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Review of Evidence of Inequalities in Health and Inequalities in Access to Health Services in Wales and the UK for Black and Minority Ethnic Groups, Asylum Seekers and Refugees, and Gypsy and Traveller Communities

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This is a summary adaptation by Welsh Government Knowledge and Analytical Services staff of a wider-ranging piece of work, based on a rapid evidence scoping study, produced by Constantino Dumangane Jr. as part of a four month long PhD Internship with the Welsh Government. The study was funded jointly by the Welsh Government and the Economic and Social Research Council (ESRC).

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INTRODUCTION

The review summarises the evidence on the health of particular Black Minority Ethnic groups in Wales and the UK. The first two chapters provide context and an overview of the methodology and definitional issues. Subsequent chapters cover the main themes and key health issues for Black African people, South Asians, Refugees and Asylum Seekers, and Gypsy and Traveller communities. Throughout the report, Welsh data are used wherever possible, with other UK data used only when this is not available and if such data are likely to be broadly applicable to Wales.

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CHAPTER 1: CONTEXTUAL ISSUES

The purpose of this chapter is to provide a picture of Wales' population, its ethnic composition and the main health issues. The chapter provides definitions of the main terms related to ethnicity and summarises the key health issues affecting the ethnic groups in the Welsh context which are covered by the review.

THE POPULATION OF WALES

The 2011 Census recorded a 5% increase (153,300 people) in the Welsh population over the previous decade, from 2.9 to 3.1 million people. Ninety three percent identified as White British. The local authorities with the highest population growth were Cardiff (12%), Pembrokeshire (8%) and Bridgend (8%). The Black Minority Ethnic population grew by almost 2 percentage points from 2.1% to 4.0% of the Welsh population (ONS, 2012b).

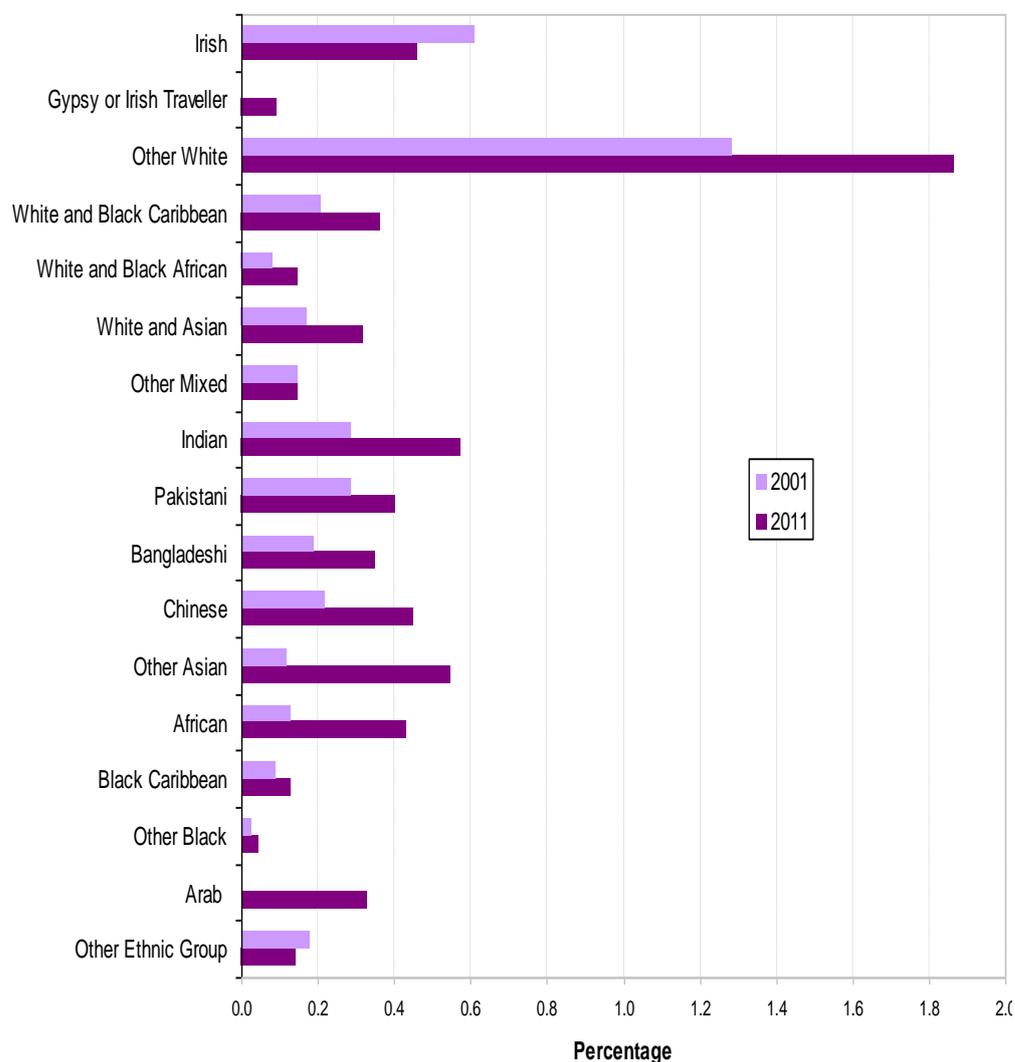
As Table 1 shows, the largest Black Minority Ethnic group in Wales is Indian or British Indian (0.6% of the total population), followed by Polish, Irish and Chinese (0.5% each respectively), African, Pakistani or British Pakistani, White and Black Caribbean (0.4% each respectively) and Bangladeshi (0.3%). All of these groups have populations in excess of 10,000. The local authorities with the highest proportions of Black Minority Ethnic people are Cardiff (15.2%), Newport (10.1%) and Swansea (5.9%), (ONS and Jackson, 2012). Figure 1 shows the proportion of the Welsh population represented by each main Black Minority Ethnic group in 2001 and 2011.

Table 1: Ethnic Composition of Welsh population in 2011

All usual residents: Wales	Numbers	Per cent
All categories: Ethnic group	3,063,456	100.0
White British	2,856,646	93.2
Indian or British Indian	17,347	0.6
Polish	16,357	0.5
Irish	14,138	0.5
Chinese	13,793	0.5
African	13,548	0.4
Pakistani or British Pakistani	12,260	0.4
White and Black Caribbean	11,106	0.4
Bangladeshi, British Bangladeshi	10,708	0.3
Arab	9,989	0.3
Other Western European	9,627	0.3
White and Asian	9,085	0.3
European Mixed	6,691	0.2
Other White	6,026	0.2
Filipino	5,808	0.2
All other ethnicities	50,327	1.6

Source: ONS and Jackson, 2012.

Figure 1 Percentage of Wales' population by ethnic group, 2001 and 2011



Source Wales ONS data: (ONS and Leake, 2013)

The UK is becoming more ethnically diverse and by 2051 it is projected that 20% of the population will be from a Black Minority Ethnic background - up from 8% in 2001 (Wohland et al., 2010) - but there is a great deal of variation around the UK, with the highest concentrations in London and other large cities.

