



**All Ireland
Traveller Health Study
Our Geels**

Health Service Provider Study



All Ireland Traveller Health Study

Health Service Provider Study Part B of Technical Report 1

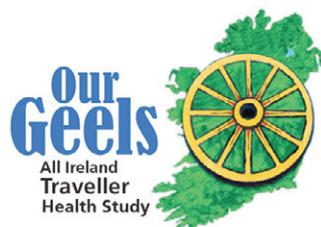
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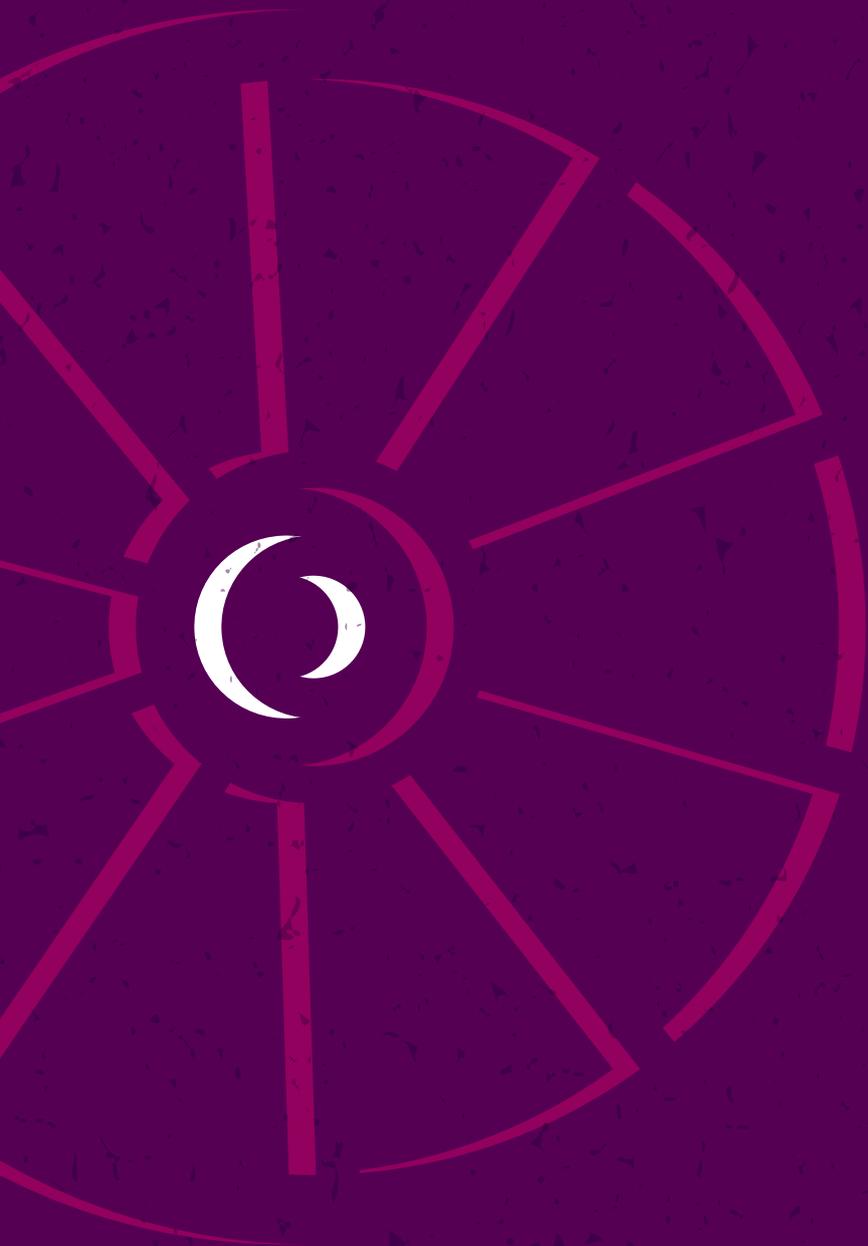
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INTRODUCTION: INTERNATIONAL EXPERIENCE OF INDIGENOUS MINORITY HEALTH



Measures to overcome barriers to Health Promotion and Health Care for Minority Populations

There is a strong international literature on the health needs of minority groups ranging for example from the Inuits of Canada (Young, 2003; Health Council of Canada, 2005) the Aboriginals and Maoris of Australia and New Zealand (Carson *et al.*, 2007; Davis *et al.*, 2006; Anderson *et al.*, 2006; Pincock, 2008) Blacks, Hispanics and Native Americans in the United States (Rhoades, 2003; Roubideaux, 2005; Kaufman *et al.* 1998) and South America, immigrant Asian and West Indian populations in the United Kingdom (Davey-Smith *et al.*, 2000; Smaje and Le Grand, 1997), and Roma and Gypsy populations in Europe (Parry *et al.*, 2007; Cemlyn, 2009; Vokó *et al.*, 2009; Hajioff and McKee, 2000). Indeed the Irish in Britain and the US have been documented extensively also (Clucas, 2009; Kelleher *et al.*, 2006; Scally, 2004; Garrett, 2002; Abbotts *et al.*, 1997). This literature concerns itself with several aspects of catering equitably for distinctive groups and individuals across society. At the level of provision of services, barriers may be encountered such as language and norms of behaviour. Health care providers may fail to appreciate nuances of understanding that lead to an inadequate treatment experience. Access may be impeded by resources, eligibility and means of payment. Cultural aspects such as family and social support and the differing needs of men and women are all considerations. Practicalities in infrastructural delivery, including mobile populations and distance from care, are all important. Krieger (2003) emphasises the need to distinguish factors associated with race and culture from those of economic disadvantage, to ensure an adequate understanding of policy and practice. Services must find a fine line between ensuring all are treated equitably and fairly on the one hand and imposing on the other hand a 'one size fits all' model that consciously or unconsciously has the effect of hindering participation or adequate care for a vulnerable individual (National Economic and Social Forum, 1996; Quirke, 2001). This literature clearly has resonances for the assessment of health services from Travellers' perspective, using increasingly well recognised quality assessment procedures of norms of care such as those of the Picker Institute in the United Kingdom, employed in 2007 in the first general consumer satisfaction survey undertaken by the Republic of Ireland's HSE (Boilson *et al.*, 2007).

There is international evidence of disparities in indigenous health:

'Indigenous peoples have low standards of health. Their poor health is associated with poverty, overcrowding, poor living conditions, social exclusion, discrimination and this is compounded by reduced access to health care and prevention. Some indigenous groups as they move from traditional to transitional and modern lifestyle to transitional and modern lifestyles,, are rapidly acquiring lifestyle diseases, such as obesity, cardiovascular disease and type 2 diabetes, and physical, social, and mental disorders linked to misuse of alcohol and of other drugs. Indigenous people should be encouraged, trained and enabled to become increasingly involved in overcoming these challenges' (Gracey and King, 2009)

Indigenous minorities across the world tend to be much poorer than the majority populations, they experience higher rates mortality for all causes of deaths and higher rates of chronic disease, such as hypertension, obesity, heart disease and suicide. These disparities continue to increase and this suggests that the level of response and societal intervention has not been effective in addressing these inequalities. The Inverse Care Law (those who are most in need of medical care are least likely to receive it - see Tudor Hart, 1971) also applies as they have less access to services. In a systematic review by

Marrone (2007), of 37 studies on current status of healthcare access and utilisation among indigenous people in North America, Australia and New Zealand, she found a low utilisation of quality health care services, as many of the indigenous communities were isolated in remote rural areas and had limited access to primary, secondary or specialised health care. She noted that Native populations in North America have a significantly higher prevalence of type 2 diabetes than white majority populations. Even when other factors such as socio-economic status; health insurance and chronic conditions are controlled for the racial and ethnic disparities are still apparent (Marrone, 2007; Davey Smith, 2000).

According to the Indian Health Services report (Indian Health Service, 2006), the American Indian and Alaskan native people have long experienced lower health status and higher mortality than the general US population, native children and youths are more than twice as likely to die in the first 4 years of life as is the general population, infants die at a rate of 8.9 per 1,000 live births, compared with 7.2 per 1,000 for the US all-races population. They also have lower life expectancy that is almost 6 years less than that of the US all-races population (Indian Health Service, 2006). Their age-adjusted death rates are greater than for the general US population for: Alcoholism - 740% higher; Tuberculosis - 500% higher; Diabetes - 390% higher; Injuries - 340% higher; Suicide - 190% higher. The leading cause of death for American Indian and Alaska Native men is coronary heart disease, followed by accidents, chronic liver disease, suicide, diabetes mellitus, cerebrovascular disease, and pneumonia/influenza (Rhoades, 2003). American Indian and Alaska Native men are also less likely to seek medical help and more likely to pursue risk-taking behaviours such as binge drinking and failure to use seat belts. Their prevalence of type-2 diabetes among children is higher than that of any other ethnic group. Evidence suggests that these disparities exist due to inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences. These are broad quality-of-life issues rooted in economic adversity and poor social conditions.

A 1993 study of mortality and social class in New Zealand examined the changes in mortality rates for Maori and non-Maori men over a 10-year period. Between 1975-7 and 1985-7 the researchers found a 54% decline in Maori mortality and a 23% decline in non-Maori mortality, however the Maori mortality rate was still 2.8 times the non-Maori rate. Differences in social class explained a significant proportion of this difference, but a substantial portion remained attributable to ethnicity alone (Pearce *et al.*, 1993). Earlier studies which examined differences in mortality rates between Maori and non-Maori males also found that while much of the difference was attributable to social class, a substantial proportion could only be explained by ethnicity (Pearce *et al.*, 1983; 1984).

Health Status of Indigenous Peoples

'On current rates, one-third of young indigenous men aged 15 will be dead before age 60, compared with 8% in the Australian population. This four-fold increase in risk of death, is largely due to excess mortality from such causes as ischaemic heart disease, suicide, and Type 2 diabetes. Its reduction must be a priority for indigenous health services' (Pearce et al., 1993).

The burden of disease and injury in Aboriginal and Torres Strait Islanders, cardiovascular disease and mental disorders were the major disease categories in the indigenous Australian population in 2003, accounting for 32% of the disease burden. Chronic respiratory disease, diabetes, and cancers were the next three leading causes, each accounting for 8% of the total indigenous Australian disease burden. The disease burden caused by cancer in the indigenous population (8%) is much lower than the burden it causes in the total Australian population (19%) because indigenous people are dying earlier, from other causes.

The life-expectancy gap between indigenous Australians and non-indigenous Australians is 17 years. It is a gap that compares especially poorly with similar societies, such as New Zealand, where the gap between indigenous and non-indigenous life expectancies is 7 years (Australian Indigenous Health Infonet 2009)

Because more is now known about the causes of ill-health in indigenous communities, something can be done about the effects.

'In terms of the health gap, 50% of it is due to the fact that when indigenous people get sick they die much more quickly. The other 50% is due to risk factors. We need to provide access to quality care, focus prevention around tobacco control and diet, and invest in a health workforce.' (Vos et al., 2007).

A review of the access of Pacific people¹ to health services in New Zealand (Young, 1997) acknowledges the limited information available and draws together what research has shown about Pacific people's health service usage. The paper highlights the barriers of acceptability of health services to Pacific people in addition to geographical and financial barriers to access (Young, 1997).

According to Marrone (2007), following a review of 138 population based studies on ethnicity, culture and race, longitudinal studies suggest that self-reported racism precedes negative health outcomes. The strongest associations were observed for mental health outcomes (psychological stress and depression) and health-related behaviours (substance abuse, alcohol abuse and smoking). Rates of substance and alcohol abuse are substantially higher among indigenous groups, which have also been shown to be related to increased rates of suicide. A review of suicide rates among indigenous

¹ This minority population were originally from the Polynesian Islands and migrated to New Zealand (NZ) for work, they are now living in NZ for three generations and are NZ citizens, but feel they get treated differently because of their ethnic origins, they are commonly referred to as Pacific people or Pacificians and data is now disaggregated to identify their health experience in New Zealand.

populations in Canada, the U.S., New Zealand and Australia found that suicide rates among indigenous young adult men were the highest out of all age groups and were 2 to 5 times higher than the general population (Marrone, 2007). Moreover, studies have shown that among American Indians and Alaska Natives perceptions of racial discrimination and marginalisation are related to substance use and depressive symptoms.

The study on the Health Status of Gypsies and Travellers in England (Parry *et al.*, 2004) found that *'There is now little doubt that health inequality between the observed Gypsy Traveller population in England and their non-Gypsy counterparts is striking, even when compared with other socially deprived or excluded groups and with other ethnic minorities.'*

Parry found that the impact of smoking, education and access to GP service is important. She noted that educational disadvantage of Gypsy Travellers was the single most marked difference between Gypsy Travellers and other ethnic minority and social excluded populations. The findings suggested that the roles played by environmental hardship, social exclusion and cultural attitudes which emerge from the qualitative study are consistent with the finding there is a health impact of being a Gypsy Traveller over and above other sociodemographic variables (Parry *et al.*, 2004).

The findings of this study demonstrate that the health needs of Gypsy Travellers are not being met through current services and strategies in the UK. Models of good practice would suggest the need to work in partnership with Gypsy Traveller communities in the planning and delivery of healthcare, employ dedicated or specialist health workers, include Gypsy Travellers in the NHS ethnic monitoring system, and provide training to health providers to ensure cultural competence (Parry *et al.*, 2004).

The study suggested that any policy or initiative developed for Gypsy Travellers should include a commitment to a community development approach to improve the capacity of Gypsy Travellers to participate equally in their healthcare. It also suggested more dialogue between users and providers might address some of the barriers, and that the use of patient-held records would also improve the continuity of care. Health service should be culturally appropriate and take cognisance of Gypsy Traveller educational disadvantage and poor levels of literacy, for example in the form of audiotapes or DVDs to communicate health education messages. This study also suggested that the model of good practice developed in Traveller Primary Health Care projects in Ireland would be a good model to emulate (Parry *et al.*, 2004).

Barriers to Access

Evidence suggests that there is an under-utilisation of health services by ethnic minorities (Blofeld, 2003; Aspinall and Jacobson, 2004; Equalities Review, 2007). There is a concern that some Service Providers justify this under use by making assumptions about the level of reliance of people from minority ethnic groups on family support and informal caring, the level of knowledge and understanding of services and sometimes the evidence is ignored about potential service users: which describes prejudice, discrimination, distrust and a lack of appropriate services (Grewal and Lloyd, 2002; McLean *et al.*, 2003).

A study undertaken by the Commission for Health Improvement in the UK found ethnic differences in service users rating of their care in terms of: access and coordination of services; the environment in which services were provided; the provision of information; their involvement in healthcare decisions; the level of choice regarding care pathways; consideration of their physical and emotional needs and being treated with respect (Raleigh *et al.*, 2004).

