Gypsy, Roma, and Traveller Communities in Suffolk

Health Needs Assessment 2023

Contents

Terminology used in this document

The terms 'Gypsy, Roma, and Traveller' include heterogeneous groups with diverse histories, cultural and linguistic backgrounds, such as Sinti, Bargees/Boat dwellers and New Age Travellers. It is important that we recognise these terms are contested within communities, assuming different meanings in different contexts. For instance, the term 'Gypsy' carries negative connotations and is offensive to many Roma people while some Romany Gypsies are proud of being so identified[1].

Throughout this document we recognise that Gypsy, Roma, and Traveller (GRT) populations are not homogenous. A specific example from our stakeholder feedback notes that Roma populations do not want to be conflated with 'Gypsy and Traveller' populations generally – and it is noted that GRT communities are heterogenous. Romanes is an oral language with many dialects, and therefore varies even within the Roma community. There are multiple different Roma communities within Suffolk, with a distinct caste system.

However, the people within these communities do tend to share common challenges related to health and wellbeing. Therefore, this needs assessment looks holistically at GRT populations, whilst endeavouring to recognise the differences in culture, heritage, and experience in these communities.

Executive Summary

PLEASE NOTE: For ease of reading, references have not been included in the executive summary. However, the main document has full references.

Gypsy, Roma, and Traveller (GRT) communities encompass a diverse community with different histories, cultures, and beliefs. Generally, the term describes people from a range of ethnicities following nomadic ways of life. However, the number of 'settled' GRT people living in bricks and mortar accommodation has increased in recent years.

The long-standing persecution, displacement, and discrimination against the GRT community has contributed to their overall poorer health compared to the general population. At present, GRT communities are known to face some of the severest inequalities in health and care access and outcomes amongst the UK population, even when compared with other minority ethnic groups. This includes 10-25 years lower life expectancy, poorer maternal and neonatal outcomes, higher prevalence of long-term illness and poorer mental health.

When reviewing GRT related National Institute for Health and Care Excellence guidance, GRT communities were described as an 'underserved' or 'socially disadvantaged' group. Guidance highlights the need for a focus on these groups to increase utilisation of services and suggests that working with local GRT organisations would help commissioners provide services tailored to the local population. However, evaluation from the Government Equalities Office has highlighted a persistent failure, by national and local policymakers, to tackle inequalities faced by the GRT community in a sustained way. The NHS Long Term Plan gives an opportunity to direct resources towards GRT communities who have the worst health outcomes of any group. The plan states that services should be accessible to all, and it is not enough to rely on individuals who have the trust of GRT communities to deliver all their health services.

Key findings from this HNA:

When combining national and local findings, there are persistent and clear inequalities that are likely to lead to detrimental health and wellbeing outcomes for GRT communities in Suffolk. Inequalities highlighted include lower educational attainment, higher unemployment, lower occupational status, lower socio-economic status, and reduced access to health care and services.

There is a lack of reliable research and evidence regarding the health status of the adult GRT community across Suffolk and in England. However, literature has commonly identified themes such as maternal health, premature death, immunisation rates, adverse environmental conditions, reluctant engagement, and limited access to health services, as all contributing to poor outcomes.

National data and insight highlights:

- GRT families are generally younger, with motherhood often occurring at a younger age compared to their non-GRT counterparts. 2018 study showing the mean age of a first pregnancy within the Roma community was 17.3 years compared to the mean age of new mothers across England and Wales averaging at 30.7 year in 2019 and 2020.
- The average health status of a 60-year-old from a GRT community in England is similar to the average health of an 80-year-old from the White British population.
- A higher proportion of the GRT community are affected by long-term conditions, and GRT men are more likely to suffer from two or more physical health conditions than White British men.
- There is significantly lower coverage for Traveller children compared to non-Traveller children for all vaccinations in the routine children immunisation schedule.
- GRT community members are nearly three times more likely to be anxious and just over two times more likely to be depressed, with women twice as likely as men to experience mental ill-health. Suicide rates within the GRT community are higher than within the general population.
- Around three quarters of the GRT population in England and Wales live in bricks and mortar accommodation and the remaining quarter live in caravan or other mobile structures. Of these 10,000 GRT people have no place to stop as a result of chronic national shortage of sites, and 3,000 families living roadside have limited or no access to basic water and sanitation. Even if families are able to get a pitch on a Traveller site, the positions of and conditions have been shown to increase risk of poor health.
- Across England, 26% of Traveller sites are near major roads, 12% are near rubbish tips, 8% are close to industrial and commercial activity and 3% are near sewage works.
- GRT communities can face online abuse within their communities and outside their communities for opposing specific cultural norms. While many communities throughout history have used shaming as a form of social control, online 'shame pages' are now proliferating within the Irish Traveller and Romany Gypsy communities which reduces productive engagement.

Number of Suffolk GRT sites:

Internal data as of June 2023 collected from local authorities indicates are a total of 32 GRT sites across Suffolk. West Suffolk have the largest number, with a count of 12, and Ipswich have the fewest, with a count of 2.

2021 census data:

Whilst census data remains the key data source for estimates of the GRT population and their characteristics (such as self-reported health status and employment status), it is recognised this is likely to be an undercount of the true GRT population numbers. This is due to multiple factors including lower literacy levels in GRT communities, and a mistrust by some GRT community members of services/government organisations.

2021 census data for Suffolk indicates:

- 1,892 people said they were Gypsy Roma or Traveller in Suffolk, representing approximately 0.3% of Suffolk's total population. This is an increase of 1,288 people (213.25% increase) compared to the 2011 Census (604 people). This increase (mirrored nationally) is mainly attributed to the inclusion of 'White: Roma' as a distinct ethnic classification for the first time, with the first official population of Roma heritage in Suffolk recorded at 987.

- Suffolk's GRT population are generally younger compared to non-GRT populations, with 65% of Suffolk residents identifying as 'White: Gypsy or Irish Traveller' and 72% of residents who described themselves as 'White: Roma' below 40 years of age, compared to 44% of Suffolk's general population.
- The main language for over half of Suffolk's GRT population (52%), is not English, and levels of literacy remain lower in GRT communities compared to non GRT communities. Lower literacy levels can make engagement with services and the wider community more challenging.
- The most concentrated occupations within the GRT population are elementary occupations, accounting for 12.1% or employment within the community, statistically significantly higher than the non-GRT population (4.9%).
- A statistically significantly higher proportion of GRT population either do not work or work part-time compared to the non-GRT population.

Disability and health status in the 2021 census

- In Suffolk, 14.9% of the GRT population identified as disabled under the Equality Act, statistically significantly **lower** than the non-GRT population across Suffolk (17.5%) and England and Wales (18.3%).
- 6.4% of Suffolk's GRT population reported 'Bad' or 'Very bad' health, statistically significantly higher than both non-GRT populations across Suffolk (4.9%) and England and Wales (5.2%), and statistically similar to the GRT population across England and Wales (7%). However, a higher percentage of Suffolk's GRT population **ALSO** reported good or very good health in the 2021 census compared to the non-GRT population (83.7% vs 81.4%).
- This polarisation of self-reported health is similar to national findings, and also meant that a statistically significantly lower percentage of the GRT population both locally and nationally reported fair/average health status compared to non-GRT populations.
- This could be in part due to differences in cultural perception surrounding talking about/acknowledging ill-health in GRT populations. Therefore, this may need to be taken into consideration when interpreting these results.

Self-reported health status in the 2021 census for GRT and non-GRT communities:

	% of population			
	Suffolk		England and Wales	
	GRT	Non-GRT	GRT	Non-GRT
Very good or good health	83.7	81.4	83.3	82.0
Fair health	9.8	13.7	9.7	12.8
Bad or very bad health	6.4	4.9	7.0	5.2

- 37.3% of the GRT population have no qualifications, statistically significantly higher than the non-GRT population (16.3%).

Data and insights about the GRT community in Suffolk from other sources:

- A lower proportion of GRT children progress to secondary education compared to the non-GRT population.
- A higher proportion of Suffolk's GRT population utilised Special Educational Needs (SEN) support) or had an Education Health and Care Plan (ECHP) compared to the non-GRT population.

Stakeholder voices

The following information is extracted from informal interviews with various professionals that work with GRT communities in Suffolk in early 2023:

- There is a continued need to overcome stigma and the perception that non-Traveller communities have regarding Traveller communities.
- Traveller communities tend to be more likely to deal with health issues when they occur, rather than taking a preventative approach. Both men and women are not being screened for cancer.
- The term 'mental health' is not generally used within GRT communities. Mental ill-health may be reframed as 'suffering with their nerves', 'their nerves have gone against them', 'your nerves have gone'.
- Using A&E for ailments like coughs, colds and flu has been observed, this may be for multiple reasons such as lack of transport, being unable to register with a GP or being unable to get an appointment, not understanding the health system, or it just being easier/quicker to access.
- Generally, it's all about having the same people and organisations build trust and rapport with GRT communities. Trust must be built over time and there are no overnight results. The best interactions are always face to face – as communities want to see you, hear you, and gauge how much confidence they have in you.

Access to health services:

In Suffolk access to health services such as the GP remains an issue. Dental service access is also a key concern- particularly for children. Poor dental health is in linked with a lack of knowledge around good oral hygiene and lack of accessible information promoting good oral health.

In Suffolk, there is also a fear held by some GRT parents that many services designed to support children's wellbeing will result in the child being taken away from the parents- services are met with resistance when trying to work with GRT families. Strong cultural beliefs and norms in GRT mothers (specifically around the perception of them being strong, confident and capable), can result in reduced use of health support and services after birth. Parenting advice is usually passed down from generation to generation and members of the community can be resistance to perceived interferences from healthcare professionals due to fear that their child might be seen as 'vulnerable'.

During the early days of the pandemic, there was a significant acceleration in the adoption of digital tools for patient facing interactions. The GRT community are likely to experience digital exclusion. Therefore, this shift is likely to widen existing health inequalities.

It is also noted that the lay understanding of cancer within the Gypsy Traveller population is very limited. The practice of preventative health behaviour factors (for example stopping smoking) and screening services are also underutilised within GRT populations.

Services for Suffolk GRT communities:

Suffolk has dedicated community engagement officers and services that have been building trust, rapport, and most importantly supporting GRT communities, including roles such as a Maternity Advocate and a GRT Education Liaison Officer. Health Outreach Services support marginalised and vulnerable adults into mainstream health services across Suffolk, and the Ipswich and Suffolk Council for Racial Equality (ISCRE) runs culturally informed interventions to support

individuals and organisations in the statutory, private, and voluntary sectors, to understand the extent and nature of inequalities experienced by marginalised groups.

Learning from other areas, examples of best practice:

Best practice examples from other areas have shown the benefits of having a dedicated health care worker (for example a nurse) was accepted by GRT communities and provided greater impact when achieving a holistic approach to care. This may also be an area that would benefit from further exploration.

Main conclusion of this HNA:

In order to maximise engagement with GRT communities evidence shows services need to be tailored to these communities, be delivered on-site or where GRT communities live, It is also vital that differences between GRT communities in Suffolk are recognised, respected, and valued. It is only through targeted, tailored, continuous work with GRT communities, that inequalities in this population can be reduced.

Recommendations

Based on the findings of this health needs assessment, the following recommendations are made:

Area	Recommendation	Action to be taken by	When?
Culture and ways of working	1. Ensure all possible efforts are made to effectively communicate with the Suffolk GRT population to enable informed decisions about their needs.	Across the Suffolk system	Immediately
Culture and ways of working	2. Continue to build on the good work of Community Engagement Officers in building trusting relationships, showing empathy, a non-judgemental attitude, and a positive attitude to overcoming problems.	Across the Suffolk system	Immediately
Culture and ways of working	3. Ensure effective cross-system collaboration to support people from GRT communities.	Across the Suffolk system - led by the GRT High Level Steering Group	Immediately
Culture and ways of working	4. Ensure those who work with GRT communities are aware, able to signpost and support those individuals to access and use the services that are relevant to improving health and wellbeing	Across the Suffolk system - led by the GRT High Level Steering Group	Immediately
Culture and ways of working	5. Encourage key provider organisations to have a key person who is aware of services for GRT communities and can act to ensure the organisation can provide them in culturally appropriate way. This could be part of the person's wider role to provide support for other vulnerable groups.	Across the Suffolk system - led by the GRT High Level Steering Group	Over the 12 months from June 2023

Culture and ways of working	6. Completing Equality Impact Assessments in relation to new initiatives/services or service change will help to ensure the needs of key vulnerable groups, including GRT are considered, and actions put in place to meet them.	Across the Suffolk system - led by the GRT High Level Steering Group	Over the 12 months from June 2023
Health	7. Visit Suffolk GRT sites and work with colleagues across the system to encourage GP registration for GRT community members and reduce system barriers to registration where in evidence or experienced.		
Health	8. Explore the potential of offering on site visits from Health Visitors, GPs, Dentists or Nurses to increase access to services.	Public Health and Communities Suffolk - led by the GRT High Level Steering Group	Over the 12 months from June 2023
Health	9. Target GRT communities specifically in relation to mental health this includes education about what support is on offer, how to access this support, and looking at how to prevent suicides in GRT communities in Suffolk.	Public Health and Communities Suffolk	Over the 12 months from June 2023
Health	10. Deliver health promotion and improvement opportunities and work to maximise uptake of these. Specific initiatives should include: -Cancer screening -Healthy eating advice -Oral health and tooth hygiene -Childhood vaccine uptake	Public Health and Communities Suffolk	Over the 12 months from June 2023
Communication	11. Look for ways to minimise digital exclusion in GRT communities, and utilise technologies such as WhatsApp to disseminate key health and wellbeing information	Across the Suffolk system	Over the 12 months from June 2023
Planning and housing	12. Work with relevant teams to improve the wider environments surrounding GRT sites, to maximise health and wellbeing and minimise environmental hazards. Organisations that provide health care services focussing on GRT communities should also involve the relevant communities and their advocates to provide advice and information to support design and uptake of those initiatives/services.	Suffolk County Council and District and Borough Planning teams and Public Health and Communities Suffolk	Over the 12 months from June 2023
Education and skills	13. Explore routes to improving educational attainment and offering	Suffolk County Council Skills Team and Public	Over the 12 months from June 2023

	support in developing skills for employment.	Health and Communities Suffolk	

An Introduction to Gypsy, Roma, and Traveller communitie

Who are Gypsy, Roma, and Travellers?

The term Gypsy, Roma, and Traveller (GRT) does not constitute a single, homogenous group, but encompasses a range of groups with different histories, cultures and beliefs. Generally, the term describes people from a range of ethnicities following nomadic ways of life (travelling from place to place)[2]. In the UK, it is common in data collections to differentiate between:

- Gypsies (including English Gypsies, Scottish Gypsies or Travellers, Welsh Gypsies, and other Romany people)
- Irish Travellers (who have specific Irish roots)
- Roma, understood to be more recent migrants from Central and Eastern Europe

The term can also encompass other groups that travel, including but not limited to, New Travellers, Boaters, Bargees and Showpeople[3]. Further introduction to GRT communities is given in figure 1.

Figure 1: Introduction to Gypsy, Roma, and Traveller Communities

	Romany Gypsies	**Irish Travellers**	**Roma People**	**Travelling Showpeople**	**New Travellers**	**Liveaboard Boaters**
Ethnicity	Historically originated in Northern India, Romany Gypsies have been in the UK for many generations.	Irish Travellers originated in Ireland as a distinct and separate ethnic group from the general Irish population recorded since the 12th century	Historically originated in Northern India and settled in Europe (including Romania, Slovakia, Czech Republic and Poland) before migrating to the UK more recently	Anyone who travels to hold shows, circuses and fairs can be a Showperson. Many families have led this way of life for generations, and many have Romany heritage.	'New Traveller' can describe people from any background who chooses to lead a nomadic way of life or their descendants.	Anyone who lives on a boat, from all walks of life and backgrounds.
Arrival in England	Before the 16th Century - fulfilling a need for nomadic seasonal agricultural labour and selling.	Recorded from the 18th Century but probably earlier. Horse trading and then post-war construction work.	Small numbers since 1945, with a number of Roma seeking asylum in the 1990s and early 2000s, then a growth in population following EU expansion in 2004 and 2007	According to the National Fairground Archive the first recorded charter was granted to King's Lynn in 1204.	The New Traveller movement finds its roots in the free festivals of the 1960s, but people of all backgrounds have practiced nomadism	People have been living and working on boats since canals were built in England in the 18th Century.

	Romany Gypsies	Irish Travellers	Roma People	Travelling Showpeople	New Travellers	Liveaboard Boaters
					throughout history	
Language	Romany Gypsies speak English, and many Romany Gypsies also speak a Romani dialect to varying levels of fluency	Irish Travellers speak English, and some speak Gaelic/Irish. Many Irish Travellers also speak Gaelic derived Gammon or Cant.	The majority of Roma speak their European origin country's language(s). Many Roma also speak a Romani dialect, as well as English to varying levels of fluency	Showpeople primarily speak English.	New Travellers primarily speak English.	Liveaboard Boaters primarily speak English.
Accommodation type	Around ¾ live in housing and ¼ on Traveller sites in caravans or chalets. A small proportion live roadside or in public spaces.	Around ¾ live in housing and ¼ on Traveller sites in caravans or chalets. Of these, a small proportion live roadside or in public spaces.	The vast majority of Roma people live in housing, although there are disproportionate levels of homelessness and overcrowding.	Most Showpeople live on yards in the winter months and travel during the summer months.	New Travellers lead a nomadic way of life – in vans, mobile homes, caravans and a small proportion are horse drawn.	Boaters live on narrowboats, barges or river cruisers, whether on a home mooring, a winter mooring or continuously cruising on a canal, or in a marina.

Source: Friends Families and Travellers [4]

Today, the definition of Gypsy, Roma, and Traveller is primarily self-defined. Many individuals will identify within GRT communities but travel less and live in bricks and mortar accommodation. Although GRT communities are heterogenous in nature, it is important to note that the different GRT communities share many health barriers. Therefore, this report may benefit not only the GRT community defined but everyone who travels and/or is not part of a settled community[5].

Why has this Health Needs Assessment (HNA) been undertaken?

The long-standing persecution and displacement of the GRT community has contributed towards their, overall, poorer health compared to the general population[6]. Historically GRT communities have been subject to racism, driven by deep-rooted prejudice and stigmatisation - referred to as 'Anti-Gypsyism'. The European Committee against Racism and Intolerance defines Anti-Gypsyism as a:

> *"specific form of racism, an ideology founded on racial superiority, a form of dehumanisation and institutional racism nurtured by historical discrimination, which is expressed, among others, by violence, hate speech, exploitation, stigmatisation and the most blatant kind of discrimination"*[7].

This discrimination has led to economic and social constraints – generating high proportions of poverty, limited access to education, practical difficulties accessing services, fear of stigma and abuse, and impacting physical and mental wellbeing. At present, GRT communities are known to face some of the severest inequalities in healthcare access and outcomes amongst the UK population, even when compared with other minority ethnic groups[8]. This includes a ten to 25 years shorter life expectancy[9], increased prevalence of long-term illness[9], and higher occurrence of suicide and mental ill health[10].

The Health and Social Care Act (2012), contains specific legal duties regarding the reduction of health inequalities. Still, evaluation by the Government Equalities Office in date highlighted a persistent failure, by national and local policymakers, to tackle inequalities faced by the GRT community in a sustained way. This has led to a provision of services that are ill-equipped to support GRT people and their health and health outcomes[11]. In response, current national policy has stressed plans to effectively prioritise energy, attention, and resources to tackle health inequalities in clear and focused areas[12].

The last GRT HNA for Suffolk was conducted in 2012, and a paucity of local data has made it challenging to accurately assess health needs for GRT populations in Suffolk. Whilst it is recognised that even the most robust data sources, we have access to (namely the 2021 census), are likely to undercount the true size of the GRT community both nationally and locally, the release of this data still presents a timely opportunity to produce an updated HNA for Suffolk.

Literature Search: Health needs of the Gypsy, Roma, and Traveller population

As mentioned, the GRT community are known to face some severe inequalities in healthcare access and outcomes amongst the UK population, detailed data describing the communities' health needs is limited[2]. To provide a clearer picture of the health needs of the GRT community, two literature searchers were conducted to support the production of this Health Needs Assessment (HNA). These were conducted in January 2023, by the North East London NHS Foundation Trust (NELFT) and the UK Health Security Agency (UKHSA) Knowledge and Library service.

This research aimed to identify literature regarding the physical and mental health needs of the GRT population, to emphasise key areas of focus to support the overall health of the GRT community. A combination of systematic literature reviews, journal articles and grey literature were identified. Qualitative and quantitative evidence in relation to key health related themes experienced by the GRT community were collated and categorised into key themes discussed below.

General health

There is a lack of reliable research and evidence regarding the health status of the adult GRT community in England. Studies found are mainly small, localised, and descriptive epidemiological research. However, records acknowledged have commonly identified themes such as maternal health, premature death, immunisation, adverse environmental conditions, reluctant engagement, and limited access to health services.

The majority of records consistently indicate that GRT communities have poorer overall health and wellbeing compared to other ethnic minority groups and to the population as a whole. Literature has shown that the GRT community have a shorter lifespan compared to general population, ranging between 10 to 25 years shorter on average[9]. Similarly, an all-Irish Traveller study, conducted in 2010, found mortality rates to be 3.5 times greater than the general population and that age-specific mortality rates were higher for both males and females across all age groups when compared to the general population[10]. The report also identified cause specific mortality to be higher compared to the general population, shown in table 1. The table shows unrounded

calculations for excess deaths. There were 91 extra deaths in Traveller males in 2008 compared to what would be expected if Travellers had the same mortality as the general population (rounded). For females, there were 43 excess deaths.

Table 1: Cause specific mortality for Travellers from All Ireland Traveller Health Study, 2010[10]

Cause of death	Standardised Mortality Ratio for Male Travellers (95% confidence interval)	Excess Deaths in Male Travellers	Standardised Mortality Radio for Female Travellers (95% confidence interval)	Excess Deaths in Female Travellers
Cancer	242 (135-399)	12.9	176 (80-334)	6.0
Heart Disease and Stroke	337 (203-536)	19.5	489 (261-837)	16.2
Respiratory	746 (373-1335)	13.8	536 (174-1252)	6.3
External Causes *(e.g., accidents, poisonings, suicides)*	548 (364-792)	33.3	393 (144-855)	7.0
All Other Causes	271 (140-474)	11.1	263 (113-517)	7.8
All Deaths	372 (297-460)	90.7	309 (221-419)	43.3

Source: All Ireland Traveller Health Study Our Geels [10]

In 2021 the University of Manchester published a cross-sectional study analysing data from five waves (July 1, 2014, to April 7, 2017). Data was focused on inequalities in health-related quality of life (HRQoL) and five determinants of health in older adults, across all ethnic groups, represented in the English General Practice Patient Survey[13].

Results showed HRQoL was worse in men and women who describe themselves as 'White: Gypsy or Irish Traveller'. The study stated that the average health status of a 60-year-old in a GRT community in England is similar to the average health of an 80-year-old from the White British population. Inequalities were widest for those who described themselves as 'White: Gypsy or Irish Traveller'.

Most recently, in 2023 the Evidence for Equality National Survey (Evens) of ethnic and religious minorities published findings with views included from the largest number of Gypsy, Roma, and Traveller participants in any national survey to date[14]. Research revealed health disparities between GRT people and the rest of the population. GRT men were 12.4 times as likely to suffer from two or more physical health conditions than White British men, while Roma men were five times as likely, both figures were higher than any other ethnicity.

Access to health and social care services was found to be a large issue for Roma people when compared to any other ethnic group. Roma people were 2.5 times more at risk of not having access than the white British population. The survey also found that GRT people experienced highest levels of socioeconomic deprivation. About 51% of Gypsy Travellers and 55% of Roma participants had no educational qualifications. They were also less likely to be in the highest occupational positions, and also had high rates of financial difficulties and benefit receipts. GRT people were among the least likely of ethnic groups to be in employment, and when they did have jobs the COVID-19 pandemic they were the most likely to be in precarious employment. After adjusting for age, 85% of Gypsy or Traveller men and 65% of Roma men were in precarious employment, compared with 19% of white British men.

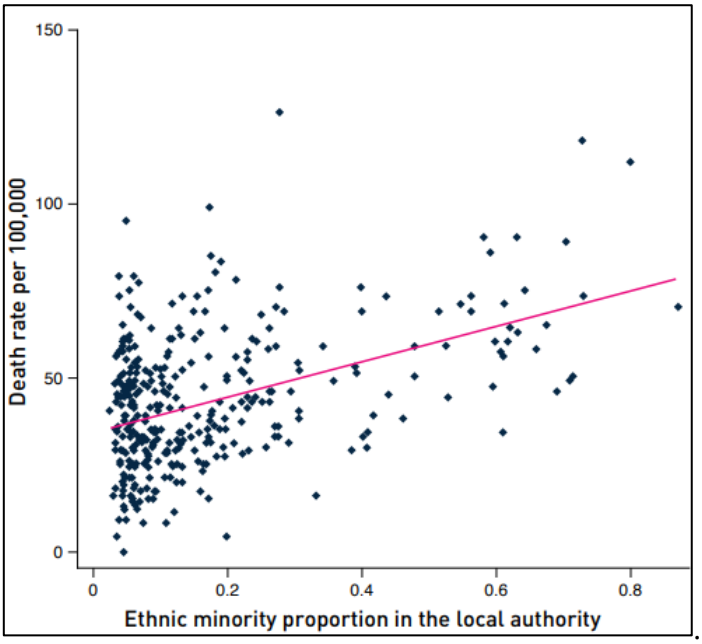
62% of GRT people had experienced a racially motivated assault. The percentage exceeded that for any other ethnic minority group. One in three experienced a physical racist attack, and, of Roma people, 47% had experienced a racist assault, while 35% had been physically attacked[14].

