities experienced by Gypsy, Roma and Traveller communities in Kent. The formation of the Integrated Care System, along with policy drivers such as Core20Plus5, provide opportunities to strategically address many of the health and care needs described in this review.

**Recommendations:**

* Public Health in Kent County Council to act as a system leader to disseminate the findings of this health needs assessment to key partners across organisational boundaries and to advocate for Gypsy, Roma and Traveller health needs across relevant strategic and service developments.
* System partners to commit to addressing the health needs of Gypsy, Roma and Traveller communities using levers such as the Integrated Care Strategy, Health and Care Partnership Prevention strategies and District/Borough Council Plans.
* System partners to identify accountability mechanisms and governance structures to ensure that Gypsy, Roma and Traveller health and care needs are being systematically reviewed and addressed against clear and measurable outcomes.

**Gap 3: More joined-up working**

A gap discussed by the stakeholders was ensuring that local areas are aware of their local footprint, their community’s needs and how best to support them. Stakeholders highlighted the importance of partnership working and understanding local populations through collaborative working with district and borough councils, the police and other public services. There should be consideration regarding utilising the relationships and experience of the voluntary sector and grassroot organisations. An integrated approach should be developed when working with the Gypsy, Roma and Traveller communities, as the health needs are wide ranging and complex, and it should be recognised that these needs are often multi-factorial and inter-related (e.g. housing, education etc).

**Recommendations:**

* Kent County Council Public Health to explore setting up a multi-agency network, to bring together service providers working to support the Gypsy, Roma and Traveller communities, enable discussion and sharing of good practice and arising challenges, and offering a co-development model. A [service directory](https://www.gypsy-traveller.org/services-directory/) developed by FFT is available, listing voluntary sector organisations who work with Gypsy, Roma and Traveller communities in Kent.
* All partners should consider how to secure representation or ‘expert by experience’ on key advisory groups and decision-making bodies on issues that are important for the Gypsy, Roma and Traveller communities and which are impacting their health, wellbeing and livelihood.

**Gap 4: Invest in developing trust and culturally competent services**

One consistent finding throughout this work has been a mistrust of services and/or professionals held by Gypsy, Roma and Traveller communities. To ensure trust is built and embedded within communities, there must be an offer of trusted professionals who provide information and support when required; either via a charitable organisation, local authorities (KCC site managers) or groups that the communities regularly engage with.

There was a gap acknowledged by stakeholders regarding the need for workforce training focused on the cultural and historical backgrounds of the Gypsy, Roma and Traveller communities. An issue highlighted was that professionals engaging with these communities (especially front-line such as GP receptionists) are often unaware of cultural sensitivities regarding communication and engagement, which consequently, can act as a further barrier to accessing services for these communities.

**Recommendations:**

* Statutory services with high Gypsy, Roma and Traveller footfall to identify champions to engage and develop relationships with Gypsy, Roma and Traveller communities.
* NHS Kent and Medway ICB, Kent County Council, district and borough councils, police and education settings should consider mandating cultural awareness training for professionals who deliver a front-line service to these communities (e.g. clinical staff, GPs, customer-facing roles such as receptionists, teachers). The Kent Safeguarding Children multi-agency partnership website offers a [Gypsy and Traveller cultural awareness course](https://www.kscmp.org.uk/training/multi-agency). This should be completed as a minimum.

**Barriers of access to and uptake of services**

**Gap 5: Address health and mental health literacy**

There is concern around the accessibility and appropriateness of health messaging to these communities. For Roma communities, there is a gap in services concerning information that is offered in their native tongue and for Gypsy and Traveller communities there is some low literacy levels which results in lack of understanding of health information. The language barriers and lack of literacy skills within these communities present a distinct disadvantage for these groups and this assessment highlighted the limited resources available to accommodate language and literacy levels in this community.

**Recommendations:**

* Kent County Council Public Health department to work with national partners (OHID and DoHSC) to develop appropriate materials to be shared within these communities.
* NHS Kent and Medway ICB and Kent County Council should consider commissioning and developing accessible and appropriate resources for the Gypsy, Roma and Traveller communities to ensure there is increased awareness of disease and symptoms, health prevention and promotion and the health services available. Professionals should consider alternative formats of communication, either via easy-read materials, visual mediums such as videos or specific campaigns aimed directly at this community which are co-produced in an innovative and appropriate manner.
* Kent County Council’s Public Health department to consider running a bespoke health promotion/prevention campaign aimed directly at Gypsy, Roma and Traveller communities, encompassing greatest health needs and barriers in accessing healthcare and ensuring the appropriate language or medium is used to relay this information.
* Kent County Council Communications Directorate to undertake an assessment across planned public health campaigns to consider their potential impact on inclusion health groups, including Gypsy, Roma and Traveller communities.
* Adult education settings within Kent to explore how they can improve adult and digital literacy levels within this community to ensure connectivity and use of health and other services. This is noted as a long-term investment into improving the overall lives and opportunities.

