Developing the Cultural Competence of Health Professionals Working with Gypsy Travellers

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This project explored one of the issues affecting access to health care services by Gypsy Travellers, namely the cultural competence of health professionals. The aim of the project was to support the development of cultural competence in health professionals through an exploration of staff attitudes, knowledge, and understanding of the cultural identity and health needs of Gypsy Travellers.

Participants were drawn from community nursing services and members of the Irish Traveller community. The data collated from staff suggested there was limited understanding of Gypsy Traveller culture, health needs, or issues affecting the community, and the perceptions held were informed largely by negative media stereotypes.

The benefits of honest, nonjudgmental, open discussion within professional forums about the existence and impact of bias and prejudice on practice were highlighted alongside the need for an improved understanding of the issues faced by Gypsy Travellers to improve access to care by this often excluded and marginalized community.

Definitions of *Gypsies* and *Travellers*

In the United Kingdom, *Gypsy Travellers* is an umbrella term consisting of Welsh and English Romanichal or Romany Gypsies, Scottish and Irish Travellers, and, more recently, European Romanichals or Roma. Other traveling communities include Fairground or Showmen, New Travellers, and Bargees (also known as Water Gypsies).

Liegeois and Gheorghe (1995) define *Gypsies* as ethnic groups that formed as commercial, nomadic, and other groups traveling away from India from the 10th century and mixing with European and other groups during their diaspora. The term *Traveller* is said to describe a member of any of the native European ethnic groups whose culture is characterized by nomadism, occupational fluidity, and self-employment, including people who have stopped traveling temporarily or permanently because of educational or health needs.

Introduction

The health status of Gypsy Travellers is considerably poorer than other English-speaking minority ethnic groups (Cemlyn, Greenfields, Burnett, Matthews, & Whitwell, 2009; Doyal, Cameron, Cemlyn, Nandy, & Shaw, 2002; Parry et al., 2004; Royal College of Gynaecologists, 2001; Van Cleemput, Parry, Thomas, Peters, & Cooper, 2007). The reasons for this disparity are generally attributed to poor accommodation, poor access to health services and education, discrimination, and racism, both actual and perceived (Facione & Facione, 2007). Other reasons are thought to be a lack of understanding of the needs of Travellers and Gypsies by health professionals.

This project focused on an issue affecting access to health care services by Gypsy Travellers: the cultural competence of health professionals. Evidence suggests that receiving cultural competence training increases confidence and awareness of the care requirements of ethnic minority patients (Beach, Rosner, Cooper, Duggan, & Schatzer, 2007; Pearson et al., 2007). Training enables people to become more reflective about their practice and cultural competence. Developing a comprehensive understanding of a minority group's culture enhances communication and facilitates the flexibility and openness necessary for communication between people of differing cultural backgrounds.

The project recruited health professionals drawn from community nursing, including health visiting (public health practitioners), to begin to understand their information needs about and attitudes toward Gypsy Travellers. Irish Travellers were also recruited to establish what they felt were the important things that health professionals should know about the community and to answer the questions health professionals had about Gypsy Travellers. The project was based on the need not only to provide information about the community but also to understand the attitudes and perceptions staff had of the community and raise awareness of the impact these might have on practice and service delivery. Although the project focused primarily on the needs of individual professionals, it is acknowledged that if there is no firm commitment to cultural competence at an organizational level, as individuals move on, good practice may be lost to organizational memory.

Background

There have been a number of studies investigating the health of Gypsy Travellers (Barry, Herity, & Solan, 1989; Feder, Vaclavik, & Streetly, 1993; Hawes, 1997; Parry et al., 2004). The emergent themes are common to other excluded communities: an inverse relationship between health needs and access to or use of services, poor housing conditions, high unemployment, and lack of access to education. Concern for the health status of the Gypsy Traveller community remains despite the focus of government policy on the reduction of health inequalities, because Gypsy Travellers appear not to have benefited from the improvement in health experienced by other communities.

