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Traveller Community and health practitioner stories of self and each other: A poststructural narrative analysis

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The University of Edinburgh
2018

Declaration

I declare that this thesis has been composed solely by myself and that it has not been submitted, in whole or in part, in any previous application for a degree. The work presented is entirely my own.

Signed



.....
Natalie Forster

October 2018

Abstract

Research attention to Gypsy and Traveller health has grown in recent decades and highlights significant inequalities in health and access to services experienced by these groups. Existing work in this area tends to prioritise consideration of how Gypsies and Travellers speak from a position of belonging to their particular ethnic or cultural group, often producing fixed and universal claims about the health beliefs and experiences of Traveller Communities. Little research explores the social production of Gypsy and Traveller health identities, or how ethnicity may intersect with wider identity positions in Traveller Community accounts of health. In addition, health practitioner and Traveller Community accounts have rarely been considered alongside one another, and the ways health practitioners construct identities in relation to their work with Traveller Communities has largely evaded the gaze of health and sociological research.

This thesis sought to contribute to understanding of these areas. It examined the identity positions Traveller Community members and health practitioners project for themselves and each other, and where these identities collide or coalesce in stories of health interactions. Poststructuralist informed narrative inquiry guided interviews with Romany Gypsies, Irish Travellers and health practitioners working with these groups. This approach was chosen for its view of identity as multiple and shifting, and as it enables concurrent attention to both the discourses governing possibilities for talk about Traveller Community health, and how actors work within these constraints to give accounts of themselves.

An analysis of participant narratives reveals two overarching areas of potential concordance or dissonance in the identity positions claimed by health practitioners and Traveller Community members. The first contrasts the 'body work' practitioners undertook to downplay 'professional' identity and position themselves as close to community members, with Gypsy and Traveller requests for greater access to professional advice and medical screening. The second concerns divergence in the extent to which Traveller Communities were presented, and presented themselves, as future-oriented in relation to their health. Drawing on poststructuralist theory, I argue that representations of Gypsy and Traveller orientations to time and space are central in the positioning of these groups as compliant or resistant to health advice, and to understanding relations of power and resistance in health interactions. The

thesis generates insights for communication between health workers and Traveller Community members, suggesting a need for attention not only to cultural or structural barriers, but reflection on how practice is influenced by the stories we tell about Traveller Communities, the identities practitioners claim for themselves in relation to their work with 'disadvantaged' groups, and the interests these serve.

Lay summary

Research suggests that Gypsy and Traveller Communities experience significantly poorer health outcomes and increased difficulties accessing health services compared to many other groups. Explanations for these inequities in existing literature tend to focus in on the unique health beliefs and experiences of these groups and produce sweeping statements about how Traveller Communities *are* in relation to health. This risks categorising Traveller Communities as ‘all the same’ or reinforcing the exclusion of Gypsies and Travellers by emphasising their difference.

The research reported on here aimed to accommodate variety and complexity in Traveller Community health narratives by exploring how Gypsies and Travellers may experience health not only as a Gypsy or Traveller, but by reference to other everyday roles. It also sought to address the lack of opportunities observed within existing research for Gypsies and Travellers to tell their own stories and describe themselves in relation to their health. By considering health practitioner and Traveller Community accounts within the same study, it intended to hear both ‘sides’ of the story and understand where these groups are ‘reading from the same page’ and where the stories we tell may need to be adjusted to work more effectively together. These aims were accomplished through the adoption of a narrative approach involving interviews with Romany Gypsies, Irish Travellers and health practitioners working with in a public health capacity with these groups.

Findings revealed two key areas in which there was potential for misalignment in the roles that health practitioners and Traveller Communities project for themselves and each other. The first concerned stories about access to health screening and advice. While health practitioners often worked to portray an image as close to community members by downplaying ‘professional’ signals, Traveller Community members themselves communicated a desire for greater access to professional advice and medical screening. The second relates to differences in the degree to which Gypsies and Travellers were presented as concerned with their future health. While Traveller Communities often accepted the need to change their behaviour now to be healthy in future, an ingrained narrative that Travellers were less able to prioritise future health led to a reluctance to broach health behaviour by practitioners. This thesis adds to understanding of how communication between health workers and Traveller Community members can be facilitated. It suggests a need to consider not only

cultural or structural barriers to health and service access but promote reflection on the ways that taken for granted stories and the framing of practitioner roles may impact on practice.

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Transcription key

()/(word)	Signifies uncertainty about speech
[word]	Indicates authors insertion
[Indicates beginning of overlap in speech
]	Indicates end of overlap in speech
...	Signifies where words have been removed from the quote
(laughs)	Indicates laughter

CHAPTER 1 - Introduction

“We are what we pretend to be, so we must be careful about what we pretend to be” – Kurt Vonnegut

This thesis explores the preferred health identities of Gypsies and Travellers and where these identities collide or coalesce with those expressed by health practitioners in relation to their work with these groups. There is mounting evidence that Traveller Communities experience significant health inequalities (Cook *et al.*, 2013), accompanied by increasing analysis of the reasons for such poorer health status (Foldes and Covaci, 2012). Indeed, the ‘problem’ of Traveller Community health can be understood as a contested and politicised space, characterised by competing claims about the nature of Gypsy and Traveller relationships to health. Whether differences in health status are best accounted for by cultural or structural factors forms the crux of much of this debate (see for example Smith and Newton, 2017). Rather than adding another voice to such analysis, or providing further explanations for Traveller Community health, I aim to create a space whereby ways of talking *about* Gypsy and Traveller health, and their attendant effects, are themselves opened up for questioning. The thesis intends to redress what I saw as limited opportunities within existing literature for community members to describe *how they wish to be seen* in relation to their health, as well as a gap in understanding around how practitioners present accounts of themselves and their roles when working with Gypsies and Travellers. I argue that we cannot understand the exclusion or inclusion of Traveller Communities in matters of health, by examining only cultural differences, or structural barriers in access, important though these may be. Rather, I suggest that we must also appreciate the potential for concordance or discordance in the versions of self that Traveller Community members and health practitioners project for themselves and each other, or in the spirit of the above quote, what they each ‘pretend to be’.

This chapter begins with a justification of the terminology adopted throughout the thesis in relation to both Traveller Communities and health practitioners and sets out the reasons for the particular focus on public health roles and practice. Following this, and in a bid to establish the topic’s contemporary relevance, I place the thesis against a backdrop of popular culture, media and policy treatment of Traveller

Communities and demonstrate the limited degree to which discourses on Traveller Community rights have been taken up in practice. The contribution of the research to existing fields of inquiry, and that on Traveller Community health in particular, is then outlined, before I set out the rationale for the theoretical approach adopted and attend to its potential limitations. An account is given of my own position in relation to the study, providing the reader with an insight into the motivations and values that have inevitably shaped my orientation to the research. The chapter finishes by detailing the structure and argument of the remainder of the thesis.

1.1 Definition of terms

There is considerable definitional confusion surrounding the use of terminology to refer to Traveller Communities (Maestri, 2017). The terms 'Gypsies', 'Roma', 'Travellers' and 'Traveller Communities' are often used individually, or in combination, as container categories to describe diverse groups. This is despite the distinct cultures of these communities and their potential self-identification with one label in particular (Leeds GATE, 2014). For instance, the label of 'Roma', which is used as a political category in Europe (Council of Europe, 2012; Traveller Movement, 2015), is often extended to encompass Traveller communities native to the UK, even though this term is not usually acceptable to English Romany Gypsies, Irish Travellers, or Scottish or Welsh Gypsy Travellers. A distinction must be made too with groups who are regarded as occupational or cultural as opposed to 'ethnic' Travellers such as Showmen and Circus people, New Travellers, and Bargee communities who live on canals in the UK (Traveller Movement, 2015). While English Romany Gypsies, Irish Travellers, and Scottish and Welsh Gypsy Travellers are recognised as distinct ethnic groups in UK legislation, occupational and cultural Traveller Communities have not been granted the same status. This is sometimes on the preference of groups themselves, with Showmen and Circus people preferring to define as trade groups (Leeds GATE, 2014). While all of the Traveller Communities discussed above have a history of nomadism, most members of these communities no longer travel full time and have now settled in housing (Bancroft, 1999; Ringold, 2000; Clark and Greenfields, 2006). This is the result of difficulties maintaining a nomadic lifestyle in the face of policies, state systems and service provision oriented towards sedentarism (Greenfields and Smith, 2010), and in some European contexts, due to forced settlement (Bancroft, 1999). Even when settled in

permanent accommodation, Traveller Community members may travel occasionally or seasonally however (Niner, 2004). Although not always treated as such in policy, a move into housing does not lead to a loss of Gypsy or Traveller identity, which must be recognised as based on distinct ancestry, history, and cultural traditions (Van Cleemput and Parry, 2001). As this research involved Romany Gypsies and Irish Travellers specifically, the terms 'Gypsies and Travellers' or 'Traveller Communities' are used throughout the thesis. As these expressions were used by the Traveller organisation who supported the research and by Gypsy and Traveller participants themselves, they were judged as acceptable. The plural 'communities' is adopted in recognition of the diversity of Traveller Community groups. Exceptions to the use of these terms are found however in direct quotes, or when citing research pertaining specifically to groups other than Romany Gypsies or Irish Travellers.

The thesis is situated at the intersections of sociology and public health. A decision was taken to focus the research on public health, since public health is concerned with the health of the population (Orme *et al.*, 2007), including differential health outcomes across social groups (Dew, 2012), and is underpinned by principles of equity and social justice (World Health Organisation, 1986; Dew, 2012; Faculty of Public Health and European Public Health Association, 2017). The health inequity experienced by Gypsy and Traveller community members thereby falls firmly under a public health remit. The thesis involved practitioners working in any of the three domains of public health practice as outlined by the Faculty of Public Health: health improvement; health protection and improving services (Griffiths, Jewell and Donnelly, 2005). The term 'health practitioner' is adopted throughout, rather than 'public health practitioner' to reflect the involvement in the study of those explicitly badged as public health workers (e.g. 'public health practitioners' or 'public health specialists'), as well as those who are employed in wider occupations and sectors but who nevertheless undertake public health work. I use 'practitioners' rather than 'professionals' when referring to participants, as some health workers in the study distanced themselves from the latter term.

It is recognised that I have drawn an artificial distinction between Traveller Community members and health practitioners here, and that these positions can, of course, coincide. None of the Gypsy and Traveller Community members involved in

the study identified as health practitioners. However, some Gypsy and Traveller participants volunteered at the Traveller Community organisation supporting the research, which involved participating in meetings and activities connected with health. This enabled some insight into how Gypsy and Traveller health identities are affected by involvement in health-related work, with this reflected upon in findings where relevant.

1.2 Traveller Community rights in public, political and health spheres
Traveller Community 'lifestyle' has become something of a 'bestseller' in popular culture (Barnett, 2011), reflecting a seeming 'fetishisation' of these groups in society. This is illustrated by the publication of numerous Gypsy and Traveller biographies (Whyte, 2001; J. Smith, 2008; Smith-Bendell, 2009; Walsh, 2009; Mckinley, 2011; see for example Docherty, 2013) and increasing television coverage devoted to Traveller Community lives. Channel 4's "Big Fat Gypsy Weddings" programme, a "revealing documentary series that offers a window into the secretive, extravagant and surprising world of gypsies and travellers in Britain today" (Channel 4, 2013) is typical of this trend, with viewing rates at the time exceeding those of any other C4 documentary (Frost, 2011). Other programmes have followed suit, including 'Thelma's Gypsy Girls', 'My Big Fat Gypsy Christening', 'My Big Fat Gypsy Christmas', and more recently, 'Gypsy Kids: Our Secret World'. As is evident from the use of language in the programme titles and descriptions, these voyeuristic depictions often reinforce the 'otherness' of Gypsy and Traveller Communities. Such coverage reflects media discourse on Traveller Communities more generally, which has long perpetuated hostility towards these groups and entrenched divisions between Traveller Communities and 'settled' society (Morris, 2000; Leahy, 2014; Richardson, 2014; Cihan Koca-helvaci, 2016). Recent analysis of in print media coverage of Gypsies and Travellers in Scotland found that Gypsies and Travellers received an inordinate amount of attention relative to their population size (an average of 1.5 stories per day over the 120 days studied) and categorised 48% of these articles as representing these communities negatively (Amnesty International, 2014). This included associating Traveller Communities with dirt and reinforcing stereotypes of criminality by referring to encampments as 'illegal' rather than 'unauthorised' (Amnesty International, 2014). Indeed, media discourses which reproduce the 'otherness' of Traveller Communities often centre on the relationship

of Traveller Community members to space, constructing these groups as 'place invaders' who symbolise threats to spatial and public order (Kabachnik, 2010).

Media depictions of Gypsies and Travellers are reflected in everyday talk and public attitudes towards these groups. According to the 2014 Global Attitudes Survey (Pew Research Centre, 2014), 50% of people in Britain held an unfavourable view of Gypsy or Roma Communities, while a recent YouGov survey reports that 42% of respondents would be 'unhappy with a close relative having a long-term relationship or marriage with a Gypsy/Traveller' (YouGov on behalf of the Traveller Movement, 2017). An analysis of comments about Gypsies and Travellers in online discussion forums found similar representations of Traveller Communities to those employed in the media, including connotations with crime or lawlessness; the categorisation of Traveller Communities as 'other' or 'abnormal'; and the generalisation of individual behaviour to communities as a whole (Rowe and Goodman, 2014). Negative attitudes toward Gypsies and Travellers have been found among politicians (Turner, 2000) as well as public service professionals. This is evidenced in police officers' use of a private Facebook page to post racist remarks about Traveller Communities (Bowcott, 2017) and findings of a recent evidence review which highlight the discriminatory and prejudiced attitudes of European health care providers towards Romany women in maternity services (Watson and Downe, 2017).

For all the damage of media representations such as those found in programmes such as 'Big Fat Gypsy Weddings', controversy surrounding this coverage has provoked dialogue and generated opportunities to challenge portrayals of Traveller Communities (Taylor, 2012; Press Association, 2015). Out of this contestation is a growing movement of young Gypsy and Traveller activists speaking out about the inequities they face (Clark, 2017). Examples of high profile and successful legal challenges to discrimination against Traveller Communities, such as the case brought against a Wetherspoons pub in London (BBC, 2015) have also helped to bring the injustices experienced by these groups into the public eye. Yet, as the above research on public attitudes illustrates, the rights of Gypsies and Travellers have, to date, received limited traction in popular discourse. Indeed, the acceptability of racism against these groups doesn't appear to have shifted in the 13 years since this was badged as the 'last "respectable" form of racism' by the then Chair of the Commission for Racial Equality (BBC, 2004).

Ambiguity around whether abuse toward these groups constitutes racism, due to their position as a white and often indistinguishable minority, is one possible reason for the lack of purchase of Gypsy and Traveller rights in society:

In popular understandings of racism in Britain there is a blind spot in relation to Gypsy-Travellers. It is also a grey area in respect to the use of the concept of racialization. They are white Europeans, runs the logic, therefore the antipathy felt by other white Europeans towards Gypsy-Travellers cannot be “racist” (Garner, 2017:1)

Goodman and Rowe (2014) found that an insistence that derogatory comments towards a white group could not be considered racist was similarly used to deflect accusations of racism in remarks made about Gypsies and Travellers on discussion forums. While a ‘norm against racism’ was clearly displayed in contributions to the discussion, no such social sanctions governed the admission of prejudice towards Gypsies and Travellers, particularly where comments were predicated on experience rather than ‘hear-say’ (Goodman and Rowe, 2014). Goodman and Rowe (2014) therefore point to the importance of retaining a distinction between the categories of ‘racism’ and ‘prejudice’. Recent considerations of the place of race in the field of ethnic and racial studies similarly suggest a need to preserve race as a concept and call for more precision in its use. Meer (2018) for instance, argues that the category of race must be extricated from that of post-colonialism, stressing the distinct contribution of race in understanding ‘whiteness’ and the social processes that surround it.

Responding to the scarcity of material explicitly employing the concept of race to Gypsy and Traveller Communities, Garner (2017) points to the planning system as a significant mechanism in the racialisation of these groups. This is exemplified in a recent parliamentary debate on ‘Gypsies and Travellers and local communities’ (HC Deb, 9 October 2017); the title itself suggesting that Gypsies and Travellers are not part of local neighbourhoods (McDonagh, 2017). Within this debate, the relationship of Traveller Communities to the law, and who can and cannot be defined as ‘genuine’ Gypsies and Travellers, were core themes (HC Deb, 9 October 2017). Recent changes to the definition of Gypsy and Traveller ethnicity for planning purposes now excludes those who have ceased to travel permanently (Department for Communities and Local Government, 2015). This reduces Traveller ethnicity to a culture of nomadism, denies the rights of groups to self-define, and forces families to travel to qualify for places on authorised Gypsy and Traveller sites.

The racialisation of Gypsies and Travellers is also apparent in the area of health, and comparable tensions are apparent surrounding the recognition or denial of Traveller Community ethnicity in this domain. After receiving very little attention in health policy historically (Parry *et al.*, 2007), Gypsies and Travellers were targeted more explicitly in UK and European policy in the mid to late 2000s. In 2005, the Decade of Roma Inclusion was launched; a pledge signed by 12 European countries (not including the UK) to address Roma poverty and exclusion, and reduce inequalities between Roma and non-Roma in a number of priority domains, including health (International Steering Committee, 2005). Traveller Communities were later included in the UK Department of Health Pacesetters programme, which was initiated in 2008 and focused on addressing health inequalities across communities (Van Cleemput *et al.* 2010). A Primary Care Service Framework for Gypsies and Travellers was set out in 2009 and Traveller Communities were among four 'socially excluded groups' singled out for attention by the Department of Health 'Inclusion Health' programme, along with people who are homeless, sex workers and refugees and asylum seekers (Department of Health, 2010; Social Exclusion Task Force, 2010). While this marks a shift in policy to explicitly consider the needs of Gypsies and Travellers, it is notable that UK policies frame the health needs of Traveller Communities through the broad lens of inequality and exclusion rather than by reference to race or ethnicity, which itself is likely to have repercussions for how this issue is approached.

This policy attention has coincided with a surge in research in this area, with a review of the literature illustrating that the majority of work on Gypsy Roma and Traveller health has been undertaken post 2010 (Cook *et al.*, 2013). However, as has been shown for parallel areas, the surge of interest in Gypsy and Traveller health has delivered little by way of improvements in circumstances for these groups, and policy appears to have preserved the inequity experienced by Traveller Communities as part of the status quo. For instance, while the evaluation of The Decade of Roma Inclusion has been hindered by the poor availability of data (Fésüs *et al.*, 2012), evidence suggests that this has made limited tangible difference to the lives of Roma people (Fésüs *et al.*, 2012; Rorke, Matache and Friedman, 2015; Sándor *et al.*, 2017). This limited success has been attributed to resource issues, a lack of measures to enforce implementation, ill-defined and limited involvement of Roma and their representatives, and restricted autonomy of government actors

involved in the process (Decade of Roma Inclusion Secretariat Foundation 2015, cited in Brüggemann, Friedman and Friedman, 2017). The Decade has been credited with raising the profile of Roma inequality and ensuring this stays on the political agenda (Brüggemann, Friedman and Friedman, 2017), feeding into the later European Commission's (2011) Framework for National Roma Integration Strategies. However, the EU Framework has encountered similar challenges in delivering on Roma inclusion. Indeed, in 2012, Britain was judged by the European Commission as having failed to implement all measures to address discrimination set out in the Framework, including those specifically pertaining to health (European Commission, 2013). The UK's impending exit (at the time of writing), from the European Union creates further doubt with respect to institutional and political leadership to promote the inclusion of Gypsy and Traveller Communities. A ministerial working group was established in November 2010 and outlined 28 commitments to addressing disparities in outcomes experienced by Gypsy and Traveller Communities, including five health specific pledges (Communities and Local Government, 2012). Progress toward these commitments is currently being reviewed in a Select Committee Enquiry. Many of these commitments were process driven, addressing questions around what more needs to be done. This has resulted in a number of reports and guidelines (Ministerial Working Group on Tackling Inequalities experienced by Gypsies and Travellers, 2014) that review the current state of affairs and produce further statements of the problem, but which have not moved beyond rhetoric to concrete action. The issue of data monitoring is a case in point. The 'Hidden Needs' Inclusion Health report (Aspinall, 2014), reiterated the extensiveness of gaps in data monitoring for Gypsies and Travellers that had been articulated years earlier (Doyal *et al.*, 2002). However, its recommendation of including Gypsies and Travellers as ethnic groups in the NHS data dictionary has yet to be translated into practice. This again shows some hesitancy with regard to the explicit use of race or ethnicity in framing efforts to address Gypsy and Traveller health, and suggests similar ambiguity surrounding the definition of Gypsies and Travellers for health purposes to that found in planning policy. This picture is further complicated by the fact that health is itself a contested attribute (Smailes and Street, 2011) which can give rise to varying definitions of, explanations for and approaches to Traveller Community health.

1.3 Contribution of the thesis

The above discussion highlights the politicised and racialised nature of talk about Traveller Communities in political, public and health spheres. The discourses or cultural narratives governing talk about, and practices towards Traveller Community members have been examined in areas such as social geography (Bancroft, 2000; Holloway, 2005; Richardson, 2006; Kabachnik, 2009, 2010, 2012; Shubin and Swanson, 2010; Shubin, 2011), education (Cudworth, 2008; Bhopal, 2011; Bhopal and Myers, 2016; Hamilton, 2017), media and cultural studies (Jensen and Ringrose, 2013; Casey, 2014; Goodman and Rowe, 2014; Leahy, 2014; Okely, 2014; Rowe and Goodman, 2014; Tremlett, 2014a; Pusca, 2015), social welfare (Vanderbeck, 2009) and academia (Stewart, 2013; Crowley and Kitchin, 2015; Acton, 2016). By comparison, less attention has been paid to the discursive construction of Traveller Communities in relation to health, and existing work has tended to avoid troubling the racialisation of Gypsies and Travellers in this area. Given the extensive critique of Traveller Community representations in public discourse and other fields of inquiry, the limited attention to the social construction of Travellers in relation to health, and of health in relation to Travellers was surprising.

It could be argued that there is a culture/structure divide in explanations offered for Traveller Community health in the literature. Research in this area is weighted heavily toward an analysis of Traveller Community health beliefs and attitudes, as distinct and often homogeneously conceived cultural groups. This search for, and assignment of characteristics to Traveller Communities in relation to health can itself be considered a form of racialisation, with this concept encompassing social group differentiation through the attribution of cultural characteristics (Fox, Moroşanu and Szilassy, 2012). Although there exist well-established sociological critiques pointing to the potentially stigmatising effects of using concepts of race, ethnicity and culture to explain health differences (Ahmad, 1996; Fernando, 2002; Ahmad and Bradby, 2007), these are not widely referenced in the literature on Gypsy and Traveller health. Matthews (1998) forms one exception to this, arguing that the dominance of a biomedical perspective may pathologise Traveller Community culture. Some challenge to arguments of cultural difference has also been made on the grounds that structural barriers are more salient in explaining the differential health status of these groups (Smith and Newton, 2017). Indeed, such arguments are underpinned by a wealth of health services research that, while not explicitly critiquing essentialist

cultural explanations, has long highlighted numerous structural constraints impinging on the ability of Traveller Communities to attain an equitable standard of health (Feder, 1989; Van Cleemput and Parry, 2001; Cemlyn *et al.*, 2009; Foldes and Covaci, 2012; McFadden *et al.*, 2018). It was only recently however that the relative importance of cultural versus structural barriers has been subject to direct and in depth empirical scrutiny, drawing on data from Gypsies and Travellers themselves (Smith and Newton, 2017).

Despite the long recognition of structural barriers impinging on Gypsy and Traveller health, difficulties in accessing health services among these groups have persisted (McFadden *et al.*, 2018), suggesting that this recognition has not been met with sufficient action to address these injustices. I was keen to explore the stories that lie behind action or inertia to improve Traveller Community health, as well as the ways that ingrained narratives of both health service providers and Traveller Community members may limit efforts to tackle inequalities, even after structural barriers are removed. The research set out in this thesis is based on the idea that narrative is not merely a carrier of meaning, but constitutive of the social world, and that vice versa, narrative possibilities are shaped by the discursive or socio-cultural conditions of a society at a particular time (Tamboukou, 2013). Thus, rather than adding a further interpretation of the causes of Traveller Community health, this research turns its attention to the narratives employed to explain Gypsy and Traveller health, and their constitutive effects, as objects of study in their own right. Understanding the discourses or narratives influencing the possibilities for speech, thought and action in this area will provide insight into those that perpetuate or can challenge conditions of inequality for Traveller Communities.

Awareness of Traveller Community culture and its potential impact on health communication and interaction is well attended to in the literature (Vivian and Dundes, 2004; Dion, 2008; Francis, 2010a, 2010b; Lane and Tribe, 2010; Davis and Lovegrove, 2016). Yet, communication is also likely to be influenced by the roles and identities that Traveller Community members and practitioners project for themselves and each other, or, to borrow from Frank (2002), their diagnoses of each other as people. A gap in existing research was identified around the versions of self that Gypsies and Travellers, and health practitioners claim within health interactions. Hodgins, Millar and Barry (2006) contextualised the willingness of Traveller

Communities to draw on structural explanations for their health by reference to the risk of 'spoiling' one's identity. However, the identity implications and management of potential stigma by Traveller Communities in the face of the health inequalities they experience is yet to be explored in depth. In addition, few studies in the area of Traveller Community health consider the perspectives of Traveller Community members and health practitioners alongside one another, and to my knowledge, no studies have examined the ways that health practitioners present accounts of themselves when describing their work with Traveller Communities. It is to these areas that the current research also seeks to contribute.

The literature to date has tended to present a homogeneous picture of Traveller Community health. The potential for diversity and intersectionality in health experience within and across Traveller Community groups is less often considered. This tendency to homogenise groups and uphold binaries between Gypsies and Travellers and 'settled' society is identified within the parallel area of planning, as a further device for the racialisation (Garner, 2017). In addition, Garner (2017: 10) points to the ways that the tabloid press portrays Travellers as 'virtually never normal citizens', overlooking the mundane and ordinary aspects of life among Traveller Communities. Such representations resonate with discourses of Orientalism, which construct 'the Orient' as an unfamiliar and romantic, but also inferior 'Other', in whose reflection the Western self is constituted (Said, 1978). Indeed, Lee (2000) suggests that 'Gypsylorism'¹ operates in a similar fashion, singling out and discursively constructing Gypsies and Travellers as groups. The relationship between the West and 'the Orient' or 'Other' is not maintained through separation, but through contact and exchange (Hirose and Pih, 2011). The Orient can be both a subject of allure as well as disdain, reflected in the appropriation of non-western culture and symbols (Sardar, 1999). Indeed, Hirose and Pih (2011), in regard to consumption, show the significance of 'authentic' experience of the other in validating one's own authenticity. This resonates with concern for what constitutes 'genuine' Gypsies and Travellers in society, and with the simultaneous romanticisation and contempt for nomadic lifestyles (Bhopal and Myers, 2008) in historical and contemporary representations of these groups. A recent Gypsy and Traveller rights campaign 'We Are All So Many Things' (London Gypsies and

¹ A term referring to members of the Gypsy Lore Society, established in 1888 and those writing in the associated Journal of the Gypsy Lore Society, dedicated to scholarship on Gypsies

Travellers, 2017) seeks to counteract essential representations of these groups, pointing to the multiplicity of identities and everyday roles and contributions of Traveller Community members. Within this research, I aim to open up for questioning those narratives that position Traveller Community members as intrinsically different or Other regarding their health. By looking at characterisations of Traveller Communities in relation to health, by both community members themselves and health practitioners, I aim to contribute an understanding of the racialisation of Traveller Communities in health spheres. I explore the narratives shared by Gypsy and Traveller Community members and the population more generally, as well as where these groups draw on distinct narrative resources or forms of storytelling due to the uniqueness of their social position. In seeking to understand how Gypsy and Traveller ethnicity intersects with wider identity positions in relation to health, I aim to attend to the mundane as well as unusual health experiences of Traveller Communities and avoid reinforcing images of these groups as exotic. The specific research questions addressed by the thesis are as follows:

1.3.1 Overarching research aim

To explore how Traveller Community members and health practitioners position themselves and each other amid multiple, competing and co-existing narratives surrounding the 'problem' of Traveller Community health?

1.3.2 Specific research questions:

- What are the constructs of health drawn upon by health practitioners and Gypsies and Travellers?
- What are the preferred health identities of Gypsies and Travellers?
- What are the preferred identities of health practitioners in relation to their work with Traveller Communities?
- How do health constructs and preferred identities collide or coalesce in the narratives of Traveller Community members and health practitioners?

1.4 Theoretical approach

A poststructural lens was taken for the research since, to borrow Fox's (1993) phrase, it enables an examination of 'the politics of [Gypsy and Traveller] health talk'. A poststructuralist approach rejects ultimate truth claims, instead viewing any

spoken or written representation of 'truth' or 'reality' as dependent upon the particular historical and cultural context², and infused with power (Coveny, 1998; Cheek, 2000). Poststructuralism favours a 'responsibility to otherness' over a 'responsibility to act' (White, 1991). While the latter necessitates set definitions of people and phenomena, and the closing down of some modes of thought, poststructuralism aims to uncover voices that may be silenced by such tendencies. This approach was therefore well suited to the research, which seeks to challenge attempts to fix representations of Gypsies and Travellers in relation to health in existing literature. In its commitment to subjugated voices and exposing the contingency of knowledge and group constructions, poststructuralism also helps to avoid the stigmatisation of those who may be deemed as out of step with dominant ideas and practices (Wright, O'Flynn and Macdonald, 2006), as may be the case where Traveller Community members are presented as practicing health differently. By acting, as far as possible, as a conduit for the stories and identities expressed by Traveller Community members and health practitioners, the research aims to create a space whereby dominant narratives 'about' Traveller Community members can be opened up to challenge, and whereby community members are able to present a version of themselves in relation to health.

In accordance with the emphasis on multiple truth claims, poststructuralists deny the existence of an autonomous and essential self, existing outside of social relationships (Elliot 2005). From this perspective, identity is not coherent and stable but fragmented and fluid, instead changing according to social position or time point, and negotiated through interactions with others (Blumenreich, 2004; Osgood, 2010). Rather than treating Gypsy and Traveller accounts of health as fixed inner attitudes, a poststructural theoretical orientation therefore enables a critical examination of how Gypsy and Traveller health identities are produced within, and constrained by, the differing discourses operating in society about the health of these groups. Using a research approach that theorises identity as multiple, fluid and shaped by

² It is important to distinguish between the differential usages of culture throughout this thesis. The above section critiqued explanations for differential health outcomes predicated on the cultural distinctiveness of Traveller Communities. I do not however deny any influence of culture on health; this stance that would be incompatible with the theoretical position adopted. The thesis does not seek to elaborate cultural differences between Traveller Communities and other social groups, but rather examines the overarching cultural conditions of society that produce definitions of and approaches to Traveller Community health, including the construction of ethnic and cultural difference itself.

discursive processes therefore enables exploration of the potentially conflicting identity positions held by individual Traveller Community members and practitioners amid the contested narratives in circulation. It also facilitates attention to how identity as a Traveller Community member, or health practitioner working with these groups may intersect with other identity positions in stories of Gypsy and Traveller health. The work of Foucault and Deleuze and Guattari is drawn on in particular for this study, theorists who are categorised as falling within a poststructuralist tradition (though not necessarily identifying themselves as such).

1.4.1 Foucault on discourse, power and subjectivities

Foucault's work has been particularly influential in understanding how subjectivities or 'selves' are produced through discourses (Rose, 1999), including those on health and illness. Foucault defined discourses as 'practices that systematically form the objects of which they speak' (Foucault, 1969). His work investigated the processes through which some discourses come to be afforded legitimacy, or truth status while others are relegated (Foucault, 1980; McHoul and Grace, 1995; Cheek, 2004). It also examined the constitutive effects of dominant discourse on the possibilities for knowledge, speech and action within a given time point. For Foucault, knowledge and power were bound together; the authoritative knowledge produced through discourse enables techniques of power to be exercised such as surveillance or confession, which in turn, generate further knowledge (Foucault, 1977, 1980). Foucault's theories led to a radical re-conceptualisation of power, illustrating that power cannot be understood only by reference to negative effects such as repression, denial or exclusion but must be seen as *productive*, both of knowledge and also forms of subjectivity (Foucault, 1980). Foucault's theories therefore assist in understanding the extent to which the identities of Gypsies and Travellers, and health practitioners are shaped by dominant health discourses, and their associated entanglements in relations of knowledge/power. In *Discipline and Punish* (1977), Foucault illustrates a shift away from the visible and coercive operation of power (exemplified by crude forms of public punishment), to more insidious disciplinary forms of power which govern through the production of 'docile bodies' who monitor their own behaviour in line with dominant discourses. Foucault termed this type of power 'biopower' (Foucault, 2004). Power, as conceptualised by Foucault is therefore not possessed or wielded by individuals or institutions, but is characterised as 'omnipresent', and operates as a 'network of relations constantly in tension, in

activity' (Foucault, 1977: 26). For Foucault, it was therefore necessary to study the 'micro-politics' of power and its exercise at a local level (Foucault, 1980). Foucault coined the term 'governmentality' (Foucault, 2007), to refer to this 'conduct of conduct' (Foucault, 2003) and the concurrent focus on the population and individual subjects (Fox 1993). Inherent in the definition of power as 'action upon an action', is the presence of agency and the possibility of resistance, since were there not the potential for struggle, there would be no relation of power (Foucault, 1982:789). An application of Foucault's theories was therefore felt appropriate to examining the potential for struggle purported in the literature between accepted public health doctrine, and the culture and practices of Traveller Communities. While individuals are theorized as having agency within the constraints of discourse by Foucault, "their intentionality is never their own", in so far as they are restricted by their historical and linguistic context (Heller, 1996). As such, Foucault has received criticism for his view that there exists no means of resistance outside of power relations (Fox, 1993). Foucault's theories also provide limited depth on the forms that resistance may take (Pickett, 1996). For this reason, the work of Deleuze and Guattari (1984, 1986), which expands upon the idea of resistance introduced by Foucault (Lash, 1984; Fox, 1993; Reid, 2003; Bignall, 2008) will also be utilised in the research, to understand the possibilities for resistance available to Traveller Communities and practitioners.

1.4.2 Expanding resistance with Deleuze and Guattari

Deleuze and Guattari share Foucault's view of power as productive of subjectivities, viewing individuals and bodies as inscribed by social (and physical) forces (Lash, 1984), rather than free from constraints (Deleuze, 1992; Fox, 2002; Winslade, 2009). Deleuze and Guattari coined the concept of the body-without-organs (BwO) to refer not to an anatomical body, but a political space or territory on which a struggle takes place between the motivations or 'desire' of individuals and the social, psychological and physical relations that seek to limit what the body can do (Deleuze and Guattari, 1984; Fox, 2011). Winslade describes how Deleuze and Guattari conceive of a map of intersecting "lines of power" which:

express assumptions about how the world is, how life works, who each person is, which identities are legitimate, and which are marginal (2009: 336)

These lines of power then act to "territorialise" the BwO through "marking out limits" and prescriptions for normative action upon it (Fox, 2002). The clustering of relations

that seek to territorialise the body, together with a body's own desires are referred to by Deleuze and Guattari as 'assemblages' (Fox, 2011). It is the sum-total of the elements of the assemblage that constitute the BwO and the limits and possibilities of what a body can do (Fox, 2011).

Deleuze and Guattari locate the capacity for resistance in their concept of desire (Deleuze and Guattari, 1984). They were critical of the psychoanalyst Lacan's notion of desire as a 'lack', which exists in the realm of the symbolic and instead conceived of desire as a positive force which, similar to Foucault's conception of power, is productive and has real effects (Fox, 1993). The capacity of desiring and experimenting individuals provides opportunities for new relations to be generated (Fox, 2012), for example, through new connections, experiences, changes in the environment, or a confrontation, and which enable a de-territorialisation of the BwO (Fox and Ward, 2008). The relationship of Nomads to the state symbolised resistance and this de-territorialised subject in Deleuze and Guattari's work (Deleuze and Guattari, 1986). The outcome of de-territorialisation is a 'nomad subject'; one who, in a moment of reflexivity steps temporarily outside of those identities and roles ascribed it, to become 'other' (Fox and Ward, 2008). For Deleuze and Guattari, it is the process of 'becoming' other rather than the fixing of identity, in which escape from power is achieved. Deleuze and Guattari distinguished between 'striated' and 'smooth' space; state apparatus striate space by measuring and quantifying it, and are oriented towards occupation and sedentarism (Deleuze and Guattari, 1986). Nomads on the other hand distribute themselves in, or 'flow' across an open space (characterised by the desert or the steppe) which is free from the lines and codes imposed upon state space (Deleuze and Guattari, 1986). However, while Deleuze and Guattari do make reference to an absolute form of de-territorialization (characterised as a line of flight) and a 'nomadic' subject free from the constraints of power, this is conceived an ideal, and something which is never fully realised (Reid, 2003). The territorialisation and de-territorialisation of the BwO was therefore viewed by Deleuze and Guattari as a continual process (Fox, 1993; Winslade, 2009). Assemblages continually evolve as the mix of relations, or their relative intensities alter, and the de-territorialised subject is always re-territorialised, although the pattern of power inscriptions may alter (Fox, 1993), with the result that an individual can 'do more or different things than before' (Fox, 2012). Given the tradition of nomadism in Traveller Communities, this

theoretical perspective had immediate appeal in helping to unpack the struggles of power and resistance that may exist in the relations between Traveller Communities and health discourses, services, and practitioners.

1.4.3 Is poststructuralism a just approach?

It is also important to acknowledge and respond to some notable and well-rehearsed critiques of poststructuralism however. Although a concern with power and its entanglement with knowledge production are central to poststructuralist theory (Fox, 2014), the usefulness of such approaches in challenging unequal power relations and achieving social change has been questioned on a number of counts. The privilege given to language and discourse in poststructuralist work is argued to downplay attention to the material body (Williams, 2006) or concrete realities (Buchhansen, 2005; Howarth, 2013), leading authors to question the application of poststructuralism to the study of social structures or institutions (Howarth, 2013). However, following Atkinson's (2002: 80) argument that 'action is (almost) always determined by ideas, whether we are cognisant of them or not', I judge the value of a poststructuralist approach to lie in the tools it provides for scrutinising systems of thought and speech that create and sustain social structures (including those reproducing health inequalities for Traveller Communities).

A further criticism directed at work in a poststructuralist vein focuses on the refusal of these approaches to engage in normative evaluation; a stance argued to undermine action for social justice (Taylor, 1984; Howarth, 2013), and potentially reinforce the subjugation of marginal groups (Cole, Hill and Rikowski, 1997). Poststructuralist conceptions of identity as fragmented and multiple, and the restriction in focus to the local operation of power, are further principles argued to immobilise action to improve social conditions, by weakening opportunities for collective identification and action (Kelly, Cole and Hill, 1999; Cole, 2003). These issues are of obvious relevance to the focus of this research, which concerns the inequity experienced by Traveller Communities in relation to health. However, I argue that it is possible for poststructuralist work to contribute towards achieving social justice without making strong normative claims. I find the potential of poststructuralist approaches to be encapsulated in Foucault's statement that 'my point is that not everything is bad, but that everything is dangerous' (Foucault, 1984: 343). A poststructuralist approach will enable the dangers associated with the

different discourses on Traveller Community health to be elucidated, which can then inform our selection from among those available. Moreover, in the scepticism of poststructuralist approaches toward all knowledge claims and labels, they force us to question the very concept of social justice itself (Atkinson, 2002) and the categorisation of minority or marginalised groups (Tremain, 2015) on which our attempts at social change are founded. This enables an unmasking of the ways that power is operating even within efforts for social justice, including those of researchers themselves. Whether a focus on multiple identity positions and local sites of power reduces opportunities for solidarity is also questionable. Highlighting within group differences, and the co-existence of ethnic and other identity positions (e.g. as mothers, fathers, employees, carers, students etc.) may weaken group mobilisation for rights, but it may also encourage cohesion across ethnic groups by suggesting that we are unified in our difference, and by drawing attention to shared experiences and common humanity. Lastly, since it is within personal and institutional contexts that wider discourses find their outlet and are reproduced, limiting the sphere of analysis to local micro political relations of power does not necessarily preclude a focus on broader social processes (Atkinson, 2002).

1.5 The research(er) story – locating myself in the research

In keeping with poststructuralist concerns regarding the power effects of (re)presentations advanced through the research, I must situate myself in relation to this work. Following Savin-Baden and Howell Major (2013), I have considered my positionality in relation to three areas: a) the research topic, b) research participants, and c) the research context and process. Here I discuss my general orientation to the research topic, how my interest in the research area developed, and how this standpoint may have influenced the research. The impact of my position in relation to participants and the research process and setting will be discussed in my account of study methods (Chapter 3) and woven throughout the presentation of findings where this is of contextual importance.