Britain is also an ageing society. The number of people aged 65 and over is projected to increase by 23% from 10.3 million in 2010 to 12.7 million in 2018 (ONS, 2010; ONS, 2011; Rutherford, 2012). As a result of population ageing there will be greater numbers of elderly dependents (Rutherford, 2012).

Future projections for England and Wales suggest that there will be 2.4 million Black Minority Ethnic people aged 50 years and over in 2016, rising to 3.8 million by 2026 and 7.4 million by 2051 (Lievesley, 2010). There will be just over half a million Black

Minority Ethnic people aged 70 years and over by 2016, more than 800,000 by 2026 and as many as 2.8 million by 2051. Generally, older people from Black Minority Ethnic backgrounds tend to report poorer health than others (Bajekal et al., 2004). There is also evidence that some experience age-related changes such as hypertension and cardiovascular problems at an earlier age (Crimmins et al., 2007), and that health differences associated with ethnicity are greatest among older people (Houses of Parliament, 2007).

It is reasonable to assume that should the projected increase in Black Minority Ethnic older people in Wales occur, there will be an increased number of Black Minority Ethnic older people requiring personal social services and requiring some kind of help with daily living activities (Lievesley, 2010).

The UK has been multi-cultural to varying extents for centuries. After the Second World War, large-scale immigration from former colonies occurred into many parts of Britain, linked to local labour market opportunities (Vickers et al., 2013). These migration patterns and their interaction with more recent socio-economic changes and legislation on the dispersal of asylum-seekers continue to influence the location of Black Minority Ethnic groups and their health experiences. Currently in the UK, over 50% of people who identify themselves as Indian, Pakistani, Bangladeshi, Black Caribbean and Black African were born in this country (Ahmad and Bradby, 2007; Vickers et al., 2013). The consequence of increased diversity is that the UK is now often referred to as being 'super-diverse' (Finney and Simpson, 2009; Fanshawe and Sriskandarajah, 2010). The Black Minority Ethnic populations tend to be younger than the general population. For example, 30% of the Bangladeshi population in the UK is under 15, compared with 17% of the White British population

In the 2011 census, 78% of residents in Wales described themselves as being in good or very good health (compared to 81% in England), with 18% reporting a long-term limiting condition (ONS, 2012c). The Census shows large variations in reported good and poor health between respondents of different ethnicities. Among Gypsies and Irish Travellers 29.8% reported their health as 'Not Good', compared with only 8.4% of the African ethnic group (ONS, 2013). Unpaid care provision also varied with the highest rate reported by Gypsy or Irish Traveller (10.7%) and the lowest rate by White and Black Africans (4.9%).

The incidence rate for all cancers for males in Wales is around 8% higher than in the UK as a whole, and for prostate cancer 14% higher. It is suggested that some of this variation may be explained by differences in the availability, as well as rate of uptake, of the prostate specific antigen (PSA) test both for the general, and the Black Minority Ethnic populations (Cancer Research UK, 2008).

Among females across the UK, the incidence of breast cancer is highest in Wales (at 130 per 100,000) and lowest in Northern Ireland at 115 per 100,000 (Cancer Research UK, Men's Health Forum and NCIN, 2013a; ONS, 2012a), and the female incidence of bladder cancer in Wales is 10% higher than the rate for the UK. However, mortality rates for bladder cancer in Wales for both sexes are comparable to the rest of the UK (ONS, 2012a).

Lung cancer is the second most common cancer in men after prostate cancer with more than 23,000 new cases diagnosed in Wales in 2010. More than 18,500 women were diagnosed with lung cancer in 2010, making it the third most common cancer in women after breast and bowel cancer. More than 80% of people diagnosed with lung cancer are over the age of 60 and more than one in five deaths in the UK is attributed to lung cancer, making it the most common cause of cancer death. There is a higher incidence of lung cancer in Scotland and Northern England and lower incidence in Southern England, the Midlands, Wales and Northern Ireland (Castle, 2012).

In Wales, it is estimated that one in four adults experiences mental health problems or illness at some point in their lives, and one in six experience symptoms at any one time (Welsh Government, 2012). Around 2% of people have a severe mental illness such as schizophrenia or bipolar disorder, and around 10% of children between the ages of five and 16 have a mental health problem, with many more having behavioural problems (Welsh Government, 2012). The incidence of dementia is strongly age-related and around one in 16 people over 65 and one in six over the age of 80 will be affected by it (Welsh Government, 2012).

CHAPTER 2: METHODOLOGY

The scoping study on which this report is based involved examination of more than 400 data sources. The primary consideration for inclusion was whether they included Welsh data on the protected characteristic of race specific to the chosen populations.

The review was conducted through an exploratory search of academic journals as well as online databases including: OVID, Scopus and Web of Knowledge, Embase, King's Fund, Medline, PsychINFO, National Research Register, PubMed, Social Care Institute for Excellence and the Kings Fund. Additional websites and sources reviewed included: Cancer Research UK; Health Survey England; Ethnic Diversity in UK Social Research; Health and Social Care Services Department of Health; Information Centre about Asylum Seekers and Refugees; Macmillan Cancer Support; Marie Curie Cancer Care; National Institute for Clinical Excellence; National Institute for Health Research (US); National Cancer Research Network; National Survey for Wales; NHS Evidence: Ethnicity and Health; Office for National Statistics; Public Health Research Consortium; Public Health Wales; Race Equality Foundation; Save The Children, Travelling Ahead; Welsh GP Access Survey; Welsh Health Survey. Data was also gathered from NHS Evidence online, governmental reports on health inequalities, Equality and Human Rights Commission reports, research briefings and by following references from documents to further articles and reports.

The online search strategy used the terms: 'health', 'access', 'ethnicity', 'inequ*', '*rac',¹ 'discrimination', 'help-seeking', 'uptake', and 'stereotype', to locate studies from Wales and the United Kingdom in general where gaps existed in Welsh-specific research. The literature included research papers, policy documents, reports, leaflets, and information published on web sites. The criteria for inclusion were kept deliberately broad.

The scoping study explored three main questions²:

1. What is the research evidence on the health of people with the protected characteristic of 'race'/ethnicity in Wales (specific to Black Minority Ethnic people, Refugees and Asylum Seekers and Gypsies and Travellers) compared to the general population?
2. What is the research evidence in relation to their access to health services?
3. What gaps are there in the research base?

A consultation with a panel of deliverers of health and social care in Wales was held to discuss the preliminary findings from the scoping exercise. Delegates included service user and carer representatives, practitioners and other key stakeholders. Members of this panel and other stakeholders were also asked to comment on the

¹ An asterisk* denotes a truncation of a term. This allows the user to search for terms sharing the same root e.g. 'inequ*' searches for both 'inequality' and 'inequity', '*rac' searches for both 'race' and 'racism'.