The COVID-19 Pandemic

The coronavirus disease (COVID-19) was disproportionally affected ethnic minority populations including GRT communities. Within the GRT population there is evidence of a higher risk of morbidity and mortality [15–17]. The University of Manchester published a report, in 2021, regarding the ethnic inequalities in COVID-19 mortality within a local authority[18]. Results showed a clear relationship between the COVID-19-related death rate and the ethnic minority proportion of the population within a local authority in England and Wales, shown in figure 2 below. The graph shows, a local authority with twice the average number of ethnic minority people experienced a 25% higher COVID-19-related death rate. Whilst this looked holistically at ethnic minority populations, it is expected similar results would be found if applied to GRT population alone. A report completed by Brunel University London investigated new ways to talk about COVID-19 for better health with a focus on the GRT communities and migrant workers[19]. Results showed that experiences of COVID-19 vaccinations were shaped by historic and ongoing discrimination which led to suspicion and reduced uptake within the community. Many individuals were worried about side effects, including effects on fertility, and participants thought their concerns around vaccine safety were not taken seriously or addressed. While many had had at least one vaccine dose, participants said they and people they knew had refused subsequent doses, particularly concerning the booster doses. Similarly, Kuhlbrandt, et al., (2023) explored the experiences of individuals from GRT groups in England to understand why they decided to take up or avoid COVID-19 vaccinations[20]. Results showed that vaccine decisions were affected by distrust of health services and government stemming from prior discrimination and barriers to healthcare which persisted and worsened during the pandemic. This vaccine hesitancy indicates that risk of morbidity could be further increased within the GRT community alone. Increased risk of morbidity has also been associated with a higher frequency of previous underlying health conditions, travelling and close-knit family lifestyle, and lack of basic amenities[15].

Evidence has also indicated that there has been increased marginalisation of the GRT community caused by the pandemic[21].

Figure 2: Local authority ethnic minority concentration and COVID-19-related mortality

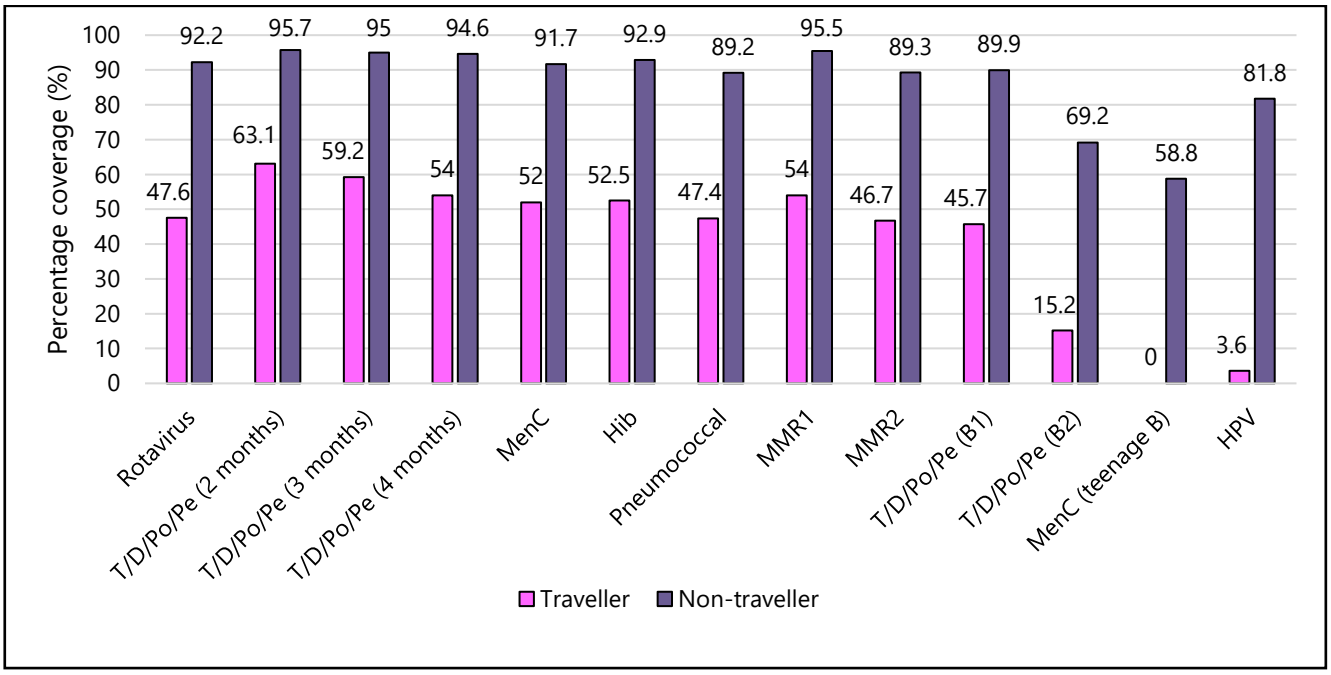


Source: University of Manchester

Immunisation

The GRT population are at higher risk of vaccine-preventable diseases and, despite the widespread availability of vaccinations, outbreaks continue to disproportionately effect the community[22–24]. Dixon et al., (2016), completed an audit of vaccination history of 214 Traveller and 776 non-Traveller children registered at a general practice in England[25]. Results showed there was significantly lower coverage for Traveller children compared to non-Traveller children for all vaccinations in the routine children immunisation schedule at all time points evaluated, with coverage over 30% lower for each individual vaccine in Traveller children compared to non-Traveller children, shown in figure 3.

Figure 3: Coverage (%) for each vaccine in the order of the childhood immunisation schedule across Traveller and non-Traveller participants



Source: [*Vaccine uptake in the Irish Travelling community: an audit of general practice records*]

Several studies have highlighted an array of additional barriers to childhood immunisation within GRT communities [26–28]. Ellis et al., (2020) completed a small-scale study interviewing mothers from GRT backgrounds in south-west London. Results showed that low take up of antenatal care services, self-declared parenting expertise, family support, timing of immunisations and waiting on vaccinations until the children were talking were key reasons given for reduced uptake[27]. Similarly Newton and Smith (2017), conducted five focus groups with 16 site dwelling Gypsy and Traveller women with pre-school aged children, aiming to explore the believes around immunisation and the barriers faced within Gypsy and Traveller communities[26]. The study identified a limited understanding of causation and risk within the Traveller population and found that Traveller mothers were reluctant to follow immunisation guidance due to the fear of their child being perceived as 'vulnerable.' Finally, Jackson et al., (2017) led semi-structured interviews with 174 Travellers from six Gypsy, Roma and Traveller communities regarding their opinion on vaccinations, and potential facilitators and barriers[28]. Results showed that there was a broad acceptance of childhood and adult immunisation with younger generation parents compared to elders. Jackson identified several obstacles to attending immunisations, including discrimination, low literacy, and language barriers. Limited understanding regarding multiple/combined childhood vaccines, adult flu and whooping cough, antenatal vaccines and HPV vaccinations was also highlighted[28]. This is important not only for the maintenance of standard immunisation uptake rates, but also due to the need for rapid roll out of the COVID-19 vaccination.

Maternal health

The GRT community is known to have higher birth-rates than that of the wider population. Parry et al., (2007) completed a study investigating the health status of the Gypsies and Travellers in England[8]. Results showed that, within the population examined, the women Traveller population had an average of 4.3 children each, compared to 1.8 amongst women within the non-Traveller population. The study showed that Traveller women were more likely to experience at least one miscarriage (29%) compared to the non-Traveller women investigated (16%). 6.2% of Traveller women also reported the occurrence of a premature death of a child.

Similarly, the Friends, Families and Travellers (FFT) charity have highlighted that Traveller mothers are twenty times more likely to experience the death of a child compared to the wider population[29], with increased risk of miscarriages, stillbirths and neonatal deaths. FFT found an association between higher rates of maternal death during pregnancy (and after childbirth), and poor environmental conditions[4]. Many Traveller women living on unauthorised encampments during pregnancy have been known to experience frequent evictions by police with some individuals facing as many as three evictions in the space of two weeks, leading to further anxiety and insecurity regarding the regularity of visits from trusted midwifes and accessibility to hospitals[30].

Avci et al., (2018) investigated the attitude and practice of family planning methods among Roma women. Results showed that the mean age of first pregnancy of Roma women was 17.3 years[31]. This is considerably lower than the standardised mean age of mothers across England and Wales consistently averaging at 30.7 years reported in 2019 and 2020 by the ONS[32]. Avci linked this high prevalence of adolescent pregnancies to the attitudes within Roma society. Early marriage is a defining feature of the Roma communities traditional lifestyle which encourages young men and women. Young people who do not have regular jobs and do not maintain their schooling are supported once married in accordance with their family's wishes. The desire to have a family with many children and the consequent high number of pregnancies and children could reinforce the acceptance level and enables those who adhere to these traditions to gain status within Roma society. This dynamic could therefore increase acceptance of adolescent pregnancies[31].

Traditional ideologies surrounding women's bodies within the communities have also been shown to created barriers towards maternal health. Literature has highlighted that the Roma community believe the discussion of menstruation, pregnancy or birth can lead to dishonour and is generally associated with shame[33]. Within the Roma community specifically, it is often found that once pregnancy is announced it must not be discussed thereafter. Upon announcement women are seen as 'Marime' and will be forced to isolate from the community (where possible) and will no longer be allowed to carry out their domestic duties such as cooking and cleaning until the baptism of the child or after 6 weeks[34]. Sometimes translated as 'ritual pollution or avoidance', 'Marime' is a central value in Romani society that defines the shape and boundaries of their natural and spiritual universe. The FFT completed a national maternity review regarding the engagement and outreach work with Gypsies and Travellers[30]. Results found that across Gypsy, Roma, and Traveller communities, upon pregnancy women have been shown to prefer use of public toilets, have limited access to cooking facilities and strict rules around cleaning kitchen. This was due to beliefs that these activities are not hygienic and could affect the pregnancy. This could result in many women not drinking enough fluids as they are anxious about needing the toilet and not having a public facilities within close proximity.

Those who describe themselves as English Gypsy, Irish Traveller and Romanian Roma women take great pride in being confident mothers. This has been shown to lead to the reduced use of health support and services after birth. Parenting advice is usually passed down from generation to generation and members of the community can be resistant to perceived interferences from healthcare professionals due to fear that their child might be seen as 'vulnerable'[35].

Breastfeeding has been found to be uncommon for Gypsy and Traveller women. Within their culture it is viewed as an 'immodest act'[36]. Pinkney (2012), completed a study investigating the

early infant feeding practice of Gypsy and Traveller women in Western Cheshire Primary Care Trust and their attitudes towards breast and formula feeding[36]. Results found that most of the Gypsy and Traveller participants opted to formula feed their infants, with less than 3% following the practice of breast feeding at birth and 0% following at six to eight weeks.

The discussion of contraceptives and sexual health is also traditionally described as a delicate subject (especially for those from an Irish cultural background)[37]. Research conducted by the crisis pregnancy agency has shown that Irish Travellers source the majority of their knowledge on sexual health and contraception through word of mouth within the community, with young men believing that protection and safe sex is the women's responsibility. Due to beliefs, Irish Traveller women were also shown to hide information regarding their sexual health from their community.

Dental health

The Gypsy and Traveller community experience oral and dental problems often resulting in hospital intervention. Dental problems within the community have been associated with knowledge around good oral hygiene and lack of accessible information. The FFT charity and the National Health Service (NHS) completed a collaborative programme to improve the oral health of Gypsy and Traveller communities in Sussex in June 2010[38]. The report highlighted that there was a lack of knowledge regarding foods that affect oral health and a limited understanding good oral hygiene within communities. Similarly, a small study focusing on Traveller children in London also found that two thirds of participants had poor dental health and 40% did not brush twice daily[39,40]. Likewise, a previous study conducted in East Hertfordshire identified high levels of unmet dental needs within the Gypsy and Traveller community, including low levels of dental registration and little use of preventative services available[41].

Long-term illness

It has been reported that individuals within the GRT community are more likely to have a long-term illness, health problem or disability which limits daily activities or work[4]. Parry et al., (2007) completed a study assessing the health status of members of the Gypsy and Traveller community in England compared to non-Travellers[8]. Results showed that 42% of the Traveller community are affected by long-term conditions compared to 18% of the general population. Risk factors for chronic diseases such as obesity, sedentary behaviour and smoking have been shown to be more prevalent in both Roma and All-Irish Traveller communities[42,43]. Traveller community members are also more likely to experience chest pain, arthritis and respiratory problems [4]. However, limited evidence regarding long-term illness is available, with MP Ian Bryne questioning the Department of Health and Social Care, in December 2022, regarding their assessment of mortality and long-term illness within the community. The question was answered by the Parliamentary Under Secretary of State at the Department of Health and Social Care, Neil O'Brien, stating that no specific assessment has been made to date.

Cancer

Although cancer mortality is declining across the general population, the Gypsy Traveller communities' beliefs and culture have been shown to inhibit cancer treatment, and care. The lay understanding of cancer within the Gypsy Traveller population is sometimes very limited, with members of the community describing the nature of the disease to be distinctly gendered and contagious[44,45]. Many within the community may also believe that they should not be informed that they have the illness as discussing cancer can 'harm individuals overall resilience and make the disease worse'[46], influencing their utilisation of treatment and cancer services. A number of studies reinforce this finding of a 'taboo' surrounding the discussion, treatment, and care of cancer[44–49]. Berlin et al., (2018) completed a study exploring English Romany Gypsy and Irish Traveller communities understanding of cancer. Results suggested that many GRT families do not discuss the disease as it can invoke bad luck- with one individual stating:

> "'I think that's because they'll never find a cure for it, all the research and that they do, they're never going to find a cure for it and I think that's why it's so, people don't like to talk about it because there's hundreds and hundreds of different types of cancer and they haven't found a cure for any one of them yet…".

Berlin found that within the GRT community cancer is referred to by many names including *the C word*, and *the bad thing*, with individuals expressing distress when mentioning the word due to personal experience with one individual stating:

> "…my daughter will say is, "that old cover" or "that disease", I think I try not to say the word "cancer" but at some point, I'm forced to and part of that is because my mother dying of it, I think it's almost for me, it's like it brings back her to me straightaway soon as I mention it ... so I think I don't mention cancer unless I have to because then it brings back how she was".

Berlin also reported viewing cancer as much more severe and serious compared with other potentially life-threatening diseases. For example, an individual stated:

> "Everyone's got diabetes. When I was told I'd got sugar diabetes, I was neither here nor there. I really didn't bat an eyelid".

However, views are changing towards cancer, with a varied level of openness and increased motivation to seek help[49]. This suggests that increased efforts within the GRT population could have greater impact.

The adoption of preventative health behaviours and screening services are also underutilised within GRT populations. Condon et al., (2021) completed a qualitive study exploring the experiences of cancer diagnosis, treatment, and care among the GRT population[49]. Results highlighted, that barriers to early detection were largely at the level of primary care, with a good relationship with doctors and clarity in communication being the predominant gateway to efficient access of services. Condon et al., (2021) completed another study identifying knowledge and experiences of cancer prevention and screening among the GRT community[50]. Results emphasised that community members acknowledge the link between preventative health behaviours such as healthy diets, stopping smoking, drinking less alcohol, and using sun protection, and the reduction in the risk of cancer. However, throughout the community a lack of confidence in their effectiveness may still persist. Women within the community were also shown to utilise cervical and breast screening services but the use of screening services within the male population was low due to the community ideals of stoical masculinity.

Mental health

Mental ill-health is a common issue across all populations, with 1 in 4 people within the general population experiencing mental ill-health of some kind each year and 1 in 6 people within the general population reporting experiences of 'common mental health problems' such as depression and anxiety in any given week in England[51]. Suicide is increasing in prevalence. The ONS reported a 6.9% increase in suicides in England and Wales from 2020 to 2021 within the general population (from 5,224 to 5,583 deaths)[52].

The Traveller Movement published a policy briefing addressing mental health and suicide in March 2019[53]. The briefing highlights findings from an all-Ireland traveller health study (AITHS), reporting the Irish Traveller suicide rate to be six times higher compared to the general population, accounting for 11% of all Traveller deaths. The briefing reported a seven times and five times higher suicide rate for men and women respectively when compared to the general population[54]. Likewise, the briefing showed that high rates of suicide among the GRT population in Britain were reported in 2009 Equality and Human Rights Commission (EHRC) review of inequalities experienced by GRT communities[55], which confirmed anecdotal evidence of a disproportionately high suicide rate amongst this group. In 2016, the EHRC published 'Healing a divided Britain' this report stated that 'Gypsies, Travellers and Roma were found to suffer poorer mental health than the rest of the population in Britain and they were also more likely to suffer from anxiety and depression[56].

FFT published a research paper in 2020 regarding suicide prevention in GRT communities. Evidence highlighted that GRT community members are nearly three times more likely to be anxious and just over two times more likely to be depressed, with women twice as likely as men to experience mental ill-health [57]. The National Suicide Prevention Strategy highlights the need for local authorities to tailor suicide prevention approaches to their local communities. However, when FFT assessed local suicide plans, only 6% mentioned GRT communities[57]. Mental ill-health is known to be interconnected with several factors which the GRT population often experience increased levels of, including incarceration, substance misuse, bereavement, domestic violence, inadequate social support, and discrimination. There is a considerable cultural taboo regarding suicide within the Travelling community, with recognition of mental-ill health being described as 'a betrayal of the tribe' [58].

Shaming and the effects of digital misinformation

In 2021, The Traveller Movement released a report discussing shaming within the GRT community. 'Shaming', or 'scandalising', are actions that intend to cause someone else to feel shame for being or doing something that another person(s) feels is wrong or undesirable by their 'community behavioural standards'[59]. Public shaming aims to damage a person's image, sense of self-worth and mental health. Shaming has also begun to manifest in 'shame pages' online. Some Irish Traveller and Romany Gypsy individuals have been creating 'Traveller shame pages' and 'Gypsy shame pages' with the purpose of publicly humiliating other members of their own community. The high suicide rates may be partly attributable to this online abuse, shaming and discrimination.

GRT communities face this online abuse within their communities and outside their communities. While many communities throughout history have used shaming as a form of social control, online 'shame pages' are now proliferating within the Irish Traveller and Romany Gypsy communities[59].

Gypsy, Roma and Traveller women can face tight-knit community surveillance and risk bringing shame to themselves and their families if they do not dress, behave, or present themselves in a manner that complies with traditional gender roles. Within the report, respondents spoke to the level of scrutiny they can experience with women and shaming regards to their clothing, make-up, hair dye, skin colour, body type, and weight. In the digital context, this extends to social media posts and online profiles. Where image-based sexual abuse and so-called 'revenge porn' occur, shame pages, profiles, and group chats can be used to circulate the online abuse and further degrade the victim-survivor[59].

In addition, GRT women are not expected to have multiple romantic relationships or sexual partners. Many GRT women are married young, and divorce is not seen as an option due to religious belief and community tradition. Regardless of whether there is drug misuse, domestic abuse or other serious marital problems, wives are often expected to remain in the marriage and can face shaming if they do not. Remarrying can also be taboo in cases where GRT women have been widowed[59].

GRT women who are lesbian, gay, bisexual, transgender, queer, questioning, intersex, or asexual (LGBTQIA+) or have a disability also face shaming. LGBTQIA+ women from the Gypsy, Roma or Traveller communities can experience additional shame on the basis of their sexual orientation or gender identity[59].

The FFT paper states that the lack of education and understanding demonstrated is reinforced through negative media coverage, including online shaming, as well as negative stereotypes, and scapegoating. A further 2021 report by The Traveller Movement on Travellers and Crime[60] showed that 96% of respondents have heard negative stereotypes regarding Travellers and crime, with further evidence from YouGov, 2017, stating that over a third of British parents would be unhappy if their child had a play date at the home of a Gypsy or Traveller[61]. This dangerous misinformation can spread from the media to the public and impact legislation and authorities' responses. Overall, a combination of negative stereotypes; lack of education, and a lack of legal or social protection, further endangers an already marginalised cohort[59].

The 2021 Traveller Movement Report calls for more education on misinformation and how this harms marginalised groups, including the LGBTQIA+ community, at an even higher rate. Certain minority groups may have limited literacy and education levels that make them vulnerable to harmful misinformation, conspiracy theories and abuse. Romany, Gypsy and Traveller women and girls have been misinformed about the health impacts of certain diet pills and nasal tanning sprays online that cause severe harm[59].

Engagement with health services

Within GRT communities, seeking healthcare assistance is often difficult. In addition, it is known to take time to establish trust between members of the GRT community and healthcare professionals. Studies have shown that community members are commonly poorly informed regarding available services, often feel anxious that they will encounter discrimination and lack of acceptance, and experience cultural differences around treatment options offered within the services available. According to research completed by FFT, over one third of GRT people report that they find information from health professionals hard to understand. Over 45% of their service users reported low or no literacy; therefore, without support may find it difficult to read medical letters, get registered and understand information given by health professionals[62].

The Office for National Statistics completed a qualitative study exploring the lived experiences relating to health within Gypsy and Traveller communities in England and Wales in December 2022[63]. Results showed that participants had previous experiences of perceived discrimination and derogatory attitudes by healthcare providers. An individual stated:

> "My daughter took her little boy… they went up to the hospital, her, and her husband. They took the baby in [for routine check-up]. They took the blood, but he had a mark, where he fell, because he was crawling and getting to walk, was nothing, was nothing, nothing at all to worry about. He [doctor] kept him in overnight to get checked

> out and said he has been abused… [now] they will not take the children to doctors or hospital. My daughter will not take the children. If I don't take them, they don't go because she's afraid they [will get] took off her. She's very, very worried".

Participants also described beliefs that discussing ill-health or seeking healthcare could worsen health conditions, with evidence that participants would only access healthcare if extremely unwell, with an individual stating:

> "In our community it's not until… we're on our last legs or something… We drop dead or we should have got help… So even if you had loads of pain or something like that, you wouldn't go until it got to the point".

This delayed health seeking behaviour was particularly evident amongst men. Women often stated they preferred the need for female health practitioners for certain health conditions with an individual stating:

> "You can't go to a normal doctor that's the problem, because you say, well, if you've got problems that you need to talk to women about, you can't sit there and talk to a man about it. And then you're forced to talk to a man about it…. You say, 'well, I want to talk to a woman.' They're like, 'no, well, you have to go with somebody else".

Delayed appearances to healthcare services among Gypsy and Traveller communities was also acknowledged by local authority study participants.

Several participants explained methods of self-management for health symptoms through the use of home remedies. Though participants used the healthcare system, home remedies were said to have been used intergenerationally, particularly for managing minor ailments. This prolonged use of home remedies could reduce utilisation of screening and preventative care leading to delayed diagnosis and treatment.

During the early days of the pandemic and onwards, there has been a significant acceleration in the adoption of digital tools for patient facing interactions. This digital movement of health services during the pandemic meant that different populations could access services required. However, the GRT community may be more likely to experience digital exclusion. Therefore, this shift may widen existing health inequalities being faced by the GRT community [64].

General Practice registration

It is known that the GRT population struggle to exercise their right to register for and access healthcare; failure on the part of the health and social care system to make a proportionate response to address these risk factors is well evidenced. Multiple studies have described low levels of general practice (GP) registration within nomadic communities[65–67].

In July 2021, FFT published a report titled 'Locked out: A snapshot of access to General Practice for nomadic communities during the COVID-19 pandemic'[67]. The study showed that out of the 100 GP surgeries contacted, 13 refused registration to patients who were unable to provide proof of identity, 8 refused registration to patients who were unable to provide proof of address, and 39 refused registrations to patients unable to provide both identification and address. A further 11 of 19 surgeries, who would otherwise register the patient, refused to register individuals who were unable to use their online registration facilities and 2 of 8 surgeries, who would otherwise register the patient, refused to support the completion of the necessary forms once the individual had disclosed, they had low literacy and would like support. The remaining 21 GP surgeries either did not answer the phone on three different dates and times (n=17) or declined registration for other reasons (n=4). Overall, 77 out of the 83 GP surgeries contacted refused registration, indicating that care is extremely difficult to access for individuals suffering multiple disadvantages including, no permanent address, no form of identification, digital exclusion and low or no literacy skills. This study followed previous research completed in 2019 by FFT whereby 24 out of 50 GP surgeries contacted would not register the individual for similar reasoning. Yet, when evaluated for their work with 'people whose circumstances may make them vulnerable' the Care Quality Commission (CQC) still rated all practices evaluated in FFTs research as 'good' or 'outstanding', an area of evaluation which should highlight issues presented [66]. Whilst it is noted that primary care services have been under extreme stress due to the pandemic, the occurrence of such obstacles to registration continue to worsen from 2019, in breach of the nomadic communities' human rights and legal entitlements.

Wider determinants of health

The GRT community are known to experience a range of health difficulties including those addressed above; however, many members of the GRT population also recognise that their health is affected by a number of so-called 'wider determinants of health' outside the immediate health field. These can include factors such as education, employment, and housing.

Research shows that 22% of those in employment from a GRT background work in elementary occupations[4]. Elementary occupations consist of simple and routine tasks which mainly require the use of hand-held tools and often some physical effort[68]. Literature has shown that health is distributed unequally by occupation, with workers in elementary occupations reporting worse health, and having higher probability of musculoskeletal conditions, disability and earlier death when compared to workers in different occupational sectors[69].

60% of the GRT population have no formal qualifications [4]. Literature has shown that adults with higher educational attainment have better health and lifespan compared to those with lower attainment levels. Tertiary education has also been shown to be associated with infant mortality, life expectancy, child vaccination, and enrolment rates[70].

'Healthy homes' was a key theme discussed across literature[4,63,71]. Around three quarters of the GRT population in England and Wales live in bricks and mortar accommodation and the remaining quarter live in caravan or other mobile structures[72]. Of these 10,000 GRT people have no place to stop as a result of chronic national shortage of sites, and 3,000 families living roadside have limited or no access to basic water and sanitation[73]. Even if families are able to get a pitch on a Traveller site, the positions and conditions of such sites have been shown to increase risk of poor health. Across England, 26% of Traveller sites are near major roads[72], 12% are near rubbish tips[72], 8% are close to industrial and commercial activity[72] and 3% are near sewage works[4,72]. The World Health Organisation reported, household air pollution was responsible for 3.2 million global

deaths in 2020, and that the combined effects of ambient air population and household air pollution are associated with 6.7 million premature deaths a year, globally[74]. Likewise, research conducted by the Traveller Movement showed that 55% of individuals from the GRT community interviewed reported poor air quality, asthma, and repeated chest infections[71,75].