Parry et al. (2004) found that Gypsy Travellers had higher death rates for all causes and lower life expectancy than the non-Traveller population. This study also found Gypsy Travellers to be more likely to have long-term illness or disability; compared with local and national data, bronchitis, asthma, and angina were much more prevalent in Gypsy Travellers. Gypsy Travellers also had more problems with mobility, self-care, pain, anxiety, and depression. They were also found to have high levels of infant mortality and perinatal death, low birth weights, and high child accident rates.

Travellers have expressed the need not to have specialist, targeted services but that nurses and doctors be taught to respect people (Van Cleemput et al., 2004). Where specialist workers were provided, Travellers expressed an appreciation; however, the expressed need was to experience service on par with other users. There is evidence (Hawes, 1997; Parry et al., 2004; Van Cleemput et al., 2007) suggesting that one of the reasons Gypsy Travellers fail to access health services in a timely fashion is the expectation and past experience of poor treatment. The marginalization of Gypsy Traveller communities is deep-rooted, and although laws legitimizing discriminatory treatment, imprisonment, and even execution for being a Gypsy were largely repealed during the 19th century, the Commission for Racial Equality (CRE; 2006) describes Gypsy Travellers as continuing to experience the last "respectable" form of racism. It is argued that negative stereotypes perpetuated in the media influence the public's view and attitude toward Gypsy Travellers, leading to racist attitudes becoming acceptable and rational (Morris, 2000).

Narayanasamy (2002) suggests that racism is at the root of many barriers to health encountered by Black and minority ethnic (BME) people and concludes that the development of transcultural nursing models and assimilation of these into practice is vital in combating these barriers. Professional development that leads to self-awareness, an awareness of diversity, the ability to care for individuals, and being open to other cultures is a process encapsulated in the notion of cultural competence (Jirwe, Gerrish, & Emami, 2006).

Aim and Objectives

The aim of the project was to support the development of cultural competence in health professionals working with Gypsy Travellers. To achieve this aim, it was necessary to understand the needs of staff. The first objective, detailed next, was identified. Two further objectives designed to increase the understanding health professionals had regarding Gypsy Traveller cultural identity and health issues were identified.

Establishing the kind of attitudes held by staff, and the range of questions they had, was crucial to the development of cultural competence resources tailored to the needs of staff. The objectives were:

1. To identify the questions and attitudes health professionals had regarding Gypsy Travellers

2. To develop an information booklet based on the frequently asked questions of health professionals pertaining to the cultural identity and health needs of Gypsy Travellers

3. To develop the content for cultural competence training with specific reference to Gypsy Travellers

Methods

Two groups of participants were involved in the development of the resource contents: community health staff and Irish Travellers. Of the community

nursing participants, 40 staff members (varying in seniority and including school nurses, health visitors [public health practitioners], community matrons, health care support workers, and nursery nurses) from different services and directorates within an inner-city community health trust agreed to participate.

A mixed-method approach, consisting of anonymous survey data, group discussions, and one-to-one sessions, was adopted.

To maximize candor, staff members took part in an activity that would ensure complete anonymity. They were asked to take two sheets of paper; on one they were asked to write down three things, words, or statements that came to mind on hearing the terms *Gypsy* or *Traveller*. On the other, they were asked to write down two questions about Gypsies and Travellers that they wished to have answered. The questions were scrutinized and, where necessary, reframed (while maintaining the gist of the question) to reduce any perceived offense when used to interview the Traveller community.

The findings from health staff were taken back in feedback sessions and were used to establish what information staff themselves felt would be useful in addressing attitudes formed in absorbing negative stereotypes. These consisted of discussions on Traveller culture, health inequalities within the Traveller community, and the factors that affect access to health services. Participants also talked about their understanding of cultural competence and what the constituent components might be. Afterward, discussions took place on how private views might affect the way that health care workers practice and whether it was possible to compartmentalize personal views and professional practice. There was also some discussion on what informed one's views: Did negative media stereotypes, influential "others," or personal experience influence professionals? Participants were then given

examples of some of the comments written by staff on hearing the terms *Gypsy* or *Traveller* and asked to consider these questions:

1. If you were from a community about whom these views were held and you knew you were viewed in this way, how might it affect the way you accessed a service?