² This summary adaptation deals with the first of these questions. The full report is available upon request.

draft report and these informed a discrete set of policy recommendations provided separately to the Welsh Government.

DEFINITION OF TERMS

The following chapters report on the health inequalities and inequalities in access to health services for each of the four Black Minority Ethnic groups covered by the review: Black African, South Asian, Refugee and Asylum Seekers, and Gypsies and Travellers. Each chapter identifies and discusses some of the most prevalent and problematic health issues affecting that group. The definitions of the terms used are outlined below.

ACCESS

For the purposes of this review, 'access' to health services is understood to embody some or all of the following facets;

- Whether or not barriers to health services exist due to lack of appropriate provision of information about existing services; where to go and how to access them.
- Whether services are in reasonable physical reach (within the local community) of their users.
- Whether users with particular characteristics attempt to access health services and the reasons why they might not do so.
- Whether health services providers are perceived to provide care that sensitively accommodates ethnic minorities' needs (related to, for example, particular language, dietary, cultural, religious or faith-related needs).
- Whether appropriate and equitable referrals are made to other services and whether medical record-keeping is conducted in a consistent, fair and equitable manner (Szczepura, 2005).

'RACE' AND ETHNICITY

In current policy discourse, ethnicity and 'race' are often used interchangeably, (Vickers et al., 2013) but in reality they are two distinct concepts. Race is an assigned social category based on certain biological characteristics, which has often led to the imposition of a hierarchy of superiority and inferiority related to these characteristics (Hirschman, 2004). This is based on the scientifically false notion that human beings can be separated into biologically distinct races (Miles and Brown, 2003).

Ethnicity is a concept that refers to a shared culture, group history, or way of life (Wallman, 1977; Ford and Harawa, 2010; Bhopal, 2007). A standard definition of ethnicity is: "...a shared culture and way of life, especially as reflected in language, folkways, religious and other institutional forms, material culture such as clothing and food, and cultural products such as music, literature, and art." (Johnson, 2000: 109-110).

Thus ethnicity is complex and fluid and can refer to identity, culture and belonging as well as to religion, nationality and geography. Ethnic groups typically define themselves, but are also commonly defined by stereotypes employed by others. This report uses the classification of ethnicity adopted by the UK 2011 Census: aspects of life that an “*individual identifies with including race, culture, religion and nationality*” (Houses of Parliament, 2007).

WHITE

The term White is used to group all persons who describe their ethnicity as British, Irish or from other European ancestral origins that identify themselves as White (ONS, 2012d).

BLACK MINORITY ETHNIC

Black Minority Ethnic can be used to mean the main Black and Asian and mixed racial minority groups or, with the inclusion of ‘and’, to include all minority communities, including White minorities. They are groups of people sharing historical, cultural, or national origins and who are numerically a minority within society. Ethnicity is a ‘protected characteristic’ under the Race Relations (Amendment) Act 2000, updated by the Equalities Act 2010. The Black Minority Ethnic population in Wales is diverse and a long history of inter-ethnic unions has resulted in an unusually large share of the population being of mixed parentage or classified as of “other” ethnicity by the Census.

ASIAN (SOUTH)

Asian (South) covers persons who identify themselves as having Asian or Asian British ethnicity. For purposes of this report these persons have Asian ancestry and identify their ethnicity as Indian, Pakistani, Bangladeshi or other South Asian ethnicities (Bhopal, 2004).

BLACK AFRICAN

Black African is used to describe persons who identify themselves as Black British, African, Caribbean or other ethnicities with African ancestral origins (Bhopal, 2004a).

REFUGEES AND ASYLUM SEEKERS

The United Nations High Commission for Refugees defines a refugee as “*a person who is outside his or her country of nationality or habitual residence; has a well-founded fear of being persecuted because of his or her race, religion, nationality, membership of a particular social group or political opinion; and is unable or unwilling to avail him– or herself of the protection of that country, or to return there, for fear of persecution*” (UNHCR, 2011).

An asylum seeker is someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the European Convention on Human Rights which states that; “*No one shall be subjected to torture or inhuman or degrading treatment or punishment. A person can make a claim for protection based directly on Article 3 of ECHR as states are prohibited from returning a person to a country where she/he may suffer a violation of his/her rights under Article 3*” (Refugee Council, 2013).

GYPHY AND TRAVELLER

In the UK a plethora of groups fall within the definition of 'Gypsies and Travellers'. 'Gypsy Travellers' or 'Traditional/ethnic Gypsy Travellers' include Irish Travellers, Scottish Gypsies/Travellers, English Gypsies, Welsh Gypsies or Kale.

Gypsy/Roma can include people who *may* identify themselves as Gypsies and/or Romany and/or Travellers, and/or Romanichal Gypsies (e.g. Eastern European Gypsies, Circus/Show people and New Travellers (Greenfields, et al., 2007; Matthews, 2008).

CHAPTER 3: HEALTH OF BLACK AFRICAN PEOPLE

HEART DISEASE

Coronary Heart Disease (CHD) often called Ischemic heart disease (IHD) is part of the Cardio Vascular Disease (CVD) family. It is characterised by reduced blood supply to the heart muscle, usually due to disease of the coronary artery. Its risk increases with age, smoking, high cholesterol levels, diabetes, and hypertension (high blood pressure). CHD is more common in men than women, but the gap between genders becomes smaller past the age of 50 (NHS Choices, 2013). The risk of developing CHD is associated with a mix of factors including genes, lifestyle, and environmental factors (Nazroo, 1998; Diabetes UK, 2010).

Cardiovascular diseases are the main cause of death in the UK, causing around 170,000 deaths in England and Wales each year. Some Black Minority Ethnic groups may be more likely to suffer premature cardiovascular disease than others, but much remains unknown about how ethnicity affects these diseases (British Heart Foundation and ESRC, 2011). Rates are higher for Black people from East African backgrounds but very low both for people of Caribbean and West-African backgrounds (Aspinall, 2005). The Black population within the UK have higher rates of stroke and there is evidence of ethnic inequalities in access to treatment. Behavioural risk factors - such as smoking, alcohol consumption, poor diet and physical inactivity - can vary widely between ethnic groups (Scarborough, et al., 2011). Risk factors such as obesity and diabetes are all important, while measurements such as the body mass index are less useful because people from different ethnic groups have widely varying healthy body mass ratios.

CEREBROVASCULAR DISEASE (STROKE)

Stroke incidence for both men and women in the Black ethnic group is higher than in the White ethnic group (Diabetes UK, 2010; Saltus and Kaur-Mann; 2005; Sproston and Mindell, 2004). Men born in the Caribbean are 50% more likely to die from strokes than the general population (Heim and MacAskill, 2006; Hull et al., 2011a).