**Gap 6: Overreliance on short-term projects**

This work highlighted how projects supporting Gypsy, Roma and Traveller communities are often short-term. Often, engagement with communities is either time-limited due to funding or driven by passionate and committed individuals, rather than a system-led and sustained approach. This is unsustainable in the long term.

**Recommendations:**

* NHS Kent and Medway ICB and Kent County Council to explore sustainable funding opportunities for inclusion group and health inequalities in vulnerable populations, as there must be adequate funding to ensure there is long-term investment and the necessary support for these communities.
* NHS Kent and Medway ICB should embed good practice into mainstream services and encourage all Primary Care Networks to undertake an Inclusion Health [Self-Assessment Tool](https://www.inclusion-health.org/pcn/). The tool takes around 10 minutes to complete and once the self-assessment has been completed a unique and tailored guide will help PCNs embed action on tackling issues faced by all inclusion groups and reducing inequalities into its everyday activities.

**Low uptake of services**

This paper acknowledged a gap regarding universal services (primary care and hospital services, maternity services etc) at meeting the needs of the Gypsy, Roma and Traveller communities but also the need for some specialist activity and targeted interventions and services ensuring there is dedicated resource, time and focus on developing long-term commitment to communities and their needs. In addition, there is also an inconsistent approach regarding Gypsy and Travellers who have nomadic lifestyles, and these individuals are often significantly disadvantaged in accessing secondary and specialist services (due to being unable to attend appointments as they are travelling, being moved on or unable to return to site).

**Gap 7: Low uptake of preventative services**

**Recommendations:**

* Kent County Council Public Health department to work with KCC Growth Environment and Transport (GET) Gypsy and Traveller Resident Service, to explore opportunities to train KCC site liaison managers in Making Every Contact Count Training (MECC) and/or Very Brief Advice (VBA); these professionals are well-trusted and obtain established relationships with the community.
* NHS Kent and Medway ICB and Kent County Council’s Public Health department to explore opportunities to identify and train community members to become peer educators and health champions to disseminate reliable and accurate health messaging. Professionals can identify and train community members via the [Royal Society for Public Health Training Centre](https://www.gypsy-traveller.org/royal-society-of-public-health-training/) provided by Friends, Families and Traveller charity. This may act twofold, developing knowledge and raising awareness within the community and potentially leading to secure paid work for these individuals (One You Lifestyle Advisor / health support workers etc).

**Gap: 8 Address barriers to accessing primary care**

**Recommendations:**

* NHS Kent and Medway ICB should consider working with GP surgeries and identify practices within the county who are already working with these communities or express an interest in working with them going forward. These surgeries should then have support to become ‘champions’ for Gypsy, Roma and Traveller health, developing their own surgeries into models of best practice.
* NHS Kent and Medway ICB to encourage GP surgeries to have one specialist surgery per PCN that is an ‘Inclusion Health friendly’ practice, whereby practices with a high footfall of Gypsy, Roma Traveller communities could lead but this also offers further support for other inclusion health groups, e.g. people experiencing homelessness and offenders (there are currently veteran accredited practices and LGBTQ+ - pride in practice that exist to offer furthered support to such communities).
* NHS Kent And Medway ICB should guarantee all GP practices in the county are aware that patients do not need a proof of address when registering as a new patient at the surgery; administration teams should be flexible in approach as a wide range of identification should be accepted.
* NHS Kent and Medway ICB to ensure all GP surgeries in Kent are aware of, and using when required, ‘The Big Word’ - which supports governments, global brands and local communities with language translation.
* All GP practices in Kent should be aware of the [NHS GP Access Cards](https://www.gypsy-traveller.org/advice-section/what-to-do-if-a-doctor-surgery-wont-register-you-without-a-fixed-address-or-id/) which can be shown by a patient if they are refused registration.

**Uptake of other healthcare services**

**Gap 9: Support for individuals with nomadic lifestyles**

This HNA has demonstrated the challenges faced by those community members who maintain a nomadic lifestyle and how scheduling and attending health services can be problematic and constrain access.

**Recommendations:**

* All service providers to acknowledge how nomadic living can intervene and be problematic when booking appointments or scheduling future services; phone reminders on the day of appointment helps, but this can be resource intensive.
* NHS Kent and Medway ICB to consider incentivising GP practices to support those with a high footfall of Gypsy, Roma and Traveller patients to ensure they are adequately and appropriately supporting this inclusion health group; as stakeholder engagement highlighted some surgeries are currently struggling to meet complex needs and are often doing so by giving up their own free time.
* NHS Kent and Medway ICB and Kent County Council Public Health department to consider the opportunity of a pilot scheme, ‘*the golden ticket*’ as highlighted through stakeholder engagement. In 2019 the school admission code was changed so that the most vulnerable children can access a school place more quickly. There could be an opportunity for community members from inclusion health groups to be offered health services more quickly (secondary services in particular) via a ‘golden ticket’ scheme. This would: help lessen the burden on the NHS and could be cost-effective (community members would be more likely to attend the first referral appointment, therefore freeing up their rescheduled appointments); improve the health of the community members as their needs will be met sooner and reduce the number of acute admissions; and building trust with professionals as they are seen efficiently and effectively.