Lack of Data

Anecdotal evidence and qualitative data point to continuing poor experiences and access to healthcare, quantitative evidence has been hampered by a failure of National Health Service institutions to collect ethnicity data on patients, at both hospital and primary care level (King's Fund, 2006 a,b). A great deal of activity has clearly been aimed at improving access to health services for Black, Minority and Ethnic (BME) groups; however, evaluating the outcome of projects has been difficult due to the absence of this data. Up to a third of hospital data is still not coded, according to the London Health Observatory, and few GP surgeries routinely collect information about their patients (Aspinall and Jacobson 2004). According to Sproston,

'Organisations need to gather information about and from minority ethnic communities as well as trying to provide information to them. Effective methods for identifying the needs of people from these communities and monitoring how well these are met are needed; collecting information about the make-up of populations served by means of published data and effective monitoring can highlight which groups an organisation may be neglecting and which may be over-represented' (Sproston and Mindell, 2006).

Barriers to Healthcare

In a review paper on the potential barriers to the use of health services among ethnic minorities (Scheppers, 2006) the authors concluded that potential barriers occurred at the patient level, provider level and system level:

- The barriers at patient level were related to the patient characteristics: demographic variables, social structure variables, health beliefs and attitudes, personal enabling resources, community enabling resources, perceived illness and personal health practices.
- The barriers at provider level were related to the provider characteristics: skills and attitudes.
- The barriers at system level were related to the system characteristics: the organisation of the healthcare system.

They noted that

'ethnic minority patients seem to be confronted with barriers when using health services. Yet, care providers are often oblivious to these barriers, although they may share to some extent the burden of responsibility for them. In order to enlighten care providers, as to the potential pitfalls that may exist, there is a need to explore the different factors in the creation of the barrier' (Scheppers, 2006).

According to Szczepura (2005) in most healthcare systems it is acknowledged that black and minority ethnic (BME) populations have until now experienced poorer health and barriers to accessing certain services. The author undertook a number of reviews examining the evidence on population diversity and variations in service uptake, health outcomes, effective patient communication, and involvement in decision-making, and noted that

'at the same time it is recognised that 'disparities often present as inequalities in quality', in other words even if certain groups use a service they may still experience inferior quality care and, therefore, poorer access.'

In a systematic review by Atikson on access to and uptake of National Health Services (NHS) by ethnic minorities (Szczepura, 2005; citing Atikson *et al.*, 2001), 3 dimensions of equitable access were identified: to culturally appropriate information; to services that are relevant, timely, and sensitive to the person's needs; to use the health service with ease, and having confidence that you will be treated with respect.

Szczepura concluded that equal access is clearly linked to equal care. She found evidence in her review which suggests that access-related factors may be the most significant barriers to equitable care. Szczepura defines 'equitable care' as care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location and socio-economic status. Thus monitoring of services that limits the measure to utilisation of care is inadequate if it does not consider the process, participation and outcome from that service. Healthcare systems have to be 'equality proofed' to ensure that they can ensure that marginalised populations have equality of access, participation and outcome to health care.

Quality of Services

The Lancet published two studies in 2006, which explored the outcomes of minority groups engaging with the health service. The first is a cross-sectional assessment on the quality of hospital care experienced by Maori patients in New Zealand. The findings suggested that there was a significant difference in the care the Maori patients received when compared with the majority population in New Zealand, and this disparity persisted after controlling for age, other socio-demographic factors and case mix (Davis *et al.*, 2006).

The second was a matched cohort study on cancer diagnosis, treatment, and survival in indigenous and non-indigenous Australians. It found that non-indigenous cancer patients survive longer than indigenous ones, even after adjustment for stage at diagnosis, cancer treatment, and greater comorbidity in indigenous cases Valery *et al.* (2006). It concluded that better understanding of cultural differences in attitudes to cancer and its treatment could translate into meaningful public-health and clinical interventions to improve cancer survival in indigenous Australians.

The reviews pointed to the need for increased surveillance, policy research, capacity building and community engagement and partnership in dealing with indigenous health issues (see Anderson *et al.*, 2006; Davis *et al.*, 2006; Smylie *et al.*, 2006; Stephens *et al.*, 2006).

Cultural Competence and Quality of Services

Quality is clearly linked to equality of access, participation and outcomes care, as it is accepted that 'access-related factors may be the most significant barriers to equitable care' (Szczepura, 2005). Equitable access has been defined as 'care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographical location and socio-economic... Thus, definitions of "access" that are limited to service uptake or "receipt of care" are clearly inadequate unless they also consider the process of accessing care, and the quality of care received by ethnic minority groups' (Szczepura, 2005).

Although language barriers may be important, it is also well reported that various dimensions of culture can influence successful healthcare delivery to ethnic minority populations. Cultural differences are also likely to be more persistent than language needs in immigrant groups. Cultural dimensions might include: patients' health; healing, and wellness belief systems; how illness, disease, and their causes are perceived; and the behaviour of patients/consumers seeking health care, and their attitudes toward healthcare providers.

Communication and Health Information

The evidence shows that poor levels of communication have a negative effect on access to services and on relationships between service users and professionals. Problems with communication include language barriers and poor engagement with networks used by minority ethnic groups. People from minority ethnic communities are often unaware that services are available because they have never seen or heard information about them (Katbamna *et al.*, 2000). Using a single approach to reach minority ethnic groups does not work for the same reasons it would not work in the general population. Making English language materials easy to read and including pictures can also improve access for many people from minority ethnic communities, as well as people with limited literacy and people with learning disabilities (Aspinall and Jackson, 2004; Mir *et al.*, 2001; Robinson, 2002). Posters, leaflets and outreach activity that advertise this support need to be made widely available through networks used by minority ethnic communities, for example, via community centres, places of worship and local shops, or services used by members of these communities (Aspinall and Jackson, 2004).

However, if a person is not literate in his or her own language, access to a professional who can give verbal advice in an appropriate language is needed (Betancourt *et al.*, 2002). Access to this person should be as easy as possible and should not rely only on professional referral (Mir and Din, 2003).

In ethnographic research by King and Wilson (1998) with Aboriginal health professionals and Aboriginal clients with diabetes, they found both the health professionals and the clients had limited access to relevant and useful information about the effect of diabetes on Aboriginal clients, families and communities. In order to support the stated priority given to Aboriginal health care, it was recommended that tertiary nursing courses must include content on how to deliver services in a way that is acceptable to Aboriginal people. The researchers also found that Aboriginal people do not receive culturally acceptable health care from non-indigenous providers, and concluded that until Aboriginal people are employed as part of the health team limited progress will be made in improving

the health of Aboriginal people with diabetes (King and Wilson 1998). In recent years public policy has moved to address these disparities more generally to reduce health inequalities. We discuss some exemplars further below.

Strategies to Address Barriers

Community Health Workers/Link Workers

Following a review of the role of link-workers in primary care, Gillam and Levenson (1999) found that Community Health Workers (CHWs) can make a valuable contribution to community development and, more specifically, can improve access to and coverage of communities with basic health services. There is robust evidence that CHWs can undertake actions that lead to improved health outcomes, especially, but not exclusively, in the field of child health. Link Workers can also help in interactions with the primary healthcare team, local authority, and benefits agencies. They bridge the gap between Service Providers and patients, which may sometimes require challenging the more purely biomedical model of health that concentrates on the biological process and disease end point, rather than the wider social and economic causal factors determining that disease or illness. Many Link Workers have been assertive in challenging individual and institutional racism in the UK National Health Service (NHS). The literature suggests that Link Workers can make a valuable contribution in many services, such as new patient health checks, women's health, and mental health. TCHWs are effective in increasing access to health services, increasing knowledge and promoting behaviour change. The value of a clearly defined role for TCHWs was also explored and validated by Lehmann and Sanders (2007), see also Technical Report 1 for a fuller review of Irish models of practice.

Pillinger (2003) for instance identified the following best practices in terms of quality of service:

- Participative approaches where quality is linked to choice and autonomy of users.
- User empowerment and involvement in planning.
- Improvements that include meaningful and practical methods of assessment implemented with the participation of both users and front-line staff.
- Quality objectives that are relevant and adaptable to local settings.
- Quality standards developed in partnership with staff, management and users.

Social Inclusion

A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity. Social exclusion is the process of being shut out from the social, economic, political and cultural systems which contribute to the integration of a person into the community (Cappo, 2002).

Social inclusion describes the structures and dynamic processes of inequality among groups in society. Social exclusion refers to the inability of certain groups or individuals to participate fully in daily life due to structural inequalities in access to social, economic, political and cultural resources. These inequalities

arise out of oppression related to race, class, gender, disability, sexual orientation, immigrant status and religion. Indeed, it has been argued that 'being excluded from social groups ranks among the most aversive of human experiences' (Labonte 2004).

Empowerment and Engagement

Wallerstein, in his report on the effectiveness of empowerment strategies to improve health and reduce health disparities, showed that empowering initiatives can lead to health outcomes and that empowerment is a viable and effective public health strategy.

'Empowerment is recognised both as an outcome by itself, and as an intermediate step to long term health status and disparity outcomes' (Wallerstein and Duran, 2006).

Meaningful, ongoing, respectful engagement recognises the importance of technically effective services but also takes into account the values, experiences and priorities of minorities. 'Engagement' can be explained by contrasting it with 'consultation'.

Consultation occurs when Government or a health authority says: 'Here is the problem, here is the solution. Do you have any comments?' Engagement occurs when Government or a health authority lays out the problem and invites people to participate in understanding the problem, possibly redefining the problem, and coming up with the solutions to the problem.

More and more research supports the engagement process as critical for making community-based legitimate and sustainable decisions. Giving Indigenous people and ethnic minorities a meaningful voice will lead to better health policy decisions and those decisions will be more sustainable (Wallerstein and Duran, 2006).

Handheld Records

In Scotland, the National Resource Centre for Ethnic Minority Health (NRCEMH), in consultation with Gypsy/Travellers have developed a Patient Record of Personal Health which is a handheld record to be carried by the individual. It is hoped that this will greatly improve the continuity of care for Gypsy/Travellers and that, in turn, this will have a significant impact on the inequalities of health experienced by Gypsy/Travellers.

The hand-held record system will only be successful if Gypsy/Travellers make use of it and if it is readily accepted by the NHS. Training is being offered on the use of handheld records to NHS staff and other NHS partners.

Additional Training for Health Professionals

Another strategy to improve the responsiveness of existing health services to underserved groups is to provide additional training to mainstream health workers. US research (Pediatrics) used a controlled study to evaluate a programme of additional training given to paediatric clinic staff serving low income communities in New York (Evans *et al.*, 1997). The training was given to staff in the prevention,

screening, diagnosis and treatment of asthma, with particular emphasis on ways to enhance family management of asthma. In each of 2 years follow-up the intervention clinics showed greater improvement on all measures of access, continuity and quality of care (Evans *et al.*, 1997). Primary health care services are in principle more easily accessible to minority groups in local areas; such strategies include making available healthcare professionals of the same ethnicity as the client group, recruiting ethnic or bilingual lay health workers, and providing additional training for existing health workers.

Aboriginal workers and community members naturally tend to act as enablers, facilitators, and advocates for their communities (these are the 3 key roles of a health promotion worker identified in the Ottawa Charter² WHO, 1997). Building community competency should be a key component of health promotion work.

There is some early evidence of health gains, such as reduced rates of child mortality and communicable disease in certain communities for specific subpopulations. These community studies are beginning to show that gains occur where there is collaboration between Aboriginal and Torres Strait Islander communities and Governments and comprehensive services supported by adequate and sustained funding.

Models of Good Practice at Policy Level

Aboriginal Health Services Plan 2007-2010, 3 July 2007

'Aboriginal health is holistic. It encompasses health determinants, is supported and fostered by Indigenous knowledge and know-how, and is community-based and driven. It includes health/mental health and addiction needs that call for accessible programs and services for all ages and stages of life'

Lisa Tabobondung, Executive Director: Aboriginal Health.

National Strategic Framework for Aboriginal and Torres Strait Islander Health

The National Aboriginal Health Strategy (NAHS), released in 1989 was built on extensive community consultation to produce a landmark document that set the agenda for Aboriginal health and Torres Strait Islander health. It is being cited here for good practice because it uses a holistic approach incorporating health determinants and indigenous knowledge. The NAHS is extensively used by health services and service providers and continues to guide policy makers and planners – it has been acknowledged as a model of good practice in international literature. The National Strategic Framework is a complementary document that builds on the 1989 NAHS and addresses approaches to primary health care and population health within contemporary policy environments and planning structures.

² The Ottawa charter originated from the World Health Assembly in 1977. It highlighted the role of health promotion in addressing health inequalities.

All Ireland Traveller Health Study

This National Strategic Framework is based on a commitment to the following principles:

- Cultural respect: ensuring that the cultural diversity, rights, views, values and expectations of Aboriginal and Torres Strait Islander peoples are respected in the delivery of culturally appropriate health services.
- A holistic approach: recognising that the improvement of Aboriginal and Torres Strait Islander health status must include attention to physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance.
- Health sector responsibility: improving the health of Aboriginal and Torres Strait Islander individuals and communities is a core responsibility and a high priority for the whole of the health sector. Making all services responsive to the needs of Aboriginal and Torres Strait Islander peoples will provide greater choice in the services they are able to use.
- Community control of primary health care services: supporting the Aboriginal community controlled health sector in recognition of its demonstrated effectiveness in providing appropriate and accessible health services to a range of Aboriginal communities and its role as a major provider within the comprehensive primary health care context.
- Supporting community decision-making, participation and control as a fundamental component of the health system that ensures health services for Aboriginal and Torres Strait Islander peoples are provided in a holistic and culturally sensitive way.
- Working together: combining the efforts of Government, non-Government and private organisations within and outside the health sector, and in partnership with the Aboriginal and Torres Strait Islander health sector, provides the best opportunity to improve the broader determinants of health.
- Localised decision making: health authorities devolving decision making capacity to local Aboriginal and Torres Strait Islander communities to define their health needs and priorities and arrange for them to be met in a culturally appropriate way in collaboration with Aboriginal and Torres Strait Islander health and health-related services and mainstream health services.
- Promoting good health: recognising that health promotion and illness prevention is a fundamental component of comprehensive primary health care and must be a core activity for specific and mainstream health services.
- Building the capacity of health services and communities: strengthening health services and building community expertise to respond to health needs and take shared responsibility for health outcomes. This includes effectively equipping staff with appropriate cultural knowledge and clinical expertise, building physical, human and intellectual infrastructure, fostering leadership, governance and financial management.
- Accountability: including accountability for services provided and for effective use of funds by both community-controlled and mainstream health services. Governments are accountable for effective resource application through long-term funding and meaningful planning and service development in genuine partnership with communities. Ultimately, Government is responsible for ensuring that all Australians have access to appropriate and effective health care.

This document draws together nationally agreed strategies to address specific health problems, state and territory policies and plans and the national collaborative policy and planning frameworks within which Aboriginal and Torres Strait Islander health programs are managed today.