2. If we (health professionals) hold these views, do we need to challenge them?

3. If you were a professional who held these views, what would need to happen to make you change your mind?

Traveller Community Participants

The project was publicized by word of mouth within the Irish Traveller community, and members were invited to take part in interviews that would inform a staff information booklet. They were reassured that their comments would remain anonymous, unless explicit permission was given, and that they would be consulted throughout the process.

Twenty-five Irish Travellers (20 women, 5 men), aged 20 to 60 years, agreed to take part and were drawn from council-run Traveller sites, an unauthorized encampment, and from those living in bricks-and-mortar accommodation (Housed Travellers). They answered questions that health staff posed and talked about what they felt health professionals needed to know about their community. The answers given by Travellers have been used verbatim in the booklet. On completion, the Travellers were consulted again to ensure they were happy with the way they were portrayed and that the content was representative of them.

Findings

The findings were structured into two areas: one concerning responses of health staff to hearing the

term *Gypsy* or *Traveller* and the second looking at questions articulated about the Gypsy Traveller community, with Traveller responses to those questions.

On Staff Hearing the Term *Gypsy* or *Traveller*

A total of 132 words or statements were generated by participants on hearing the terms *Gypsy* or *Traveller*, which were collated into 11 themes (see Table 1). A selection of the words and statements are included in the text.

Of the 132 words or statements submitted, 2 were categorized as positive:

> Free thinkers
> Once they get to know you and how you
> are there to help, they are friendly

The three other smallest categories (with regard to the number of responses) were associated with "Names," "Origins," and "Employment." These statements reflected knowledge of two constituent members of the Gypsy Traveller community—Roma from Eastern Europe and Irish Travellers. No mention of other Gypsies or Travellers, such as English Gypsies or Romany, New Travellers, Bargees, Fairground, or Showmen, was made.

Only three words illustrates an understanding of how Travellers might earn a living. However, the theme entitled "Media stereotypes" contained several references to theft and stealing:

> Drives (tarmac/paving)
> Jobless
> Benefit (welfare) reliance

Six references to the community being an excluded group that was seen as "hard to reach" were made, demonstrating some recognition that the community was sometimes misunderstood and isolated.

Some responses acknowledged the existence of health problems; these were attributed to nonengagement, aggression toward health staff, and refusal to accept interventions, including immunizations.

Some of the statements regarding problems encountered by Travellers implied that these were self-inflicted and based on poor relations with the settled community. Other reasons for problems were said to be disadvantage related to poor finances and benefit reliance.

Responses relating to accommodation demonstrated limited awareness that the majority of Travellers now lived in bricks-and-mortar accommodation; entries were restricted to references of no fixed abode, nomadism, and caravan dwelling.

There was a moderate number of entries regarding education; referring to poor education, poor literacy, and school non-attendance associated with mobility, responses included:

> Uneducated
> Have many uneducated children
> Can't read or write

Table 1

Themes from Responses Elicited on Hearing the Term Gypsy or Traveller

Theme	Nos.	Theme	Nos.	Theme	Nos.
Names	1	Exclusion	6	Accommodation	15
Positive	2	Health	7	Way of life	20
Employment	3	Problems	8	Media stereotypes	54
Origins	5	Education	11		

"Media stereotypes" was by far the largest theme, containing 54 separate words or statements that focused on dishonesty, violence, alcohol misuse, hygiene, rubbish, untidiness, and the inadequate care of children:

> Begging on the train with small child, disgusting
> Illiterate society without focus and purpose
> Lots of dirty children with no shoes
>
> Can't be trusted
> Dodgy lifestyle
> Stealing
>
> Own worst enemy
> Environmental hazard to any area where they settle
> Putting spells on people
>
> Cheap jewelry
> Thieves
> Con artists