**Gap 10: Address barriers to accessing maternity care and explore extended support**

The very poor health outcomes experienced by Gypsy, Roma and Traveller new-borns’ and mothers’ maternal health was noted. Often expectant mothers either present late to maternity services or not at all. As national and stakeholder engagement has demonstrated, there is greater need in terms of frequency and intensity of visits to these communities by a health visitor and this is currently a gap in terms of service provision. In addition, maternity services and health visitors can provide a useful opportunity for engagement and dissemination of public health messages into the communities, which is a gap to be further explored.

* NHS Kent and Medway ICB and Kent County Council Public Health department should acknowledge the significance of the ‘start for life’ and the inequalities and inequities experienced in infant and maternal health within these communities and consider added emphasis on resources for expectant mothers and explore how to improve uptake of maternal services.
* NHS Kent and Medway ICB to consider additional training (MECC, VBA) for maternity services and health visitors enabling them to enquire about, signpost and refer to different services that may be beneficial to these communities (immunisations, mental health services, sexual health), as these professionals can provide useful opportunity for trusted engagement. The following are some of the training opportunities that may become available for site liaison managers specifically regarding maternal health: training on parenting, attachment, perinatal mental health awareness, parent infant relationships, breastfeeding infant feeding awareness, responsive infant feeding, trauma informed care and responses, father and co-parent inclusive practice.
* NHS Kent and Medway ICB and VCSE partners to consider promoting the ‘Roma women breastfeeding’ [video](https://www.youtube.com/watch?v=Edn6Dy5ZLHk) to expectant or new mothers to encourage and increase infant feeding, especially where there is notable low prevalence.

**Address wider determinants**

**Gap 11: Little investment into community members**

This paper has also highlighted the gap regarding investment into Gypsy, Roma and Traveller communities. Opportunities are scant for recruitment from these communities and investment and development initiatives need to be explored, starting from education settings, right through to employment opportunities. There are also gaps regarding guaranteeing appropriate and adequate representation or ‘expert by experience’ from these communities on panels and decision-making boards. Finally, more needs to be done in terms of investing into and training community members, an example of this may be training up community members to become peer educators and health champions.

**Recommendations:**

* NHS Kent and Medway ICB to consider how they can recruit from the Gypsy, Roma and Traveller communities, whilst investing, developing and retaining staff from these communities.

**Gap 12: Issues around provision and quality of authorised sites for Gypsy and Travellers**

Although the majority of Gypsy and Travellers now reside in bricks and mortar, the quality of site conditions was raised as a considerable issue affecting these communities. Stakeholders listed concerns around water sanitation, overcrowding and contaminated land as examples and discussed the conditions of some sites. In addition, there is a gap in knowledge regarding which sites have access to a minimum standard of basic amenities and those who do not. There is also a gap in terms of understanding the residents on site and demographic profile of those living on Kent County Council Gypsy and Traveller sites.

**Recommendations:**

* Kent County Council’s Public Health department to work with GET Gypsy and Traveller site manager to explore a public health minimum criterion to be met at KCC sites, as poor site and living conditions were highlighted throughout this work. KCC’s Public Health department will explore opportunities to embed this in district and borough sites (with guidance from GET Gypsy and Traveller team) to ensure any Kent authorised sites and pitches have good quality facilities for these communities, and support site safety for children and vulnerable adults.
* Kent County Council’s GET Gypsy and Traveller site team to consider undertaking a ‘Census’ data collection study of KCC Gypsy and Traveller sites, enabling a better understanding of the numbers of residents and basic demographic profiles, including health needs.
* Kent County Council’s Public Health department to collaborate with partners who are consulting on Gypsy and Traveller sites (e.g. Maidstone Gypsy, Traveller and Traveller Showpeople Development Plan Document) and offer comments and suggestions around the public health expectations of any new or expanding Gypsy and Traveller sites across Kent.
* Kent County Council, district and borough councils should clearly understand that a lack of satisfactory site capacity has a direct impact on the quality and strength of access to health and social care services for the Gypsy and Traveller community.

**Gap 13: Lack of knowledge and uptake of eligible wider support for community members**

This paper has identified a gap in terms of Gypsy, Roma and Traveller communities understanding what support they are eligible for, whether financial entitlements, benefits or aids and adaptations and other forms of social care. Stakeholder engagement acknowledged that often when one professional is deemed as ‘trustworthy’ within that community, community members will present with a whole host of queries for that professional, resulting in the professional having to deal with areas outside their remit and expertise. It has been recognised both in the national research and throughout this paper the lack of uptake of these services, including statutory entitlements, which will only further reinforce inequalities and hardship experienced by these communities.