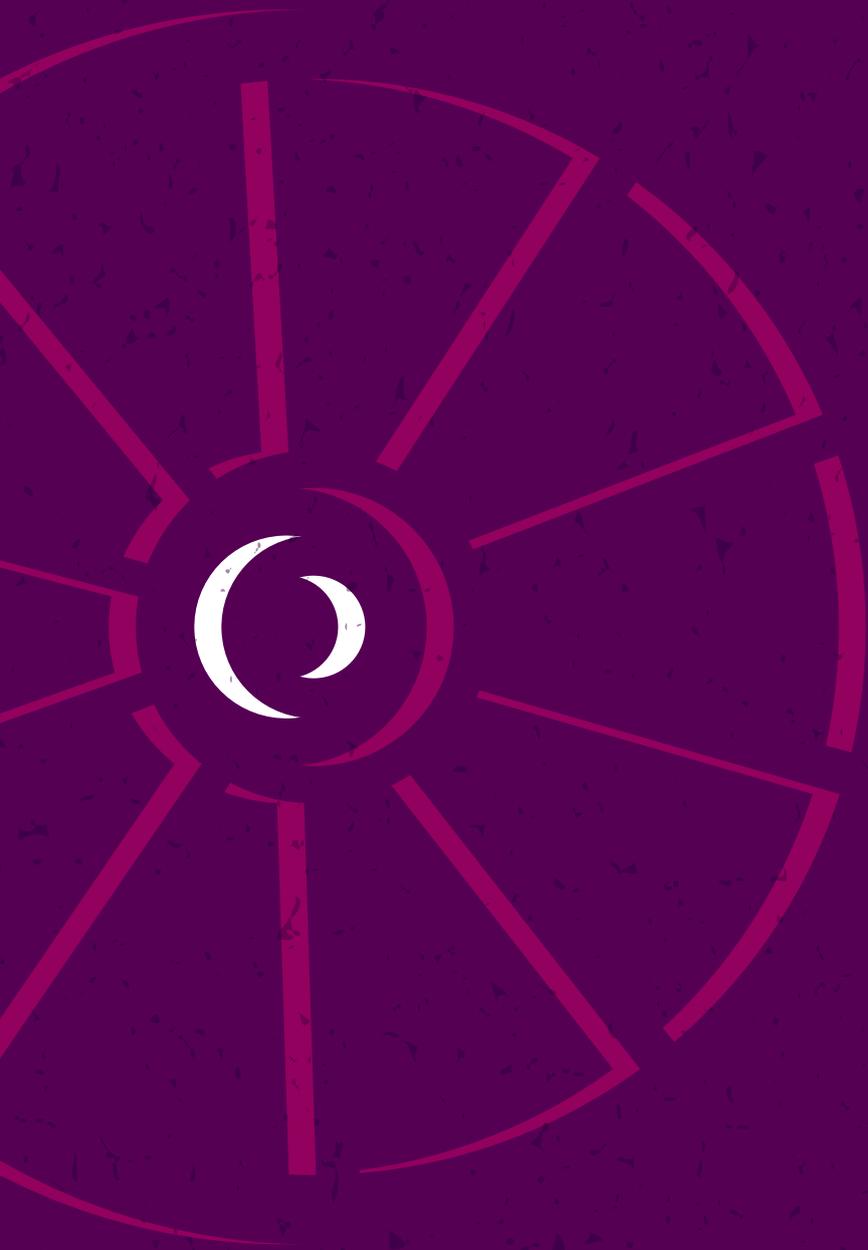
Learning from the Literature Review

We learn from this examination of the International literature that indigenous populations and ethnic minorities continue to experience extreme disparities in their health status. The evidence emerging from review of the literature that is relevant to Traveller health is that there are key elements that should be engaged in by services providers and policy makers if they want to address the continuing health inequalities experienced by minority groups. We summarise these key elements below as the need for:

- increasing prioritisation of the needs of the minority populations
- commitment from all stakeholders to reduce the gap in health inequalities that exist
- ethnic and cultural identifiers in all data sets, to disaggregate data for monitoring and evaluation
- development and implementation of equality proofing systems which monitor health access, participation and outcome for minority populations
- a social determinants approach to address the health status of minority communities (see details and reference to the social determinants in Technical Report 1)
- intersectoral working with key agencies and stakeholders
- projects to support the capacity building, engagement and empowerment of local communities
- partnership working with minority communities and Non government Organisations (NGOs) in the planning, monitoring and evaluation of services
- the training and employment of indigenous health workers from local community
- targeted services to be complementary to and not a replacement for mainstream services
- a culturally competent and quality health service
- the development of culturally appropriate education materials
- training of service providers on minority cultures
- national, regional and local policies and strategies to be developed following consultation and engagement with local communities and NGOs

These findings resonate with the discussion in Technical Report 1, to which we refer the reader for further information.

**METHODOLOGY:
HEALTH SERVICE PROVIDER
QUANTITATIVE STUDY**



This chapter reports on the Health Service Provider sub-study of the 'Our Geels': All Ireland Travellers Health Study. The aim of this study was to explore the issues that arise for Health Service Providers in providing for the Traveller community, to explore how this impacts on Traveller health and to make recommendations for improvements in same.

Setting/Sampling

This sub-study sought to undertake up to 500 Health Service Provider interviews by Computer-Assisted Telephone Interview (CATI) in ROI and NI. The methodology was purposeful and quota-based. Potential respondents were identified and recruited as follows to ensure that an acceptable quota of respondents by both professional groupings and regions was achieved.

Identification of Potential Respondents

Based on the scoping exercise conducted prior to the Traveller census when potential participants/families for the census were identified we estimated that 32% of Traveller families in the ROI were in the HSE West region, 28% were in the HSE South area and 40% were in the HSE Dublin North East and Dublin Mid-Leinster areas combined (16% in DNE and 24% in DML). In order to achieve a broad geographical spread the recruitment of potential respondents in the Republic was proportionate to this. In addition, on a more micro level where possible, the number of letters sent to Health Service Providers in each Local Health Office (LHO) region was also proportionate to the number of families identified in that area prior to the census.

The sample was purposeful and included the health professionals ranked as the top 10 accessed by Travellers in the recently completed health utilisation study. In consultation with the HSE Liaison and Implementation Group this list was further refined to include mental health services which, depending on regional variation, were either Psychiatric Hospital or Outreach Psychiatric Services. Table 3B. 1 below illustrates the maximum number of Health Service Staff required to be recruited in ROI as outlined at the outset of the study stratified by professional grouping.

The HSE provided the UCD team with a list of potential respondents broken down by both LHO area and professional groupings which was later amended and supplemented in consultation with members of the HSE Liaison Group in order to achieve a balance of respondents from each of the professional groupings across the 4 HSE Areas.

In NI the recruitment of potential respondents was also based on achieving a broad geographical distribution. In order to achieve this, and given the smaller sample size, the interviews to be completed in NI were divided among the 5 Social and Health Care Trusts. A Principal Investigator in each Trust provided a list of potential respondents supported by the Stakeholder Group in NI.

Table 3B. 1: Sample breakdown for the Republic of Ireland

	TOTAL	HSE West (32%)	HSE South (28%)	HSE Dublin North East (16%)	HSE Dublin Mid Leinster (24%)
GP staff	130	42	36	21	31
Hospital staff	100	32	28	16	24
Mental Health Services	25	8	7	4	6
PHNs	50	16	14	8	12
CWOs	25	8	7	4	6
Social workers	25	8	7	4	6
Dental services	20	6	6	3	5
Management/ policy	25	8	7	4	6
Total ROI	400	128	112	64	96

Again the sample was purposeful and included the health professionals ranked as the top 10 accessed by Travellers in our recently completed health utilisation study. The sample stratified by service for NI can be seen below in Table 3B. 2. It differed slightly from the sample in the ROI due to regional variation. That is, as the role of Community Welfare Officer is specific to the ROI and due to the small sample size in each of the groupings by Trust a category named ‘other community services’ supplemented the Community Welfare Officer and Social Workers categories. In addition, the Public Health Nursing grouping was replaced by the Northern equivalent grouping of Health Visitors.

Table 3B. 2: Sample breakdown for Northern Ireland

	Belfast Trust	Southern Trust	S.E. Trust	Western Trust	Northern Trust	TOTAL
GP Staff	6	6	6	6	6	30
Hospital Staff	5	5	5	5	5	25
Mental Health Services	1	1	1	1	1	5
Health Visitors	3	3	3	3	3	15
Other Community Services	3	3	3	3	3	15
Dental Services	1	1	1	1	1	5
Management/ Policy	1	1	1	1	1	5
Total	20	20	20	20	20	100

Recruitment

Service Providers who did not provide services to Travellers were automatically included in the sample as we had no a priori means of identifying those who do or do not provide services to Travellers. We were aware of this at the outset and included a small series of questions to elicit information from these providers as to why they do not provide for Travellers. Our sampling strategy was based on a quota sampling basis using a sliding scale process illustrated in Table 3B. 3 below. Our aim was to obtain a 60% minimum representation in each professional grouping.

Table 3B. 3: Sliding scale strategy employed to obtain our quota of 500 attained sample

Pre-contacted health service providers	Estimated response rates	Attained sample
650	78%	507
700 (+50)	72%	500
800 (+100)	65%	520
850 (+50)	60%	510
1000 (+150)	50%	500

For ease of interpretation: Taking row 1 the shaded row as an example, if 650 Service Providers were contacted and a response rate of 78% was reached, we would have 507 completed interviews. If however this was not attained another 50 service providers (row 2) could be contacted and a response rate of 72% would result in 500 attained interviews.

Recruitment was a 2-stage process. Named respondents in both NI and ROI were identified as discussed above and were then contacted by letter from the UCD team explaining the purpose and procedures of the study and inviting participation. Respondents were invited to return the letter indicating whether they would or would not take part as well as indicating a time when it would be convenient for them to be interviewed. All replies including reasons for refusing were documented as appropriate. Reminder letters were sent up to a maximum of 2 times. The list of providers (with names and contact details) who agreed to participate was given to our trained researchers who conducted the interviews.

If there was no response to the letters of invitation we posted hardcopy questionnaires with the final reminder letters, asking respondents to complete in hard copy if preferable. This enhanced participation as some respondents viewed this as being more convenient than the CATI call and returned the hard copy. In addition those who did not respond to any of the letters were followed up by telephone to offer a last opportunity to participate or establish a reason for non-response.

Interviewers

The interviews were undertaken by post-graduate students on the Master of Public Health and PhD programmes in UCD, many of whom were health professionals themselves. Inhouse training and induction were provided by the study team on the instrument and the methodology. All the interviewers had to achieve a standard level of competency before being allowed to conduct live interviews. Having received feedback from stakeholders the study team completed several in-house pilots for face validity. Each interviewer also completed pilot calls prior to going live with the survey. The paper questionnaires were entered into the CATI system by these interviewers.

Questionnaire

Following a literature review of previous Traveller studies and discussions with the TSG and the Principal Investigator Group, a draft questionnaire was drawn up and circulated to a number of health professionals inclusive of doctors, nurses, dentists and pharmacists. Detailed comments were obtained from them, and used to develop a revised instrument. The questionnaire was developed with the following criteria in mind:

- To cover major themes identified in previous studies.
- To cover major themes identified in the scoping exercise with Service Providers.
- To cover major themes identified in the current "Our Geels" study.
- To be suitable for a mainly closed instrument.
- To keep respondent burden low.

The final questionnaire contained the following sections -

Section A: capturing the demographics of the Service Provider.

Section B: capturing whether respondents provided services to Travellers and if not why not.

Section C: exploring access to and use of services by Travellers.

Section D: exploring perceptions in relation to the health status of Travellers.

Section E: exploring the interface between Travellers and the service.

Section F: exploring the provision of services to Travellers.

When the final questionnaire was drafted an electronic version was created using the computer software HTMLjQueryPHPMySQL .

Interviews

The data collection period commenced 22nd February, 2010 and was completed by 11th June, 2010. Calls were made between 8 a.m. and 8 p.m. Three call-stations were established in a dedicated survey room in UCD and operated on a rotational basis of morning, afternoon and evening based on the volume of respondents to be called on any given day. Calls lasted approximately 15-20 minutes. The outcomes of all calls were recorded.

Response

The number of potential respondents contacted was determined by the importance of ensuring that the response rate did not fall below a representative level. Saturation of information in light of triangulation with the other sub-studies was also a key consideration, that is, if the same information was recurring then the quota cell was deemed acceptable for that category of respondents. Ultimately 720 potential respondents were contacted as a minimum overall response rate of 50% and a minimum quota of 60% in each of the professional groupings and by region were sought.

- 54 of these individuals were considered unavailable to participate due to being on leave, retired, no longer in post or not having received correspondence in relation to the study. Of the remaining 666 respondents:
- 53.4% (356 Health Service Providers) completed the survey.
- 4.6% (31 Health Service Providers) responded that the questionnaire was not relevant to them as they did not have enough experience of working with Travellers to answer the questions. 29.9% (199 Health Service Providers) refused to take part.
- 11.1% (74 Health Service Providers) did not respond/could not be reached. The overall response rate is 356 out of 666 eligible respondents (53.4%), or 356 out of 592 successfully contacted (60.1%).

The number of achieved interviews based on the original quota sought is illustrated in Table 3B. 4 below, stratified by area and professional grouping.

Data cleaning

Most of the CATI data required little extra work post interview. The 3 open-ended questions did require significant checking and re-coding. These were questions 36, 50, and 54. In addition, 2 further variables, were added, one to distinguish self-completion vs. CATI responses, and one to identify which of the 5 Areas (the 4 HSE Administrative Areas and Northern Ireland) the respondents were from. A further set of additional 'skip' variables have been added to indicate responses which have been skipped in the questionnaire as a result of branching, i.e, where some respondents skip questions not of relevance to them.

Table 3B.4: Achieved Interviews

Professional Grouping	Northern Ireland			HSE West			HSE South			HSE DNE			HSE DML			TOTALS		
	OQ	AI	%	OQ	AI	%	OQ	AI	%	OQ	AI	%	OQ	AI	%	OQ	AI	%
GP	30	8	27	42	24	57	36	23	64	21	17	81	31	17	55	160	89	56
Dentists	5	4	80	6	8	133	6	2	33	3	3	100	5	3	60	25	20	80
Other community services	15	* 9	60	16	19	118	14	9	64	8	7	87	12	13	109	65	57	87
Public Health Nurses / Health Visitors	15	* 11	73	16	18	112	14	15	107	8	9	112	12	13	109	65	66	101
Mental Health Services	5	4	80	8	4	50	7	5	71	4	4	100	6	5	83	30	22	73
Management / Policy	5	5	100	8	5	62	7	1	14	4	6	150	6	4	67	30	21	70
Hospital Staff	25	12	48	32	28	87	28	23	82	16	10	62	24	8	33	125	81	65
TOTAL	100	52	52	128	106	83	112	78	70	64	56	87	96	63	66	500	356	71

OQ denotes the number originally proposed as the maximum in each grouping.