I first became interested in researching Gypsy and Traveller health when learning about human rights legislation and the multiple inequalities experienced by these groups during my undergraduate degree. I focused my undergraduate dissertation on the development of culturally accessible counselling services for Gypsies and Travellers and throughout this work, developed an interest in the ways that Traveller

Communities were defined and categorised with respect to public health. I pursued this interest further while studying for a postgraduate certificate in public health, before being really pleased to have the opportunity to undertake more substantive research in this area during PhD study. Alongside this academic interest, the burgeoning focus on Gypsies and Travellers in popular media, which often perpetuated negative stereotypes, strengthened my commitment to undertaking research to challenge representations of these groups. I therefore approached the research motivated by a concern with social justice and must acknowledge this political standpoint. The degree to which researchers should take up roles of activists is increasingly being debated in public health forums. A workshop at the 2017 European Public Health conference suggested that public health actors cannot see themselves as simply 'technicians' but must act on the 'moral mandate' of public health, a discipline which is 'founded on values such as justice, interconnectedness and solidarity' (Faculty of Public Health and European Public Health Association, 2017). That my research was driven by such motivations was, on reflection, important in approaching the Traveller organisation involved with this research for support. One of the reasons I was attracted to working with the particular organisation approached was their political engagement and concern with issues of language and representation of Traveller Communities, which chimed with the aims of the research. Yet, research in such a politicised environment also brings challenges for both researchers and supporting organisations. Given the widespread discrimination faced by Traveller Community members, it is understandable that organisations who represent Gypsies and Travellers may feel the need to act as 'gatekeepers' to protect community members from further harm and avoid jeopardising their trusted position. Members of the Traveller Community organisation that supported me with the research have described how they deliberately put barriers in place for researchers approaching for help to avoid over consultation and ensure that only those who were serious and have the required sensitivity receive support. I was conscious when approaching the organisation that staff would be attuned to various signals in order to check that I wasn't prejudiced towards Gypsies and Travellers. That in my initial contact, workers of the organisation recognised and commented positively on the fact that I use capitals to refer to Gypsies and Travellers as ethnic groups is an illustration of this dynamic. In informal communication, members of the organisation relayed alternative stories whereby people had been refused access because they had used phrases such as

'Travellers are interesting, aren't they?' which implied they were motivated more by their own curiosity as opposed to a concern for human rights. Whilst this use of language is, of course, not a substitute for being genuinely non-discriminatory, I was very aware of a need to convey my benevolence by using these recognised signals. I made sure I was aware of possible cultural beliefs of Traveller Community members, and took care in how I described the research, and in my use of language. While much of this came naturally from my reading and prior engagement in the field, this often gave rise to considerable anxiety in case I unwittingly caused offence. I was aware of the politicised environment not only through my engagement with those working in the field, but also through my interaction with those in society more generally. Describing my research interest has often acted as an opening for people to express their personal and sometimes stereotypical or prejudiced views about Gypsies and Travellers. One person asked if I'm 'pro-Gypsy', demonstrating how as a researcher I myself am positioned using a binary of those that are 'for' or 'against' Gypsies. On describing my research to others, I often see their curiosity piqued and find that, despite my best efforts, it can be difficult to avoid the very fact that my research is with Traveller Communities being treated as a form of currency that helps to establish its value or interest. Navigating these issues, and engaging with reading on the ways that practitioners uphold their own morality through their representations of groups (Kowal and Paradies, 2005) has helped me to consider the ways that I am enacting my own personal ethics through this research, including via my presentation of self within this positionality statement (Bishop and Shepherd, 2011). I have tried to consider and convey my own values to the reader and avoid becoming closed off to aspects of the literature and research data that do not fit with this stance. For example, I initially approached the research with quite a simplified understanding of practitioners as agents of oppressive discourses or institutions. This did not account for the ways that public health actors may move between approaches that seek to assimilate Traveller Communities, and those which respect cultural differences, with this potentially leading me to be under-sensitised to discourses that portray Traveller Communities more sensitively. Adopting a reflexive stance has, I hope, encouraged me to adopt a more balanced outlook toward the stories shared through the research, though it must be acknowledged that what follows is inevitably a partial reading, informed by the motivations detailed above.

1.6 Thesis overview

Having justified the terminology adopted, this chapter situated the thesis against the broader landscape of talk and practice in relation to Traveller Communities in society generally. I have suggested that despite the raised profile of Gypsy and Traveller rights in public and policy discourse (including that pertaining to health), these arguments have not been widely accepted, nor converted into tangible differences in the lives of Traveller Community members. While much work has sought to describe and explain the inequalities in health experienced by Traveller Communities (the latter often advocating cultural or structural explanations), I have pointed to an absence of research which takes up the discourses in circulation about the health of these groups, and their effects, as objects of study in their own right. I have argued that an awareness of these discourses is important, in order to understand the opportunities that these generate or curtail in relation to Traveller Community health, and have positioned a poststructural approach as appropriate to this aim. I have acknowledged that my reading of Gypsy and Traveller health represents only one among many possible and have attempted to give an insight into the value systems and motivations underpinning my particular approach.

Chapter two provides an overview of prevailing and unfolding storylines on research around Traveller Community health, tracing the historical generation of evidence on the health inequalities experienced by Gypsies and Travellers. It points to a gradual intensification of the public health gaze directed toward these groups and highlights the politics surrounding the construction of Gypsy and Traveller health as a public health problem. The chapter expands on the tension I have identified in the literature around whether the problem of Gypsy and Traveller health should be categorised as a structural or cultural problem, and addresses the possible limitations of each approach. I present a gap in research on the discursive construction of Traveller Community health, and the potentially nuanced and complex nature of Traveller Community and health practitioner identities.

Chapter three provides a rationale for the adoption of narrative inquiry as the methodology for the study and situates my own approach to narrative in relation to the diversity of traditions in this field. I outline my stance in relation to two key issues within narrative research: the examination of 'big' or 'small' stories, and the extent to which narrative approaches can raise the profile of subjugated voices. The methods

I used to generate, analyse and present participant stories are then discussed, along with key ethical issues considered throughout the research.

Chapters four to eight present the findings of the study. Chapter four provides an entry point into findings, describing the constructs of health used by Traveller Community members and health practitioners. The remainder of the findings chapters form linked pairs, reporting first on practitioner then on Traveller Community accounts around key identity issues for participants. By presenting the accounts of practitioners before those of Traveller Communities, I do not aim to privilege practitioner voices. In opting for the order chosen, I treat practitioner narratives as a further attempt to define how Traveller Community members are in relation to health among the many already available, before then providing an opportunity for Traveller Community members to respond to these narratives and have 'the last word' on how they are viewed in relation to their health. Chapters five and six examine who is given authority to define Traveller Community members in relation to health, and the nature of evidence that is used in support of these claims. In chapter five, I show how practitioners drew on a combination of scientific and experiential evidence on the health of Traveller Communities, arguing that their emphasis on the latter is significant in how they construct and maintain a position as 'specialist' in working with 'vulnerable' groups. Chapter six points to the confluence of biomedical discourses, statistics on life expectancy and embodied or experiential knowledge in Traveller Community representations of their health. Taken together, I argue that these discourses create a requirement for Traveller Community members to account for their poorer health status, increase anxiety about potentially hidden health issues and entrench 'vulnerable' identities. Chapters seven and eight address the extent to which Traveller Communities were treated, and presented themselves as fatalistic, or personally responsible for their health. Chapter seven, illustrates how discourses positioning Traveller Communities as less future-oriented and difficult to engage in relation to health create a reticence among practitioners to broach health promotion with these groups, and lead to strategies to disguise health advice. Chapter eight demonstrates the coexistence of discourses on fatalism or lack of control, and those of self-determination or personal responsibility for health in Gypsy and Traveller accounts. It suggests that counter much of the existing work in this area, Traveller Communities are not beyond the reach of health promotion doctrine,

demonstrating the concern of Gypsies and Travellers in the study to project identities as morally responsible health citizens.

To avoid clouding the narratives of participants, an analysis of how empirical findings relate to prior academic work is presented separately, in Chapter 9, rather than woven into the data chapters. Here, I pick up threads that run throughout the findings chapters and discuss these in the context of previous work on Gypsy and Traveller health and relevant theoretical literature. I first draw on theories of 'body work' to interrogate the significance of body presentation and emotional conduct in interaction between health practitioners and Traveller Communities. The maintenance of the body and emotions are argued to be crucial in how practitioners build and maintain trust with community members and construct identity positions as 'in tune' with the lives of groups categorised as disadvantaged. Such labour requirements are further argued to be mediated by institutional norms. The chapter then examines a discrepancy found between practitioner and Traveller Community reports regarding Traveller Community orientations to time. Representations of time are argued to be core to the positioning of Gypsies and Travellers as resistant to health advice, and associated attempts at the spatial or temporal regulation of Traveller Communities in health interaction. Lastly, the chapter revisits issues around the racialisation of Gypsies and Travellers in relation to health, and the employment of cultural or structural explanations, considering the research findings. While participants rarely used race explicitly as a frame, I point to the operation of cultural racism in the attribution of health characteristics to Traveller Community members which community members themselves did not identify with. I argue that the use of a racial lens must be accompanied by considerations of class and notions of disadvantage, since these lenses were interwoven in Traveller Community and practitioner explanations of health. Practitioner claims to a privileged position of acceptance in working with Traveller Communities are related to the concept of a 'White Saviour Complex', and the potential risk of this stance in perpetuating limited engagement of wider health services with these groups.

Chapter ten concludes the thesis by considering the strengths and limitations of the study. It draws out the implications of study findings for practice, and suggests recommendations for further research in the field. Consideration is given to my own

positionality and role as a Gadge³ researcher, the extent to which I can effect change through the research, and the risk that this research produces equally fixed or essential (re)presentations of Traveller Communities.

³ A Romani term used to refer to settled, or non-Romany people

CHAPTER 2 - Existing and unfolding storylines in Gypsy and Traveller health research

2.1 Introduction

This chapter reviews existing narratives in the literature on the health of Gypsy and Traveller Communities and identifies areas that are ripe for greater sociological investigation. It first explores the construction of Traveller Community health as a public health 'problem' and of Gypsies and Travellers as groups who are particularly 'unhealthy' or 'at risk' in epidemiological work. Following this, I highlight a predominant concern with understanding what makes Gypsies and Travellers unique or distinctive in relation to health, pointing to ambiguity regarding whether Gypsy and Traveller health inequalities should be explained in structural or cultural terms. A clear gap is highlighted around the empirical examination of how Traveller Community members and health practitioners give accounts of themselves amid competing narratives of Traveller health, and the limits and possibilities that available discourses create for the identities that these actors express.

As this PhD research addresses the health identities of English Romany Gypsies and Irish Travellers currently residing in the UK, the literature review prioritises a consideration of material pertaining to the health of these groups. However, international literature and that relating to other Traveller Communities is utilised where little or no literature was available focused on these specific groups and/or from the geographical context of the UK.

2.2 The social construction of 'health' and public health 'problems'

Health has been branded as a 'slippery concept' (Blaxter, 2010: 161) in that its meaning is contested, varies depending on the social context and changes over time. For example, traditional, biomedical definitions of health as the absence of disease have largely given way to more positive and encompassing descriptions, epitomised by the World Health Organisation (WHO) classification of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 1946). Though widely celebrated for advancing an aspirational approach to the promotion of health, the WHO definition has also

attracted criticism. It's characterisation of health as a '*complete state*' is not only argued to result in the medicalisation and risk categorisation of an increasing range of everyday life domains (Huber *et al.*, 2011), but to prevent the majority of the population from attaining status as healthy (Smith 2008). This definition has therefore been suggested as inappropriate in the current context of an ageing population and an increased burden of long-term conditions (Huber *et al.*, 2011). More recently, alternative definitions have been proposed, which draw on transactional understandings of stress and coping (Lazarus and Blackfield Cohen, 1977), and which view health as 'the ability to adapt and to self-manage, in the face of social, physical and emotional challenges' (Huber *et al.*, 2011; Jambroes *et al.*, 2016). Concerns about this new definition have also been raised however, including on the grounds that it advocates a reactive approach which may undermine the preventative aims of public health (Becker, 2011), and detract from action to address the broader structures of power which generate inequality in health (Czuderna, 2011; Scott-Samuel, 2011; Shilton *et al.*, 2011; Jambroes *et al.*, 2016). This struggle over how health is to be defined illustrates the socially constructed nature of health.

If health is to be understood as a social construct, it follows that those issues taken to constitute public health problems can similarly be viewed as socially produced. In their analysis of the 'New Public Health' (a term used to describe the renewed interest in the social, economic and environmental influences within the discipline), Petersen and Lupton (1996) argue that the status afforded to epidemiology as a neutral and scientific method conceals the wider social, cultural, organisational and political interests which generate 'public health problems'. Applying a Foucauldian theoretical lens on knowledge-power relations, they point to the disciplinary role of public health, which employs techniques of surveillance and risk categorisation in order to monitor and regulate individual and population behaviour in the name of health (Petersen and Lupton, 1996). Indeed, scholars in this tradition have pointed to the ways that public health agendas are often founded in concerns around moral regulation rather than objective evidence (Campos *et al.*, 2006; Pike, 2011). This body of work therefore highlights the importance of examining the social and cultural conditions which shape what is judged as a public health issue and associated action. Inspired by work in this tradition, I now turn to consider how Gypsy and Traveller health was established as an area of public health concern.

2.3 The making of the 'problem' of Gypsy and Traveller health

It is beyond the scope of the chapter to give an exhaustive summary of the evidence on the health status of Traveller Communities, which is available elsewhere (see Cook et al. 2013). Rather, this section charts the historical production of evidence on the health of Traveller Communities to understand how these groups came to be framed as particularly 'at risk' or vulnerable in health and epidemiological literature.

Early indications of the health inequalities experienced by UK Gypsies and Travellers were derived largely from the anecdotal accounts of health professionals (often health visitors)(Crout 1987; Lawrie 1983; McCann 1987; Moreton 1987; Peck 1983; Raper 1986; Streetly 1987, 1990; Windess 1987, Morris 1987, Patterson 1982, Jackson 1990, Mason 1990). Attention was predominantly given to issues affecting women and children in these reports, likely reflecting their authorship by practitioners with responsibility for maternal and child health, and who are almost exclusively women themselves. Concerns were commonly noted around accident rates in children (Lawrie, 1983; Raper, 1986); family planning and contraception (Lawrie, 1983; Raper, 1986; Crout, 1987; Streetly, 1987; Windess, 1987), immunisation (Crout, 1987; Streetly, 1987; Windess, 1987), children's developmental screening (Crout, 1987; Streetly, 1987; Windess, 1987), and infant feeding (Lawrie, 1983; Raper, 1986; McCann, 1987). Traveller women are described as treating their own health as secondary to that of their family members, and as experiencing particular hardship due to their responsibility for rearing children within challenging environments (Lawrie, 1983; Raper, 1986). Non gender-specific issues were also highlighted however, including the need for health education around alcohol, smoking and diet (Crout, 1987), risk of infection (Lawrie, 1983), high prevalence of undiagnosed conditions (Lawrie, 1983), intermarriage (Streetly, 1987) and hereditary diseases (Raper, 1986). These reports also highlighted poverty, difficulty accessing services, lack of appropriate accommodation and the poor living and working conditions experienced by Traveller Communities (Lawrie, 1983; Crout, 1987; Streetly, 1987). While positive aspects of Traveller Community health are sometimes noted, as seen in Crout's (1987: 14) suggestion that childrearing in Traveller Communities is 'generally good' and that 'house dwellers could usefully learn from their example', the predominant story here is one of health need and disadvantage. Often these accounts are sensationalist in tone and position these groups as distinct or 'Other' to the general population. For example, the titles of

numerous articles feature puns around nomadism such as 'on the road to better health' (Lawrence, 2007) or 'stopped in their tracks' (Morris, 1987), and some use ornate language and storied presentation to describe Traveller Communities and their health (see for example Morris (1987) and Windess (1987)).

Alongside the emergence of these accounts were some notable attempts to systematically assess the health status of Gypsy and Traveller Communities in the UK and Ireland (Linthwaite, 1983; Pahl and Vaile, 1988; Barry, Herity and Solan, 1989; Feder, Salkind and Sweeney, 1989; Feder, Vaclavik and Streetly, 1993; Feder, 1994; Lewis and Drife, 2001). These studies again focused mainly on issues of maternal, infant and child health and pointed to significant health inequalities (Hajioff and McKee, 2000). An early report by Save the Children in the UK (Linthwaite, 1983) reported a stillbirth rate for Traveller mothers 19 times that found in the general population. This study was poorly received by Gypsies, Travellers and representative organisations however, with findings questioned both on the grounds of methodological rigor and their negative representation of Gypsies and Travellers (Pahl and Vaile, 1988; Acton *et al.*, 1998). This highlights the potentially stigmatising effects of narratives on the poor health of Traveller Communities and the politics surrounding the production, use and receipt of evidence in this field. While later studies indicate that child health outcomes may not be as stark as initially reported by Linthwaite (1983), they also report higher stillbirth (Barry, Herity and Solan, 1989), perinatal mortality and infant mortality rates (Pahl and Vaile, 1988; Barry, Herity and Solan, 1989) compared with national figures. The Confidential Enquiry into Maternal Deaths in the UK between 1997 and 1999, suggested that Gypsies and Travellers have the highest maternal mortality rate of all ethnic groups (Lewis and Drife, 2001). These later studies also provided some confirmation of high rates of childhood accidents (Pahl and Vaile, 1988), low breastfeeding rates (Pahl and Vaile, 1988) and low and differential uptake or completion of childhood immunisations (Pahl and Vaile, 1988; Gordon *et al.*, 1991; Feder, Vaclavik and Streetly, 1993) among Traveller Communities. Studies in this period found mortality rates which were twice as high for male Travellers and three times as high for female Travellers than for settled community members, even comparing unfavourably with those among the most socio-economically disadvantaged groups in the UK (Barry, Herity and Solan, 1989). Furthermore, life expectancy at birth was calculated at 9.9 years less for Traveller men and 11.9 years less for Traveller

women than for the settled population. Self-reported health among Gypsies and Travellers was reportedly poor, with only 6% of women reporting that they hadn't experienced illness in the past 5 years and around 14% having experienced anxiety and depression (Pahl and Vaile, 1988).

While these studies provided an early attempt to quantify research on the health status of Travellers, notable gaps remained, and several criticisms were levelled at this work. Reviews pointed to the limited evidence pertaining to the UK (Hajioff and McKee, 2000) and the small scale and anecdotal nature of studies, criticising these for lacking rigor and impartiality (Doyal *et al.*, 2002; Aspinall, 2005). Given the lack of reliable demographic information on Gypsy and Traveller populations, questions were also raised about how far samples were representative and 'truly' reflected health differences between Traveller Communities and settled populations. For instance, the recruitment of Traveller Community members through health visitors in many of these studies was identified as a potential source of bias, since those in contact with health visitors might be expected have greater health needs (Acton *et al.*, 1998). Further problems were identified around the reliance on recall and self-report (Pahl and Vaile, 1988). Despite questions about the reliability of evidence, these statistics on the health status of Traveller Communities were so oft repeated and cross-cited without acknowledgement of their limitations, that they attained status as unquestionable facts, inflating the weight of evidence in the area (Doyal *et al.*, 2002). This suggests that the construction of Traveller Community health as a problem worthy of attention is not based on epidemiological evidence alone and points to the influence of additional drivers. Indeed, Hajioff and McKee (2000) argue that the predominant focus on genetics, reproductive health and communicable disease in the early literature is indicative of apprehension about the threat Traveller Communities pose to the health of the majority population, and concerns of 'contagion', as opposed to concern for the health of Gypsies and Travellers themselves (Hajioff and McKee, 2000).

There has since been a proliferation in the number of epidemiological studies on the health status of Gypsies and Travellers (Cook *et al.* 2013; Foldes and Covaci 2012; Parekh and Rose 2011, Carr *et al.* 2014). This burgeoning interest is potentially attributable to the increased policy attention to these groups through the Decade of Roma Inclusion (2005) and Inclusion Health agenda (2010). Spanning a much

broader geographical area (Cook *et al.*, 2013), this work retains a strong focus on child and adolescent health but has moved away from the earlier preoccupation with communicable diseases and genetics (Zeman, Depken and Senchina, 2003; Cook *et al.*, 2013). Work in Sheffield (Van Cleemput and Parry, 2001; Parry *et al.*, 2004, 2007, Van Cleemput *et al.*, 2004, 2007) and later, the All Ireland Traveller Health Survey (Abdalla *et al.*, 2010) have been seminal in establishing evidence on the comparative health status of Traveller Communities. These studies confirm many of the indicators of poor health among Traveller Communities suggested by earlier studies. This includes lower than average life expectancy and increased mortality rates (Abdalla *et al.*, 2010), increased prevalence of long-term conditions or disabilities which restrict everyday activity (Parry *et al.*, 2007) and fewer years spent in good health (Abdalla *et al.*, 2013) than the general population. Gypsy and Traveller Communities are significantly more likely to self-rate their general health as poor compared to socio-economically disadvantaged members of the general population (Parry *et al.*, 2007) and other ethnic minority groups (Peters *et al.*, 2009), with ethnic differences still apparent after adjusting for potential confounders such as age, sex and smoking (Peters *et al.*, 2009). Higher rates of anxiety and depression have also been found among Traveller Communities relative to the general population (Goward *et al.*, 2006) and other ethnic groups (Peters *et al.*, 2009), as well as increased rates of suicide among Irish Travellers (Walker, 2008; Abdalla *et al.*, 2010). Studies report that Gypsies and Travellers are significantly more likely to smoke compared with other groups (Parry *et al.*, 2007; Peters *et al.*, 2009). Van Hout and Hearne (2017) further suggest that previously low rates of drug and alcohol use in Irish Traveller Communities are now increasing. Early concerns regarding maternal and child health are also reinforced in more recent studies, which suggest higher rates of miscarriage (Parry *et al.*, 2007), higher infant mortality rates (Hamid, Kelleher and Fitzpatrick, 2011) and low or patchy acceptance and completion of vaccines compared to the general population (Dixon, Mullis and Blumenfeld, 2016; Jackson *et al.*, 2017).

Despite these efforts to improve evidence of Gypsy and Traveller health status, the absence of routinely collected data on Gypsy and Traveller Communities continues to hinder evidence generation on Gypsy and Traveller health (Cook *et al.*, 2013). While Gypsies and Irish Travellers were included as ethnic categories in the 2011 Census, population estimates obtained through this source are likely to be an

underestimation, as Traveller Communities may fear identifying themselves due to the risk of discrimination, and as surveys may fail to capture those who are mobile (Mulcahy *et al.*, 2017). That the Government's stated intention to include Gypsies and Travellers in the NHS data dictionary (The Traveller Movement, 2015) has not yet been enacted, further exacerbates this issue. In addition, even with the availability of robust data on Gypsies and Travellers, finding appropriate comparator groups is difficult. Traveller Communities are stratified with respect to wealth (P. Padfield, personal communication, 2010), and operate according to a somewhat separate 'economic subsystem', making it difficult to compare socio-economic status (Hodgins, Millar and Barry, 2006; Parry *et al.*, 2007). Indeed, Travellers often experience 'spatialised' as opposed to simply financial poverty, arising from their geographic and cultural exclusion (Clark & Cemlyn 2005). For instance, Traveller Community members are often forced to settle in hazardous locations that are near busy roads or refuge sites, lack basic amenities such as water and sanitation services, and are isolated from services (Cemlyn *et al.* 2009; Matthews 2008). However, the use of comparators from the most socio-economically deprived sections of the general population in many of the above studies suggests that findings are likely to provide the most conservative estimate of health inequalities experienced by Gypsies and Travellers. Overall, that evidence which is available points to significant inequalities experienced by Gypsy and Traveller Communities.

While evidence underlining the health 'needs' of Traveller Communities is now increasing, this has not yet been matched with research on how these needs can best be met. Earlier calls for greater research evaluating the effectiveness of practice and interventions to improve Gypsy and Traveller health (Doyal *et al.*, 2002; Aspinall, 2005) have been reiterated in recent reviews (Foldes and Covaci, 2012; Cook *et al.*, 2013; Carr *et al.*, 2014; McFadden *et al.*, 2018) despite a gap of over a decade. This is notwithstanding notable exceptions however (Kelly *et al.*, 2006; Mason *et al.*, 2006; Charikar, 2008; Greenfields, 2009; Molnár *et al.*, 2010; Van Cleemput, Bissell and Harris, 2010; Schaaf, 2011; Brady and Keogh, 2016; Kirwan and Jacob, 2016). The longstanding emphasis on the vulnerability of Traveller Communities, and the lack of concerted action on alleviating health inequalities has entrenched a 'deficit model' (Morgan and Ziglio, 2007) of understanding of Gypsy and Traveller health. This focus may, in part, be a reflection of a system in which funding for health interventions is allocated on the basis of demonstrated needs of

groups or communities, rather than a recognition of strengths or assets (Canvin *et al.*, 2009). An emphasis on 'need' may enable groups such as Traveller Communities, who have been historically underserved, to gain access to required resources (Doyal *et al.*, 2002; White, 2002; Canvin *et al.*, 2009). However, the literature also points to potential problems with such presentations. Crawford (1994) describes how groups who are deemed 'unhealthy' come to symbolise all those risk factors associated with illness and can come to be treated as scapegoats onto whom the health anxieties of the majority population can be projected. Indeed, this is evident in Haijoff and McKee's (2000) suggestion that early research on Traveller Community health was motivated by concerns about the risks of contagion these groups posed to majority society. Given the moral imperative of health (Petersen and Lupton, 1996), such portrayals can also stigmatise these groups and potentially damage wellbeing by reinforcing low expectations and perceptions of worth (Malin, Wilmot and Manthorpe, 2002; Canvin *et al.*, 2009). Indeed, needs-based approaches which position Traveller Communities as 'victims' or particularly 'vulnerable' are increasingly subject to challenge, as seen for instance in ongoing work in the UK to explore the assets of Traveller Communities (Leeds GATE, 2017).

This section highlights the gradual intensification of the epidemiological gaze applied to Gypsy and Traveller Communities. Gypsy and Traveller health appears to have been simultaneously highlighted and obscured as a public health problem. On the one hand, evidence has supported the identification of health needs among these groups; on the other, shortfalls in statistical information undermines the establishment of Traveller Community health as an area of concern. The politicised nature of Gypsy and Traveller health was demonstrated, and it has been suggested that the generation of, and reception to 'evidence' in this area cannot be divorced from social and cultural conditions which surround it. In particular, this concerns representations of Gypsies and Travellers as Other, as a possible risk to wider populations, and as particularly 'in need' with regard to health. Having discussed the framings of Traveller Community health status in the literature, I now move on to explore the explanations offered for the poorer health of these groups and ideas about the character of Gypsies and Travellers that are implicated within these.

2.4 Gypsy and Traveller health: a cultural or structural problem?

The employment of ethnicity to explain the differential health status of groups has long been critiqued (Bhopal, 1997; Ahmad and Bradby, 2007). Concepts of ethnicity and culture have replaced those of race in the categorisation of groups with respect to health, but have retained many of the problems of prior racial thinking (Ahmad and Bradby, 2007). Namely, the attribution of definitive and innate characteristics to groups, and the reinforcement of a 'cultural deprivation' framework that blames minorities for their poorer health (Smith and Newton, 2017). In the field of Gypsy and Traveller health, the concepts of ethnicity and culture are used imprecisely and often interchangeably (Smith and Newton, 2017). Such conceptual confusion is perhaps unsurprising given fundamental and long-standing disputes in Romany studies regarding the extent to which Traveller Communities can be considered to have a distinct ethnicity, and the defining characteristics that underpin such claims (Mayall, 2004). While some have argued that Traveller Communities are separate ethnic groups (defined according to common origin and ancestry, language and genetics), others have steered away from the use of ethnicity to understand Traveller Community identity, favouring socio-cultural demarcations (Mayall, 2004; Tremlett, 2014b). Among those who eschew a focus on 'ethnicity', Tremlett (2014b) identifies two main positions. The first, which has tended to be taken by anthropologists, delineates Gypsies and Travellers according to cultural beliefs, practices and 'way of life' (see for example Okely, 1983). The second tends to be adopted by sociologists and rejects essentialist cultural explanations, instead emphasising structural factors such as poverty in explaining the collective experiences of Traveller Communities. Similar 'camps' to those identified by Tremlett (2014b) are discernible in the literature on Traveller Community health, in regard to whether the 'problem' of Gypsy and Traveller health should be explained in cultural or structural terms. Some stress cultural influences (i.e. shared norms, customs, belief systems, and way of life) on health-related behaviours and uptake of health services. Others explain the differential health status of Traveller Communities by reference to inequalities in the social and material resources that are required to attain a good standard of health (Smith and Newton, 2017). This division between cultural and structural explanations will now be explored in more detail.

2.4.1 The cultural storyline

Helman (2007: 2) defines culture as “an inherited ‘lens’ through which the individual perceives and understands the world that he inhabits and learns how to live within it”. Culture operates at many different layers (including at societal, institutional, sub-cultural or community levels), with each individual belonging to multiple and nested cultures (Helman, 2007). Recognition of the socially constructed nature of health and the potential for health to be defined and practiced differently depending on the cultural context has led ‘lay’ conceptualisations of health to develop as an important area of study. Research into ‘lay’ experiences and theories about the causes of health and illness is used to provide insight into the systems of thought that shape people’s lifestyles and decisions around engagement with health advice and services (Nettleton, 2013). It also recognises and seeks to learn from the expertise people have of their own circumstances of inequality and disadvantage (Smith and Anderson, 2018). Qualitative research undertaken in this tradition with Gypsy and Traveller Communities tends to prioritise consideration of how Traveller Community members speak from a position of belonging to their particular ethnic and cultural group (Smart, Titterton and Clark, 2003; Zeman, Depken and Senchina, 2003; Carr *et al.*, 2014; Smith and Newton, 2017), starting from a premise of difference and seeking to elicit the distinct health-related beliefs and experiences of these groups. This work has articulated a number of cultural attributes of Traveller Communities in relation to health.

2.4.1.1 *Definitions of health*

Traveller Community members are presented as defining health itself differently from other sections of the population. Gypsies and Travellers are suggested as stoic and accepting of illness, describing themselves as healthy even when experiencing a number of health complaints (Treise and Shepherd, 2006; Van Cleemput *et al.*, 2007; Jesper, Griffiths and Smith, 2008). These groups are argued to conceptualise health and illness in predominantly physical and functional terms (Treise and Shepherd, 2006; Van Cleemput *et al.*, 2007), treating mental health issues as ‘commonplace’ and as a poor excuse for failing to keep up with everyday responsibilities compared to visible and physical health complaints (Treise and Shepherd, 2006). Yet research carried out in Sweden, albeit based on a very small sample, found Roma women to define health according to ‘inner strength’ or ‘feeling well inside’ rather than the absence of physical complaints (Alex and Lehti, 2013). Research has also suggested that Gypsies and Travellers adhere to a collective as

opposed to individualistic concept of health (Lehti and Mattson, 2001; Goward *et al.*, 2006; Hassler and Eklund, 2012; Alex and Lehti, 2013), with this finding used to explain patterns of accessing health services. Lehti and Mattson (2001) for example describe how women often attended primary care in succession, asking for similar treatments or help with similar issues. Collective definitions of health are contrasted with 'typical' forms of health service provision which are organised around the roles of autonomous individuals (Goward *et al.*, 2006). While claims about the distinct definitions of health adhered to by Traveller Communities are frequently espoused in the literature, to the best of my knowledge, research had not yet undertaken any systematic or comprehensive comparison of definitions of health used by Traveller Communities and those used by 'lay' people more generally.

2.4.1.2 Hygiene and modesty

A further aspect of Traveller Community culture that has received attention concerns hygiene practices (McLeish, 2008; Lane and Tribe, 2010). Indeed, this reflects an interest within anthropological work more generally surrounding the ways that dirt and purity are employed in the reinforcement of morality and social order (Douglas, 1966). Gypsies and Travellers are noted to believe in the greater purity of the top versus the bottom of the body (Zeman, Depken and Senchina, 2003). The bottom half of women's bodies are said to be viewed as particularly polluting during menstruation and pregnancy, with this informing preferences around care such as a desire to give birth in hospital rather than the home (Vivian and Dundes, 2004). The literature also details cultural norms surrounding the modesty and sexuality of Gypsy and Traveller women which: govern the display of women's bodies to men other than their husbands (Okely, 1983); prohibit women from having sex before marriage (Papadopoulos, 2007); and lead to a preference for sexual health not to be discussed with children (Hodgins and Fox, 2012). Cultural beliefs around cleanliness and modesty are themselves cited as leading to a reluctance to engage with some health promoting behaviours such as breastfeeding (Okely, 1983; Reid and Taylor, 2007; Dion, 2008; Condon and Salmon, 2015). Likewise Feder *et al.* (1993) suggest that immunisation is a practice through which 'symbolic boundaries' are upheld between Travellers and the majority population, illustrating how health practices are treated as separating Traveller Community members from the 'settled' population in the literature. Cultural 'taboos' around dirt, hygiene and bodily practices are often judged to be 'primitive', potentially placing Traveller Communities in opposition to

'civilised' values. However, Douglas (1966) challenges this stance, demonstrating that rituals of purity are common to both primitive and contemporary societies. Furthermore, Douglas (1966) illustrates that any attempt to create strict rules or classifications is fallible and open to contradiction, given the difficulty of encapsulating all aspects of human life, and as customs may not be upheld rigidly by members.

2.4.1.3 Traveller Communities as 'closed-off' groups

Traveller Communities are presented as having a 'cultural pride in being tough and self reliant' (Van Cleemput *et al.*, 2004: 38), and as maintaining their separation from settled society (Zeman, Depken and Senchina, 2003; Ho and Cordovilla, 2004; Treise and Shepherd, 2006; Van Cleemput *et al.*, 2007; Jesper, Griffiths and Smith, 2008). There is a common preconception that Gypsies and Travellers prefer to 'look after their own' (Minority Ethnic Carers of People Project, 2014) and are unwilling to access mainstream services (Treise and Shepherd, 2006; Jesper, Griffiths and Smith, 2008). Hesitance to accept help is suggested to be particularly apparent for issues which are 'taboo' within Traveller Communities, such as drug and alcohol use (Fountain, 2006; Van Hout, 2010), or mental health issues (Parry *et al.*, 2004; Goward *et al.*, 2006). Gypsies and Travellers are often suggested to be reliant on those within their family or community for health advice, and to have a strong tradition of sharing information inter-generationally and by word of mouth (Lawrie, 1983; Raper, 1986; Vivian and Dundes, 2004; Dion, 2008; Peinado-Gorlat *et al.*, 2015; Dixon, Mullis and Blumenfeld, 2016; Jackson *et al.*, 2017). The importance of family in providing care for older people (Lane, Spencer and Mccready, 2012) or those with a terminal illness (Jesper, Griffiths and Smith, 2008) is presented as a further cultural trait of these groups. Indeed, data from the 2011 UK Census suggests high numbers of Gypsies and Travellers providing unpaid care (Office for National Statistics, 2014), though this is not necessarily for cultural reasons.

2.4.1.5 The Travelling lifestyle and attitudes to time

The nomadism of Traveller Communities is a further aspect of culture cited as influential over health. Gypsies and Travellers have been found to make a direct link between their ability to uphold a nomadic way of life and their wellbeing, with the health benefits of nomadism including: freedom and control; the ability to maintain proximity to extended family; and fresh air (Van Cleemput *et al.*, 2007). Participants in the study by Van Cleemput *et al.* (2007) expressed their concerns about forced

assimilation and described the 'culture shock' of a move into housing as detrimental to their psychological health. However, difficulties associated with nomadism are also reported, with participants commenting specifically on the lack of appropriate accommodation options, poor facilities on official sites, and a lack of access to basic amenities and health services when living on roadside (Van Cleemput *et al.*, 2007). Condon and Salmon (2015) further suggest that travelling results in 'disrupted contact' with health professionals and point to practical difficulties such as a lack of space and privacy in caravans as creating difficulty breastfeeding for Gypsy and Traveller women.

Ideological as well as practical concerns are raised about the impact of nomadic lifestyles. Traveller Communities are presented as conceptually as well as physically nomadic, with these groups described as having different attitudes to time. Indeed, conceptualisations of time are not universal, and have been suggested as varying historically, and across cultures, connected with broader processes of social change (van Tienoven, 2018). The commodification of time and the rationalisation of labour processes during the industrialisation of society are suggested as instrumental in the subjection of individuals to greater forms of temporal control (Fox, 1999). This was evident in a transition from the task-oriented labour systems of agrarian societies, to highly routinized and clock driven work patterns (Adam, 1990; Bergmann, 1992; van Tienoven, 2018), and the imposition of a clear separation between work and leisure time (Bergmann, 1992). Hall (1994) distinguishes between monochronic and polychronic systems of time. Monochronic societies are hugely time-disciplined, employing several devices (such as clocks and calendars) for measuring and directing time. Monochronic time is conceived as linear; time periods are divided into distinct parts, activities are completed one at a time, and the adherence to pre-planned schedules is stressed. By contrast, societies that function according to polychronic time are suggested as more present-oriented, placing less emphasis on the rigid adherence to schedules, with the result that 'appointments are not taken seriously and as a result are frequently broken' (Hall, 1994: 265). Polychronic time perspectives are primarily driven by human relationships; people and activities are not allocated a specific time slot and systems of communication are open, with several activities undertaken at once. In its concern with human connection and contrast to bureaucratic structures of work performed outside the home, polychronic time has been associated with the domestic realm, and has been couched as what would be traditionally be conceived of as a 'female' approach to time. These

different time systems have also been connected with perceptions of agency, with those in polychronic societies adhering to a philosophy that one has control over time and those with monochronic understandings instead viewing themselves as governed by time (Hall, 1994). A distinction is also made between linear, clock-based conceptions of time, in which the separation of past, present and future introduces the ability to control and prepare for the future (Davies, 1994; Leccardi, 1999), and process or cyclical formations of time (Davies, 1994; Juhila, Gunther and Raitakari, 2015). The latter understand time by reference to the recurrence of events (such as day/night or the seasons), contrasting with one-directional, linear perspectives which advance a view of the future as open to change and potentially different from the past (Juhila, Gunther and Raitakari, 2015). Process understandings of time stem from an analysis of care work, which cannot be structured according to pre-determined times and durations and instead responds to needs as they arise (Davies, 1994; Fahlgren, 2009; Juhila, Gunther and Raitakari, 2015). As in polychronic approaches, different care activities are often undertaken simultaneously, making it difficult to quantify how much time has been devoted to this type of work (Davies, 1994). Though not explicitly, Traveller Community members are presented within the literature as adhering to time systems that are polychronic, as opposed to the monochronic, linear notions of time which dominate the organisation of society (including health services). Connected with nomadism, Traveller Communities are presented as leading unpredictable and unstructured lives, and as less likely to adhere to set appointment times (Lawrie, 1983; Raper, 1986; McCann, 1987; Feder, 1989; Lehti and Mattson, 2001; Goward *et al.*, 2006). McCann (1987: 295) suggests for instance that 'The Traveller woman's day is unstructured to a great degree: she only responds to the demands of the immediate', and that 'Time scheduled sessions are not suitable for this group at their present level of social organisation'. Recent research, however, found only a small minority of Gypsies and Travellers to suggest a tendency in Traveller culture not to adhere to appointments (Jackson *et al.*, 2016).

Perhaps drawing on romantic ideas of Gypsies and Travellers as liberated from the conventions of majority society (Tremlett, 2014a), these groups are also presented as affording less importance to social boundaries or rules. Peck (1983) for instance suggested that a 'cultural bias towards a life free of rules and regulations has often automatically deprived gypsies of their rights to health care, education and social

security.’ Parallel literature on education points to potential for conflict between the rules imposed by educational institutions and Traveller Community lifestyles. The highly structured school environment, with fixed rules and hierarchy has been suggested as imposing unfamiliar limits on Gypsy and Traveller children’s behaviours (Levinson, 2008; Bhopal, 2011). Teachers were found to construct Traveller culture as ‘disruptive and abnormal’, since ‘Gypsy and Traveller pupils do not fit into the neat stereotype of obedient, quiet, diligent pupils’ (Bhopal (2011: 481). Levinson (2005, 2008) points to potential conflict between Gypsy and Traveller culture and ‘mainstream’ educational environments in regard to the use of time and space during play. Traveller children were observed as disinterested in forms of play that involved set rules and turn-taking, or concentration for an extended time, with these characteristics explained by reference to “a natural restlessness” (Levinson, 2005: 514). Indeed, Levinson (2005) argues that these differences in orientation to play are one way through which Gypsies and Travellers can reassert boundaries between themselves and settled society, and maintain a distinct identity position. Such differences are contextualised by reference to the faster progression from childhood to adulthood within Traveller Communities and the greater integration into and contributions of Traveller children to adult life. This cultural context is cited to result in Gypsy and Traveller children favouring play that involves real life objects and acts as form of preparation for adult roles, and preferring a more autonomous and relaxed style of learning through observing and contributing to work alongside adults (Levinson, 2005). This approach to learning requires Gypsies and Travellers to have ‘both the (spatial) freedom to get up and move around during learning, and the (temporal) freedom to decide when to stop, start and take breaks’ (Levinson, 2008: 241). Traveller Community adherence (or lack of adherence) to rules for conduct are also considered in relation to health behaviour. Dion (2008) argues that where children are not exposed early on to ‘boundary-setting’ in a school environment, they may then struggle to manage within a system ‘in which rules and boundaries prevail’. This lack of discipline is suggested as manifest in the difficulty Gypsies and Travellers experience in declining children’s requests for unhealthy food and drinks, with this in turn suggested to prevent children learning to self-regulate their diet and even extrapolated to potentially result in the inability to abstain from risky behaviours such as substance use later on in life (Dion, 2008).