**Recommendations:**

* Kent County Council to consider working with voluntary sector and grassroot organisations to ensure that individuals from this community are aware of what support they are eligible for (e.g. working with Citizens Advice Bureau to ensure community members are aware of financial entitlements or benefits they can access, or working with Kent County Council adult social care to explore the provision of necessary aids or adaptations).
* Kent County Council’s Public Health department to consider targeted work with KCC GET Gypsy and Traveller Resident Service team to disseminate messaging and information sharing (via site liaison managers) regarding access to help and support for wider determinants and social issues.
* Kent County Council’s Public Health department to discuss with KCC GET Gypsy and Traveller team the uptake of the ‘fuel voucher’ scheme (as offered in winter 2022 by the GET team) to consider provision of such support going forward.

**Kent as system-leaders**

**Gap 14: More research is needed to develop a granular understanding of community needs**

Although this health needs assessment describes significant health inequalities within the Gypsy, Roma and Traveller communities, it has not been able to investigate many of these in depth. Given the lack of statistical data in this community, further qualitative in-depth research opportunities should be considered to enable richer knowledge and understanding. The opportunity to conduct research with these communities, also offers an opening to build trust, gain the communities’ views, co-produce interventions and provide a chance for health messaging to be presented.

**Recommendations**

* Endorse Wave 2, which consists of undertaking qualitative interviews with Gypsy, Roma and Traveller community members to understand the lived experience of these communities and in the absence of data, to undertake a health and wellbeing survey to accurately capture the health needs of different subsets. Findings will then be triangulated with Wave 1 (stakeholder engagement findings) to determine priority areas going forward.KCC’s public health department have submitted a bid application to the Clinical Research Network Kent Surrey and Sussex (CRN KSS) Under-served Funding Programme, enabling the establishment of a Gypsy, Roma Traveller research network, which will provide future opportunities for community engagement whilst building trust with members.
* Kent County Council’s Public Health department to consider future research funding opportunities to develop insight and understanding of specific topic areas including:
  + The health needs of older Gypsy, Roma and Traveller adults
  + Maternal mental health
  + Late cancer diagnosis
* Kent County Council’s Public Health department to feed findings into, and be an active participant of, regional and national fora (identifying opportunities to share best practice, advocate for and identify funding and other national resources that can be deployed in Kent).

**|**

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**|**

# 13. Appendices

**|**

## Appendix A – Stakeholder interview topic guide

Please see separate appendix on KPHO website.

**|**

## Appendix B – Project proposal

**Gypsy, Roma, Traveller Health Needs Assessment Proposal**

**Context**

The term Gypsy, Roma and Traveller is used by policymakers and researchers to describe a range of ethnic groups or those with nomadic ways of life who are not from a specific ethnicity. In the UK, it is common to differentiate between Gypsies (including English Gypsies, Scottish Gypsy/Travellers, Welsh Gypsies and other Romany people), Irish Travellers, who have specific Irish roots, and Roma, understood to be more recent migrants from Central and Eastern Europe. A 2019 Women and Equalities Committee All Party Parliamentary Group report found that Gypsy Roma Traveller people have the worst outcomes of any ethnic group across a huge range of areas, including education, health, employment, criminal justice and hate crime in the UK. The report identified a persistent failure by both national and local policymakers to tackle these inequalities in a sustained way which has led to services that are ill-equipped to support Gypsy, Roma and Traveller people to use services that they need and are entitled to[[1]](#footnote-2).

Locally in Kent a Joint Strategic Needs Assessment (JSNA) carried out in 2015 found a lack of quantitative health data available about Gypsy, Roma and Traveller populations. Qualitative data confirmed a picture of chronic and multiple health problems among many Gypsy Roma Traveller interview respondents, from diabetes, circulatory and respiratory problems, to cancer and many other health issues.

* **Policy Drivers**
* The Core 20 Plus 5 approach is designed to support Integrated Care Systems to drive targeted action in healthcare inequalities improvement. Locally Gypsy Roma Traveller are a ‘plus 5’ group.
* Inclusion health is an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people within the Gypsy, Roma and Traveller communities.
* The recent NHS Long Term Plan commits to a more concerted and systematic approach to reducing health inequalities. Local health systems have new requirements to set out how they will specifically reduce health inequalities by 2023/24 and 2028/29.
* The Houses of Parliament Commons Select Women and Equalities Committee has completed (April 2019) an inquiry into tackling inequalities faced by Gypsy, Roma and Traveller communities. This assessed the impact and progress achieved from 28 commitments to tackling inequalities made by a 2012 ministerial working group. It noted that there was a lack of focus on Gypsy Roma Traveller communities within JSNAs nationally and highlighted that this omission resulted in Gypsy Roma Traveller communities being overlooked when planning services. The Committee stated this was unacceptable given the poor health outcomes faced by Gypsy Roma Traveller communities.
* PSED duties - Gypsies and some Traveller ethnicities have been recognised in law as being ethnic groups protected against discrimination by the Equality Act 2010. Migrant Roma are protected both by virtue of their ethnicities and their national identities.

**Aim**

The aim of this Gypsy, Roma and Traveller Health Needs Assessment is to identify the health needs (including wider determinants) of the Gypsy, Roma and Traveller communities in Kent, to describe the current services and support in place to address these needs, and to identify the gaps in meeting these using evidence-based or best-practice approaches.