ONS qualitative research from 2022[63] explored the lived experiences of Gypsy and Traveller communities relating to health, to gain a greater understanding regarding the gaps in data and evidence available for this population, and to highlight priority questions needing to be addressed. Results found that members of the GRT community linked their health conditions with poor site conditions and work-related injuries. For example, a male member of the GRT community, aged 30 to 40 years, based on a local authority site, stated:

> "My hands are constantly in agony. I can't put my hands up without them going dead… it's repetitive strain injury. Working out in the cold is what does us all in. It happens to a lot of Travellers. You push your body too far just for the sake of a few quid…".

Views on possible public health consequences of poor site conditions such as overcrowding, absence of water and infectious disease outbreaks were also reinforced by local and central government participants in this ONS research.

Office for National Statistics Gypsy and Traveller research findings

2022 research from the Office for National Statistics (ONS) has explored qualitative research into the lived experiences of Gypsy and Traveller communities across England and Wales[76]. The research took the form of an open-ended, life history approach to interviews, to ensure they were participant-led. Experiences of Roma people were recommended be the focus of separate research. An advisory group recommended this approach, noting priorities and the issues affecting them are perceived to be different to those of Gypsy and Traveller communities.
Key findings included (direct copy from summary research findings):

Culture:

- Participants' life stories suggest that people differ in their desire to choose a nomadic lifestyle today, and the personal value it has to them. This can be affected by their individual circumstances, such as health, ageing, family relationships and priorities, and employment. Some Gypsies and Travellers also felt that legislation in England and Wales makes it challenging to live this way, in practice.
- The importance of close-knit family and social groups, and of shared moral values, was described by participants as fundamental to Gypsy and Traveller culture, communities, and well-being. At the same time, there was recognition that things may be changing. Some people described widening disparities between individuals and groups, and between generations across many aspects of life.
- There was also diversity in how participants described the nature of their relationships with others from non-travelling communities. This varied between people and situations.

- Throughout discussions about sharing their identity, participants recurrently expressed a desire to be recognised as an individual, not on the basis of preconceived ideas about their ethnic group.

Housing:

- Participants' living situations varied greatly. Some lived in houses or flats (often referred to as bricks and mortar), some lived in chalets on private land with only a small number of neighbours, and others on large sites owned and managed by the local authority.
- Some participants continued to live a mostly nomadic lifestyle, stopping at transit sites, or on the side of the road where they could; however, this was described as increasingly difficult. They described a lack of authorised stopping places, apprehension about being moved on by police if they stop elsewhere, and fears of prosecution because of the recently introduced Police, Crime, Sentencing and Courts Act (2022). Among those who opted to live in a house, or on one site permanently, some lamented the loss of a nomadic lifestyle. Others said they had adapted and, in some cases, preferred living in bricks and mortar.
- Although the accommodation needs and preferences of participants varied, there were fundamentals people wanted, which included living somewhere they felt safe, with access to basic amenities like electricity, water, and showers. Living near to loved ones was also described as a priority by participants, as was feeling they have a degree of choice over where, and how, they live. In circumstances where these basic conditions were not met, people described experiencing negative impacts on their mental and physical well-being.
- Increasing provision of permanent and transit sites, designed through consultation with communities, was suggested by participants as a way forward in addressing the current housing and accommodation challenges reported by Gypsies and Travellers and by central and local government participants.

Health:

- Participants described experiencing a range of health conditions, which, coupled with delayed healthcare seeking, and barriers to accessing healthcare, could create vulnerability to negative health outcomes among Gypsies and Travellers.
- Participants identified environmental factors, such as site locations and standards, and occupational hazards, which they believed to have negatively impacted their own health and the health of others in their communities. They also described challenges in registering with a GP surgery without a fixed address, particularly those living in sites or at the roadside. Delayed access to healthcare could have negative health consequences through delays in diagnoses and treatment, as well as in screening and preventative care.
- Experiences of perceived discrimination and derogatory attitudes of health care providers were also described by those who had accessed health services. This could further undermine access to healthcare, as participants worried about whether they would receive help, and whether they would face negative judgement or discrimination.
- Familiarity, understanding, and open communication with trusted health practitioners appeared to support access and engagement with healthcare.

Education and employment:

- Participants shared varied histories of access to education and educational attainment. This ranged from some who had never been to school, to others who had completed compulsory education, or gained higher level qualifications. While some spoke of enjoying their education, others described having faced numerous challenges, including perceived discriminatory behaviour from other students and teachers.

- Education and skills development were valued by participants, particularly for children, and were seen as important to employment prospects. More positive accounts of educational experiences were described by those who felt accepted by teachers, and able to be themselves at school without hiding their ethnicity. However, such positive experiences were not universal. Participants also cited perceived discrimination, inflexibility of the education system, and aspects of the curriculum seen as contradictory to Gypsy and Traveller values as reasons for withdrawing their children from mainstream education.
- Participants described barriers to employment, including a lack of skills, education or formal qualifications, and perceived discrimination from employers, colleagues, and the settled community. They spoke of facing difficulties in re-skilling from traditional occupations to new types of work, including a lack of technical skills. The introduction of new licensing requirements, for example for selling scrap metal, could also make continuing employment in occupations traditionally common among Gypsies and Travellers more difficult.

Justice:

- Participants recurrently described fearing authorities, feeling misunderstood, and a sense of being treated unfairly, linked to their own and others' experiences.
- An aspect of this was a recurrently described fear of the police and a perception that they are untrustworthy, which made participants reluctant to report crime, or seek help from the police.
- Perceived disproportionality and a sense of injustice threaded through participants' accounts of experiences with the police including in the described use of force, presumption of criminality and frequency of arrests, denial of bail and imprisonment. This was at odds with participants' own perception of their communities as microcosms of broader society, where the majority do not engage in crime.
- Several laws were also viewed as criminalising Gypsies' and Travellers' ways of life, adding to a sense of marginalisation and injustice. Community participants were not always aware of the introduction of such laws, or familiar with their content, including the Scrap Metal Dealers Act (2013) and the Control of Horses Act (2015). This led to participants describing the risk of inadvertently breaking the law, for example through engaging in occupations seen as traditional among Gypsies and Travellers, such as collecting scrap metal (see education and employment bulletin).
- Understanding, awareness, respect and involvement of Gypsies and Travellers within systems and processes affecting their lives were seen as important for improving relationships and prospects for the future.
- Examples were also shared of more positive relationships with the police, which were aided by familiarity, for example through engaging with an established community liaison officer over time, who listened to the community and was viewed as understanding Gypsy and Traveller culture. Police officers being more flexible in their requests, such as allowing people time to move on, was also seen as helping to have a greater sense of mutual trust, respect, and more positive engagement.

National policy and guidance

When reviewing published literature around GRT populations, it is also important to review national policy and guidance.

National policy and guidance specifically supporting the health of the GRT community is scarce. In 2019, the House of Commons Women and Equalities Select Committee published an inquiry titled 'Tackling inequalities faced by GRT communities'. The Committee concluded that there had been a persistent failure by national and local policy makers to tackle long standing inequalities facing GRT communities in a sustained way. However, guidance for the general population does mention GRT communities.

Table 7 shown in the appendix, outlines the available guidance found on the National Institute for Health and Care Excellence (NICE) website. A total of five guidelines were found to mention the Gypsy, Roma, and Traveller population specifically. Topics discussed included vaccination uptake, contraceptive services and the promotion of health and wellbeing. Throughout the guidance the GRT community were described as an 'underserved' or 'socially disadvantaged' group. Each guideline highlighted the need for a focus on these groups to increase utilisation of services and suggests that working with local organisations would help commissioners provide services tailored to the local GRT population. Specific guidance to provide extra training to those supporting GRT communities is advised for the treatment of type 2 diabetes and for treating hyperphenylalaninemia in phenylketonuria.

The NHS Long Term Plan also gives an opportunity to direct resources towards GRT communities who have the worst health outcomes of any group. The plan states that services should be accessible to all, and it is not enough to rely on individuals who have the trust of GRT communities to deliver all their health services. The plan acts as a useful vehicle for engagement and dissemination of public health messages to the communities, specifically considering training for maternity and pre-natal staff to enquire about, signpost and refer to services that may be beneficial to GRT women, including immunisation, dental services, mental health services and sexual health checks.

In November 2022, , the UK government released a Roma specific guidance report titled: Improving Roma health: a guide for health and care professionals[77]. The report aimed to support health and care professionals to improve services by better understanding the health outcomes that some people in the Roma community face. Main areas highlighted to help improve Roma's people's health were as followed:

- Ensuring all possible efforts are made to effectively communicate with Roma patients to enable informed decisions about their health.
- Building trusting relationships, showing empathy, a non-judgemental attitude, and a positive attitude to overcoming problems.
- Effectively facilitating access to health services.

The report also outlined that healthcare team leaders should collaborate with other local services to support people from Roma communities and healthcare commissioners should provide leadership and increased commissioning support to services for Roma communities.

In May 2023, FFT in collaboration with Roma Support Group released a new set of guidance offering insights into the experiences of GRT communities relating to maternity, with a view to improve knowledge and understanding of how to approach the planning and provision of maternity services for these groups[78]. The work was delivered as part of the Health and Wellbeing Alliance. The guidance highlights the impact of structural and institutional barriers on the maternal outcomes of GRT. With recommendations to combat these barriers including:

- Prioritising accessibility and flexibility in care provided GRT communities.
- Engage with community knowledge and traditions which can complement and enhance that of health care professionals.
- Ensuring patients facing digital exclusion are able to book appointments.
- GRT inclusive services training should be mandatory within all health and social care services.
- Carefully review all referrals to social services.
- Understand that reticence around home visits may be anchored in concerns about negative perceptions of nomadic living or insecure housing.
- Ensure that any promises or commitments made to patients are followed through, to help build relationships and avoid broken trust.

- Be aware that pre and postnatal care might not be viewed as a standard part of a health pregnancy, and ensure patients understand what care is routine and preventative.
- Cater for postpartum depression in a culturally sensitive manner, emphasise availability of mental health services, and be aware of reluctance to disclose mental health issues.
- Be aware that breastfeeding may be an uncomfortable and taboo topic for some patients from Gypsy, Roma or Traveller communities.

In addition, local authorities also have the power to support accommodation and education standards. Following the Caravan Sites and Control of Development Act 1960, local authorities have the ability to attach conditions to licenses for caravan sites if it is in the interest of the people living on the site. For example, conditions stating every site should have basic amenities such as water and electricity are in the best interest of residence. Selective licensing provides a mechanism for councils to regulate the housing in their area and ensure that people are not living in unacceptably poor accommodation.

As part of the Education act of 1962[79], local authorities must ensure that the legal right to an education is not denied to any child, including GRT children. Home education should be a positive, informed choice, not a reaction to either a poor school environment or family expectations. Schools also have a duty to ensure that no group is discriminated against and that they are challenging any inequality and stereotypes that students encounter. They have a duty to ensure that no one is bullied on the basis of their ethnicity while ensuring that children of all genders are enabled to thrive throughout their education.

The Department for Education also give guidance for relationship and sex education in secondary schools[80]. They state that the teaching should include an understanding of the religious and cultural context of the children in the school. All children benefit from age-appropriate relationship and sex education, but more needs to be done to ensure that GRT parents do not remove their children from school because of an objection to it. Schools should have a plan for how to have constructive conversations with parents to explain to them the benefits of relationship and sex education in a way that is reassuring.

In autumn 2022, the Court of Appeal rejected the Government's use of the planning definition of 'Traveller'[81]. The 2015 planning definition was found to be discriminatory – as it states that Gypsies and Travellers who have permanently stopped travelling for work due to a disability, long-term health condition or age will not get planning permission to stop on their own land and will not have their accommodation needs assessed and met through this policy.

The Court of Appeal noted[81]:

> "the nature of the discrimination…was the negative impact on those Gypsies and Travellers who had permanently ceased to travel due to old age or illness, but who lived or wanted to live in a caravan. This discrimination was inextricably linked to their ethnic identity."

Whilst it is clear that this discrimination is being recognised and addressed, it shows that indirect discrimination, on the basis of age, race and disability persists in policy.

Finally, Friends, Families and Travellers (FFT) have a 'Policy & Publication' section on their website. This section provides a database and search tool for policy, publications and information on issues affecting Gypsies and Travellers. Topics available include accommodation, criminal justice, discrimination, education and health and social care. FFT also provide guidance for healthcare professionals with regards to tackling health inequalities faced by the GRT community.

Evaluations of existing good practice

Several studies have evaluated existing good practice regarding interventions supporting health status in GRT communities[82–84]. Warwick-Booth et al., (2018) evaluated the Gypsy and Traveller Health Improvement Project which aimed to develop connections between the community and available health-related services in Leeds. Results showed that the nurse role was greatly appreciated within the community, has a high acceptability, and provided greater impact when achieving a holistic approach. Discussing broader based support such as mental health, giving a voice to community members as well as assisting with access to healthcare by registering community members, explaining conditions, encouraging attendance, accompanying people, and helping ensure better quality appointments was also seen to enhance engagement with health services. Further emphasis regarding specific characteristics of the 'nurse' was seen to be essential for successful engagement, and debate concerning the freedom and flexibility of specific healthcare delivery models was highlighted for improvement of impact.

In addition, Warwick-Booth accentuated the importance of 'Leeds GATE.'. Leeds GATE is a local Gypsy and Traveller-led civil society organisation working to address the issues which affect the homes, health, education, employment and circumstances of Gypsy and Traveller people[85]. Warwick-Booth deemed their services as an *'essential prerequisite for engagement'* as relationships and trust are known to influence impact dramatically.

Warwick-Booth also indicated the frequent use of 'Health cards'. Health cards are resources that show an individual needs extra help within the health services discreetly. The card reads 'I need some extra help' and individuals can hand these over to health care professionals for additional support to help remove modifiable barriers such as language barriers, limited knowledge on what service is needed and digital complexity. Warwick-Booth reported that 66% of participants in the GRT community have accepted a health card. Results showed this high acceptance was inversely associated with level of literacy, indicating a strong positive impact for those with no or low-level literacy skills. Stakeholders also endorsed the programme as it developed on existing relationships with the community and advanced understanding regarding the community's health needs and barriers to access.

The Roma Support Group published a self-evaluation report regarding the Roma Mental Health Advocacy Project running from December 2015- April 2021. Findings support the work by Warwick-Booth, showing that a holistic approach as well as supporting recipients to maintain contact with services, make direct appointments, accompanying vulnerable beneficiaries to appointments and providing health professionals with informational materials about how to communicate effectively with the community, provided higher engagement and greatest impact.

Heaspli, Hean and Parker (2016)[84], also completed a study drawing exploring the lived experience of vulnerability from GRT communities. Similarly, to the evaluations discussed, the conclusion emphasised that to improve impact and engagement nurses and other health- and social care professionals need to both understand and respect the community which was suggested to be achieved following emetic approach (which validates and recognises both the professional discourse as well as the individual voice), thus gaining a greater understanding of their lived experience.

In addition, many local authorities have run programs supporting the health of the GRT population. Leeds City Council made plans for the provision of new permanent Gypsy and Traveller sites across the district in order to meet Leeds's need for 62 new pitches for Gypsy and

Travellers and 15 plots for Travelling Show people between 2012-2028. These are planned to have good access to health care, schools and local services and will not be on land deemed unsuitable for general housing such as contaminated land, or land adjacent to refuse sites or heavy industry. Gypsy and Traveller input has helped to ensure the appropriate provision of sufficient and good quality sites in Leeds and helped to reduce any tensions with the settled community.

Leeds is also positively planning for Gypsies and Travellers who are temporarily stopping in Leeds through a 'Negotiated Stopping' management approach, which makes sites available at short notice for a period of up to 28 days. The Council provides basic services on the site, such as refuse collection and toilets, so these sites are significantly better than roadside conditions. This breaks the eviction cycle, as there is no immediate threat of eviction[86]. This is important as Leeds GATE's insight in January 2019 showed that insecurity of accommodation was the most important factor that was impacting on Gypsy and Traveller health.

Most recently, an Outreach Nurse post, funded by NHS Leeds CCG, and running from January 2017-March 2019, was implemented, as a result of needs identified in the 2013 Gypsy and Traveller Health Needs Assessment. This has provided better access for the Leeds community into mainstream healthcare, along with improved NHS health services engagement with Gypsy and Traveller groups. Most (just over 60%) of one specific Leeds sites residents are registered with a Health Centre. There is evidence that this post has been well received by the community, nurses have been able to build up trust and have been seen to overcome barriers to NHS health service access when needed. Nurses have been able to proactively manage health conditions, thus preventing more serious development[86].

In 2009 the Braintree district employed a GP to visit a site once a month, to help with health problems, write prescriptions and deliver opportunistic health advice. This initiative led to reductions in A&E attendance and improved the uptake of immunisations. This initiative also reported good uptake of personal records in some areas in Essex.

Data and intelligence

The Gypsy, Roma, and Traveller population nationally

This section reviews England and Wales Census findings, Suffolk breakdowns are explored later in the data and intelligence chapter.

The number of GRT people in England and Wales disclosing their ethnicity in the 2021 Census was 168,749, an increase of 111,069 compared to the 2011 Census (57,680 people). This increase is mainly attributed to the inclusion of 'White: Roma' as a distinct ethnic classification for the first time, with the first official population of Roma heritage in England and Wales recorded at 100,981. The 2021 Census recorded a total of 67,768 people who described themselves as 'White: Gypsies or Irish Travellers'. This is an increase of 17.5% when compared to the 2011 Census (57,680 people)[87].

Further age, sex distribution data regarding populations identifying as White: Gypsy or Irish Traveller" and 'White: Roma' compared to the general population in England and Wales are shown in figures 4 and 5 respectively[87].

Within the population who identify as 'White: Gypsy or Irish Traveller', data highlights that:

- Men and women each made up 50% of the total recorded population, compared to 49% and 51% of the general population respectively.
- The median age was recorded at 28-years, compared to 40-years in the general population.
- 66% were below 40 years of age, compared to 49% of the general population.
- 37% were below 20 years of age, compared to 23% of the general population.

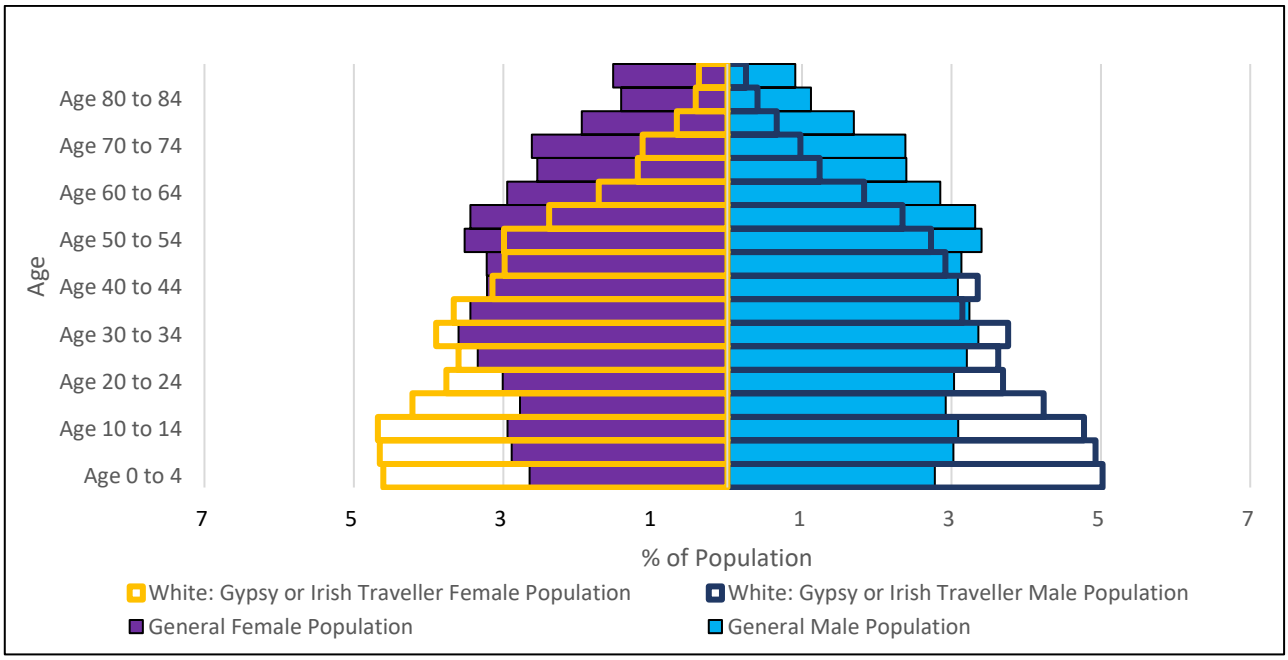
- 19% were below 10 years of age, compared to 11% of the general population.

Within the population who identify as 'White: Roma' data highlights that:

- Men and women made up 55% and 45% of the total recorded population, compared to 49% and 51% of the general population respectively.
- The median age was recorded at 32-years, compared to 40-years in the general population.
- 73% were below 40 years of age, compared to 49% of the general population.
- 22% were below 20 years of age, compared to 23% of the general population.
- 11% of both the 'White: Roma' and general population were below 10 years of age.

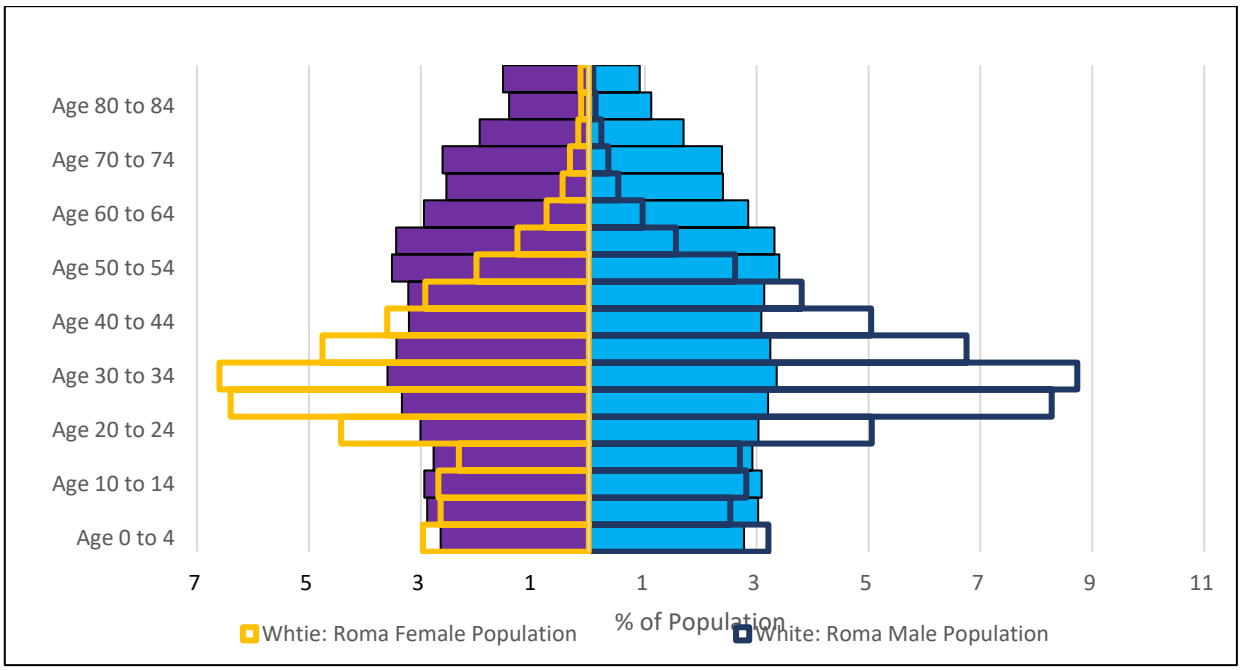
Compared to the 2011 Census, data highlights that men and women continued to contribute 50% each to the 'White: Gypsy or Irish Traveller' population. The median age has increased from 26-years to 28-years. The proportion of the 'White: Gypsy or Irish Traveller' population below 20 years of age has decreased by two percentage points- from 39% to 37%. The proportion of the 'White: Gypsy or Irish Traveller' population below 10 years of age has also decreased by one percentage point- from 20% to 19%. The 2011 Census did not include 'White: Roma' as a distinct ethnic classification; therefore, no comparisons can be made[88].

Figure 4: White: Gypsy or Irish Traveller population compared to General population by age and sex in England and Wales, 2021 Census



Source: Office for National Statistics

Figure 5: White: Roma population compared to general population by age and sex in England and Wales, 2021 Census



Source: [Office for National Statistics]

Although the census represents the most up to date and robust source for GRT population and ethnicity data, there are several challenges concerning the attainment of accurate figures for the GRT population across England and Wales.

The 2011 Census was the first time that individuals from Traveller Communities were included as a specific ethnic group, and 'Roma' was not a specific classification until the 2021 Census. GRT communities may experience low literacy levels, increasing the difficulty of completing forms and surveys. Stigmatisation has led to GRT communities forming a reluctance to engage with government organisations- especially those situated on unauthorised sites. Overall, these barriers result in underreporting of the GRT population. This is important as it may limit the awareness of the community's presence, demographic, and health needs to healthcare professionals and policy makers.

The government estimate the size of the GRT population to be as high as 300,000[2]. Research completed by the University of Salford suggests that the true size of the GRT population could be as high as 500,000[89] and other campaigners suggest that the GRT population may be closer to one million[90]. Therefore, recognition of this underreporting is essential when considering the actual health needs of the community to achieve greatest impact. Improving data for the GRT population is part of the recommendations in the Inclusive Data Taskforce report[91], aiming to achieve a more inclusive data system across England.