Parallel research points to the potential for time to act as a mechanism of social control and to the relations of power inherent in the priority given to Western, linear systems of time relative to conceptions of time within other cultures (Adam, 1990; Davies, 1994). Nanni (2011) illustrates how the imposition of dominant systems of time were integral to the colonial project in Australia. Indigenous systems of time were judged (relative to European conceptions of time) as inferior, characterised as lacking regularity or rationality and as liable to disrupt dominant conventions of time and 'order' (Nanni, 2011). It is through these discourses that Indigenous people were characterised as belonging to more primitive times, and the hegemony of what were deemed 'civilised' European systems of time was preserved (Nanni, 2011). Constructions of Aboriginal populations in relation to space merged with those in regard to time in justifications for colonial actions. Rather than claiming ownership of land by inhabiting, constructing boundaries around, and farming land, Aboriginal communities move through space in a seasonal pattern, in response to the opportunities provided by the land. Colonial practices were defended both on the grounds of a lack of ownership of land by Aboriginal communities and arguments about a lack of 'rational rhythm or regularity in the lifestyle' of Aboriginal populations (Nanni, 2011). Efforts to physically fix Aboriginal people in place through settlement and the re-structuring of Aboriginal temporalities to reflect those that were dominant, formed a key technique of power in the colonial enterprise (Nanni, 2011). Much of this was achieved through the enforcement of rigid timetables to ensure adherence to the 'regularity and uniformity' of work as conceived in European temporalities, and to overturn the rhythm and rituals by which Indigenous people organised their lives (Nanni, 2011). However, the multiple different meanings and values attributed to time creates opportunities not only for attempts at temporal control, but also resistance to them (Fox, 1999). While the above discussion demonstrates the potential significance of time and space in understanding relations of power and resistance in interactions between Traveller Communities and health services or practitioners, this is, at present, unexplored in the health literature.

2.4.1.4 Fatalism

Another oft-cited claim in the literature is that Traveller Community members have a fatalistic attitude with respect to their health (Petek *et al.*, 2006; Van Cleemput *et al.*, 2007; Dion, 2008). Fatalism is defined as 'a belief that negative outcomes may occur to oneself or others regardless of attempts for personal control' (Keeley,

Lanelle and Condit, 2009: 737). Research suggests that Gypsy and Traveller Communities may prefer not to hear a diagnosis of conditions such as cancer, believing the diagnosis itself to be detrimental to health (Van Cleemput *et al.*, 2007; Jesper, Griffiths and Smith, 2008). Fatalism is therefore presented as a view that hampers a preventative approach to health (Petek *et al.*, 2006; Van Cleemput *et al.*, 2007; Dion, 2008), leading to late attendance for health problems which in turn perpetuates poor health outcomes (Lehti and Mattson, 2001; Van Cleemput *et al.*, 2007). This relates to portrayals of Traveller Community members in relation to time explored above, since a fatalistic outlook contrasts with linear views of time that are integral to health promotion and view future health consequences as determined through current action. It is important to distinguish here between beliefs themselves and the forms of expression used by Traveller Communities however. For instance, Jesper *et al.* (2008) highlight how Traveller Community members distinguished between benign and malignant cancers, and metastasised versus localised cancer, but did so in a more storied form; referring to differences between male and female forms of cancer and their amenability to treatment. A variation of narratives on the fatalism of Traveller Communities presents these groups as having 'chaotic lives' (Gill *et al.*, 2013) and therefore an inability to give priority to preventative health in light of more pressing material and structural concerns (Hodgins, Millar and Barry, 2006; Jesper, Griffiths and Smith, 2008; Ipsos MORI, 2009; London Borough of Richmond upon Thames Public Health Department, 2014). Again, this is presented as borne out in Traveller Community members' use of health services, namely, their higher attendance at accident and emergency services and lower engagement with primary care and health education (Hodgins, Millar and Barry, 2006; Jesper, Griffiths and Smith, 2008). This too aligns with representations above of Traveller Communities as more present-focused. While recognising structural constraints on behaviour, reference to low prioritisation translates the focus back to the realm of personal responsibility, thereby forming a pseudo-structural explanation.

2.4.2 Critiquing the cultural storyline

Taken together, the above narratives suggest a picture of Gypsy and Traveller Communities as largely unconcerned with their health; as adhering to health beliefs, traditions and behaviour which stand in opposition to those promoted in the name of health; and having lifestyles which are incompatible with current systems and methods of health service delivery. As summarised by Acton:

Gypsies themselves, like members of any ethnic group, have a tender concern for their own bodily wellbeing. Nonetheless, much of the limited scientific epidemiological and policy literature on Gypsy health in the UK tends to assume rather the opposite; that along with specific knowledge about particular diseases and symptoms, health education for Gypsies must also teach a new and previously lacking concern for health (1998: 45)

Acton's statement remains true today, with Smith and Newton (2017: 3) more recently critiquing the use of cultural attitudes such as those described above to explain Gypsy and Traveller health inequalities. Many of these arguments have been so frequently repeated that they have become taken for granted 'facts' about Traveller Communities. This is exemplified in research seeking to explain low breastfeeding rates among Gypsies and Travellers. Despite data suggesting that Gypsy and Traveller attitudes toward infant feeding practices may be more neutral and less fixed than previously imagined (Pinkney, 2012), sweeping representations of their attitudes towards breastfeeding behaviours persist. The title for a recent article by Condon et al. (2015) presents an overall impression of Gypsies and Travellers as preferring not to breastfeed, and reinforces divisions between these groups and the settled majority in its choice to quote the following statement by one participant in the research: 'You likes your way, we got our own way'. This is notwithstanding data cited within the article that some mothers had indeed decided to breastfeed, which provides counter evidence to this claim. This illustrates how pervasive narratives about cultural difference can be, even despite the presence of alternative stories. Too great a focus on culture can have important implications and is critique has been well rehearsed in the literature already. Such conceptualisations can pathologise Gypsy and Traveller culture by judging this according to dominant standards for health beliefs and practices (Matthews, 1998; Fernando, 2002), present groups as irresponsible due to their rejection of some forms of health services (Hajioff and McKee, 2000) and ultimately blame communities themselves for their health problems (Ahmad, 1996; Matthews, 1998). A cultural explanation has also been suggested to obscure the role of structural and material influences on health (Ahmad, 1996; Koupilová *et al.*, 2001; Smart, Titterton and Clark, 2003) such as racism and discrimination (Ahmad, 1996; Nazroo, 2003). There is a risk that where cultural beliefs are viewed as deficient for health, this gives rise to attempts to assimilate Gypsies and Travellers and change their cultural practices (Ahmad 1996; Reid & Taylor 2007). For example, criticisms have focused on the ways in which welfare services underpinned by sedentary values act to prevent nomadism

(McVeigh, 1997), despite travelling often being cited as important for promoting mental health by Gypsies and Travellers (Van Cleemput *et al.*, 2004).

2.4.2.1 Cultural assets

To avoid the potential blame associated with the cultural explanations for Traveller Community health, some work identifies health-promoting aspects of Gypsy and Traveller culture. For example, authors point to quick recovery of Traveller Community members from illness or surgery due to stoic attitudes to health (Van Cleemput *et al.* 2004) and high levels of parental support and monitoring (Cook *et al.*, 2013). The tight bonding ties of Traveller Communities are described as beneficial in providing social support and assistance during times of illness (Van Cleemput *et al.*, 2004), preventing the isolation of older community members (Lane, Spencer and McCreedy, 2012), buffering against the negative effects of racism, discrimination and adversity (Goward *et al.*, 2006; Smith and Ruston, 2013) and promoting wellbeing (Mcquillan and Van Doorslaer, 2007; Alex and Lehti, 2013; Dimitrova *et al.*, 2013). Cultural norms among Traveller Community members have also been described as discouraging the uptake of some 'unhealthy' behaviours such as the use of drugs (Van Hout and Hearne, 2017). Indeed, increasing drug and alcohol use by Traveller Communities has been attributed, in part, to greater contact with settled community members as Gypsies and Travellers become dispersed into housing (Hurcombe *et al.*, 2012; Van Hout and Hearne, 2017). Thus, for this issue we see a reverse of the usual argument that Traveller culture is problematic for health and potentially polluting to wider society. These views reflect a growing movement in public health research away from assessing the needs or deficits of communities towards recognition of the resilience displayed by groups experiencing adversity (Canvin *et al.*, 2009), and the assets or strengths of communities in relation to health (Morgan and Ziglio, 2007; Glasgow Centre for Population Health, 2011). The application of resilience or asset-based perspectives may help to reduce stigmatisation and refocus attention on the agency of individuals and communities to influence their health and circumstances. However, these approaches have also received criticism for placing responsibility on individuals and communities to adapt to imbalances of power rather than to seeking to address them (Bottrell, 2009). Research also points to a need to recognise the ways that social context may promote or hinder resilience at different time points, rather than treat resilience as an individual trait (Backett-Milburn *et al.*, 2008; Canvin *et al.*, 2009). In addition,

while these alternative perspectives introduce balance in the consideration of culture, they too employ externally imposed standards in evaluating whether cultural practices are 'good' or 'bad' for health (Schneeweis, 2011) and as Tremlett (2009:164) has noted with regard to cultural representations, risk substituting 'the widespread notion of a "bad" Gypsy for a "good" or "misunderstood" Gypsy'.

2.4.3 The structural storyline

A further critique of cultural explanations is found in arguments which emphasise the greater salience of material and structural factors as opposed to attitudinal barriers in influencing Traveller Community uptake of preventative health behaviour and services (Hawes, 1997; Matthews, 1998; Smart, Titterton and Clark, 2003; Smith and Newton, 2017). Cultural factors refer to the 'frames' guiding how people understand and make choices in their lives, and their subsequent impact on health (Scambler, 2013), thereby incorporating attention to lifestyle influences. Material and structural factors on the other hand, denote the concrete or social conditions of society which impede or promote health chances (Scambler, 2013). This includes the unequal distribution of wealth, aspects of the environment, and racial and gender inequality for example. Smith and Newton (2017) recently brought the tension between cultural and structural influences to the fore in their analysis of Gypsy and Traveller approaches to childhood immunisation. They question the notion of a global cultural outlook among Traveller Communities concerning vaccination, and instead position structural influences as more important in influencing uptake (Smith and Newton, 2017). Similarly, work has critiqued interpretations of Traveller Community mistrust of services as a cultural orientation, and strict readings of Traveller Community health through the lens of bonding versus bridging ties (Smith and Ruston, 2013; Smith and Newton, 2017). These authors instead point to the contextual influence of racism and discrimination in generating suspicion towards mainstream health services. Smith and Newton (2017: 244) argue that 'the notion that GRTs are inalienably 'different' and 'hard to reach' has legitimised the minimal progress in reducing inequalities experienced by members of these communities'. Indeed, an in-depth reading of the literature reveals evidence that counters presentations of Traveller Communities as a group who are difficult to engage in health initiatives. Traveller Community members have often been suggested to place great importance on receiving appropriate advice, examinations or interventions from the best qualified medical professionals (Van

Cleemput *et al.*, 2007; Jackson *et al.*, 2016). Where systems of care are altered to be more accessible and welcoming to Gypsies and Travellers, there is some evidence that this in itself can be sufficient to increase uptake of services. For instance, pragmatic changes to a GP service in Doncaster (e.g. to extend appointment times and offer immunisations straightaway rather than through a referral) resulted in increased uptake of immunisation (from 4% to 70%) and cervical screening (from no uptake to 55%) by Gypsies and Travellers (Millet, 2014). These increases are despite suggestions of cultural rules pertaining to pollution and modesty (Okely, 1983) which might be expected to apply to these health issues. Acton *et al.* (1998) similarly point to examples of the acceptance of cervical screening where this was communicated clearly.

2.4.4 Critiquing the structural storyline

In emphasising the influences on health that are beyond personal control, the structural/material perspective counteracts the potential for blame to be directed at individuals or groups for their health. In considering the social context, this work also therefore moves away from the attempts to offer fixed understandings of Gypsy and Traveller beliefs within cultural perspectives. This perspective treats health beliefs and practices as produced in interaction with structural conditions, as well as attending to the impact of social structures in their own right. However, this perspective too, has attracted criticism. While this work has highlighted links between material or social circumstances and health, less attention has been given to understanding the precise mechanisms which underpin these relationships (Williams, 2003). Epidemiological research such as that on Traveller Communities has tended to study different structural influences in isolation and treat these as static variables. This is argued to reduce these determinants to individual risk factors, disregard the potentially interactive and cumulative operation of these elements, and insufficiently capture the complexity of people's lives (Macintyre, 1997; Williams, 2003; Øversveen *et al.*, 2017; Chenhall and Senior, 2018). A lack of focus on the role of institutions (including healthcare institutions) in generating or mitigating against inequalities forms a further criticism of work on structural determinants (Beckfield *et al.*, 2015). The literature on inequalities in health is largely polarised between structural perspectives on the one hand, and cultural or behavioural perspectives on the other (Øversveen *et al.*, 2017) and the politically charged nature of these positions (Scambler, 2013) is suggested as potentially

creating a false anthesis (Macintyre, 1997). Writers have called for greater consideration of the ways that health is shaped at the intersection of structure and agency, and the ways that individuals work within or resist the structural forces that influence their lives (Williams, 2003; Chenhall and Senior, 2018). Both theoretically informed research (Chenhall and Senior, 2018) and narrative methodologies (Williams, 2003) are cited as enabling attention to the relational aspects of individual, cultural and structural forces in affecting health chances.

2.5 Unfolding storylines – Traveller identity as hybrid and contingent

While cultural and structural approaches disagree on the basis of Roma identity, Tremlett (2014b) nevertheless argues that both perspectives reinforce the idea of Roma as a separate and coherent group. The preoccupation in Romany studies with the features that make people ‘Gypsy’ or ‘Roma’ side-lines similarities between Gypsies and other groups, and analysis of how broader societal discourses such as those concerning gender and class also affect these communities (Tremlett, 2014b). In addition, neither cultural or structural perspectives recognise their own role in producing and reproducing Traveller Communities as a category (Tremlett, 2014b). This section describes emerging approaches that aim to overcome these limitations in their view of identity as fluid and contingent. In doing so, it highlights unfolding and unexplored avenues in the application of these approaches to the area of Traveller Community health; avenues to which the present study seeks to contribute.

Authors have recently put forward the case for applying the concepts of ‘super-diversity’ or ‘hybridity’ (Vertovec, 2007) to the study of Gypsy and Traveller identity (Pantea, 2014; Tremlett, 2014b). Super-diversity moves away from a view of ethnicity as a fixed or stable category and instead treats ethnicity as one among many cross-cutting and interacting aspects of identity (such as labour market experience, gender, sexuality, socio-economic position, disability or geographical position) (Vertovec, 2007). The interplay or blending together of these categories leads to new or hybrid identities (Pantea, 2014). While superdiversity therefore resembles the concept of intersectionality, in that it aims to be sensitive to the multiplicity of positions that shape our experiences, it differs from intersectional approaches in that it does not retain a focus on bounded groups to the same

degree (Tremlett, 2014b). While not explicitly acknowledged as such, different framings of Traveller Community ethnicity are represented in campaigns for the recognition of Roma or Traveller Community rights. Political campaigns such as Roma Pride demand inclusion through explicit identification, recognition and celebration of Romany people and privilege notions of ethnicity. On the other hand, a recent UK campaign 'We Are All So Many Things' (London Gypsies and Travellers, 2017) embodies ideas of hybridity and superdiversity by encouraging people to recognise the constellation of roles and identities that Gypsies and Travellers occupy in society and avoid these groups being seen only through the lens of their ethnicity.

2.5.1 Health beliefs as complex and varied

A close reading of the literature reveals some challenge to essentialist representations of Traveller Communities in keeping with the approach of superdiversity (though not referenced explicitly), by those who point to variation and complexity in health attitudes and practices within these groups. Both Jackson *et al.* (2016) and Smith and Newton (2017) found very few instances of wholesale rejection of immunisation by Traveller Community members, instead pointing to the nuanced nature of these decisions. Some were accepting of immunisation but communicated a preference that children were immunised at an older age, or for separate rather than combined MMR vaccinations for example (Jackson *et al.*, 2016; Smith and Newton, 2017). Attitudes to specific vaccines varied, and beliefs differed across specific Traveller Communities and generationally (Jackson *et al.*, 2016). Decisions were also affected by personal experience and the visibility of illness in the community (Smith and Newton, 2017). The views expressed by Gypsies and Travellers towards immunisation do not appear from nowhere, and often relate to reports in the media (such as the now discredited link between the MMR and autism). This response to such media messages itself demonstrates concern and engagement to protect and promote health. Smith and Newton (2017) also highlight how individual community members differently enact supposed cultural values, including those on the importance of children, with this attitude underpinning decisions both for and against immunisation (Smith and Newton, 2017). Hints are also provided as to the potential for cultural identity to intersect with other identity positions in Gypsy and Traveller decisions about health. Van Cleemput *et al.* (2004) explained Gypsy and Traveller uptake of maternity services which breach cultural

'taboos' by suggesting that on these occasions, the role of motherhood was prioritised over adherence to cultural norms.

Though less often explored in the literature, the similarity in Gypsy and Traveller beliefs to those of other sections of the population provides a further basis for critiquing the treatment of Traveller Communities as a discrete group. As Gmelch (1996: 177) suggests: 'Travellers do not work or live in a vacuum, their identity and lifestyle is unquestionably influenced by their connexion to the larger society'. Traveller Community members have been noted to hold similar beliefs and concerns to those found in the majority population around immunisation (Jackson *et al.*, 2016; Smith and Newton, 2017), end of life and advanced care directives (Peinado-Gorlat *et al.*, 2015) and preferences for information to assist decision making in cases of acute childhood illness (Neill *et al.*, 2014). Mistrust in health services among Traveller Communities is argued to be reflective of a broader decline in public trust of health experts and advice (Smith and Newton, 2017). Indeed, smaller asides to dominant narratives of cultural difference position Gypsies and Travellers as interested in and engaged with health generally (Hodgins, Millar and Barry, 2006) as well as information and advice pertaining to specific health issues, including that on immunisation (Smart, Titterton and Clark, 2003; Smith and Newton, 2017), asthma management (Brady and Keogh, 2016), maternity care (Reid and Taylor, 2007) and cancer treatment (Jesper, Griffiths and Smith, 2008). Indeed, participants in the study by Jesper *et al.* (2008) themselves noted the need to avoid generalising about Gypsy and Traveller beliefs about terminal illness. Notwithstanding the above insights, the nuanced health attitudes and practices of Traveller Communities are often reduced within the literature to a basic and essentialising message about the (largely negative) influence of Traveller culture on health. There has, to date, been limited overt analysis of the potentially complex nature of Traveller Community accounts of health, nor the potential similarities in health narratives and identities expressed by Traveller Communities and wider groups.

Applying broader literature on lay articulations of health and illness also poses challenges to the attribution of fatalistic beliefs to Traveller Community culture. While fatalism is often reported as if this is a unique value system of Traveller Communities, cancer fatalism has been found among many other ethnic minority groups (Vrinten, Wardle and Marlow, 2016) as well as those of low socio-economic

status (Beeken *et al.*, 2011). Furthermore, whilst often presented as more prevalent in 'disadvantaged' groups, research has found that individuals of both low and high socioeconomic status employ fatalism to explain infertility (Bell and Hetterly, 2014). Some variation was apparent however in how individuals of differing social status used fatalism, owing to differential access to resources and previous experiences with health services (Bell and Hetterly, 2014). Research in this area also questions the binary categorisation of people as wholly fatalistic or non-fatalistic (Keeley, Lanelle and Condit, 2009) and has pointed to a need to distinguish between globally fatalistic remarks (where no expectations of personal control were expressed) and those implying a limited sense of control (where control was claimed over some areas but not others) (Keeley, Lanelle and Condit, 2009). The view that fatalism necessarily precludes engagement in behaviour to improve health has also been challenged. Bell and Hetterly's (2014) research disrupts the traditional dichotomy between fatalism and agency, suggesting that fatalism can in fact be agential (e.g. when people take a deliberate choice to adopt this stance), and agency can be motivated by fatalism (e.g. where higher powers are presented as also affording free will). Drew and Schoenberg (2011) similarly highlight examples whereby discourses of fate or religion actually promoted healthy behaviour, as can be seen in ideas that 'your body is a temple' or that 'God works through Doctors'. Indeed, in a similar vein, distinctions between 'lay' and biomedical or professional accounts of health are increasingly recognised as problematic. 'Lay' accounts have been demonstrated to integrate multiple and competing ideas about health (including biomedical viewpoints) (Hughner and Kleine, 2004; McClean and Shaw, 2005). Likewise, many therapies previously considered 'alternative' have been appropriated within medicine (Blaxter, 2010), and clinicians have been long been recognised to deliver medical advice in ways that are compatible with, and sometimes reinforce 'lay' or 'folk' perspectives (Helman, 1978; Blaxter, 2010). In recognition that fatalism may not act as a global or fixed outlook, research has examined the social functions that fatalistic talk fulfils (Keeley, Lanelle and Condit, 2009; Drew and Schoenberg, 2011), giving insight into the potential benefits of fatalism as opposed to negative connotations which stem from the privileging of autonomy, control and independence in Western societies (Bell and Hetterly, 2014). This work points to the role of fatalism in balancing gaps between the universal desire to achieve health, and circumstances which limit possibilities for health (Keeley, Lanelle and Condit, 2009). According to this reading, fatalism can be described as a rational response to

circumstances such as poor health or long-term illness (Keeley, Lanelle and Condit, 2009), and witnessing deteriorations in the health of other community members (Drew and Schoenberg, 2011). This helps to understand why fatalism is often associated with disadvantaged groups, for whom the gap between health and resources is particularly great (Keeley, Lanelle and Condit, 2009). Indeed, this argument is reflected in Smith and Newton's (2017) work, which adopts a critical realist stance and views the health beliefs and practices of Traveller Communities as shaped through an interaction between the agency of Gypsies and Travellers, and the structural constraints or freedoms they are afforded by the world in which we live. However, Bell and Hetterly (2014) found that fatalism can actually help people to maintain hope with respect to fertility outcomes, contrasting with previous depictions of fatalism as a negative or pessimistic orientation. Keeley et al. (2009) report three specific functions of fatalism: 'stress relief'; 'uncertainty management'; and 'sense making'. The stress relief function of fatalism refers to the avoidance of worry and stress about potential illness. Managing uncertainty describes the use of fatalism to cope with the unpredictable nature of illness. Finally, sense making refers to the ways that participants used fatalism to rationalise one's current behaviour and deal with the consequences of past behaviour (e.g. where participants claimed that the opportunity to change one's behaviour was now too far gone). It has also been suggested in previous literature that fatalistic remarks may enable a form of face-saving and protection from potential blame or embarrassment (Bolam *et al.*, 2003). Keeley et al. (2009) were unable to substantiate this function within their study however, which analysed the content of participant responses alone, since any explicit mention of the use of fatalism to save face, would itself result in a loss of face for participants.

While fatalism is therefore a concept which is being subject to increasing problematisation, there is, at present, very little which applies this debate specifically to Gypsy and Traveller Community health beliefs. Counter recent developments in the conceptualisation of this term, fatalism is often uncritically accepted as a fixed inner health belief within the literature on Traveller Community health.

2.5.2 The discursive production of identity

The above reported literature starts to form some challenge to the narrative of Traveller Community members as homogeneous in their rejection of certain forms of health services, and to the use of culture or structure as rigid explanations for Gypsy

and Traveller health. However, one aforementioned criticism remains unaddressed: that neither cultural or structural perspectives explicitly consider the role they themselves play in creating and sustaining notions of Traveller Community group identity and 'truths' about Traveller Communities and their circumstances. In the case of the former approach, this takes the form of essential claims about Traveller health beliefs, and in the latter, judgements about the causal relationships between social structures and Traveller Community health beliefs and behaviours. Neither approach attends to the discursive processes and associated power relations through which Traveller health identities are produced, claimed or resisted, nor the limits or possibilities for action that result from different forms of talk about Gypsy and Traveller health (including those produced by researchers and academics).

The work of Frederik Barth (1969) is relevant here. Barth (1969) was critical of prior anthropological presumptions (such as those found in the Traveller Community health literature) of an 'internally shared culture' among ethnic groups. Challenging the notion that ethnic distinctions are maintained through geographical and social separation, Barth illustrates the continuation of ethnic boundaries despite movement across them and contact between different groups. As such, Barth (1969: 15) urged the study of on-going social relations through which ethnic boundaries themselves are constituted and maintained, rather than 'the cultural stuff' that these boundaries contain. In common with the approach advocated by Barth (1969), this study examines the criteria employed to construct and sustain boundaries between Traveller Communities and others, in relation to health, by both public health practitioners and community members themselves.

Indeed, some work (beyond the realm of health), has sought to apply this approach to an understanding of Gypsy and Traveller identity. Buckler (2007) studies how 'Gypsiness' is learned and taught through particular forms of storytelling. This includes a preference for grounding stories in connections with known, real people, and a reinforcement within stories of the dangers associated with 'strangers' who are not known and trusted. These storytelling practices are shown to contrast with the attempts of settled community members to produce stories which speak to the motives of Gypsies as a 'singular, cohesive and bounded entity', creating the potential for communication to breakdown in interactions between these actors (Buckler, 2007). However, this work also produces some challenges to the notions

of boundary employed by Barth (1969). Although Barth acknowledges the fluidity of boundaries, Buckler (2007) argues that a line is nevertheless drawn which is recognisable to individuals positioned either side of it. Indeed, this concept is suggested to be potentially less applicable to groups such as Gypsies and Travellers, for whom a distinct claim to ethnicity is contested, and who are therefore 'always and inescapably on both sides of any boundary' (Buckler, 2007: 8). Buckler (2007) shows how boundaries between, and the storytelling conventions governing groups are not deterministic, but liable to shift when confronted with other ways of interacting, and during efforts to establish mutual ground. This highlights the importance of attending to the ways in which boundaries are maintained, as well as the ways they may dissolve or breakdown (even temporarily).

The relative absence of a discursive lens in the literature on Traveller Community health specifically is puzzling, given how prominent this has been in the examination of other aspects of Gypsy and Traveller lives, including the construction and regulation of Gypsies and Travellers in relation to space and place (McVeigh, 1997; Bancroft, 2000; Kabachnik, 2010; Clark, 2014; Turner, 2016), and the othering of Gypsy and Traveller Communities in the media (Clark and Campbell, 2000; Morris, 2000; Amnesty International, 2014; Richardson, 2014). It is also surprising given the well-established critique of health promotion as a source of regulation (Petersen and Lupton, 1996), and the frequent positioning of Traveller Communities as culturally resistant to this advice. Authors in the field of Romani studies generally have highlighted the need to look at the politics surrounding the labelling and categorisation of Roma, as opposed to merely focusing on their lifestyles and traditions (Vermeersch, 2007). However, as will now be demonstrated, this hasn't yet been explored in depth in the area of Traveller Community health and this therefore formed a key area that I sought to address through the research.

We have seen already that fatalism has been questioned on the grounds that its distinction from agency is, in fact, more complex and nuanced than often assumed. Yet some have also problematised the motivations which lie behind the use of fatalism as a concept, and its potentially harmful consequences. For instance, it has been argued that research on fatalism is biased towards a focus on underserved groups (such as Traveller Communities) who are labelled as 'others' and who are seen as 'problematic or ignorant' (Drew and Schoenberg, 2011). Authors have

therefore cautioned against treatment of fatalism as a characteristic of groups who are disadvantaged:

Negatively framing fatalism and then constructing it as a belief among individuals of low SES justifies their subordination and blameworthiness (Bell and Hetterly, 2014: 71)

Yet again, in the Traveller Community health literature, there is little overt recognition of the role that discourses such as fatalism may play in reinforcing the exclusion of these groups. Within this study, I do not treat fatalism as an inner health belief that reflects the material circumstances in which one lives, but as a social construct that is applied to and used by groups to position themselves in relation to self and others; examining the work that this performs for people and the effects that this has.

There is some research available that critiques the labels applied to Traveller Communities in regards to their health from a phenomenological approach, and which questions externally defined, normative definitions of Gypsy and Traveller 'vulnerability' for example (Heaslip, Hean, and Parker 2016a; Heaslip, Hean, and Parker 2016b). Heaslip et al. (2016b) argue for a blending of this 'etic' approach with an 'emic' perspective that understands the 'essence' of vulnerability, as experienced by community members themselves. This work aims to achieve a sense of the 'shared humanness' of Gypsy Traveller Community members and others, thereby transcending individual experience. It therefore challenges the external labelling of Traveller Communities while maintaining a concern with inner 'lived experience'. However, using this perspective, the labels applied to Traveller Communities are challenged only up to a point, with the ascription of vulnerability itself remaining unquestioned.

There are also some notable exceptions to the lack of focus on discursive constructions of Traveller Communities in relation to health. Schneeweis (2011) analysed the construction of Roma people in Romanian health promotion materials, finding three conflicting but co-existent discourses. The first, most dominant discourse positioned Roma as disadvantaged and 'in need' of intervention or 'correction' from non-Roma people, and drew a contrast between 'modern' health service practices, and the 'traditional' Roma methods of health promotion (Schneeweis, 2011). In this discourse, behaviour change was presented as

requiring 'persuasion and influence', including through appeals to fear (Schneeweis, 2011). The second discourse, while still having the dominant discourse of behaviour change and integration at its root, advocated a different solution; the incorporation of Roma culture into health messages (Schneeweis, 2011). Alongside these main discourses, Schneeweis (2011) found evidence of a third 'just the Roma' discourse however. This contextualised the differences of Roma communities and did not depict Roma according to stereotypes, but recognised diversity and presented Roma as able to articulate their health needs and choices. While health promotion documents adhering to this latter discourse contained a lack of practical solutions for health professionals, this was viewed as beneficial in preventing practitioners from operating according to preconceived ideas about Roma people and culture. The extent to which these findings are directly transferable to the UK is not currently clear, since, to the best of my knowledge, no comparable analysis of the discursive construction of Traveller Communities in relation to health has yet been conducted. In addition, the work of Schneeweis (2011) was limited to an analysis of health promotion materials about the Roma, and questions therefore remain around how far identities and constructions of Traveller Communities in relation to health may differ in the talk or stories of health practitioners and Traveller Communities. Further exception is found in the work of Reid (2005), and Reid and Taylor (2007). Reid (2005) applies Foucault's notion of discourse to critique discussions of Traveller Community culture in maternal health care. She argues that epidemiological studies which are presented as objective fact have resulted in problematic understandings of Traveller culture among midwives and suggests that the dominance of medical discourses in informing maternity practitioners' views give rise to portrayals of Travellers as at greater risk with regard to their health. This in turn is suggested to result in a fixed view of Traveller culture as standing in opposition to healthy pregnancy and childbirth and associated problems of victim blaming and assimilation attempts (Reid, 2005; Reid and Taylor, 2007). Reid (2005: para 25) also comments that there 'has been little resistance by traveller women to the persistence and dominance of medical discourse'. Through her feminist lens, she explains this by presenting Traveller Community women as a group who have been silenced by: the masculinised construction of Traveller Communities overall; their experiences of racism, discrimination and inequality; and the authority of medical discourse in defining and acting on Traveller Community needs. As a result, Reid (2005: para 26) argues that Traveller Community women are forced to 'structure

their world through dominant discourse', a language in which, owing to its scientific and ethnocentric nature, they are suggested as 'relatively inarticulate'. In this respect Reid (2005) therefore appears to reinforce the very 'them-us' perspective of that she aims to deconstruct; Traveller Community members' are presented as doing health differently as a result of their culture, but find their own ways devalued in a system that privileges a biomedical understanding of health. There is limited room in Reid's analysis for the possibility that Traveller Community members may draw on similar discourses to other groups in society or utilise biomedical perspectives. Later work by Reid and Taylor (2007), while acknowledging that Traveller culture is enacted in a fluid way, nevertheless makes general claims about the cultural attributes of Traveller Communities in relation to maternity care. For instance, where they suggest that 'bottle-feeding seemed well rooted in Traveller culture' (Reid and Taylor, 2007: 254). This leaves unanswered questions about which health discourses have currency in Traveller culture, and the extent to which dominant discourses also filter into the ways that Traveller Community members talk about health and illness. In addition, this work focuses particularly on maternity care, and only one of Reid's articles reports on empirical research, with this incorporating the views of Traveller Communities alone and neglecting to include the voices of health practitioners.

Critique of dominant representations of Traveller Community members in relation to health can also be found in the work of civil society organisations who represent Traveller Community members. The Minority Ethnic Carers of People Project (2014) produced a book entitled 'Two Sides of the Same Story' which challenges many of the misconceptions about Gypsies and Travellers commonly heard among service providers (though not specific to health). This includes statements that Traveller Communities prefer to 'look after their own', are 'hard to reach' and 'don't want to engage with outsiders'. Although not explicitly adopting a discursive approach, this work shows an acute awareness that the stories that we tell about community members have the power to shape the practices, experiences and identities of health practitioners and Traveller Communities. This therefore also reinforces the salience of an in-depth and empirical examination of these discourses and their implications, looking specifically at health in the UK context.

Radley and Billig (1996) distinguish between the treatment of health narratives as conduits to people's fixed inner health beliefs, versus socially situated 'accounts' through which they present versions self and identity. This comparison also helped to crystallise my understanding of the current literature on Traveller Community health, and the specific contribution that I could make through this research. As shown earlier, the literature on Traveller Community health predominantly adopts the former of Radley and Billig's (1996) approaches, affording a taken for granted status to Traveller narratives and producing concrete and universal claims about the health beliefs and circumstances of Gypsies and Travellers. It is to the latter of Radley and Billig's (1996) categories that I concern myself in the present study, examining the identity positions that Traveller Community members and health practitioners project for themselves and each other through the health stories they tell. This incorporates attention to how identities are negotiated in relation to prevailing societal discourses. The concept of identity is not altogether absent from discussions of Gypsy and Traveller health. Greenfields and Smith (2011) for example looked at the health impact of a denial of ethnic identity following a move into housing, as well as the ways that strength of belonging to a Gypsy Traveller Community enabled resilience in response to difficult living environments. However, this work treats identity (or the denial of identity) as a further factor which explains health experiences and outcomes, rather than studying the *health identities* of Gypsies and Travellers in their own right. Some consideration of Traveller Community health identity is also evident in research on how Traveller Community members describe the causes of their health (Hodgins, Millar and Barry, 2006). Previous research indicates that those experiencing structural disadvantage are often unwilling to admit the existence of health inequalities (Blaxter, 1997; Smith and Anderson, 2018). This reluctance to label the inequality one experiences is explained as an attempt to avoid stigma and reclaim agency (Smith and Anderson, 2018). Yet, by contrast, research with Traveller Communities has found a greater willingness to describe the structural inequalities experienced (Hodgins, Millar and Barry, 2006). This difference in findings is potentially due to the use of vignettes in interviews with Travellers, since talking about the health of others rather than oneself invokes less risk of spoiled identity (Hodgins, Millar and Barry, 2006). Alternatively, Hodgins et al. (2006) suggest that the strength of identification with Gypsy or Traveller ethnicity, and increased politicisation of the needs experienced by these groups may better allow them to acknowledge inequality and accept a

version of themselves as 'needy, requiring intervention and assistance' (Hodgins, Millar and Barry, 2006: 1988). Further research is required to explore in more detail how Traveller Communities manage the potentially stigmatising effect of experiencing health inequalities, particularly since other studies have found Traveller Community members to express surprise or disbelief that their health compares so poorly to other sections of the population (Van Cleemput *et al.*, 2007; Jenkins, 2010).

2.6 Health practitioner identities

This final section of the chapter examines the treatment of health practitioner roles and identities in current literature on Traveller Community health. This is important given calls for more research on those in positions of power, as opposed to that which makes detailed accounts of the beliefs and practices of marginal groups available for utilisation by more powerful groups (Acton, 1974; Vanderbeck, 2005). Such appeals have not been followed through to fruition in the area of Gypsy and Traveller health to date, and health practitioners who work with Traveller Community members have largely avoided the gaze of health and sociological research (Watson and Downe, 2017). Likewise, research rarely considers the narratives of health practitioners and Gypsies and Travellers alongside one another (though Jackson *et al.*, 2016 forms a notable exception). That literature which does examine practitioner perspectives highlights troubling examples of racist and discriminatory attitudes and practice (Janevic *et al.*, 2011; Jackson *et al.*, 2016; Watson and Downe, 2017). This includes views expressed by service providers that Roma, Gypsy and Traveller women are less educated, intelligent or health literate (Janevic *et al.*, 2011; Watson and Downe, 2017), do not listen to or comply with health advice (Watson and Downe, 2017); are negligent of their children's health (Jackson *et al.*, 2016; Watson and Downe, 2017); and are uncivilised and less human (Watson and Downe, 2017). Practitioners have also been found to suggest that Traveller Community members misuse emergency services (Jackson *et al.*, 2016; Watson and Downe, 2017) and fail to prioritise health appointments (Jackson *et al.*, 2016). The literature describes the experience of 'Gypsy fear' among health workers (Janevic *et al.*, 2011). Practitioners in the study by Jackson *et al.* (2016) relayed accounts of colleagues who were frightened about working with Traveller Communities, and some practitioners described feeling intimidated by groups of

Traveller men when visiting sites. Goward et al. (2006) point to the influence of negative media coverage, suggesting that practitioners internalise harmful stereotypes about Traveller Community members. Work also points to a lack of understanding of Gypsy and Traveller culture. For example, practitioners have been noted to struggle to provide support where Traveller community understandings of mental health do not match their own (Goward *et al.*, 2006). Yet, sensitivity is needed in order that a focus on cultural awareness does not lead to rigid assumptions about the needs of Traveller Communities which fail to accommodate potential within group differences. Even positive portrayals of Gypsy and Traveller culture, such as the preference to care for elderly relatives at home, where extrapolated to the community as a whole, may lead to the withholding of support that some families may wish to receive. Rigal (1997) found that health care professionals tended to discuss only injectable methods and intrauterine devices for family planning due to assumptions of poor compliance with drug regimens, despite Gypsies and Travellers favouring oral contraceptives. A tension is therefore evident between producing guidelines for practice which respect cultural preferences while avoiding creating uniform recommendations that give little scope for individual variation.

There are some examples of programmes that have helped to overcome the discrimination Traveller Communities face in access to services, including the use of Roma health mediators in Europe (Roman *et al.*, 2013). Other examples of initiatives to reduce barriers to health care among Gypsies and Travellers include: outreach; the development of specialist health provider roles or dedicated services to work with Traveller Communities; and provision of handheld records to enhance continuity of care (McFadden *et al.*, 2018). However, evidence on the effectiveness of interventions to increase service accessibility and address the racism and discrimination experienced by Traveller Communities within health environments is lacking (Watson and Downe, 2017; McFadden *et al.*, 2018). Watson and Downe (2017) found that where Traveller Community members have contacts who work in the health sector or receive support from Romany health workers this improved access to these services, as did knowledge of one's health care rights. Cultural awareness training for health providers delivered in collaboration with Traveller Community members is another common strategy. However, in keeping with the critique explored above, concerns have been raised that cultural awareness training

may reinforce 'essentialist racial identities' and stereotypes (Watson and Downe, 2017), entrench ideas of 'otherness' (Kowal, Franklin and Paradies, 2013) and deny the complexity of identity (McFadden *et al.*, 2018). Indeed, some work in this area highlights the promise of an intersectional, or hybridity lens (such as that explored above) for addressing racism and discrimination. Watson and Downe (2017) explain more positive encounters in which Traveller Communities are seen as intelligent and capable by reference to social identity theory, suggesting that approaches based in multiple categorisation can avoid dehumanisation and rigid insider/outsider classifications (Watson and Downe, 2017). In tackling racism and prejudice, Howard and Vajda (2016: 43) stress the need for practitioners working with Romany people to be 'reflective about our own positionality and practice' in order to become more aware about the 'operation of invisible power'. By invisible power Howard and Vajda (2016) are referring to the unspoken privilege attached to 'whiteness' that results in a lack of recognition of power relations amongst members of the majority population working with Romany communities. This approach, they suggest will enable the ways that such invisible power impacts on the "sense of self and position among those who work for 'Roma inclusion'" (Howard and Vajda, 2016: 52). Howard and Vajda (2016: 50) therefore agree that it is not enough to seek to reduce discrimination by increasing practitioner knowledge of the situations faced by excluded groups; these efforts must challenge 'the deep-seated beliefs and the unconscious bias that everyone carries with respect to Roma people and communities'. Yet, they also stress that this can be very difficult for practitioners who have been programmed to deny any attention to the role whiteness plays in contributing to their privileged positions, and instead favour alternative explanations such as professional ability, education and job roles (Howard and Vajda, 2016). Daly (2015) also points to the importance of creating a space whereby practitioners can reflect on their unconscious prejudices, and the ways these attitudes may enter into their practice with Traveller Community members. To date, research and interventions with the aim of increasing accessibility of health services have focused predominantly on alleviating cultural or structural barriers. In addition, health practitioner perspectives have been approached in much the same way as those of Gypsies and Travellers; both parties are presented as holding fixed inner beliefs which they bring with them to health encounters. To the best of my knowledge, research has not yet been undertaken to empirically investigate the versions of self that practitioners present in stories about their work with Traveller Communities, and

how they may strive to uphold these identities through their practice. Much work therefore exists to understand how communication between practitioners and Traveller Community members may breakdown due to a lack of cultural awareness, or pragmatic barriers. A gap is evident however, around how communication may be hindered or facilitated by concordance or discordance in the identities that health practitioners and Traveller Communities project for themselves and each other.