AI denotes the number of achieved interviews

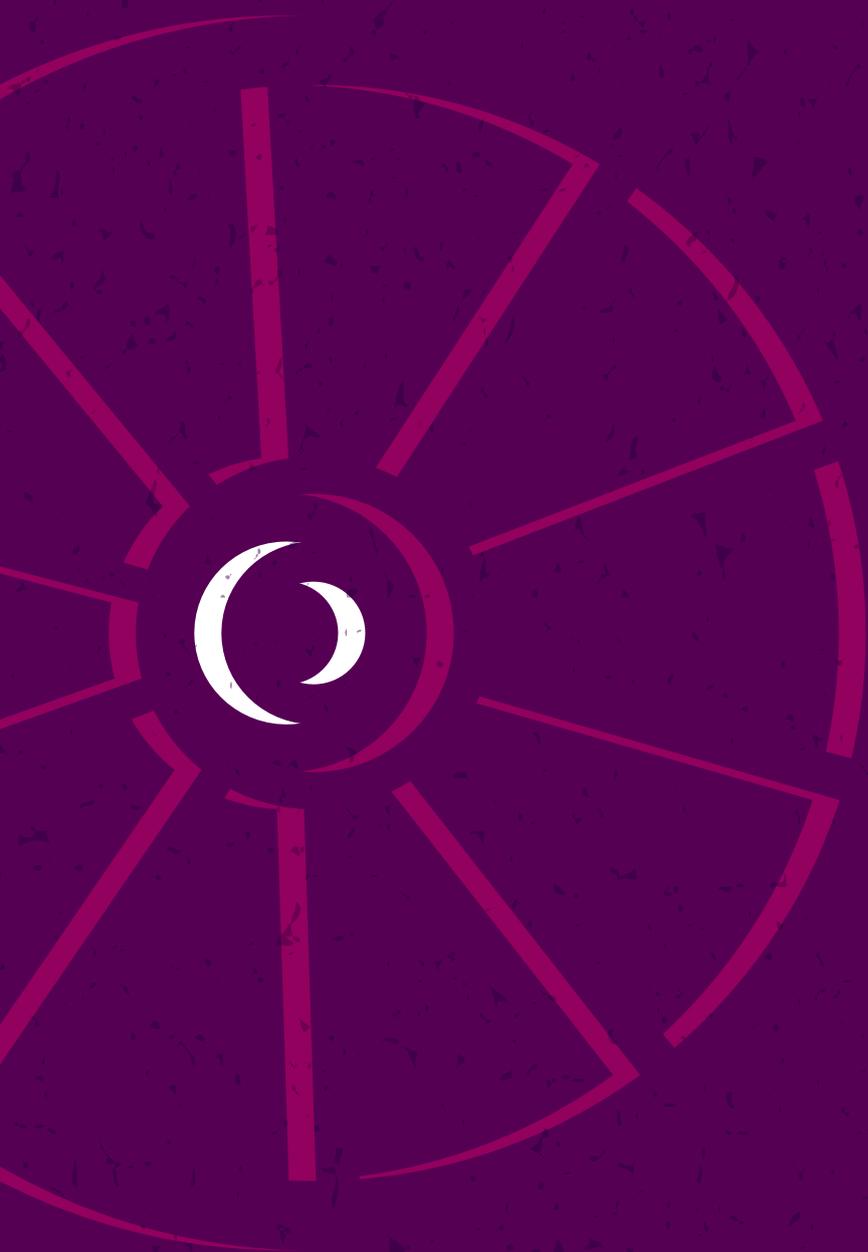
% denotes the percentage of the original quota achieved

* 5 of respondents in the community services grouping in the North were coded as Health Visitors for branching purposes.

Hospital staff interviewed included consultant doctors in key services such as A & E, Paediatrics, Obstetrics and Cardiology; nurses at various levels of responsibility and management staff.

A response of 'Refused' was recorded for 6 of the respondents in the data in relation to their professional grouping. These are included in the table above under the professional grouping given to the study team at the recruitment phase.

RESULTS



Data is presented in the results section in sequence according to question. Exact numbers are given for each response - note these may vary as totals depending on whether the question was skipped by the respondent. Short comments on some specific tables are provided to support interpretation. Sections B to F inclusive are broken down by region (NI) Northern Ireland and (ROI) the Republic of Ireland and by three categories 'GPs', 'Hospital Staff' and a third category 'Other Professional groupings'. Testing for significance was undertaken according to jurisdiction and professional category as appropriate. Analysis was undertaken using the R statistical software programme. Both a chi-squared test for association, and a Monte-Carlo based test, an analogue of a Fisher's exact test for association, in each table are reported.

Section A: Demographics

A very diverse group of professionals responded to the survey (Table 3B. 5). GPs and nurses constituted the largest groups, as per the quota methodology. They all had substantial experience (Table 3B. 6), with similar median experience of 21-25 years in each main occupational group (data not shown). The majority were female (63.8%, data not shown), in keeping with the general health services demographic in both jurisdictions.

Table 3B. 5: Respondent: Occupation

Occupation	n
GP	81
GP (NI)	7
Hospital Staff	77
Mental Health Services	22
Public Health Nursing Service	56
Health Visiting	16
Community Welfare Officer	24
Social Worker	26
Dental Services	19
Management/Policy	20
Refused	6
N/A	2

Table 3B. 6: Respondent: Working experience

Working experience (in years)	n
0-5 years	7
6-10 years	26
11-15 years	36
16-20 years	45
21-25 years	64
26-30 years	74
30+ years	102
Refused	0
N/A	2

Table 3B. 7: Respondent: Age group

Age group	n
20-30	3
30-40	61
40-50	135
50-60	129
60-65	16
65+	9
Refused	1
N/A	2

Table 3B. 9: Total size of GMS list served (for GPs in ROI)

	exc. 0s
Min	100
1st Quartile	1,000
Median	1,215
Mean	1,606
3rd Quartile	1,850
Max	11,000
N/A	281

Table 3B. 8: Respondent: Location of practice

Location	n
City	61
Suburb	59
Town	178
Village	11
Other	42
Refused	3
N/A	2

Table 3B. 10: Total size of list served (for all GPs)

	exc. 0s
Min	230
1st Quartile	2,120
Median	3,500
Mean	4,888
3rd Quartile	7,423
Max	11,400
N/A	349

Table 3B. 11: Number of beds in the main hospital serviced (for hospital staff only)

	Inc. 0s	exc. 0s
Min	0.0	25.0
1st Quartile	52.0	147.5
Median	200.0	250.0
Mean	345.6	443.5
3rd Quartile	320.0	400.0
Max	900.0	900.0
N/A	279.0	296.0

Section B: Service to Travellers

Table 3B. 12: Provision of service to Travellers

	Never	Rarely	Sometimes	Often	Very Often	Refused	n
Total (n)	9	25	87	116	109	2	348
Overall (%)	2.6	7.2	25.0	33.3	31.3	0.6	
NI (%)	6.5	13.0	19.6	50.0	10.9	0.0	46
ROI (%)	2.0	6.3	25.8	30.8	34.4	0.7	302
Pearson's Chi-squared test $\chi^2 = 18.1349$, df = 5, p-value = 0.002782			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 18.1349$, df = N/A, p-value = 0.01099				
Total (n)	9	25	84	114	108	2	342
Overall (%)	2.6	7.3	24.6	33.3	31.6	0.6	
GP (%)	2.3	8.0	10.2	28.4	50.0	1.1	88
Hospital Staff (%)	6.6	7.9	26.3	36.8	21.1	1.3	76
Other (%)	1.1	6.7	30.9	34.3	27.0	0.0	178
Pearson's Chi-squared test $\chi^2 = 33.0959$, df = 10, p-value = 0.0002625			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 33.0959$, df = N/A, p-value = 0.0004998				

Most respondents had some experience of provision of services to Travellers. Relatively few respondents reported rare contact and just 2.6% said they never provided services to Travellers.

Note the substantial difference between the NI respondents and the ROI respondents, with half of the NI respondents reporting that they were providing services 'Often' whereas the ROI respondents had a wider spectrum of experience. GPs were the provider group with most frequent contact; half of this group very often provided services.

Section C: Access to and Use of Services

In this section respondents were asked a number of questions in comparison to non-Traveller patients in similar social circumstances. Overall, respondents considered Travellers less likely than other patients to access and use their services. There were significant differences between different service user groups, in how they categorised Travellers, and these patterns were not the same across all the questions asked. In particular Travellers were felt not to engage as effectively with preventive services, except antenatal services. Travellers were also more likely to receive prescriptions. Traveller men tended to present later than is desirable.

In comparison to non-Traveller patients in similar social circumstances, are Traveller patients more or less likely to:

Table 3B. 13: Understand how to use your service?

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	19	123	153	34	13	7	2	351
Overall (%)	5.4	35.0	43.6	9.7	3.7	2.0	0.6	
NI (%)	0.0	39.6	45.8	8.3	0.0	6.3	0.0	48
ROI (%)	6.3	34.3	43.2	9.9	4.3	1.3	0.7	303
Pearson's Chi-squared test $\chi^2 = 10.9322$, df = 6, p-value = 0.0905			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 10.9322$, df = N/A, p-value = 0.08796					
Total (n)	19	119	152	33	13	5	2	343
Overall (%)	5.5	34.7	44.3	9.6	3.8	1.4	0.6	
GP (%)	4.6	29.9	51.7	8.1	5.8	0.0	0.0	87
Hospital Staff (%)	4.0	35.5	43.4	9.2	1.3	4.0	2.6	76
Other (%)	6.7	36.7	41.1	10.6	3.9	1.1	0.0	180

Overall, most respondents thought Travellers were either about as likely (43.6%) or less likely (35.0%) to understand how to use their service. There was a wider range of opinion on this issue in ROI than NI. Patterns of opinion on this issue were similar according to professional grouping.

Table 3B. 14: Understand how to access your service?

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	14	96	154	62	17	6	3	352
Overall (%)	4.0	27.3	43.8	17.6	4.8	1.7	0.9	
NI (%)	0.0	27.1	47.9	16.7	2.1	6.3	0.0	48
ROI (%)	4.6	27.3	43.1	17.8	5.3	1.0	1.0	304
Total (n)	14	93	153	60	17	4	3	344
Overall (%)	4.1	27.0	44.5	17.4	5.0	1.2	0.9	
GP (%)	4.6	20.5	48.9	17.1	9.1	0.0	0.0	88
Hospital Staff (%)	4.0	23.7	46.1	18.4	1.3	4.0	2.6	76
Other (%)	3.9	31.7	41.7	17.2	4.4	0.6	0.6	180
Pearson's Chi-squared test $\chi^2 = 19.5288$, df = 12, p-value = 0.07654			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 19.5288$, df = N/A, p-value = 0.06447					

Overall there was a spectrum of opinion on whether Travellers understand how to access respondents' services. Just under half of respondents rated Travellers as about as likely to understand as others (43.8%) and just over a quarter (27.3%) as less likely. This did not differ across jurisdictions.

There was a trend of borderline significance for the Other Professionals category to find Travellers less likely to understand (31.7% compared to 20.5% of GPs and 23.7% of hospital staff).

Table 3B. 15: Keep appointments

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	51	168	83	20	0	9	1	332
Overall (%)	15.3	51.0	25.0	6.0	0.0	2.7	0.3	
NI (%)	14.3	64.3	14.3	0.0	0.0	7.1	0.0	42
ROI (%)	15.5	48.6	26.6	6.9	0.0	2.1	0.3	290
Pearson's Chi-squared test $\chi^2 = 10.5487$, df = 5, p-value = 0.0611			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 10.5487$, df = N/A, p-value = 0.08996					
Total (n)	50	165	82	20	0	7	1	325
Overall (%)	15.4	50.8	25.2	6.2	0.0	2.1	0.3	
GP (%)	16.7	51.2	26.2	5.9	0.0	0.0	0.0	84
Hospital Staff (%)	12.9	61.4	12.9	4.3	0.0	7.1	0.0	70
Other (%)	15.8	46.2	29.8	7.0	0.0	0.0	0.0	171
Pearson's Chi-squared test $\chi^2 = 23.3007$, df = 10, p-value = 0.00969			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 23.3007$, df = N/A, p-value = 0.008496					

Travellers were considered less likely (51.0%) or much less likely (15.3%) than others to keep appointments. There was no significant difference according to jurisdiction in likelihood of Travellers keeping appointments compared with others. While all health professionals score Travellers less likely than the settled community to keep appointments, hospital staff (61.4%) assess Travellers as less likely to do so than other patients to a significantly greater degree than the other two professional groupings.

Table 3B. 16: Be on time for appointments

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	35	136	125	16	2	12	1	327
Overall (%)	10.7	41.6	38.2	4.9	0.6	3.7	0.3	
NI (%)	14.3	40.5	31.0	4.8	0.0	9.5	0.0	42
ROI (%)	10.2	41.8	39.3	4.9	0.7	2.8	0.4	285
Total (n)	34	132	125	16	2	10	1	320
Overall (%)	10.6	41.2	39.0	5.0	0.6	3.1	0.3	
GP (%)	8.4	48.2	38.6	2.4	1.2	1.2	0.0	83
Hospital Staff (%)	10.0	42.9	31.4	5.7	0.0	8.6	1.4	70
Other (%)	12.0	37.1	42.5	6.0	0.6	1.8	0.0	167
Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 18.4853$, df = N/A, p-value = 0.07846								

Respondents considered Travellers to be less likely (41.6%) or much less likely (10.7%) than other patients to be on time for appointments and there was no significant difference according to jurisdiction or professional grouping. Hospital staff had the widest spectrum of opinion on this issue.

Table 3B. 17: Comply with instructions about treatments

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	25	149	131	7	1	14	3	330
Overall (%)	7.6	45.1	39.7	2.1	0.3	4.2	0.9	
NI (%)	4.3	38.3	42.6	4.3	0.0	10.6	0.0	47
ROI (%)	8.1	46.3	39.2	1.8	0.4	3.2	1.1	283
Total (n)	25	145	130	7	1	11	3	322
Overall (%)	7.8	45.0	40.4	2.2	0.3	3.4	0.9	
GP (%)	2.9	50.0	46.6	1.1	0.0	0.0	0.0	88
Hospital Staff (%)	9.6	37.0	37.0	4.1	0.0	9.6	2.7	73
Other (%)	9.9	46.0	38.5	1.9	0.6	2.5	0.6	161
Pearson's Chi-squared test $\chi^2 = 25.3335$, df = 12, p-value = 0.01332			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 25.3335$, df = N/A, p-value = 0.007996					

Compliance with instructions about treatments was again rated as less likely or much less likely by appreciable numbers of respondents, 52.7% overall (42.6% NI and 54.4% ROI). GPs on this question assess Travellers as being less likely to comply with instructions than other groups, but the overall assessment suggests some difficulties with perceived compliance by all professional groups, with the hospital category showing the widest range of opinion.