**Scope**

The scope of this needs assessment will focus on:

* All Gypsy Roma Traveller communities within the county of Kent regardless of accommodation type noting that nationally three in four Gypsies and Travellers live in non-caravan accommodation. The APPG report found that migrant Roma communities face inequalities that are very different to those faced by Gypsies and Travellers. We will need to disaggregate the data where we can and take a stakeholder view of how to capture health needs by specific community.
* The Robert Wood Johnson model of ill health recognises the significant impact that wider determinants play in health. This HNA will aim to describe, and where possible quantify, upstream factors as well as capturing information on morbidity and mortality.
* Service mapping will be limited to upper and lower tier local authority commissioned and/or delivered services and NHS commissioned and/or delivered services.
* Recommendations will guide ongoing Kent-wide developments in reducing health inequalities and improving health outcomes for Gypsy Roma Traveller communities.
* In no way is this piece of work looking to duplicate any current projects or initiatives, rather it seeks to learn from findings and inform and influence ongoing engagement with the Gypsy Roma Traveller population and address issues that perhaps have not had focus prior to this assessment. Appendix 3 contains current projects and initiatives that we are currently aware of.

Out of scope

* New Travellers
* Bargees and boaters
* Travelling Showpeople

Although these communities share many of the barriers faced by people who are ethnically Gypsy, Roma and Irish Traveller they are not included specifically in this assessment. However, many of the outcomes and recommendations may be applicable.

**The Approach**

The Office for Health Improvement and Disparities (OHID) Inclusion Health Team recently identified many areas where inequalities in Gypsy Roma Traveller health have been documented nationally:

* Wider determinants
  + Low income and high unemployment
  + Poor educational experience and outcomes
  + Lack of/ insecure housing and poor conditions
  + Racism and discrimination
* Health
  + Worse outcomes than general population across most health indicators (where data is available)
* Access to health care
  + Being refused registration
  + Discrimination and poor experiences
  + Lack of cultural sensitivity
  + Stigma
  + Low literacy
  + Language barriers
  + Digital barriers

This HNA will use an epidemiological and corporate approach described by Stevens and Rafferty[[2]](#footnote-3) to:

* Describe, and where possible quantify, the scale of health needs faced by Gypsy Roma Traveller communities across the life-course **(epidemiological)**.
* Obtain stakeholder views on the needs for health and care services amongst Gypsy Roma Traveller communities and elicit views on the extent to which these needs are currently being met and barriers faced **(corporate)**
* Map current community, health and care services available to Gypsy Roma Traveller communities against evidence-based/best practice standards in order to make an assessment of met and unmet need.

**Methods**

It is widely accepted that there is only a small number of routine data sources available to describe Gypsy Roma Traveller health needs, including wider determinants of health (OHID reference). Kent Public Health Observatory recently carried out a scoping review of Gypsy Roma Traveller HNAs carried out elsewhere in the UK to determine information sources used. Approaches common to all HNA were:

* The annual schools census was used as one of few sources of systematically collected national data about gypsies and travellers.
* A lot of the analysis was using figures from literature reviews rather than raw data sources.
* There was not a lot of raw data to use, some areas used surveys or conducted their own.

OHID has highlighted that ethnicity classifications for Gypsy, Roma and Traveller groups are not included in the NHS data dictionary and do not appear in NHS hospital data sets which are based on the 2001 census categories.

**Desktop research**

**Desktop research** will be undertaken to quantify the scale of health needs and identify evidence-based/best practice interventions to meet these.

* Steps

1. Where it is available, use routinely collected data to:
   1. collate demographic information about the composition, size and location of Gypsy and Traveller populations in Kent County Council and trends over time, including age and household composition profiles (a snapshot survey will be given to site managers to complete regarding the basic demographic composition of the sites – [survey can be found here](https://forms.office.com/Pages/DesignPageV2.aspx?subpage=design&FormId=DaJTMjXH_kuotz5qs39fkFqP0x4USpNMioLeL6-V1wJUMEpYTDNWU1RSNUVFSTJDTldTUDNFT0VKQS4u&Token=fa19792f1c3344c6af9d2fd0e7743be8) )
   2. quantify Gypsies, Roma and Traveller populations by accommodation type and local authority using Kent Gypsy and Traveller Accommodation Needs Assessments (GTANAs).
   3. describe and quantify upstream health needs (see Appendix I for a list of possible routine data sources).
2. Use locally sourced data (e.g. surveys) if available to add insight to the epidemiological data.
3. Where routine data is not available use evidence from the literature (previous HNAs and research reports) to estimate scale of need focussing on areas listed above (see Appendix II for a list of other information sources from KPHO review).
4. To use findings from recent Gypsy Roma Traveller Health Needs Assessments (found through KPHO scoping review), recent national research reports (within last 5 years) and NHSE/OHID inclusion health evidence to identify ‘what works’ to reduce inequalities in health amongst Gypsy Roma Traveller communities in order to map local services against these.