The Traveller Caravan Count

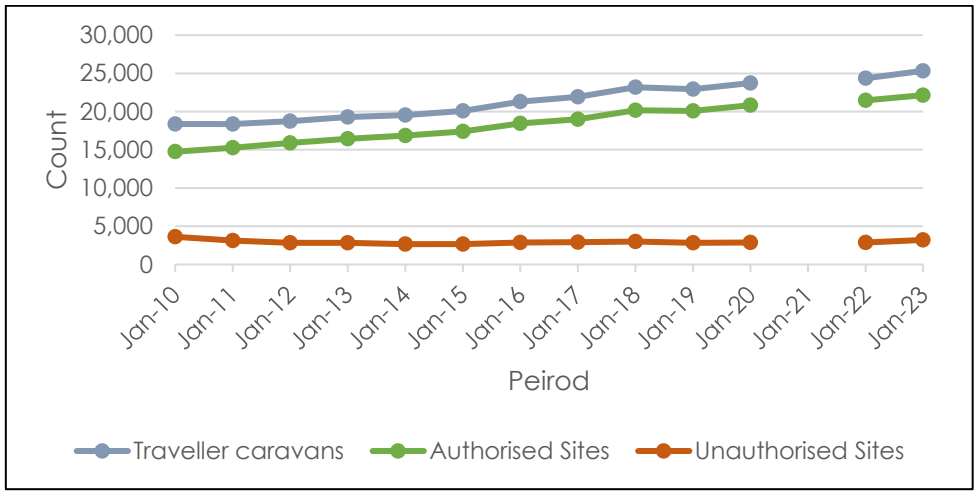
The Traveller caravan count covers the number of caravans and Traveller sites in England; this data has been collected since 1979. Data is compiled by local authorities in England, biannually (January and July) reflecting winter and summer residence and travelling trends. The information released is based on data returned and collated by the Department for Levelling Up, Housing and Communities. Overall, it provides a snapshot of the number of caravans on authorised socially rented sites, authorised privately funded sites, unauthorised developments (sites on land owned by Travellers for which planning permission has not been granted) and unauthorised encampments (occur when trespassers occupy land belonging to private landowners or public authorities without permission)[92]. In line with official guidance from the UK Statistics Regulation, the

decision was taken to suspend the summer (July) 2020 and the winter (January) 2021 collections of Traveller caravan data due to the COVID-19 outbreak[93].

Figure 6 shows the winter traveller caravan count, presenting the total number of traveller caravans, total number of authorised sites and total number of unauthorised sites, across England, between January 2010 and January 2023. Results show that 87.4% of caravans counted in January 2023 were on authorised land and 12.6% were on unauthorised land.

- The total number of traveller caravans in January 2023 was 25,333, this is an increase of 3.9% when compared to January 2022 (24,371 caravans).
- The number of caravans on authorised privately funded sites in January 2023 was 15,354, a 4.4% increase compared to the January 2022 count (14,700 caravans).
- The number of caravans on authorised socially rented sites was 6,792, a decrease of 1.3% since the January 2022 count (6,877 caravans).
- The number of unauthorised caravan was 3,187 in January 2023, an increase of 10.2% since January 2022 (2,892 caravans). Of these 3,187 unauthorised caravans, 2,716 (85.2%) were reported on unauthorised developments, a 14.3% increase compared to January 2022 (2,377 caravans). 471 of the unauthorised caravans, were on unauthorised encampments a 9.3% decrease when compared to January 2022 (515 caravans).

Figure 6: The total number of Traveller caravans, total number of authorised sites and total number of unauthorised sites, across England, between 2010 and 2023, recorded annually in January classified as the 'winter count'



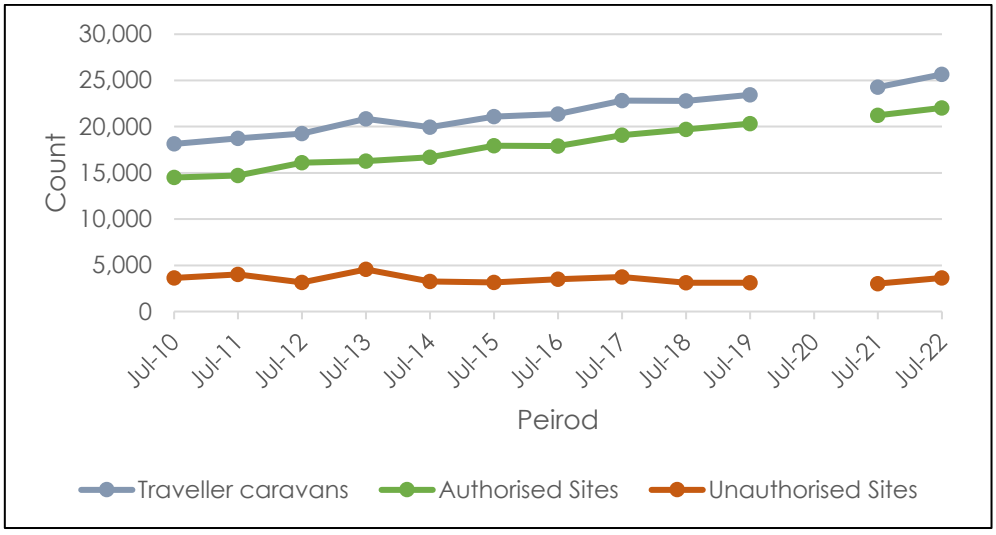
Source: Traveller Caravan Count

Figure 7 shows the summer traveller caravan count, presenting the total number of traveller caravans, total number of authorised sites and total number of unauthorised sites, across

England, between July 2010 and July 2022. Results show that 85.9% of caravans counted in July 2022 were on authorised sites and 14.1% were on unauthorised land.

- The total number of traveller caravans in July 2022 was 25,653, this is an increase of 5.7% when compared to July 2021 (24,259 caravans).
- The number of caravans on authorised privately funded sites in July 2022 was 15,400 a 4.0% increase compared to the July 2021 count (14,801 caravans).
- The number of caravans on authorised socially rented sites, in July 2022 was 6,631, similar (0.2% decrease) to the July 2021 count (6,643 caravans).
- The number of unauthorised caravans was 3,622 in July 2022, a 16.5% increase compared to the July 2021 count (3,023 caravans).
- Of the 3,622 unauthorised caravans, 2,853 (78.8%) were reported on unauthorised developments, a 18.8% increase compared to July 2021 (2,316 caravans).
- 769 (21.2%) of the unauthorised caravans, were on unauthorised encampments an 8.1% decrease when compared to July 2021 (707 caravans).

Figure 7: The total number of traveller caravans, total number of authorised sites and total number of unauthorised sites, across England, between 2010 and 2023, recorded annually in July, classified as the 'summer count'



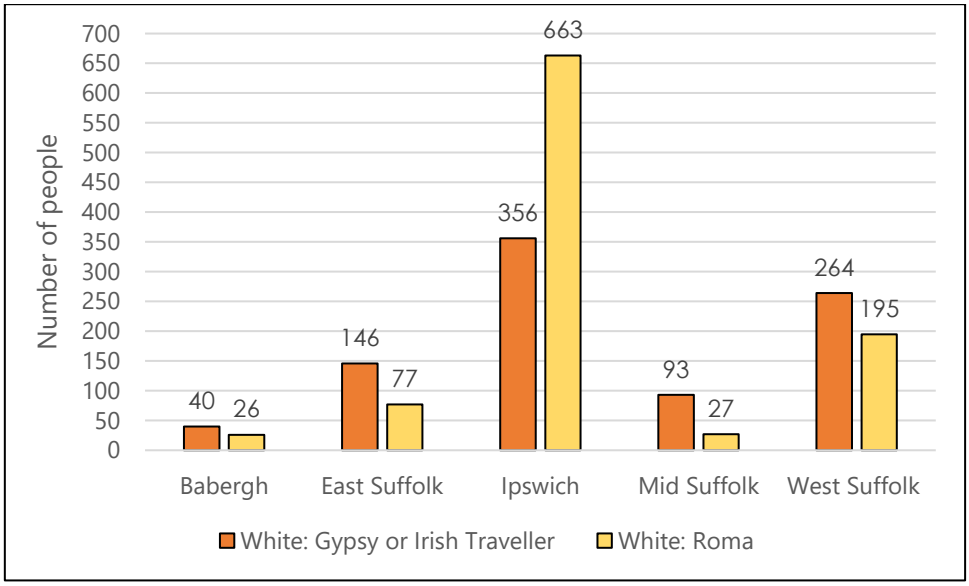
Source: Traveller Caravan Count

Gypsy, Roma, and Travellers in Suffolk

Population

Across Suffolk a total of 1,892 GRT people disclosed their ethnicity in the 2021 Census (approximately 0.3% of Suffolk's population), this is an increase of 1,288 people compared to the 2011 Census (604 people). The first official population of Roma heritage in Suffolk was recorded at 987, and individuals who described themselves as 'White: Gypsies or Irish Travellers' was recorded at 905 (a 301 person increase from the 2011 Census). When comparing districts and boroughs across Suffolk, Ipswich has the highest count of GRT people with 356 identifying as 'White: Gypsies or Irish Travellers' and 663 describing themselves as 'White: Roma'. Babergh has the smallest count recording 40 'White: Gypsies or Irish Travellers', a decrease of 11 compared to the Census 2011, and 26 identifying as 'White: Roma'[87], shown in figure 8. The Census map tool also provides a breakdown of the population by ethnicity at local authority district level for both the White: Gypsy or Irish Traveller population in 2021 and the White: Roma population in 2021.

Figure 8: Ethnic Groups White: Gypsy or Irish Traveller and White: Roma population across Suffolk Districts & Boroughs as reported in the 2021 Census



Source: Office for National Statistics

Further age, sex distribution data regarding populations identifying as White: Gypsy or Irish Traveller" and 'White: Roma' compared to the general population in Suffolk are shown in figures 9 and 10 respectively[87].

Suffolk data highlights:

- Men and women made up 51% and 49% of the total recorded population identifying as 'White: Gypsy or Irish Traveller', compared to 49% and 51% of the general Suffolk population respectively.
- The median age of the 'White: Gypsy or Irish Traveller' population in Suffolk was recorded at 29-years for men and 30-years for women, compared to 44-years and 47-years within Suffolks general population for men and women respectively.
- 65% of the "White: Gypsy or Irish Traveller' population were below 40 years of age, compared to 44% of Suffolks general population.
- 35% of the 'White: Gypsy or Irish Traveller' population were below 20 years of age, compared to 21% of Suffolks general population.
- 19% of the 'White: Gypsy or Irish Traveller' population were below 10 years of age, compared to 10% of Suffolks general population.

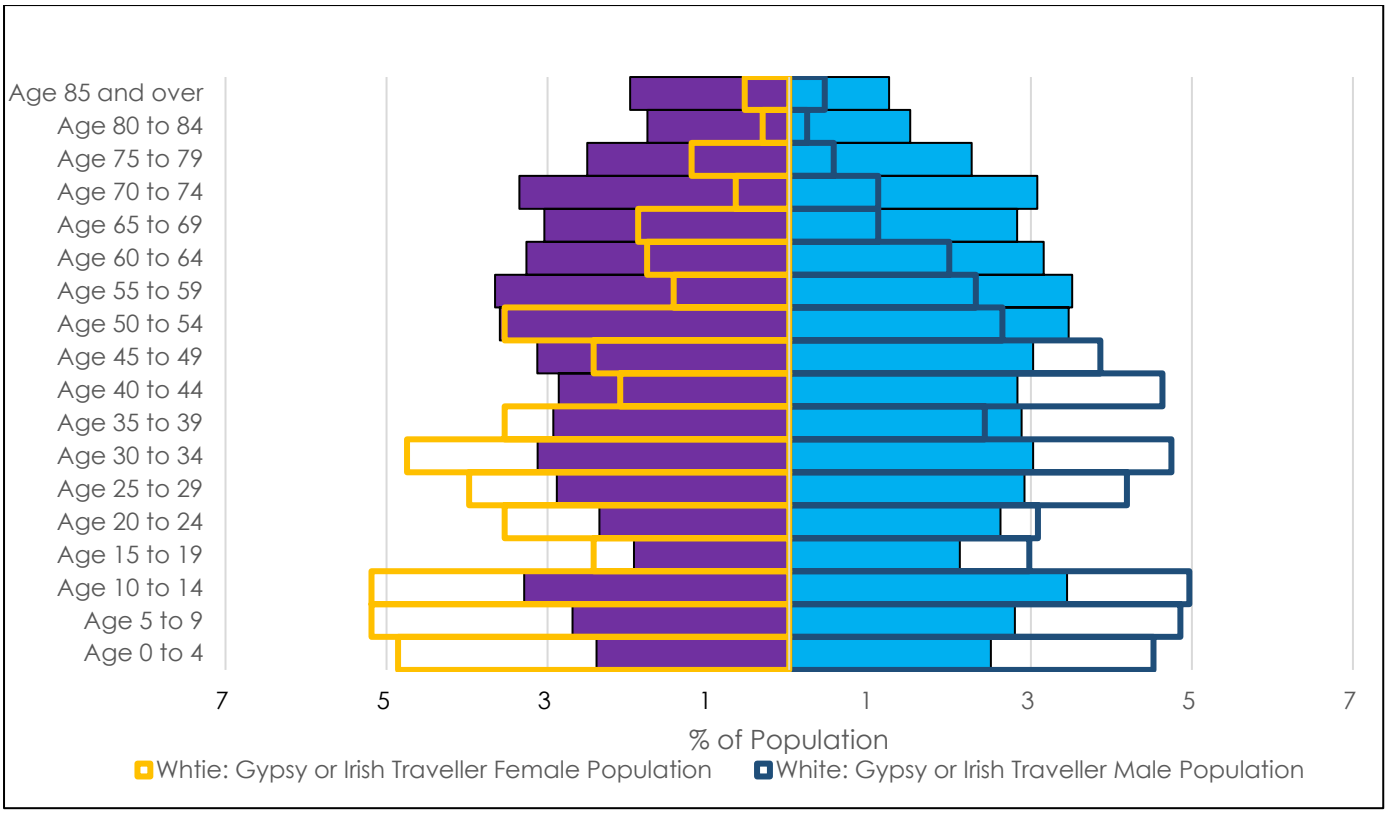
Suffolk data also highlights:

- Men and women made up 54% and 46% of the total recorded population identifying as 'White: Roma', compared to 49% and 51% of the general Suffolk population respectively.
- The median age of the 'White: Roma in Suffolk was recorded at years for 29-years for both males and females, compared to 44-years and 47-years within Suffolks general population for men and women respectively.
- 72% of the 'White: Roma' population were below 40 years of age, compared to 44% of Suffolks general population.
- 33% of the 'White: Roma' population were below 20 years of age, compared to 21% of Suffolks general population.
- 17% of the 'White: Roma' population were below 10 years of age, compared to 10% of Suffolks general population.

Compared to the 2011 Census, data highlights that the proportion of men identifying as 'White: Gypsy or Irish Traveller' has increased by five percentage points (from 46% to 51%) and the

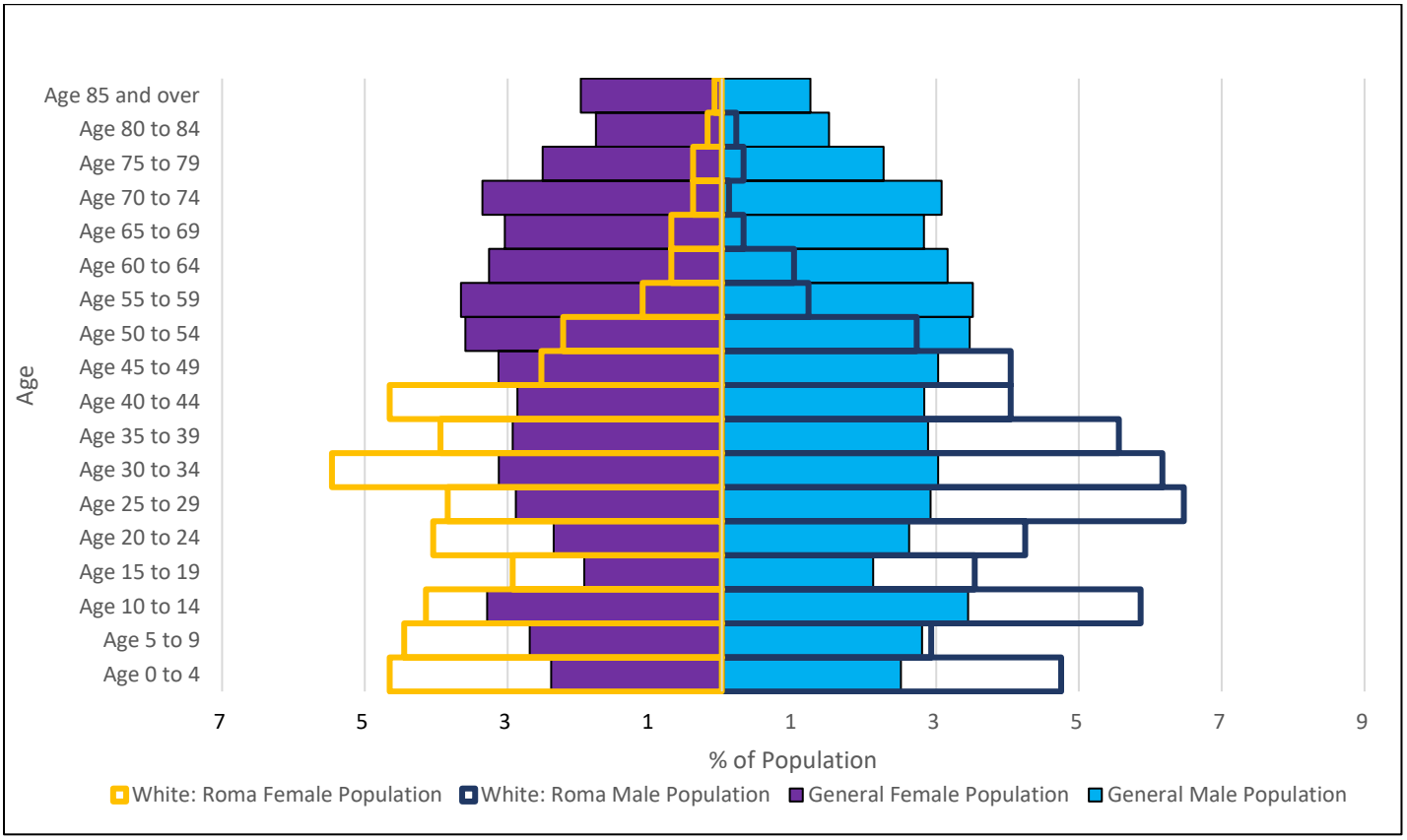
proportion of women identifying as 'White: Gypsy or Irish Traveller' has decreased by 5 percentage points (from 54% to 49%). The proportion of the 'White: Gypsy or Irish Traveller' population below 20 years of age has increased by two percentage points- from 32% to 35%. The proportion of the 'White: Gypsy or Irish Traveller' population below 10 years of age has increased by three percentage point- from 16% to 19%. The 2011 Census did not include 'White: Roma' as a distinct ethnic classification; therefore, no comparisons can be made[88].

Figure 9: White: Gypsy or Irish Traveller population compared to General population by age and sex in Suffolk, 2021 Census



Source: Office for National Statistics

Figure 10: White: Roma population compared to General population by age and sex in Suffolk, 2021 Census



Source: Office for National Statistics

Gypsy, Roma, and Traveller Sites

Table 2 shows the number of GRT sites within each lower tier local authority in Suffolk. GRT sites, refer to permanent sites with plots for which the Traveller signs a licence and pays rent. Sites can be privately owned by the GRT community or by local authorities. Within a site there are 'pitches' or 'plots', these are spaces required to accommodate 'one household equivalent' and vary according to the size of the household. Typically, a family pitch will provide space for a mobile home and touring caravan, space for parking, and an shared use of an amenity block[94]. Within each site there is a varied number of pitches dependent on the size of land. A 'Good Practice Guide' for designing gypsy and Traveller Sites can be found here: Designing Gypsy and Traveller Sites.

Across Suffolk there are a total of 32 GRT sites. Ipswich has two permanent GRT sites, both privately owned. East Suffolk has a total of 6 GRT sites. 3 of these sites are permanent and the remaining 3 are temporary unathoirsed sites. Of the 3 permanent sites in East Suffolk one, Romany Lane Traveller Site, is owned by East Suffolk Council. The remaining 5 sites are privately owned. West Suffolk have 12 permanent GRT sites, all of which are privately owned. In Babergh and Mid Suffolk, in line with their Joint Local Plan Examination findings there are: 12 Gypsy and Traveller sites, 3 Travelling Showpeople permanent sites and 7 Gypsy and Traveller sites with temporary planning permission.

Table 2. Total number of Gypsy, Roma, and Traveller sites within Suffolk's LTLAs.

Lower Tier Local Authority	Number of GRT sites
Babergh & Mid Suffolk	12
East Suffolk	6
West Suffolk	12
Ipswich	2

General Health

General health is a self-assessment of a person's general state of health. As part of the 2021 Census, individuals were asked to assess whether their health was very good, good, fair, bad, or very bad. This assessment is not based on a person's health based over a specific period of time but provides a more general measure of an individual's subjective opinion of their general health.

A comparison of general health between Gypsy, Roma and Traveller and non-Gypsy, Roma, and Traveller population in Suffolk and England and Wales as of the day of the 2021 Census is given in the figure 11.

6.4% of Suffolk's GRT population reported 'Bad' or 'Very bad' health, statistically significantly higher than both non-GRT populations across Suffolk (4.9%) and England and Wales (5.2%), and statistically similar to the GRT population across England and Wales (7%).

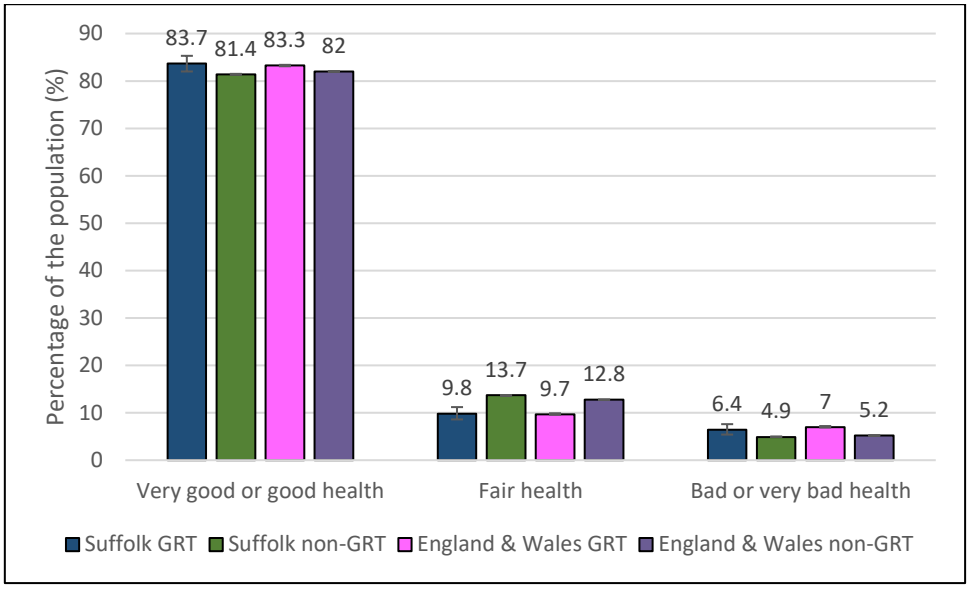
However, it is also important to note that 83.7% of Suffolk's GRT population reported 'very good' or 'good' levels of health, this is statistically significantly higher than Suffolk's non-GRT population (81.4%), and statistically similar to both the GRT (83.3%) and non-GRT (82%) population across England and Wales.

9.8% of Suffolk's GRT population reported 'Fair health', statistically significantly lower than the non-GRT population across Suffolk (13.7%) and England and Wales (12.8%), and statistically similar to the GRT population across England and Wales (9.7%).

This polarisation of self-reported health mirrors national findings. This could be due to a younger age demographic in GRT populations but could also be in due to differences in cultural perception surrounding talking about/acknowledging ill-health in GRT populations. Therefore, this may need to be taken into consideration when interpreting these results.

National reporting indicates that GRT ideas regarding health and illness are closely related to notions of good and bad fortune, purity and impurity, and inclusion and exclusion[95], this may also impact self-reported health status. It is known that the GRT community faces some of the starkest inequalities in healthcare access and outcomes amongst the UK population, including when compared with other minority ethnic community groups.

Figure 11: Comparison of general health between Gypsy, Roma and Traveller and non-Gypsy, Roma, and Traveller population in Suffolk and England and Wales, 2021 Census



Source: Office for National Statistics

Disability

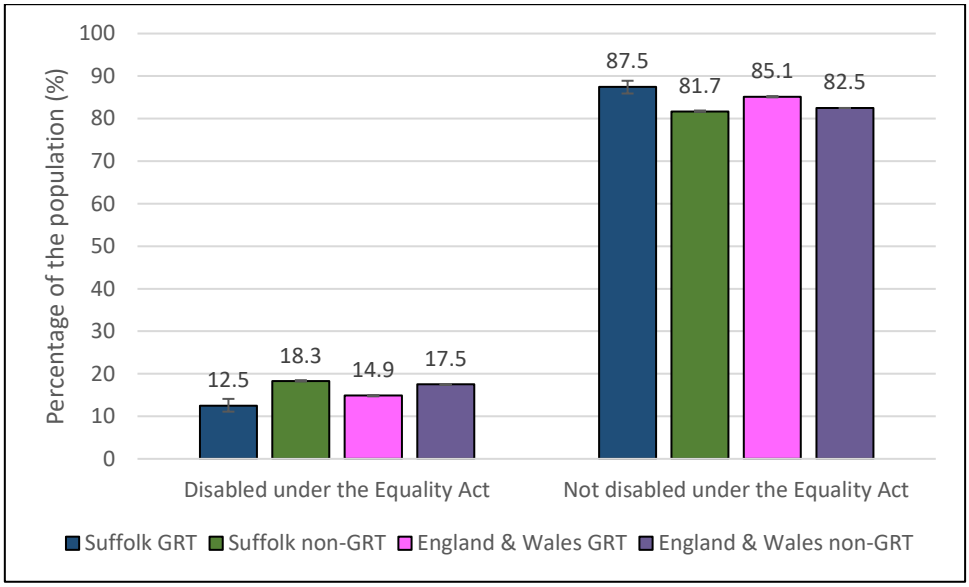
In the 2021 census, in order to identify disability, the ONS asked: "Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?". If the respondent answered yes, a further question "Do any of your conditions or illnesses reduce your ability to carry out day-to-day activities?" was asked. The question aims to collect data that more closely aligned with the definition of disability in the Equality Act (2010). The Equality Act defines an individual as disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to carry out normal day-to-day activities.