Table 3B. 18: Attend for follow-up at your service

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	30	159	117	16	1	9	1	333
Overall (%)	9.0	47.7	35.1	4.8	0.3	2.7	0.3	
NI (%)	11.1	44.4	37.8	0.0	0.0	6.7	0.0	45
ROI (%)	8.7	48.3	34.7	5.6	0.4	2.1	0.4	288
Total (n)	30	155	117	15	1	7	1	326
Overall (%)	9.2	47.5	35.9	4.6	0.3	2.1	0.3	
GP (%)	5.8	51.7	36.8	4.6	1.1	0.1	0.0	87
Hospital Staff (%)	6.9	48.6	33.3	2.8	0.0	6.9	1.4	72
Other (%)	12.0	44.9	36.5	5.4	0.0	1.2	0.0	167

Attendance for service follow-up was rated as less likely (47.7%) or much less likely (9.0%) by a majority of respondents (55.5% NI and 57.0% ROI) and was not significant according to jurisdiction. There was a significant pattern according to Professional grouping, the 'Other' category having the highest probability of considering attendance much less likely.

Table 3B. 19: Attend referral appointments from your service

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	27	155	105	14	0	20	2	323
Overall (%)	8.4	48.0	32.5	4.3	0.0	6.2	0.6	
NI (%)	4.9	51.2	36.6	0.0	0.0	7.3	0.0	41
ROI (%)	8.9	47.5	31.9	5.0	0.0	6.0	0.7	282
Total (n)	27	151	105	13	0	18	2	316
Overall (%)	8.5	47.8	33.2	4.1	0.0	5.7	0.6	
GP (%)	11.5	54.0	32.2	1.2	0.0	0.2	0.0	87
Hospital Staff (%)	4.2	47.9	32.4	1.4	0.0	12.7	1.4	71
Other (%)	8.9	44.3	34.2	7.0	0.0	5.1	0.6	158
Pearson's Chi-squared test $\chi^2 = 20.4537$, df = 10, p-value = 0.02524			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 20.4537$, df = N/A, p-value = 0.02399					

A majority (56.4%) of respondents thought Travellers less likely or much less likely to attend referral appointments from their service. There was no difference according to jurisdiction in respondents' assessment of Travellers' likelihood of attending referral appointments. GPs (65.5%) were significantly more likely than other groups to consider Travellers would not attend, and only just over one third of respondents felt Travellers and the general community had similar patterns of behaviour.

Table 3B. 20: Make use of preventative services

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	72	171	49	3	0	24	2	321
Overall (%)	22.4	53.3	15.3	0.9	0.0	7.5	0.6	
NI (%)	16.7	42.9	23.8	2.4	0.0	14.3	0.0	42
ROI (%)	23.3	54.8	14.0	0.7	0.0	6.5	0.7	279
Pearson's Chi-squared test $\chi^2 = 8.3899$, df = 5, p-value = 0.1360			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 8.3899$, df = N/A, p-value = 0.1254					
Total (n)	71	167	48	3	0	22	2	313
Overall (%)	22.7	53.3	15.3	1.0	0.0	7.0	0.6	
GP (%)	20.7	64.4	12.6	1.2	0.0	1.2	0.0	87
Hospital Staff (%)	26.1	40.6	10.1	2.9	0.0	18.8	1.5	69
Other (%)	22.3	52.9	19.1	0.0	0.0	5.1	0.6	157
Pearson's Chi-squared test $\chi^2 = 32.0134$, df = 10, p-value = 0.0003984			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 32.0134$, df = N/A, p-value = 0.000499					

Travellers were considered by a very clear majority of respondents as being less likely (53.3%) or much less likely (22.4%) than others in similar circumstances to avail of preventative services. There was a significant difference according to professional grouping; however, with hospital staff more likely to report that they did not know, although a majority in all professional groupings thought Travellers less likely to so do.

Table 3B. 21: Make use of treatment for long-term illness

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	15	114	114	15	4	20	7	289
Overall (%)	0.5	39.4	39.4	5.2	1.4	7.0	2.4	
NI (%)	2.5	37.5	35.0	7.5	0.0	15.0	2.5	40
ROI (%)	5.6	39.8	40.2	4.8	1.6	5.6	2.4	249
Total (n)	15	112	113	15	4	17	6	282
Overall (%)	5.3	39.7	40.0	5.3	1.4	6.0	2.1	
GP (%)	4.6	42.5	49.4	2.3	1.1	0.0	0.0	87
Hospital Staff (%)	6.2	32.8	32.8	7.8	4.7	14.1	1.6	64
Other (%)	5.3	41.2	37.4	6.1	0.0	6.1	3.8	131
Pearson's Chi-squared test $\chi^2 = 29.0991$, $df = 12$, p-value = 0.003809			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 29.0991$, $df = N/A$, p-value = 0.002499					

There was a spectrum of response to the question of Travellers making use of treatment for long-term illness, though with substantial numbers considering it less likely (39.4%) and with no significant pattern across jurisdictions. There was a significant difference in response according to Professional groupings, again with high rates of 'don't knows' (14.1%) among hospital staff.

The next two questions related to use of antenatal and postnatal care.

Table 3B. 22: Make use of antenatal care services

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	15	69	99	15	5	25	4	232
Overall (%)	6.5	29.8	42.6	6.5	2.1	10.8	1.7	
NI (%)	3.2	25.8	41.9	6.5	0.0	22.6	0.0	31
ROI (%)	7.0	30.3	42.8	6.5	2.5	9.0	2.0	201
Total (n)	15	67	98	15	4	22	4	225
Overall (%)	6.7	29.8	43.5	6.7	1.7	9.8	1.8	
GP (%)	5.8	24.4	59.3	8.1	1.2	1.2	0.0	86
Hospital Staff (%)	2.1	25.5	34.0	6.4	2.1	29.8	0.0	47
Other (%)	9.8	37.0	33.7	5.4	2.2	7.6	4.3	92
Pearson's Chi-squared est with simulated p-value (based on 2000 replicates) $\chi^2 = 46.3083$, df = N/A, p-value = 0.0004998								

This question shows a wide range of response but marks a more positive shift in that respondents thought it about as likely (42.6%) or more likely (6.5%) that Travellers would make use of antenatal services. There was no significant difference according to jurisdiction.

There was a highly significant difference according to professional grouping in answering this question, with relatively high rates of 'don't know' from hospital staff (29.8%) not engaged in obstetrical care.

Table 3B. 23: Make use of postnatal services

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	12	81	92	15	4	27	6	237
Overall (%)	5.1	34.2	38.8	6.3	1.7	11.4	2.5	
NI (%)	2.9	26.5	41.2	5.9	0.0	23.5	0.0	34
ROI (%)	5.4	35.5	38.4	6.4	2.0	9.4	3.0	203
Total (n)	12	78	92	15	4	24	5	230
Overall (%)	5.2	34.0	40.0	6.5	1.7	10.4	2.5	
GP (%)	4.6	33.7	48.8	9.3	2.3	1.2	0.0	86
Hospital Staff (%)	6.5	30.4	28.3	0.0	2.2	32.6	0.0	46
Other (%)	5.1	35.7	37.8	7.1	1.0	8.2	5.1	98

Again, compared with the responses to other questions, Traveller women seemed to come close to meeting the expectation of Service Providers for this type of care, with 38.8% rating it about as likely and 6.3% more likely that Travellers would make use of postnatal services. This may suggest something about how Traveller women use antenatal care in contrast to other services.

Table 3B. 24: Make use of any screening services which you offer

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	25	113	75	10	2	13	3	241
Overall (%)	10.4	46.9	31.1	4.1	0.8	5.4	1.2	
NI (%)	17.9	35.7	35.7	0.0	0.0	10.7	0.0	28
ROI (%)	9.4	48.4	30.5	4.7	0.9	4.7	1.4	213
Total (n)	25	111	74	10	2	10	1	233
Overall (%)	10.7	47.6	31.7	4.3	0.8	4.3	0.4	
GP (%)	10.3	59.8	26.4	3.5	0.0	0.0	0.0	87
Hospital Staff (%)	16.7	31.2	29.2	6.2	2.1	14.6	0.0	48
Other (%)	8.2	44.9	37.8	4.1	1.0	3.1	1.0	98
Pearson's Chi-squared test $\chi^2 = 29.2276$, df = 12, p-value = 0.003645			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 29.2276$, df = N/A, p-value = 0.002999					

Travellers were considered by a majority of respondents (57.3%) as either less likely or much less likely to make use of any screening services offered, with a highly significant pattern according to professional grouping, GPs rating it as least likely compared to the other groupings.

Table 3B. 25: To be prescribed medicine

	Much less likely	Less likely	About as likely	More likely	Much more likely	Don't know	Refused	n
Total (n)	6	22	167	55	10	17	13	290
Overall (%)	2.1	7.6	57.6	19.0	3.4	5.9	4.5	
NI (%)	0.0	0.0	65.8	18.4	0.0	10.5	5.3	38
ROI (%)	2.4	8.7	56.4	19.1	4.0	5.2	4.4	252
Total (n)	6	22	165	54	10	15	11	283
Overall (%)	2.1	7.8	58.3	19.1	3.5	5.3	3.9	
GP (%)	0.0	4.6	58.6	31.0	4.6	0.0	1.1	87
Hospital Staff (%)	1.5	5.8	73.9	7.2	1.5	8.7	1.5	69
Other (%)	3.9	11.0	49.6	17.3	3.9	7.1	7.1	127
Pearson's Chi-squared test $\chi^2 = 37.6269$, df = 12, p-value = 0.0001767			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 37.6269$, df = N/A, p-value = 0.0009995					

Likelihood in being prescribed medication marks a change in trend of response, a majority in both jurisdictions thinking it either about as likely (65.8% NI and 56.4% ROI) or more likely (18.4% NI and 19.1% ROI) than anyone else. There was however a highly significant difference according to professional grouping, a clear majority of hospital staff (73.9%) thinking this about as likely as anyone else.

The next 4 items asked respondents to indicate in their experience, in general, at what stage do members of the Travelling community present for care:

Table 3B. 26: Men from the Traveller community

	Very Early	Early	About the Right Time	Late	Very Late	Don't know	Refused	n
Total (n)	2	4	33	88	95	18	8	248
Overall (%)	0.8	1.6	13.3	35.5	38.3	7.2	3.2	
NI (%)	0.0	0.0	16.0	44.0	28.0	12.0	0.0	25
ROI (%)	0.9	1.8	13.0	34.5	39.5	6.7	3.6	223
Total (n)	2	4	33	85	95	16	6	241
Overall (%)	0.8	1.7	13.7	35.3	39.4	6.6	2.5	
GP (%)	0.0	0.0	18.8	47.1	31.8	2.4	0.0	85
Hospital Staff (%)	2.4	7.3	7.3	34.2	29.3	14.6	4.9	41
Other (%)	0.9	0.9	12.2	27.0	48.7	7.0	3.5	115
Pearson's Chi-squared test $\chi^2 = 35.0687$, df = 12, p-value = 0.0004567			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 35.0687$, df = N/A, p-value = 0.0009995					

Table 3B. 27: Women from the Traveller community

	Very Early	Early	About the Right Time	Late	Very Late	Don't know	Refused	n
Total (n)	5	39	121	78	14	12	6	275
Overall (%)	1.8	14.2	44.0	28.4	5.1	4.7	2.2	
NI (%)	0.0	16.1	45.2	25.8	3.2	9.7	0.0	31
ROI (%)	2.1	13.9	43.9	28.7	5.3	3.7	2.5	244
Total (n)	5	39	121	74	14	10	4	267
Overall (%)	1.9	14.6	45.3	27.7	5.2	3.7	1.5	
GP (%)	1.2	12.8	65.1	18.6	2.3	0.0	0.0	86
Hospital Staff (%)	1.8	11.1	33.3	35.2	9.3	7.4	1.8	54
Other (%)	2.4	17.3	37.0	30.7	5.5	4.7	2.4	127
Pearson's Chi-squared test $\chi^2 = 27.3606$, df = 12, p-value = 0.006854			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 27.3606$, df = N/A, p-value = 0.003998					

Table 3B. 28: Children from the Traveller community

	Very Early	Early	About the Right Time	Late	Very Late	Don't know	Refused	n
Total (n)	28	64	93	51	12	11	6	265
Overall (%)	10.6	24.1	35.1	19.2	4.5	4.2	2.3	
NI (%)	5.0	25.0	35.0	25.0	0.0	7.5	2.5	40
ROI (%)	11.6	24.0	35.1	18.2	5.3	3.6	2.2	225
Total (n)	28	64	91	50	12	9	4	258
Overall (%)	10.8	24.8	35.3	19.4	4.6	3.5	1.6	
GP (%)	17.4	40.7	33.7	5.8	1.2	1.2	0.0	86
Hospital Staff (%)	5.4	23.6	38.2	18.2	3.6	7.3	3.6	55
Other (%)	8.6	13.7	35.0	29.9	7.7	3.4	1.7	117
Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 46.4068$, df = N/A, p-value = 0.0004998								

Table 3B. 29: Women from the Traveller community for antenatal care

	Very Early	Early	About the Right Time	Late	Very Late	Don't know	Refused	n
Total (n)	11	20	72	37	13	12	11	176
Overall (%)	6.3	11.4	41.0	21.0	7.4	6.8	6.2	
NI (%)	9.1	4.5	45.5	13.6	4.5	18.2	4.5	22
ROI (%)	5.8	12.3	40.3	22.1	7.8	5.2	6.5	154
Pearson's Chi-squared test $\chi^2 = 7.2863$, df = 6, p-value = 0.2952			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 7.2863$, df = N/A, p-value = 0.2964					
Total (n)	11	20	72	34	12	10	9	169
Overall %	6.5	11.8	42.6	20.1	7.1	5.9	5.3	
GP (%)	7.1	15.5	58.3	14.3	2.4	2.4	0.0	84
Hospital Staff (%)	2.9	8.6	31.4	25.7	2.9	14.3	14.3	35
Other (%)	8.0	8.0	24.0	26.0	20.0	6.0	8.0	50
Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 45.9385$, df = N/A, p-value = 0.0004998								

There are striking differences between the 3 Traveller demographic groupings in the timing of their presentation of care, with men reported as especially likely to present late and children most likely to be early or on time. There is no significant difference in this pattern according to jurisdiction. GPs were significantly more likely to think children presented early or on time, whereas both hospital and other staff categories were significantly more likely to think women present late than GPs. Again, this may reflect the different ways in which services are used and the sequence of referrals.

Section D: Health Status

Respondents were asked to rate in importance factors having an impact on Traveller health. This of course, represents a purely external view of the determinants of Traveller health, but it is of interest to see what Service Providers think affects Traveller health. A clear majority, in both jurisdictions, considered all these wider determinants as of some importance.