CANCER

Rates of some types of cancer, including breast, bowel and lung, are lower for Black African and Caribbean population than for White people, while stomach cancer incidence is around 50% higher, myeloma is around twice as high, and prostate cancer is three times higher (National Cancer Intelligence Network, 2009)³. The rate of liver cancer is around twice as high in Black Africans, African-Caribbeans and South Asians.

³ With more than 37,000 new cases diagnosed every year in the UK, prostate cancer is the most common cancer in men. Men of African and African-Caribbean descent are three times more likely to develop prostate cancer than White men (National Cancer Intelligence Network, 2009).

Every year, around 50,000 people in the UK are diagnosed with breast cancer. It is the most common cancer diagnosed in women. Whilst Black and Asian women have lower breast cancer incidence than White women, they tend to be diagnosed at a later stage and as a result, experience lower survival rates (National Cancer Intelligence Network, 2009). Both Black African and African-Caribbean women are less aware of the signs of breast cancer than White women (Lloyd Knight, 2012; Copson, et al., 2013) and 43% of Black Minority Ethnic women in the UK say they never check their breasts. Furthermore, 45% of Black women who have reached the right age for breast screening have never attended a screening appointment.

Cervical cancer in 2010 is the third most common form of gynaecological cancer after uterus and ovarian among women under the age of 50. Cervical cancer is the most common form of cancer in women under 35 years of age in England (National Cancer Intelligence Network, 2010). Research indicates that rates of cervical cancer are higher among women born in the Caribbean than for other women in England and Wales. Research on Black women involved in cancer screening programmes shows evidence of lower uptake of cervical cancer screening (Brenes and Paskett, 2000). In a national NHS cancer survey, it was shown that 32% of Black Minority Ethnic women were unaware of their risks of developing cervical cancer compared to 18% of White women (NHS, 2008).

Prostate cancer is the most common form of cancer diagnosed in men in the UK. It is the second most common cause of death from cancer after lung cancer (Cancer Research UK, 2012) and by 2030 is projected to be the most common cancer (Mistry et al., 2011). A longitudinal research report in England found that Black males of all ages were found to be significantly more likely to have a diagnosis of prostate cancer than White men (National Cancer Intelligence Network, 2009).

Prostate cancer is generally diagnosed in men over the age of 50 and the risk increases with age. A man is 2.5 times more likely to develop prostate cancer if his father or brother has been diagnosed with it, compared to a man with no family history. Research suggests that there is a direct correlation between African-Caribbeans' diets and prostate cancer (Prostate Cancer UK, 2013).

In England, African-Caribbean men have a greater risk of developing prostate cancer and are more likely to present with prostate cancer at a younger age (Ben-Schlomo, 2007; Metcalfe, 2008). The death rate from prostate cancer is 30% higher in Black men compared to their White counterparts (National Cancer Intelligence Network, 2012). Research indicates that African-Caribbean men in the UK have a relatively poor awareness of prostate cancer (Westminster City Partnership, 2010; Pedersen, et al., 2012).

Bowel cancer affects 1 in 18 people - men and women of all ages, cultures and backgrounds. Research indicates that colorectal cancer (also known as colon cancer, rectal cancer or bowel cancer) rates in both Black men and women in the UK are lower than their White counterparts (National Cancer Intelligence Network, 2009) but there is concern that the incidence may increase due to this group's lower awareness of screening for the disease (Cancer Research UK, Men's Health Forum and NCIN, 2013). When diagnosis is made early, before it has had a chance to spread, bowel

cancer can be cured in 9 out of 10 cases - yet only 9% of patients of all ethnicities are diagnosed at the earliest stage.

DIABETES

Black Minority Ethnic people are at higher risk of developing diabetes than White people (Diabetes UK Cymru, 2013). Type 2 Diabetes is up to five times more prevalent in the Black population than in the White population. The prevalence of diabetes is markedly higher (around 10%) for Indian and Black Caribbean men, and Indian men and Pakistani women have the highest prevalence of diabetes mellitus amongst all populations (Sproston and Mindell, 2004; Diabetes UK, 2010).

Some Black Minority Ethnic groups have a tendency to develop Type 2 Diabetes at an earlier age than people from the White population (25 years and over compared with 40 years and over in the White population). In the African-Caribbean population, Type 2 Diabetes is up to five times more prevalent than in the White population (Aspinall, 2005).

MENTAL HEALTH

Rates of psychiatric hospital admission are around three times higher than average for Black Minority Ethnic groups in England. African-Caribbeans are also more likely to be detained and treated under the Mental Health Act, and to receive medication, rather than be offered alternative treatments including talking treatments such as psychotherapy (Fountain and Hicks, 2010).

Studies show that the diagnosis of psychosis among Black Caribbean people is much more common (up to seven times) than among the White British (Cooper et al., 2008; Reininghaus et al., 2010).

NHS statistics on Mental Health (NHS Information Centre, 2009) show that the proportion of mental health service users who spent time in hospital was higher for Black Minority Ethnic groups than for the White population. Just under 10% of those in the White group were hospitalised, compared to 11.5% of the Asian or Asian British group; 14.3% of the Mixed group; and 18.9% of the Black or Black British group.

CHAPTER 4: HEALTH OF SOUTH ASIAN PEOPLE

HEART DISEASE

South Asian men are 50% more likely to have ischaemic heart disease (IHD) than men in the general population. People of Bangladeshi descent have the highest rates, followed by Pakistanis, then Indians and other South Asian populations (Harriss, 2007). Cardio-vascular disease (CVD) is more prevalent in men from the Indian subcontinent with the higher incidence hypertension, diabetes mellitus and coronary heart disease. High rates of stroke are also seen in Bangladeshi and Pakistani women (Nazroo, 1998; Nazroo et al., 2005; Harriss, 2007).

CVD is much more common and likely to occur earlier among South Asian people than in Chinese or White people (Hull, et al., 2011; Heim and MacAskill, 2006). Men born in South Asia are 50per cent more likely to have a heart attack or angina than men in the general population. Bangladeshis have the highest rates, followed by Pakistanis, Indians and other South Asians.

DIABETES

The incidence of diabetes is higher in men than women in the general population, with higher rates for Bangladeshi, Pakistani and Indian patients (Health and Social Care Information Centre, 2005; Primatesta and Brookes, 1999). Many studies have reported a much higher prevalence of diagnosed non-insulin dependent diabetes (Type 2 Diabetes) among South Asians (Barnett, et al., 2006), with South Asians being six times more likely to have Type 2 Diabetes than someone from the White population (Baradaran et al., 2006; Greenhalgh et al., 2011). Mortality directly associated with diabetes amongst South Asian migrants is around three and a half times that in the general population, and the disease renders South Asians more susceptible to blindness, kidney disease and the need for amputation.