It is important to acknowledge that counter narratives to those of discrimination are evident among practitioners. The above call for greater research focused on the roles of 'oppressors' as opposed to only the 'oppressed' conveys a sense of fixed power relations between groups. However, empirical work which examines youth welfare efforts with Traveller Communities (Vanderbeck 2009, Vanderbeck 2005) suggests that people do not occupy a static position as 'oppressed' versus 'powerful' or 'resistant' versus 'compliant'. Vanderbeck (2009) found that discourses and practices adhered to by 'youth working' practitioners could not be easily classified as either assimilationist or empowering. Practitioners were critical of practice which attempted to erode Traveller culture, and expressed a commitment to ensuring that services were user led (Vanderbeck, 2009). However, they simultaneously outlined a hope that outreach would lead to greater use of mainstream services, and sometimes promoted positive views to young people about school when parents were not present (Vanderbeck, 2009). Similarly, Kowal and Paradies (2005) found that practitioners working with Aboriginal communities discursively constructed Indigenous health attitudes as understandable and rational given the contextual constraints. Discourses employed by practitioners functioned to uphold the position of Aboriginal communities as "morally sound health seeking citizens", as well as practitioners' own morality by rejecting attempts to control or change Aboriginal beliefs (Kowal and Paradies, 2005, p. 1353). The context in which practitioners work must also be recognised; balancing the requirements to obtain funding or meet targets while also providing services that are acceptable to Traveller Communities is noted as a key challenge by practitioners (Reid 1993; Vanderbeck 2009). Peck's (1983: 365) early practice reflection on working with Gypsies and Travellers: 'I sometimes feel that I have lost my way as a health visitor', highlights the potential struggle practitioners may experience in meeting the requirements of their professional roles when practicing with Traveller Communities. Relations of power may sometimes tip away from practitioners and toward the supposedly 'oppressed' group. Gypsies and Travellers are not simply

passive recipients of health services. Maintaining the trust of Traveller Communities was a key concern of welfare staff, and Gypsies and Travellers often reminded staff of their ability to withdraw from the programme if the services were not appropriate to them (Vanderbeck, 2009), suggesting that Gypsies and Travellers were not without agency in influencing service provision. Nor were Gypsies and Travellers straightforwardly resistant to all welfare provision, engaging with some of the welfare services or activities offered (Vanderbeck, 2009).

Given the recognition of racism and discrimination towards Traveller Communities, the importance of building of trust between Traveller Community members and practitioners is noted persistently in the literature (Lhussier, Carr and Forster, 2016; Mcfadden *et al.*, 2016). Indeed, practitioners have been found to emphasize the requirement that the 'right person' is employed to work these groups (Jackson *et al.*, 2016). Schneeweis (2011: 304) similarly found that success stories of good communication and partnership between doctors and their Roma patients referred to 'the doctor of the gypsies,' or the 'true guest of honor'. Practitioners have been found to describe those who work with Travellers as 'more understanding and less judgemental' than other colleagues (Jackson *et al.*, 2016). However, there has been little in depth empirical analysis of which attributes are taken to constitute identity as the 'right person' to work with Traveller Communities. Sociological work on the place of the body in the performance or performativity of identities (Butler, 1990), and attention to the role of 'body work' in employment (Gimlin, 2007) are potentially useful here. This work illustrates that it is no longer the products of labour alone which are bought and sold, but also the bodies, or body attributes of employees (McDowell and Court, 1994). The concept of 'body work' concerns the work that health practitioners do to manage their own bodies and those belonging to the individuals with whom they work (Twigg *et al.*, 2011). Brown *et al.* (2011) point to the centrality of body work, in addition to verbal communication, in the ability of professionals to establish and maintain trust in gynaecological health care. They call for further research examining the embodied nature of trust in a wider range of healthcare settings and with other health professionals (Brown *et al.*, 2011). In a similar vein, conceptualisations of the emotional labour associated with some employment positions is also likely to have analytical purchase in understanding the establishment of relationships between Traveller Community members and health practitioners. 'Emotional labour' or 'emotion work' refers to the ways that employees process emotions in order to project

the facial and body image that their position demands (Hochschild, 1983). Hochschild suggests that emotion work involves three components:

First, they require face-to-face or voice-to-voice contact with the public. Second, they require the worker to produce an emotional state in another person – gratitude or fear, for example. Third, they allow the employer, through training and supervision, to exercise a degree of control over the emotional activities of employees (Hochschild, 1983: 147).

By this definition, health practitioners involved in the present research can be characterised as involved in emotional labour. Practitioners working in a public health capacity may seek to generate a range of emotional reactions in those they work with, including: a sense of security, trust and acceptance in their advice and ability; reflection on one's current situation and possible actions; anticipation, hope or perhaps even worry about future health outcomes; or a sense of enjoyment or pleasure in the process of health promotion activities themselves. While some practitioners were working in a more strategic public health role and therefore worked less directly with community members, even these individuals had experienced face-to-face interaction with Gypsies and Travellers during a tour of the Traveller site or at one-off health promotional events and activities. Finally, although the extent of institutional governance of emotion may vary depending on employment sector, health practitioners are often required to work in accordance with professional codes of conduct which stipulate guidelines and boundaries regarding emotional expression. The UK Public Health Register (UKPHR) Code of Conduct (2013: para 7) advises that UKPHR registrants should 'Treat everyone politely and with respect' for example. The Nursing and Midwifery Council code of conduct (2015: 15) states "make sure you do not express your personal beliefs (including political, religious or moral beliefs) to people in an inappropriate way". Indeed, it has been suggested broadly that the increasing bureaucracy of modern organisations has entailed a move away from the establishment of relationships through personal or emotional exchange toward the implementation of strict rules and the separation of private and work life (Gerth and Wright Mills, 1958). Some have suggested that professions have become increasingly stripped of emotion and become too technical and procedure driven (Hingley Jones and Ruch, 2016). Indeed, this resonates with recent debates on whether we should view public health practitioners as not just technocrats, but politically and emotionally motivated in achieving social justice (Faculty of Public Health and European Public Health Association, 2017). Hochschild (1983) suggests that people may experience a

tension that can be harmful for their wellbeing where they are required to project emotions as part of their job role that contrast those they are experiencing. In response to this tension, Hochschild (1983) distinguishes between two responses. The first is 'surface acting', where people feign the required response while retaining the authentic emotion underneath. An alternative reaction was 'deep acting' where employees alter their emotional state to fit with the emotions they were required to project (for instance, by rationalising the behaviour of airline passengers to make this more acceptable).

Despite the likely involvement of emotional labour in a range of healthcare settings, a recent review of emotion work in health care suggests that the majority of research focuses on clinical roles and particularly nursing (Riley and Weiss, 2016). The focus on nursing is likely owing to the place of 'care' in claims to specialist expertise within the nursing profession (Bolton, 2000) as well as the fact that nursing is still a female dominated profession and gendered assumptions treat emotion work as women's work (Riley and Weiss, 2016). Emotion management has been neglected within social work (Winter *et al.*, 2018) and again, is not something that has explicitly been applied to health work with Traveller Communities.

2.7 Summary

The literature review has highlighted the gradual construction of Gypsy and Traveller Community health as a public health problem. Far from being a neutral endeavour, evidence production in this area is argued to have been affected by a number of socio-cultural influences, as reflected, for example, in the greater attention to Traveller Community women and children than men, and the early focus on health conditions that pose a risk of contagion. The chapter has also highlighted conflicting explanations for the poorer overall health of these groups, with a particular tension evident between cultural and structural perspectives. An enormous amount of qualitative research has focused on the influence of culture, looking to uncover the inner health beliefs and attitudes of Traveller Communities, and assess their compatibility with health promotion advice and 'mainstream' health systems. Others question the use of a cultural lens due to its potential to blame Traveller Communities for their poorer health status, and instead emphasise the role of social structures on health. While the structural approach provides some critique of the stories told about the health of Traveller Communities, the solution advocated is in

replacing the cultural discourse with another more accurate one; that it is societal structures and not culture that prevent Traveller Communities from attaining the best possible standard of health. These approaches therefore share a concern to uncover the reality of the influences on the health of Gypsies and Travellers and potentially reinforce considerations of Traveller Communities as a bounded group. The chapter has pointed to limited consideration of the potentially multiple, co-existing and conflicting identities which operate for Traveller Communities in relation to health and pointed to key gaps in understanding around how practitioners construct and perform identities in relation to their work with these groups. I have argued that a gap in analysis exists (notwithstanding a few notable exceptions) with respect to how the different discourses in circulation (including those produced through academia) impact on conceptualisations of, and approaches to improve Traveller Community health. The following chapter outlines the methodological approach adopted by the study in order to contribute greater understanding in these areas.

CHAPTER 3 - Methodology: Generating another story about Gypsy and Traveller health

3.1 Introduction

This chapter outlines the approach to researching the preferred identities of practitioners and Traveller Community members taken in the study. It begins by restating the overall aims guiding the research. The rationale for adopting the methodological approach of narrative inquiry, in support of these aims, is then provided, including a discussion of how I approach narrative in light of the study's poststructural theoretical orientation. Following this, the concrete approach to data collection is outlined, encompassing methods for sampling and recruiting participants, and for generating, analysing and presenting stories. Throughout this presentation of methods, I endeavour to give a reflexive take on key challenges I experienced in the field and how these were managed, specifically with respect to: generating storied data; self-disclosure; and negotiating researcher boundaries. The chapter finishes with a discussion of fundamental ethical issues arising through the research, and how these were dealt with in practice.

3.2 Research aims

As identified in the literature review, the area of Traveller Community health is a contested territory, characterised by competing, but often nonetheless essentialising claims about how Gypsy and Travellers *are* with respect to their health. When reflecting on existing work, I found it troubling that frequently repeated statements by those in positions of relative power (and often 'outsiders' to those communities being described) came to be regarded as unquestionable 'facts' about Gypsies' and Travellers' relationship to health. I therefore sought out an approach which would lay bare and open up to questioning the 'stock stories' (D'Arcy, 2016) told about Traveller Community health, and their associated impacts. This includes a consideration of researchers' roles in (re)producing representations of Gypsies and Travellers, something which is virtually absent in the health literature to date. While consideration of identity was important, I also wished to avoid the tendency already critiqued in the literature review, of viewing practitioner or Traveller Community identities as stable and homogeneous, instead seeking an approach that

acknowledges the conflicting and nuanced ways in which these groups position themselves. Having earlier justified the adoption of a poststructuralist theoretical perspective in pursuit of these aims, the chapter now provides a rationale for the selection and variant of narrative inquiry adopted as the methodology for the research.

3.3 Narrative inquiry

As the research intended to examine the impact of stories told about Traveller Community health, narrative approaches had immediate appeal. This methodology has been applied successfully to understand the construction of Gypsy identity (more broadly), and the significance of storytelling practices in interactions about accommodation between Gypsies and service providers (Buckler, 2007). It therefore shows promise for the study of Gypsy and Traveller health identities, and the role of stories in communication between Traveller Communities and health practitioners.

A diversity of approaches are contained under the term narrative inquiry (Riessman, 1993; Squire, Andrews and Tamboukou, 2008; Stanley and Temple, 2008). Squire et al. (2008) distinguish between two major traditions underpinning narrative research: 1) humanist approaches, and 2) culturally-oriented and linguistic approaches informed by structuralism, poststructuralism and postmodernism. Humanist approaches tend to employ individual biographical or life story methods, assume unity and coherence in people's stories and identities, and emphasise individual agency in the ordering and telling of events to construct a meaningful account of identity (Loots, Coppens and Sermijn, 2008; Squire, Andrews and Tamboukou, 2008). By contrast, those in the latter tradition examine the broader structures and workings of power that condition narratives, and instead treat stories as a means through which people enact socially situated *performances* of numerous and sometimes contradictory aspects of self and identity (Loots, Coppens and Sermijn, 2008; Squire, Andrews and Tamboukou, 2008). In keeping with the philosophical underpinnings of the research, and the aim to allow for the potentially multiple identities of Traveller Community members and health practitioners, poststructuralist informed narrative inquiry was adopted for the study, inspired by exemplars in this tradition (Blumenreich 2004; Goodley & Roets 2008; Roets et al. 2008; Sermijn et al. 2008; Tamboukou 2008).

Discourse analysis was considered as an alternative methodological approach since it shares a concern with the ways in which talk and language is shaped by, and reproduces wider social norms (Riley and Hawe, 2005). However, discourse analysis has been criticised for reducing people entirely to 'positions in discourse' (Hollway, 1994). A narrative approach was therefore favoured since it affords greater agency and creativity to individuals (Riessman, 1993) to produce an 'account of themselves', albeit examining how they do so within discursive constraints (Burck, 2005; Goodbody and Burns, 2011). In its attention to time and context (Riley and Hawe, 2005), a narrative approach also assists in understanding the complexity of people's lives and social interactions (Kirkman, 2002), thereby enabling the production of rich detail on the layered and shifting positions of Gypsies and Travellers and health practitioners depending on the context. Having described the overall orientation to narrative research adopted by the study, it is necessary to state my position in relation to two connected debates in the field: the interest in big versus small stories, and the extent to which narrative research is judged as raising the profile of subjugated voices.

3.3.1 Big or small stories

In adopting a narrative approach, it is necessary to define what I take to be a story. A distinction is often made in narrative research between 'big' and 'small' story approaches (Squire, Andrews and Tamboukou, 2008; Sools, 2013). Big stories are typically generated through research interviews where participants tell their stories, often over several hours, with little interruption from the researcher (Squire, Andrews and Tamboukou, 2008; Sools, 2013). Small stories, on the other hand tend to describe naturally occurring talk, attending to the 'micro-linguistic and social structure' of everyday interactions (Squire, Andrews and Tamboukou, 2008). This distinction between small and big stories need not only refer to the type of data generated however, but can also inform the analytical approach (Sools, 2013). Thus, attention to big stories enables larger patterns and dominant themes to be discerned (Pheonix, 2008; Sools, 2013). By contrast, small story approaches focus attention on subtle storylines that do not necessarily fit 'neat' definitions of stories (Pheonix, 2008) and the process of performing identity and agency rather than only the content of narratives (Sools, 2013). With respect to health and illness research, Sools (2013) suggests a number of avenues to which a small story approach can contribute. For example, small stories can help to explore health (as opposed to

illness) since the taken for granted nature of health may mean that it is not considered exemplary enough to feature in big stories (Sools, 2013). Furthermore, small stories enable exploration of the entanglement of health with other life issues; of incoherence, as well as coherence in the construction of health or illness experiences; the on-going construction of health or illness throughout time, rather than through retrospective reflection; and the negotiation of multiple and varying moral positions regarding health which bring opportunities to transform dominant or pervasive stories (Sools, 2013). The adoption of a small story approach was therefore deemed most useful for this research due to its capacity to explore if and how Gypsies, Travellers and practitioners draw upon multiple identity positions or discourses available, as well as how these are negotiated in conversation with myself during and outside of research interviews.

3.3.2 Raising subjugated voices

Though dilemmas of representation are a concern in all research, they are particularly acute in research, such as that reported here, which aims to critique representations of a group as 'other' without perpetuating their 'otherness' (Burck, 2005). Narrative research is often presented as having emancipatory potential through its ability to raise the profile of subjugated voices (Riley and Hawe, 2005). Indeed, the role of stories as a potential form of resistance to power has been noted as a common interest which ties together the different branches of narrative research (Squire, Andrews and Tamboukou, 2008). The operationalisation of this aim differs per narrative tradition however. For instance, some approaches reject a view of the researcher as able to look within narratives and reveal what is not clear to participants themselves, instead adopting a minimal approach to analysis which allows stories to speak for themselves and generates insights by simply placing narratives alongside one other (Frank 2010). Such an approach attempts to prevent the researcher from 'finalising' representations of participants through the research process (Frank 2010). As Gypsies and Travellers have been subject to multiple attempts to define how they are with respect to health by those outside of the community and have had limited opportunities to shape their own image in this regard, this minimalist approach to analysis was initially considered. However, further reading revealed that raising the profile of marginalised voices was less straightforward than it had first seemed. An approach of allowing participant voices to 'speak for themselves' has been criticised for affording narratives a privileged

status and treating these as representing an individual's 'authentic' experiences or feelings (Atkinson 2009; Thomas 2010). This claim is argued to conceal the social production of stories (Atkinson 2009) in terms of both the contextual influences on the storytelling event (Blumenreich, 2004), and the researchers privileged position and inevitable influence over how to condense and present people's stories (Osgood, 2010). This PhD research sought to understand the ways that Traveller Communities and practitioners construct accounts of themselves and each other when talking about Traveller Community health, and the potentially shifting and contradictory identity positions available to these actors. A more analytic approach was therefore felt appropriate, since this attends to the performative nature of stories and narratives, told to achieve certain representations, given the social context (Atkinson 2009; Riessman 1993; Stanley & Temple 2008). The research therefore treated research interviews as a 'political occasion' (Riley and Hawe, 2005, p. 230), within which participants located themselves among the varying possibilities available to talk about Gypsy and Traveller health.

Researchers claiming to 'give voice' through narrative research have also been criticised for expressing their own 'personal ethics', aligning themselves with the experience of the 'oppressed' patient rather than that which is taken to be the uniform, oppressive narrative of the professional (Atkinson 2009). Indeed, this dilemma around personal ethics is one which dates back to Becker's (1967) question of whether sociologists should 'take sides' with the 'underdog'. Yet, as the work by Vanderbeck (2009) has shown, this is likely to be a simplification of the much more 'fluid' circulation of power between practitioners and Traveller Community members. I was also concerned that the strategy of letting stories speak for themselves might have the opposite effect of that intended; to leave a reading of Traveller Community members' narratives so open may enable them to be used in support of the aims of those in relative positions of power. I therefore felt that precisely because of my personal ethics, it was important to offer my own reading of narratives. This is accompanied however, by reflexive commentary (set out in the introduction and throughout findings chapters) which gives insight into how my interpretations were formed (Blumenreich, 2004) and the potential influence of my experiences, motivations, and similarities or differences to research participants on the data and findings generated. In keeping with the poststructuralist approach to narrative, stories are seen as emerging in the context of localised acts of telling. It

follows that the stories generated are treated as a partial representation of health practitioner, and Gypsy and Traveller identities (Lucius-Hoene and Deppermann, 2000). This in itself means that the research does not 'finalise' participants but presents this thesis as one possible reading, open to dialogue, further interpretation by audiences of the research (Riessman, 2008) or reuse, amendment or embellishment (Frank 2010).

3.4 Methods

Poststructuralist informed narrative inquiry guided the operationalisation of all phases of the research, which utilised qualitative interviews, supplemented by informal participant observation. These methods were adopted with the aim of creating opportunities for Traveller Community members and health practitioners to tell stories about their experiences and, in doing so, give contextually situated accounts of self and identity.

3.4.1 Sampling and recruitment

3.4.1.1 Site selection

As described above, the research started from a recognition of the ways that Traveller Communities are defined as a homogeneous community in relation to health, and a desire to open up this presentation to potential challenge. Since the research also aimed to explore how Traveller Community and practitioner identities may be entangled with other identity positions or wider societal discourses, a decision was made to focus the research on one geographical location, with a single 'community' of Gypsies and Travellers. Although a maximum variation approach to sampling (Baker & Edwards 2012; Patton 1990) from sites across the UK was initially considered, such an approach was rejected since this would make it difficult to determine the extent to which individuals within a community might move between individual and shared/community stories. A focus on a tight-knit community was therefore favoured as this attends to the potential for the same events or contexts to be storied differently by individual Traveller Community members and health practitioners. This is in keeping with the theoretical framework, which takes a plurivocal approach that examines the multiple, interacting and competing

perspectives surrounding Traveller health and moments of connection or ruptures throughout the community (Stehlik, 2004).

The research was carried out in an area of Northern England⁴. Selection of the specific location for the research was driven by both theoretical and practical concerns. Firstly, an area was required in which significant numbers of Gypsies and Travellers reside. Secondly, it was important to select an area in which initiatives to improve Gypsy and Traveller health were ongoing. This ensured that health practitioners working with Traveller Communities could be recruited to the research, and meant that Gypsy and Traveller stories about engagement as well as exclusion from health services and initiatives could be accessed, thereby helping to achieve rich data (Miles and Huberman, 1994). As Traveller Communities are minority groups who may be mistrustful of research or wish not to disclose their identity due to previous experiences of discrimination, recruitment has been noted as challenging (Brown & Scullion 2009; Cemlyn & Briskman 2002). As such, this research recruited Gypsies and Travellers through an organisation working with Traveller Communities (Brown and Scullion, 2009; Davies, 2009). A third consideration in the selection of a study locale was therefore the existence of such an organisation, and their agreement to support the research. Recruiting Gypsies and Travellers through this organisation also helped to ensure that the research was conducted sensitively and in a culturally appropriate manner (Grogger, Mayberry and Straker, 1999; Brown and Scullion, 2009). Finally, practicality also informed this choice in terms of the researchers' ability to travel to undertake the research. Initial contact with the Traveller organisation approached for support was made through a known contact in another Traveller Community organisation.

3.4.1.2 Traveller Community sample

Similar considerations to those guiding the selection of a research site informed the sampling of Traveller Community members for the research. Initially, the research aimed to recruit from one 'community' (e.g. Romany Gypsies or Irish Travellers) encompassed under the broad grouping of 'Traveller Communities'. This aim was in keeping with divisions drawn between diverse sub-groups (Powell, 2008) and in light

⁴ Given the relatively small and close-knit network of Traveller Communities, representative organisations, and health practitioners who work with these groups in the UK, the precise location of research has been anonymised to protect the confidentiality of participants.

of the separation of Irish Travellers and Romany Gypsy residents between two sites in the study area. However, an open-minded approach to recruitment and the conceptualisation of 'community' was maintained during the research and was led by the self-definitions of Gypsies and Travellers themselves. In practice, recruiting members from only one ethnic community was neither practical, nor necessary conceptually. Participants identified as either Romany Gypsies or Irish Travellers, and some communicated strong preferences about which label they were identified by. However, activities at the organisation drew these distinct groups together, and differences were not generally drawn between Romany Gypsy and Irish Traveller experiences of health, by either community members themselves or those from the representative organisation. I avoided recruiting those who were experiencing unusually adverse events (e.g. Traveller Community members currently battling against a high-profile eviction for example) which might lead to extreme accounts, instead aiming to access accounts that were more 'typical' of everyday health concerns and engagement with health services.

Traveller Community participants were initially identified through engagement in activities at the supporting organisation, and with the assistance of staff. Snowball sampling (Patton 1990) was then used to recruit Gypsy and Traveller participants to the research. Snowball sampling is an approach which is beneficial when accessing groups who are stigmatised or may be reluctant to take part in research (as has been suggested for Traveller Communities), since introductions from those who are trusted can encourage participation (Atkinson and Flint, 2001). Snowball sampling also helped to avoid problems associated with recruitment through organisations alone, including the exclusion of those who are not in contact with services and selectivity in the identification of participants by gatekeeping organisations (Groger, Mayberry and Straker, 1999; Brown and Scullion, 2009; Abrams, 2010). For the purposes of this research, a snowball approach also enabled the boundaries of the 'community' to be drawn by participants themselves rather than pre-determined. Snowball sampling "plays into social dynamics of accessibility in terms of power and rights: who may find and possess what type of knowledge about whom?" (Noy, 2008). Thus, the process of snowball sampling itself contributed information about who was deemed to have authority to speak about health that helped to contextualise research findings. It is important to acknowledge that sampling was subject to a degree of convenience however, in that it was dependent on

suggestions from workers at the organisation, in the early stages of the research particularly, as well as introduction to those I happened to meet during participation in organisational activities. Given the potential difficulties that have been noted around the recruitment of Traveller Communities to research due to over-consultation and potential mistrust, this was accepted as a limitation of the research. Ten Traveller Community members were recruited to the research. Table 1 provides an overview of the characteristics of Gypsy and Traveller participants.

Table 1: Sample of Traveller Community members involved in the study

Participant	Ethnicity	Accommodation type
Patricia	Irish Traveller	Local authority site
Lucy	Gypsy	Housing
Brigid	Irish Traveller	Local authority site
Bernadette	Irish Traveller	Local authority site
Catherine	Irish Traveller	Local authority site
Kelly	Irish Traveller	Local authority site
Sophia	Gypsy	Housing
Charlotte	Gypsy	Housing
Jane	Irish Traveller	Local authority site
Eleanor	Irish Traveller	Housing

While the research had intended to interview Gypsy and Traveller men and women, it proved difficult to recruit men. This is reflective of trends in current health literature, and likely results from the fact that health and community activities at the organisation were almost exclusively aimed at women, creating fewer opportunities to meet and discuss health with Traveller men. That I am a woman myself may also have contributed, meaning that connections could more readily be formed with Traveller women, and as, for some individuals, and in some settings, a female researcher talking alone to a Traveller man may be viewed as inappropriate (Okely, 1983). While the absence of Traveller men in the sample might be treated as a limitation in the research, this also brought benefits. Balancing breadth and depth in small sample sizes, and the challenge of comparing diverse accounts were key considerations in sampling decisions. Given the small-scale nature of the research, it would not be possible to include sufficient numbers in each cell of a sampling grid to illuminate how different characteristics (e.g. gender, age, ethnicity,

accommodation type, extent of engagement with health services) influence the stories told. Nor was the research concerned with using maximum variation sampling to identify experiences that were common to Traveller Communities as a whole. This would also mark a move away from the spirit of the research, which aims to avoid essential representations and explore how multiple and shifting subject positions may co-exist in the account of any one individual. As such, a homogeneous sample with respect to gender enabled attention to complex and unique identity presentations even among a relatively homogeneous group (Traveller Community women). Some variation was nevertheless evident in the sample of Traveller Community participants with respect to ethnic sub-group, accommodation type, engagement with volunteer work at the organisation, life stage, experience of parenthood, and health status or experience of long-term condition(s). The ways that these various positions interacted and were employed in the accounts of Traveller Community women are discussed throughout the findings chapters. Traveller Community members under the age of 18 were not included in the study.

When recruiting Traveller Community members to the research, time was first spent building trust with Gypsies and Travellers and those who work with Traveller Communities by visiting the community organisation and participating in group activities. Information about the research was provided gradually, before then inviting participants to take part in interviews. Despite concerns around possible difficulties in recruitment, most Gypsies and Travellers approached were willing to take part in the research, likely as a result of approaching Traveller Community members through an organisation and staff who were known and trusted. Indeed, Traveller Community members were often very willing to discuss their health and were remarkably open about their experiences.

3.4.1.3 Public health practitioner sample

Given that Traveller Communities are a minority group, there was a restricted sample of practitioners working in a public health capacity with these groups in the study area. Although some practitioners (e.g. Specialist Health Visitors) are frequently described as working with Gypsy and Traveller Communities, there are no nationalised roles with a specific remit to improve Gypsy and Traveller health. In addition, service provision for Traveller Communities is often patchy, reliant on short

term funding and dependent on the actions of local champions (Aspinall, 2005). These factors therefore meant it was not possible to say definitively which type of health practitioners would be approached at the outset of the research. This was further complicated by the fact that public health as a discipline has a broad focus and involves a wide range of professionals. Public health has been described as 'Everyone's business' (NHS Providers, 2017), with this echoed in initiatives such as 'Making Every Contact Count' (Public Health England, 2016), which encourage all NHS staff to capitalise on routine interactions with the public to introduce conversations and advice about health improvement. For the purpose of this study, practitioners were defined as having a public health remit where they practiced in any of the three domains of public health practice as defined by the UK Faculty of Public Health (Griffiths, Jewell and Donnelly, 2005).

Given the locally specific nature of public health service provision for Traveller Community members and the difficulty therefore in identifying potential participants from outside of the field, members of the Traveller organisation supported in the identification of health practitioners to be approached for their involvement in the study. This was followed by a snowball approach to sampling to generate further contacts. Table 2 details the characteristics of the eight health practitioners who participated in the study. There was some variation in the practitioner sample according to the sector in which they work (e.g. local authority, NHS or civil society), their job role (e.g. as public health practitioners, public health specialists, midwives, or community health workers) and whether they worked in strategic or more applied positions. Although one of the eight practitioners involved in the research was a man, given the very limited number of male health practitioners working with Gypsies and Travellers in the area, this individual has been allocated a female pseudonym to protect their anonymity.

Given the diversity in local provision for Traveller Community health, and the diversity of practitioner roles working with these groups, it is unlikely that practitioners will have a coherent identity. While there was previously a National Association of Health Workers for Travellers that might have contributed to such a sense of shared identity, this disbanded in 2007. However, practitioners' common position in working with or for Traveller Community members provided at least one possible axis through which some sense of collective identity could be articulated.

Drawing the sample from one geographical area allowed access to similarities and differences across practitioner accounts, and between the accounts of practitioners and Traveller Communities in relation to the same events and circumstances.

Table 2: Sample of health practitioners involved in the study

Participant	Employment sector
Hazel	Local authority
Karen	Local authority
Caroline	Local authority
Becky	Civil society organisation
Sandra	Civil society organisation
Louise	Local authority
Nicola	NHS
Linda	NHS

3.4.2 Generating stories

While in practice data generation is not separable from analysis, as the researcher begins to form interpretations during engagement with people in the field (Riessman, 2008), these processes are discussed separately here for clarity.

3.4.2.1 Interviews

Data was generated through interviews with community members and health practitioners. Interviews with practitioners took place either at the organisation supporting the research, or at practitioners’ workplaces. Interviews with Traveller Community members were held at the organisation supporting the research, or in participants’ homes. All participants gave their permission for the audio-recording of their interviews, which were then transcribed verbatim.

In keeping with a leaning towards ‘small’ stories, interviews did not ask people to recount their life-stories, but adopted a more interactive style which allowed

participants to move in and out of storytelling mode alongside offering more general observations, or to use stories to support or refute conversational claims (Bamberg and Georgakopoulou, 2008). Participants were prompted in ways that encouraged them to tell stories about times and sequencing of events in their lives. For example, by asking participants to give examples of events, and to describe these in detail, using phrases such as 'can you tell me about a time when that happened?', 'or can you tell me about a time that displays that at its most clearest', as well as follow up questions such as 'what happened next/then'. Interview guides for Traveller Community members and practitioners are provided in Appendices 1 and 2. However, interviews were left sufficiently open to allow participants some control over the direction of the discussion (Riessman, 2008). While Sermijn et al. (2008) advocate a technique of asking people to decide for themselves where to begin telling their story to avoid imposing identity positions onto participants, this was not felt appropriate for the present research. As can be seen in the excerpt from the start of an interview using this approach (Sermijn, Devlieger and Loots, 2008), such a request can be uncomfortable for participants and may therefore discourage participants from telling their stories. I did however try to avoid asking participants directly about how their experiences of health were influenced by their ethnicity, instead allowing people to draw on different identity positions as they saw fit. That said, I did sometimes ask more directly about Gypsy or Traveller identity where I was struggling to keep the conversation flowing.

When planning and conducting interviews, a great deal of consideration was given to the forms of health talk that are available to people and how to get access to everyday accounts of health (as opposed to only illness) through the research. The majority of research on narratives of health and illness has focused on illness as opposed to health (Lawton, 2003; Hughner and Kleine, 2004). This likely results from the status of health as a taken for granted or unremarkable experience (Scheper-Hughes and Lock, 1987) which is not, therefore, deemed story worthy. That health is not something which is achieved, but a state that is constantly striven towards and always open to challenge by the onset of illness further complicates this issue. The combination of a small story approach, and asking people specifically to describe times when they were healthy was successful in encouraging Traveller Community members to talk about experiences of health as well as illness.

I found that participants often did not switch very readily into storytelling mode during interviews. This gave rise to a concern that despite my efforts to phrase questions in a way that invited participants to tell stories about their experiences (e.g. asking about concrete scenarios, and sequences of events), I was not generating data that was compatible with a narrative approach. This was particularly so for practitioners, and it seemed as if processes of professionalisation may discourage professionals from telling about their work in more 'everyday' formats such as stories. Cornwell's (1984) distinction between people's public and private accounts of their lives is also relevant here. Cornwell (1984) found that when interviewed for the first time, people often provided polite (public) responses, but that over time, and as she developed a closer relationship with participants, she increasingly accessed private accounts, which included more negative or controversial details of their experiences. In addition, direct questions were more likely to evoke public accounts, while invitations to tell stories resulted in a shift to more natural forms of communication and reduced the power imbalance, resulting in the provision of private accounts (Cornwell, 1984). Whether research can ever access 'private' or authentic accounts is however debatable (Radley and Billig, 1996), given that accounts cannot be separated from the audience and social context in which they are told. In the case of some health practitioners interviewed, I sensed a greater reluctance to discuss times in their practice that were challenging or some form of censorship over what was disclosed. This was less often the case for Traveller Community members, who more often told stories about their health and experiences of services, and who for the most part readily provided details about positive and negative aspects of their health, their family circumstances, and their experiences with health services.

In light of the ways that stories may evolve or change as relationships with participants develop, I considered undertaking second interviews to explore how stories and identity presentations may alter over time. However, after engagement in the field it was decided that this was neither appropriate nor necessary. Given concerns described above about over-consultation, I felt that it was important to ensure the demands of taking part in the research were not too onerous for Traveller Community members. Some Gypsies and Travellers themselves drew interviews to an end or indicated that they had provided all the information they could on the subject using statements such as 'that's all, I have nothing else to say now'. To ask

these individuals to take part in further interviews was felt to be inappropriate. This decision was also informed by the views of Traveller Community members at a conference I attended, who suggested that they become tired of repeated requests from researchers for information. In the case of practitioners, simply undertaking a second interview was unlikely to be sufficient in developing the degree of trust required to increase their ease in telling stories or discussing potentially challenging or embarrassing experiences in their work, where they had not done so already. However, participation in activities and meetings at the organisation supporting the research enabled engagement with most Traveller Community and health practitioner participants outside of interviews, thereby providing an alternative means of accessing the ways that stories change across time and context.

3.4.2.2 Informal participant observation

Where participants gave permission, data generated through informal observation and discussion during fieldwork visits, and participation in routine activities at the Traveller organisation were utilised for the study and recorded in the form of detailed field notes. This included participating in activities such as healthy cooking sessions, gardening and a sewing group; accompanying Traveller Community members to health events or meetings; and sitting in on meetings between health practitioners and staff from the Traveller Community organisation. Pragmatically, this was achieved through weekly visits to the supporting organisation during the fieldwork phase of the study. Informal observation facilitated consideration of the extent to which narratives are well rehearsed, and may change over time, or according to the social context or audience, as well as similarities or differences between reported and enacted practices. In addition, by spending time with community members, I was able to observe if and how community members themselves drew on and used narratives about their ethnicity when talking about their health. Observation records (see Appendix 3) were also kept for each participant to record my reflections on the ways that interpersonal interactions surrounding interviews, and similarities or differences between myself and participants may have influenced the data generated.

3.4.2.3 Self-disclosure and researcher boundaries

An important consideration throughout the research was the amount of information that I should disclose to participants about myself and my own views. In some

cases, this decision was straightforward. I declined to provide any information where this would breach participant confidentiality, or alter existing views that people held toward one another in the research field. However, when asked questions about myself, providing that these didn't require the disclosure of detailed personal information, I answered them. For instance, Traveller Community members often asked where I was from, or whether I had children, while practitioners often asked about my study and my organisational affiliations. Disclosures of this kind may be seen within some research traditions as biasing the data generated and indeed, I was sometimes concerned that I was disclosing too much. However, as the research was asking people to give very detailed and personal accounts of their own lives and experiences, I felt that it was important to provide some information about myself in order to counter the imbalance associated with the one-directional flow of information in research interviews. I also hoped that this would help participants to feel more comfortable in sharing their stories, particularly given that participants may not necessarily have trusted me straightaway. This applies both to Traveller Community members due to misrepresentation and discrimination, but also to practitioners, for whom telling stories about their experiences to a stranger carries some risk of judgement regarding their professional standing and conduct. Concerns for both groups are amplified by the highly politicised area of the research, in which people are (rightly) very sensitive about how Traveller Communities are talked about, and what language is used when doing so. An openness to respond to questions about myself also had benefits. For instance, reflecting on the questions I was asked by participants helped me to contextualise findings from interviews. Furthermore, it enabled points of connection and dissonance between myself and participants to emerge, producing valuable insights into shared understandings and practices with respect to health, and how identities were formed in the process of interaction. It is also important to note that although I took care not to be too leading within interviews, participants were very able to express disagreement with suggestions that I offered when needed and demonstrated this on many occasions. Rather than trying to control out my influence on the research, I have sought to make this visible to the reader throughout my analysis and presentation of findings.

Similar consideration was required with respect to drawing boundaries around my role and practices as a researcher. At the outset of the research, I discussed with members of the supporting organisation how far, if at all, I should undertake

advocacy work alongside the research. Given the pressures around time and capacity faced by the organisation, it was important to try and 'give back' and support their work where possible. However, we felt that involvement in formal advocacy work was not appropriate since it would blur the boundaries of the researcher role and as I do not have advocacy training. It was agreed that where need arose, I was able to assist in small tasks such as reading letters for community members or relaying issues back to the organisation where participants expressed a wish for me to do so. Generally, there were few occasions where this was needed.

3.4.3 Analysis and presentation of stories

3.4.3.1 Transcribing interviews

Approaches to the transcription of interviews vary according to the aims of and approach to narrative inquiry (Elliot 2005; Riessman 2008). Since this research views stories as socially produced, I ensured that my own talk was included in transcripts, in order to capture the ways that data is co-constructed throughout the interview (Riessman, 2008; Sools, 2013). The issue of whether or not to 'clean up' participant transcripts or to retain details of accent, mispronunciations, or colloquial terms is also often debated (Oliver, Serovich and Mason, 2005). Avoiding 'cleaning up' the transcript might cause offence if participants were to later read representations of their words (Oliver, Serovich and Mason, 2005). This also invites readers to make assumptions about participants, for instance, by associating accent or terminology with education or particular social classes (Oliver, Serovich and Mason, 2005). Yet, to clean up the transcript represents an active imposition of the researcher's interpretation of participants' intended phraseology. As the research treats language as an important means through which identity is constructed, and strives to avoid, as far as possible, the (re)presentation of participants, I resisted cleaning up participant transcripts. I was however, sensitive to any aspects of participants' speech that were unique and may therefore lead them to be identifiable, changing this where required.

3.4.3.2 Analysing narratives

There are no prescriptive guidelines for the analysis of narrative data (Riessman, 2008). As such, the analysis and presentation of narratives was informed by exemplars of narrative research (Riessman, 1990; Blumenreich, 2004; Goodley and

Roets, 2008; Roets, Reinaart and Van Hove, 2008; Sermijn, Devlieger and Loots, 2008; Tamboukou, 2008), and remained sensitive to the stories emerging through the research. A dialogical/performative approach to data analysis was adopted, due to its view of identity as 'plurivocal', and of stories as performed and produced within particular contexts to achieve particular functions (Riessman, 2008). Following the theoretical framework, the analysis process attended to the multiple and shifting identity positions people draw on when producing a version of self, and the ways people move within relations of power and resistance (Blumenreich 2004; Goodley & Roets 2008; Roets et al. 2008; Sermijn et al. 2008; Tamboukou 2008). The analysis incorporated attention to the presentation of identity through both the content of participants' accounts and how stories are told (Riessman, 2008). Insights from Fraser (2004), Goodbody and Burns (2011), Richmond (2002), Phoenix (2008), Riessman (2001) and Lucius-Hoene (2000), on the pragmatics of narrative analysis were used to develop methods for operationalising the analysis process. The analysis was broken into four phases which were followed in a flexible and iterative manner:

Stage 1: analysed individual narratives for how the identities of each participant were constructed within multiple nested contexts; from macro discursive conditions through to more micro levels of interaction. Specifically, this stage examined the construction of identity at three layers, also attending to the interaction between them:

1) The discursive

Examined how dominant discourses create possibilities or limits for the identities that can be expressed, and how actors draw upon these discourses when accounting for themselves.