Within the second largest theme, "Way of life," the focus was mobility and nomadism. High teenage pregnancy rates were cited; and drinking, fighting, and being nonconformist were considered prominent features of Traveller life. Responses included:

> Troublesome set of people
> High intake of alcohol in adults
> Lawless

Questions from Health Staff

The 82 questions posed by staff groups were grouped into 13 themes (see Table 2). There were very few questions about Gypsy Traveller origins, what defined Gypsy Travellers, and where or who the local Gypsy Traveller communities were. The greatest numbers of questions concerned culture

Table 2
Themes from Questions Articulated by Health Staff

Themes	Nos.	Themes	Nos.	Themes	Nos.
Discrimination	1	Aspirations	4	Nomadism	9
Origins	2	Accommodation	6	Culture	14
Names	2	Services	6	Education	15
Local Travellers	3	Income	8	Health	3
Exclusion	9				

and education. These questions focused on what it was like to be a Traveller, why Travellers lived the way they did, and what Traveller values and traditions were.

There was some evidence of recognition that Travellers were an excluded group and that this necessitated finding ways to reach out to the community. Nevertheless, some questions were couched in a way that implied self-imposed exclusion. A small selection of the questions asked and Traveller responses are included here.

> Staff question 1. Why do they not mix with those outside their community?
>
> Traveller response: We do mix … if we get close to a friend. It's not easy because they don't understand the culture, but we like mixing with people who understand us.
>
> Staff question 2. Why do they like isolated lives?
>
> Traveller response: Sometimes you might feel that it's easier to be with people who understand you … it can be hard mixing … and then you still see signs saying "No Travellers."

Staff question 3. Do you feel isolated?

Traveller response (Housed; as opposed to a Traveller site with caravans and trailers): I feel very isolated, not just me but my children … they're lost. My daughter's got a Facebook page for her English friends and another for her Traveller friends and family … she more or less has two identities … I think psychologically somewhere down the line, there's problems with things like that. That's why I make a conscious effort to show her more of the Traveller's way of life.

It was evident from some questions that broad assumptions were being made about Travellers' unwillingness to mix with the settled community. Travellers' responses agreed that there was a preference for mixing with members of their own community; however, this was not to the exclusion of the wider community. The apprehension expressed by some Travellers about mixing with the settled community, or "country people," was associated with negative past experiences and the need to preserve culture.

Staff question 4. Do you feel discriminated against?

Traveller responses:

Yes. Like going to pubs, you see the sign "No Travellers." If you're having a wedding, they won't give you a function room if they find out you're a Traveller. When you're walking on the street, sometimes you get racist remarks.

Sometimes. Like the other day, my children were being called trailer trash, but what's interesting to me was the week after the program on Travellers' weddings on television, they got some status in school. It's

interesting how people can change their point of view if they're given enough information.

Questions arose from staff suggesting that living in accommodation other than a house was abnormal. Inferences drawn from questions about nomadism illustrated a lack of awareness of how deeply embedded within Traveller culture the need to roam might be. There was little expressed by health staff that indicated an awareness of the pressures on Travellers to abandon a traveling lifestyle or a realization that there were now more Travellers living in houses than on Traveller sites

Staff question 5. Why are you called Travellers if you're living in a house?

Traveller response (Housed): Travellers' nothing to do with whether you're living in a house or a trailer; it's to do with your blood. It comes from our ancestors, so it doesn't make a difference where we have to live or where we stay. We have Travellers' blood.

Staff question 6. What are the main values of the Traveller community?

Traveller response: Being strict with the children. Making sure they marry within the community, but not necessarily … some do marry outside the community. Passing on the traditions to the next generation … what was taught to me.

There was also an assumption that education was unimportant to Travellers, There appeared to be limited understanding of the tensions that might exist for Travellers between engagement in formal education while preserving the importance of maintaining cultural life and the value of informal education.

Staff question 7. Why isn't education important to them?

Traveller response: My daughter's at school and I want her to do well, but it's important for her to see the other side of life as well … here she doesn't know who she is, she's losing her identity.