Figure 12 shows a comparison of disability between GRT and non-GRT population in Suffolk and England and Wales as of the day of the 2021 Census.

14.9% of Suffolk's GRT population identified as disabled under the Disability and Equality Act. This is statistically significantly lower than the non-GRT population across Suffolk (17.5%) and England and Wales (18.3%). Similarly, the GRT population across England and Wales reported a statistically significantly lower proportion of its population identifying as disabled under the Disability and Equality Act (12.5%). The reasons for this are likely to be similar to those mentioned in relation for self-reported health status, and not disclosing poor health.

A lower proportion of GRT people recognising/reporting their disability status could mean individuals do not access benefits they are entitled to. They may also not access services or receive care which they are eligible to receive.

Figure 12: Comparison of disability between Gypsy, Roma and Traveller and non-Gypsy, Roma, and Traveller population in Suffolk and England and Wales, 2021 Census



Source: Office for National Statistics

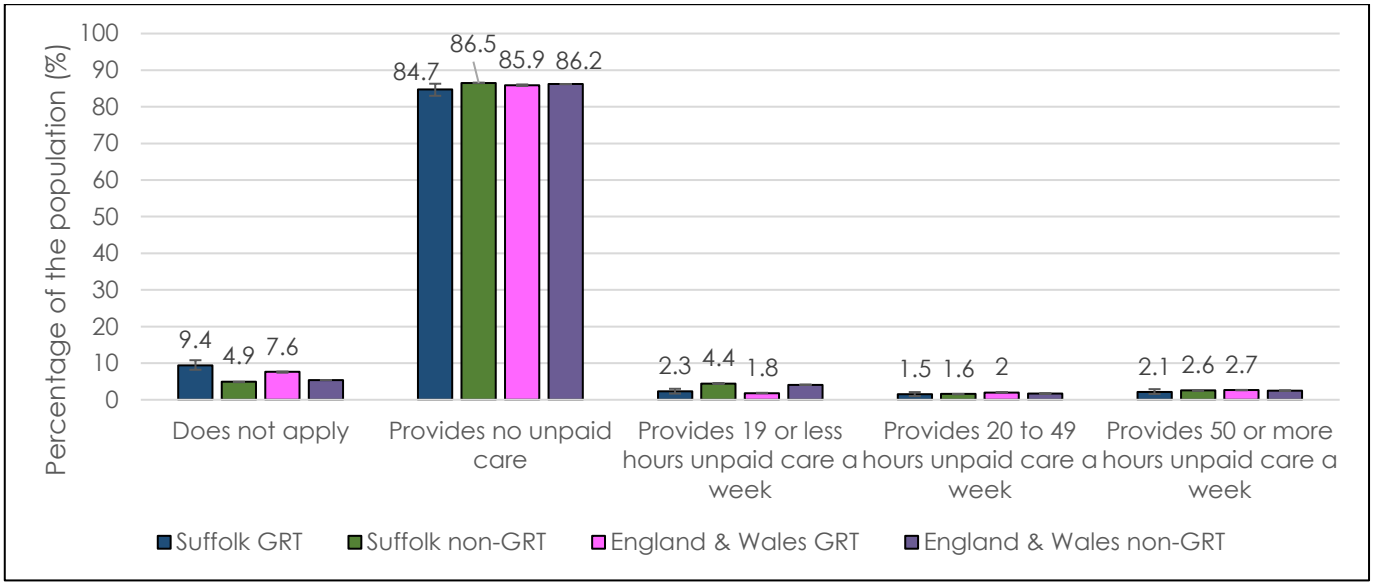
Unpaid care

An unpaid carer is defined as anyone who cares, unpaid, for a friend or family member who due to illness, disability, a mental health problem or an addiction cannot cope without their support. Figure 13 gives a comparison of unpaid care between Gypsy, Roma and Traveller and non-Gypsy, Roma, and Traveller population in Suffolk and England and Wales as of the day of the 2021 Census.

Data shows that a statistically significantly higher proportion of Suffolk's GRT population provide 20 to 49 hours of unpaid care a week when compared to non-GRT populations across Suffolk and England and Wales, and when compared to the GRT population across England and Wales. Compared to Suffolk's non-GRT population, the proportion of Suffolk's GRT population providing 50 or more hours unpaid care a week was also statistically significantly higher.

Literature has shown that unpaid carers suffer poorer physical and mental health. A report published by Carers UK titled 'Carers Health and experiences of primary care, the charity's examination of unpaid carers' found that 60% of carers report a long-term health condition or disability[96]. Therefore, it is essential to ensure unpaid carers within Suffolk's GRT community receive the support they need and are entitled to.

Figure 13: Comparison of unpaid care between Gypsy, Roma and Traveller and non-Gypsy, Roma, and Traveller population in Suffolk and England and Wales, 2021 Census

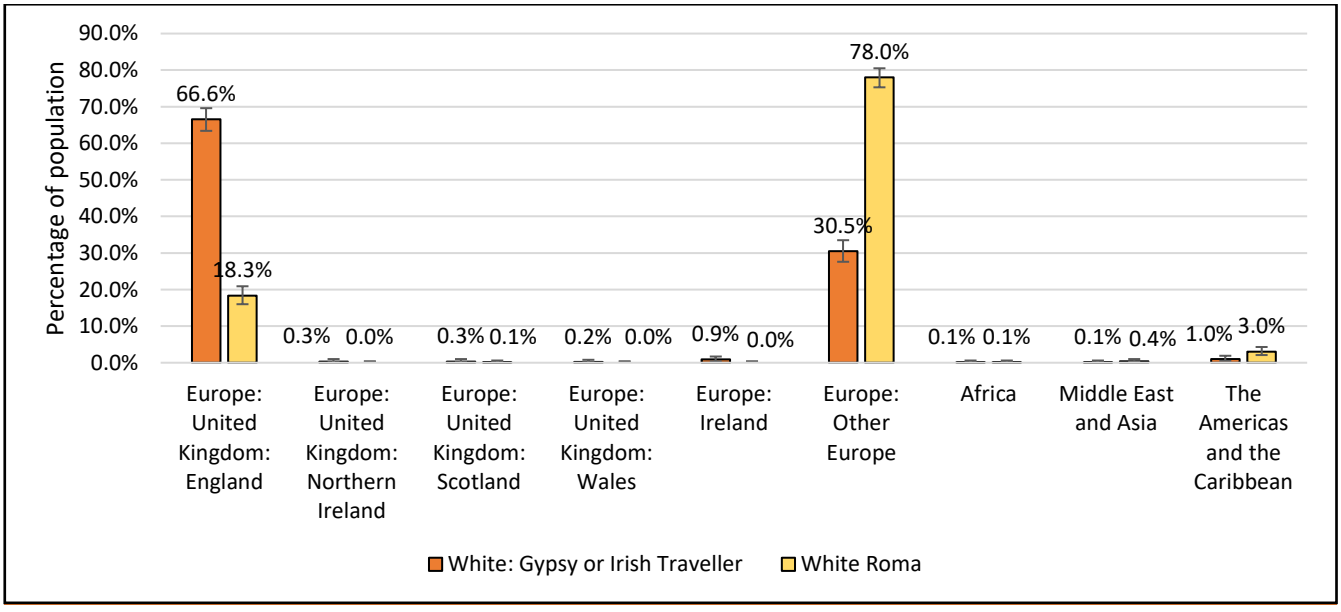


Source: Office for National Statistics

Country of birth and length of UK residence

Figure 14 gives a breakdown of the country of birth for individuals who identify as 'White: Gypsy or Irish Traveller' or 'White: Roma' in Suffolk in the 2021 Census. Results show that, of the population recorded, 67.4% (611 people) of those who identified as 'White: Gypsy or Irish Traveller' and 18.4% (182 people) of those who describe themselves as 'White: Roma' were born in the United Kingdom. 31.3% (284 people) of those who describe themselves as 'White: Gypsy or Irish Traveller' and 78% (771 people) of those who identify as 'White Roma' were born in a different country in Europe. 1.2% (11 people) of those of identified as 'White: Gypsy or Irish Traveller' and 6.3% (46 people) who describe themselves as 'White Roma' were born out of Europe.

Figure 14: Comparison of the country of birth of those who identify as 'White: Gypsy or Irish Traveller' or 'White: Roma' in Suffolk, 2021 Census



Source: Office for National Statistics

Of those GRT people living in Suffolk who were not born in the UK the age of arrival is given in table 3. 13.1% of those who identify as 'White: Gypsy or Irish Traveller' and 23.2% of those who describe

themselves as 'White: Roma' arrived before the age of 16. 18.8% of those who describe themselves as 'White: Gypsy or Irish Traveller' and 53.8% of those who identify as 'White: Roma' arrived between the ages of 16 and 50 years. 0.4% of those who identify as 'White: Gypsy or Irish Traveller' and 4.7% of those who describe themselves as 'White: Roma' arrived at 50 years or older. The high proportion of arrivals under the age of 30 may indicate an increased demand for children, young people, and young adult services, this could increase the demand maternity and sexual health resources.

Table 3: Age of arrival in the UK

	White: Gypsy or Irish Traveller	White: Roma
Born in the UK	67.6%	18.4%
Arrived in the UK: Aged 0 to 15 years	13.1%	23.2%
Arrived in the UK: Aged 16 to 24 years	6.0%	18.3%
Arrived in the UK: Aged 25 to 34 years	6.6%	19.5%
Arrived in the UK: Aged 35 to 49 years	6.2%	16.0%
Arrived in the UK: Aged 50 to 64 years	0.2%	3.9%
Arrived in the UK: Aged 65 years and over	0.2%	0.7%

Source: Office for National Statistics

Table 4 shows the length of residence of the GRT population in Suffolk. Out of the GRT population in Suffolk who were not born in the UK, 1.8% of those who identify as 'White: Gypsy or Irish Traveller' and 6.4% of those who describe themselves as 'White: Roma' have had residence for 10 years or more. 25.9% of those who describe themselves as 'White: Gypsy or Irish Traveller' and 58.9% of those who identify as 'White: Roma' have had residence in the UK for a least 2 years or more, but less than 10 years. 4.5% of those who identify as 'White: Gypsy or Irish Traveller' and 16.3% of those who describe themselves as 'White: Roma' have had residence in the UK for less than 2 years. This data suggests the population is changing at pace, and service providers/ commissioners will need to take this into account when planning services to meet need.

Table 4: Length of residence in the UK

	White: Gypsy or Irish Traveller	White: Roma
Born in the UK	67.7%	18.4%
10 years or more	1.8%	6.4%
5 years or more, but less than 10 years	14.0%	32.6%
2 years or more, but less than 5 years	11.9%	26.3%
Less than 2 years	4.5%	16.3%

Source: Office for National Statistics

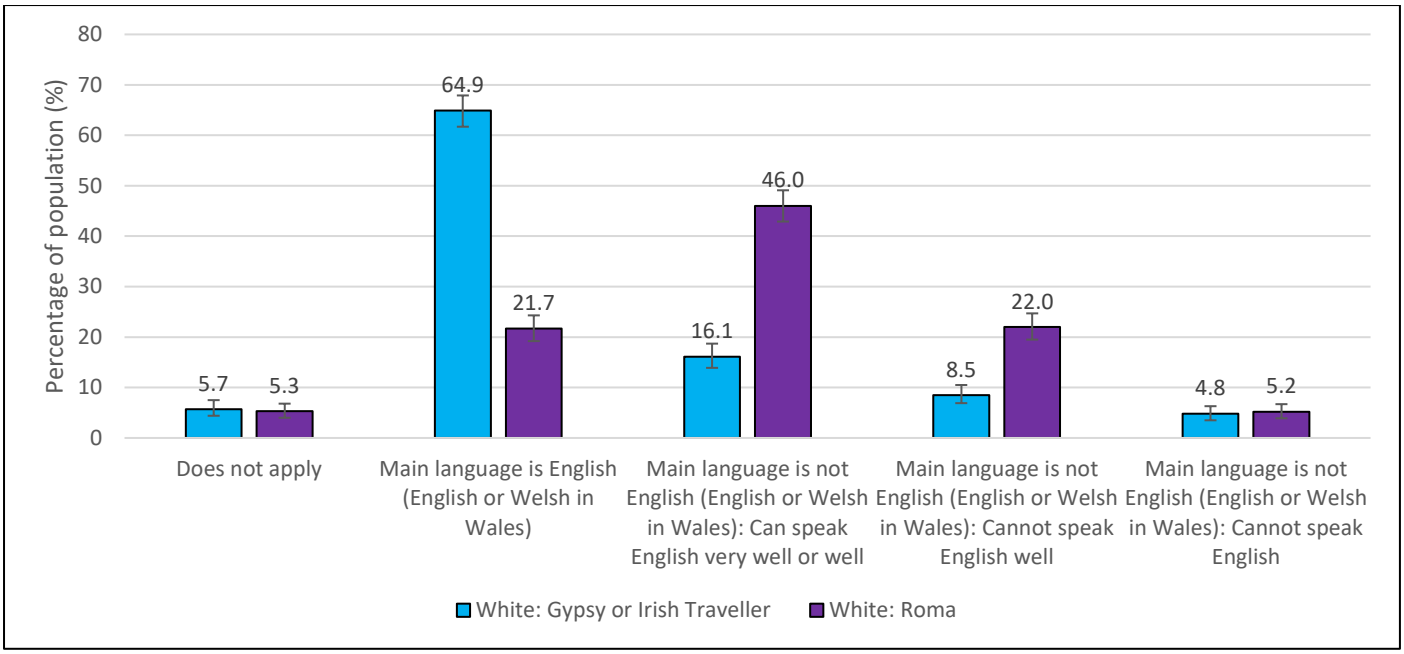
Language capabilities

For over half of Suffolk's GRT population (52%), their main language is not English. A limited proficiency in English may affect individuals' ability to connect with and utilise health professionals and services. This underutilisation could disproportionately increase the risk of poor health.

Figure 15 shows a breakdown of Suffolk's GRT populations regarding their self-reported proficiency in the English language. For 64.9% of those who describe themselves as 'White: Gypsy or Irish Traveller' and 21.7% of those identifying as 'White: Roma', their main language is English (English or Welsh in Wales). 28.9% of those who identify as 'White: Gypsy or Irish Traveller' and 72.7% of those who describe themselves as 'White: Roma' state that their main language is a different European language to English. For those where English isn't their main language, 16.1% of 'White: Gypsy or

Irish Travellers' and 46% of 'White Roma' people state they can speak English very well or well, and 13.3% of those who describe themselves as 'White: Gypsy or Irish Traveller' and 27.1% of those who identify as 'White: Roma' cannot speak English very well or cannot speak English at all. Therefore, with just over a fifth (20.5%) of Suffolk's GRT population reporting a limited ability in the English language it is essential that our health professionals and services are well equipped to support the GRT populations needs. This could lead to an increased efficacy of resources and better overall health for the community.

Figure 15: The proficiency in the English language of those who identify as GRT people in Suffolk, 2021 Census

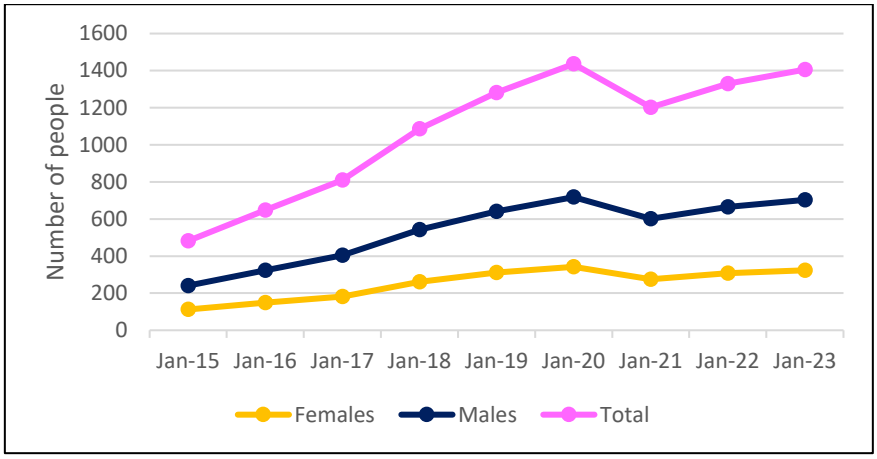


Source: Office for National Statistics

School Census

The School Census collects information from primary schools, secondary schools, special schools, maintained nurseries, academies and pupil referral units three times a year. It's completed electronically and private schools are not included. Data collected includes special educational needs, year of study, sex, and ethnic group. The total number of the GRT population identified in the School Census in Suffolk has increased by 5.7% since 2022 from 665 people to 703 people in 2023 (54.1% males, 45.9% females). This is also a 17.0% increase compared to the January 2021 estimate (601 people) and a 191.7% increase compared to the January 2015 estimate (241 people), the progression is shown in figure 16.

Figure 16: Gypsy, Roma, and Traveller population in Suffolk identified in the School Census between January 2015 and January 2023



Source: School Census

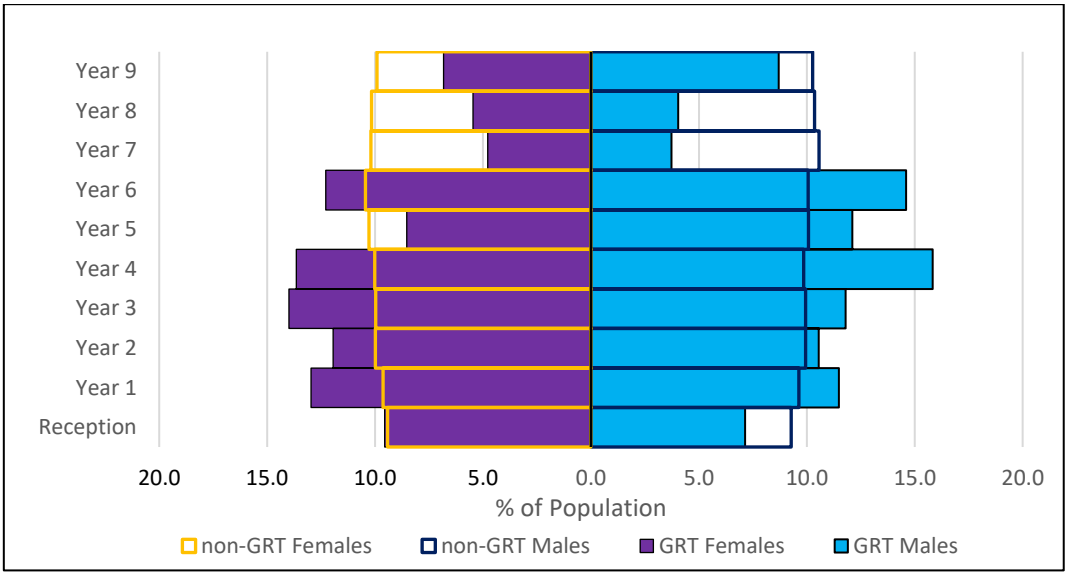
Internal school census data shows that the schools with the highest numbers of GRT school children are all in Ipswich, specifically 79.4% of GRT school children are at schools in Ipswich. The top 3 schools with the highest numbers of GRT pupils are all primary schools and equate to 35.8% of the total GRT CYP school census population.

The breakdown of GRT children, compared to non-GRT children, identified in the School Census January 2023, by national curriculum year and sex, is shown in figure 17. The proportion of the GRT population identified as in their sixth national curriculum year or below was higher for both females and males when compared to the non-GRT population. 83.5% of the male GRT population identified in the school census were recorded in year 6 or below, 14.7 percentage points higher than the non-GRT proportion of 68.8%. Similarly, 82.9% of the female GRT population identified in the school census were recorded in year 6 or below, 13.2 percentage points higher than the non-GRT proportion.

The proportion of the GRT population identified in their seventh national curriculum year or higher was lower for both females and males when compared to the non-GRT population. 16.5% of the male GRT population identified in the school census were recorded in year 7 or above, 14.7 percentage points lower than the non-GRT proportion of 31.2%. 17.1% of the female GRT population identified in the school census were recorded in year 7 or above, 13.2 percentage points lower than the non-GRT proportion of 30.3%. This data suggests a lower proportion of GRT young people continuing their education from primary to secondary level. These children could potentially be being educated in the home environment. However, the recorded number of Electively Home Educated (EHE) GRT children in Suffolk remains low. 2023 data for Suffolk children who are EHE is captured on a system known as Capita One, however ethnicity is only complete for about 80% of records. Capita One has 26 students with a GRT ethnicity recorded as EHE[97].

Young people experience huge physical, psychological, and behavioural changes as they mature from children to adults, supporting those from a young age is essential to ensure future good health and wellbeing. In the UK, half of all lifetime cases of psychiatric disorders start by age 14 and three-quarters and a quarter of 11 to 19 year olds live in households with the lowest incomes – at a population level, deprivation increases the likelihood of having worse physical, mental and sexual health outcomes, or being killed or seriously injured on roads[98]. With the GRT school population being a primarily younger demographic, it is essential that individuals receive the correct support to reinforce physical, cognitive, emotional, social, and behavioural development, improving overall health and health outcomes.

Figure 17: Gypsy, Roma, and Traveller population compared to the non-Gypsy, Roma and Traveller population in Suffolk identified in the School Census, January 2023, split by national curriculum year



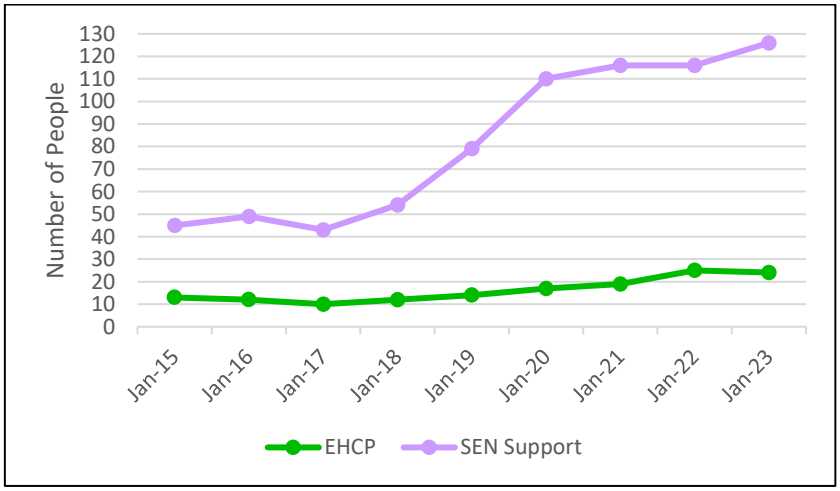
Source: School Census

Special Educational Needs (SEN)

Special educational needs (SEN) support is what schools and similar settings use to find and meet the needs of children with SEN. Similarly, an educational health and care plan (EHCP) is for children and young people who have specific educational, health and social care needs above the support that is available via SEN support. Figure 18 shows the number of GRT people receiving SEN support or an EHCP between January 2015 and January 2023.

In January 2023, 21.3% of the GRT population identified in the school census were shown to utilise SEN support or an EHCP, 4.5 percentage points higher than the non-GRT population (16.8%). Although the number of people identifying as GRT within the school census has increased between January 2015 and 2023, the proportion of GRT people using SEN support or an EHCP has decreased by 2.7% (24.1% in 2015, 21.3% in 2023).

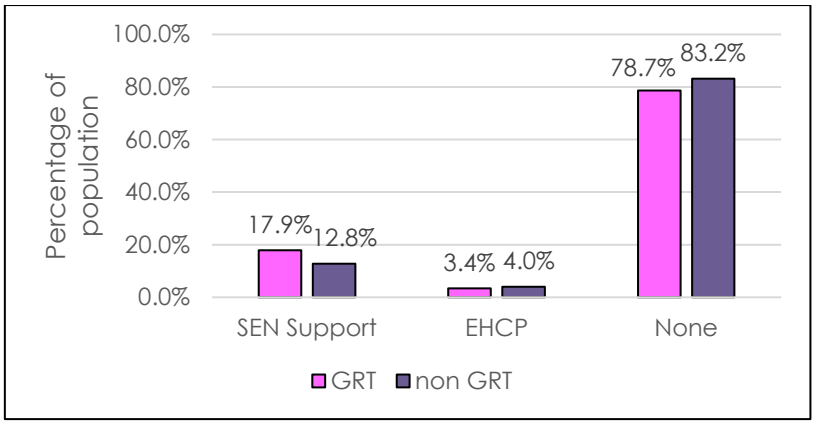
Figure 18: Gypsy, Roma, and Traveller population identified as requiring SEN support or supported by an educational health and care plans (EHCP) between January 2015 and January 2023



Source: School Census

Figure 19 shows a comparison of the proportion of the GRT and non-GRT population identified to use SEN support or EHCPs in the January 2023 school census breakdown. Across the GRT children identified in the school census to utilise either SEN support or an EHCP, 17.9% utilise SEN support, 5.1 percentage points higher than the non-GRT population utilising SEN support (12.8%), and 3.4% have an EHCP, 0.6 percentage points lower than the non-GRT population (4.0%).