2) The positioning of characters in stories

Explored how participants position themselves in relation to others in the stories told, and how this supports their identity claims.

3) The interpersonal

Analysed how the identity positions expressed by participants were accomplished through interpersonal interaction with myself, the researcher.

A set of analytical questions asked of the data for each domain is set out in Appendix 4. Overall, the analytic framework provides insight into the “the stability, generality and context dependency of an identity aspect in question” (Lucius-Hoene and Deppermann, 2000). In addition to the above layers of analysis, this stage also noted the constructs of health that were used by each participant and which underpinned the identities expressed.

Each narrative was uploaded into NVivo software management programme and coded according to each level of analysis. For example, an overarching theme was developed for the discursive level with sub themes for different discourses that are present in participants’ accounts (e.g. The imperative of health, low life expectancy of Travellers).

Stage 2: involved the production of a story map for each individual (Richmond, 2002) which presents a summary of how the different forms of positioning at each above layer of analysis came together to constitute participant identities.

Stage 3: compared and contrasted narratives within Traveller Community and practitioner participant groups. Narratives were compared not only for the content, but for differences in style and tone (Fraser, 2004). The overall accounts of practitioners and Traveller Community members were then compared to see how the different accounts mapped onto each other, exploring areas of convergence and divergence in the identity positions expressed by Traveller Community members and health practitioners, and in the ways these different participant groups talk about Gypsy and Traveller health.

Stage 4: entailed the organisation and presentation of an overall narrative about the stories generated through the research.

The multi-layered form of analysis undertaken, combined with the desire to explore similarities and differences both within and across practitioner and Traveller Community accounts gave rise to considerable complexity and therefore challenge in how to present findings. For each participant, there were a number of points of interest in terms of how identity was constructed through: their interpersonal

engagement; the positioning of actors in their stories; and the discourses they drew upon. While there was much commonality across narratives in how individuals sought to position themselves, there were unique aspects to the narratives in how they did so. There was a need to balance attention to individual variation, while also finding a way to group and discuss similar aspects of the data together in order to present a meaningful account for the reader. This was accomplished by starting with the discourses that were used in participant accounts, since by definition, these were less likely to be unique to individuals. The implications of these discourses for the identity positions that can be claimed, and how these inform the positional and interpersonal aspects of participant narratives could then be mapped out. This produced clusters of discourses, strategies for positioning characters in stories, and aspects of interpersonal interaction which together surround key identity issues at stake for practitioners and Traveller Community members. This process was undertaken for both Traveller Community and practitioner groups, before looking across these different clusters to identify the ways that these may, in turn, shape interaction between these actors.

This approach to presenting stories throughout the thesis does ‘fracture’ participants’ narratives to a degree, something that narrative approaches ordinarily try to avoid. However, this is in keeping with the poststructuralist approach adopted in the research, which explores multiple and fragmented aspects of self and identity. The decision to report in this way was also driven by a desire to be inclusive of all participant stories. Due to the number of participants involved in the research, it was not possible to present extended accounts of participant narratives, necessitating an approach of looking across narratives to find common (and broad) narrative threads, under which individual stories (including similarities and differences) could be presented. That said, it is hoped that the use of cross-referencing and summary retains a sense of the preferred but conflicted identities for each participant.

3.5 Ethical issues

Approval was sought for the study through the University of Edinburgh ethics review process and from the NHS Hospital Trust from which some practitioners were recruited. The British Sociological Association Statement of Ethical Practice (British Sociological Association, 2017) also guided research conduct. While consideration

of ethics and issues of power are woven throughout the thesis, this section addresses how fundamental principles of ethical practice were ensured.

Given the high levels of illiteracy among Gypsy and Traveller Communities, there was a need to adapt the usual processes of seeking informed consent. Information about the study was provided to participants in a written format (Appendices 5 and 6), as well as recorded onto CDs which were given to Gypsy and Traveller participants to keep. However, in practice, the provision of CDs appeared to be of limited use in ensuring informed consent, with no participants reporting having listened to this. The provision of the CD did appear to have the alternative and unanticipated effect of helping to build relationships with participants however, with Gypsy and Traveller Community members often expressing appreciation that I had made the information accessible in this way. Information about the study was therefore provided to Gypsy and Traveller study participants verbally (alongside the written information sheet), which proved to be a much more appropriate method of ensuring informed consent. These reflections are consistent with research on the effectiveness of methods to increase comprehension of study information among research participants (Flory and Emanuel, 2004). Statements on the consent form were read to participants where needed, and after this, participants were comfortable and willing to sign written consent forms (Appendix 7), a copy of which they were also given to keep. To ensure that participants had sufficient time to consider whether they wanted to take part in the research, information about the study was given to participants at least one week before they were interviewed. Assurance was given that participants were able to opt out of the research at any time (up until the date at which the findings would be published), without giving a reason, and that if they chose to do so, this would not affect their rights in any way. A process of continuous consent (Richards and Schwartz, 2002; British Sociological Association, 2017) was also followed, particularly when seeking permission to include information volunteered during informal interaction with participants outside of interviews. Echoing Guillemin and Gillam's (2004) distinction between procedural ethics and 'ethics in practice', managing processes of consent in the field was often more difficult than planned. For instance, participants and those supporting the research could be quite forceful in suggesting to others that they should take part, and it was sometimes necessary to respond to this by following up with suggested participants and making it clear that they were not obliged to do so.

Participants' contributions have been anonymised by using pseudonyms, to ensure that they cannot be identified. I opted not to ask participants to choose their own pseudonyms, in case they selected names shared by others in the community who hadn't taken part, but who may then be mistaken for having done so. In order to select names that were culturally appropriate, I generated pseudonyms for Gypsy and Traveller participants from the family trees of Romany Gypsy and Irish Traveller families which were available online. For health practitioners, I used an online random name generator. The small research field, combined with a tendency to provide extended excerpts of people's speech in narrative research posed particular challenges for maintaining participants' confidentiality. This was dealt with by changing or removing details of participant accounts that could lead them to be identified. When participants suggested others who might take part in the research that had already been interviewed, I avoided indicating that this was the case and simply thanked them for their suggestion. Again, upholding confidentiality was more challenging in practice than expected. For instance, I often found that those in the research field didn't afford the same importance to confidentiality that I did as a researcher. People sometimes asked for information disclosed by others in interviews that would breach their anonymity and it was necessary to state explicitly that I could not provide this.

Careful attention was given to safeguarding the rights and wellbeing of participants in the research process. Details of people's stories were asked for tentatively (e.g. 'do you mind saying a little bit more about that?') in order that people did not experience pressure to provide information they did not want to disclose. Participants rarely became upset during the research, but where this was the case, it was made clear to participants that they did not have to continue with the interview. Where advocacy issues emerged during interviews, these were (with participant's permission) made known to advocacy workers at the supporting organisation. Lone worker protocols of the supporting organisation were followed to ensure the safety of the researcher in cases where research interviews were conducted in participants' homes.

Another key ethical consideration in the research, given the small population of Gypsy and Traveller Communities was the potential for consultation fatigue. Gypsies and Travellers are over-researched, yet have seen little by way of concrete

improvements to their lives as a result (Brown and Scullion, 2009). I was therefore careful to avoid raising expectations about what would result from the research among both community members and the organisation supporting the research. Key to managing this issue was ensuring that the support and involvement asked for from the organisation and participants was not too burdensome (Brown and Scullion, 2009). Members of the Traveller organisation supporting the research have commented positively on my ability to work independently. Where possible, I also tried to 'give back' to participants and the supporting organisation, including by promoting events held or resources developed by organisation, sharing a report on emerging findings, giving community members lifts to events during fieldwork, making a phone call for a participant, and assisting one community member to get a car insurance quote using a comparison site. I debated whether to return to participants with transcripts from the interviews and invite them to make changes to these. However, as practitioners were judged to be more likely and able to review transcripts given practical considerations around illiteracy, I decided not to do so in order to avoid reproducing any power inequality between practitioners and Traveller Community members with respect to the ability to retract information.

3.6 Summary

This chapter has outlined the methodological and practical approach taken for the study. The combination of a poststructuralist theoretical underpinning and narrative methodology has been suggested to enable a dual focus on the constraints discourses impose for Traveller Community and health practitioner subjectivities, as well as the ways these groups use or work within these discourses to construct preferred identities. This approach also encouraged consideration of the potentially multiple identities of these actors. In doing so, the methodology adopted responds to key gaps identified in the literature around: a) the role of identities other than ethnicity in informing how Traveller Community members account for their health; and b) how the identities and practices of health practitioners and Gypsies and Travellers are informed by the forms of talk about Traveller Community health that are available. The chapter has also rationalised the methods for generating and analysing data which were adopted and reflected on key challenges experienced with respect to conducting myself and 'doing' ethics in the field. Some of these issues are common to all qualitative research, such as considerations around self-

disclosure and researcher boundaries for instance. Others were more unique given the research area. The politicised environment surrounding Traveller Community research heightened challenges in relation to: gaining the trust of both sets of participants; accessing practitioner accounts of unsuccessful as well as successful practice; and managing existing relationships between actors in the small research field. Likewise, the operationalisation of some key ethical principles demanded greater attention, including the protection of anonymity within a small and well-connected network, and ensuring informed consent in cases of illiteracy. The next chapter begins the presentation of study findings with a consideration of the definitions of health used by Traveller Community members and health practitioners.

CHAPTER 4 - Reading from the same page? Traveller Community, general population and practitioner definitions of health

4.1 Introduction

This chapter explores the repertoires of health definitions used by Traveller Community members and health practitioners involved in the study. A decision was made to begin the findings chapters by discussing the ways participants represent the concept of health, since ideas about the nature of health will have implications for the identities and practices of Traveller Community members and health practitioners. As such, the chapter provides a foundation for later chapters, which examine the possibilities and limits in the identity positions available for these actors. Definitions of health employed by Traveller Community members are first presented and compared with those found in 'lay' sections of the population more broadly, with this demonstrating qualitatively similar representations of health. Definitions of health used by practitioners are then discussed. The chapter highlights a large degree of convergence in constructions of health used by Traveller Community members, members of the lay population more generally, and health practitioners. All groups reference multiple and wide-ranging aspects of health, encompassing narrow health outcomes or behaviours through to broader concepts of psychological and social wellbeing. A key difference is however identified between Traveller Community and health practitioner framings of social wellbeing.

4.2 Traveller Community health constructions

As shown in the literature review, existing work on Gypsy and Traveller health has tended to explore the health beliefs, attitudes and practices of Traveller Communities as an isolated group. Work in this area has largely focused on Gypsy and Traveller beliefs about the causes of health and illness and, with some exception (Hodgins and Fox, 2012), does not give in depth consideration of how Traveller communities construct health. Given that constructions of health are a product of our position in society, and shaped at the intersections of class, gender and culture (Nettleton, 2013), it is reasonable to assume that Traveller Community members may define health differently to other groups. However, as was also

demonstrated in the literature review, the tendency for studies to focus in on the specific perspectives of Traveller Communities has led to definitions and beliefs about health being interpreted as unique to these groups, even where they have been found among other sections of the population. To date, there has been limited systematic comparison of the extent to which Gypsy and Traveller Community members use similar or different constructions of health to those found in the wider population. It is to this gap that the following discussion aims to contribute. In doing so, I do not claim to offer a fixed interpretation of the meanings that Traveller Community members ascribe to health and how these differ from those expressed by other groups, but rather aim to give an indication of how far Gypsy and Traveller definitions draw on broader cultural narratives about what counts as health.

4.2.1 Talking about 'health'

Previous studies on lay accounts of health and illness have highlighted the difficulty people have describing 'health' (Blaxter, 1990), suggesting that health wasn't an idea which people had given prior thought to defining or which people were well rehearsed in discussing. Within this study, Traveller Community members did not appear to have the same level of difficulty in articulating what health is, with most offering some reflections in this regard. This is likely owing to the differences in the framing of the questions within the current study, which asked people to think of times in their life, when they were healthy/not healthy and to elaborate on why they describe themselves in this way at those times, rather than asking for definitions of health in abstract terms. This strategy enabled participants to elaborate on why they considered themselves to be healthy in more concrete terms. It is also potentially a reflection of change in context; it has been argued that health now occupies a much greater place in public consciousness, meaning that people are likely to find it easier to talk about this concept (Nettleton, 2013). That said, there were examples of difficulty describing health, particularly among those with poor health or who were less concerned with behaving healthily, as has been found before (Blaxter, 1990). While participants were for the most part able to describe health, they often appeared more comfortable discussing episodes of illness, serving as testament that illness as opposed to health is a more remarkable event and more story worthy. The unspoken nature of health was also reflected in the research process itself. When asked to suggest others whom it would be useful to interview, participants tended to recommend those who had experience of health issues and viewed those

without health problems as having less to contribute. While it is possible therefore that the research process has reinforced this approach of knowing health through illness, this was countered by the involvement of Traveller Community members without long-term conditions in the research.

4.2.2 Health definitions

The most striking finding with respect to health definitions employed by Gypsies and Travellers was how closely these mirrored those found in research on lay definitions of health among the general population (Blaxter, 1990; Hughner and Kleine, 2004). Indeed, all definitions of health used by Traveller Community members related to categories of health which have been documented previously, and the phrases used by Traveller Community members interviewed were often remarkably similar to those used by participants of other studies. Table 3 provides a detailed comparison of Traveller Community health definitions and those found in the wider literature. Categories of health definitions detailed in Table 3 are discussed in turn below, for clarity. However, in actuality, Gypsy and Traveller Community members often employed multiple definitions in their constructions of health.

As in previous studies of lay health beliefs among the general population (Blaxter, 1990; McKague and Verhoef, 2003; Hughner and Kleine, 2004), Traveller Community participants often drew on narrow biomedical definitions of health as ***the absence of illness***. While existing research suggests that those experiencing long-term conditions are less likely to define health as the absence of illness (Blaxter, 1990), this definition was used by Traveller Community members currently living with and without chronic illnesses. Again, this is likely to be reflective of the approach taken which enabled people to reflect on times when they felt healthy (including historically).

Table 3: A comparison of health definitions used by Traveller Community members and those found in the wider literature on lay health beliefs

Definition of health	Example statements from Traveller Community participants	Example statements from the wider literature (Blaxter 1990)
Health as the absence of illness	I never had any ailments I didn't get colds or anything (Charlotte)	Health is when you don't have a cold
	I've not had like no problems health wise or anything so I think it's alright (Lucy)	When you don't hurt anywhere and you're not aware of any part of your body
	Never hardly went to the doctors (Patricia)	Because he's never seen a doctor in 50 years
	Was never in hospital for anything (Brigid)	
Health as ability to undertake everyday activities	I could go'n stand down at the bus stop and wait for a bus and go in town (Patricia)	Health is being able to walk around better, and doing more work in the house when my knees let me
	She was about eighty-five she could do as much as what a 18 year old could do (Lucy)	Being able to do what you want to when you want to health is freedom
	Used to keep the house really well... see to the three children (Charlotte)	

Definition of health	Example statements from Traveller Community participants	Example statements from the wider literature (Blaxter 1990)
Health as a reserve	He was he's a lucky man to be alive the way he lived his life (Eleanor)	He goes out on the drink but never gets a hangover or a headache
	Old women at 50 you think 3 children there's not an ailment on them it's just some people's bodies is different (Brigid)	Both parents are still alive at 90 so he belongs to healthy stock
	That's the finish, drained, exhausted, run down, or shut down	He has had an operation and got over it very well Done, broken down, finished, cracked up, washed out
Health as lifestyle	I wouldn't say I'm very healthy I smoke twenty fags a day (Kelly)	I call her healthy because she goes jogging and she doesn't eat fried food. She walks a lot and doesn't drink alcohol
	I'm quite healthy nowadays erm compared what I used to be cause...I used to smoke... but in the way of eating I'm not a very healthy eater I do eat a lot of junk food (Eleanor)	She does all the right things. She eats plenty of fruit
	I think I've got quite a healthy lifestyle really erm I always go for a walk every day when I go home (Lucy)	
Health as fitness	Before that I was really fit, really healthy (Charlotte)	There's a tone to my body, I feel fit

Definition of health	Example statements from Traveller Community participants	Example statements from the wider literature (Blaxter 1990)
	Your health and strength is everything (Catherine)	I can do something strenuous and don't feel that tired after I've done it
	My sisters 43 and she's a bit fanatic one of them fit fanatic people and she's real thin (Brigid)	My skin is good and my hair isn't greasy and I can do all the things I want without feeling tired
	She's overweight but that's not because that she's not tried to be healthy and fit (Lucy)	
Health as having energy	I wake up in the morning feeling fresh I think oh I'll get up I'll do this I'll do that (Lucy)	Full of get up and go
	You're full of energy (Eleanor)	Bright in mind and body
	I'm not as tired and I've the energy to do things (Brigid)	Feeling like conquering the world
	You're up you're bouncing about (Bernadette)	I feel like getting out of bed in the morning
	I've got no energy in me body (Sophia)	When I'm healthy I feel like tackling the cooker and getting it clean
Health as mental wellbeing	I've got a bit of peace and contentment about that and I feel more relaxed and at ease about things (Eleanor)	Relaxed

Definition of health	Example statements from Traveller Community participants	Example statements from the wider literature (Blaxter 1990)
	When I'm down I just being truthful I just don't know what to do with myself (Catherine)	Emotionally you are stable, energetic, happier, more contented and things don't bother you so
	Frustrated, Fed up, Down, Miserable	Happy to be alive Glad to get up each day
Health as social relationships	Me children's me life and I shout and I think what were you I sometimes think what am I doing shouting at children for no reason sometimes (Brigid)	Not short with people Enjoying the family, having more patience with them
	It makes you feel down and miserable when you know that he's not well (Sophia)	She paints and she's a member of the theatre club and a lot of other groups
	I was an outgoing person I wouldn't stay in I'd be out Friday Saturday and Sunday (Jane)	I call her healthy because she's always doing things for other people
	I lost children I were down but now I've gained children into the world and now I'm back up I feel better in meself that's the best thing about it as long as I've got	

Definition of health	Example statements from Traveller Community participants	Example statements from the wider literature (Blaxter 1990)
	my family and my family and children I feel perfect my health is perfect (Catherine)	
Health despite disease/levels of health and illness	I haven't got a great big illness but I have like health iss- problems like chronic fatigue and anemia high blood pressure sometimes but nothing really major so I'm healthy usually (Brigid)	I'm very healthy apart from this arthritis
	You have to pick yourself up its different when you've got a cold or a flu or anything like that that's completely different but it's when you get big problems big problems that's it (Catherine)	

Functional definitions of health, as the ***ability to undertake everyday activities*** (Blaxter, 1990) were also common in Gypsy and Traveller accounts. While particularly evident in the accounts of those who were living with chronic illness, a definition of health as function came through in nearly all accounts. This definition of health encompassed the ability to fulfil: social roles such as looking after children or caring for family members; domestic responsibilities such as cooking or cleaning, education and paid or voluntary work; and social or leisure activities such as going out for dinner, going to car boot sales, taking the children on trips out, or attending church. This resonates with Hughner and Kleine's (2004) category of health as 'freedom, the capacity to do', which refers to the ability to undertake not only essential tasks but having the control to live life as you choose.

A definition of ***health as a reserve*** is used to refer to the idea that differences in individual constitutions influence people's susceptibility to illness, sometimes despite their risk behaviour (Blaxter, 1990). This was present in Traveller Community narratives to a degree, and mirroring findings from the general population (Blaxter, 1990), was often used to describe the health status of others as opposed to oneself. The notion that health is a resource which depletes gradually over time was also evident in participants' language, which was again analogous to that found in wider studies (Table 3).

Unlike in previous research, which has shown that people tend to describe others rather than oneself as healthy as a result of 'virtuous behaviour' (Blaxter, 1990), some Traveller Community members did describe themselves as healthy due to their ***lifestyles***. Again, this might be accounted for by the study approach, with interviews focusing mostly on how participants described themselves in relation to their health, and which therefore provided less opportunities for community members to describe the health of others they knew. As was found in research by Blaxter (1990), the definition of one's health according to lifestyle behaviour tended to be introduced by those who gave priority to explanations of individual control over health, those who were younger and/or those who did not have a long-term health condition. This is not to say that lifestyle behaviour was absent in the accounts of those with long-term conditions, but rather that, in these interviews, discussion of lifestyle behaviour tended to be prompted by the researcher and to be linked to the management of existing health conditions.

Participants sometimes referred to health in terms of 'fitness' or 'strength' or used these terms synonymously with health. **Health as fitness** was connected with a definition of health as lifestyle, and with physical and sporting activity. This theme was less apparent than others in participant accounts however, chiming with findings in the wider literature that men were more likely than women to define health in terms of physical fitness (Blaxter, 1990). Indeed, engagement in physical activity or training was explicitly suggested by Eleanor to have a gendered dimension when she describes men as more likely to do physical training. However, Eleanor went on to explain how changes in Traveller Community lifestyles to become more settled meant that children were more often in school, and women therefore had more time to go to the gym.

Traveller Community members interviewed often defined **health as having energy**, reflecting definitions of health as vitality in existing studies of lay health beliefs. Definitions of health as energy were connected with ideas about the body, which was described as both fuelled by, and as the container for this energy. Participants not only referred to physical energy, but emotional energy. Eleanor described being 'mentally drained', when undergoing stresses and strains caused by difficulties in a family relationship for example.

Mental health was discussed frequently by Gypsies and Travellers when defining their health, perhaps unsurprisingly given that most participants reporting having experienced mental health issues and/or having taken anti-depressants at some point in their lives. Experiences of anxiety or depression were most commonly reported. Some women specifically described experience of post-natal depression, and one person described having difficulty socialising or leaving home. When defining mental health, a separation is made between negative definitions focused on the presence or absence of mental health conditions and more positive and encompassing definitions (Royal Society for Public Health, no date; Keyes, 2006). Positive definitions are in turn divided between hedonic approaches focused on short term emotional states of wellbeing or happiness (the pursuit of pleasure and avoidance of pain), and eudemonic approaches which encompass the extent to which people are satisfied with life, have a sense of purpose, scope for self-actualisation, experience autonomy and have control over their lives and environments (Lamers, 2012). Given the rates of mental health issues experienced,

it is unsurprising that Gypsy and Traveller participants often used negative definitions focused on the presence or absence mental health conditions. However, as shown in Table 3, community members also drew on broader definitions of mental health, albeit often to illustrate poor rather than good mental health. Examples of achieving emotional wellbeing were reflected much less frequently in participant's comments and happiness was not a term used by any participants when describing their states of health. As Table 3 demonstrates, Traveller Community members did refer to emotional states when describing their health, and some participants made reference to enjoyment or pleasure gained from a Travelling lifestyle, or activities such as gardening for instance. Eudemonic dimensions of wellbeing were also apparent, whereby responsibilities to children and participation in employment were described as providing a sense of purpose, and as preventing boredom and encouraging socialising which are important for wellbeing. The importance of autonomy and independence was noted as important for mental health in the context of living with long-term conditions, as was a control over the environment in relation to the difficulties posed by living on the same plot as a large extended family, and an ability to cope with domestic tasks in a trailer versus a house.

As has been found for women among the wider population (Blaxter, 1990), many participants defined times of health by reference to their **social relationships**, or their ability to participate in social activities. Almost all participants described the positive impact on mental health of being around friends and family and a sense of belonging to a wider community. Traveller Community members presented their own health and wellbeing as interconnected with that of family members. Catherine's comment in Table 3 presents fluctuation in mental health, 'feeling down' or 'up', as corresponding straightforwardly with times of loss and the arrival of children respectively. Indeed, the profound effect of the death of family members among Traveller Communities is something that has been described in previous studies (Van Cleemput *et al.*, 2004). Like participants in Blaxter's (1990) study, Gypsies and Travellers described health in terms of their ability to cope with or relate to family members, and their attitudes towards others. Furthermore, times of health were connected with interest and ability to participate in social life. The lack of value attached to a Traveller identity has clear potential to impact on the social wellbeing of participants. Brigid described being made to feel low, ashamed, and humiliated by

prejudice when accessing health services for instance. Catherine similarly alluded to the impact on mental health of being forced to downplay identity, the difficulty finding employment, and the requirement to declare one's illiteracy when accessing services.

Traveller Community women often introduced the idea of different **levels of health or illness** in their accounts, distinguishing between minor health complaints such as common colds, flu, or feeling generally down or tired, and more serious health issues. This theme was also evident in participants' comparisons of their own health at different time points in their lives and of one's own health with the health of others. Participants sometimes described themselves as healthy despite living with health complaints, resonating with previous categorisations of **'health despite disease'**. Having described herself as experiencing a number of health conditions including arthritis, high blood pressure, anaemia, and being on anti-depressants, Sophia goes on to state that it is the health of her husband who is living with long-term effects of a brain injury that is the 'main concern'. These narratives have some resonance with existing literature which describes stoicism and low expectations with respect to health among Gypsies and Travellers (Van Cleemput *et al.*, 2007). Yet as demonstrated through comparison with wider literature, this potential to describe oneself as healthy even when experiencing disease is not unique to Traveller Communities (Cornwell, 1984; Blaxter, 1990). Furthermore, when reading participant's whole accounts, what might be classified as expressions of stoicism often sat alongside accounts of great pain, suffering, struggle in carrying on with everyday tasks. In addition, not all participants laid claim to health and many explicitly described themselves as unhealthy due to illnesses experienced. Indeed, the distinction drawn between minor and major health issues itself implies some limits to attempts at the preservation of 'health' when experiencing disease. While there were certainly many instances of Traveller Community members describing keeping busy, refusing to 'lay down and die' and the need to fight or not give in to illness, Catherine's quote in the above table illustrates that boundaries were drawn with respect to the health issues that can be endured. Some research has questioned whether stoicism is necessarily negative, suggesting that it may actually promote resilience in the face of illness (Moore *et al.*, 2012). When there is not, in the words of Sophia, a 'miracle pill' for a disease, treating stoicism as an inappropriate response may be questionable. This leads on to a related point, which

is that stoic positioning did not lead to a lack of uptake in health services. Rather, Traveller Community members described seeking help for all manner of health issues, from minor to major complaints.

4.2.3 The place of health

Some research examining lay perspectives has pointed to the huge potentiality that health, as such a general and abstract category, seems to encapsulate; health is defined as 'everything' (Davis *et al.*, 1992) and with it everything is possible (Herzlich and Pierret, 1987). This trend was also evident in the accounts of Traveller Community members. This appeared to take two forms in the narratives. Health was presented by one participant as all you need; paramount to, and rendering all other needs superfluous:

Catherine: we don't need cars we don't need money we don't need nothing else people might be on big fat gypsy wedding that 'ah we've got everything' there's good and bad in everyone let me tell ya but like what I say as long as we've got our health and strength and we feel well in ourself to look after our children then that's it that's all we need we don't need nothing else

A view of health as everything was also evident in Traveller Community members' descriptions of what they could do when describing times of health. When looking back and describing previous times in their lives when they were healthy, participants sometimes appeared to overestimate their abilities. Charlotte suggested for instance 'I erm could do everything (laughs) and it's not only that I could I did'. Brigid similarly describes how 'when I was 27 God forgive me I could...run anywhere do anything lift anything'. Catherine described her health during a previous pregnancy as 'perfect'. Where times of health were defined by reference to lifestyle we also see the employment of such extremes, as seen in the following statement by Eleanor: 'we had a good life we had a good healthy life together we always ate healthy and done everything right'. Indeed, Sophia appeared to recognise and correct this potential to exaggerate one's abilities when reflecting on times of health:

Sophia: a few year ago I were alright its only come this last two to three year that me health 's gone as its honest to god me health 's gone as it has gone cause I could do any- you know what I mean I not to say I could jump off of a cliff or something but I you could you know keep going motivate yourself

This suggests both the revered position of health, as well as a degree of romanticisation of the concept of health among participants. Since these statements were made in relation to previous health states, they may reflect this form of talk and

embody a sense of nostalgia about previous health states. The distance acquired when looking back fondly may encourage positive reflections on health. Such forms of telling may create important implications for health identities however, potentially helping to preserve views of health as difficult to attain.

4.3 Health practitioner definitions of health

Public health practitioners were asked in interviews to define health in the context of their work with Traveller Communities. Reflections from the responses to this question, along with other insights throughout interviews more generally about what was felt to constitute health or a lack of health in Traveller Communities are discussed here. These are grouped into three categories which could be discerned from practitioner accounts: 1) life expectancy and the prevalence of health conditions; 2) lifestyle behaviour; and 3) broader definitions of health. Thus, while the first two consider narrow definitions of health focused on the presence of disease and risk factors for disease, the third illustrates more holistic notions of health articulated by practitioners. As there was less by way of surprising results in the definitions offered by practitioners they are reported here more concisely than definitions articulated by Traveller Community members.

4.3.1 Life expectancy and the prevalence of health conditions

When describing the health of Traveller Communities, practitioners sometimes drew on narrow definitions of health centred on the presence or absence of disease, and highlighted inequalities in health outcomes experienced by Gypsy and Traveller Communities. Most practitioners described the lower life-expectancy, higher infant mortality rates and greater instances of stillbirth among Traveller Communities. Given how well reported these statistics are in the literature, it is unsurprising that practitioners define Traveller Community health in this way. Practitioners also commonly cited mental health issues and a higher prevalence of diseases such as COPD, arthritis, dental problems and measles in these groups. One participant described reports of epilepsy and eating disorders although these were presented as not necessarily prevalent in the community as a whole. Higher incidence of accidental injury in Gypsy and Traveller children was highlighted by one practitioner, although others described lifestyle risk factors for childhood accidents.

4.3.2 Lifestyle behaviour

Practitioners also defined the health of Traveller Communities in relation to lifestyle behaviours. Smoking, use of alcohol or drugs, diet or exercise were those issues discussed most often. Letting children play in unsafe environments was a further behaviour identified, with this presented as contributing to rates of accidental injury described above. Other issues were cited less frequently, including domestic violence, the consumption of energy drinks or fizzy drinks, use of sunbeds, immunisation, sexual health, dental care, and postnatal care. While all practitioners defined the health of Traveller Communities in relation to lifestyle behaviour, there was variation in the behaviours or combinations of behaviours that practitioners discussed. In addition, there appeared to be competing claims around the extent to which Traveller Community members were engaging in these behaviours, as with smoking for example:

Karen: I don't think many of them smoke I don't I didn't see any of the ladies smoking or anything

Caroline: I mean there's alcohol there's smoking there's drugs there's a whole range of things there's poor diet

Similarly, a couple of practitioners presented certain health issues or lifestyle behaviours as more of a problem than others, referring to these issues as 'big things' or 'biggies'. However, again, the issues which were weighted in this way varied according to different practitioners:

Louise: I think the big things are mental health issues, domestic violence and alcohol so I think they're the three biggies

Linda: immunisations that's always a biggy

Linda: one of the big things certainly that [name] found and I found is the amount of takeaways they have

Linda also presented some health behaviour issues deemed negative for health as 'classic' throughout the interview, referring specifically to the consumption of takeaways, fizzy pop, and a reluctance to breastfeed:

Linda: they usually come out with a er a pat answer was 'ah no we don't do that⁵ in our community'... breastfeeding's a classic

⁵ 'That' is used here generically by the practitioner to refer to any health issue which is considered to be unusual among Traveller Community members

Such presentations of these behaviours as classic, along with the suggestion that Traveller Communities give an 'off pat' answer reinforce ideas that negative health behaviours are typical of, and long engrained in Traveller Communities. Nicola's use of 'they'd all be sort of talking to me about how many cans of red bull they drank a day' has a similar effect, generalising this behaviour and reinforcing this as the norm within Traveller Communities. Such presentations may perpetuate commonly held representations about the behaviours that are found in Traveller Communities and in turn create a narrative that is itself quite difficult to challenge. While there are some examples of shared narratives around behavioural health issues in Traveller Communities, they mostly appear to vary across individual practitioners. This suggests that discourses on the prevalence of lifestyle behaviours in Traveller communities may be less well established, leaving more room for interpretation based on personal experience and observation. However, consensus was apparent that health related lifestyle issues were a problem within Traveller Communities, even where there was disagreement around which issues these were.

Although behaviours were often associated with Traveller Communities as a whole, practitioners did occasionally report these to be less static, or as varying according to individuals. One practitioner described how some younger Traveller Community women chose to breastfeed their babies for example and described changes in community attitudes towards contraception over time:

Linda: using contraception more. Once upon a time they'd kind of leave it to God as they would say

Some practitioners seemed reluctant to present Travellers as engaging in negative behaviours, as seen below in Becky's quote:

Becky: and also because of heavy smoking possibly heavy drinking erm by their own admission and erm they might eat then order a takeaway very late at night and this would happen on quite a few nights

The use of tentative language such as 'possibly' and 'might' initially suggests some hesitation in presenting Traveller Communities as exhibiting these behaviours. However, the shift to use less cautious language toward the end of the quote; 'this would happen on quite a few nights' nevertheless provides a more concrete claim about Traveller Community behaviour.

4.3.3 Broader definitions of health

Practitioners did not draw solely on narrow definitions related to disease prevalence and behavioural risk factors but incorporated attention to mental, social and economic wellbeing. Practitioners described the high levels of stress experienced by Traveller Community members due to being moved on or difficulties finding accommodation, with this sometimes connected with risky health behaviours. Karen suggested for example:

Karen: a lot of them [Gypsies and Travellers] are quite agitated...they've got a lot on their minds I think that's what I think came across to me, kept nipping out for joints

Practitioners recognised a strong sense of social support within Traveller Communities as beneficial to health. However, one practitioner raised concerns around social isolation and loneliness among Traveller Community women living on the site. Some practitioners presented bringing people together and providing opportunities for social connection as a health improvement outcome in itself. One practitioner described how health education sessions provided a form of escapism from difficult daily realities such as potential eviction and daily responsibilities such as childrearing, cleaning and the 'traditional roles of Traveller women'.

Some practitioners discussed a desire to develop the skills and capacity of Traveller Communities in order that they can, as Karen remarked, 'help themselves', whether that be through increasing health literacy or community development approaches. Practitioners made reference to 'people reaching their potential', or empowering Traveller Communities to 'have better lives' within their definitions of health and cited the need to address inequalities in life chances with respect to educational outcomes, employment opportunities and housing which in turn impact on health and life expectancy. Low levels of school attendance by Gypsy and Traveller children was discussed by many practitioners. Practitioners recognised the potential for different employment preferences among Traveller Communities, as well as the desire to protect against cultural erosion which may give rise to different schooling choices. However, participants also lamented what they saw as a lack of 'aspiration', particularly among Traveller Community women, and low levels of engagement in education, which was presented as providing opportunities and tools to move forward in life generally, as well as improving health literacy. Practitioner views were split however regarding whether general literacy training should be provided. While

some practitioners presented this as essential to making population-wide health messages more accessible to Traveller Communities, others saw this as forcing unwanted agendas onto these groups.

Connected with these concerns, employment opportunities and the financial wellbeing of Travellers also featured in practitioners' representations of Traveller Community health. Caroline expressed a concern that the conditions of life and lack of employment opportunities may lead to a turn to criminality, although following this with a comment suggesting this to be true also of other sections of the population, such as those on benefits:

Caroline: I do worry about the conditions of life and you know the limited opportunities and options that do mean eventually you lead to criminality or other things because there's so few ways of making a living

Karen too raised concerns about criminality, claiming some men within the local Traveller Community to be illegal money lenders. Karen placed a particular emphasis on the economic position of Traveller Communities in her narrative, reflecting what she described as an interest in financial inclusion:

Karen: in their [Traveller Community members'] own minds they can't do anything they they they're not job ready they can't you know can't read or write so how are you gonna do that

Karen therefore described a need to empower Traveller Community members in order to avoid fostering dependency on benefits. Indeed, literacy training was mentioned specifically in relation to this issue, yet a contradiction was evident in Karen's suggestion that literacy training could focus on filling out benefit forms; an approach which would also lead to dependency.

4.4 Summary

This chapter has discussed the ways that Traveller Community members, and health practitioners define the idea of health as a general concept. It has demonstrated huge convergence in the narrative resources used to define health among Traveller Community members and wider sections of the 'lay' public. The extensiveness of this similarity has not, to my knowledge, been previously reported in the literature. This calls into question narratives of Traveller Communities as working toward different goals or standards of health, which, given the value

attached to health in society, may themselves have the propensity to stigmatise. Narratives that Traveller Communities are stoic and describe themselves as healthy despite disease often underpin claims that Traveller Communities are less likely than others to engage with health services. This may reinforce a disinclination to try and engage with these groups. Highlighting the commonality in definitions of health used by Traveller Communities therefore calls into question those narratives that position conceptualisations of health as the reason for problems in accessing health services and point to greater potential for dialogue with respect to health than previously assumed.

The chapter has also enabled some comparison of health definitions used by Traveller Communities and health practitioners (in the context of their work with these groups). It must be acknowledged however, that Traveller Community members and practitioners are here defining health from different standpoints: the former providing a first-hand account of experiences, and the latter defining the health of a group with whom they work. Overall, there was a high degree of symmetry in the definitions of health used by Traveller Community members and health practitioners. Both drew on a multifaceted understanding of health, spanning narrow biomedical definitions of health as the absence of illness, lifestyle behaviour, and a recognition of the broader psychological and social dimensions of health. Again, this alignment shows some promise for communication, suggesting that Traveller Community members and practitioners construct the goal of health similarly. However, some key differences were also apparent regarding representations of social support available in the community and attitudes toward education and employment. Both Traveller Community women and health practitioners shared views generally about the benefits for health of economic and educational engagement. While some community members raised concerns about challenges in securing employment, there was little to suggest that Traveller Community women have a lack of 'aspiration' to engage in education or employment.

Having introduced the concepts of health employed by Traveller Community members and practitioners, the remaining findings chapters explore the preferred identities expressed by participants, and the ways these identities were accomplished through: the discourses participants drew upon; the forms of self-

other positioning employed; and interpersonal interaction with the researcher. The first of these chapters now follows, exploring how discourses on the nature of evidence worked to reinforce the specialist identities of practitioners as able to work with Traveller Communities.

CHAPTER 5 - 'Where the real work goes on' and 'splendid white middle-class isolation': practitioner identities as in touch with 'vulnerability'

5.1 Introduction

This chapter examines the nature of evidence used by practitioners when describing the health status of Traveller Community members, and its significance in drawing boundaries around who has, and who lacks authority to speak and practice in relation to Traveller Community health. The chapter will show how health practitioners construct preferred identities as particularly in tune with the needs and experiences of Traveller Communities and other 'vulnerable' or 'disadvantaged' groups. An identity as expert in working with Traveller Communities is argued to be generated and sustained through a confluence of: a) discourses on the relative value of different forms of knowledge; b) the positioning of self as close to communities and distant from 'other' professionals; and c) dissociation of self from the researcher in regard to education. The role of these respective elements in constructing the identities of practitioners will now be examined in more detail.

5.2 Discourses drawn upon and used

5.2.1 Public health discourses on Traveller Community health

As shown in the following quotes, practitioners often drew on 'scientific' public health discourses on Traveller Community health, incorporating references to research, evidence and statistics when describing the health needs of these groups:

Nicola: I had no experiential expectations so I suppose I went in having read the limited literature erm that access to care was gonna be an issue for them and that health outcomes are poor and that some of the negative health behaviours as I perceive as negative like smoking and alcohol domestic abuse abuse and things like that were issues that were going to be needed to be tackled

Sandra: we knew that there was erm a is it high mor- high mortality rates or

Researcher: yeah yeah

S: yeah high is it high or low I don't know how to pru- put it [when babies are dying

R: yeah I think it's high]

S: [is it a high mortality rate

R: yeah high infant mortality]
S: they have high infant mortality rates in under 5s

Louise: actually by living together they do I think from the research I might be wrong but I think they do a lot better if they're together don't they than if they're settled and their outcomes are a lot better

Louise also described 'reading up' more generally about Gypsy history prior to working with these communities, to better understand 'where they're coming from'. Only two practitioners referenced the seminal Sheffield study on Gypsy and Traveller health, both of whom were working in a more strategic capacity in public health. Indeed, these same two practitioners were the only ones to mention the Gypsy and Traveller Health Needs Assessment undertaken in the area, although it is important to state that practitioners weren't asked about these pieces of work specifically. Thus, practitioners tended to reference evidence on the health of Traveller Communities in a general way as opposed to citing specific sources. Indeed, evidence on the poorer health of Traveller Communities appeared to have achieved a taken for granted and well-rehearsed status among practitioners working in the area. Practitioners sometimes described such knowledge as being passed on explicitly, either by other practitioners or Traveller Community members themselves:

Becky: we knew because we'd been told that erm the inoculation levels were very very low and that there had been measles epidemics in the Travelling Community

Linda: this woman told me this Traveller said its quite common now for a lot of women lot of women to smoke a bit more dope to smoke less cigarettes, interesting

However, at other times, received wisdom about the health issues or behaviours of Traveller Communities is not attributed to a particular source:

Caroline: I mean we know there are issues around alcohol

Linda: everyone knew that a lot of the R- erm just from being around in [place name] and working as a midwife a lot of people knew that Travellers didn't want to get the MMR er because of all the controversy

Louise: I've never directly worked with Gypsies and Travellers but I've kind of been working or I've worked in public health for twenty years so I kind of was aware of the issues if you like

The phrases 'we know', 'everyone knew', as well as the suggestion by Louise that she was aware of Traveller Community health issues tangentially by definition of working in public health, illustrates how these narratives have become well-

rehearsed truths about community members. Sandra's use of the term 'obviously' when referring to the use of sunbeds among young Traveller women, and Karen's use of 'ain't there?' after a statement about high levels of domestic violence in the community also signal an expectation that the researcher will have a shared understanding of these issues.