Staff question 8. Why do you allow your kids to miss out on school?

Traveller response: Traveller boys, when they're 14 or 15, they want to do what their fathers is doing, so they wanna start working for their living … because some of them be married at 16 some at 17 or 19. They more or less take up in their father's footsteps. They learn at a young age at 14 and 15 so they have a trade when they get married. That's why Traveller children, boys, doesn't continue school … and girls don't continue school because they've got to work the way Traveller women work, they have to learn to cook, clean, and provide.

Questions about aspirations spoke of dreams and goals for the future, both for children and for Travellers in general.

Staff question 9. What dreams or goals do you have for your children?

Traveller response: I'd want them to follow in our footsteps, but that'd be their decision, I can't make that decision for them.

My dreams are their dreams really. There are certain rules for me and certain things I wouldn't accept them doing, but if they choose to work and have a life before they settle down then I'm happy for them to do that.

Staff question 10. What does the future hold for Travellers?

Traveller responses: I don't think about the future much really, I don't, I don't really get time … to be honest … I just hope for the future that everyone's happy and there's no tragedy.

I think we're gonna become extinct, that's exactly my thoughts. It's OK having four or five sites but there's loads of Travellers out there and they're disappearing … the law's making things hard.

An assumption that Travellers didn't like working was made, and questions were asked about how they made money or whether they claimed benefits.

Staff question 11. Do Travellers have or hold down full-time jobs?

Traveller response: We like to work for ourselves … the men will work tarmac, sell carpets, rugs, sell sofas … going to markets or selling them door to door. They might buy and sell cars.

Regarding health and accessing services, some questions did recognize that a nomadic lifestyle might pose difficulties when trying to access health services, and it was clear that that there was a need to make services more responsive and appealing.

Staff question 12. What can we do to make services more appealing to you?

Traveller responses: You want to go somewhere where you feel you're gonna be listened to … you're not gonna be judged.

I feel if they told us more about the services, if they came and talked, we'd understand a bit more about them.

Some interest in health issues affecting Travellers was noted, and questions about preferences concerning illness and death and where care was delivered were asked. In addition, there were questions about gaining a deeper understanding of Travellers.

Staff question 13. What specific health issues do Travellers have?

Traveller responses: There's loads of Travellers who's depressed, too much stress, too many problems … and they won't get help, or maybe they'll get depression tablets from the doctor but they won't see anyone else, 'cause if anyone finds out, you'll be blacklisted … they'll think you're a nutter.

I don't know if we're different from other people … maybe we take a while to go to the doctor, sometimes you've that many things to be seeing to, you leave things to the last minute … when it's really bad.

Staff question 14. What's the most important thing health professionals should know about Travellers?

Traveller responses: Sometimes Travellers need things explained. You'll be dying of shame and you won't say you didn't understand. We need things put simply … not so many big words … you think you're breaking it down for us, but you're not.

A lot of us are ignorant of things … we won't get ourselves checked out, we're afraid … we don't go unless we really, really have to.

Although staff members were asked to provide questions regarding Gypsies and Travellers, those questions were used to interview community participants who were drawn solely from the Irish Traveller community. As a result, it was acknowledged that the scope of the booklet was limited by both the depth and range of topics covered and by the limitations imposed by community participants coming from the Irish Traveller community only. Readers of the booklet were advised that although Gypsies and Travellers had similar cultural practices, they were distinct ethnic groups and should be seen as such.

Staff responses to the terms *Gypsy* and *Traveller* enabled the content of staff training to be developed in a way that addressed levels of ignorance and negativity regarding the wider Gypsy Traveller communities. This involved providing definitions that distinguished among the different Gypsy Traveller groups and their origins, history, and cultural practices.