Please note we have had confirmation from KHPO that routinely collected Census data is unlikely to be available until March 2023. Therefore, we have made the decision to carry out the HNA but place a ‘holding space’ until this data becomes available.

**Stakeholder approach**

The aims of the stakeholder approach are to:

* understand the health needs of Gypsy Roma Traveller groups from their own perspective including the factors contributing to poor health outcomes
* obtain a wider stakeholder perspective on Gypsy Roma Traveller groups’ health needs and the configuration of current services to adequately and effectively meet demand/need and service user acceptability (interview questions can be found in the appendices)
* obtain service information to map services against expressed and epidemiological need and identify unmet need and service gaps.

The stakeholder needs assessment will be carried out in 2 waves.

Wave 1

The aims of this wave are to:

1. identify those stakeholders (commissioners, service providers, Gypsy Roma Traveller community advocates) who will be key informants for the needs assessment and who can also facilitate access to Gypsy Roma Traveller communities in Kent.
2. build a picture of the Gypsy Roma Traveller communities within Kent from key stakeholders including an assessment of met and unmet health and care needs.
3. co-design Wave 2 participatory research to uncover Gypsy Roma Traveller community members' perceptions on their collective needs, as well as their attitudes towards these needs.

Key stakeholders who work with or have recently worked with these groups will also provide insight into the day-to-day culture of the Gypsy, Traveller and Roma communities, and some of the gaps and what might work with regards to health promotion and health improvement with these groups in the future. This insight will be collected by means of short conversations, using listening analysis e.g. listening to and recording issues raised by staff, by telephone conversations with individuals who had been identified as having good working knowledge of Gypsy Traveller and Roma needs, and a number of dedicated meetings with staff who continue to work with these communities.

Wave 2

The aims of this wave are to:

1. conduct qualitative research with Gypsy Roma Traveller communities to:
   1. provide a deeper understanding of the issues faced in relation to health and social care services, barriers to access and gaps in services.
   2. co-design recommendations for service improvements.

It is expected for Wave 2 to commence around April/May 2023 and Wave 2 methodology will be further developed as findings emerge from Wave 1.

**Conclusions and Recommendations**

1. Findings will be used to identify areas for service improvements based on unmet needs, an understanding of effective evidence-based interventions and interventions that are sensitive and acceptable to Kent’s Gypsy Roma Traveller communities.
2. Recommendations will be made in line with local strategic direction and national policy.

**Deliverables**

**Short report** – a slide deck using infographics and/or short video and anonymised narratives to describe health needs across the life-course including case studies.

**Data report** – publicly available word document describing approach, data sources, findings and recommendations.

**Project management**

* Timelines

Key dates:

* Initial scoping of key stakeholders to be completed by Jan 2023
* X3 steering groups to be set up; Jan; Feb; March to check and challenge progress of the HNA.
* Finalised draft HNA to be circulated to steering group by end of March for comment.
* Finalised document by June 2023

Gantt chart

Removed for anonymity.

Governance and steering group

A steering group will be formed to guide and challenge the health needs assessment, as well as offering amendments and suggestions to the draft products. The steering group will have responsibility for sign-off on the final products.

It is proposed that the steering group meet monthly until the HNA has been finalised in draft form in order that the steering group will have the opportunity to comment, identify omissions and provide clarification before the document is finalised.

The steering group will also offer support via email and where appropriate have the opportunity to participate in stakeholder interviews to offer their perspective.

**Steering group stakeholders (to meet monthly):**

|  |
| --- |
| **Job role / organisation** |
| PH specialist / lead for HNA |
| PH consultant |
| PH director |
| Gypsy Roma Traveller manager KCC |
| KPHO |
| Christ Church University |

**Stakeholder engagement / interview participants**

Below is a list of key stakeholders who will provide information that is representative of the Gypsy Roma Traveller community / signpost to other relevant sources or stakeholders/groups (individuals highlighted in **blue** will be participating in stakeholder interviews). Please note this is a live table and may change.