The nature of 'evidence' was also discussed in relation to more strategic work to improve Traveller Community health by those working in this capacity. For example, Hazel described how the recent health needs assessment in the area had been directed by community members and the Traveller organisation to highlight a gap that they knew to exist around palliative care, due to recent community experiences:

Hazel: it wasn't in terms of classic research the most robust but the the questionnaires that we got the data from is pretty solid erm and I think it what it did was it it basically reinforced very clearly the findings from the Sheffield research erm echoed it almost almost completely erm we didn't put in any questions about immunisation which was a big erm gap on our part but it was I think partly because there was so much focus on erm dying and death and you know counselling and all sorts of other things and I think it it now I can sort of think that was partly steered by the organisation because they had seen gaps and they wanted to draw attention to those gaps but erm but as I say we it w- there were some interesting findings

While Hazel explicitly articulated respect for 'community' or 'cultural expertise', a lack of input early on from public health practitioners is presented as influencing the degree of scientific rigour with which the questionnaire was conducted. The prioritisation of end of life care is suggested to have resulted in other issues such as immunisation being missed. This use of the needs assessment to confirm existing knowledge highlights the politics surrounding the generation of 'evidence' on Traveller health needs, and the contingency of this evidence on recent histories and experiences of Traveller Communities.

5.2.2 'Folk' tales on Traveller Community health

While 'scientific' evidence therefore occupied an important place in practitioner accounts, alternative discourses were also apparent which formed some challenge to the role of this evidence. The clearest illustration of adherence to counter-discourses was where practitioners expressed explicit doubts about, or directly questioned scientific evidence on health. This challenge of public health evidence was most evident in Linda's account. Although it is now widely accepted that the link

between autism and the MMR has been disproven, Linda highlighted a potential for this evidence to change and confirm this link in the future:

Linda: you know they heard as we all did back in the day that urm you could get autism from the MMR well maybe you can maybe you can't as far as I know that the link isn't there particularly at the moment but things change

Both here and in her suggestion elsewhere in the interview that, with respect to beliefs about the risks of MMR immunisation, 'they [Gypsies and Travellers] might be right', Linda directly questions public health evidence on the benefits of immunisation. While Linda resists presenting Gypsies and Travellers' as incorrect in their beliefs about vaccination, she does also state that she must be guided by the evidence which is currently available. This tendency was also evident in the reluctance of some practitioners to explicitly label health behaviours as negative, even where these are well established as such in research. Nicola for instance, corrects her description of smoking and domestic violence as 'negative' to instead state those 'I perceive as negative'. There is also some ambivalence in Becky's suggestion, when discussing the need for informed choice surrounding the use of alcohol and consumption of saturated fat, that 'you've gotta know what's going to happen to you possibly'. The use of 'possibly' here highlights the tension that can arise for practitioners delivering health promotion advice since 'risky' behaviour doesn't always impact on people's life expectancy. Similar trends are again apparent in Linda's discussion of early inducement in pregnancy for Traveller Communities. Drawing on her experience, Linda hypothesised that Traveller Community women have pregnancies that are slightly shorter than 40 weeks. Linda's explanation for this difference is somewhat unclear, in that she starts to present this as the result of genetic differences before correcting herself to suggest that 'we've all got the same genetic background fundamentally'. She suggests that Traveller women 'have this kind of thing that they really do not like being overdue their [due] dates' and attributes this to the innate knowledge passed-down through Traveller Community women regarding what's best for them during their pregnancy:

Linda: although they the- don't necessarily have the scientific knowledge maybe some of their presumptions are correct erm passed down from family to family

As such, Linda does not position current 'scientific knowledge' as the most important source of evidence, but places this on an equal footing with community held knowledge. Although she suggests that she can't yet 'prove' this difference, Linda

indicates an expectation that this will be proven in the future, suggesting the convergence of these different forms of knowledge. She goes on to discuss how she will therefore push for Traveller Communities to be induced early, where they indicate this as their preference, and avoids being governed solely by the formal evidence that is available:

Linda: there is a disproportionate amount of still births for all sorts of reasons but one of them is placental insufficiency post term so you get a few things like that and it filters down but it's probably actually scientifically correct as well but their innateness of knowing that I think important to listen to not not dismiss and not say I know best cause I'm the midwife but go with some of that stuff

Another example of practitioners accepting explanations which stand in contrast to 'scientific' understandings was evident in Hazel's account:

Hazel: I heard the most extraordinary story from er and she was a quite a senior health visitor she was about to retire...she told me that erm a lot of she was very pro Gypsy a lot of Gypsies shouted particularly men because they were deaf and you know that they went quite deaf quite early and I said oh so there's sort of possibly something genetic and she said no no no n- no she said no they told me erm it it well its genetic now it was from sitting on the wagons and the wagon wheels were metal so as they went along the road with the clip clop of the horses and the metal wagon wheels it was so loud that they eventually went deaf and I said well that couldn't be inherited and she said no no it no it i- no it is it and I was like (laughing) sorry if that's like saying if you if you dock a dog's tail its puppy i- puppies 'll have short tails it's like no they don't they still always have long tails you know it's kind of (laughs) you're a bloody senior health professional talking this complete but a Gypsy had told her that

The practitioner sets the context of the story by stating that the practitioner in question is a 'senior health visitor' and 'pro-Gypsy'; details that help to explain her surprise that this individual would ascribe to the provided explanation for Traveller Community hearing problems. They also help convey the pervasiveness of misgivings about the community by illustrating that even those with significant expertise and who are well intentioned make essentialist and questionable claims about these groups. This excerpt also illustrates the kinds of stories and evidence that have currency, and the explanations for health that are taken to be legitimate. In this case, surprise that these views are expressed by a 'senior health professional' rest on understandings of what is known to be possible scientifically. That the explanation had been provided by a Gypsy provides further contextual detail. It is possible that as the practitioner is 'pro-Gypsy' they might buy into the stories that Traveller Communities tell about themselves, even where these do not correlate

with scientific explanations.

A further counter discourse to that of scientific evidence was evident in the priority given to subjective evidence on the health of Traveller Communities. This was sometimes reflected in the language used by practitioners, as in Hazel's use of the phrase 'it feels like' when describing the higher prevalence of accidental death in Traveller Communities, and where she suggests that high consumption of alcohol by men 'just seems to be accepted' within Traveller Communities. Some practitioners described how you could know the 'facts' about the poor health of Travellers on the one hand, but come to understand this differently on witnessing this first hand:

Becky: you can see that never mind reading the statistics of of a Gypsy Traveller man living to 56 you you you've its written on their faces by the lines on their faces really they seem to age very quickly in health terms compared to the general population...you can see by what they say and physically sometimes how they carry themselves that their health is not on par with what you'd call the general population

The statement 'never mind reading the statistics' positions this more formal evidence as less significant than observational evidence. Direct observation of Gypsy and Traveller health status is presented as confirming or supporting statistics, but also as bringing this home or helping this information sink in for the practitioner. Becky's suggestion that Traveller Community members wear their lower life expectancy on their faces perhaps connects with stereotypical ideas of Gypsies and Travellers as spending extended time outside and as having 'swarthy' or weather beaten skin (Holloway, 2005). In contrast to representations of the health of groups found in clinical evidence, the language used by this practitioner to describe the observed health status of Traveller Communities is poetic and emotive, as seen in the suggestion that the stress and poor health of Travellers is 'written on their faces by the lines on their faces'. This fits with an overall tendency throughout Becky's account to talk in an impassioned way. The notion that the faster ageing of Traveller Community members was visible in their appearance was also hinted at in the account of another practitioner however:

Louise: this woman she must have been oh early 20s she looked a lot older than that but she must have been about early 20s

Louise went on to reference the healthy appearance of this women's baby as a 'big fat lovely healthy-looking baby', before correcting her use of 'fat' to 'chubby'. This suggests that practitioners may be supplementing public health discourse on what

makes people healthy, with additional observational markers in judging the health of the people they meet.

The difference between 'dry' statistics and hearing the stories of Traveller Community members also operated at a more strategic level, where some practitioners discussed the forms of evidence that were most likely to catch people's attention and prompt action to address Traveller Community health:

Hazel: if people are dutifully following process then when a community needs assessment comes onto their desk that says these things should happen they should be thinking OK how do I get these things into the strategic planning of these organisations and there would be evidence that they'd taken steps to do that and I actually don't think mostly it happens like that I think mostly it's a kind of that's really interesting but I've already got a massive workload but if somebody walked through the door and talked to them passionately about it and said can I come back to you in six weeks' time and just see how it's gone something probably would happen

Within the above extract, someone speaking personally and passionately to, and developing a relationship with those in public health is presented as more effective than simply providing a paper copy of evidence. This was particularly so given the numerous needs identified within a given area, and public health practitioners' heavy workload. This mirrors the presentations of practitioners working more directly with community members above in that hearing or seeing the situation first-hand is presented as bringing the cold facts or evidence to life and as therefore more powerful than written evidence. Sandra similarly emphasised the importance of hearing about Gypsies and Travellers' experiences from community members themselves:

Sandra: we heard quite a lot rough stories really about the way they'd been treated and I think when you hear it from the horse's mouth so to speak it makes you think twice

Likewise, Caroline reflected that it had been useful for Clinical Commissioning Group members to see the community for themselves and the 'human side of things' to counteract potential stereotypes. Louise described how community members gave a 'powerful' presentation to council workers, thereby also positioning stories and personal engagement with community members as a form of evidence which holds more sway. She discussed a visit to the site that had been arranged for health practitioners with the aim of increasing understanding of health needs and described how this had enabled her to gain a greater appreciation of how and why Traveller

Community members lived their life as they did. Louise suggested that conversations and observations during her visit to the Traveller Community site had changed her perception of what the health issues were for Traveller Communities. However, she described the importance of the community needs assessment in generating robust evidence to inform the prioritisation of Gypsy and Traveller health needs, suggesting that a balance is needed between different forms of evidence, or perhaps that different forms of evidence have different functions. In addition, the suggestion that experiential evidence could be more impactful than distanced or formalised evidence was not noted by all practitioners. This distinction was less evident in Nicola's account for instance, in keeping with her tendency to talk in a very objective way throughout her interview.

5.3 The positioning of self in relation to others

5.3.1 The emotional labour of health work

Connected with practitioners' emphasis on Traveller Community health status as having to be seen to being believed, practitioners highlighted the emotional impact of witnessing the health of Traveller Communities first hand. Both Becky and Sandra described the personal impact of hearing of stories from several Traveller Community women who have experienced infant mortality for instance:

Becky: the infant mortality 's very high within the community which is shocking shocking to the young shocking to anybody but particularly shocking to the young mums...because you could have a group and everybody I mean everybody could have lost a child

Sandra: I was like you're not just telling me one person this is woman after woman after woman telling me these really shocking stories about you know me sister lost a baby the mother themselves their daughter so it was obviously you know a subject a sensitive subject but one that was very honestly happening and they were being very honest about it to me so yeah erm you can relate as a mother

Hearing these stories first hand is presented as shocking, and particularly so for those who themselves identify with the experience of motherhood. Both Becky and Sandra drew attention to the difference in health or life-chances or that they could expect for themselves, and those experienced by Traveller Community members. Becky's statement 'you can't make up those kind of stats' draws on the common trope of 'you couldn't make it up' often used in storytelling to present something as

so unusual or unlikely that it is beyond imagination. Her comment elsewhere in the interview that the life expectancy of a Traveller man is the same as when her dad was alive introduces comparison between her own sphere of reference and expectations for health. Sandra draws a similar comparison between Traveller Community expectations for health and those for herself and her 'community'.

Sandra: I was quite shocked because I I personally in my circle of people I know have never come across anyone who's lost a baby to me that's unheard of in my community erm I've never known anyone have a stillborn baby and I've never known anyone's child die

While it is left unclear how Sandra is drawing boundaries in relation to her own 'community', she is nevertheless making a distinction between herself and Traveller Communities. Louise suggested that she felt 'sad' about levels of unmet need in Traveller Communities, using a similarly emotional term. Emotionally charged terminology was also apparent in Karen's account, when she suggests that Traveller Community members' attitudes to benefits 'upset me actually'. The ways that this emotional engagement was balanced with professional roles is elucidated further in Louise's narrative. When confronted with the needs of Traveller Communities on site, she describes a desire to simply roll her sleeves up and try to fix the problems she saw:

Louise: yeah well do you know what I wanted to do because my background 's nursing and erm my ini-immediate response which was very irrational was erm I wanted to go and do a health visitor training and then go back and work on the site just being a health visitor on the site I just wanted to go and do it

Researcher: mmm

L: was my initial reaction thought why it's just easier to do it yourself I just want to do it [so that was my]

R: (laughs)

L: I thought I really wanted I really felt very erm sad really that this group of people had this level of health need and were not getting the service that they should be getting

This emotional response is at odds with her more strategic position in public health; Louise's suggestion that her reaction was 'irrational' suggests that these emotions are out of place in the context of her public health role. This highlights that emotions may be afforded less credence by practitioners than other drivers such as 'evidence' when articulating a rationale for public health action. This is perhaps unsurprising given that acting on evidence is something that features strongly in the 'foundation stories' of the discipline of public health (Dew, 2012).

It is important to state, however, that not all practitioners communicated the emotional impact of their work. Indeed, this tendency to describe emotional responses to hearing about the situations of Traveller Communities appeared to be most (though not exclusively) apparent in the accounts of those who distanced themselves from a traditionally 'professional' role and occupied community-based roles. The following excerpt from Nicola, a health 'professional', serves to illustrate this contrast, with infant mortality rates here defined in much more neutral terms:

Nicola: I suppose many of the Traveller women that I've worked with have known of somebody from their community or within the community who have lost a child and they bring that into their discussion and their relationship as well with me as well

5.3.2 The 'splendid white middle-class isolation' of 'other' practitioners

When discussing the health needs and circumstances of Traveller Communities, practitioners often positioned themselves as more 'in touch' with the lives of Traveller Communities and other vulnerable groups, when compared with their colleagues. When doing so, practitioners distanced themselves from 'other' practitioners who were more ignorant of the realities of everyday life for those who are 'disadvantaged'. Notions of class were often drawn upon to underpin claims of greater empathy with these groups:

Caroline: all I'm saying is I think more than most people in public health I'm used to working with vulnerable groups and disadvantaged communities and I I don't tend to judge as harshly but I think other people sort of have impressions of this very lawless [Traveller] community where women are downtrodden and kids are uneducated and it's a life of crime and they die at fifty and all the rest of it really I think for a lot of people in public health I mean...these are people who spend their life in splendid white middle class isolation they don't understand how people in housing estates live and I have to give intelligence

Here, Caroline presents herself as less judgemental of Traveller Communities, as well as those experiencing disadvantage more generally. She draws on this position of understanding to lay claim to authority in this area; placing herself in a role of educating or giving 'intelligence' to practitioners in 'splendid white middle-class isolation' and who are therefore less accustomed to working class community life. Paradoxically, Caroline's rejection of the impressions she attributes to other practitioners, of Traveller Communities as lawless, uneducated, in dire health need, and oppressive to women, actually reinforces these views. It does so as her own lack of judgement is predicated on the idea that there are aspects of life to be found

in Traveller Communities that might invite such judgement. It also essentialises differences between Traveller Community and 'middle class' values, denying the possibility that Traveller Community members can also be middle class. Similar ambiguities appear elsewhere in the interview around presumptions of violence in Traveller Communities:

Caroline: what did bother me was the fact that people were overwhelmingly unremittingly negative 'oh you don't wanna go up to [Traveller Community site]' you know it was almost like you know like I can remember saying to one girl what it the fu- you know fucking (alamore or sommat) she was saying yeah they've got guns up there and everything and it since transpired that yeah that does happen (laughs)

Researcher: ah right I hadn't- I didn't realise- right

C: I think somebody from [the Traveller Community] site shot someone

Researcher: ah ok

C: or so I don't know whatever

Caroline rejects the perceptions of 'other' practitioners before going on to suggest there had indeed been an incident of gun crime in on the Traveller site. The humour with which Caroline reports this event introduces a degree of sensationalism about crime in these groups, while her use of 'whatever' goes on to convey her own indifference to the situation. Here and throughout her narrative, Caroline appears to lay claim to a preferred identity as someone who is hardened to and used to working with groups exhibiting 'problematic' behaviour. She describes receiving these reactions from colleagues often 'cause of the nature of the people I work with'. This itself seems to draw on glamorised ideas of 'toughness'. Indeed, this is a recurring theme throughout her narrative, including where, in relation to the risk of community members setting fires in meeting spaces on site she suggests 'providing they don't torch us while we're in there it should be fine'. These ideas were also expressed more generally in relation to Caroline's views about the role of third sector organisations. Caroline was critical of attempts by third sector organisations to model themselves on commercial organisations (e.g. by creating Chief Executive Officers). She was also critical of the third sector in general for becoming an arm of the state by uncritically accepting funding arrangements focused on narrow health outcomes. She raised concerns that in doing so, third sector organisations are moving away from a position of greater tolerance and understanding of people, and the provision of an alternative to state services. In keeping with this view, Caroline suggested that those working in charitable organisations should be more tolerant of service user behaviours, with this again presented as a source of contention between herself and the views of other public health practitioners:

Caroline: I work with people who say to me I've said to them 'why aren't you back at the drug agency' 'oh they chucked me out' 'why?' 'cause I said this or I did this' and I think well if you don't expect someone off their head on drugs to tell you to fuck off why you in this role you know and I just think I go back to public health and they say to me yeah but there has to be protocols in services I say yeah but that's for professionals not for people as long as they're not punching your lights out

This again fits with Caroline's romanticised presentation of practitioners who are most able to deal with groups on the margins. The importance of an identity as in-tune with communities is also apparent where Becky describes workers as 'street smart' and positions this as important in their ability to engage with Traveller Communities. Sandra similarly positioned herself as used to working with people from a deprived background and as less shocked by the circumstances in which people live:

Sandra: there's still things that come up week after week that surprise me so (laughs) erm yeah but I think you can be surprised and not show it or be interested instead of going 'oh my god really' (laughs) which I think some people I think some people do actually do that you know they'll be quite I mean we work in erm quite deprived backgrounds because my role with the NHS is to work in that ten percent of deprived communities in [place] so I am used to erm talking to families who've got drug and alcohol problems who are lived in an over cramped houses who are struggling erm so it doesn't really phase me and if I do see something that does phase me I will keep it to myself because I've had a lot of years training and I think it's something natural that you would do anyway if you're that type of person

Sandra contrasts her familiarity with disadvantage, and her own approach of managing and disguising any shock or disapproval with that of a co-worker, attributing this difference to her colleague's more 'privileged background':

Sandra: she's [colleague] from quite a privileged background and she's University educated and erm to quite a h-hi-high specification and she has always worked in top jobs and earned quite a lot of money and erm you know...she's quite well to do and speaks quite posh and erm sometimes she'll see things and go 'oh my god [name] you wouldn't believe this family I've just seen' you know and she'll be like you know 'they did this and they did that and they did this and they did that' and she's like oh it were disgusting you know and you really can't be like that (laugh)

This echoes Caroline's depiction of those who are privileged as less aware of and more judgemental of the reality of people's lives. Karen similarly points to a refusal to display shock as significant in gaining the trust of community members, offering the following interpretation of Traveller Community members revealing their breasts to her: 'they were just out to shock me and I didn't get shocked'. These narratives

illustrate how practitioners furnish an identity as someone 'in touch' with, and less judgemental of community life, with this forming one way in which practitioners articulate a position of authority in their work with Traveller Communities and other 'disadvantaged' groups.

Some practitioners articulated a division between public health professionals in general and workers in other sectors, particularly those in more clinical roles. Both Hazel and Louise presented those working in the discipline of public health as particularly concerned with addressing health inequalities, and Hazel suggested that public health representatives have greater recognition of the broader determinants of health. Yet, participants also pointed to divisions within the discipline of public health. Hazel distinguished herself from public health workers with a medical background, who were suggested to advocate an individualistic approach to public health and favour legislative and punitive methods for encouraging healthy behaviour. Louise similarly suggested that practitioners in mainstream services often lack an understanding of why people are in the situations they're in. Hazel positioned herself as operating from a health promotion perspective which recognised the complex reasons underpinning people's behaviour and encouraged people to adopt behaviours willingly. She did, however, cite the avoidance of resistance, or 'backlash' as the reason for avoiding more prescriptive approaches. Public health itself was presented by Karen as an approach that is difficult to grasp and not always understood, particularly among elected members who were sometimes described as undermining public health efforts. After the recording was switched off, Louise reflected on the ways that public health and community work were seen by other spheres of the health service:

Louise said that there were different cultures in health and that from experience of working as a nurse, there was a sense among people within hospitals that that's where the best staff work and that community work is where people go when they get older and settle down, have kids. But as she entered community work, Louise says she got a sense that that was where the real work goes on. She felt that people in other health sectors can be more judgemental about where people come from. She described how public health can be seen as a bit of a softer option as you're not working on the frontline, suggesting that it is not looked upon positively and can be seen as removed from what is happening on the ground (Extract from field notes)

The idea of public health as where you go to settle down was also present in Karen's narrative. Karen expressed regret that she no longer works as directly with

community members but described a need to move away from more insecure community development roles to get a 'proper job'.

These accounts illustrate the ways that practitioners establish common identities surrounding their role in working with Traveller Communities either by reference to their particular affinity with the situations in which particularly disadvantaged or vulnerable groups find themselves, or by reinforcing a sense of common shared values relative to 'other' practitioners. Through these techniques, practitioners could position themselves as championing the rights or needs of Traveller Community members, and to some extent as swimming against the tide when doing so.

5.4 Interpersonal interaction

5.4.1 Distancing self from academia

Practitioners' preferred identities as closer to, and more in tune with Traveller Communities and other 'disadvantaged' groups were sometimes accomplished through interpersonal interaction with myself. Participants did so by dissociating themselves from academia or education and establishing this as a key difference between themselves and myself. See for example my reflections taken from Becky's observation record:

Throughout conversations I got the impression that Becky was trying to distance herself from academia – suggesting that she couldn't have done a PhD, that they [members in the organisation in which she worked] forced her to do a Masters and on one occasion describing her dissertation as 'not very academic'

Becky raised the issue of PhD study on a couple of occasions in conversation outside of her interview, repeatedly commenting on the lengthy period of study this involved and suggesting that I must be 'living and breathing' the research. Becky regularly downplayed her own education and abilities, suggesting on one occasion that she'd been a 'social experiment' in that she'd been unusual in receiving an opportunity to attend grammar school given her background. At another point, I cringed as Becky suggested that I would be earning a large salary after I was done studying, correcting her that this wouldn't be the case. The number of comments Becky made of this type suggests that this relationship with education forms an important aspect of her preferred identity. Yet despite these explicit identity claims,

and attempts to distance herself from academia, Becky drew widely on academic ideas and concepts, referencing feminism, the theories of Paulo Freire and theory surrounding community education. At the same time, I was very conscious that by virtue of my engagement in PhD study, I was being 'othered' by Becky; positioned as part of a 'privileged' group, which potentially carries a negative status as someone distanced from, and different to community members and workers. Karen positioned herself similarly in relation to education and myself, the researcher. She described her difficulties in going back to undertake Masters study after many years out of education, suggesting that she was 'rubbish at writing'. These overt identity claims were reinforced through smaller asides, when Karen joked that she 'could read, sort of' on receiving the information sheet, and when she suggested that like Traveller Community members she is a 'hands-on' and 'practical' person. Thus, Karen also appeared to establish her difference from myself through her treatment of study. A similar dynamic was evident in my interaction with Sandra. During the interview, Sandra identified the limits of university education in providing understanding the lives of community members:

Sandra: they will send erm a university-trained nutritionist who's 21 year old has never had children to work with a group of Mums who'll be like 'well you've not even got how do you understand the challenges of feeding a baby a healthy diet?'

Here, the hypothetical practitioner who is not only university educated, but young and inexperienced in raising children of his or her own, is positioned by Sandra as incapable of understanding the reality of the challenges surrounding infant feeding. These are all characteristics (though perhaps debatably in the case of the label 'young'!) that could apply to myself. Karen's suggestion that I didn't 'look old enough to be doing a PhD' and that I 'looked about 12' positions me similarly. Thus, although speaking in general terms, Sandra's comment prompted me to consider the extent to which I can fully appreciate the difficulties that Traveller Community members might experience. Though not all practitioners did so, this further illustrates the ways that practitioners could reinforce 'street smart' identities through their positioning of self, relative to the researcher.

5.5 Summary

This chapter illustrates the multiple narrative layers through which practitioners constructed identities as having particular expertise in work with Traveller Communities and groups they categorised as similarly disadvantaged. By emphasising the importance of experience and face-to-face engagement with Traveller Communities relative to formal and distanced evidence, practitioners could reinforce their specialist and unique knowledge about these groups. This identity position was further bolstered by emphasis on one's personal rather than purely professional care for the community, and the drawing of boundaries between self and 'other' professionals, who were deemed to be less accustomed with the reality of life for these groups. Narratives, which draw on sentimentalised ideas of being moved by another's plight and reinforce ideas around the unique understanding of these practitioners of Traveller Community circumstances are perhaps understandable given the likelihood that Traveller Community members may be mistrustful of practitioners who are not known. However, these stories are also potentially harmful in reinforcing divisions between the worlds of practitioners and Traveller Communities, and in sustaining the position of Traveller Community members as 'vulnerable' and only responsive to specialist health services. The next chapter explores the sources of evidence that Gypsy and Traveller Community members drew on in describing their health, and the implications for their health identities.

CHAPTER 6 - 'I wouldn't change to be anything else': vulnerability to poor health and its problem for Traveller Community identities

6.1 Introduction

Discourses on the nature of evidence were significant in shaping the health identities that could be claimed by Gypsy and Traveller participants. Gypsies and Travellers drew on a combination of biomedical discourses, those on the lower life expectancy of Traveller Communities overall, and those on embodied and experiential knowledge when defining their health status. The chapter suggests that adherence to biomedical discourses, together with awareness of the lower life expectancy of Traveller Communities overall combined to create a key identity tension for participants, with the poorer health of these groups seeming to invite explanation by Traveller participants. Furthermore, the difficulties Traveller Communities experienced relative to other groups (and myself) in getting access to health services reinforced concerns that health issues were present but undetected. This worked to entrench a position of 'vulnerability' and 'neediness'. In light of this context, discourses on embodied and experiential health knowledge were used to emphasise requirements for greater support, or to challenge decisions or treatment by health practitioners.

6.2 Discourses drawn upon and used

6.2.1 Biomedical discourse

Traveller Community members drew clearly on biomedical discourse in their accounts of health and illness. Biomedical understandings adhere to narrow and reductive definitions of health, locating the causes or risk factors for illness within the individual body, emphasising personal responsibility for health, and downplaying attention to the social or environmental causes of illness (Warwick-Booth, 2012). The medical profession's close ties to the production of scientific knowledge and technological development has reinforced the expert and unique position of medical practitioners in interpreting symptoms, producing a diagnosis and specifying a treatment plan. In keeping with this discourse, Traveller Community members often presented illness as latent and only detected through medical screening. In doing

so, participants sometimes positioned themselves as unable to judge their own health status definitively, instead placing this firmly in the realm of medical expertise:

Lucy: if you're not going and like talking to professionals yeah you might think your lifestyles healthy but if they examine you no you're not you're unhealthy

Here Lucy suggests limits to one's own evaluation of health status, which must instead be confirmed by 'professionals'. This is despite Lucy's presentation of herself as very informed about health throughout her narrative. This tendency was also apparent at the end of the interview, when Lucy appeared concerned that other opinions generated through the research may contrast with her own assessment of what makes her healthy:

Lucy: probably when you asked all the others they'll have different opinions than mine it'll all be different they'll probably think that I might not even actually be healthy but I have actually been and they've told me I seem to be alright

Here, Lucy uses medical judgement to provide external validation of her own assessment of her health when she says: 'I have actually been and they've told me I seem to be alright'. Others also referenced the potential for illness to be hidden from view and emphasised the importance of receiving physical examination and tests which could look beneath the surface of the body to reveal any hidden health complications. Indeed, a lack of examination or follow up investigation were often presented as a source of dissatisfaction where Traveller Community members recounted negative experiences of accessing health services:

Brigid: I said 'doctor how do you know what's wrong with him if you're only writing down you have to check him' 'Oh I can see' I said 'you can see through his body?' he just looked at me and I just thought I won't be able to argue with him because I don't think you should be a doctor if you're not going to look at a person proper do you?

Brigid's question 'you can see through his body?' explicitly acknowledges the limitations of tests that look superficially at bodily appearance. There is some challenge of the professional in the form of Brigid's direct questioning of the doctor about a lack of examination. This is also evident in her comment of 'I don't think you should be a doctor if you're not going to look at a person proper', which questions the doctor's motivations and aptitude for their job and positions them as negligent. Yet, Brigid also places herself in a position of disempowerment relative to the Doctor, where she suggests she 'won't be able to argue with him'. Acceptance of

and challenge to medical expertise appear to be entwined here. It is not the need for medical intervention that is being resisted, rather, the Doctor is challenged for not following what are deemed to be the appropriate medical procedures. What is demonstrated here is therefore not a wholesale rejection of medical treatment or support, but rather a criticism of individual agents of the medical system for inequality in the application of medical care and services. Jane used similar story elements to those of Brigid when stressing the importance of being examined and tested by medical practitioners, perhaps unsurprisingly given that these participants are related:

Jane: I can go to my doctor now and say right I've got a pain there they won't examine you just 'scription you a number of times I have like spots on my head and I went to the doctor and I said doctor I went in and I went doctor I've got a spot on me head he never examined me never looked did I have them just wrote me a prescription for it sure couldn't a that been anything how does he know what it was well they do that every time

Jane's statement of 'sure couldn't a that been anything' also raises a concern about serious illness going undetected because of a lack of thorough examination. Both Brigid and Jane question the ability or motives of practitioners for what they deem to be an unsatisfactory level of medical investigation. Charlotte also indicated a concern that illnesses requiring urgent treatment were not being addressed quickly enough due to long waiting times for GP appointments.

Many Traveller Community members articulated a desire for greater biomedical surveillance and screening, not only to investigate health complaints, but also as a pre-emptive assessment of health. Two Traveller participants indicated a desire to be tested for Alzheimer's due to family members having the disease, and a concern that they may therefore be more susceptible themselves. Patricia similarly reported an intention to ask for tests of her kidneys:

Patricia: I went with the same pain an he said it was a kidney infection and give me the medication and it still didn't work but...so I'm gonna persist see if it is owt...I'm gonna ask is there any tests you can do to see if its anything to do with me kidneys for me or whatever

Brigid also highlighted a need for more health checks in general:

Brigid: I went the other day like for a body scan thing for me kidneys they said me kidneys is fine me liver is fine everything's fine so I hope next (forty years I've got like this I'd be happy)...but with like health visitors should come out more I think to check

you and like you should get your do you ever see they call em they should check you more for like kidneys and things like that I think do you
Researcher: like an MOT thing
B: yeah I think they should do that and then I do think like the nurses should come out and check the children and check you're alright and some poor people can't get into doctors sometimes it takes you two weeks to get an appointment

Within Catherine's account, this need for greater health surveillance and screening was also extended to cover behaviour. She described a need for monitoring of dangerous driving on the Traveller Community site for instance, and here described her concerns around the level of health checks her child had received:

Catherine: it's like my baby's four month old I've only ever seen a midwife once how do they know that that child's not getting neglected that child's not getting abused come on at the end of the day they don't know

Both Catherine and Jane suggested that there was a need for expansion in the groups targeted for cervical cancer screening or the HPV vaccine, as seen for example in the following excerpt:

Jane: see that's another thing now about Travellers well also is we could have we don't get the medical help that we need we couldn't little girls who's fifteen sixteen gets married right yeah they have to wait til thirty five and forty thirty or its over twenty five to find out they've got that cervical cancer now once they get married automatic it should be put for teenage married woman to go in and get that smear test I don't believe it should be over twenty five because these girls is getting married at sixteen and having kids maybe half that there were if they got checked for when they first got married and had a child then they could () that on a part of their life maybe have it for five year and die then d'you know what I mean () I think it's ridiculous how they treat people for that cervical cancer for erm you're not allowed to get smear tests til you're over twenty five or something because obviously what do they expect these young by the time they've got to twenty five they could be dead cause it's spread and killed them do you know what I mean

The above quote articulates a demand for cancer screening to be available to wider sections of the population and resonates with Traveller Community participants' requests for access to tests for Alzheimer's which have not yet been developed. Differences are therefore evident between public health approaches to assessing risk or rationalising the availability of screening, and those found in Traveller Community narratives. Arguments for broadening access to screening or immunisation in Traveller Community accounts were based on the identification of a gap in available services and couched in terms of equity in access to services and

treatment across the population. As before however, Traveller Community members did draw in an element of biomedical assessment of risk. This is seen in the Traveller Community suggestions that the prevalence of people within a family with dementia might place individuals at an increased risk of developing the disease. Similarly, in the extract above, Jane suggests that a tendency for Traveller Community women to marry earlier may mean they are at greater risk of cervical cancer and therefore need earlier screening. Yet, these arguments differ from justifications underpinning the allocation of public health measures such as screening, which are based on risk-benefit calculations and scientific evidence. In the case of cervical screening, this is not routinely offered to women under 25 due to difficulty in detecting abnormal cells which will go on to develop into cancer among this age group. This therefore suggests some gaps in explanation about which tests are available and why tests are only offered to certain sections of the population.

It is also important to acknowledge that not all Traveller Community members wanted greater access to screening however, and Kelly described how she attended the GP reactively, in response to health complaints. This fits with her specific presentation of self as generally unconcerned in relation protecting her health. Nevertheless, for the most part, the above narratives illustrate that Traveller Communities, were open to, and in fact wanted greater medical scrutiny of their bodies.

Biomedical discourses were also reflected in the use of medical terminology by Gypsies and Travellers, and emphasis on receiving the opinions of specialist health professionals:

Patricia: he'd been diag- manic depressant at the time but I think they say bipolar now but he was in hospital in and out and things I mean he wasn't just diagnosed by a doctor he was in hospital by the psychiatr- proper diag- you know what I mean

Here, Patricia demonstrates her awareness of changes in the medical labels used to refer to bipolar disorder. She also stresses that the community member she is referring to had not simply been diagnosed by a doctor, but had received a 'proper' diagnosis from a psychiatrist, in hospital, with biomedical expertise therefore used here to validate illness claims. There were instances of Traveller Community members mispronouncing or having difficulty remembering the names of diseases, as well using 'lay' terminology. As has been noted in previous research (Treise and

Shepherd, 2006), Traveller Communities sometimes used less direct phrases to refer to mental health issues including 'bad with me nerves', 'baby blues', and seeing 'imaginary friends'. There was also some suggestion that the word 'mental' has negative connotations due to its associations with madness. However, there were also numerous examples of Traveller Community members using more medicalised terminology such as 'mental health', 'depression', 'postnatal depression', 'manic depressant', 'bipolar', and 'anxiety' instead of, or in addition to 'lay' terms. Catherine used both 'baby-blues' and 'post-natal depression' for instance. Charlotte referred to the need for 'self-care' and 'self-management', terms often employed in medical and public health discourse. She also described GP practices as 'sign posters' to other services and referenced recent changes in health and social care systems. This demonstrates that, as has been demonstrated for other sections of the population (McClellan and Shaw, 2005), Traveller Community members had incorporated aspects of biomedical and 'health professional' discourse into their talk about health and illness.

6.2.2 Low Life expectancy

Many Traveller Community members involved in the study also drew on epidemiological evidence on their lower life-expectancy and poorer health outcomes. Catherine explicitly referenced research evidence on the lower life expectancy of Travellers:

Catherine: [community member] done her research before she died of cancer and er it was you die before 50 in Travelling in Travelling Community you die before 50

Eleanor on the other hand suggested that this was a narrative that she'd heard in conversation, highlighting its well-rehearsed nature:

Eleanor: I know it's sixty for Travellers I know that because I've heard people talk about it a good few times so it's their lifespan is sixty but then settled people obv- obviously sixty eighty I'd say probably twenty year on to that

The lower life expectancy of Travellers was also acknowledged by Brigid and Kelly. While Patricia and Jane didn't mention life expectancy specifically, Patricia referenced the 'bad health' of Travellers, while Jane suggested that 'we [Travellers] die with a lot of things like cancer'. Sofia and Lucy did not discuss the lower life expectancy or poorer health of Travellers as a group however. The recognition and use of discourses on lower life expectancy by most Traveller Community

participants contrasts with previous research in which Gypsies and Travellers expressed surprise that their health compared so poorly with that of other groups (Van Cleemput *et al.*, 2007). This is perhaps reflective of increasing attention to, and politicisation of the health inequalities experienced by Traveller Communities since the publication of this seminal work, as well as the influence of the Traveller representative organisation in the area studied.

6.2.3 Embodied and experiential knowledge

In addition to the use of biomedical discourses and those on lower life expectancy, Traveller Community members often cited the role of their own embodied and experiential knowledge in judging health and the pursuit of treatment options. This reflects a discourse on the expertise of 'patients' and the empowerment of individuals in decisions about their health and care:

Brigid: cause you know the difference in your own body like your body felt different now you've tired all the time...so you notice the difference in your own body from health to another

Catherine: when you're up you're up and when you're down you're down you know when you're not feeling well and when you are feeling well

The role of experiential knowledge is also apparent in Jane's commentary on the support available for those with mental health difficulties:

Jane: when I go to the doctor and they give is () how is tablets going to help like i- give you tablets how's that going to help they've got to offer somebody to sit down and talk to somebody that's suffered with them problems to know like [community member] suffered from mental health like proper mental nerves bad for years and she now she knows how to control it herself do you know what I mean like could probably speak could properly do a story and tell people how to help their self do you know what I mean

In asking 'how is tablets going to help', Jane explicitly questions the effectiveness of medical intervention and instead positions community members with experience of mental health difficulties as better placed to offer advice on how to manage these issues. This recommendation is, again, in keeping with the rise of patient involvement discourses which have sought to provide a greater role for 'lay' community members in the provision of health care and advice through roles such as health trainers, expert patients, patient advocates and care navigators. Charlotte describes drawing on medical advice and services selectively and judiciously, in combination with responsiveness to her own body when making decisions about the

uptake of treatment in relation to the management of her chronic condition:

Charlotte: I've got to be really careful cause I don't want to put any wei- I'm trying to lose weight but it doesn't move and like over the winter I had three lots of steroids so they stop you losing weight and they put you some on and even though you're not eating any different or exercising any more or less you still and it just doesn't come back down well I've I've I've managed to get ten pounds off (laughs) yeah but the last steroid I had was in January I think so its took from then to so its 6 half of the year to try and just get ten pound back off and me arthritis isn't better and I know when I go that's partly what put me off going to the doctors because they'll want to give me them which yes it will make me arthritis better for a while but it'll put more weight on and the more weight I have the more pressure then is on me joints so that's erm it's a vicious cycle that I've got no way out of really

Connected with statements of embodied knowledge, and in contrast with biomedical discourses, Traveller Community members sometimes presented health or a lack of health as something that was apparent to a medically untrained eye, through the observation of the body. Suggestions that illness is signified by physical appearance (such as turning a different colour, losing hair, or having black circles under your eyes) resonate with earlier practitioner statements about health being written upon the bodies of community members. Indeed, the body was sometimes described as both as a surface on which health is written and read by others, as well as one that can be worked on by oneself to present health identities to others:

Charlotte: so it's just make yourself look OK so other people cause if people keep asking you if you're alright you want to say no and then you're not but if you if you look OK nobody asks and you're like it's a circle you kind of y-fake it til you make it that's what it's called (laughs)

Charlotte demonstrates the interaction between the self, others and the body. Admitting to others that you're not OK is presented as reinforcing this identity presentation in one's own mind. In this statement the performative aspect of health identities as well as the ways that these are shaped through social relationships becomes clear. Outwardly presenting one's appearance in a way which signifies that you are OK is therefore a way of avoiding this attention and having to admit poor health status to oneself and others. These suggestions about the visibility of illness contrast with the above emphasis on medical tests that could look beneath the surface of the body. As the above discussions demonstrate, Traveller Community members used biomedical discourses in conjunction with embodied knowledge and expertise when defining their health status. Nevertheless, there was a strong emphasis in participants' accounts on the role of biomedical systems in detecting

illness and providing assurance of health status. The ways in which the above discourses played out in the positioning of characters in Traveller Community stories about health will now be explored in more detail.