There is evidence of perceived shame associated with choosing healthier options when cooking, such as low fat cooking and particular physical activities that involve certain dress codes. Furthermore, researchers found that amongst first generation South Asian populations who were attempting to make behavioural changes, cultural and religious factors were likely to prevent them from making some of their health adjustments. Language barriers and access issues also prevented their full engagement with activities and changes at home (Johnson, et al., 2011).

CANCER

Research shows that South Asians generally have a lower incidence of cancer than the White British population (National Cancer Intelligence Network, 2010). However, according to the National Cancer Intelligence Network (2009) the following cancers are more prevalent in South Asian populations;

- Mouth cancer is around 50per cent higher in South Asian females and around twice as high in South Asian women aged over 65;
- Cervical cancer is around twice as high in South Asian females aged over 65.

In the UK, low uptake of breast screening has been observed among South Asians (Bahl, 1996). A study of Pakistani and South Asian women living in Scotland indicated that they were at risk of late diagnosis of breast cancer because they do not go for screening (Cancer Research UK, 2004). The study showed that compared with White Scots and other White and ethnic groups, Pakistani women are least likely to take-up a first invitation to a breast screening clinic. Researchers from the University of Edinburgh found that;

- Non-attendance was 41.9% for Pakistani women and 32.7% for Indian women, compared with 23.1% for White Scots.
- For other South Asian females, including Bangladeshis, the proportion not attending was 3%.

In the UK, breast cancer studies that involve South Asian populations are limited (Bahl, 1996). In the first robust large scale, longitudinal systematic evidence based English cancer research pilot scheme (Szczepura et al., 2008), involving over 200,000 participants, breast screening results for South Asian groups (i.e. Hindu-Gujarati; Hindu-Other; Muslim; Sikh; South Asian Other) were compared with the results for non-Asian White British participants. Breast screening uptake for South Asian women was significantly lower than for non-Asians in multiple rounds of the study. The disparities in uptake were most pronounced between White and South Asian Muslim women. Although disparities in breast screening have reduced over time for South Asian women, they are still significant (Szczepura et al., 2008).

In a more recent breast cancer awareness study, it was observed that Bangladeshi women, and to a lesser extent Pakistani women, had lower breast cancer awareness than Indian women (Forbes et al., 2011). Suggested reasons for this lack of awareness were attributed to lack of, or poor, English language skills.

Pakistani and Bangladeshi men and women are around three times more likely to be diagnosed with liver cancer than White men and women. For Indian men and women, the risk is around 50% higher than White men and women (Lloyd Knight, 2012).

Oral cancer incidence is strongly related to age, though the patterns are quite different for men and women⁴. For men, age-specific incidence rates increase sharply from around age 45 and peak at ages 60-69, before falling in the over 70s. Prevalence rates of mouth cancer are higher in the South Asian population than in the general UK White population (Rastogi et al., 2008). Chewing smokeless tobacco products has been shown to make individuals more susceptible to developing oral cancer (Auluck et al., 2009).

Research has revealed that members of the South Asian population are only half as likely as other people to take up an invitation for bowel cancer screening and 15% less likely to attend breast cancer screening (Price et al., 2010). Rates were

⁴ All data provided on request by: the [Office for National Statistics](#) (October 2011); the [ISD Scotland](#), (September 2011); the [Welsh Cancer Intelligence and Surveillance Unit](#) (September 2011); the [Northern Ireland Cancer Registry](#) (September 2011).

particularly low for the Muslim subgroup (Szczepura et al., 2008). Both men and women from the South Asian population are far less likely to return an initial home test kit or to subsequently successfully complete the testing process, than are non-Asians (Price et al, 2010).

Cervical cancer is nearly twice as high in South Asian women aged over 65 than White women, but research has consistently shown low uptake of cancer screening programmes (cervical and breast) by Black Minority Ethnic groups in the UK, particularly South Asians, compared to the White British population (Paskett et al., 1997; Brenes and Paskett, 2000). Webb, et al., (2004) examined cervical screening records and found uptake in South Asian women to be 69.5%, compared with 73% by other women. The research also found that South Asians were more likely to be 'never screened' than other women (14.7% vs. 10.3%), which was not explained by confounding factors.

In the UK, the reluctance of South Asian women to undergo cervical screening has been attributed by Bentham, et al., (1995) to cultural reasons, whilst Naish et al. (1994) concluded that administrative and language barriers, inadequate surgery premises, and concerns about sterility were more important than attitudinal barriers.

Lung cancer is the most common cancer in Bangladeshi men. Bangladeshi and White men have the highest risk of lung cancer. Lung cancer remains the top ranking cancer in South Asian groups where smoking rates are higher than the majority population (Cancer Research UK, 2008; NHS National Cancer Action Team BME Cancer Voice, 2013). There is some evidence that smoking rates are particularly high amongst some ethnic groups, including Bangladeshis.

SEXUAL HEALTH

A small research study with women of White British, African-Caribbean, Pakistani and Indian backgrounds about testing for the human papillomavirus (HPV) found participants were not fully aware of the sexually transmitted nature of HPV and its link to cervical cancer (McCaffery et al., 2003). Women from the British and African-Caribbean groups expressed positive views about testing, and welcomed the added protection that HPV testing could offer, but South Asian women were less positive. Issues included the concerns that bonds of trust could be broken between women and their spouse. In the event of a positive test for HPV women described anticipating feelings of 'anger', 'hurt' and 'suspicion' towards their current sexual partner and the questioning of the history of previous sexual partners. Women, particularly those in the Indian and Pakistani groups, also expressed serious concern and, in some cases, fear that their partner might attribute the blame for HPV infection to them, irrespective of their own previous sexual behaviour. It was suggested that women in the Indian and Pakistani groups thought that the test might be used as a test of faithfulness.

For Indian and Pakistani women, testing was also perceived to reflect non-traditional cultural or religious practices concerning sex. Muslim beliefs were described by some of the Pakistani women as potentially prohibiting screening, drawing on examples of the limits imposed on abortion, women visiting male doctors and concerns that

cervical screening may affect unmarried women's virginity, with Sharia law⁵ identified as particularly restrictive.

Evidence suggests that South Asian women, especially Pakistani and Bangladeshi women, may have unmet family planning needs; use of contraception amongst those of child-bearing age being lower (59% among Pakistani/Bangladeshi women compared with 88% in White women) (Aspinall, 2005; Raleigh et al., 1997a).

TOBACCO, SMOKING AND ALCOHOL USE

Research based on the Health Survey for England⁶ suggest that Bangladeshi men have one of the highest smoking rates of any ethnicity (Sproston and Mindell, 2004; Erens, et al., 2001; Crawley, 2009; Craig and Shelton, 2008; Craig and Mindell, 2008).

Smokeless tobacco is a broad term that refers to a range of tobacco products including those which are chewed, sucked or inhaled. Chewing tobacco is particularly prevalent among South Asian populations. These products contain tobacco, areca nut, betel leaf, flavourings and spices (ASH, 2011).