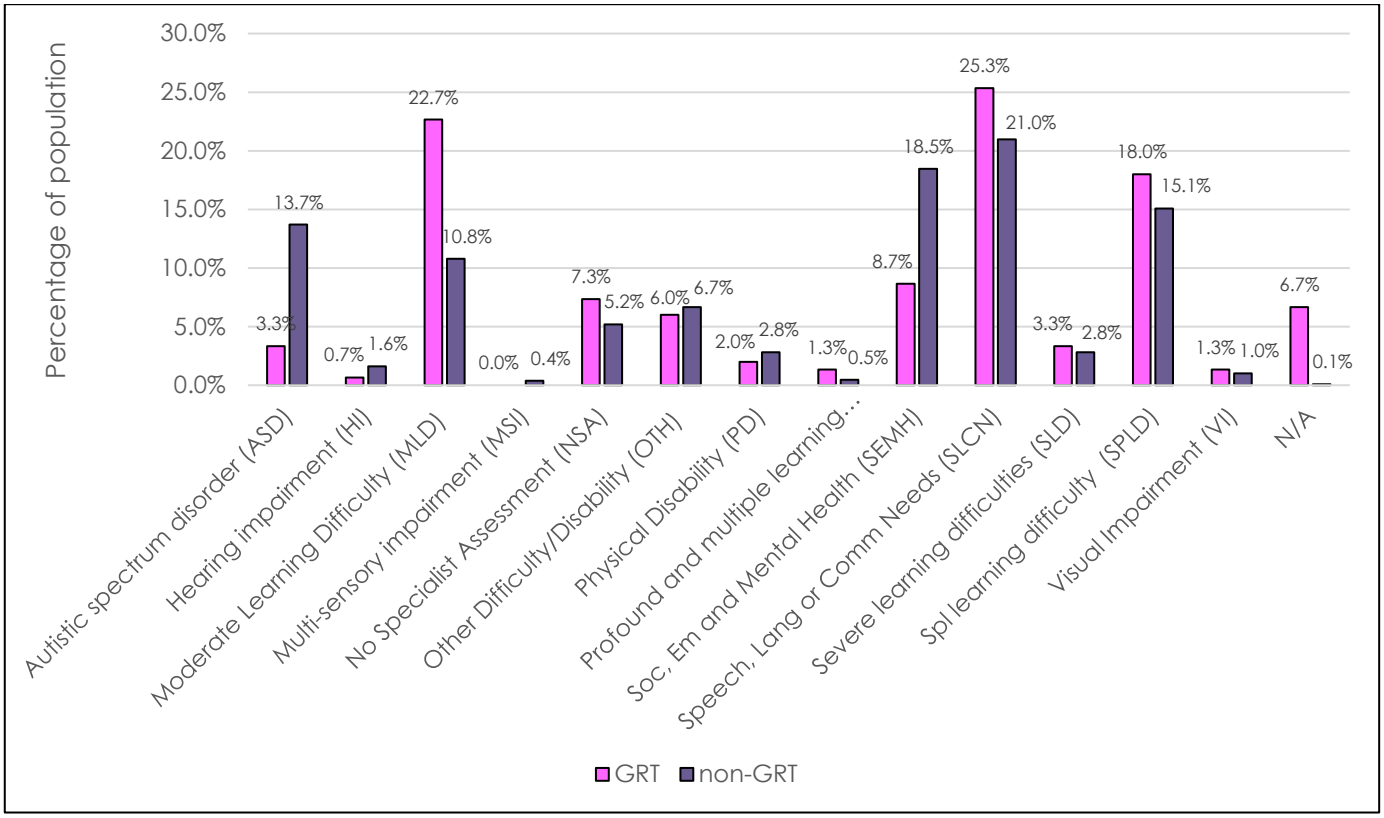
Figure 19: Comparison of the proportion of the Gypsy, Roma, and Traveller population and non-Gypsy, Roma and Traveller population identified to use SEN support or EHCPs in the January 2023 school census



Source: School Census

Looking at SEN and EHCP support in more detail, figure 20 shows a breakdown of the primary needs of GRT and non-GRT children requiring SEN support or EHCPs. A quarter (25.3%) of GRT children requiring SEN support or EHCPs had a recorded relating to speech, language or communication,4.4 percentage points higher than non-GRT children (21.0%). This was closely followed by a 'moderate learning difficulty (MLD). Children with a MLD have greater difficulty than their peers in acquiring basic literacy and numeracy skills and in understanding concepts. MLD was identified as the primary need for 22.7% of GRT children receiving SEN support or with an EHCP, 11.9 percentage points higher than in non-GRT children (10.8%). Just under a fifth of GRT children (18.0%) requiring support have been categorised as having special learning difficulties (SPLD), affecting the way information is learned or processed including disabilities such as dyslexia. This is 2.9 percentage points higher than non-GRT children (15.1%). This indicates that there is a large need for support for GRT children.

Figure 20: **Primary need of GRT and non-GRT children requiring SEN Support or supported by a EHCP in January 2023**



Source: School Census

Highest level of qualification

The highest level of qualification is derived from the Census question asking residents of England and Wales aged 16 years and over to indicate all qualifications held- or their nearest equivalent. This may include foreign qualifications where they were matched to the closest UK equivalent. Therefore, this dataset provides estimates that classify usual residents aged 16 years and over by their highest level of qualifications.

The types of qualification included in each level are:

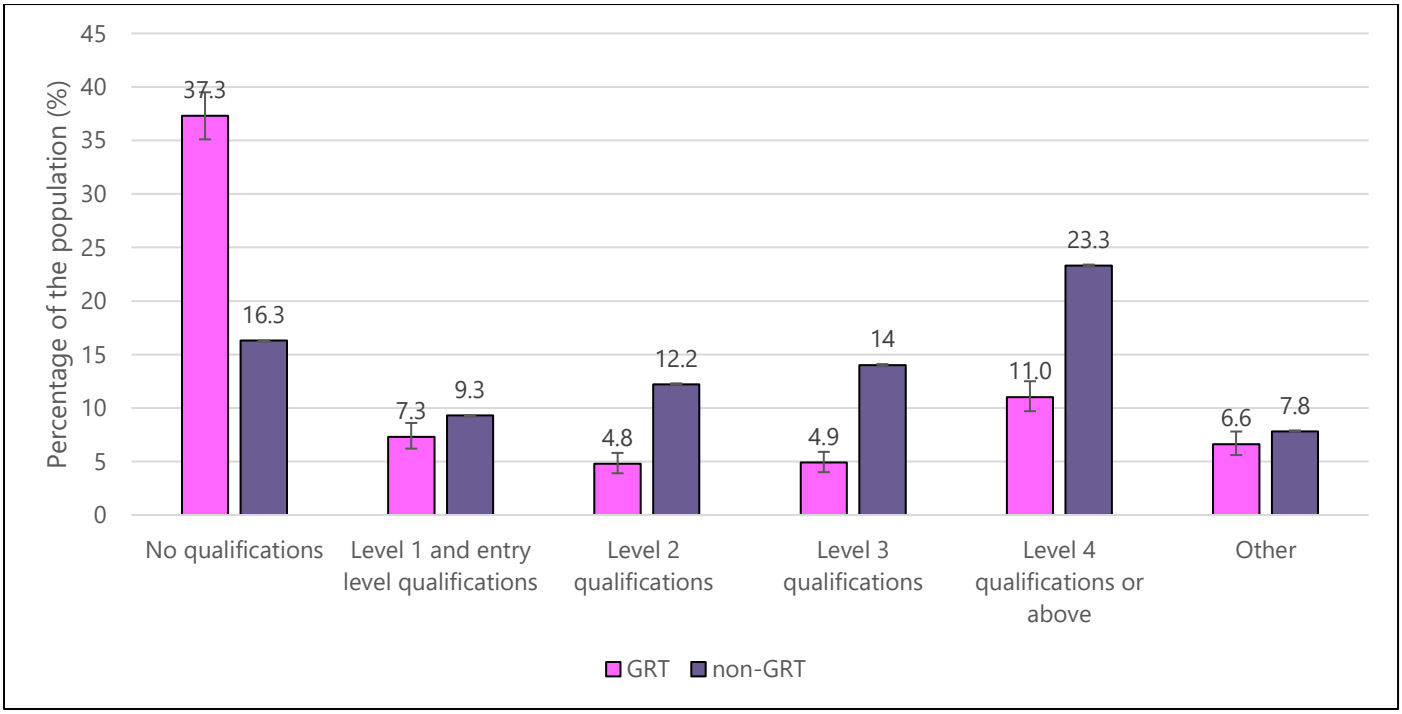
- **No qualifications**: no formal qualifications
- **Level 1 and entry level qualifications**: one to four GCSE passes (grade A* to C or grade 4 and above) and any other GCSEs at other grades, or equivalent qualifications.
- **Level 2 qualifications**: five or more GCSE passes (grade A* to C or grade 4 and above) or equivalent qualifications.
- **Apprenticeships**
- **Level 3 qualifications**: two or more A Levels or equivalent qualifications
- **Level 4 qualifications and above:** Higher National Certificate, Higher National Diploma, Bachelor's degree, or postgraduate qualifications
- **Other qualifications**, of unknown level.

For equivalent qualifications, see Measuring the data

Please note, apprenticeships data collected by the census did not include the level or type of an apprenticeship. Advanced further education was deemed the best fit overall for traditional trade or craft and modern apprenticeships.

Figure 21 and table 5 shows the highest level of qualification for both the GRT population and non-GRT population in Suffolk. 37.3% of the GRT population in Suffolk have no qualifications, more than double and statistically significantly higher than the non-GRT population (16.3%). However, 6.6% of the GRT population have a different form of qualification recorded under 'other', statistically similar to the non-GRT population in Suffolk.

Figure 21: Highest level of qualification comparison between the Gypsy, Roma and Traveller population and non-Gypsy, Roma, and Traveller population in Suffolk, 2021 Census



Source: Office for National Statistics

Table 5: Highest level of qualification comparison between the Gypsy, Roma and Traveller population and non-Gypsy, Roma, and Traveller population in Suffolk, 2021 Census

	GRT	Non-GRT	GRT population statistically significantly
No qualifications	37.3%	16.3%	Higher
Level 1 qualification	7.3%	9.3%	Lower
Level 2 qualification	4.8%	12.2%	Lower
Apprenticeship	3.7%	5.4%	Lower
Level 3 qualification	4.9%	14%	Lower
Level 4 qualification	11%	23.3%	Lower
Other qualification	6.6%	7.8%	Similar

Source: Office for National Statistics

A lower level or unrecognised qualification has been associated with poorer health and a reduced lifespan compared to higher-educated peers. Research also indicates that tertiary education, particularly, is critical in influencing infant mortality, life expectancy, child vaccination, and enrolment rates[70].

Providing opportunities for members of the communities to complete more qualifications at all levels could improve health and wellbeing outcomes.

Employment

Employment data is collected within the 2021 census, Standard Industrial Classification (SIC) codes classify people aged 16 years and over who were in employment between 15 March and 21 March 2021 by the code that represents their current industry or business. The SIC code is assigned based on the information provided about a firm or organisation's main activity.

Classifications include:

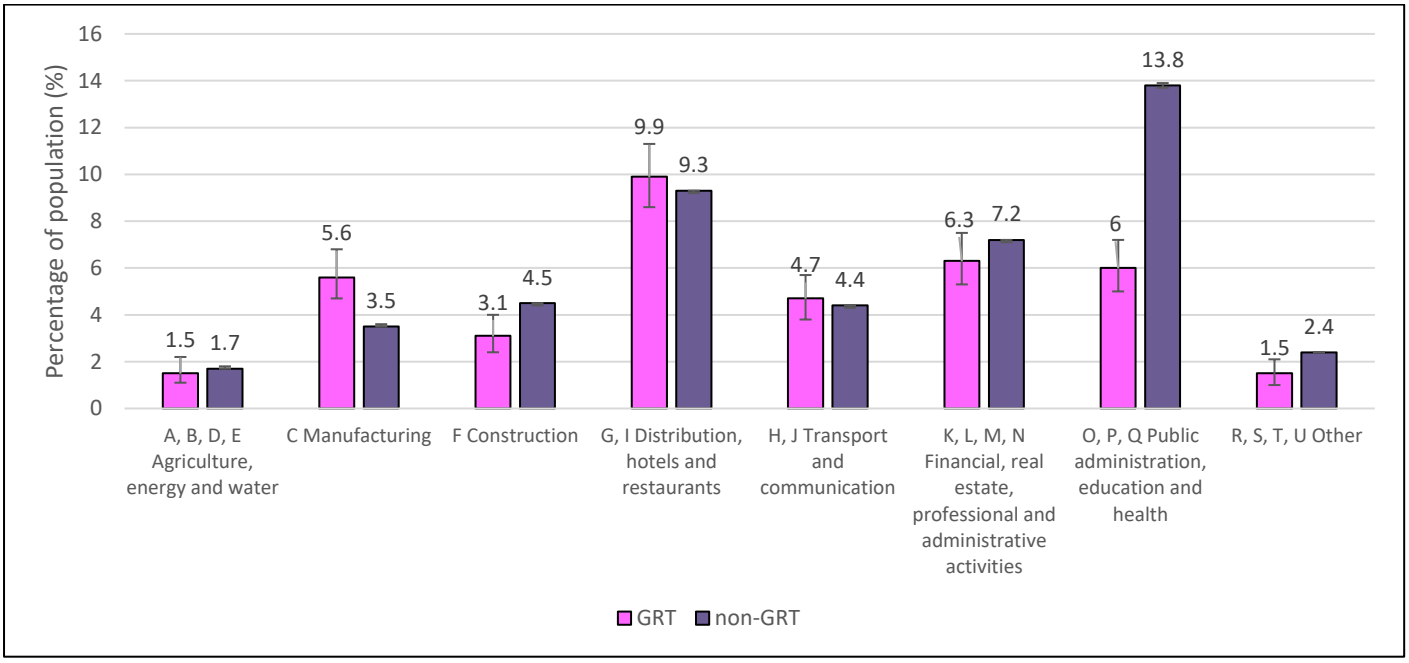
- **A, B, D & E:** Agriculture, energy, and water
- **C**: Manufacturing
- **F:** Construction
- **G & I:** Distribution, hotels, and restaurants
- **H & J:** Transport and communications
- **K, L, M, N:** Financial, real estate, professional and administrative activities
- **O, P, Q:** Public administration, education, and health
- **R, S, T U:** Other

Figure 22 shows a comparison of the GRT and non-GRT populations' current employment by industry (SIC codes) in Suffolk.

Statistically significantly higher proportions of the GRT population work in the following occupations compared to their non-GRT counterparts:

- Manufacturing (5.6% for GRT vs 3.5% for non-GRT)
- Transport and communications (4.7% for GRT vs 4.4% for non-GRT)

Figure 22: Comparison of the Gypsy, Roma, and Traveller and non-Gypsy, Roma, and Traveller populations current employment by industry in Suffolk, 2021 Census



Source: Office for National Statistics

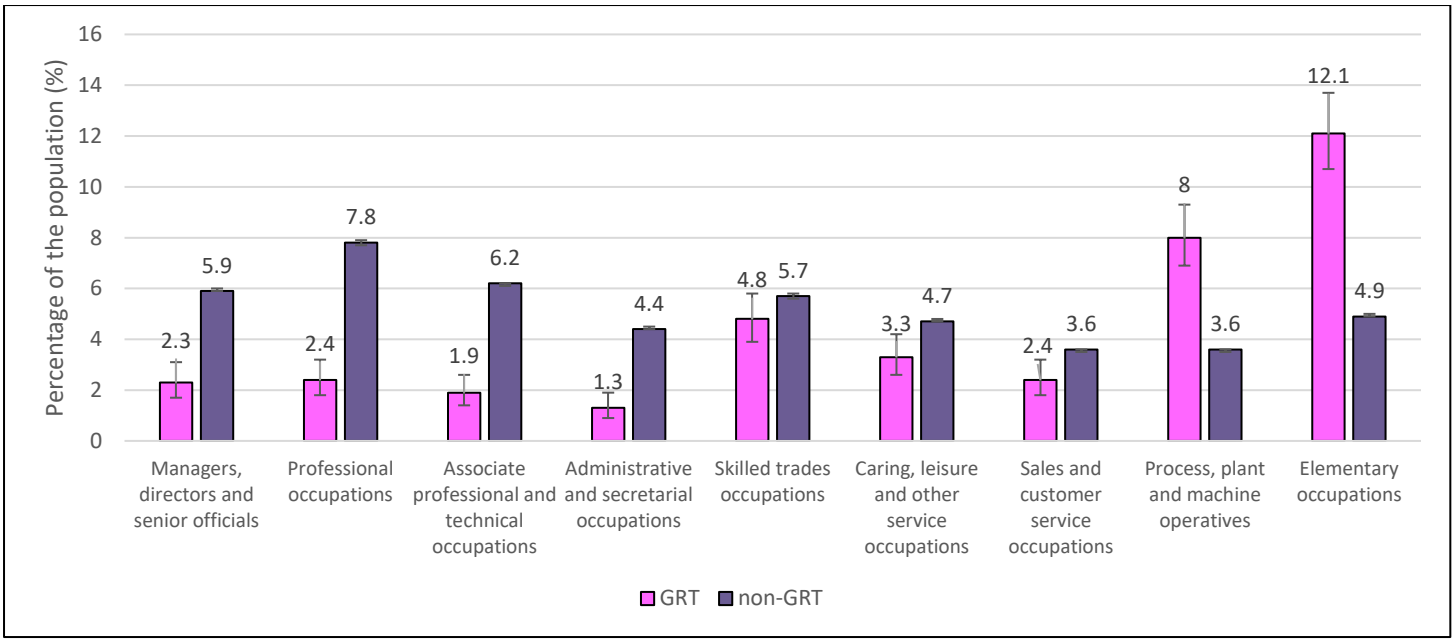
Looking at types of roles more specifically, figure 23 shows a comparison of the current occupations of the GRT and non-GRT population in Suffolk.

The GRT populations had statistically higher percentages of people employed in elementary occupations compared to their non GRT counterparts (12.1% vs 4.9%).

GRT populations were also had statistically significantly higher employment in process, plant and machine operative occupations (8. % vs 3.6%). Subsequently, GRT populations were less likely to be employed in more senior or managerial roles.

Literature has shown workers in elementary occupations reporting worse health, and having higher probability of musculoskeletal conditions, disability and earlier death when compared to workers higher up the occupational hierarchy[69]. Therefore, the GRT population in Suffolk could be at a greater risk of disabilities and early death and may be more likely to report overall worse health when compared to the non-GRT population in Suffolk.

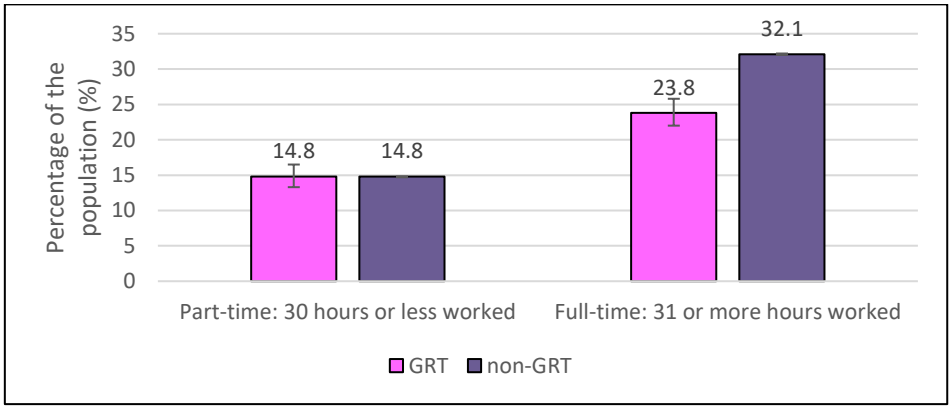
Figure 23: Comparison of the Gypsy, Roma, and Traveller and non-Gypsy, Roma, and Traveller populations current occupation in Suffolk, 2021 Census



Source: Office for National Statistics

A statistically significantly higher proportion of GRT population either do not work or work part-time compared to the non-GRT population in Suffolk. Figure 24 shows the hours worked by the GRT and non-GRT population in employment in Suffolk from the 2021 census.

Figure 24: Comparison of the Gypsy, Roma, and Traveller population and non-Gypsy, Roma, and Traveller population in employment, hours worked per week in Suffolk, 2021 Census



Source: Office for National Statistics

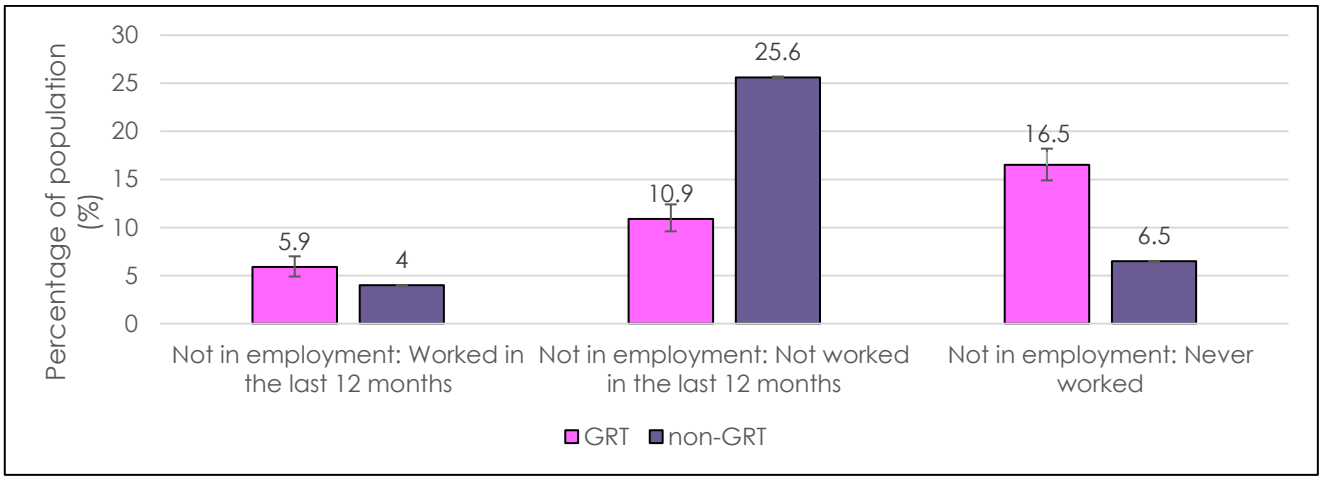
The COVID-19 pandemic led to a rise in unemployment across the UK. This rise in unemployment has been shown to be distributed unevenly across society with the highest rates among young

people aged 18-24 (14%), people with lower qualifications (7.8%) and people from minority ethnic groups (7.6%) including the GRT population[99].

Figure 25 shows the employment history of those unemployed as of the 2021 Census Day for both GRT and non-GRT populations in Suffolk. 5.9% of the GRT population were not in employment but had worked in the last 12 months, statistically significantly higher than the non-GRT population (4%). 10.9% of the GRT population were not in employment and had not worked in the last 12 months, statistically significantly lower than the non-GRT population (25.6%). 16.5% of the GRT population were not in employment and had never worked, statistically significantly higher than the non-GRT population (6.5%). Overall highlighting a statistically significantly higher level of unemployment within the GRT population in Suffolk.

Being in good work is better for your health than being out of work. Good work improves health and wellbeing, not only from an economic perspective, but also in terms of quality of life. Unemployment bad for health and wellbeing, and is associated with an increased risk of mortality and morbidity, including: limiting long-term illness, cardiovascular disease, poor mental health, suicide and health-harming behaviours[100]. Therefore, Suffolk's GRT population may have increased risk of health and wellbeing when compared to the non-GRT population in Suffolk.

Figure 25: Comparison of the Gypsy, Roma, and Traveller population and non-Gypsy, Roma, and Traveller population employment history of those unemployed at time of the 2021 Census in Suffolk



Source: Office for National Statistics

Economic activity status

The 2021 Census asked everyone completing the census aged 16 years and over to answer the questions on their economic activity status. The data indicates:

- 37.4% of the GRT population were employed (excluding full-time students), statistically significantly lower than the non-GRT population (45.8%).
- 4.1% of the GRT population were unemployed, seeking work or waiting to start a job already obtained and available to start working within 2 weeks (excluding students), statistically significantly higher than the non-GRT population (1.9%).

Research has found that lower socioeconomic status (SES) can have as similar impact on health as smoking or a sedentary lifestyle, and has been associated with reduced life expectancy of 2.1 years, similar to being inactive (2.4 years)[101]. SES is a measure of an individual or family's economic and social position in relation to others, based on income, education, and occupation.

Analysis of 2021 census data shows that compared to the general population, Suffolk's GRT population have higher levels of unemployment, and when they are employed, they are typically working in more routine and manual occupations. Suffolk's GRT population have a lower level of

qualifications and a lower level economic status. All of these factors mean that Suffolk's GRT population may be disproportionately at risk to poorer health and wellbeing when compared to the general population.

Hate Crime

44% of British adults openly express negative attitudes against Gypsy, Roma, and Traveller communities - more than for any other protected characteristic group. Police officers consider hate crime to be the most common issue Gypsies, Roma, and Travellers report to them, but it is estimated that fewer than 15% of hate incidents are reported to the police. Friends, Families and Travellers note that the press often share misleading and hate-provoking messages about Gypsies, Roma and Travellers and the government's hate crime action plan does not go far enough to prevent hate crime against Gypsy, Roma, and Traveller communities[102].

In Suffolk, from 2018 to March 2023, there were 23 Hate crime/incident investigations where the word 'Gypsy' was included on the record. Everyone has a responsibility to stand up against hate, prejudice and negative stereotypes and the government has a duty to prevent and punish discrimination and hate crime.