**REMOVED FOR ANONYMITY**

|  |  |
| --- | --- |
| **Data Overview** | **Source** |
| Gypsy Roma Traveller populations by local authority:  England and Kent (borough/district council) | Census  2011 Gypsy and Traveller only  2021 Gypsy and Traveller; Roma people |
| Population information on Gypsies, Roma and Traveller people  (housed and travelling) by local authority, to assess need for pitches. | Gypsy and Traveller  Accommodation Needs Assessments (GTANAs) |
| Population of children and young people in schools who identify as  ‘Gypsy/Roma’ or ‘Traveller of Irish Heritage’.  By borough/district council | Pupil roll data (DoE) disaggregated by locality and ethnicity.  Data combines Gypsy and Roma people and has Traveller of Irish Heritage as separate category |
| **Wider Determinants** |  |
| **Educational attainment**  Meeting expected standard KS2 in  reading, writing and maths  % with grade 5 and above GCSE Maths and English  **School exclusions:** suspension and permanent exclusion rates and persistantly absent from school | 2011 and 2021 Census data |
| **Employment**  Economic inactivity  Employment gender gap | 2011 and 2021 Census data |
| Home ownership and renting | 2011 and 2021 Census data |
| **Accommodation**  Number of caravans on  Traveller and Travelling sites,  unauthorised encampments and  unauthorised developments, by borough/district council  New social housing lettings | Ministry of Housing, Communities  and Local Government -  Traveller Caravan Count  <https://www.gov.uk/government/collections/traveller-caravan-count>  New social housing lettings - GOV.UK Ethnicity facts and figures (ethnicity-facts-figures.service.gov.uk) |
| **Health** |  |
| Coronavirus (COVID-19) related deaths by ethnic group, England and Wales and Kent County | ONS |
| Vaccines and Immunisations  Gypsy Roma Traveller vs. county level childhood immunisation | COVER statistics |
|  |  |

**KPHO Scoping Review of Gypsy, Roma, Traveller Needs Assessments – data sources**

|  |  |  |  |
| --- | --- | --- | --- |
| Indicator | Source | Who used it? | Years |
| Life Expectancy | CRE, 2004  Inequalities Experienced by Gypsy and Traveller Communities: a review, EHRC, 2009 | West Sussex | 2004 |
| Infant Mortality | Inequalities Experienced by Gypsy and Traveller Communities: a review, EHRC, 2009 | West Sussex | 2009 |
| Miscarriage and Stillbirth | The Health Status of Gypsies and Travellers in England, report for Department of Health, Parry et al, University of Sheffield, October 2004 | West Sussex | 2004 |
| Infant Mortality | National Clinical and Health Outcomes Knowledge Base | Devon | 2007 |
| Low Birth Rate | National Clinical and Health Outcomes Knowledge Base | Devon | 2002-2007 |
| Comparison of population age structure | Census | Wiltshire | 2011 |
| Comparison of Gypsy and Traveller community characteristics, compared to overall national figures. (dependent children in lone parent households, good health, 16+ no qualifications and economic activity) | Census | Wiltshire | 2011 |
| Geographical distribution of Gypsy or Traveller individuals | Census | Wiltshire | 2011 |
| Children in school, absences, attainment, proportion with SEN, EHCP or pupil premiums | 2019 school census/January 2018 school census DfE | Wiltshire | 2019 |
| Primary Care registration | Parliament, 2019 | Wiltshire | 2019 |
| GP Practice Registration | Friends, Families and Travellers, 2019 (charity) | Wiltshire | 2019 |
| Smoking rate by ethnic group | GP Primary Care data – Smoking NA | KCC (Debbie Smith) |  |
| Map demonstrating the distribution of Gypsy children in schools | 2019 school census | Wiltshire | 2019 |
| Location of sites | Caravan Count | West Sussex | 2010 |
| Demographics | Own survey (28 participants) | North Somerset | 2012-2013 |
| Household Structures | Own survey (28 participants) | North Somerset | 2012-2013 |
| Access to Services | Own survey (28 participants) | North Somerset | 2012-2013 |
| 'Caravan Count' of Gypsy and Traveller sites | Department for Communities and Local Government (DCLG) | West Sussex | 2010 |
| Ethnic monitoring data | School Census - Department for Education | West Sussex | 2010 |
| Housing and Planning | Housing and Planning Department of Districts | West Sussex | 2010 |