A study conducted by the International Agency for Research on Cancer found that areca nut and betel quid, which are common additives in smokeless tobacco products, are both carcinogenic and increase users' risk of developing oral cancer (Hecht, 2003; Sharma, 2003). Almost 90per cent of oral cancers are associated with tobacco use.

Chewing tobacco is highly addictive and studies have found that users have blood nicotine levels that are as great, or greater than, that of cigarette smokers (Benowitz, et al., 1998 in Millward and Karlsen, 2011:4). These products are also associated with a range of other diseases which are prevalent among the UK's South Asian population, including cardio-vascular disease and diabetes. (Akhtar, et al., 2012).

A study that looked at tobacco use among Bangladeshi and Pakistani adults found that smoking among men was seen not only as socially acceptable, but as deeply socially ingrained among Bangladeshi men, contributing to group cohesion and identity (Bush et al., 2003).

ALCOHOL

A literature review commissioned by the Joseph Rowntree Foundation focused on the alcohol patterns of Black Minority Ethnic groups and found that Bangladeshis are less likely to consume alcohol than other ethnic groups, and drinking rates are low,

⁵ Sharia (Islamic law) is derived directly from the Qu'ran and sets out a legal system which governs individual and social life. The interpretation of Shari'a principles and practices vary considerably both among and within Muslim societies and communities.

⁶ The Health Survey for England is funded by the Health and Social Care Information Centre and gathers information on physical health, lifestyle behaviours, social care, physical measures, mental health and wellbeing. More information on the survey can be found at: <http://www.hscic.gov.uk/healthsurveyengland>

but Sikh men exhibit high rates of heavy drinking, and are over-represented for liver cirrhosis. However, second generation male Sikhs are less likely to drink, and drink heavily, than their forebears.

MENTAL HEALTH

Within South Asian populations, the prevalence of learning disabilities is reported to be three times that in majority populations. Of these families, 19% have more than one member with a learning disability (Mir and Britain, 2001).

Although there is evidence that general practitioner (GP) consultation rates in Black Minority Ethnic population are significantly higher than in the majority population, research indicates that South Asian patients are less aware of the existence of specialist services to assist them in mental health issues (Katbamna et al., 2002).

Research found that mental health is not a familiar concept in Chinese and Pakistani communities (Newbigging et al., 2008). Pakistani people appeared to tend to isolate it from other health-issues, conceptualising it negatively in the context of religious teachings, while for Chinese people mental wellbeing appeared to reflect hard work and material wellbeing. Lloyd (2009) interviewed Black Minority Ethnic people about their mental health and found that middle aged and older Pakistani men and older Indians (male and female) had significantly higher levels of mental illness than older White men and women.

CHAPTER 5: HEALTH OF REFUGEES AND ASYLUM SEEKERS

Refugees and Asylum Seekers in Wales are concentrated in a small number of towns and cities (Robinson, 2005; Aspinall and Watters, 2010). Asylum seekers are dispersed to National Asylum Support Service (NASS) accommodation in Cardiff, Newport, Swansea and a small number in Wrexham. As of April 2013, there were 1,597 people seeking asylum living in Wales, with the majority from Afghanistan, China, Eritrea, Iran, Iraq, Pakistan, Somalia, Sudan and Zimbabwe (Crawley, 2009). Limited research has been conducted on the experiences of refugees living in Wales. A study by Robinson, et al., (2006) showed that the majority were living in rented accommodation and about a third of respondents said that they were living in poor quality housing conditions. Research concludes that a high proportion of asylum seekers throughout the UK (including Wales) are dispersed into areas of high deprivation (Home Office, 2004; Stewart, 2012; Swansea City and County Council, 2010; Phillips, 2006). This is supported by research suggesting that a substantial proportion of refugees in Wales live in Communities First areas (Swansea City and County Council, 2010).

Asylum seekers are a heterogeneous group and as such their health status and needs vary, according to their country of origin and personal and family circumstances, but there is a lack of robust information on the size, distribution and country of origin of refugees and asylum-seekers living in Wales. It has been reported that mental health problems, sexual health needs, a high incidence of HIV and AIDS, and self-reported injury and torture are some of the problems affecting their health status, and evidence to suggest that this population frequently live in poor housing, have high levels of unemployment and poor access to education (Aspinall and Watters, 2010; Crawley, 2004; Crawley, 2009).

HEALTH ISSUES

Asylum seekers are a particularly vulnerable group and may have had health and health-related problems arising from their experiences witnessing or experiencing torture, abuse or the death of family or community members. Furthermore there is some evidence to suggest that the health status of some individuals deteriorates in the years following arrival in the United Kingdom, due to living in poverty and the restrictions placed on their freedom (Crawley, 2009). Other issues may include;

- Incomplete immunisations;
- Communicable diseases such as tuberculosis, HIV/AIDS and other sexually transmitted diseases;
- Mental health problems which may be related to past experiences or pre-existing problems but also may be due to or exacerbated by current circumstances;
- Poverty, homelessness; and

- Racism, discrimination, and loss of status.

Adams et al. (2004; p. 1550) cite a number of studies reporting that “[...] *refugees are at a higher risk of psychiatric disorders such as depression, suicide, psychosis, post-traumatic stress disorder, and substance misuse, often directly related to past physical or psychological trauma*”. Rates of psychosis among White people immigrating to predominantly White populations are estimated to be twice as high as within the general population, and four times as high among Black people immigrating to predominantly White populations (Adams et al., 2004).

As part of research conducted on the health experiences of refugees living in Wales, respondents were asked to describe their physical health before and since arriving in the UK on a five-point scale (ranging from 1, very poor to 5, very good). The results showed that a significant proportion of respondents said that they felt that both their physical and mental health had deteriorated since they arrived in the UK, 22.8% and 38.2% respectively (Crawley, 2009: p.32).

Virtually all the descriptions of decline in mental and physical health since arrival in the UK are related to anxiety, stress, depression and the isolation associated with being a refugee, the asylum process and separation from home and family. There is some evidence from qualitative responses that mental health problems in particular are exacerbated by the housing and employment situations in which many refugees find themselves (ibid).

BARRIERS

Although accessing healthcare is difficult for many vulnerable groups, it is a particular issue for refugees and asylum seekers. Jentsch et al (2007) have identified a number of possible reasons for this, including:

- Lack of awareness of how to access the NHS;
- Unfamiliarity with model of care provided by the NHS. Depending on their country of origin, asylum seekers and refugees may have very different expectations and experiences of primary healthcare. For some, primary care may lack credibility or be perceived as a second class service, whilst for others it may be a completely unfamiliar concept;
- Lack of available information;
- Unrealistic expectations of the NHS;
- Difficulty in finding a GP with whom to register;
- Language and communication difficulties. Language barriers are a key issue with regards to accessing services, including access to healthcare for people whose first language is not English. Research suggests that it can create so much anxiety that some Refugees and Asylum Seekers tend not to discuss all of their health problems (Bahl, 2001, Jentsch et al., 2007);
- Lack of appropriate documentation allowing access to NHS services; and

- Concern that dealings with health services may not be confidential.