Table 3B. 30: Socio-economic factors

	Not at all important	Somewhat important	Neither important nor unimportant	Important	Very important	Don't know	Refused	n
Total (n)	7	11	37	97	182	17	5	356
Overall (%)	2.0	3.1	10.4	27.2	51.1	4.8	1.4	
NI (%)	2.1	8.3	10.4	25.0	47.9	4.2	2.1	48
ROI (%)	1.9	2.3	10.4	27.6	51.6	4.9	1.3	308
Total (n)	7	11	37	95	178	15	5	348
Overall (%)	2.0	3.2	10.7	27.3	51.1	4.3	1.4	
GP (%)	1.1	3.4	17.1	33.0	42.0	2.3	1.1	88
Hospital Staff (%)	2.6	0.0	6.5	41.6	39.0	7.8	2.6	77
Other (%)	2.2	4.4	9.3	18.6	60.7	3.8	1.1	183

A clear majority (78.3%) of respondents considered socio-economic factors as either important or very important to Traveller health. Socio-economic factors were considered as either important or very important in both jurisdictions (72.9% in NI and 79.2% in ROI). Whilst a large majority of all professional groupings similarly agreed, the Other grouping was clearly the most likely to consider such factors very important (60.7%).

Table 3B. 31: Cultural ways

	Not at all important	Somewhat important	Neither important nor unimportant	Important	Very important	Don't know	Refused	n
Total (n)	1	10	31	137	160	13	4	356
Overall (%)	0.3	2.8	8.7	38.5	45.0	3.6	1.1	
NI (%)	0.0	4.2	12.5	37.5	41.7	4.2	0.0	48
ROI (%)	0.3	2.6	8.1	38.6	45.5	3.6	1.3	308
Total (n)	1	10	31	135	156	11	4	348
Overall (%)	0.3	2.9	8.9	38.8	44.8	3.2	1.1	
GP (%)	1.1	5.7	8.0	42.0	40.9	1.1	1.1	88
Hospital Staff (%)	0.0	0.0	5.2	42.9	44.2	6.5	1.3	77
Other (%)	0.0	2.7	10.9	35.5	47.0	2.7	1.1	183

Cultural factors similarly were clearly rated as important (83.5%) by respondents overall. Just 1 respondent in the entire survey thought culture not at all important. A clear majority of respondents in both jurisdictions (79.2% NI and 84.1% ROI) and across professional groupings thought culture important or very important, not significantly different in any category.

Table 3B. 32: Environmental conditions

	Not at all important	Somewhat important	Neither important nor unimportant	Important	Very important	Don't know	Refused	n
Total (n)	2	8	41	117	173	11	4	356
Overall (%)	0.6	2.4	11.5	32.9	48.6	3.2	1.1	
NI (%)	2.1	6.3	10.4	31.3	45.8	4.2	0.0	48
ROI (%)	0.3	1.6	11.7	33.1	49.0	2.9	1.3	308
Total (n)	2	8	41	115	169	9	4	348
Overall (%)	0.6	2.3	11.8	33.0	48.6	2.6	1.1	
GP (%)	0.0	2.3	15.9	51.1	29.5	0.0	1.1	88
Hospital Staff (%)	0.0	1.3	13.0	27.3	49.3	7.8	1.3	77
Other (%)	1.1	2.7	9.3	26.8	57.4	1.6	1.1	183
Pearson's Chi-squared test $\chi^2 = 36.7794$, df = 12, p-value = 0.0002426			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 36.7794$, df = N/A, p-value = 0.0009995					

Environmental conditions were again rated as either important (32.9%) or very important (48.6%) by a large majority of respondents overall. A clear majority agreed in both jurisdictions (77.1% NI and 82.1% ROI). Similarly most respondents in each of the 3 professional groupings rated environmental conditions as important, though again there was a highly significant difference between the categories, with GPs least likely of the three groups to rate this factor as very important (29.5%) though a majority rated it as important (51.1%).

Table 3B. 33: Social and community networks

	Not at all important	Somewhat important	Neither important nor unimportant	Important	Very important	Don't know	Refused	n
Total (n)	1	11	50	149	120	21	4	356
Overall (%)	0.3	3.1	14.0	41.8	33.7	5.9	1.1	
NI (%)	0.0	4.2	12.5	37.5	39.6	6.3	0.0	48
ROI (%)	0.3	2.9	14.3	42.5	32.8	5.8	1.3	308
Total (n)	1	11	50	147	116	19	4	348
Overall (%)	0.3	3.2	14.4	42.2	33.3	5.4	1.1	
GP (%)	0.0	3.4	20.5	54.6	15.9	4.6	1.1	88
Hospital Staff (%)	0.0	1.3	10.4	39.0	37.7	10.4	1.3	77
Other (%)	0.6	3.8	13.1	37.7	40.0	3.8	1.1	183
Pearson's Chi-squared test $\chi^2 = 24.8646$, df = 12, p-value = 0.01548			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 24.8646$, df = N/A, p-value = 0.007996					

Social and community networks were also rated as important (41.8%) or very important (33.7%) by a large majority of respondents overall. Again also, as with the other determinants, the three health professional groupings rated their importance highly, but GPs were once more significantly less likely to rate networks as very important (15.9%) compared to the other two groups.

Table 3B. 34: Individual lifestyle factors

	Not at all important	Somewhat important	Neither important nor unimportant	Important	Very important	Don't know	Refused	n
Total (n)	1	12	41	138	146	12	5	356
Overall (%)	0.3	3.4	11.5	38.7	41.0	3.4	1.4	
NI (%)	0.0	4.2	16.7	41.7	33.3	4.2	0.0	48
ROI (%)	0.3	3.3	10.7	38.3	42.2	3.6	1.6	308
Total (n)	1	12	41	137	141	11	5	348
Overall (%)	0.3	3.4	11.8	39.4	40.5	3.2	1.4	
GP (%)	0.0	6.8	11.4	51.1	28.4	1.1	1.1	88
Hospital Staff (%)	1.3	0.0	9.1	40.3	40.3	7.8	1.3	77
Other (%)	0.0	3.3	13.1	33.3	46.5	2.2	1.6	183
Pearson's Chi-squared test $\chi^2 = 26.463$, df = 12, p-value = 0.009225			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 26.463$, df = N/A, p-value = 0.005997					

Individual lifestyle factors were rated as important (38.7%) or very important (41.0%) by a similarly large majority, again not significantly different according to jurisdiction, but with GPs more likely to rate lifestyle as important (51.1%) rather than very important (28.4%) compared to the other two professional categories.

Table 3B. 35: Access to services

	Not at all important	Somewhat important	Neither important nor unimportant	Important	Very important	Don't know	Refused	n
Total (n)	2	19	60	139	121	11	4	356
Overall (%)	0.6	5.3	16.8	39.0	34.0	3.1	1.1	
NI (%)	0.0	10.4	16.7	33.3	33.3	6.3	0.0	48
ROI (%)	0.7	4.6	16.9	39.9	34.1	2.6	1.3	308
Total (n)	2	19	60	137	117	9	4	348
Overall (%)	0.6	5.4	17.2	39.4	33.6	2.6	1.1	
GP (%)	1.1	11.4	27.3	43.2	14.8	1.1	1.1	88
Hospital Staff (%)	0.0	3.9	15.6	39.0	33.8	6.5	1.3	77
Other (%)	0.6	3.3	13.1	37.7	42.6	1.6	1.1	183
Pearson's Chi-squared test $\chi^2 = 35.6337$, df = 12, p-value = 0.0003710			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 35.6337$, df = N/A, p-value = 0.0004998					

Finally, in this section, respondents were asked to rate access to services in importance as a health determinant. This was rated also as important (39.0%) or very important (34.0%) by a majority of respondents, with no significant difference according to jurisdiction. A majority of all 3 professional groupings rated this as important or very important also, but again the GPs differed from the other 2 groups in being statistically least likely to rate this factor as very important (14.8%). The rating of the importance of this factor was a little lower than the others, possibly suggesting that service providers see access as somewhat less important than some of the other determinants.

Figure 1: What things impact most on the health of the Traveller community?

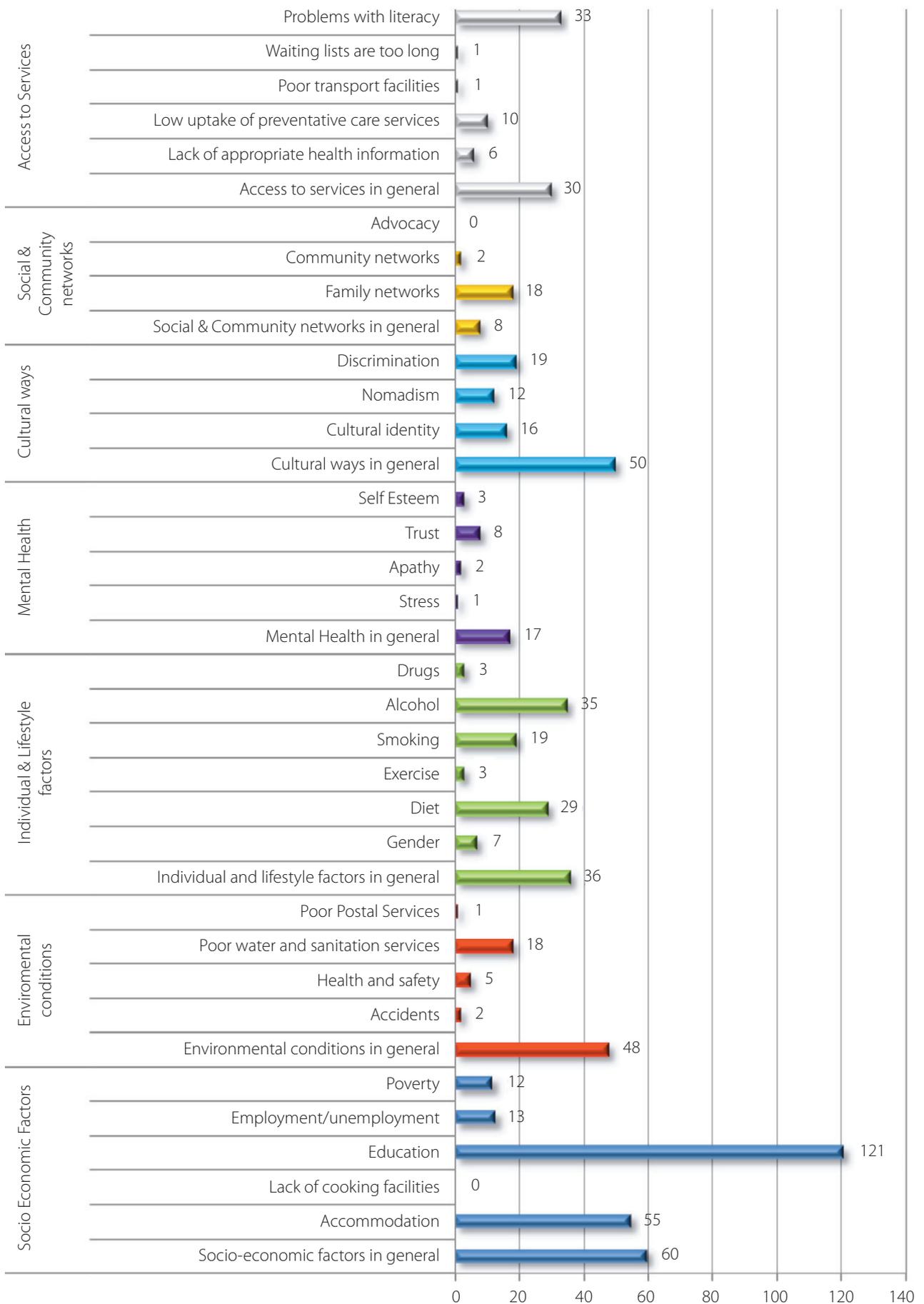


Figure 1 gives the response to an open question in which respondents were asked to list the three factors they considered made the most impact on the health of the Traveller community. The question was put first unprompted and then if necessary prompted from a list of factors in 7 categories. Accordingly respondents could make their own open suggestions or give their reaction to a preset list. Frequency of mention is presented in the figure. This shows that education was clearly in front of any other determinant as a cited factor, followed by socio-economic factors in general, accommodation adequacy and cultural factors. Notably lifestyle factors, including smoking, alcohol and drugs did not rate very high mention. Of other comments spontaneously made, violence, particularly against women was highlighted.

Section E: Interface Between Travellers and Your Service

Overall respondents reported significant difficulties for Travellers in using their services. There were marked difficulties with understanding instructions and understanding the nature and cause of their illness. Respondents felt that Travellers had less difficulty with asking questions and understanding the language used in the responses to these. It was not felt to be difficult to establish a relationship of trust with most of their Traveller clients.

In this section, respondents were asked in general, to what extent their Traveller patients found the following interactions easy or difficult:

Table 3B. 36: Understand instructions about treatments

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	6	44	125	128	14	11	2	330
Overall (%)	1.8	13.3	37.9	38.8	4.2	3.2	0.6	
NI (%)	2.2	8.9	24.4	48.9	8.9	6.7	0.0	45
ROI (%)	1.8	14.0	40.0	37.2	3.5	2.8	0.7	285
Total (n)	6	44	124	125	14	9	1	323
Overall (%)	1.9	13.6	38.4	38.7	4.3	2.8	0.3	
GP (%)	0.0	21.6	40.9	31.8	4.6	1.1	0.0	88
Hospital Staff (%)	1.4	10.8	41.9	39.2	4.1	2.7	0.0	74
Other (%)	3.1	10.6	35.4	42.2	4.4	3.7	0.6	161

Respondents gave a range of responses when asked how easy or difficult it was for Travellers to understand instructions about treatments. Opinion was divided, mainly being rated as neither easy nor difficult (37.9%) or as difficult (38.8%). There was no significant difference in response according to jurisdiction or professional grouping.

Table 3B. 37: Understand the nature and cause of their illness

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	3	26	102	161	17	10	1	320
Overall (%)	0.9	8.0	31.6	49.8	5.3	3.1	0.3	
NI (%)	2.3	6.8	34.1	45.5	6.8	4.6	0.0	44
ROI (%)	0.7	8.3	31.5	51.1	5.1	2.9	0.4	276
Total (n)	3	26	101	158	17	8	0	313
Overall (%)	1.0	8.3	32.3	48.9	5.3	2.5	0.0	
GP (%)	0.0	9.1	28.4	58.0	3.4	1.1	0.0	88
Hospital Staff (%)	1.3	6.8	37.8	46.0	4.1	4.1	0.0	74
Other (%)	1.3	8.6	31.8	48.3	7.3	2.6	0.0	151

Asked if Travellers generally understood the nature and cause of their illness, a third (31.6%) thought it neither easy nor difficult but almost half (49.8%) thought it difficult for Travellers. Again there was no significant difference by jurisdiction or professional grouping and the tendency therefore was to rate this as difficult for Travellers.