Stakeholder engagement and primary research

As part of the Suffolk GRT HNA, stakeholder views were sought as to key issues impacting GRT residents during February and March 2023. The information in this section has been summarised based on informal interviews with various professionals that work with GRT communities. It is provided by theme rather than person/organisation. However, detail in the appendix gives a broad overview of professionals and community members approaches to engage with this work. Where appropriate findings have been split to reflect observations within Roma communities, and other Traveller communities living in Suffolk. Where findings have been similar for multiple Traveller communities the abbreviation GRT has been used.

Reoccurring themes in speaking with individuals:

- Acknowledging differences within the GRT communities in Suffolk.
- Services need to be tailored to GRT communities, delivered on-site or where GRT communities live in, order to maximise engagement.
- Building trust and rapport are crucial in working effectively with GRT communities.
- There is a fear that many services designed to support children's wellbeing will result in the child being taken away from the parents - services are met with resistance when trying to work with GRT families.
- Access to health services such as the GP remains an issue. Dental service access is also a key concern - particularly for children.
- There are opportunities to improve health prevention and promotion activities - for example improving diets, cancer screening, health checks.
- Levels of literacy remain lower in GRT communities compared to non GRT communities- and may leave members of the community at risk of exploitation.

Many themes highlighted below reflect national Gypsy and Traveller research highlighted earlier in this document, particularly in relation to housing, health access, culture, and family values. It should be noted that whilst a range of professionals and GRT community members were approached to engage with this Health Needs Assessment, these views only represent a point in time sample. It is acknowledged that community member views were from site visits, rather than those living in bricks and mortar residences for example.

Please note that a list of Suffolk GRT services, and a Suffolk COVID-19 vaccination study supplementing this information, are available as appendices.

Area / theme	Key points
Culture and heritage	• Roma populations do not want to be conflated with 'Gypsy and Traveller' populations generally – and it is noted that GRT communities are heterogenous. Romanes is an oral language with many dialects, and therefore varies even within the Roma community. There are multiple different Roma communities within Suffolk, with a distinct caste system. • Roma are often excluded in Romania and in other European countries due to their ethnicity, and face discrimination when travelling home. • The term 'Gypsy' is seen as derogatory by Roma – and Roma may use the term in a derogatory way towards other Roma communities. • Whilst in Suffolk the predominant language is Romanian speaking, there are also community members from the Czech Republic, Spain, Hungary and Portugal for example. The Bulgarian Roma community is also significant. • Recent Roma migrants may be overlooked and not recognised within the wider GRT population. There are differences between Roma those arrived in last 20 years and those that being here much longer. Many recent Roma arrivals in Ipswich have travelled from Spain. They live in houses as opposed to caravans – but are always ready to move to new communities if opportunities arise. It is important to recognise that there are differences **within** the Roma community- and not just between Roma and other Traveller communities. • In Roma communities, church is very important and a highly valued social opportunity, with the day at church dedicated to God. • Roma tend to marry at a young age (around 16), and it is culturally accepted that the boy will pay a sum of money to the girl's family. There is a hierarchical value system associated with this – with girls deemed to have 'favourable' physical features and being a virgin, attracting a higher value. Marriages may be known about for a long period of time – with some reports of young children in primary schools already stating they know who they are going to marry. • Culturally GRT communities marry and have children at a younger age comparatively to the general population, however introduction of the Marriage Act 2023 means that 16 to 17-year-olds are no longer able to marry or enter a civil partnership under any circumstances.

Area / theme	Key points
	This change in the law has been seen by some in the GRT community as trying to undermine cultural traditions. • Historically, a lot of young people were taken out of education at the age of 11 as Traveller communities didn't want 'mixing' with non-Traveller communities. This still happens through the elective home education of Traveller children. However, there is a concern about the level of education post the age of 11. • Also historically, if boys left education at 11 and then went to work for 5 years they would be seen as a man. Yet within the general population they would still not be an adult. This leads to friction, as many young men in Traveller communities see themselves as adults before the wider population or the law would. • It has been reported that some Traveller families living in 'bricks and mortar' have purposefully kept their Traveller heritage from their children until their 16th birthday – to avoid stigma/ discrimination from non-Travellers (sometimes referred to as 'Gorgers').
Health and wellbeing	In relation to health, being part of the Traveller community can be detrimental for a number of reasons: • For those living by the roadside or in unauthorised encampments, the very nature of their life means that they don't have a registered GP or dentist. They are therefore reliant on A&E / minor injuries/ walk-in centres. • Traveller communities tend to be more likely to deal with health issues when they occur, rather than taking a preventative approach. Both men and women are not being screened for cancer. • Life expectancy is considerably lower in Traveller communities compared to the general population – An example was given of a male Traveller in his mid-40s stated that there wasn't any point in making plans for his old age – as he knows none of his family made it past 65, and he believed he will be dead by that point also. • One individual reflected it almost feels like a '1970's era' within GRT communities- with a lack of preventative health care, poor access to services, cultural barriers, and issues around the 'male ego' meaning that men in the community in particular feel they should not admit to being unwell. An example was given of one man who told the rest of

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	his community he was going on holiday – but was actually undergoing serious heart surgery. • Many older GRT community members have challenges with literacy. Care should be taken by health professionals around how to convey information about supporting the health of the individual. **Babies, children, and young people:** • Preventative health checks and appointments are encouraged by Health visitors (HV) (for example attending smear tests, or accessing contraception). However, sometimes the wait for an appointment can lead to declining an appointment. • Generally, there is good attachment and bonding between mother and baby. In Roma families, toys such as rattles / wooden blocks / books etc are not a cultural norm, but there is lots of talking to the baby to stimulate development. • In relation to the main Traveller site in Ipswich, there have been lower numbers of referrals to community paediatric specialists than would be expected given the demographics of the community, this could be indicative of unmet need and that this community is underrepresented. • Whilst language is a key barrier, it is also recognised that parental attitudes to health services may also present challenges in getting children help and support. Some view therapy as something that is 'done in hospital and that's it', with no support needed by the family. Different priorities may mean that appointments are missed (for example, some may not see Speech and Language Therapy appointments as a priority for their children to attend). • Parents tend to be open to discussions about their child's wellbeing but may need additional support due to low levels of literacy and a lack of knowledge about what and how to access support. • Roma communities tend to regard institutions/ services with a high level of suspicion. There is hesitancy towards vaccination – especially in women and girls who link it with sterilisation. • When speaking about maternal mental health, the use of the words 'post-natal depression' are avoided by professionals (due to stigma around mental health), instead they tend to use the term 'baby blues'. A lot has changed since COVID, and HV have not got the capacity or resources to undertake some of the wider support work that they might have previously been able to (noting this was outside of their role to begin with).

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	For example, HV can't ring dentists or doctors to try to get appointments anymore. Another example of this is immunisation. Typically, a HV will visit the mother once pre-birth, once at 6-8 weeks post birth and then again at around a year post birth. At the first couple of visits the benefits of immunisation will be flagged. However, if these immunisations are missed, the next chance they have to see the mother and child may not be until the child is a year old. In the interim, a GP may flag to the HV that these immunisations have been missed, but unless there is another 12 week check (which isn't routine), there is no further opportunity to promote this. **Adult health:** • Young men in the Traveller community often start very physical work at a young age. Consequently, this increases their risk of developing musculoskeletal conditions at a younger age. • Type 2 diabetes may also be higher in GRT communities - due to increased consumption of convenience/fast foods. Higher levels of hypertension in GRT communities have also been observed. Lots of people in the Roma community can tell you about their family members losing limbs due to diabetes. • Respiratory problems for communities in both bricks and mortar as well as caravans are a concern. • The term 'mental health' is not generally used within GRT communities. Mental ill-health may be reframed as 'suffering with their nerves', 'their nerves have gone against them', 'your nerves have gone'. This sounds much more temporary, and some community members are worried about having their children taken away if they acknowledge they are struggling. • Lack of seatbelt use in vehicles remains an issue, and as a result there are high levels of injuries/ deaths from road traffic incidents. Parents may need to be reminded to use car seats for their children. • There are opportunities for other health promotion activities – for example increasing sunscreen use particularly in men within the community who work predominantly outdoors. • In relation to sexual health women in the communities may have gaps in knowledge around pregnancy. For example - about egg fertilization and how the baby develops. **Dental care and diet:** • Access to dental care is a big concern across GRT communities.

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	• There is evidence of high levels of consumption of sweet foods and drinks, and some young children in the community have obvious dental decay (black teeth). • Dental health has always been a big issue in the Roma community. There is no importance placed on 'baby teeth' – as they are seen as temporary and will fall out. Children experiencing pain due to decay has been witnessed, as have abscesses and children having to have teeth extracted at hospital. Regular tooth brushing practices are not established, although there is evidence of families asking for more help than in the past. • There is a duality in terms of diets in Roma communities. Whilst there is a strong emphasis on home cooking, a lot of children are rewarded using sweets and chocolate. A lot of work has been done around education of packed lunches - so choosing healthier options or encouraging families to take up free school meals. • Roma tend to have a healthier diet *in* Romania, as junk food is expensive. Fast food options in England are a lot cheaper – and so these options are consumed instead. **Use of the GP and A&E** • Using A&E for ailments like coughs, colds and flu has been observed, this may be for multiple reasons such as lack of transport, being unable to register with a GP or being unable to get an appointment, not understanding the health system, or it just being easier/quicker to access. • GP registration is difficult – and added language barriers are faced for Roma when systems are automated (for example 'press 1 for reception… press 2 for an appointment'). Face to face misinterpretations can also occur due to language and communication barriers (for example expressive hand gestures may be mis-read). • Poor literacy is common, and Roma typically won't access health services easily. They may also think payment is needed to access health services. In Roma communities, language is a big challenge in relation to almost all areas of life- from accessing benefits to GP and pharmacy services. Repeat prescriptions for children's medication can be an issue – especially for the drugs that must be taken without interruption. • Another barrier is filling in key health forms, even if a translator is present - misinterpretation can occur. For example, a translator's

Area / theme	Key points
	phone number is put down instead of the person who the form is about. • Many Roma prefer to travel to their home country to access healthcare. This is due to multiple reasons: no translation is required, and even though they may be on low incomes, if they pay a fee to see for example, a paediatrician they know they will be seen on a particular day at a particular time. • Roma communities, especially those recently from eastern Europe in last few years, tend to view healthcare predominantly through an illness lens (rather than the maintenance of good health). Therefore, they may be less likely to use preventative health services, or antenatal / maternity services. • Roma parents may also have unaddressed health needs. Some families will travel back to Romania to have medical investigation/tests. However, if they receive medications, they are unable to bring them back to England in bulk. Management of long-term conditions in both adults and children can be challenging. • NHS dentistry appointments were noted as being challenging for general populations to access and this was exacerbated in GRT populations. It was also noted that knowing what's 'healthy' was often challenging – For example, parents may be unknowingly feeding their children high sugar drinks and snacks, contributing to dental decay. • Often, those in the GRT community won't access GP services until their health is extremely poor. • Preventative interventions to improve health can be really good – but you need to find an 'in' in the local community and give them the right information in a simple way. • Use of language is also key. An example of this is cancer in Traveller communities. Cancer tends to be known as 'the bad thing', rather than using the word cancer. This is because having cancer is seen as unlucky. Therefore, preventative screening promotion may need to be reframed. For example, promoting the positive stories – where individuals get screened, and everything is fine. However, this point needs to be considered in relation to the earlier point about GRT communities not seeking GP help until they are really unwell – in these instances cancer may be picked up at a late stage – due to hesitancy to access services.

Area / theme	Key points
	• Low levels of health literacy mean that special attention is needed in terms of the language used for any health interventions.
Housing	• Roma are very family focused, with homes that are busy, multi-generational and often include extended family. It is normal to have 6-8 children, and traditionally, mothers start having children at a young age. • Quite often there are multiple Roma families within a property, so building the understanding of the family networks and wider families is crucial. Quite often families live in private-rented accommodation. Families may 'mix-and-match' family units based on support needs (for example a new mother may live with grandmother / or other family members might visit to help in the early days of motherhood). • Living conditions are generally clean and tidy but can vary greatly in size. Overcrowding can be an issue in Traveller caravans, and it isn't always possible to follow guidelines around safer sleeping for example. There may also be a lack of space for children to play, or there may be no separation of kitchen and living areas – which could increase the risk of accidental childhood injury (scalds/burns etc). • The Broadgrass Green site in Elmswell is mainly of Irish linage travellers, and some Roma. But there are also large numbers that would be considered 'non-Travellers' - people struggling financially, with bad credit who cannot rent or obtain a mortgage through the usual routes. • Roma family homes are typically privately rented, and immaculately clean inside. As houses tend to be small and multigenerational, the community tend to meet outside of houses, however this can cause friction with other non-Roma members of the community, as this may be perceived as anti-social behaviour. • Roma see a very clear distinction between "inside" and "outside". This means that the inside of homes will be absolutely spotless, while the outside can be very messy. In Romania, rubbish will often be thrown from apartment windows and pile up outside. • There is a continued need to overcome stigma and the perception that non-Traveller communities have regarding Traveller communities. For example, there can be a reluctance from contractors to enter the site to conduct repair based on preconceptions. • In relation to welfare and benefits- many people in Traveller communities are reliant on services / support workers helping them to

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	secure their benefits. There is a need to support and empower Traveller communities to be able to be more independent. • The roadside homeless may not be getting benefits they are entitled to, as they are not in an area long enough to make a claim. They may also struggle to find a gas supply and tend to be reliant on being near garages/ services /supermarkets or leisure centres for basic needs such as water and showering. This is in contrast to 'roadside economic travellers'. These populations tend to travel from area to area finding and promoting work. They normally have a base somewhere, with caravans of that have central heating and double glazing. • Traveller populations are not likely to have a credit record that enables them to get access to reputable loans / credit. Some may take out 'bad' credit to buy a caravan that then ends up costing more than a house would. • Traveller housing can vary in quality, many residences are immaculate and described as being able to 'eat your dinner off the floor'. But some static sites are equivalent to low grade social housing and others may be struggling in overcrowded touring caravans.
Welfare	• There is a fear that many services designed to support children's wellbeing will actually result in the child being taken away from the parents. As a result, services are often met with resistance and distrust when trying to work with GRT families. • In relation to finances, many of the families HV teams work with are eligible for child benefit. However, the families don't want to be seen as 'scrounging off the government'. They are here to work and therefore won't claim. Families may ask for help accessing food parcels, or the £2 food bags supplied by some churches. • The transient nature of GRT communities can mean that contact with GRT families is difficult. For example, if a mother moves location temporarily but soon after birth, this may cause concern with services regarding families welfare. Services encourage keeping in contact – but this can be challenging. • Continuity of healthcare provision is also a challenge – from accessing medications to getting consistent and timely support. It can also mean children are less visible to services as a result. Quite often there is a lot of mobility within the country, with families travelling back and forth around different areas (example given Ipswich to Birmingham). This

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	can make it easy for children and families to 'fall through the system', for example failing to get registered with a GP. • There is a lack of data around who is accessing childcare funding (the data will show who takes up the funding but not who doesn't). Therefore, it is not known to what extent GRT communities take up this offer. In addition, this funding needs to be thought about flexibly for this cohort. Some are likely to move around more than others- and therefore need to 'port' their funding between settings. Funding is also organised termly – which may not help with access. • Adult literacy and language (for non-English speaking Travellers) is a challenge. Concern was also raised that if non-literate GRT members are reliant on their literate peers- this may leave them open to exploitation – i.e., those in the community that can read and write, take advantage of those that can't. An example was given where translators had misled individuals into paying **them** money for health care access.
Education and employment	• GRT children are not always in school, meaning education is missed, but this may also lead to educational needs (such as dyslexia) being missed, or diagnosed later than in non-GRT children. Lots of children and young people in the community don't progress to secondary education. • It is rare for a Roma child to attend pre-school or nursery prior to starting school. Education is not viewed as high priority for many Roma families, with a strong emphasis on going to work and making money. In England, children start school at a younger age than in Romania – and not all families are aware of this – which can mean children miss reception year schooling for example. • Roma children are often starting education 'on the backfoot', with development not as advanced as their non-Roma peers. Sometimes additional needs have been picked up, but quite often this is not the case. Whilst there is growing acceptance of support, Roma families remain less keen to have special educational needs formally recognised in their children. • Attendance is often poor in Roma children, and some may miss Reception year education completely. Absence in the summer is also noted. Romanian schools break up in June, and families may want to travel home whilst flights are cheaper. It is not uncommon for children to stay absent until late September and even October. • Teachers that can effectively build bonds and show they care about Roma children's wellbeing and education may help in Roma families

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	becoming more trusting. Building these strong, trusted relationships with Roma families is key, they need trusted people in educational settings that will help them navigate the system and support them with language and communication barriers. This can lead to educational staff regularly stepping 'outside' of their roles. For example, making opticians appointments for all children in the family, or going to appointments with the family. • Quite often families may be anxious or frightened, worried that their children will be told they can't come to school, or they will be held back in school. They need to be supported through the process and reassured that health, social care and education can work together to provide a good outcome for their child. There is a responsibility of professionals in the system to help families navigate their way through. • Low levels of literacy are prominent, and families rarely have email addresses to send any information too (and even if they did, they would not be able to understand the information). Any process reliant on the written word is a challenge. • People working in education have witnessed the lack of equity when working with Roma families, with one professional noting "if the dad had been a White British Lawyer this wouldn't be the case". Even with people in the education system supporting families, quite often the professionals need to have an 'in' / established relationship with the service they need help from, to ensure they get the outcomes needed to improve health. • Gross motor skills are well developed, and Roma children will typically spend a lot of time at local parks 'playing out'. • Many in the Roma community work in manual jobs, with language barriers being a key issue to finding other employment. However, this cycle is often difficult to break – as long working hours mean finding time to attend English classes etc a challenge. • Many Traveller families may travel from Suffolk and Norfolk to Cornwall, typically between April-October. This may be for work purposes (such as Daffodil harvests / working in farming/ agriculture), but this may also be for recreational reasons as well. There is the opportunity to earn a good wage, but this can only be achieved through physical work.
Working with GRT communities effectively	Applicable to GRT communities: • Generally, it's all about having the same people and organisations build trust and rapport with GRT communities. Trust must be built over time and there are no overnight results. The best interactions are

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	always face to face – as communities want to see you, hear you, and gauge how much confidence they have in you. • A mix of videos and audio to communicate information is likely to be more effective than any written material. • Health interventions need to be bespoke to GRT communities. • It is vital that anyone visiting sites is trusted for meaningful engagement to occur. • WhatsApp is key means of communication. The ability to send voice notes means that communication is easier. An example of this is letter translation. An image of the letter can be sent to a trusted individual who can sent a voice note back explaining the content. This means that younger community/family members (these are usually more likely to be able to read) don't have to be relied upon. This can also help overcome feelings of embarrassment or worry the recipient may have about sharing content with other members of their community directly. • It is noted that digital exclusion is also still an issue – whilst WhatsApp is a key tool, not everyone will have access to it, or know how to use it. You also need Wi-Fi or an internet connection to use this – which isn't always available or accessible. • In an ideal world there would be a specialist HV aligned to GRT communities, who could take a more holistic approach to improving health and wellbeing. • An example of work in a Clinical Commissioning Group (CCG – now Integrated Care Board (ICB)), to develop a health help card for GRT populations has been highlighted as good practice. This card can be given discretely to any professional/service to aid individuals in accessing services. This can also help individuals feel they have 'permission' to access help and support. An example of this is provided below. An example of the health help card developed to assist GRT populations access key services.

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	 Source: [103] **Roma communities:** • The background of exclusion toward Roma communities both in Romania and when they travel, has led them to believe that everyone will reject them. They tend to be distrustful of authority / statutory services. There is a general mistrust of government and health services, with COVID-19 being given as an example. Roma communities were resistant to the vaccine as they thought it might be another Holocaust. • Roma are quite closed about the rapport between different Roma groups. Therefore, whilst it may be well intentioned to have a member of the Roma community translating, the differences between different Roma communities may mean that this isn't appropriate or could even be counterproductive. It may be more appropriate to have a Romanian speaking translator in these cases. However, it was also noted by other contributors that Romanian may also not be the best language to communicate with Roma – Their first language may be Romanes – which has many dialects and is not one unified language. • Roma tend to have a trusted **person** rather than service/ or institution, so building trusted relationships is crucial. • It is important to identify the authority within the community, to find out who the influential leaders are, and engage with them – they are conduits for the wider community.

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	• Community members appreciate the time taken to reach out to explain and discuss issues and challenges – and appreciate visits to the Roma community, as opposed to trying to navigate services themselves. Any outreach workers must develop trust with the community, once this is achieved members of the community will be keen to keep communication channels open. • For health visitors, the best route to working with Roma families was to pay home visits. The usual practice is to offer clinic appointments, but these can prove challenging to attend for numerous reasons including mothers not having access to transport and not understanding the purpose of visiting the clinic. • Many Roma families have access to smart phones but wouldn't use this for reading information – rather they would use for texting/phoning or for their children to watch videos. This can be a good way to communicate health promotion messages (e.g., safer sleeping advice) – the health visitor would sit with the mother and watch the video together. • It was noted that the online safer sleeping resource is really helpful, as its online and can easily be translated into other languages. A version of this tailored to immunisations would help improve communication of the importance of childhood vaccinations. Also written information in Romanian that could be given out to non-English speaking families about vaccinations would be helpful. • The HV team tend to use different language when engaging with Roma families, to simplify messages, but also to overcome some stigma around certain conditions (particularly mental health). An example of this – a HV might ask 'do you ever feel sad or cry' rather than enquiring about post-natal depression (PND). It was noted that living in a large community/ having a large support network such as in Roma communities can be a good protective factor against PND. • Some HV material is still delivered by post- this is problematic due to lower levels of literacy, and that GRT communities don't always have access to post / or are able to receive it at all. • There is a strong Pentecostal church presence within the Roma community, and working with the church may help improve trust and rapport. • There are opportunities to work with young Roma who are now growing into educated adults and can be key community champions in improving health and education in the Roma community.

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	• Education colleagues mentioned that it would be great if there were still Sure Start centres- that really brought everyone together around the child and the family. It was noted that it feels like often services are working in silos, where a community hub approach would be much more holistic and effective. Schools are taking on so much of the work in trying to address health and social care concerns as well as education, but it would be much more effective if services were more joined up. It would be especially beneficial to have a key worker/ link worker "a real person" to link in with to ensure the needs of this community are better served. • Taking the time to understand cultural practices and norms is key. For example, Greek Roma mothers may stay at home for 40 days with their new baby- and won't cook dinners etc. So, the husband may temporarily move out. **Travellers:** • There used to be a community room on one of the Traveller sites- which was just outside of people's caravans. If clinics / health promotion opportunities could be based out of that, that would be beneficial too. • Successful engagement events have been held with site visits with a health bus. Men are usually more interested in engaging if there is physical equipment – such as blood pressure monitoring machines or oxygen monitors. • When working with Traveller communities or engaging / trying to find out information it is good practice to keep gender groups separate, and to split into bracketed age groups of about 5 years (e.g., 20-25 year olds). • Information cascades are key- engage with key members of the community that will cascade the information to others. • Health literacy is really important for Traveller communities, but always be mindful of the content. For example, using straightforward imagery that would resonate with populations.

Community feedback

In April 2023, two private Traveller sites were visited where occupants were willing to participate in answering a few questions. There were not many people around, and Communities Officers spoke to approximately 5 different families which equated to 8 people in total.

When talking about health needs:

- One member said that no health care professionals attend the sites anymore. They used to have access to a health visitor, but this is no longer the case. Most of the people living on the site have been able to and have been happy with, registering with a local GP, and have access to health care and dentistry as and when it is needed.
- One of the people we spoke to had experienced a traumatic mental health crisis. This resulted in the individual being sectioned under the Mental Health Act for a period. The experience of this person within a psychiatric setting was very positive and has enabled a supported recovery. Access to vital medication has not appeared to be an issue.

Do you feel safe:

- On both sites there were initial issues with anti-social behaviour not only from the wider community but also internally. These issues have appeared to have been resolved and there seemed to be no concerns for safety. Each site seemed to be friendly and amenable to one another.

Housing needs:

- Both sites were on private land and there were no housing issues identified.

Relationships outside the community:

- The people we were able to speak to appeared to be able to integrate with the wider community, whether that be through the schools, or health care professionals. One person approached us to ask about home-schooling for a child. The person was interested if there was any information Communities Officers could offer regarding this for the child's future and was planning ahead for this eventuality.

On a separate visit by a Community Engagement Officer to a different site, as part of a routine welfare discussion 45 residents were engaged in conversation[104].

- 30 people were happy with the service [health]
- 5 were worried about mobility.
- 16 needed to stop smoking (financial)
- 11 could not access dental care.
- 6 found travelling to the local hospital difficult
- Outside of family members 22 said they would not know where to go for mental health support.

Aligning key health priorities and strategic and policy actions

Evidence from national data, literature reviews and stakeholder engagement have identified significant health needs within the GRT population. Table 7 summarises the key health priorities

that have arisen from collating research within this health needs assessment. Defined health priorities are coupled with associated goals set out in Suffolk and North East Essex[105], and Norfolk and Waveney[106] joint forward plans and joint health and wellbeing strategies.

Table 6: The key health priorities for the Suffolk Gypsy, Roma, and Traveller population summary- with corresponding evidence

	Key health priority	Suffolk and North East Essex Joint forward plan & Joint health and wellbeing strategy link	Norfolk and Waveney Joint forward plan & Joint health and wellbeing strategy link
Child Health	• Poor uptake of England routine children immunisation programme. • Poor dental health.	**Start Well- Children and young people.** To ensure children, young people and families have access to a care pathway that facilitates a standardised and improved way of working across the system to achieve better outcomes. **Be Well- Dental/Oral Health** To ensure children, adults and older people can prevent oral health problems through public health campaigns, working with schools, universities, and health care professionals. To ensure homelessness, transient populations, and at-risk groups, can use priority pathways through NHS commissioned services to access Dental Support.	**Improving Services for Babies, Children, Young People & Maternity** To ensure successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach.
Maternal Health	• Poor maternal and neonatal outcomes (miscarriage, still births, neo-natal deaths). • High prevalence of teen pregnancy	**Start Well- Maternity & Neonatal Care.** To ensure women with heightened risk of preterm birth or complex pregnancy will receive targeted care and the health of preterm babies will be better protected. Women will have improved access to information and their records and be able to access services and information in a more convenient and efficient way. To support decisions about their care using digital technologies enabling them to exercise more choice and control over their care.	**Improving Services for Babies, Children, Young People & Maternity** Continued development of our Local Maternity and Neonatal System (LMNS) including the Three-Year Maternity Delivery Plan.