MENTAL HEALTH

Crawley's (2009) survey research with Refugees and Asylum Seekers found that around a third (36.6%) of respondents received medical treatment at the time of the survey. Many respondents said that they were currently receiving treatment for depression, most commonly in the form of anti-depressants and/or counselling. Some complained that they had not received appropriate help with their mental health issues, and commented on the lack of access to counselling and other forms of support. Others stated that they did not want any help and wanted to deal with their depression on their own or with the help of friends or the church (Crawley, 2009).

There is some evidence to suggest that public attitudes and the actions of public bodies may contribute to refugees and asylum seekers' mental health problems. When asked whether they had experienced any negative public attitudes or racism since arriving in Wales almost half (49.6%) of Crawley's survey respondents said that they had experienced negative public attitudes and racism whilst living in Wales, and a third said that they had been discriminated against on the basis of their skin colour, ethnic origin or religion.

Nearly a quarter of respondents (23.6%) described difficulties in accessing medical treatment, including difficulties and delays in securing appointments with GPs, dentists and hospital consultants, and the length of waiting times for appointments, especially with consultants. It is not known how these findings compare to those for the rest of the population.

CHAPTER 6: HEALTH OF GYPSIES AND TRAVELLERS

THE GYPSY AND TRAVELLER POPULATION

A traditional, and defining, characteristic of the Gypsy Traveller lifestyle has been mobility. However, as this has become increasingly difficult to maintain (Cemlyn et al., 2009), a diminishing number are nomadic and more have chosen to live on caravan sites and in permanent housing (Powell, 2013). Housed Gypsies and Travellers constitute around two-thirds of the UK's population of approximately 300,000 Gypsies and Travellers (Crawley, 2004).

The Housing (Wales) Act 2014 places a duty on Local Authorities to assess the need for Gypsy and Traveller sites and to meet the needs identified. Data from the 2011 Census shows that there were around 2,785 Gypsies and Travellers living on 85 sites across Wales, with the highest numbers in Cardiff, Pembrokeshire and Carmarthenshire.

Studies have highlighted the poor quality of some public sites, which are often located in places that are both unhygienic and unsafe for family life. Overcrowding on such sites is common and many are located on polluted land close to industrial estates and motorways, under electricity pylons and next to sewage works. Researchers have determined that isolation and exclusion is a central feature of the lives of many Gypsies and Travellers, both geographically and culturally.

WHAT WE DO KNOW ABOUT GYPSIES AND TRAVELLERS' HEALTH IN THE UK?

The paucity of systematic data collection and information on the health and use of health services by Gypsies and Travellers in the UK is a common theme in the literature (Aspinall, 2005; Doyal, et al., 2002; Feder and Hussey, 1990; Fountain, 2006; Matthews, et al., 2008; Parry, et al., 2004; Patel, 2005; Van Cleemput, 2001; Van et al., 2007), but more is available from Ireland which may be relevant to the Traveller population in Wales. The All-Ireland Traveller Health Study looked at the uptake and experience of healthcare services to find that Travellers had higher levels of physical and mental ill-health and used health services more often than the general population, but reported poorer quality health care experiences (McGorrian et al., 2012: 178-9).

Research suggests that Gypsies and Travellers experience the poorest health of any ethnicity (Cemlyn et al., 2009; McLeish, 2008; Bragg, 2008; Beach, 1999), with a higher incidence of: asthma, diabetes, cardiovascular disease, strokes, respiratory problems, arthritis, accidents, infant mortality, and mental illness. The evidence also shows that Gypsies and Travellers are more likely to suffer from chronic illnesses and health problems that are limiting to daily activities, or to be the main carer for a dependent relative with a chronic illness (Parry et al., 2007a).

Research indicates that Gypsies and Travellers are around three times more likely to be anxious and twice as likely to be depressed as the rest of the population (Goward et al., 2006). Gypsy and Traveller women are estimated to be twice as likely as men

to experience mental health problems (Parry, et al., 2004). A multiplicity of factors may contribute to their depression, including stress related to accommodation challenges, unemployment, and racism and discrimination by public services and the wider public (Papadopoulos and Aspinall, 2005). For many, being forced into housed accommodation has been associated with depression and anxiety (Cemlyn, et al., 2009). Furthermore there is a paucity of culturally sensitive and informed counselling available to Gypsy Traveller communities to assist them in dealing with depression and bereavement (Cemlyn, et al., 2009; Lau and Ridge, 2011).

There is some evidence of a significantly higher rate of disability amongst Gypsies and Travellers than among the wider population (Greenfields, et al., 2007). Although this is inferred from a question on caring rather than disability as such, and while non-response was a problem, 32% of Romany families, 39% of those who identified as 'others', 14% of New Travellers, 10% of Show people and 10% of Irish Travellers were 'caring for someone with a disabling condition which impacts on their day-to-day activities' (Greenfields, et al., 2007: 114; Cemlyn et al., 2009).

Although minimal research has been undertaken into the dental/oral health needs of Gypsies and Travellers, there is some indication that they suffer from a high level of unmet oral and dental care health, often due to their inability to obtain regular check-ups and a high intake of sugary sweets in childhood (Dion, 2008).

Additionally, Gypsies and Travellers have been identified as having health conditions connected to alcohol and heart disease, often linked to depression (Cemlyn et al., 2009; Parry, et al., 2004). In some communities, an increased incidence of certain genetic conditions has been reported due to inter-marriage (Badger, et al., 2009; Bittles, 2000; Bittles, 2001; Zhivotovsky, et al., 2001).

Immunisation is reported to be lower than in the settled community. Other illnesses due to poor living conditions have been reported, including diarrhoea, increased asthma, parasites and skin conditions and rashes (Feder et al., 1993; Saltus, 2006; Swansea City and County Council, 2010).

Compared to the settled population, infant mortality and maternal death rates are higher and life expectancy is significantly lower in the Gypsy Traveller community (Cemlyn et al., 2009; Doyal, et al., 2002). Poor living conditions, often complicated by the risk of eviction, and lack of contact with medical or midwifery practitioners have been suggested as major reasons for many deaths that could have been prevented (Cemlyn et al., 2009).

BARRIERS TO RECEIVING HEALTHCARE

A number of barriers to receiving healthcare have been identified in research undertaken by EHRC (2007), including:

HOUSING MOBILITY

Postal services may be erratic or non-existent to those with a nomadic lifestyle, making it difficult to keep appointments (if missed, the patient may then go to the

bottom of the waiting list), reduced continuity of care, and causing problems with obtaining repeat prescriptions to treat chronic conditions.