Table 3B. 38: Understand factors concerning their health and wellbeing

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	7	31	118	144	22	11	2	335
Overall (%)	2.1	9.3	35.2	43.0	6.6	3.3	0.6	
NI (%)	2.1	10.6	38.3	36.2	6.4	4.3	2.1	47
ROI (%)	2.1	9.0	34.7	44.1	6.6	3.1	0.4	288
Total (n)	7	31	116	141	22	9	1	327
Overall (%)	2.1	25.2	35.5	43.1	6.7	2.7	0.3	
GP (%)	2.3	4.5	34.1	53.4	5.7	0.0	0.0	88
Hospital Staff (%)	1.3	2.7	36.0	46.7	6.7	5.3	1.3	75
Other (%)	2.4	15.2	36.0	36.0	7.3	3.0	0.0	164
Pearson's Chi-squared test $\chi^2 = 24.2474$, $df = 12$, $p\text{-value} = 0.01882$								

There was again a range of opinion on whether Travellers understand factors concerning their health and wellbeing. A majority of respondents thought it either difficult (43.0%) or very difficult (6.6%) for Travellers. GPs were the professional grouping who thought this most problematic, rating it as either difficult (53.4%) or very difficult (5.7%).

Table 3B. 39: Understand the vocabulary you use

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	12	87	119	95	26	8	2	349
Overall (%)	3.4	25.0	34.1	27.2	7.4	2.3	0.6	
NI (%)	4.2	14.6	31.3	33.3	10.4	4.2	2.1	48
ROI (%)	3.3	26.6	34.6	26.3	7.0	2.0	0.3	301
Pearson's Chi-squared test $\chi^2 = 7.0972$, df = 6, p-value = 0.3120			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 7.0972$, df = N/A, p-value = 0.2764					
Total (n)	12	86	117	93	26	6	1	341
Overall %	3.5	25.3	34.3	2.7	7.6	1.7	0.3	
GP (%)	5.7	25.0	43.2	20.5	4.6	1.1	0.0	88
Hospital Staff (%)	4.0	23.7	32.9	25.0	7.9	5.3	1.3	76
Other (%)	2.3	26.0	30.5	31.6	9.0	0.6	0.0	177
Pearson's Chi-squared test $\chi^2 = 19.7955$, df = 12, p-value = 0.07105			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 19.7955$, df = N/A, p-value = 0.05347					

There was also a range of opinion on whether Travellers understand the vocabulary health professionals use, reflecting perhaps the range and complexity of situations in which Travellers engage with services. It was seen as neither easy nor difficult by just over a third of respondents (34.1%) but with similar numbers either side of this estimate rating it as either easy (25.0%) or difficult (27.2%). There was a difference of borderline statistical significance among the Professional groups with GPs most likely to state that it was neither easy nor difficult (43.2% compared to 32.9% of hospital professionals and 30.5% of the other category).

Table 3B. 40: Carry out written instruction (for example, with information leaflets or prescriptions)

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	4	14	50	161	90	15	4	341
Overall (%)	1.2	4.1	14.7	47.2	26.4	4.4	1.2	
NI (%)	0.0	0.0	20.8	45.8	25.0	6.2	2.1	48
ROI (%)	1.4	5.8	13.7	47.4	26.6	4.1	1.0	293
Total (n)	4	17	50	156	90	13	3	333
Overall (%)	1.2	5.1	15.0	46.8	27.0	3.9	0.9	
GP (%)	1.2	3.5	17.4	51.2	20.9	5.8	0.0	86
Hospital Staff (%)	1.3	5.3	16.0	46.7	20.0	6.7	4.0	75
Other (%)	1.2	5.8	13.4	44.8	33.1	1.7	0.0	172
Pearson's Chi-squared test $\chi^2 = 21.4035$, df = 12, p-value = 0.04477			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 21.4035$, df = N/A, p-value = 0.03848					

Asked how easy it was for Travellers to carry out written instructions, for example with information leaflets or prescriptions, most respondents rated this as either difficult (47.2%) or very difficult (26.4%). There was no difference in response according to jurisdiction. However there was a significant variation according to professional grouping, the Other Professionals category being most likely to rate this as very difficult for Travellers (33.1%, compared with 20.9% of GPs and 20.0% of hospital staff).

Table 3B. 41: Ask questions about their condition

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	20	87	101	97	17	10	2	334
Overall (%)	6.0	26.0	30.2	29.0	5.1	3.0	0.6	
NI (%)	8.5	23.4	36.2	19.2	6.4	4.3	2.1	47
ROI (%)	5.6	26.5	29.3	30.7	4.9	2.8	0.4	287
Total (n)	20	85	100	95	17	8	1	326
Overall (%)	6.1	26.1	30.7	29.1	5.2	2.4	0.3	
GP (%)	5.7	28.4	31.8	31.8	2.3	0.0	0.0	88
Hospital Staff (%)	7.9	26.3	30.3	22.4	6.6	5.3	1.3	76
Other (%)	5.6	24.7	30.2	30.9	6.2	2.5	0.0	162

There was again a spectrum of opinion on whether it was easy for Travellers to ask about their condition, from very easy through to very difficult. A third thought it neither easy nor difficult (30.2%), flanked either side by those who thought it either easy (26.0%) or difficult (29.0%). There was no difference in pattern according to jurisdiction or professional grouping.

Table 3B. 42: Ask questions pertaining to the consultation/treatment event

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	17	90	103	96	12	8	3	329
Overall (%)	5.2	27.3	31.3	29.2	3.6	2.4	0.9	
NI (%)	4.4	30.4	32.6	21.7	4.4	4.4	2.2	46
ROI (%)	5.3	26.9	31.1	30.4	3.5	2.1	0.7	283
Total (n)	17	89	101	95	11	6	2	321
Overall (%)	5.3	27.7	31.4	29.6	3.4	1.9	0.6	
GP (%)	5.7	30.7	34.1	28.4	1.1	0.0	0.0	88
Hospital Staff (%)	6.7	34.7	24.0	24.0	5.3	4.0	1.3	75
Other (%)	4.4	22.8	33.5	32.9	3.8	1.9	0.6	158

Asked more specifically how easy it was to ask questions about the consultation or treatment event, there was again a wide spectrum of response, with no difference according to jurisdiction or professional grouping. Relatively few respondents rated it as very difficult (3.6%), however.

Table 3B. 43: How easy or difficult do you find it to establish a relationship of trust with your Traveller patients?

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Don't know	Refused	n
Total (n)	20	108	100	52	14	29	30	353
Overall (%)	5.7	30.6	28.3	14.7	4.0	8.2	8.5	
NI (%)	2.1	29.2	31.2	12.5	6.2	12.5	6.2	48
ROI (%)	6.2	30.8	27.9	15.1	3.6	7.5	8.8	305
Total (n)	20	108	99	52	14	27	25	345
Overall %	5.8	31.3	28.7	15.1	4.1	7.8	7.2	
GP (%)	6.8	39.8	28.4	14.8	3.4	1.1	5.7	88
Hospital Staff (%)	6.5	39.0	26.0	9.1	3.9	5.2	10.4	77
Other (%)	5.0	23.9	30.0	17.8	4.4	12.2	6.7	180
Pearson's Chi-squared test $\chi^2 = 21.8064$, df = 12, p-value = 0.03975			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 21.8064$, df = N/A, p-value = 0.03948					

Respondents were asked how easy or difficult it was to establish a relationship of trust with their Traveller patients. There was again a range of opinion but the majority found it either easy (30.6%), or neither easy nor difficult (28.3%). Relatively few found it very difficult (4.0%). There was a significant difference according to professional grouping, in that hospital respondents were least likely rate this as difficult (9.1%) but had the highest refusal rate for this question (10.4%). GPs had lower rates of 'don't know' or refusal to answer this question than the other 2 groups.

Section F: Provision of Services to Travellers

Table 3B. 44: Do you conduct domiciliary visits?

Yes	No	N/A
172	164	20

Respondents were asked if they conducted domiciliary visits and 51.2% of those to whom it was applicable said yes.

Table 3B. 45: Is information on how to use your service translated into a format that can be easily understood by Travellers (e.g. posters)?

	Yes	No	Don't know	Refused	n
Total (n)	172	164	10	5	351
Overall (%)	49.0	46.7	2.8	1.4	
NI (%)	52.2	47.8	0.0	0.0	46
ROI (%)	48.5	46.6	3.3	1.6	305
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Total (n)	169	161	10	5	345
Overall (%)	49.0	46.7	2.9	1.4	
GP (%)	51.1	45.5	3.4	0.0	88
Hospital Staff (%)	44.0	46.7	2.7	6.7	75
Other (%)	50.0	47.2	2.8	0.0	182
Pearson's Chi-squared test $\chi^2 = 18.6504$, df = 6, p-value = 0.004797	Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 18.6504$, df = N/A, p-value = 0.005497				

Respondents were about equally divided, yes (49.0%) or no (46.7%), on whether information on how to use their service was translated into a format that can be easily understood by Travellers, with no difference according to jurisdiction. There was a significant difference in response according to professional grouping, in that hospital respondents were least likely to answer yes to this question (44.0%) and more likely to refuse (6.7%).

Table 3B. 46: Is information on how to use your service disseminated in a way that ensures Travellers receive it (e.g. information sessions)?

	Yes	No	Don't know	Refused	n
Total (n)	174	159	14	4	351
Overall (%)	49.6	45.3	4.0	1.1	
NI (%)	41.3	52.2	6.5	0.0	46
ROI (%)	50.8	44.3	3.6	1.3	305
<hr/>					
Total (n)	172	155	14	4	345
Overall (%)	49.9	45.0	4.0	1.2	
GP (%)	46.6	52.3	1.1	0.0	88
Hospital Staff (%)	37.3	50.7	9.3	2.7	75
Other (%)	56.6	39.0	3.3	1.1	182
Pearson's Chi-squared test $\chi^2 = 16.9791$, df = 6, p-value = 0.00936	Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 16.9791$, df = N/A, p-value = 0.007996				

Traveller advocates to help support service delivery. Half (50.0%) in NI and over half (59.3%) in ROI said yes. There was a highly significant difference according to professional grouping. The Other Professional category being much more likely (73.6%) to report such engagement than GPs (39.8%) or hospital staff (41.3%).

Again, asked if information on how to use their service was disseminated in a way that ensures Travellers receive it, such as information sessions, respondents were about equally divided, yes (49.6%) and no (45.3%) and there was no difference according to jurisdiction. Hospital staff again differed significantly in their response, being least likely to say yes (37.3%) and most likely not to know (9.3%).

Table 3B. 47: In the course of your usual practice, is there engagement with Traveller Advocates to help support service delivery?

	Yes	No	Don't know	Refused	n
Total (n)	204	136	10	1	351
Overall (%)	58.1	38.7	2.8	0.3	
NI (%)	50.0	47.8	2.2	0.0	46
ROI (%)	59.3	37.4	3.0	0.3	305
Total (n)	200	134	10	1	345
Overall (%)	58.0	38.8	2.9	0.3	
GP (%)	39.8	60.2	0.0	0.0	88
Hospital Staff (%)	41.3	46.7	10.7	1.3	75
Other (%)	73.6	25.3	1.1	0.0	182
Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 60.2705$, df = N/A, p-value = 0.0004998					

Respondents were asked whether in the course of their usual practice, there was engagement with Traveller advocates to help support service delivery. Half (50.0%) in NI and over half (59.3%) in ROI said yes. There was a highly significant difference according to professional grouping. The Other Professional category being much more likely (73.6%) to report such engagement than GPs (39.8%) or hospital staff (41.3%).

Table 3B. 48: Have you ever received Traveller Cultural Awareness training?

	Yes	No	Don't know	Refused	n
Total (n)	157	192	1	1	351
Overall (%)	44.7	54.7	0.3	0.3	
NI (%)	41.3	58.7	0.0	0.0	46
ROI (%)	45.3	54.1	0.3	0.3	305
Total (n)	153	190	1	1	345
Overall (%)	44.3	55.1	0.3	0.3	
GP (%)	18.2	81.8	0.0	0.0	88
Hospital Staff (%)	34.7	62.7	1.3	1.3	75
Other (%)	61.0	39.0	0.0	0.0	182
Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 54.4767$, df = N/A, p-value = 0.0004998					

A majority of respondents (54.7%) said they had never received cultural awareness training. There was no difference according to jurisdiction in response to the question. However, there was a marked difference according to professional grouping, 61% of the other professional category said yes, followed by 34.7% of hospital staff and just 18.2% of GPs.

Table 3B. 49: How helpful was this training?

	Very unhelpful	Unhelpful	Neither helpful nor unhelpful	Helpful	Very helpful	Don't know	Refused	n
Total (n)	2	4	28	62	59	1	1	157
Overall (%)	1.3	2.5	17.8	39.4	37.6	0.6	0.6	
NI (%)	5.3	0.0	10.5	31.6	52.6	0.0	0.0	19
ROI (%)	0.7	2.9	18.8	40.6	35.5	0.7	0.7	138
Total (n)	1	4	28	60	58	1	1	153
Overall (%)	0.6	2.6	18.3	39.2	38.0	0.6	0.6	
GP (%)	0.0	0.0	25.0	43.8	31.2	0.0	0.0	16
Hospital Staff (%)	0.0	0.0	15.4	50.0	34.6	0.0	0.0	26
Other (%)	0.9	3.6	18.0	36.0	39.6	0.9	0.9	111

A majority of respondents who had received such training found it either helpful (39.4%) or very helpful (37.6%), with no significant difference according to jurisdiction or professional grouping.

Table 3B. 50: Do you think having an ethnic identifier is helpful to Health Service Providers when providing services to Travellers?

	Yes	No	Don't know	Refused	n
Total (n)	189	102	57	3	351
Overall (%)	53.8	29.0	16.2	0.9	
NI (%)	78.3	17.4	2.2	2.2	46
ROI (%)	50.2	30.7	18.4	0.7	305
Pearson's Chi-squared test $\chi^2 = 15.8676$, df = 3, p-value = 0.001207	Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 15.8676$, df = N/A, p-value = 0.002999				
Total (n)	183	102	57	3	345
Overall (%)	53.0	29.6	16.5	0.9	
GP (%)	30.7	48.9	19.3	1.1	88
Hospital Staff (%)	48.0	29.3	21.3	1.3	75
Other (%)	65.9	20.3	13.2	0.6	182
Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) $\chi^2 = 33.8588$, df = N/A, p-value = 0.0004998					

A majority of respondents (53.8%) agreed that an ethnic identifier is helpful. There was a highly significant difference according to jurisdiction. A clear majority in NI, where there is an ethnic identifier used by some providers, agreed (78.3%), whereas respondents in ROI were more divided, just half said yes (50.2%) and around a fifth (18.4%) did not know. There was also a significant difference according to professional grouping to this question, with GPs (30.7%) least likely and the other category most likely to agree (65.9%) and hospital staff in the middle (48.0%).