Discussion

Some of the health inequalities experienced by Gypsy Travellers are recognized as being due to poor access to health services, poor literacy, and poor accommodation and lifestyle choices. A lack of understanding by health professionals about the needs of the community coupled with discriminatory practices, individually or institutionally orchestrated, are also linked to reduced access and use of services by Gypsies and Travellers. Gypsy Travellers often cite past negative experiences and the expectation of poor reception as one of the reasons for failing to access health services in a timely or appropriate fashion. The necessity to unpack aspects of this issue and explore how Gypsy Travellers were viewed by health professionals formed the basis of this project, which included examining attitudes and reflecting on what changes, if any, needed to take place.

During data collection, at the point of generating responses to hearing the terms *Gypsy* and *Traveller*, some staff members asked: "Am I doing this with my personal or professional hat on?" The inference from this question suggests a perceived ability to compartmentalize professional and personal views. Whether this is possible or to what degree this might be done is questionable. Nevertheless, the United Kingdom Nursing and Midwifery Council (NMC) Code of Conduct (Nursing and Midwifery Council, 2008) states that individuals must demonstrate both a personal and professional commitment to equality and diversity. Here there appears to be no line between the personal and professional.

Although nurses and midwifery health professionals are subject to the NMC Code of Conduct, they are inevitably influenced by and reflect the wider society within which they live. Within the caring professions, the motivation to express professional group norms that reflect the NMC Code of Conduct is high; however, it can be argued that having also been influenced by negative and racist societal views, health professionals' behavior and practice will inevitably be tinged with negative or contentious views to a greater or lesser degree.

Within professional groups, the expression of negative views may be suppressed to fit with what is seen as the group norm. Subsequently, it may be difficult to conclude whether professionals are genuinely culturally competent or whether they are just expressing views that support the group norm. Dowden and Robinson (1993) suggested that the suppression of prejudice is not always motivated by personal or professional integrity or an inner hunger for justice or equality. Rather, the suppression of prejudice is often motivated by an attempt to conform to perceived social or group norms regarding the appropriateness of expressing prejudice. As cultural norms become progressively more negative regarding overt expressions of prejudice toward ethnic or racial groups, and as people become more sophisticated, they become motivated and skilled at repressing socially inappropriate forms of prejudice. Crandall, Eshleman, and O'Brien (2002) also hypothesized that expressed prejudice was a direct function of its social acceptability, and the public expression of prejudice was very highly associated with social approval of that expression. This view speaks to conclusions reached by the Commission for Racial Equality (2006) maintaining that discrimination against Travellers was the last "respectable" form of racism, resulting in negative views about the Traveller community achieving acceptability and going unchallenged as a result.

Although the existence of "respectable" racism is acknowledged, within professional circles it may still be considered unwise to divulge such views. Jones's (2010) work on unconscious bias concludes that having prejudice is normal but admitting to it is career suicide. This can lead to a culture of denial, which in turn perpetuates failure to explore attitudes and raise awareness of our unconscious biases. He argues that awareness of our bias is therefore pivotal to achieving sustainable and authentic behavior change, and he suggests that we develop control of our natural prejudicial instincts by accessing our ability to prevent innate reactions from becoming behavior. Jones suggests that, as with muscles, which have memory for repeated actions, we can develop this ability by increasing our awareness of our own prejudices through practice. Self-awareness is an integral part of many cultural competence frameworks and is indeed fundamental to the reflective process within nursing practice.

If individuals fail to acknowledge the pervasive nature of bias, prejudice, discrimination, and

the negative impact it may have, both on practice and on the delivery of equitable service, it will be difficult to move forward to a point where a safe environment can be developed in which to discuss and unpack those issues that inform professional practice when working with Gypsy Travellers. Currently, the main forum where these issues are addressed is within the equality and diversity training agenda; however, for authentic assimilation of cultural competent values to take place, there is a need for robust and open discussion within the practice arena (Campinha-Bacote, 2008). There is potential for this concern to be addressed through practice development and clinical supervision forums; however, there is a need for buy-in at a high organizational level.