PREJUDICE AND DISCRIMINATION

There have been many reports of a reluctance or refusal to register Gypsy and Traveller families on GP lists, to make appointments or to arrange for repeat prescriptions. In addition, doctors or health visitors may refuse to visit certain sites for home visits and some taxi companies may refuse to collect patients from sites. Gypsies and Travellers often experience difficulty and discrimination accessing health care, including in registering with local GPs, and in finding information in GP surgeries inaccessible. Consequently Gypsies and Travellers often resort to using Accident & Emergency services for basic health care, with minimal, if any, follow-up health care (Cemlyn et al., 2009; Greenfields, et al., 2007).

CULTURAL BARRIERS

Limited literacy and knowledge of how the healthcare system works may be a barrier to understanding letters, the implications of missing an appointment, the treatment offered, how to self-medicate or the need for continuing medication to treat chronic conditions.

There are socio-economic, culture-specific, traditional and religious reasons for Gypsy and Traveller women failing to access well woman clinics, family planning services, urogenital clinics and gynaecological services, including cervical screening (e.g. lack of privacy to discuss certain health issues).

Health beliefs can be very different from those of settled people, for example, a tendency to classify problems as immediate, or not important, has been reported. An inability to meet needs immediately, for example, by providing vaccination when an outbreak of childhood disease is reported, is sometimes regarded as indicative of showing a lack of interest on the part of the health professional (EHRC, 2007).

HOSPITAL AND AMBULANCE AND EMERGENCY SERVICES

Jesper et al. (2008) noted a lack of understanding of the culture of Gypsies and Travellers in hospitals. Interviewees reported that elderly patients admitted to hospital or hospice could feel threatened and scared by the lack of cultural familiarity. Many Gypsies and Travellers were unable to read and write and were reluctant to inform health providers of this. Research also identified Gypsy and Traveller's inability to complete forms due to literacy issues (Greenfields and Home, 2006). Research suggests that there is a greater tendency among Gypsies and Travellers to use Accident and Emergency (A&E) units to seek treatment (Beach 1999; Beach, 2006).

Additionally, Gypsy and Traveller children also have higher accident rates than the general population of UK children, partly due to children being physically active and often living and playing in unsafe caravan sites (Cemlyn et al., 2009). Accidents and deaths on sites from car and road related injuries are also common. Some of these

accidents⁷ are due to many authorised sites being located near dangerous and busy roads (Cemlyn et al., 2009; Clark and Greenfields, 2006; Greenfields, et al., 2007). Research suggests that increased maternal stress could be linked to the demands of mothers worrying about their children's activities while playing in unsafe areas (Cemlyn et al., 2009; Greenfields, et al., 2007). Although comprehensive data on Gypsy and Traveller children is minimal, the few existing studies have found higher rates of illness among Gypsy and Traveller children compared with children of other ethnicities (Pahl and Vaile, 1986; Van Cleemput et al., 2007). Other researchers have found high rates of premature death in children (Parry, et al., 2004; Parry et al., 2007b). Research has found low immunisation rates for Gypsy and Traveller children in families that were highly mobile, which often has resulted in a lack of health care continuity and poor availability of specialist health visitors for the Gypsy and Traveller communities (Peters et al., 2009).

Research indicates that the needs of terminally ill Gypsies and Travellers are being overlooked by hospitals and GPs (Jesper et al., 2008), and that while they prefer to die at home, there was often minimal, if any, support from healthcare professionals to assist them to stay at home. None of the people interviewed in their study had been able to use palliative care services for their family members (regardless of accommodation status). The reasons included: pride in caring for a person at home, clashes with medical staff over large numbers of visitors, and limited knowledge of the services available. Enforced mobility reduced access to GPs and made it difficult to organise programmes of palliative care to support Gypsies and Travellers who wished to die at home.

Inadequate health assessment monitoring suggests that many health professionals remain unaware of the healthcare needs of Gypsies and Travellers (Cemlyn et al., 2009; Clark and Greenfields, 2006). Research indicates that the Gypsy and Traveller mortality rate is between 1 and 1.5 times that of the housed population (Baker, 2005; Greenfields, et al., 2007). Furthermore, a confidential enquiry into maternal deaths found a disproportionate number of maternal deaths amongst Gypsy and Traveller women, in fact the mortality rate was found to be higher than any other ethnic group (Lewis and Drife, 2001) due to poor housing/caravan sites and being forced to move on in some cases, which often led to inadequate and discontinuous health and maternal care.

SMOKING

Peters et al. (2009) reported some interesting differences between Gypsy and Traveller and Pakistani Muslims, African Caribbean, and White adults living in five geographical locations in England. There were significant differences in smoking status, with more Gypsies and Travellers being current smokers (58%) compared with 25% or less in the comparator groups. For all examined health outcomes, Gypsies and Travellers had significantly poorer outcomes compared with the White population.

⁷ Beach (2006) reported a higher rate of accidents among children, related to parental difficulties in accessing appropriate information on accident prevention and the impact of poor quality sites on injury rates.

DOMESTIC VIOLENCE

Within Gypsy and Traveller communities there are pressures to maintain traditional gender roles, including 'hyper-masculine roles' (Lau and Ridge, 2011. Matthews (2008) highlights Traveller men's health issues; their indifference and lack of attendance at medical centres relative to Gypsy Traveller women. Evidence suggests that domestic violence is relatively common in these communities, which impacts on self-esteem and depression (Caffel and contributions from NPHS HIAT team, 2009; Carr and Robbins, 2009, EHRC, 2007, Van Cleemput, 2000). A 2007 review discussing Gypsies and Travellers' health in Wrexham found that '61% of married English Gypsy women and 81% of married Irish Traveller women interviewed for the study had experienced direct domestic abuse' (EHRC, 2007). The review makes the point that Gypsy Traveller women who have experienced domestic violence will have suffered it more severely, and over a longer period of time, than other women.

HEALTH-RELATED BELIEFS AND EXPERIENCES OF GYPSIES AND TRAVELLERS

In a qualitative study involving Gypsies and Travellers with experience of ill health in England, researchers found that poor health and daily encounters of ill health among extended family members were normalised and accepted (Van Cleemput et al, 2007). The researchers also identified four consistent themes amongst Gypsy and Traveller related to their health experiences:

- there was a 'travelling way' of doing things in the community;
- low expectations of having good health;
- a need to remain self-reliant and maintain control of all aspects of their lives; and
- fatalistic tendencies and a fear of death.

The researchers concluded that Gypsy and Traveller communities share strong family ties from which cohesive cultural beliefs and attitudes underpin the health beliefs and decisions to access health services (Van Cleemput, et al, 2007: 208). In the research, Gypsies and Travellers' ill health was seen as a normal and inevitable consequence of adverse social experiences that was stoically and fatalistically normalised and accepted as a way of life. The researchers recommended that in order for health care provision to be effective with Gypsy and Traveller communities, multi-agency awareness of their issues, coupled with multi agency approaches to tackling their problems is needed.

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