	Key health priority	Suffolk and North East Essex Joint forward plan & Joint health and wellbeing strategy link	Norfolk and Waveney Joint forward plan & Joint health and wellbeing strategy link
		Aims to develop & support workforce to offer high quality, kind and compassionate care for our service users and partners.	
Adult Health	• Shorter life expectancy and HRQoL. • Higher prevalence of long-term health conditions. • Limited understanding of cancer, prevention approaches and available treatment.	**Age Well- Ageing Well Programme** To enable the ageing population to live a healthier life for longer, in the person's preferred place of residence, by anticipating the health, care and wellbeing needs of the population, identifying people at an earlier stage and providing a multi-disciplinary approach to their needs through the Neighbourhoods model from 2023. **Stay Well- Long term conditions including cancer, cardiovascular disease, diabetes etc...** To ensure all communities are enabled to live healthy lifestyles, aware of concerning symptoms for long-term health conditions and know how to seek appropriate help. To ensure people have access to a wide range of high quality and timely services leading to an early diagnosis. To ensure workforce and infrastructure are in place to support faster diagnosis.	**PHM, Reducing Inequalities & Supporting Prevention** Early Cancer Diagnosis- Targeted Lung Health check Programme. Cardiovascular disease prevention.
Mental Health	• High prevalence of cultural shaming. • High Suicide rates.	**Be Well- Healthy Behaviours.** To ensure children, adults and older people feel safe in their home and community. **Be Well- Dental/Oral Health** No treatment for acute or mental health will be delayed by patients	**Improving Services for Babies, Children, Young People & Maternity** Reducing health inequalities including an initial focus on asthma, epilepsy, and mental health. Develop and improve an appropriate offer across

	Key health priority	Suffolk and North East Essex Joint forward plan & Joint health and wellbeing strategy link	Norfolk and Waveney Joint forward plan & Joint health and wellbeing strategy link
	• High prevalence of mental health difficulties such as depression and anxiety.	not being able to access NHS Dentistry **Feel Well- Mental Health including suicide prevention.** To ensure people maintain good mental and physical health and are resilient. To ensure people live in resilient and inclusive communities. To ensure people receive the best quality integrated services to achieve recovery and good mental health, delivered in the right way, in the right place and at the right time. To ensure people receive the best care and support when experiencing a mental health crisis.	Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs. **Transforming Mental Health Services** Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities, this includes enhancing and expanding skills and knowledge of mental health across our population, providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy. Mobilise mental health system collaboratives to facilitate partnership working and delivering better health outcomes for our residents. See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs- with focus on dual diagnosis and complex emotional needs (CEN).
Lifestyle behaviours	• Limited utilisation of preventative healthcare. • High prevalence of	**Be Well- Healthy Behaviours.** To ensure children, adults and older people are supported to make healthy food and drink choices and are supported to be physically active. **Stay Well** To ensure all communities are enabled to live healthy lifestyles, aware of concerning symptoms for long-term health conditions	**PHM, Reducing Inequalities & Supporting Prevention** Developing and delivery of two strategies to support prevention: A population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the 'Core20plus5' approach.

	Key health priority	Suffolk and North East Essex Joint forward plan & Joint health and wellbeing strategy link	Norfolk and Waveney Joint forward plan & Joint health and wellbeing strategy link
	obesity and sedentary behaviour. • High prevalence of smoking.	and know how to seek appropriate help.	Smoking during pregnancy- Develop and provide maternity led stop smoking services for pregnant women and people.
Access and use of health services	• Limited GP registration. • Limited Dental registration. • Lack of trust regarding available health services.	**Be Well- Dental/Oral Health** To ensure homelessness, transient populations, and at-risk groups, can use priority pathways through NHS commissioned services to access Dental Support. **Be Well- Personalised Care** To ensure people have maximum control over their health and wellbeing care and support. To ensure people have expert support to make the care decisions that are right for them. **Stay Well- Primary Care** To ensure a system-wide approach to managing integrated urgent care and same-day care for patients, and a more sustainable model for practices.	**Improving UEC** Improving emergency ambulance response times. Expand virtual ward services. Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals. **Primary Care Resilience & Transformation** Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience. Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years. **Elective Recovery & Improvement** Effectively utilise capacity across all Health System Partners. Implement digital technology to enable elective recovery. **Transforming Care in later life** To develop a shared vision and strategy with older people that will help us to transform

	Key health priority	Suffolk and North East Essex Joint forward plan & Joint health and wellbeing strategy link	Norfolk and Waveney Joint forward plan & Joint health and wellbeing strategy link
			our services to be easy to access and designed and wrapped around the needs of older people.
Wider determinant of health	• Discrimination within education, health services and community. • Poor site locations and standards. • Limited proficiency in the English Language.	**Be Well- Healthy Behaviours.** To ensure that children, adults, and older people are able to live in a clean and sustainable environment. To ensure children, adults and older people have opportunities to volunteer to help them connect with, and support others.	**Transforming care in later life** Seeking to minimise health inequalities as a result of the impact of COVID-19. This will also include wider factors that impact health and wellbeing such as housing and the environment we live in.

Conclusion

Gypsy, Roma, and Traveller (GRT) communities encompass a diverse community with different histories, cultures, and beliefs. Generally, the term describes people from a range of ethnicities following nomadic ways of life. However, the number of 'settled' GRT people living in bricks and mortar accommodation has increased in recent years.

GRT communities are known to face some of the severest inequalities in health and care access and outcomes amongst the UK population, even when compared with other minority ethnic groups. This includes reduced life expectancy (up to 25 years shorter), higher prevalence of long-term illness, and poorer mental health.

The number of GRT people in England and Wales disclosing their ethnicity in the 2021 Census has increased significantly since the 2011 Census. However, a large proportion of this increase is attributed to the inclusion of 'White: Roma' as a distinct ethnic classification for the first time. True counts of the GRT population are still likely to be an underestimate due to their higher mobility across the country, low literacy levels, and reluctance of the GRT community to engage with services/ authority due to stigmatisation.

Across Suffolk a total of 1,892 GRT people disclosed their ethnicity in the 2021 Census (approximately 0.3% of Suffolk's population), this is an increase of 1,288 people compared to the

2011 Census (604 people). The first official population of Roma heritage in Suffolk was recorded at 987, and individuals who described themselves as 'White: Gypsies or Irish Travellers' was recorded at 905 (a 301 person increase from the 2011 Census). Ipswich had the highest number of GRT people.

Whilst the NHS Long Term Plan gives an opportunity to direct resources towards GRT communities who have the worst health outcomes of any group, national reporting highlights the failure of both national and local policymakers to tackle inequalities faced by the GRT community in a sustained way.

There are opportunities to improve the health and wellbeing in GRT communities through a range of public health and wider initiatives. These opportunities include:

- Increasing screening uptake (e.g., cancer screening)
- Increasing utilisation of NHS health checks
- Increasing childhood vaccination rates
- Identifying MSK needs within GRT communities and offering routes to access support in managing this and other long-term conditions effectively.
- Helping GRT communities navigate and access care (specifically GP and dental care)
- Providing education and support around healthy diets for both adults and children
- Working to improve mental health education and enabling GRT communities to seek further support where required.
- Recognising language and literacy barriers, and working with GRT communities to offer services that are easy to access (e.g., using WhatsApp to communicate), whilst also recognising that some members of the community may face digital exclusion)
- Working with planning colleagues to maximise the positive environmental surroundings (and minimise risk from air pollution / other environmental hazards)
- Improving educational attainment and offering support in developing skills for employment.
- Working with health service providers to consider the needs of GRT communities in the design and delivery of services.

Suffolk has dedicated and effective community engagement officers that have been building trust, rapport, and most importantly supporting GRT communities. It is vital that these bonds are maintained. Best practice examples from other areas have shown the benefits of having a dedicated health care worker (for example a nurse) as a means to increase acceptance by GRT communities and provided greater health related impact when achieving a holistic approach to care. This may also be an area that would benefit from further exploration.

Services need to be tailored to GRT communities, delivered on-site or where GRT communities live in, order to maximise engagement. It is also vital that differences between GRT communities in Suffolk are recognised, respected, and valued.

It is only through targeted, tailored, persistent work with GRT communities, that inequalities in this population can be reduced.

Recommendations

Based on the findings of this health needs assessment, the following recommendations are made:

Area	Recommendation	Action to be taken by	When?
Culture and ways of working	1. Ensure all possible efforts are made to effectively communicate with the Suffolk GRT population to enable informed decisions about their needs.	Across the Suffolk system	Immediately
Culture and ways of working	2. Continue to build on the good work of Community Engagement Officers in building trusting relationships, showing empathy, a non-judgemental attitude, and a positive attitude to overcoming problems.	Across the Suffolk system	Immediately
Culture and ways of working	3. Ensure effective cross-system collaboration to support people from GRT communities.	Across the Suffolk system - led by the GRT High Level Steering Group	Immediately
Culture and ways of working	4. Ensure those who work with GRT communities are aware, able to signpost and support those individuals to access and use the services that are relevant to improving health and wellbeing	Across the Suffolk system - led by the GRT High Level Steering Group	Immediately
Culture and ways of working	5. Encourage key provider organisations to have a key person who is aware of services for GRT communities and can act to ensure the organisation can provide them in culturally appropriate way. This could be part of the person's wider role to provide support for other vulnerable groups.	Across the Suffolk system - led by the GRT High Level Steering Group	Over the 12 months from June 2023
Culture and ways of working	6. Completing Equality Impact Assessments in relation to new initiatives/services or service change will help to ensure the needs of key vulnerable groups, including GRT are considered, and actions put in place to meet them.	Across the Suffolk system - led by the GRT High Level Steering Group	Over the 12 months from June 2023
Health	7. Visit Suffolk GRT sites and work with colleagues across the system to encourage GP registration for GRT community members and reduce system barriers to registration where in evidence or experienced.		
Health	8. Explore the potential of offering on site visits from Health Visitors, GPs, Dentists or Nurses to increase access to services.	Public Health and Communities Suffolk - led by the GRT High Level Steering Group	Over the 12 months from June 2023

Area	Recommendation	Action to be taken by	When?
Health	9. Target GRT communities specifically in relation to mental health this includes education about what support is on offer, how to access this support, and looking at how to prevent suicides in GRT communities in Suffolk.	Public Health and Communities Suffolk	Over the 12 months from June 2023
Health	10. Deliver health promotion and improvement opportunities and work to maximise uptake of these. Specific initiatives should include: -Cancer screening -Healthy eating advice -Oral health and tooth hygiene -Childhood vaccine uptake	Public Health and Communities Suffolk	Over the 12 months from June 2023
Communication	11. Look for ways to minimise digital exclusion in GRT communities, and utilise technologies such as WhatsApp to disseminate key health and wellbeing information	Across the Suffolk system	Over the 12 months from June 2023
Planning and housing	12. Work with relevant teams to improve the wider environments surrounding GRT sites, to maximise health and wellbeing and minimise environmental hazards. Organisations that provide health care services focussing on GRT communities should also involve the relevant communities and their advocates to provide advice and information to support design and uptake of those initiatives/services.	Suffolk County Council and District and Borough Planning teams and Public Health and Communities Suffolk	Over the 12 months from June 2023
Education and skills	13. Explore routes to improving educational attainment and offering support in developing skills for employment.	Suffolk County Council Skills Team and Public Health and Communities Suffolk	Over the 12 months from June 2023

Appendix 1: GRT guidance releases

Table 7. Gypsy, Roma, and Traveller Guidance release on NICE website

Title (identification code)	Type of guidance Last reviewed	Gypsy, Roma, and Traveller guidance
Vaccine uptake in the general population (NG218)	NICE guideline May 2022	The committee agreed that it is important to increase the routine vaccine uptake in GRT populations. The committee agreed that unless the GRT population are made aware that they are eligible for NHS vaccinations and given help to access them, they are unlikely to be vaccinated. The committee agreed that local authorities, health visitors or community involvement could help to ensure that these people are not overlooked for vaccinations. CHIS should identify children who are eligible for vaccination but are not registered with a GP practice. When commissioned, they should send invitations to parents and carers or ensure this cohort is highlighted to the service commissioner.
Community pharmacies: promoting health and wellbeing (NG102)	NICE guideline August 2018	Community pharmacies are well positioned to promote health and wellbeing in their local community, including those from GRT populations. There is a need to address health inequalities by working with agencies to tailor health and wellbeing interventions to suit the GRT populations needs and preferences and maximise their impact. Establishing links to integrate community pharmacies with other health and care organisations may result in upfront costs but it may be offset through quicker access to the right treatment for the GRT population.
Contraceptive services under 25s (PH51)	Public health guideline March 2014	Health and wellbeing boards, including directors of public health, local public health leads and local authorities, should carry out and publish the results of comprehensive joint strategic needs assessments for young people's contraceptive services. This should include details on young people within the GRT community.

		Provide additional support young people in the GRT community to help them gain immediate access to contraceptive services and to support them, as necessary, to use the services. Use a range of methods, including the latest communication technologies, to provide young people within the GRT community with advice on sexual health and contraception. Ensure all support staff who may come into contact with young people within the GRT community are experienced in working with them.
Advocacy services for adults with health and social care needs (NG227)	NICE guideline November 2022	Commissioners and advocacy providers should consider working with local organisations that have the skills, knowledge, and networks to help promote access to advocacy for the GRT population. Culturally appropriate advocacy is critical to achieve equity and social justice, and to reach GRT communities. Advocates should already be knowledgeable about existing health inequalities and should use this knowledge to influence and improve their work within the community. Working with local organisations would help commissioners provide services tailored to the local GRT population.
Flu vaccination: increasing uptake (NG103)	NICE guideline August 2018	Consider outreach opportunities for GRT groups in line with local practice and patient group directions arrangements. Consider using peer-led approaches for inviting GRT groups who are eligible for flu vaccination.

Appendix 2: Gypsy, Roma, and Traveller services in Suffolk

Table 8 gives a list of services provided for the Gypsy, Roma, and Traveller population in Suffolk.

Table 8. **Suffolk Gypsy, Roma, and Traveller Services**

Service name & link	Address	Services provided
One Voice 4 Travellers	Head Office: 3A Hope Lane Country Park, Marshland St James, Wisbech, Cambs PE14 8JD	Working with and supporting members of the Gypsy Traveller and Roma communities who are in conditions of need, hardship or distress caused by or associated with violence. Work to support the Gypsy, Traveller, and Roma community members to enable them to make informed choices. To encourage engagement and participation within the Gypsy, Traveller, and Roma community and also with the wider community. To promote good relationship by raising the cultural competence of service providers.
Health Outreach Services	Health Outreach NHS Main Office 70-74 St Helens Street Ipswich Suffolk IP4 2LA	Health Outreach supports marginalised and vulnerable adults into mainstream health services across Suffolk. This includes: • Individuals experiencing homelessness. • Gypsies and travellers. • Asylum seekers. • Refugees. • Migrant workers. • Ex-offenders. They are a multi-disciplinary team made up of general and mental health nurses, social workers, outreach practitioners, support staff, a qualified psychological practitioner, a drug & alcohol trainer, and locum GP sessions.
The Norfolk & Suffolk Gypsy, Roma, and Traveller Service		The Norfolk & Suffolk Gypsy, Roma and Traveller Service is a traded service covering Norfolk, Suffolk, and the wider East Anglian region. The Service provides expert assistance to landowners to manage unauthorised encampments on their land. The Service offers highly regarded advice and training on Gypsy, Roma, and Traveller issues. Any organisation or individual can buy into the Service, whether a public body, voluntary organisation, or private landowner.
Maternity Advocate (Cristina Mitrica)	Maternity Block, Ipswich Hospital	Cristina is an assistant to the Maternity service, supporting the service in its work with vulnerable communities, particularly Roma communities.

Gypsy, Roma, and Traveller Education Liaison Officer (Katie Magill)	Endeavour House 8 Russell Rd Ipswich Suffolk IP1 2BX	Katie supports GRT families to engage with education. Katie visits private sites and housed GRT families across the county, offering direct support to families who experience barriers to learning. Katie works closely with parents and consults with relevant professionals to promote attendance, ascription, and continued engagement within educational settings.
Food Museum Association for Suffolk Museums		Food Museum has GRT collections on permanent display. The Museum has received Arts Council Funding to create events that celebrate GRT heritage and culture. Early-stage discussions are taking place for a potential GRT festival during GRT History Month in June 2024.
The Ipswich and Suffolk Council for Racial Equality (ISCRE)	46A St. Matthew's Street, Ipswich, Suffolk IP1 3EP.	ISCRE runs culturally informed interventions to support individuals and organisations in the statutory, private and voluntary sectors, to understand the extent and nature of inequality experienced by individuals and groups in fields such as the criminal justice system, housing, employment, education, health and social care. The aim is to encourage them to implement policies and practices which will eliminate discrimination and promote equality of opportunity, and good relations, between all persons.
Friends, Families and Travellers	Community Base, 113 Queens Road, Brighton, East Sussex, BN1 3XG	FFT work to end racism and discrimination against Gypsy, Roma and Traveller people and to protect the right to pursue a nomadic way of life. FFT support individuals and families with the issues that matter most to them, at the same time as working to transform systems and institutions to address the root causes of inequalities faced by Gypsy, Roma and Traveller people.
The Traveller Movement	40 Jeffrey's Road, Stockwell, London, SW4 6QX	The Traveller Movement aims to advocate for and work with the Gypsy, Roma, and Traveller people to tackle discrimination and promote equality. The Traveller Movement supports and produces work using a collective community assets-based approach for addressing ethnic Romany Gypsy, Irish Traveller and Roma inequality, exclusion and discrimination and promoting their rights.

Appendix 3: Stakeholder engagement methods

Professional stakeholder engagement was conducted in February 2023. Colleagues were approached by email, as well as newsletter announcements (for example in 'Suffolk Headlines' a newsletter sent to Suffolk schools). Leads for the HNA also attended the GRT High Level Steering Group (HLSG) to gain further potential contacts for engagement work. A GRT HNA steering group was also formed in January of 2023, bringing together key professionals who would be beneficial to engage in the HNA process.

Consent was obtained to include stakeholders inputs to this HNA.

Input was collated from:

- Friends, Families and Travellers -a leading national Traveller led charity.
- Health visitors and community paediatric specialists
- Inclusion officers and leads.
- Community engagement officers
- Health Outreach
- Schools

Appendix 4: COVID-19 Vaccination case study

The information provided below is a case study that has been shared on the Local Government Association (LGA) learning exchange and published on the NHS Futures platform and Association of Directors of Public Health (ADPH) East of England (EoE) website in March 2022.

Suffolk County Council's Covid Response team was created to manage the Covid-19 Pandemic. The team consisted of a range of skills, from various sectors across the Council and included some new posts to enable the Council to respond to the impact of the virus. Within the team, there were a branch of Community Engagement Officers who worked to increase vaccine uptake in specific communities.

Suffolk County Council were already working with the Roma community through a group called Ipswich Roma Inclusion Support (IRIS). This group had been created from a recognised need for extra guidance, engagement, and care, especially by Suffolk schools.

The aims were:

- To gain an understanding of the concerns, establish the messages the group were hearing.
- To build trust within the community so that the right guidance around Covid-19 could be shared.
- To find ways of collaborating so that the community would receive, digest, understand and respond to the right information.

Suffolk's Roma community was hesitant about vaccination. The community were hard-hit early in the pandemic, with two young men tragically passing away, leaving young families without a father or an income. An interpreter trusted by the community informed us that during a call to his mother immediately before sedation in intensive care, one of these men had said (or his mother had understood) that he was to be given an injection. His subsequent death led some in the community to conclude that the pandemic was being used as a pretext to give Roma people lethal injections. People who had previously engaged with the NHS began to withdraw and even routine and childhood vaccinations were being missed within this community.

Many people living in Roma communities have been at high risk of contracting COVID-19, due to both their domestic circumstances – living in multi-generational households – and their occupations, working primarily in food processing factories or as delivery drivers.

In September 2020 a Romanian-speaking Community Engagement Officer contacted the leader of a local Roma Pentecostal Church by phone. The church leader was able to cascade messaging to his community as regulations changed and as the pandemic progressed.

Suffolk's Roma communities largely do not access British media, but receive their news via Romanian TV stations, Facebook, WhatsApp, TikTok and YouTube. When the COVID-19 vaccines were first approved, a great deal of misinformation was being posted online and quickly being shared and translated into many languages.

Misinformation was seen by the community officers first-hand through social media, content included conspiracy theories. By following these sites directly, the community officers gained a greater understanding of what the community believed. From the work within the group, it was soon established that the younger people were influencing older people by circulating video clips. This approach was used a lot, and once the clips were shared in WhatsApp, the wider group regarded the source as trustworthy as it was received and sent by one of them. Some of this misinformation originated in the United States and was couched in Evangelical language, making Evangelical Christians in Suffolk particularly susceptible to believing the claims.

In January 2021 police attended the Church's Sunday meeting, as non-Roma local residents had complained of a large number of people gathering during lockdown. At the time religious groups were allowed to meet under strict guidelines, but this Church does not meet in a recognisable church building, using a community building instead.

During the following week, the Romanian speaking Officer helped the leader to put in place measures to make future meetings COVID secure, such as holding two services in order to facilitate better social distancing. The following Sunday, Community Engagement Officers attended in order to encourage the church to follow COVID guidance, including recording the names of all participants, taking temperatures, social distancing both inside and outside the building, cleaning of touch points, a one-way system, and the use of hand-sanitisers.

All this occurred as the vaccine was being rolled out by age-group. Discussing this with the Church Leader, the Community Engagement Officer was able to ascertain some of the motives behind the apparent hesitation within the community. The leader generously agreed to allow doctors to attend both services at the church one Sunday in order to provide accurate information and to answer questions about the vaccination.

The Community Engagement Team then worked in partnership with local doctors and the Roma Pentecostal Church to organise and deliver a Question-and-Answer session regarding the COVID-19 vaccines. The officers contacted a GP surgery to make the request for help and had a great response, with doctors keen to be involved. In the end a Romanian paediatrician, whom some of the community knew through having children as patients, and a known GP (female) volunteered to come. This provided the Roma community with accurate information and, coupled with support around safety measures, helped the community to protect themselves from COVID-19.

The session took place a few weeks later, in February 2021. During the second meeting, a local male, Black Pentecostal Pastor also arrived who is well-known and respected by the church. The Question-and-Answer happened during the last 10-15 minutes of the first service, and the first 10-15 minutes of the second service, resulting in all attending having a chance to interact.

The GP began by explaining how vaccines in general work and then the Romanian doctor asked people for their questions. Cultural differences meant that conversation sounded very aggressive and intense at times – so having a Romanian Paediatrician who understands the emotive way of discussing a topic was incredibly useful to monitor the dialogue. This resulted in factual information being shared clearly in an atmosphere of mutual respect. The two meetings were attended in person by a total of around 110 members of the Roma community.

The Q&A sessions were broadcast on Facebook Live by the church for those who could not attend, and an edited version of recordings from mobile phones was later posted on YouTube by SCC with the permission of all involved and was viewed at least 80 times. The editing by the Council wasn't to avoid content, but to cut down the length, to merge recordings, and to remove some of the questions where they weren't loud enough to hear. The clip was untranslated as some was in Romanian and some in English, and it was felt that the audience were able to understand the content directly in the way it had been recorded which was predominately in Romanian, although a few parts were in Romanes.

The leader and the community appreciated the session, and the relationship was developed further. The fact that the Officer was an outsider of the group created a bit of distance and enabled the relationship to build on trust, so much so that the leader continued to use the Officer as a safe route to find out answers to questions throughout the pandemic.

Outcomes:

- This event provided accurate information about the COVID-19 vaccines to members of the Roma community who were then able to share it within their community.
- By using the format of a Question-and-Answer session an atmosphere of respect and openness was created.
- The Community Engagement Team's support of the Church to put in place measures which allowed them safely to continue in-person worship services during lockdown.
- Continued relationship of trust between the Church and the Community Engagement Team, so that the Church felt they were able to ask questions after this event to clarify rules and restrictions.
- When home testing became available, the Community Engagement Team was able to supply tests to the Church and explain their use, enabling them to encourage Church members to test before attending Sunday services.

Glossary

A&E – Accident and emergency
AITHS- All Ireland Traveller Health Study
ASD – Autistic Spectrum Disorder
CCG – Clinical Commissioning Group
CEN- Complex emotional needs
EHCP – Educational Health & Care Plan
EHE - Electively Home Educated
EHRC- Equality and Human Rights Commission (EHRC)
FFT – Friends Families and Travellers
GRT - Gypsy, Roma, and Traveller
HI – Hearing Impairment
HRQoL – Health-Related Quality of Life
MLD – Moderate Learning Disability
MSI – Multi-Sensory Impairment
NA – Not Applicable
NELFT – North East London Foundation Trust
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
NSA – No Specialist Assessment
ONS – Office for National Statistics
OTH – Other Difficulty/Disability
PD – Physical Disability
PMLD – Profound Or Multiple Learning Disabilities
SEMH – Social Emotional And Mental Health
SEN – Special Educational Needs
SES – Socio-Economic Status
SIC- Standard Industrial Classification
SLCN – Speech Language Or Communication Needs
SLD - Severe Learning Difficulties
SPLD – Special Learning Difficulties
SS - Settled Sites
STTS – Short Term Transit Sites
UE – Unauthorised Encampments
UKHSA – UK Health Security Agency
VI – Visual Impairment

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