Despite doubts about how effective assessment tools are, Brach and Fraser (2002) conclude that a business case can be made for cultural competence training as an effective tool for reducing disparities in health care. In examining cultural competence, the focus must be not only on individuals within an organization but on the organization itself. Organizations that seek to meet the needs of culturally diverse clients must demonstrate systemic and clinical cultural competence by examining the processes and structures that support discrimination (Betancourt, Green, & Carrillo, 2002).

Campinha-Bacote (2008) argues that one construct that has received little attention is cultural desire. Cultural desire is described as the motivation to "want to" take part in the process of moving toward cultural competence rather than to "have to." This issue appears to be a key factor in unpacking reasons for the gap between knowledge and practice when caring for Gypsy Travellers or members of any BME community.

The NHS and the desire to tackle health inequalities were founded on principles of social justice. Pacquiao (2008) closely links the notion of cultural competence with the pursuit of social justice and a commitment to the protection of human rights. Where the promoted organizational social norms mirror the components of cultural competence frameworks, organizational cultural competence provides a backdrop for staff and, in so doing, reinforces social justice values.

The business case for cultural competence training can still be made in financially straitened times, with improved patient care, experience, and satisfaction being outcomes that speak very clearly to the quality agenda (Glazner, 2006; Pearson et al., 2007). The development of a more culturally competent workforce leads to more effective care (Brach & Fraser, 2002; Leininger & McFarland, 2002), and services with an awareness of the cultural identity and health needs of Gypsy Travellers are better positioned to provide services that meet the needs of that community (Foster Curtis, Dreachslin, & Sinioris, 2007). Movement of the debate from equality and diversity to that of embedding cultural competence will demonstrate the responsiveness of health services to diverse community needs.

Conclusion

The aim and objectives of the project were to support the development of cultural competence in health professionals who might come across Gypsy Travellers professionally. Four key points emerged from the project:

1. Health staff members often had a limited understanding of Gypsy Traveller culture, health needs, or issues affecting the community. Data collated from anonymous responses and discussions generated in the feedback sessions suggested that many participants had

perceptions of Gypsies and Travellers that were informed by negative media stereotypes. The focus of questions about the community was education and culture, with very few questions regarding health or discrimination.

2. Staff members appeared confident in their ability to compartmentalize their professional and personal views; however, how easily or effectively this can be done is questionable, and we may leak negative views back and forth into different areas of our lives.

3. Given the opportunity to discuss uncomfortable issues in a safe environment, staff members demonstrated willingness not only to challenge themselves but to also be challenged and to explore their attitudes. Time spent in the development of the frequently asked question booklet, incorporating the staff feedback sessions, provided opportunities to share and explore the potential influence of negative media coverage of the Gypsy Traveller community on professional practice. In reviewing examples of the data during these sessions, many staff members commented on how seeing several negative stereotypes together engendered a feeling of uneasiness, causing them to reflect on what knowing that others had negative perceptions of them might mean for the Gypsy Traveller community.

4. Establishing bias as a normal human survival mechanism can help provide an environment where negative views can be challenged without alienating the holders of those views. Doing this facilitates safety and allows the benefits of honest, nonjudgmental, open discussion within professional forums to be demonstrated. Within this environment, it is then possible to talk more freely about the existence and impact of bias, prejudice, and discrimination on professional practice.

Based on the issues identified from the data analysis conducted for this project, three areas for further work have been identified:

1. Development and delivery of training for health staff in partnership with Gypsy Travellers that identifies the existence of different ethnic cultures within Gypsy Traveller communities

2. Development of robust cultural competence training programs, including the use of validated competency assessment tools, firmly embedded within the mandatory equality and diversity agenda

3. Targeted interventions and outreach to raise awareness within the Gypsy Traveller community of available services

There is potential to improve Gypsy Traveller engagement with services and health professionals, such that community members are empowered to access mainstream services and, in due course, contribute to reduced health inequalities. Culturally competent commissioners and providers, who are sensitive to the needs of Gypsy Travellers and able to build partnerships across statutory and voluntary organizations and the Gypsy Travellers, will be well positioned to develop joint and effective responses to the health needs of the Gypsy Traveller community. ◆

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