6.3 The positioning of self in relation to others

Taken together, the above discourses had two main implications for the identities of Traveller Community members. The first was the need to account for one's position, by definition of belonging to a group with such poor health outcomes. The second related to the ways that an absence of screening led to uncertainty over one's health status and therefore intensified concerns that health issues were not being attended to appropriately. These will now be discussed in turn.

6.3.1 Poor health and its problem for identity

In a society in which health, and the pursuit of health is treated as a moral imperative (Petersen and Lupton, 1996), belonging to a group who is described as having poor health status may amplify the potential for negative judgement and this appeared to create a key identity tension for participants. See for example the following extract from Kelly's account:

Researcher: Is there anything that you think that's good about being a Traveller for health?
Kelly: I dunno cause Travellers like the lowest what is it
R: like life expectancy?
K: life expectancy it's like they all die young don't they I dunno obviously I wouldn't change to be anything else I dunno Travellers isn't very healthy obviously but

Kelly's acknowledgement of the lower life expectancy of Gypsies and Travellers is immediately followed by the statement 'obviously I wouldn't change to be anything else', which appears to affirm and express pride in one's identity as a Traveller Community member. The use of 'but' following the statement that Travellers aren't healthy seems to encapsulate this moment of challenge and ambivalence with respect to her position. A more explicit reference to this tension is found in Catherine's account:

Catherine: you die before 50 in Travelling in Travelling Community you die before 50 because the health is that poor it is unrecognisable not not because of we want to be like that it's because we lack a doctors we lack a

dentists we can't get them because as soon as we give our address or our postcode that is it that's it they don't want to know us

Here Catherine clearly attempts to counteract the risk of blame or judgement associated with belonging to a group with poor health when she suggests this is 'not because of we want to be like that', and instead points to structural factors influencing the health of Travellers such as the discrimination which restricts access health services. Following a description of the difficulty gaining access to GPs, and before moving on to discuss a lack of employment opportunities available to Traveller Communities, Catherine similarly describes a tension between the freedom to express her identity as a Traveller, and the avoidance of discrimination:

Catherine: its hard trust me when you're a Traveller and yeah I'd never deny what I am because I'm happy for what I am I'll tell you the truth

This chimes with the following quote from Patricia's narrative in which she responds to a question about whether Traveller Community members on site discuss health with each other:

Patricia: yeah sometimes yeah about what they've got and what they 'ant and you know cause no a lot nine out of ten of them now goes they're not backward they know what d'ya know what I mean and they go to doctors and things like that where years ago we wouldn't of done but they do now yeah they do talk to each other or what have you or do you know where I should go and this that y'know what I mean

Patricia's assertion that Gypsies and Travellers are not 'backward' points to the potentially stigmatising effect of discourses that Travellers do not go to the doctors. The accounts of Kelly, Catherine and Patricia therefore illustrate the potential for identity as a Gypsy or Traveller to be spoiled by discourses on the low life expectancy, poor health and lower health service attendance of these groups. This tension was one that required management by participants through the positioning of self and others when offering explanations for the poorer health of Traveller Communities. The ways that Gypsies and Travellers managed this identity tension through the position of self in relation to others when offering explanations for the poorer health of Traveller Communities will now be explored.

As seen in the quote by Catherine above, one of the ways that the negative status associated with poor health could be countered was by stressing the role of structural conditions such as discrimination and inequity in access to resources and services required for health. This was also apparent in Jane's account in which the

lower life expectancy of Travellers is explained by not having access to full health checks and receiving appropriate treatment:

Jane: you see that's why we die with a lot of things like cancer and things like that because we won't get no medical help

The following exchange between Catherine and Bernadette similarly positions inequality in access to services as underpinning the different health outcomes of Traveller Communities, presenting an extreme charge about the withholding of treatment:

Catherine: I think in the the ways like fr- cancer things like that there I think there should be a be- another way to cure it because at the end of the day there's all different kinds of things to cure different things but I think there should be something to cure that [alright they do
Bernadette: I think they are] they are a cure for cancer but they're not giving it to the poor they're only giving it to the rich because I'm not being ignorant what I'm going to say where do you ever hear tell of a well to do person dying with cancer
C: No no
B: Look how many in the royal family
C: In the Travelling Co- In the Travelling Community in the Travelling Community
B: like wildfire
C: it's like wildfire in it

The suggestion that there should be something to cure cancer in the above extract is interesting in seeming to demonstrate overconfidence in the ability of the health services to provide this and downplaying the challenging and on-going nature of this task. The view that there is in fact a cure for cancer that is withheld from the poorer sections of society presents a picture which raises fundamental questions about the equity of the health system, one that is underpinned by an unwillingness to address cancer among poorer or marginalised sections of the population, rather than a scientific inability to do so. This extract highlights the ways that identity as a Traveller is interwoven with other identity positions, with the withholding of treatment presented through a lens of poverty in addition to status as a Traveller Community member.

Others referenced the hardship of Traveller Community lifestyles, particularly in relation to accommodation, when explaining poorer health outcomes. Here too we see the connection between explanations for health status and identity. Why a

Traveller Community lifestyle is adhered to despite the difficulties this creates for health appeared to be treated as something that must also be accounted for by participants:

Patricia: they build you a shed with a kitchen in and think they've give you a luxury and you have-its somewhere to cook but you still live in your own caravan and everything I know you've probably got a option of a house but ask them if they'd live in where they'd want to put you I mean I have seen photos of where the council have sent Travelling women on their own one parent families genuine one parent families with children to houses and I've seen the photos...you wouldn't put a dog in em so I think it's a way of life what causes a lot of bad health with Travellers cause in a trailer you put your fire on you're warm when you go to bed you turn em off its freezing all night until you get up the next morning...I mean a lot of em is more used to the cold than they are the heat

Brigid: me first ever [episode of illness] that's what ever caused it all being on roadside but some people don't understand how hard it is d'you know what I mean I know it's our choice I'm not saying that people say 'ah it's your own choice' but if it's your choice know what I mean in a house I couldn't live because I'm used to having people around me it is our choice but it isn't...it's a choice for the council to gives you somewhere to go know what I mean that's why it took me it took me five six years maybe more to get on [name of site] and I had to squat to get on there (laughs) had a hard fight I fought them I court for it didn't I...but took me how all that times that's what I mean that's why I never really noticed my health went downhill about that time that was when I was thirty two... but Travellers don't live a big age they don't I think that's the lifestyle they live like towing trailers up and down cause I'm not being rude people think you get everything free being a Traveller but you don't cause you get up in the morning and you gotta move then you gotta move cans of water then you gotta go bottles of gas then you've got generators it's not easy like what like now don't get me wrong [name of site] is comfort you can't beat it but I wouldn't give me Travelling life I love it I love it too much like I if it was up to me I wouldn't be here I'd be on the roadside today but that's life as they say but your health goes very bad very very very bad when you're a road side Traveller...God help us they say Travellers had they had a hard old life but it's what can you do its their way of life innit healthy but I think with like a a me- as me Mam said to me the other day you can see the difference why some and I'm not being rude people in houses lives longer than Travellers because they've good lifestyle like me Mammy now she's got her plot made into a house...they've put a extension bedroom everything on it so she said she can understand how people can live now they're much comforts even that...cause don't get me wrong its lovely them trailers sometimes you think oh its lovely to pull out but it gets too hard

In the excerpts above, both participants introduce characters into their narrative beyond the interview (council workers and generalised others) and position these characters as lacking understanding of the hardship of living conditions for Traveller Communities. In Patricia's account, council workers are presented as overestimating

the impact of improvements to the site. In the second, people generally are viewed as not understanding how hard Travellers' lives are, and a misconception is cited that Travellers 'get everything free'. Both narratives, albeit in different ways, appear to respond to real or imagined arguments about the choice of Travellers over their lifestyle, and which may position Gypsies and Travellers as responsible, in some part, for their poorer health. Patricia's response emphasises the lack of real choice available, given the poor-quality housing that is offered as an alternative to living on site. Brigid responds by celebrating the importance of the Travelling life ('I wouldn't give me Travelling life I love it I love it too much') and by emphasising the lack of choice over the ethnicity into which you are born ('they say Travellers had they had a hard old life but it's what can you do its their way of life innit'). She too highlights the lack of support from the council for this aspect of Traveller culture when she sets her own choice against the choice of the council to 'give you somewhere to go', therefore balancing out responsibility for the living conditions of Travellers that give rise to poorer health. Although talking more personally and not about the lower life expectancy of Travellers overall, Charlotte similarly described the challenges of living life on roadside as a child due to a lack of medical help and access to amenities. At one point she describes the social isolation she experienced when living in a house, and her decision to move back to roadside to receive support from people within her own community:

Charlotte: I couldn't live in the house I couldn't cope...so we had to...leave the house erm move into a trailer onto roadside camp because there was no support in the house for me there was no I'd obviously me children help and things like that but you feel like you're putting upon them and the medical care wasn't great it really wasn't erm and so I needed some people from my own community just to even just to look out and...to feedback some positivity...to make you feel like there's some point

Following acknowledgement of the lower life expectancy of Traveller Communities, Eleanor described aspects of Traveller lifestyle that were healthy. This included eating boiled stews, as well as the benefits of living on roadside such as being out in the fresh air, and away from central heating and electricity which she positioned as harmful to health and affecting mood. However, Eleanor too, highlighted the influence of transient compared to sedentary lifestyles on the health of Traveller Communities:

Eleanor: settled people they do they have a routine where they'll exercise once a week they'll go to the gym once a week see not many Travelling people do that mainly if it is anyone in the family it'll be the men that probably

goes training but mainly the women don't really train don't do much exercise that was back then but now nowadays like I said the Travelling life is changing and everyone is different and become more settled and they've got yards and they've got houses and the Travellers is a lot more settled these days that what they used to be so when you get settled you you get familiar with things around you and then you start doing other different things whereas you wouldn't do it when you were Travelling cause your times took up cooking and cleaning and looking after the kids and the kids is with you 24 hours a day 24 hours a day whereas when you're in a house your children's not with you your children 's in school you've got your time free you can do what you want so you probably tend to go to the gym whate- do whatever you wanna do

Settled life is described as enabling a 'routine' which facilitates healthy lifestyles. The shift in Traveller lifestyles to become more settled is presented as enabling greater familiarity with local facilities, and freedom to engage in activities to support health and wellbeing since children are in school. The above extract also demonstrates the web of influences and identity positions that intersect with living arrangements to influence health. The impact of a Travelling lifestyle is differently felt for men and women, with a transient lifestyle presented as less restrictive of men engaging in exercise, and which may be attributable to division in domestic and childrearing responsibilities. Elsewhere in her interview, Eleanor also described the ways that Travelling impacted on education around health.

Narratives about the protection of children within Traveller Communities were one further strategy through which participants could counteract potential judgement and engage in the restor(y)ing of more positive health identities. This was most explicit in Catherine's account:

Catherine: the best thing about Travellers you would never ever ever see a child in care you would never see a child getting abused you would never see a child getting neglect you would never ever see nothing like that never see nothing like that but in a different community it's a completely different () thing

This tendency is also apparent in the account of Brigid however, who responded to a health practitioner's prejudice by saying 'are my kids dirty? Is my kids molested?', thereby challenging discrimination and the associated shame with evidence that her children are well looked after and healthy. Given that the importance of children is stressed within Gypsy and Traveller accounts, stories about risks to child health among these groups are likely to have a particularly damaging effect on identity for community members.

Discourses on the lower life expectancy of Traveller Communities also influenced the identities that could be claimed by Gypsies and Travellers by limiting expectations for future health. A difference was apparent in how the discourse on the lower life expectancy of Traveller Communities was employed by Gypsies and Travellers themselves, and by public health professionals. Life expectancy is used within public health as measure applied across populations, taking into consideration mortality rates across the life-course. This is reflected in the definition of life expectancy by Hazel, a public health practitioner involved in the study:

Hazel: the whole thing about life expectancy it's not the average age it's if everybody when they were born might be expected to live to say 70 and in this group of people a third of them die before they're twenty then the life expectancy becomes 50 you know so it's not, the ones that make it to 50 will almost certainly live on and may live on just as long as the others but fewer of them will ever even get there

By contrast, we see in the account of the following participant how discourses on lower life expectancy were read much more personally by Traveller Community members, with this in turn impacting on expectations and hopes expressed for future health:

Bridget: like they say a life age of Travellers is only 50 anyway some some might live not even past that I hope I live I hope I live past that time point I hope I live past fifty odd to see me children grow up and get married and have their own family then I don't care

This is also reflected in Catherine's earlier suggestion that 'in Travelling Community you die before 50' and Kelly's suggestion that 'they all die young'. This demonstrates how public health narratives may be transformed when taken up and used by 'lay' sections of the population. As Novas and Rose (2000) remark with respect to genetic tests; 'information on risk will have consequences for individuals who receive it.' As Gypsies and Travellers in the study by Van Cleemput et al. (2007) were not aware of how poorly their health compared to other groups, it is unlikely that these discourses had contributed to articulations of low expectations for health found in this earlier study. However, within the current research, this formal discourse on the life expectancy of Traveller Communities was often accompanied by anecdotal reports of others in the community dying at a young age. While the discourse on Traveller Community life expectancy does not appear to be alone in impacting on the health expectations and identities that Traveller Community members can express, the narratives of those involved in this research demonstrate

that this is likely to have some role in closing down other plotlines and entrenching low expectations for health among Gypsies and Travellers.

6.3.2 Being fobbed-off and fighting for rights

Most participants highlighted how their position as Traveller Community members meant that they often did not receive the medical help they needed. While the degree to which accounts were politicised varied across participants, nearly all participants (except for only Eleanor and Sophia) relayed stories of themselves or others in the community having trouble getting access to services or being treated differently by health service staff because of their ethnicity. Patricia suggested that GPs 'don't want them [Travellers] in half of them' meaning that Travellers were forced to register with practices further from home. Kelly also described the discrimination when attempting to register with GP practices:

Kelly: we've been refused millions of times as soon as like they hear you talk they just put down the phone
Researcher: really? Do you think when they hear you talk they must think they think you're a Traveller straight away and just put down the phone
K:

Discussing this discrimination, Kelly later suggests that 'before obviously it used to bother us but now it don't bother us cause we're just used to it so now we just don't even let it upset us'. This conveys resignation over the inaccessibility of services and the normalisation of these experiences. In addition to difficulty getting registered, Brigid described the shame she experiences when attending health services:

Brigid: some doctors you think oh they looks like you've 90 heads even in hospital before I went to the [hospital] and they look at you like like up and down you think shameful because you're a Traveller

She described people looking at her like 'they think you're dirty' and the differential attitudes of staff to Traveller Communities, with the result that she feels 'out of place', and 'can't wait to get out of' the GP surgery. Charlotte also described being made to feel different when registering with a GP practice:

Charlotte: when I went to register it was well yeah we take your kind on erm and so you always felt like you wasn't welcome there you di- me care really suffered

Stories of health information or treatment being withheld or being 'fobbed off' by health practitioners were common in Traveller Community accounts. Charlotte felt that during her childhood her family 'slipped through the net' of care when they were living on roadside. She describes receiving little follow up after a serious accident, and experiencing recurring tonsillitis that was left unresolved due to practitioner negligence:

Charlotte: I had it [tonsillitis] all the tim- like just about all the time and the GPs then in them days they just I think that they thought we was dirty it was because I was we was a Gypsy and it was 'oh it's just a stomach bug' because I'd go with a belly ache...we was with the same GP for years and years and he di- he just kept saying no it's it's another stomach problem

Jane similarly described receiving a lack of support with longstanding mental health issues, with her position as a Traveller presented as exacerbating this inattentiveness:

Jane: I've suffered yeah about 8 about 8 years now an and its getting no better and the doctors don't give you no help and all that like that you get no help especially when you're a Traveller you get the best of nothing

Catherine summarised the withholding of information about health conditions as follows:

Catherine: what I'd like for them to turn around and tell us our problems straight away instead of waiting seven or eight month down the line and what good is it then to us when we're better

She imparted her frustration about the lack of health information received by Travellers, both in general and in relation to the provision of full explanations for health problems and symptoms. Catherine expressed her frustration that she hadn't received explanations for numerous miscarriages she'd experienced. She articulated a need for greater explanation over the illnesses that MMR vaccines protect against; greater care in describing the HPV vaccine to young Traveller women; and more in-depth information about post-natal depression and available support:

Catherine: they can pass me a box of tablets or take one of these a day that's the way they tell you but if that was anyone else from out of our community they'd have to sit down and explain every single thing (Catherine)

Such poor communication was interpreted as stemming from an assumption that Travellers were unable to engage with information offered:

Catherine: people might think they're thick because they can't read and write but we need () people with these posh words we don't know them we need someone to sit down to us and talk proper to us say well look this why you've had lost this baby and that's why you've lost that and this this and that but they haven't they haven't they just think 'ah Travellers put it in the bin they're alright'

Some participants described using strategies to test out whether services were discriminating against Travellers. For instance, Bernadette described how after being refused registration to a GP practice, she gave the address of a house adjacent to the Traveller site to demonstrate that she should be in the GP boundary. Recognition of, and possibilities for subverting discrimination often hinged on one's visibility as a Gypsy or Traveller. Participants described how markers of belonging to a Traveller Community (including how you talk, an address known to be a Traveller site, or physical appearance) often prompted a change in attitude or response among staff.

In the context of combined discourses on the need for biomedical intervention to detect illness, and the poorer health of Traveller Communities, the denial of health screening, tests, examination and treatment intensified community members' concerns that illness was going undiagnosed and treated:

Jane: this is what we get prescription with whatever fobbed off not caring where one time really and truly we could be really sick and they'll tell us no

Jane's statement 'this is what we get' appears to explain this treatment by reference to her position as a Traveller Community member. This concern that Traveller Community members have illnesses that are untreated was communicated often in Jane's account. Catherine similarly suggested that the symptoms she reported were not taken seriously by health practitioners and relayed her apprehension that herself or others in the community may have health issues that are unrecognised. Catherine describes how a family member died of cancer after having initially being diagnosed with pneumonia and having experienced few symptoms:

Catherine: my sister had a cough and didn't know what the cough was and boom two years down the line well not even two years within six months she was dead and buried come on because she had a cough and she had lung cancer at the end of the day its told they told we they told we that its pneumonia now from pneumonia from cancer was completely different kind of thing and the only things she had was a cough and a pain in the back

After witnessing the death of this family member, Catherine describes her anxiety that she may experience a similar health complaint, describing how when she got a chest infection it 'kept on playing on me mind about cancer cancer cancer cancer'. She describes her attempts to obtain health tests to gain reassurance about her state of health. The doctor agreed to undertake blood tests and a chest x-ray in recognition of her recent family experience and to provide peace of mind. This initially counteracts Catherine's worry that she had an underlying physical health condition: 'I felt better in meself because they'd done that for me I thought yeah they're helping me'. However, she goes on to describe how the situation continued due to a failure to address underlying mental health issues giving rise to anxiety over her physical health. Catherine's account clearly illustrates the ways that access (or lack of access) to biomedical processes of diagnosis, combined with awareness of the risks to health in Traveller Communities (here signified by the early death of a community member), exacerbates concerns about poor health, which in turn manifests in further demand for screening or testing of health:

Catherine: he says to me 'they is nothing wrong with you' I said 'I know there's nothing wrong with me cause I know that I'm fit and well but why am I feeling like this please tell me why I am feeling like this', 'well I don't know' I says 'but you're a doctor you should be sitting me down and taking bloods out of me and doing this and doing that me iron' I said 'and me haemoglobin' I said 'just take anything what you can take off me to see why am I feeling like this' nothing no we've done what we can do

Indeed, other participants also communicated concerns that they could have serious illnesses which may not be acted upon quickly enough without access to health services:

Charlotte: I spent two weeks trying to get her a doctor's appointment I don't know what's wrong with her I don't know how it I don't know how urgent it is, it might be routine...it could be anything I don't know what could be wrong with her but they didn't know that and I didn't and it took e- it took actually four weeks to get in

Jane: like we could have toothache we could have pain in our head we could have belly ache we could have anything water infection how do we know people die every other day...when you ring up you doctor er 'ah sorry no appointments today'

Relatedly, participants often emphasised the potential seriousness of episodes of illness, again supporting the importance of getting access to services urgently:

Brigid: I even have a friend she's a diabetic doctor gave her insulin never told her what she had to eat she said she had to go back to him she said doctor

am I allowed to eat 'oh I forgot to tell you you're not allowed to have certain foods with it but that was stupid cause she could have killed herself couldn't she

Catherine: you could be dying on that floor, 'no' I went to a doctors before a clinic and me I was pouring with blood me legs was pouring with blood they wouldn't even put a bandage on would not even put a bandage on and the blood was trailing everywhere no wouldn't put a bandage on me foot told me to go to A&E I could of bled to death

This pattern of telling about being denied access to health services and the potential for dire circumstances as a result is chosen as an alternative to other possible, more uncertain, or less tragic results. This serves as a storytelling function which helps to dramatise events and emphasise a position of Traveller Communities as vulnerable and neglected. Put together with earlier discussion of the importance of health in Traveller Community narratives, a binary is set up; health is 'everything', yet Travellers 'get nothing'. These narratives have potential to entrench a position of opposition between Travellers and health services or practitioners; in the face of concern that health issues are undetected or diagnosed, unyielding service responses prompt narratives which emphasise the extreme consequences of this behaviour, in turn feeding anxieties that health issues are going undetected.

The difficulty gaining access to health services and fear that health issues were going undetected fed into narratives of Traveller Community as needing to fight for their health care entitlements. When challenging discrimination and negotiating access to treatments, Traveller Community members often drew on discourses above around their own embodied expertise. Traveller Community members were not, therefore, powerless within health encounters and the data was replete with stories about participants having fought to attain their rights. These stories often followed similar plots; of Traveller Community members triumphing over medical practitioners to get access to required treatments. See for example the following excerpt from Brigid's narrative:

Brigid: I said doctor you've been ignorant since I come in here I know pain I'm not stupid well I think he was trying to say I was making it up I said doctor 'I know pain' and when it all come out I had a a kidney infection and things like that I said yo- 'oh we- we- well we we we're very sorry' I said 'it's no good being sorry about it' I says

Here Brigid uses her experience and interpretation of pain to counter the Doctor's presumed interpretation that she was 'making it up' and to justify pushing to receive

diagnosis and treatment. The story ends with the acknowledgement that she did in fact have a kidney infection, and with the doctor apologising for the error. Similar trends are apparent in the following excerpt from Patricia's narrative in relation to an ongoing health complaint:

Patricia: well lately on Friday when I went to the doctors I've I'm getting this pain and I've had it for a week again and I don't think this is what's frightening me I don't think it is anything to do with the arthritis what I've got because it's in me side and me back and it comes down me stomach I think it's something to do with me kidneys

Researcher: right

P: and I tried to 'ah no just take your pain killers it'll be from the arthritis just take your pain killers I'll give you ant-' I said 'I can't take anti-inflammatories' I said 'over me stomach' 'ah just take these ones they don't affect your stomach' 'right' I took they made me feel sick and ill so I won't take em 'well we're running out of options what to treat you wi-' I said 'well I can't help that' I said if I can't take em' erm so on Friday I have to do I've got an appointment with the nurse practitioner because it's a carers thing they send you an appointment out for a full check-up and I'm gonna really persist on Friday over this pain because I don't think it's anything to do with me arthritis at all a few month ago I went with the same pain an he said it was a kidney infection and give me the medication and it still didn't work but I don't think it is ow- I don't believe its owt to do with me arthritis cause it's a different pain what I'm getting and I've had it for a long for a few month and its it comes and goes constantly

R: and does the doctor think it's to do with the arthritis

P: yeah but I don't think it is because the last time I went with it I had no pains with the arthritis I didn't go over that he said it was a kidney infection and he give me antibiotics for it and it didn't even ease it or clear it up so I'm gonna persist see if it is owt I don't I mean I think its sommat to do with me kidneys or sommat

R: yeah yeah yeah so you're gonna go back and ask him about it and see what?

P: yes I'm gonna ask the- is there any tests you can do to see if its anything to do with me kidneys for me or whatever

R: yeah what do you think's making him stick with the arthritis idea

P: because the specialist told me when I went to the hospital when you get arthritis it's in your bones the one I've got and it does make your hands and that funny right now my hands don't look too bad but when they swell up me fingers look all crooked and it affects you it's your bones now I get a lot of pains in me legs with it when it comes in me knees and me ankles down at the bottom and he said it's the pain off them cause they get that inflamed it shoots up your legs and whatever and your hip and from your hip it can cause pains

around your stomach and round here the pains but I don't think this one is because the simple reasoning I haven't got the pain in me hip off the arthritis to be causing it d'ya know what I mean?

R: ahha ahha

P: so god knows

Patricia's story demonstrates how a combination of knowledge is drawn upon in producing explanations for her symptoms. She opens the story by describing her concern due to experiencing a pain which is dissimilar from her usual symptoms and which therefore seems unrelated to her arthritis and instead potentially connected to her kidneys. The statement 'I don't think it is anything to do with the arthritis', or similar, is repeated on a number of occasions throughout the above extract, suggesting that the demonstration of this fact is an important function of the story. The doctor is positioned as dismissive of Patricia's perspectives, reiterating that the pain likely results from her arthritis, and affording little concern to Patricia's own experiential knowledge about her body's reaction to anti-inflammatories. The doctor's reported statement that they are running out of treatment options conveys a hint of frustration and through this statement he positions himself as powerless to any further action, shifting the responsibility back onto and even directing a degree of blame at Patricia herself. This is reflected in Patricia's reaction which reiterates that this situation is beyond her control. Patricia's reference to her embodied expertise provides a means through which the explanation provided by the doctor can be challenged and access to care negotiated. Patricia combines her knowledge of the different types of pain she experiences with information gleaned by medical practitioners about how arthritis affects the body. She cites the fact practitioner had himself diagnosed this same pain as related to her kidneys on a previous occasion as well as the fact that the pain does not fit with an explanation of a specialist (who's opinion, in accordance with earlier statements might be afforded greater plausibility than the GP) on referred pain. The combination of this evidence appears to give this person the ammunition required to 'persist' in gaining access to tests that could determine other possible causes. However, the statement 'God knows' at the close of this narrative also conveys some limits to her own knowledge and to her hope that this issue will be resolved. While Jane's story displays some differences to that of Patricia, this too illustrates the ways that embodied knowledge was used when negotiating access to treatment:

Jane: I think the law should be changed for the laws is of medical help in that way when young children comes in I think they should give you the medical

proper medical help and for young children especially more kids out there at the minute you go in there even if your child's got a rash you don't know what it is my sister went down with a full blown it was meningitis no one'll tell me different full blown rash from head to toe an r- black and blue bu- rash yeah went to the [name of hospital] sees this doctor 'oh yes got to take bloods' 'what is is doctor?' 'don't know got to take bloods wait 48 hours' so I said 'you're not gonna give him no medication?' 'oh no I can't give him no m-' now he could have been dead er not give him no medication for forty eight hours so me sister she was crying 'alright love' she said so I said 'no love I says you'll get those antibiotics now' I said to him he says 'no no no no (y)' I said 'if you don't get the dose of antibiotics' I gets him up by the neck and shoved him against the wall I said 'you get the antibiotics now' I said 'cause in 48 hours this baby could be dead' I said 'oh' so he comes back over to me and he says 'I'm very very sorry me don't understand' he was like one of 'me not understand me very very sorry you right me should give baby antibiotics me not know sorry this could be meningi- this could be coccal meningitis' they never did know never did push to know exactly what was wrong with me sisters child but clearly it was meningitis but he was gonna wait 48 hours that child could have been dead

Jane's opening to the story serves to highlight its purpose in demonstrating the current inadequacies of medical support for Traveller Communities, and the law in protecting the health care rights of these groups. Indeed, Jane's account was highly politicised, with the majority of discussion about her health oriented to highlighting the inequalities experienced by Gypsies and Travellers. This is an extreme example of a direct and aggressive challenge to a medical professional. Yet, the story follows a similar plotline to those presented earlier; one of triumph over the GP who is either negligent or unskilled, with Jane's intervention presented as crucial in ensuring that treatment in a situation of life or death was received. That the GP is also reported to have apologised serves to support this claim. Jane oscillates during the narrative between a need for medical opinion and her own ability to diagnose the child's illness. The statements 'if your child's got a rash you don't know what it is' and that they 'never did push to know exactly what was wrong with me sisters child' convey the need for medical diagnosis. However, suggestions such as 'my sister went down with a full blown it was meningitis no one'll tell me different' and 'but clearly it was meningitis' position Jane as able to identify and counteract potential illnesses and the consequences. This again illustrates the ways that biomedical and experiential expertise sat alongside one another in Traveller Community members' accounts. Like in the account of Patricia, Jane describes the bodily signs of illness (a 'full blown rash') to demonstrate a need for treatment to the listener. The following, more general statement about the behaviour of Traveller Communities in health care encounters with which Jane closes her narrative, and the interview itself provides

insight into the moral of the story. Although Jane recognises her aggressive behaviour as problematic, the difficulty getting access to services and treatment, and the inability to have one's voice heard and attended to, gives rise to this behaviour:

Jane: when we go to the hospital we might be loud shout scream get barred off the doctors they ban us cause we are arguing to be heard that's all I have nothing else to say now

The following extract taken from Charlotte's interview follows an account of how an illness she experienced during childhood was overlooked because of discrimination by the GP. Charlotte's narrative exhibits some differences in the pattern of telling to those already presented, falling somewhere in between Jane's highly politicised account and the absence of any implication of discrimination in the specific instance reported by Patricia above:

Charlotte: my [family member] erm when her first baby was born who's the same age as [name of her own child] when she was first born she was born with erm whooping cough apparently babies can't be born with whooping cough I think it was whooping cough yeah I think and so she was born with it and so she ca- at by 6 days the baby was really poorly cause of she was born normally and so they got you get sent home the next day as you do with a new baby and there's nothing really wrong with her at that point erm and s- s- s- like she was coughing and the so at first it's well it might be something in the air is mucus clear and all that by six days I re- she was really seriously ill erm and me [family member] took her to the GP ah it's just basically you're a first time Mum and you're over reacting so he sent her away and she went back again oh I think she went on the fifth day then she went back the next day and she went look there's something seriously wrong with this baby and they're like no there isn't don't be silly and I don't know if she stopped breathing or something she ended up getting sent to [name of hospital] in [place name] and when she got there there was only ten percent she only had erm she had 90% she wasn't taking in 90% of the oxygen so she was only taking in ten percent of what she needed erm and that's when they found out she had I think it was whooping cough and so that then possibly they don't but that could of been a one off but and a and me [family member] was had made them aware that she'd been to somewhere where the peop- ...so she'd said well we I've been to somewhere and they had I think its whooping cough I do- it must be and so she's like it affects her lungs it affects and they said no couldn't be because me [family member] never had it and she's well we've had our injections our so maybe well it it shows you that you you do know your own baby and that you really do need to be persistent sometimes erm

Charlotte's story follows on from a discussion of discrimination based on ethnicity, implying that this too is a narrative about discrimination preventing access to services. Yet Charlotte's reflection that this instance 'could have been a one off'

does indicate some reticence to treat this as evidence of more widespread discrimination. This is in keeping with Charlotte's narrative overall in which references to discrimination are made infrequently and in which she often blames herself for not pushing hard enough to get access to services or for the deterioration of her health. However, like the other narratives reported, Charlotte's excerpt tells of an instance whereby a Traveller Community member has difficulty accessing the required treatment and entails a struggle with respect to who has authority to assess the state of the child's health. Charlotte posits that it is not necessarily the case that discrimination has lessened but rather that Mum's have become more 'persistent' in obtaining care for their children, with this providing the context for the telling of this more concrete story. Her suggestion here '*apparently* babies can't be born with whooping cough' again demonstrate that medical opinions are not received uncritically. The GP is presented as dismissive of the mother's assessment of the health of her child, instead characterising this as over-worrying due to her status as a first-time mother. The trajectory of the narrative is similar to those discussed above; serving to demonstrate an incorrect assessment by a medical practitioner and that things were in fact as the community member anticipated them to be. Yet, like Patricia, Charlotte does not step outside of biomedical discourses here entirely, with medical parameters in terms of the percentage of oxygen being cited to help demonstrate that there was a problem which had been missed. The moral of the story ('it shows you'), as before, serves to highlight the role of the mother's own experiential knowledge as a form of evidence which can be drawn upon in health interactions, and the need to persist in getting access to treatment.

The above examples have illustrated how introducing knowledge of one's own body or one's children's bodies appeared to assist Traveller Community members in re-balancing potentially unequal power relations within health care encounters. These illustrations vary in terms of the extent to which they suggest this re-balancing that was achieved, with Jane's example appearing to come close to a near reversal of power relations. There were also some examples of Traveller Community members challenging racism and discrimination more directly as seen in the following story relayed by Brigid:

Brigid: some doctors can be funny you know some nurses can be funny with being a Traveller before my o- my old my grandfather was in hospital the doctor was that ignorant me mammy said 'is he your patient?' 'yeah' he looked at him he he got his coat like this [demonstrates holding coat in a

pinch as if not to want to touch it] mammy said excuse me (mate) he's no disease that's a brand new coat' 'well I never said he had' Mammy said 'well you wouldn't pick another patient's coat up like that would you?' said he went with his two fingers like that Mammy said 'I I'm I'm a I'm a I I might be a Traveller but I'm not dirty' 'Oh no no I didn't mean that'

Likewise, Bernadette reports questioning a refusal to register her at a GP surgery as follows:

Bernadette: I says top and bottom of it I says you're racist I said I walked out and I never went back

However, some Traveller Community members described limits in the extent to which they were willing or able to challenge health staff and institutions. Brigid describes a reluctance to take action that would lead to personal repercussions for a health practitioner for example:

Brigid: Mammy reported him but he he was nearly struck off only for like for being prejudiced but it was alright then Mammy said leave him cause we wouldn't like to let him lose his job but you can't treat people like that know what I mean

Jane, Lucy and Brigid conveyed a lack of confidence that efforts to question discrimination would bring change, and therefore expressed disillusionment regarding these efforts:

Lucy: so obviously like they have done wrong but there's nothing you can do

Brigid: me Mam was gonna sue them and I said just let em on cause its not worth suing them but you can't fight win with people like that especially Travellers don't get no farther on know what I mean cause awful things often happen to you by police and doctors but you just let it go because you think you won't get no farther on

Others adopted strategies to subvert discrimination. For instance, Lucy described how her Grandmother was often sent home early from hospital when they found out she was a Gypsy. As a result, Lucy's Mother stopped extended family from visiting her in hospital in order to disguise her identity as a Traveller for fear that she too would receive the same treatment. While Gypsy and Traveller Community members showed resourcefulness in negotiating access to services, these efforts could come at a cost however, with Charlotte pointing to the fatigue which results from continually pushing to access care:

Charlotte: like it [deterioration in management of long-term condition] was both my fault as well cause I should have been more pushy but I'd been ill for so long I you kind of give up being pushy (laugh)

It is also important to highlight that negative experiences were not always interpreted through the lens of discrimination. For instance, when discussing reasons for a missed diagnosis of meningitis, Kelly suggested 'after all the hospitals is only human they're not god they are only normal people and they do try and do the best they can but I dunno'. In addition, most Gypsies and Travellers acknowledged diversity in the attitudes and practices of individual health professionals, applying the principle that there is 'good and bad' in every community to their experiences and judgements of health practitioners.

Overall, an inability to get access to health services, diagnosis and treatment, in conjunction with a discourse on the poor health of Travellers, together perpetuated a sense of one's health status as unknown and entrenched identities of Travellers as 'vulnerable' in relation to their health and 'in need' of health services. Indeed, this was reflected in the accounts of some community members who presented themselves as desperate for, but denied help by health providers and services:

Catherine: I was crying out for help but they wouldn't give me no help

Indeed, this representation of Traveller Communities is also apparent in Catherine's description of the few occasions that practitioners visit the Traveller organisation or site to provide health information:

Catherine: there's that many around the table we can't ask them questions what we want to ask because there's that many mouths going tell me this love tell me that love tell me this tell me that because there's that many people wants to know things because we're all like like we're saying we're all Travellers and we want to know these type of things what's happening then they haven't got time haven't got time to think never mind anything else

6.4 Interpersonal interaction

6.4.1 Researcher privilege

The position of Gypsies and Travellers as often unable to access required health services and therefore as particularly vulnerable in regard to their health was reflected in interpersonal interaction between myself and participants. Participants

differentiated their own experiences with services from those that I could expect personally as a member of the settled community:

Jane: we don't have a doctor to check us like you might get a full do you know an average person lives longer when they get a full health check

Catherine: But a doctors you know how you could ring a doctor yeah and they could get if you were very sick and you could get a doctor to come to your house we couldn't get that

Bernadette: They won't come out

Here the use of the pronoun you ('like *you* might get', '*you* could') explicitly draws a distinction between myself and participants. Indeed, participants sometimes implied that I would have difficulty understanding the challenges they faced as Traveller Community members, or may doubt the veracity of their accounts given such differences in my own sphere of reference. During her interview Catherine pleaded with me to believe how difficult life was as a Traveller, with this appeal repeated using near identical terms on four occasions during the interview:

Catherine: it's hard please believe me especially when you're a Traveller with the NHS and your health and things like that there very hard

Patricia's use of 'you see' above when describing the different style of living of Travellers also signifies a need to explain this lifestyle to the settled researcher. Jane describes a lack of understanding among those who are not part of Traveller Communities as follows:

Jane: Travellers gets treat you've gotta live there I know you obviously don't a lot of 100% of the world don't understand about Travellers just cause I'm a Traveller meself know what I mean (laughs)

Later on in her narrative Jane addresses the possible attitudes I myself hold toward Travellers more directly:

Jane: I think if they [practitioners] understood more about Travellers obviously but it's like yourself if you thought Travellers were bad you work with Travellers now so obviously you might understand a bit but before you worked with them you probably heard all these bad things about d'you know what I mean

This again points to the ways that I was positioned as potentially lacking an appreciation of Traveller Community experiences, or even harbouring prejudiced views prior to working with Traveller Communities. Smaller asides in the accounts of other Traveller Community members also point to some tension in how participants

are to position me when discussing discrimination. Brigid's use of 'I'm not being rude' before suggesting that people in houses live longer due to easier lifestyles, as well as when discussing general perceptions that Travellers get everything for free, suggests that she is conscious that these references to the settled community, which I myself belong to, may cause me offence. Bernadette similarly prefaced her statement about the lack of 'well to do' people dying with cancer with 'I'm not being ignorant', and her comment that Travellers are pushed to one side just because of who they are with 'I'm not being funny'; a phrase used 'to downplay the effect of a sensitive or non-politically correct comment' (Baxter and Wallace, 2009). This points to a potential dilemma for participants when talking about racism to someone who, while not racist themselves, nevertheless belongs to settled communities in which racism often prevails.

At other points, Traveller Community members sought to align the researcher alongside themselves when telling stories about health encounters. For example, Brigid invites the researcher to make a judgement on the GP when she asks 'I don't think you should be a doctor if you're not going to look at a person proper do you?' and 'he shouldn't be a doctor really should he?'. Some participants appeared to use the researcher to validate their illness claims; demonstrating their bodily symptoms in the interview. This was sometimes performed in conjunction with stories highlighting the inadequacies of care, as in the case of Jane; 'I went eight year ago about me ankles look and they're still swelled'. However, a physical demonstration of health issues was not always put to this use, and sometimes, as in the case of Sophia, this seemed simply to be performed as a way of corroborating the illness claims made to the researcher.

6.5 Summary

In accord with previous research on lay presentations of health (McClellan and Shaw, 2005), Traveller Community members drew on a combination of 'lay' definitions, embodied knowledge and biomedical ideas when defining their health. Support was also found within this study for the complicated nature of resistance to health advice and professionals (Armstrong and Murphy, 2012). Gypsy and Traveller narratives were not characterised by wholesale acceptance or rejection of biomedicine, and participants appeared to simultaneously accept and reject medical authority.

Traveller Community members sometimes sought to challenge medical authority not by using an alternative source of knowledge (although this was sometimes the case as exemplified above) but using the rules of its own game, claiming that practices weren't sufficiently invasive or medically rigorous. Traveller Community members expressed faith in medicine but raised concerns about the fallibility of medical practitioners and often, specifically, their willingness to apply the correct process. The potential for people to hold and utilise contradictory ideas about health is infrequently explored in the literature focused on Traveller Community health, which has often presented Traveller Community members as being somehow beyond the reach of health systems or as operating according to modes of thought contrary to biomedicine. This research has illustrated some of the ways that Traveller Community members were striving to reach into biomedical services and use medical explanations to supplement knowledge about their health and bodies accumulated through experience. It has also illustrated how the inability to get access to medical services and treatment can impact on possibilities for the health identities Traveller Community members can express. Knowledge of the poorer health of Traveller Communities overall, combined with a lack of biomedical scrutiny meant that Traveller Community members were often concerned that health issues go undetected. This was further reinforced by the greater difficulty that Traveller Community members relayed in getting access to services than other sections of the population (including the researcher).