Table 3B. 51: How often do you think that Travellers experience discrimination in their use of health services in general?

	Never	Rarely	Sometimes	Often	Very Often	Don't know	Refused	n
Total (n)	21	65	140	57	36	28	2	349
Overall (%)	6.0	18.6	40.1	16.3	10.3	8.0	0.6	
NI (%)	2.2	19.6	47.8	10.9	13.0	6.5	0.0	46
ROI (%)	6.6	18.5	38.9	17.2	9.9	8.3	0.7	303
Total (n)	21	65	134	57	36	28	2	343
Overall %	6.1	18.9	39.0	16.6	10.5	8.2	0.6	
GP (%)	6.8	22.7	38.6	19.3	6.8	5.7	0.0	88
Hospital Staff (%)	8.0	18.7	36.0	17.3	12.0	6.7	1.3	75
Other (%)	5.0	17.2	40.6	15.0	11.7	10.0	0.6	180

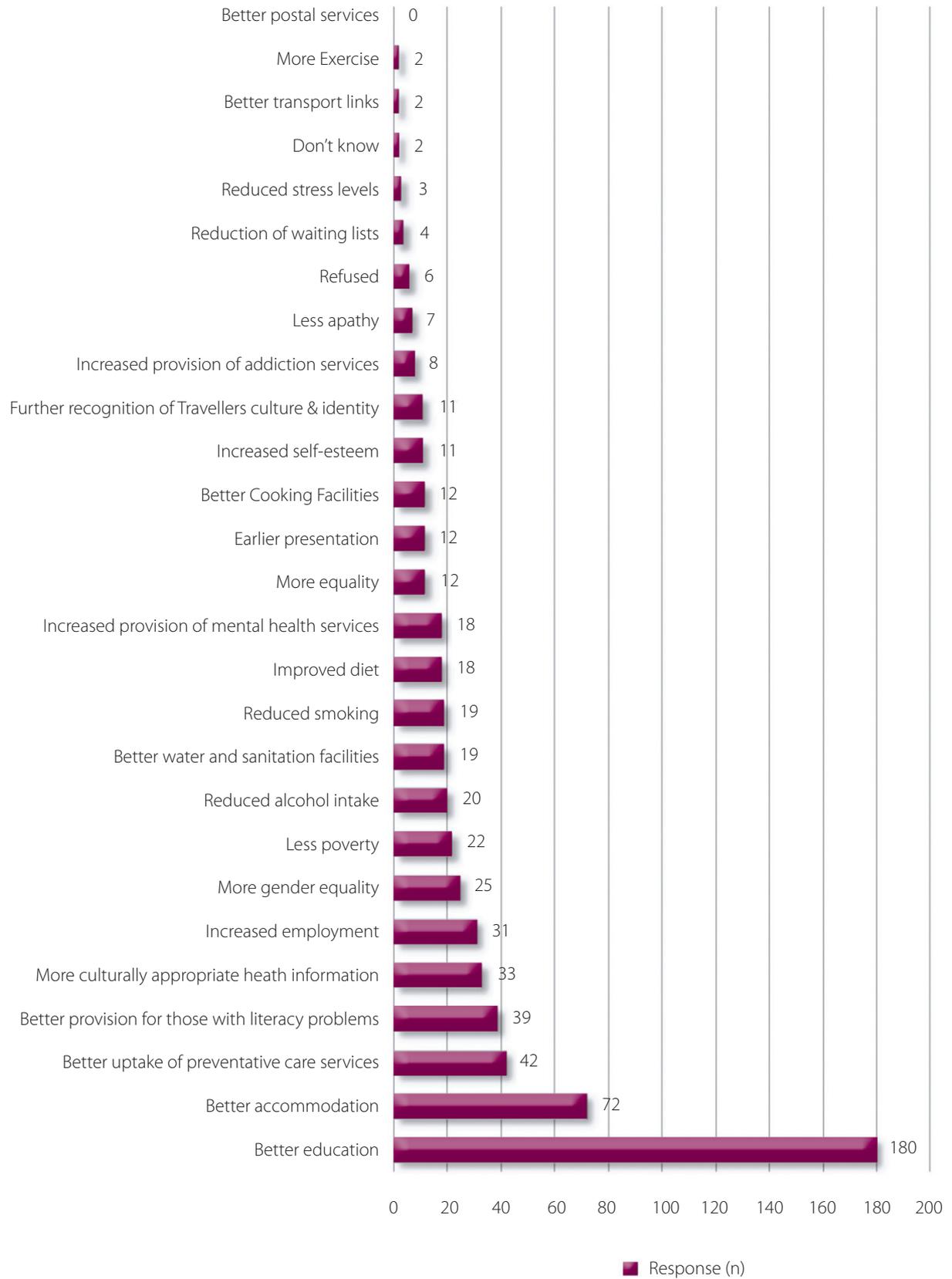
Respondents were asked two questions about discrimination. Firstly, they were asked how often they thought Travellers experience discrimination in their use of health services in general. While there was a wide range of responses to this question most respondents (66.7%) agreed either that it sometimes occurred (40.1%), or more often than that (26.6%). There was no significant difference of opinion on this according to jurisdiction or professional grouping.

Table 3B. 52: How often do you think Travellers experience discrimination in their use of the type of service you provide?

	Never	Rarely	Sometimes	Often	Very Often	Don't know	Refused	n
Total (n)	121	118	74	19	3	9	3	347
Overall (%)	34.9	34.0	21.3	5.5	0.9	2.6	0.9	
NI (%)	50.0	26.1	6.5	10.9	2.2	4.4	0.0	46
ROI (%)	32.6	35.2	23.6	4.7	0.7	2.3	1.0	301
Pearson's Chi-squared test χ^2 14.8659, df = 6, p-value = 0.02133			Pearson's Chi-squared test with simulated p-value (based on 2000 replicates) χ^2 = 14.8659, df = N/A, p-value = 0.03048					
Total (n)	120	114	73	19	3	9	3	341
Overall (%)	35.1	33.4	21.4	5.6	0.9	2.6	0.9	
GP (%)	39.5	34.9	18.6	5.8	0.0	0.0	1.2	86
Hospital Staff (%)	32.4	28.4	20.3	10.8	1.4	5.4	1.4	74
Other (%)	34.3	34.8	23.2	3.3	1.1	2.8	0.6	181

When asked how often they thought Travellers experience discrimination in the use of the type of service respondents they themselves provided, the pattern was somewhat different in that some people still indicated they thought discrimination sometimes or more frequently than that occurred (27.7%), but considerably less frequently than in general. There was a significant difference according to jurisdiction, half (50.0%) in NI saying it never occurred but just over a third (32.6%) in ROI saying never. There was no significant difference according to professional grouping on this question.

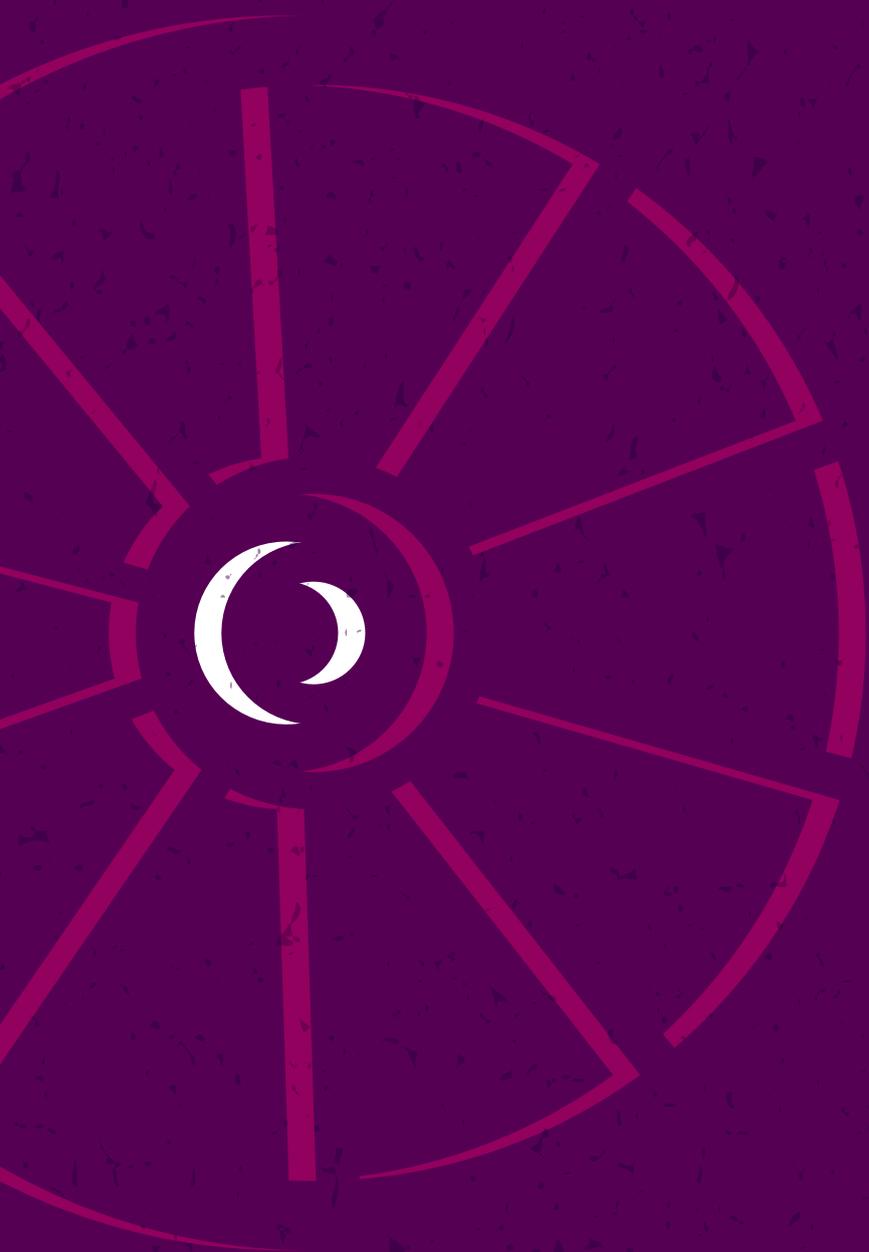
Figure 2: What things would most improve the health and wellbeing for the Traveller community?



All Ireland Traveller Health Study

Figure 2 again presents the response to an open-ended question on what 3 factors would most improve the health and wellbeing of the Traveller community, the format being both unprompted and then as necessary, prompted. Frequency of mention is presented in rank order. Again, better education was ranked by far the most highly, followed by better accommodation, better uptake of preventive services, better provision for those with literacy problems and more culturally appropriate services.

DISCUSSION



DISCUSSION

This Service Providers survey gives valuable insight into aspects of the current service delivery for Travellers and complements information gathered from other parts of the study. Respondents were selected in a purposeful manner but do represent a diversity of practice across all the main services and a spectrum of experience. We sampled in this way, as opposed, for example, to a bi-national random sample, because Traveller populations are concentrated in particular areas and many health professionals do not have much practical experience of care delivery to Travellers. Whilst as a consequence very few reported no Traveller engagement at all, and this was the principal reason given also for non-participation of those others we contacted, those interviewed extend from people with daily engagement with Travellers to those who see them less commonly.

This is agreement by Service Providers on many of the points Travellers themselves raised as problems, such as literacy, difficulty in following prescribed instructions, understanding of the consultation and the clinical implications of the encounter. These are well established points and are reinforced here. There are notably few differences according to jurisdiction suggesting a fairly typical reality, even though with the caveat that respondent numbers in NI are relatively small.

There is quite a lot of supportive evidence that suggests Service Providers, particularly those actually dealing with Travellers, do understand some of the dilemmas and barriers Travellers face and are willing to engage with addressing these. Travellers and Traveller advocates appear to have achieved quite a level of recognition on a number of issues. For instance, the majority of Service Providers do show an understanding of the wider health determinants and clearly recognise the importance of socio-economic, environmental and cultural factors, as well as individual lifestyle and access issues. They also acknowledge discrimination as a possible factor in service delivery. Education was recognised as critically important by Service Providers, both as a contributory factor for ill-health and the principal means of improving it. These findings in this section of the survey are significant positive considerations to capitalise upon in implementing the findings of All Ireland Traveller Health study as a whole.

Service Providers do agree too that communication and trust are factors of importance in working to provide services for Travellers. Again there is a need for a 2-way process here in triangulating these findings with the other parts of this survey. Trust, dignity and respect were important to Travellers in the census survey and the qualitative accounts amplify the importance of this. The professional, clinical ethos displayed by the service providers in this survey is important, as is quality of engagement. The scientific literature supports the need for cultural training in dealing with minority groupings and service providers seem very positively inclined to support that, on this evidence.

It is of interest that the ethnic identifier finds support in NI, where it is actually in place in some areas already and that there is still ambivalence about this in ROI. This shows the need for consultation and engagement with service providers on the ground if this is to be actually implemented into the future.

There are some notable differences according to professional category that merit comment and further policy exploration. GPs were the hardest group to engage with this survey, particularly in NI. This reflects the fact that they operate in a busy environment, are regularly asked to take part in surveys and many have no Traveller list. We did not have enough of the 'rarely or never' category to explore reasons for this in sufficient depth. However, given that the choice of doctor scheme still operates in ROI it is likely that the reasons given a decade ago in the Task Force Report (Report of the Task Force on the Travelling Community, 1995) are similar and still relevant today. The qualitative consultation corroborates that many of the barriers are practical and operational in nature. GPs were least likely to rate as very important the wider health determinants, least likely to have had engagement with Traveller advocates or awareness training. However, they were more likely to find engagement with Travellers easier than other groupings, reflecting the fact that they provide frontline services and offer care for minor as well as more serious conditions.

The hospital respondents differ in their response to the GPs, again reflecting the nature of care they offer. They are most likely to prescribe medication on a par with other patients, to have encounters that present difficult communication challenges and have little engagement with continuity of care or preventive service issues. The Other Professional category does contain a heterogeneous group of community or management providers, but they have the most appreciation of the issues Traveller advocates wish to see addressed and have had more engagement with those issues.

There are some important demographic concerns raised in this survey that link to findings in the other sections. We see that children are the first priority with Travellers, and women engage earlier than men. The presentation for antenatal and postnatal care continues to be important. Given the mortality findings in the vital statistics sections, particularly for men and in relation to respiratory and cardiovascular disease, it is important also to get earlier and more active engagement, especially in primary care, and to address the need for more engagement by Travellers in preventive services and follow-up, particularly for management of chronic disease, such as for respiratory and cardiovascular conditions. The poor health of male Travellers documented in our other reports, and the perception that they present particularly late for care, suggest need for urgent action to engage with this group of people.