**Current projects / initiatives (live table)**

|  |  |  |  |
| --- | --- | --- | --- |
| Project: | Project aims: | For: | Delivered by: |
| Immunisation / vaccine uptake in Gypsy and Travellers in West Kent | * Between January and March 2023, facilitated workshops with residents in West Kent Gypsy/Traveller sites and key stakeholders (Kent County Council Head of G/T, Maidstone District Council, West Kent PCN, West Kent primary school, SAIS and Heath Visiting Service) to co-produce a list of interventions to increase immunisation uptake and to agree the content and delivery of these interventions for each community. | Gypsy and Travellers in West Kent | KCHFT |
| Eastern European Communities in Thanet | * By end March 2023, we will continue to engage and work collaboratively with the Thanet Multi-agency Task force, the Margate Primary Care Coordinator and representatives of the Eastern European and Roma communities to understand the barriers to health screening and immunisations, and agree the content and deliver a series of health workshops focused on reducing health and vaccine inequalities. * Co-produce health educational materials (videos, slide decks, lesson plans) which will address myths and misconceptions relating to vaccinations and barriers to health screening. * Recruit and train 5 peer educators who will support behaviour change and increase knowledge and awareness of vaccination programmes within Eastern European communities in Thanet. | Eastern European communities in Thanet | KCHFT |
| Covid-vaccine engagement work | * Engagement work undertaken during the Covid-19 pandemic regarding engaging with the Gypsy Roma Traveller population and covid vaccines; yet to meet with Samantha regarding this. | Gypsy Roma Traveller communities (need further information) | KCHFT |
| Cancer inequalities | * Gypsy Roma Traveller cancer inequalities work formed part of the Inclusion Groups section of wider Kent and Medway Cancer Inequalities project. | Gypsy Roma Traveller community | Kent and Medway cancer alliance |
| Traveller movement (multiple projects) | * Roads to Success Research [https://wp-main.travellermovement.org.uk/wp-content/uploads/2022/04/Road-to-Success-Report-2022.pdf](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwp-main.travellermovement.org.uk%2Fwp-content%2Fuploads%2F2022%2F04%2FRoad-to-Success-Report-2022.pdf&data=05%7C01%7CMegan.Abbott%40kent.gov.uk%7C7760632d779e4383bf1708daefe68b70%7C3253a20dc7354bfea8b73e6ab37f5f90%7C0%7C0%7C638086071955247415%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=%2Bg62ZDNUlU8FKdFMWfM3GIkl51f5D%2Bs3m9hCmv%2FFJoA%3D&reserved=0) * BESTIE toolkit | CYP in traveller community | Traveller movement |
| FLUX | * The lead partner on the new initiative 'Flux' - a series of creative arts interventions that aim to improve the mental health and wellbeing of marginalised children and young people in Kent, who are at risk of self-harm or worsening mental ill health. Partners: Living Words, The Gulbenkian, Ideas Test Community Art Kent.   *Note: they have not run a project directly with Roma young people, but they are supporting and including a group that is doing a project with CYP in Roma community through Shepway Youth Hub in Folkestone.* | Marginalised CYP in Kent | Living Words |
| Kent Police engagement work | * Briefly discussed engagement work undertaken by equality and diversity manager and community liaison team (need more information about this) | Gypsy Roma Traveller community | Kent Police |
| Healthy communities programme Kent | * Targeted team to work solely with migrant communities to deliver public health key messages. * Cultural awareness training – 36 courses across Kent and 1 train the trainer course | Gypsy Roma Traveller community | KCHFT |
| Roma vaccine work | * This report is an outcome of an insight study to identify whether Roma people from the Czech Republic and Slovakia, living in Kent County, are at risk of a lower uptake of the vaccine and if so, why. * The second part of the report provides recommended actions that could support increased uptake of the vaccine in areas of high Roma populations. * [Final Report.pdf](file:///C:\Users\Abbotm03\AppData\Local\Microsoft\Windows\INetCache\Content.Outlook\87H26IDQ\Final%20Report.pdf) | Roma community | KCC and Compas |
| Perinatal equity and equality | * Targeted communities around perinatal health inequalities across Kent and Medway. Worked with an organisation called Compas, who helped by engaging with eastern European women which included travellers. * [Perinatal equity and equality:: NHS Kent and Medway (icb.nhs.uk)](https://www.kentandmedway.icb.nhs.uk/get-involved/engagement-projects/current-engagement-projects/perinatal-equity-and-equality) | Gypsy Roma Traveller communities | K&M ICB |
| The Grange Practice, Ramsgate | * Community engagement and outreach initiative * Good established relationships with Gypsy Roma Traveller community * Writing up as case study as evidence of best practice | Gypsy Roma Traveller community – Thanet | The Grange Ramsgate |
| NHS card | * NHS right to register card which says 'I have the right to register and receive treatment from a GP practice.'    I do not need a fixed address.    I do not need identification    Anyone in England can see a GP. | All Gypsy Roma and Traveller to access GP – do not have to have a registered address | National |
| Bus booking pilot with the traveller community | * Require more information | Gypsy Roma Traveller community | KCHFT |
| UKCRF healthy eating practices | * Understanding ethnic minority groups’ perspectives on healthy eating and how we can change the trajectory in obesity through healthy eating. | Sevenoaks Gypsy Roma Traveller site |  |
| Breastfeeding uptake in Roma women | * Roma mothers talk about breastfeeding – Kent project.   <https://ihv.org.uk/news-and-views/voices/roma-mothers-talk-about-breastfeeding/> | Roma women | Darzi fellow project – health visitor |
| Women and family hub – Dunkirk | * Dunkirk Women and family hub | All Gypsy Roma and Traveller communities | KCHFT |
| Parenthood leaflet | * Ready for parenting – community leaflet   [ReadyforParenthood-GRT-community-booklet.pdf (southeastclinicalnetworks.nhs.uk)](https://www.southeastclinicalnetworks.nhs.uk/wp-content/uploads/2023/01/ReadyforParenthood-GRT-community-booklet.pdf) | New parents in Gypsy Roma Traveller Community | SE Clinical Network |

1. [Tackling inequalities faced by Gypsy, Roma and Traveller communities - Women and Equalities Committee (parliament.uk)](https://publications.parliament.uk/pa/cm201719/cmselect/cmwomeq/360/full-report.html) [↑](#footnote-ref-2)
2. Stevens A, Raftery J, eds. Health care needs assessment: the epidemiologically based needs assessment reviews. Oxford: Radcliffe Medical Press ,1994. [↑](#footnote-ref-3)