CHAPTER 7 - 'They really liked me': how practitioners sought to maintain their accepted status when broaching lifestyle behaviours

7.1 Introduction

Previous findings chapters have explored the implications of discourses on Traveller Community health needs or disadvantage for the identities claimed by practitioners and community members. The remaining findings explore the extent to which Traveller Communities were positioned/positioned themselves as accepting control for their health, and how this affects conceptualisations of practitioner and Traveller Community roles with regard to health promotion. Beginning again with practitioner narratives, this chapter argues that, in the context of discourses which position Traveller Community members as 'hard to reach', differently oriented to time, and fatalistic, broaching health behaviour was viewed as potentially threatening to practitioners' preferred identities as liked and accepted by these groups. The chapter illustrates the positioning strategies used by practitioners to manage this dynamic and balance the introduction of behavioural advice with maintaining one's trusted status.

7.2 Discourses drawn upon and used

7.2.1 Gypsy and Traveller attitudes to time

When describing the health of Gypsies and Travellers, many practitioners' imparted ideas about Traveller Community members' orientations to time. The concept of time is integral to the discipline of public health, which is concerned with the evaluation of current behaviour based on a concern for future health consequences. Traveller Community members were presented as less time disciplined than the majority population, described as living generally for the present and as planning less for the future. The discussion of Traveller Community members' attitudes toward time was most explicit in Becky's account, as seen in the following excerpt:

Becky: also the communities we serve don't always live by the industrial clock so consequently if there's a party, a funeral, a wedding they need to go

out and earn some money then the course you're running will be pretty far down the list

Reference to Traveller Communities as not living by the 'industrial clock' presents these groups as somehow resistant to customs of time centred around employment. Becky expands on the implications of such attitudes towards time for the design of health promotion sessions later in the interview:

Becky: we try and do it so it's not like a whole classroom day so its short and sharp and its fun there's no rules so we've had to try and change it cause when you're in the classroom you'll have to say right mobile phones off you know put your own rules together which we can do with the with the Traveller Community but you can't tie them up in like you can't use that kind of structure and framework for them because they love their lives in a different way and they don't live by the industrial clock or they don't live like erm perhaps the general population would

Gypsies and Travellers are presented as less tolerant of the imposition of structure on how they use their time (as may be the case in a classroom), and there is a sense of Traveller Communities as having less respect for rules. The suggestion that Gypsies and Travellers 'love their lives in a different way' explicitly positions Travellers as different from other sections of the population in this respect. The phrases 'you can't tie them up' and Becky's suggestion later in the interview that it is important that Traveller Community members 'don't feel constrained or constricted' in sessions evoke romantic stereotypes of freedom associated with a nomadic lifestyle. Engagement with those activities described above as competing with health promotion sessions (e.g. funerals, weddings or work opportunities) might be read as a contradiction in Becky's narrative, since this demonstrates adherence to externally defined timeframes and commitments. However, Becky appears to be suggesting that these attitudes to time are particularly manifest in relation to enforced rules or timescales. Both Becky and Sandra (perhaps unsurprisingly given that they work for the same organisation) present Gypsies and Travellers as living a fast-paced life:

Sandra: when we do cookery the ladies work so fast erm you know they're like chopping ten to the dozen and then next next next and everything's done in like an hour whereas usually it might take two hours they just crack on with it at super speed

Although left slightly ambiguous, Becky appears to attribute the fast-paced nature of Traveller Community life to the potential of being moved on by authorities at short notice when living on roadside: 'they're incredibly bright intelligent community because they have to be in terms of survival and and eating so they're they're really

fast cooks'. In addition to ensuring that health promotion sessions did not resemble a classroom, this fast-paced nature of Traveller Community lifestyles was emulated in the design of frenetic and high energy health education sessions, in an attempt to maintain the interest of community members. The language Becky uses seems to convey a sense of both Gypsies and Travellers, and health promotion sessions as somehow unruly: Travellers 'just hit the tables'; onions for cooking are not passed out but 'lobbed'; the practitioner adopts strategies to 'get them [Traveller Community members] going'; and reference is made to 'crowd control'. Although differences in attitudes to time between Traveller Community members and other groups are not described as starkly in the narratives of Karen, Louise, Nicola and Linda, they too made smaller references to Traveller Community lifestyles as differently structured. For instance, Karen presented Gypsies and Travellers as having a short attention span in health promotion sessions and described Gypsies and Travellers as leading 'sort of chaotic lives'. Louise similarly indicated an expectation that life on site would be more chaotic than she found on first visiting. In addition, Nicola and Linda (as well as Becky) pointed to missed health care appointments as an issue among Traveller Communities. Practitioners' presentations of Traveller Communities in relation to time help to provide a context for the health beliefs they ascribed to Traveller Communities, particularly in relation to fatalism and control over future health, something that will now be discussed in more detail.

7.2.2 Traveller Communities as fatalistic

Many practitioners described Traveller Communities as adopting a fatalistic stance towards health. This is perhaps unsurprising given that this is a narrative often found in the literature on Traveller Community health:

Becky: they have a very kind of erm intoxicating philosophy of you only have today you can't control tomorrow which does make them kind of live life to the full especially in terms of smoking and drinking (laughs) and erm eating erm so I mean it obviously the general population might be thinking more in a long-term view about pensions and about retirement and about settling down I don't think there's that in their Traveller culture so that has its benefits because yo- perhaps you have a shorter better quality of life (laughs) erm but it has its health downsides because they're not really preparing themselves for old age because they don't think they're gonna be around for old age and statistically a lot of them aren't

Here, Travellers are explicitly presented as living for the day and as viewing the future as something beyond control. These fatalistic attitudes are described as

cultural and therefore something which may distinguish Travellers from other groups, but also explained by low expectations for health. Such beliefs are presented as problematic, encouraging engagement in 'unhealthy' behaviour and discouraging preparation for retirement years. Yet, despite being presented as problematic for health, Becky also appears to convey a degree of admiration for this approach, with benefits cited in terms of quality of life, and the use of laughter following this statement also positioning this behaviour as amusing. This hints at a key tension between, on the one hand, discourses in society promoting discipline and willpower with respect to the adoption of healthy behaviour, and on the other, those that celebrate and glamorise resistance to these attempts at control. Representations of Traveller Community members as fatalistic were also prominent in Sandra's account:

Sandra: some people will be a bit scared to tell the truth and some people don't want to hear the truth an we do find in this community they really really do not want to hear the truth about things

Sandra positions Traveller Communities as preferring to remain ignorant of risk factors for illness, with the use of 'in this community' cementing this as a cultural attribute. Linda similarly contrasts Traveller Community attitudes of 'it was meant to be' and 'that's life' in relation to the death of a child, with her own beliefs about the possibility of prevention:

Linda: more of the Travellers the kids do die of German measles or measles and er so that can be a a not so good thing but then they take it on the chin and say well it was meant to be which I find I find that hard it was meant to be you know we did have seven children one died of measles that's life that [I] would say [is] a not so good one [aspect of Traveller Community life]

However, at times, practitioners softened suggestions of fatalism as a cultural attribute of Traveller Communities. Sandra for example, suggests how a reluctance to listen to health advice is not unique to these groups:

Sandra: but we find that with most communities you know you can keep banging on about stuff but if they don't wanna hear they don't wanna hear and its just people isn't it

Moreover, fatalism was not always presented as a global attribute of Traveller Communities. A fatalistic stance was sometimes presented as changing over time and varying according to the health issue at stake or the perspectives of individuals. For example, while Traveller Community fatalism regarding cancer prevention forms an explicit discourse in both Becky and Sandra's accounts, community members are

not presented as wholly rejecting of attempts to broach this issue, but as more willing to discuss cancer prevention on a one-to-one basis. This explanation does not fit with the experience of Karen however, who was unsuccessful in broaching the prevention of cancer with an individual community member, suggesting that engagement with this advice is likely to be influenced by other contextual influences. Presentations of fatalism were not straightforward in Linda's account either. For some health issues, such as use of contraception, Linda described a trend toward increased agency taken by Traveller Community women:

Linda: the Traveller Community seems to be using contraception more once upon a time they'd kind of leave it to God as they would say I think people are taking control a bit more...so I've seen an increase in women ah I went to see someone and it was she she'd only had the baby ten days before she said yeah I've got me implant in I said 'really?' and she'd gone already off her own back which I never used to see

In her response of 'really?', Linda indicates a degree of surprise that the Traveller Community woman described had taken control over her contraception, suggesting that she is still operating from expectations of fatalistic behaviour among Traveller Communities. However, this extract does demonstrate recognition of the ways that attitudes towards health may change over time. The following extract from Linda's account also highlights the potential for diversity among Gypsies and Travellers with respect to the acceptance of intervention in the process of childbirth, specifically, the uptake of a membrane sweep to induce labour:

Linda: you either find them saying yes because they wa- they want that [a membrane sweep] or vehemently no because they almost wanna leave it to God to see what happens and they just leave it natural and also sometimes I think that the Travelling women aren't as kind of open perhaps to that kind of cause it is quite invasive we've gotta remember that just cause we've done tens of thousands im- and some people you know you another midwife 'd just go yeah do it but it's much more you know they keep the sexual things under wraps erm you know so in them perhaps being virgins and stuff and they don't like talking about that things much and its quite an invasion of privacy

That Linda also draws attention to cultural beliefs around protecting women's modesty highlights the ways that practitioners combine fatalism with other explanations for Traveller Community members' decisions surrounding uptake of health services. In addition, practitioners appeared to form judgements about how best to engage individuals, not only based on their ethnicity, but wider subject

positions. In the below extract, Linda describes an individual's approach to health as the result of not only her identity as a Traveller, but also as a teenager:

Linda: yeah I think there's times when you can say about smoking or drinking this and it's like they they're still teenagers sometimes an they're not interested in listening not interested in changing they just wanna be one of the crowd even if they're pregnant

Existing literature points to the influence of witnessing illness and death among friends and family on expressions of fatalism (Drew and Schoenberg, 2011). Loss of family members was cited by practitioners as a key reason Traveller Community members didn't want to hear or talk about health issues, particularly among older Gypsy and Traveller women:

Sandra: if they have had a few bereavements in their families and obviously family's the most important thing then they can actually be quite sensitive and quite erm quite ignorant in that they really don't wanna hear

Becky highlighted the dilemma this posed in that Traveller Community members do not therefore receive important health information, but also suggested that engagement with this subject is at odds with Gypsy and Traveller lifestyles, reinforcing this as a cultural response. At times, the provision of health advice seemed to interfere with the remembrance of friends or family members, as seen in the account of Karen below:

Karen: I mean I don't know whether it's because actually her [family member has] died now and there isn't anybody else who's gonna get cancer you know thinking arou- you know in that that way or just not bothered not ah I don't know I don't know she might do I mean it was only a very quick conversation you know ten minutes around you know she was more interested in her [family member] and the you know the star in the sky that came up every night and that's my [family member] and you know ver- quite they're quite religious people aren't they you know so so you know you've gotta respect that you can't like I you know it's like well actually if you don't wanna talk about it that's you () its two years it's you know erm but yeah she was a bit like I don't wanna don't wanna know but then again that she's only one person

In Karen's account, the community member concerned rejects attempts to discuss the prevention of cancer in the community, preferring to engage at a more spiritual level, in the memorialisation of her family member: 'the star in the sky that came up every night'. There is therefore some conflict apparent between this approach and the more matter of fact approach of the practitioner, who is concerned with delivering information to prevent cancer, and who seems to express some surprise

that this community member is still unable to discuss the subject two years after the death of her relative. Again however, the above excerpts, do not present Traveller Community members as straightforwardly fatalistic, but demonstrate how a discussion of cancer may be too painful to engage with in the context of recent experiences of loss. Even where Traveller Community members view illness as preventable, they may find it too difficult to hear information about the preventability of illness.

Discourses of fatalism were less evident in the narratives of Nicola, Caroline and Louise, with these practitioners offering more explicit challenges to notions of Traveller Community members as unconcerned with their health or reluctant to engage with health services. In general, Nicola presents Gypsy and Traveller women as engaged with antenatal care for instance. She relayed examples of interaction whereby individual Traveller Community women were very receptive to, and acted on health advice received, although a broader culture of negative health beliefs and behaviours within Traveller Communities is also described as prohibiting individuals from adopting healthy behaviour:

Nicola: I suppose one of the things that I have struggled with with one woman was around smoking cessation (laugh) and felt erm that if it'd just been herself and myself or when it was just herself and myself I felt as if some of the messages and the support I was trying to give regarding her reducing the cigarette consumption with the aim of stopping during the pregnancy and the benefits for her and the benefits for the baby when there were just the two of us you could see the cogs turning and that sort of apparent understanding and accepting but as soon as anybody else came into the situation they had more influence than I did and I find that quite difficult and quite challenging to know how to deal with really so that's somebody who I truly believe does understand and wishes to alter their behaviour erm does not have the support within the community to do so and I'm not quite sure where we go with that

That the Traveller Community member concerned is presented as absorbing and accepting information provided and seems keen to alter her behaviour introduces a counter narrative to one of fatalism in Traveller Communities. However, this individual's acceptance of the link between smoking and health is not described as pre-dating the practitioner's intervention, but as something that she had to work to get the young woman to accept (represented in the use of 'cogs turning'). This again seems to support presentations of Traveller Communities as not particularly attuned to the potential consequences of the adoption of unhealthy behaviour. As does Nicola's laughter following her statement that addressing smoking was a particular

challenge which appears to signify that this is unsurprising. Nicola therefore still positions herself as working against the tide of community health beliefs. Louise also counters representations of fatalism Traveller Communities when she describes how a community member was extremely engaged in discussions around how to improve the health of residents on the site:

Louise: she was incredibly anxious and she em spoke to she spoke to us about not being able to see a GP feeling constantly worried about her own health that she didn't want to die and leave three children that she didn't feel that she was getting advice off anyone about what she should be doing with this baby about feeding about erm she found a lump on her breast which was to do with breast you know erm having had a baby but she was who does she speak to where does she go er she she was losing blood she wasn't sure if that was normal and all of those and she was just inc- hyper anxious erm that she talked about seeing domestic violence on and around the site and how could we manage that and she didn't she seemed very erm almost well informed in some ways about lots of health things to look out for but not, but but then very anxious about not being able to then speak to anyone or get the support she needed in order to address what she thought she was finding

Louise portrays this Traveller Community member as extremely attuned with respect to her health and as anxious to ensure she received access to appropriate information to inform the management and promotion of her health. Louise's use of 'almost well informed' does however suggest some limits in her presentation of this individual's health literacy, and again conveys a degree of surprise over this attitude. Caroline articulated the most direct challenge to narratives about Gypsy and Traveller disengagement with health and health services. Speaking of her experience offering health checks for Traveller Community members on site, she describes the receptivity of Traveller Community members:

Caroline: but I think if there is a reticence about services and health and all the rest of it but um um we didn't find that reticence that [day] we were there we had over 60 people come for their blood pressure well women and a couple of the lads but it was the same the second time round when we went round the caravans not one women said to us no...people were very welcoming very positive they spoke quite openly and you know just addressed a number of health issues they had

While one negative experience was reported by Caroline whereby a Traveller Community member had become aggressive in response to health workers asking his relative questions about her life more generally, Caroline described this in individual terms rather than treating this as indicative of the reactions of the community as a whole.

Cultural explanations of fatalism were combined or conflated with structural explanations in the accounts of some health practitioners. This is perhaps unsurprising given that fatalism is often associated with 'disadvantaged' groups (Keeley, Lanelle and Condit, 2009). For example, reflecting on a presentation by a colleague, Hazel suggests that those who are less educated and from lower classes are less likely to act on invitation letters for mammography screening, with a blurring of categories between these sections of society and Traveller Communities:

Hazel: it's almost like the people who are most highly motivated are likely to be well educated and relatively middle-class... but he [colleague] said it's not more in BME groups not coming its its people with a level of educational attainment who they get the letter and they put it in the bin erm and then I think that's really interesting cause that would almost certainly be the same for Gypsies and Travellers I would be erm surprised if if they took up those sorts of offers although we did ask whether people had had a letter for the n-about the NHS health check and it was only something like 12 or 14 had and about ten of those had gone and gone and had their NHS health check so that seemed really good (laughs) so maybe a letter coming with their name on it from their practice saying please phone us and make an appointment for this maybe that is a good thing cause I was actually quite surprised and pleased erm that people were going but yeah

The above narrative is one that is well rehearsed in public health discourse, in which it is often stated that the 'worried well' are most likely to benefit from health interventions on offer. The explanation for poor uptake of services here differs from that presented earlier on in Hazel's account, with low educational levels presented as the predominant factor, over and above those associated with ethnicity. While structural factors are recognised as influencing health and uptake of services, these factors are still understood by reference to the behavioural factors that result from them; these sections of society are more likely to be the type of person to put a screening letter 'in the bin'. Yet, a contradiction was evident here in that most Traveller Community members were found to have taken up the offer of NHS health checks. Hazel's narrative highlights the ways that practitioners draw on conflicting and competing narratives about Traveller Communities in relation to health. However, her admission of surprise that Traveller Community members had taken up health checks nevertheless points to the persistence of narratives about Traveller Community members' reticence to accept health interventions, even in the face of conflicting evidence. Karen also combines different explanations when making sense of her difficulty broaching prevention with a community member who had recently lost a family member to cancer:

Karen: it's not on their priority list basically health at all they like to learn and they like to you know cooking and all that but actually doing it in their home is a totally different thing I think it's erm health is the last thing on their agenda I think surviving is th- the first thing (laughs) but

Health is presented as a low priority for Traveller Communities compared to 'survival' which she goes on to define in terms of financial income and basic needs such as feeding children and heating homes. Whilst Traveller Communities are presented as enjoying opportunities for learning available through healthy cooking sessions, this is not deemed indicative of actual engagement in the promotion of their health. Like Hazel, Karen draws similarities between Traveller Community members' and those who experience disadvantage more generally:

Karen: I think with the Travelling Community like I was saying health is the last thing I mean I suppose in in a deprived area health is your last thing you know you wanna survive so it's almost like I don't know I mean none I've found you know I don't think many of them smoke I don't I didn't see any of the ladies smoking or anything like that but like you know I suppose if you're looking at a children's centre in [place name] you know yeah I've got no money but actually you know but you can buy your fags d'you know what I mean its that its almost trying to re-prioritise things for them and say you know like immunisation

Karen alternates between individual and structural explanations for Traveller Community health throughout her account. The statement that there is a need to 're-prioritise things' for Traveller Communities (above) and her suggestions elsewhere in her interview, that people need a 'kick start', and she'd like Traveller Communities to 'take responsibility for' themselves sit alongside a recognition of material constraints such as the inability to purchase fresh and healthy food. As for references to screening letters being put in the bin in Hazel's account, narratives of a lack of prioritisation of health translate structural determinants back into the realm of personal responsibility and control; the solution for improving health is presented as lying not in the alleviation of the inequalities which hamper engagement with health such as poverty and education, but in what community members need to do themselves: re-prioritise their values and take more control over their health.

7.2.3 Traveller Communities as a 'hard to reach' group

Practitioners also drew on discourses of Traveller Communities as a 'hard to reach', or 'exclusive' group who are unwilling to engage with, and even potentially hostile to, outsiders. Becky for instance, describes Traveller Communities as potentially

unaccepting of health workers, while Sandra relays her apprehension when beginning to work with these groups:

Becky: I just thought it would be interesting work really and it was a bit of a test to see if we erm if we could work with that community and if they will accept us

Sandra: when it started like I say I was I was quite like 'urr I'm really nervous don't know what to expect of these people'

Sandra's suggestion that she 'didn't know what to expect of these people' reinforces a sense of Traveller Communities as a hidden group, with whom few people knowingly come into contact. Elsewhere in the interview, Sandra conveyed an expectation of feeling 'intimidated' and suggested she was 'scared' of working with Traveller Communities, something Caroline also points to among health service staff. Discourses of Traveller Communities as difficult to engage and of these groups as potentially posing a risk to health workers are also evident in the accounts of Karen and Nicola:

Nicola: with regard to the community as a whole I was really w- been really warmly accepted and welcomed so whether that has been to do with the way that I went about it in approaching [name of community organisation] and other services to sort of help me in erm but I have never felt threatened or urm I've never felt at risk when I've gone to either a roadside site or a or the main site which was things that my colleagues were telling me that they had experienced before or feelings that they they had felt before... so I I spose that was the biggest thing that sort of fear of safety or vulnerability when approaching the community and that I had to preconceptions about which I have to say I've completely dismissed now

Karen: you have a perception don't you of what they're like really rough and hard and then actually people aren't you know you just got to treat everybody the same you know as if they were just um you know an everyday p- which they are so that was my first encounter

A discourse of Traveller Communities as unlikely to engage with complete outsiders is evident in Nicola's explanation that approaching Gypsies and Travellers through trusted organisations contributed to her acceptance within the community. That Nicola describes her preconceptions about risks to her personal safety as influenced by discussion with colleagues points to cultural narratives of Traveller Community members as potentially hostile. Likewise, Karen's preconception that Traveller Community members would be 'rough' and 'hard' reinforces notions of Traveller Communities as potentially aggressive. Karen's use of encounter (on two occasions

in the interview) also appears loaded and suggestive of potential disagreement⁶ as opposed to other more neutral terms that could have been employed such as met or meet for instance. Nicola similarly suggested that prior to her work she had no 'exposure' to the Traveller Community. When Karen suggests treating Travellers 'as if' they were an everyday person, before correcting this distinction, a struggle is evident around whether engaging with Traveller Communities is viewed as similar or different to engaging with other groups. This was also explicit in Sandra's account when she described Traveller Community members as different in that they are more mistrustful, but similar in that they did not fit stereotypes that she had been led to believe in. Indeed, practitioners often explicitly noted the role of wider social stereotypes of Traveller Communities, such as those of criminality, in shaping preconceptions about Traveller Communities:

Sandra: it wasn't what I expected because I thought they'd be like a- maybe they'd be horrible people from the way that stereotyped and you know are they gonna pinch something out of my bag (laughs) I was like oh God really worried about things like that but no not at all they were welcoming they were nice erm

Caroline: I'd like to be able to say I didn't have any expectations but I think that probably wouldn't be true what I was given was an overwhelmingly negative perception by everyone

Many practitioners gave honest and reflexive accounts of these presumptions about Traveller Community members prior to working with these groups and indicated explicitly that any initial concerns about Traveller Community members being rejecting of, or hostile to them had not been borne out in practice. Indeed, the following practitioner made a very direct challenge to the idea that Traveller Community members were necessarily mistrustful:

Louise: they mistrust authority and they don't they don't they don't yeah they don't trust statutory services that wasn't my view on that day it felt people apart from that one woman it felt like it they all really wanted to engage and make things better for themselves and their kids

While initially accepting the discourse that Traveller Community members are mistrustful of authority, Louise draws on her experience of interacting with Traveller Community members to suggest a counter discourse of Traveller Community

⁶ The word encounter originates from the Middle English 'incounter', meaning a meeting of adversaries and in Latin literally translating to in (in) + against (counter)

members as active in discussions to improve conditions for themselves and their families.

7.3 The positioning of self in relation to others

This section moves on to explore the implications of the above discourses for the identities of practitioners, their roles in working with Traveller Communities, and how practitioners drew upon these discourses when positioning themselves in relation to others.

7.3.1 Becoming accepted

In keeping with the discourse of Traveller Communities as an exclusive group, practitioners often positioned themselves as being 'weighed up' or vetted by Traveller Communities when beginning work with these groups:

Sandra: I'm not sure how accepting they were to start with because they take you like that you know you don't come in and be accepted straight away they'll suss you out so I think I was being sussed out for the first few weeks (laughs)

Becky: they need to look at your faces and know who you are and they need to trust you and they like familiar faces having said that they will accept new faces but they weigh you up really quickly

Furthermore, in the context of the above discourse of Traveller Communities as exclusive groups, practitioners presented their unique position of acceptance as an important aspect of their preferred self and identity. For example, when asked about her response to a successful health promotion session, Karen's repeated use of 'they really liked me' prioritises consideration of how accepted she was as a person, as opposed to other outcomes that may have been cited such as community members listening or taking information on board:

Karen: they really liked me (laughs) they really liked me they were showing you me the they were showing me their tits they must of liked me (laughs) no it was quite funny it was I just thought it was you know that's really nice that they you know they accepted me they'd never met me before you know and by the end of the session they were l- they were opening up... they do still remember me you know this was five years ago and they s- you know when I went round they wen oh I remember you from that thing you know I remember you from the you know so which is nice really you know cause they do- I think they're very untrusting of people there's not many people that'll trust and they like or they you know but obviously they do me

Here, discourses that Traveller Communities are 'untrusting' are used to reinforce practitioner status as occupying a privileged position of integration into the community. The statement that Traveller Community members remembered Karen from a previous session acts as further validation of her claims that she is liked and accepted. That Traveller Community members were presented as particularly candid about any feelings of dislike, conveyed a further risk that any lack of acceptance is publicly displayed, and was also used by some practitioners as confirmation that they were liked by community members:

Sandra: believe you me if they don't like you if you don't fit into their group they will let you know in no uncertain terms they won't do it behind your back they'll do it to your face so erm I feel like because that's never happened to me (laughs) they must like me yeah (laughing)

Nicola: they're very articulate at expressing when the care they've received has been good or not so good so they are very good at giving feedback if you're open to it

By describing herself as having been granted a 'privileged window' into the lives of Traveller Communities, Becky reinforces the idea of Traveller Communities as an exclusive group:

Becky: it gives us a window into we're privileged window into a life that you would only read about in in in in-a- a red top mag or the daily hate you know about how horrible the community [is]

The use of the term window is interesting in portraying someone looking in as opposed to a more active form of participation with the community. Sandra also describes the privilege she felt in being able to share in some parts of Traveller Community members' lives such as viewing pictures of weddings once she had become more accepted, and suggests she is 'proud' to work with Traveller Community members. It was not only Gypsies and Travellers who were presented as scrutinising practitioners when first approaching these communities, but also organisations advocating for the rights of these groups. Traveller Community organisations were presented as gatekeepers who are protective over Traveller Communities and reluctant to allow others to access this group:

Karen: [name of Traveller organisation] tend to think they're the only people who can work with Gypsies and Travellers which actually it's not true you know and I think that's what they've done they've they've just sort of alienated-not alienated themselves they just work in silo basically

Hazel: I think [Name of Traveller organisation] much more mature organisation now but I think initially they hung onto their Gypsies and Travellers a bit you know that that they were the people who really understood the issues really understood the culture understood the challenges and therefore they needed to be funded to meet those needs and whilst that was true to some degree and I'm really really pleased to see that I think that organisation's moved on quite a lot in the last few years and much more into a place where they're saying we want to see every agency that's working around inequality or deprivation to be able to provide a good service to Gypsies and Travellers

This was connected with issues of power by Hazel, who was critical of a tendency among health service staff to rest their 'sense of themselves as professionals' on knowledge about or ability to work with certain groups. Indeed, this connects with arguments presented in Chapter 5 on the ways that this knowledge was employed in practitioners' identity claims. One practitioner mistakenly assumed that the individual leading the Traveller rights organisation was a Traveller Community member herself, and interpreted this individual as holding particular power in negotiating the terms on which other community members could engage with 'outside' services:

Karen: she's another top dog like [name] you know and it's like you will do it my way or no way and not it's almost like seeing things in erm you know with blinkers on isn't it you know I'm the only one who can help them I'm the only one who can understand them

Karen used phrases such as 'top dog' and 'your ladies' to suggest that some members of the community have particular influence over others on a couple of occasions during the interview. This is stated more explicitly still where Karen says of one woman who is felt to have this influence, that 'she's the one that basically if she's interested in something she'll get all the women to do it'.

Sandra explained her trusted position as resulting from community members realising that she 'wasn't just going to throw the towel in' and Nicola described herself as more likely to be accepted by community members by virtue of her professional role:

Nicola: as with most women midwives are accepted you know th- that we we're seen as a positive erm contribution to their wellbeing and not seen in the same light as say social workers

Karen describes trying to be really nice and the fact that she is a friendly person when making sense of her relationship with community members. Becky however conveyed a sense of this accepted status as more fragile and open to change:

Becky: luckily because of the community health educators and the way they work and the kind of people they are erm touch wood it does work and it it'll continue to work really yeah

The use of the phrases 'touch wood' and 'luckily' position workers as having a limited degree of agency over whether they will be trusted, and how long this position will be maintained. Although identifying key and stable characteristics and qualities of workers as influencing their acceptance, Becky simultaneously relayed a sense of identity as more changeable, and described significant impression management work during engagement with Traveller Communities:

Becky: sometimes it's incredibly tiring because it's like being in being in character it's like being on stage or being in on character for that period of the healthy session so you have to be a certain kind of person and you have to be tough relentless and happy and jolly and wisecracking all the time

This process of adopting, dropping and changing aspects of self-presentation in response to the community one is working with is also suggested where Becky likens her role to that of being in character, being on stage and elsewhere in the interview, to a stand-up comedian. Becky described absorbing and recycling the language and expressions used by the communities she works with by way of easing integration. Here, the practitioner presents language as a kind of carrier, or to borrow Goffman's (1956) term, as a 'sign vehicle' of one's familiarity with Traveller Communities.

7.3.2 Downplaying 'professional' identity

In conjunction with the above noted tendency of practitioners to present themselves as more 'in tune' with Traveller Community member lifestyles, some practitioners sought to downplay any 'professional' associations when engaging with Traveller Community members. Those working in community educator roles emphasised their position as part of the communities they served while some with status as 'professional' health workers often adopted strategies to dissociate themselves from this identity when providing health advice. This was connected with the avoidance of 'preaching' to community members, which may signal judgement over their health behaviours. This distinction was also entangled with class by practitioners, some of whom stressed their working-class identity as important in engaging with Traveller Community members about health advice:

Karen: I wasn't anybody really posh or I wasn't anybody who thought I was better than them you know and I think you know that's why they started asking me questions so just made it really really simple

Karen suggested her acceptance by community members not only results from a lack of judgement, but her class position ('not being posh') and went on to identify a similarity between herself and Traveller Communities in terms of being 'hands on practical people' as opposed to being academically educated. Becky and Sandra similarly refer to class, identification with community members and the absence of a professional agenda when articulating what works in engaging with Traveller Community members:

Becky: a lot of the community health educators have a- are from er- incredibly deprived sometimes brutalised backgrounds sometimes they're not it's a really eclectic mix erm so they wear their history on their faces and they can engage very quickly so you might have somebody who's struggled with alcohol dependency talking to a group of alcoholics this is the theory or you might have an ex heroin addict talking about drugs cause it just lends a bit more authenticity mixed in with a community member that's not got an health problems any issues at all but just wants to help the community but they do tend to be gregarious and friendly and they're not badged up with any kind of authority so that informality and no agenda really they're pretty transparent

Sandra: I strongly believe in community health education because I don't think anyone from any community's gonna listen to somebody in a white jacket telling em what to do erm with a stethoscope round their neck and coming out with language and long words that they really really don't understand erm I'm a [place] girl I live in [place] I work in [place] so I can actually say to people I you know if I go deliver a four week cookery course I'll say I've just got all these ingredients from Morrisons at [place name] round the corner so that they can't say we'll I was looking for whatever them noodles or this so and so a piece of ginger I can't get that round here you know

The community health educators that work in the organisation are described as coming from sometimes 'brutalised' backgrounds and this is presented as lending them a degree of credibility and authenticity which leads them to be more readily accepted. Like Traveller Community members, community health educators are described as wearing their history on their faces. Elsewhere in the interview Becky describes herself and her colleagues as 'blue collar worker working class mentality' and cites an example of a session by a 'professional health worker' which was less successful as 'it was too literate and it was too classroomy', with the result that Traveller community members were 'bored, disinterested disengaged'. Sandra too suggests the lower likelihood that Traveller Communities, but also communities

more generally (vaguely defined), will engage with information provided by those with the markers of professionals: 'a white jacket', 'stethoscope' and 'long words'.

Nicola and Linda, who themselves occupied professional roles described ways in which they sought to downplay signifiers of this professional identity when engaging with Traveller Communities. Both described presenting themselves as a guest when visiting Traveller Community homes, with Nicola describing attempts to reverse power relations between herself and community members by reading her notes aloud to ensure openness. Linda described the body work that she undertook in order to signal informality and distance herself from her 'professional' role, including not wearing a uniform, taking her shoes off, sitting cross legged on the floor, and using her first name as opposed to her professional title in order to avoid occupying the role of an 'expert' or giving the impression that she is different from the community. She also distanced herself from the more patronising approach she saw exhibited by other midwives.

Practitioners also emphasised their personal as opposed to purely professional care for Traveller Community members and their enjoyment of working and spending time with community members:

Becky: we love them you know we love being with them the they're a they're a not everyone does they're a joy to be with I love those Travellers because they're so fast they're so exciting its so intoxicating being with them they really appreciate everything that you do for them

In suggesting that 'not everyone' enjoys being with Travellers, Becky distinguishes herself from other practitioners and reinforces her status as among an exclusive group of practitioners able to work with Travellers. Becky's suggestions elsewhere in the interview that she has 'the best job in the world' and that she is 'not quite sure if it's a proper job', also serve to reinforce her enjoyment of the work, as does her statement about the benefits of the work for her own 'mental and emotional health'. Karen also tended to represent her relationship with Traveller communities in personal terms e.g. 'I think they're a lovely bunch I get on really well with Gypsies and Travellers' and described a colleague who 'loves' working with Travellers. Sandra's later statement of 'I get on really well with Gypsies and Travellers' similarly demonstrates a blurring of the personal and professional in interactions with Traveller Communities. Likewise, Linda makes a claim to her particular connection to, and proficiency and interest in working with Traveller Communities:

Linda: I particularly probably above everybody apart from [colleague] that's my kind of little bag that I like looking I like dealing with the Travellers and they've got to know me quite well

Here, the phrase 'that's my kind of little bag' conveys a sense of ownership over this area of work, with claims to this position not only underpinned by the endorsement of Traveller Community members themselves, but a greater interest in work with Traveller Communities than other practitioners. Hazel described how much she enjoyed working with Traveller Community members, having met 'absolutely lovely people' and suggested that she would 'love' to do more work with this group. Louise's earlier description of her 'irrational' urge to retrain in order to be able to fix the issues that she saw when visiting the site herself also points to some tensions in balancing these reactions and her more distanced 'professional' role.

Nicola described the personal impact of her work to a lesser degree than others interviewed and articulated her relationship with the community in more distanced terms than other practitioners. She does however describe herself as enjoying working with ethnic minority groups and proud of the relationship she formed with a young Traveller mother. Indeed, the tendency to present oneself as personally connected to communities was most apparent in (but not exclusive to) the accounts of practitioners who, by their own definition, worked in community as opposed to more professionalised roles. This is perhaps unsurprising given attention to the maintenance of boundaries between health practitioners and patients in professional and ethical codes of conduct for nursing and midwifery for example. A counter story to the importance of downplaying professional identity is also apparent in the account of Caroline where she suggests that a worker was more accepted due to her role as nurse and midwife (as well as her position as an older woman).

7.3.3 Difficulty broaching health behaviour

Discourses of Traveller Communities as fatalistic combined with those of Travellers as 'hard to reach' to create a concern among practitioners about broaching health behaviours. Given the potential judgement surrounding health behaviour, raising these issues risked undermining the trust that practitioners had developed with community members. Nicola for example describes the tension between maintaining acceptance and the need to address health behaviours as part of her professional role:

Nicola: I found it very difficult to raise those [behavioural] issues because I felt as if I was going into a community that I knew I needed to gain acceptance within so I putty footed around I was trying to erm make relationships and gain the confidence of the community and I know that I wasn't fulfilling my role in tackling some of those negative health behaviours

This tension was particularly felt where practitioners broached sensitive issues.

Sandra relayed a story of attempting to broach cancer prevention with a group of Traveller Community women for example:

Sandra: I had another woman and she said in front of everyone she she held her hands up and went [name] she says erm and I'll never forget this she went 'don't you believe what will be will be if you're gonna get cancer you're gonna get cancer if you're gonna have a heart attack you're gonna have a heart attack what will be will be' and I'm said 'no actually I don't agree' and they all looked at me as if to say 'oh my god you're challenging one of the most important women in the room' because obviously the older community members are really looked up to and respected and what they say is usually what's believed...I actually stood up and said 'no I couldn't couldn't disagree with you more' erm whereas someone might be a bit intimidated and go oh yeah and slink away I was like 'no no you can stop yourself from getting cancer if you eat healthily drink in moderation stop smoking exercise' and you know I said 'I know it sounds boring but that's the facts and I know not everybody will do it but that's the fact of life if you look after yourself of course there will be the odd person who it's in their genes and yeah they will get cancer they've had a lif- healthy life and chances are they might get it and they might die' but you know we've explained to them if you do look after yourself you're less likely to get it and the more you mistreat your body the higher up the scale you are more likely to get it and I don't think they'd actually I honestly genuinely believe they'd not thought about that

Sandra's use of 'I'll never forget this', and the similar narration of this event on another occasion during the interview suggests that this story is a key and well-rehearsed account of her work. Throughout the story, Sandra's own convictions that 'you can stop yourself from getting cancer' and that 'that's the fact of life' are contrasted with the fatalistic view of the community member that 'what will be will be'. Challenging the community member's view is presented as risky, as shown by the reported responses of community members and Sandra's later description in the interview of these actions as 'brave and bold'. Sandra also goes on to more explicitly address the tension between a desire to befriend Traveller Communities and the requirement to deliver health advice as part of her role:

Sandra: you can get a bit big headed and want everybody to like you (laughs) and erm you know some some weeks you go fantastic and you come out feeling really really good and thinking oh yeah everybody liked me in there and erm but other other weeks like I say about the one with erm that was the day with the skin cancer DVD when the woman said 'oh don't you

believe that' and I was like 'well no' but if I was trying to win friends I woulda just put my head down and gone oh yeah yeah I believe that but I didn't and that's not like me because I don't usually I I can be quite quiet and I don't usually challenge people but I felt like even though she was kind of their leader I had to make a stand and say I disagree with you... and that's what they're that's what the end of the day that's what why we're there we're there to try and encourage little lifestyle changes that in the end will make a difference and will ultimately save the NHS money because that's what we're all getting funded for at the end of the day that's our job

Here, the requirements of Sandra's role in encouraging lifestyle changes are explicitly opposed to actions of trying to win friends. Again, the need to confront community members' fatalistic stance is presented as a difficult task, and one which contrasts with Sandra's usual character. At times, professional distance seemed to be employed to guard against the sense of personal failing that might result from being unable to broach health issues or sessions going less successfully. In the above example, Sandra couches the need to challenge the behaviour of Traveller Communities as part of her job role, as well as her desire to prevent poor health in these groups. This tendency was also evident in the interview with Becky when she tended to fall back on outlining a professional obligation to address sensitive issues when describing a session that hadn't gone well:

Becky: you feel very deflated really but you kinda know professionally that you've tried

It is possible that this presentation of professional responsibility to address behaviour acts as a mechanism to separate the person from the professional and protect against personal rejection as a result of broaching more sensitive issues. Practitioners also appeared to deal with this difficulty by limiting their expectations for what can be achieved to simply having provided information about lifestyle issues, after which community members can make a free and informed choice regarding how they act on this information:

Karen: you just have to give them an informed choice you have to give them the tools and then they have to make an informed choice

Sandra: we feel our job's done if we've said it and we've given the facts and the information'

This further highlights how practitioners reconcile personal and professional roles in the context of their work with Traveller Community members. Some practitioners appeared to present lifestyle issues as an intractable problem. For example, both Louise and Caroline describe healthy lifestyles as a minor focus in their work even

though these issues were described as prevalent in Traveller Communities. These issues were presented as best tackled by the Traveller organisation. This is possibly the result of the trusted position of this organisation and in the case of Caroline, since the small scale and time limited nature of her work with these groups was unlikely to be sufficient to address health behaviour. Linda described limiting the information she provided on contraception based on her perception of Traveller Community members' cultural beliefs. As such, practitioners themselves sometimes appeared to express a degree of fatalism over the extent to which they could engage Traveller Community members with respect to health behaviour.

7.3.4 Dressing up health information

Another strategy adopted by practitioners to manage the potential for health advice to jeopardise trust was to dress up or market health promotion advice in ways that were deemed more acceptable to community members. Traveller Community members were presented as particularly concerned with their physical appearance, with this sometimes hindering the uptake of healthy behaviours:

Linda: this woman told me this Traveller said its quite common now for a lot of women...to have boob jobs and to not breastfeed because they don't want their tits to be saggy to cause they'd be proud of their tits if you notice a lot of them you can see that cleavage

As such, practitioners often reported selling healthy behaviour in terms of its benefits for promoting physical attractiveness:

Linda: her daughter says 'oh I drink a lot of Coca-Cola' I said 'well maybe consider not' she said 'I'll go onto diet' I said 'they say diet 's no good you know consider sparkly water' she said 'really?' I said 'yeah if you wanna do good things for your teeth keep your teeth nice and white good for the baby'

Here Linda employs two mechanisms to frame health advice in a more acceptable way. Firstly, she emphasises the benefits of drinking water not only for the health of the mother and baby, but as keeping teeth white. Secondly, Linda's use of 'they say' distances her from the advice being provided. Sandra also presented Traveller Community members as concerned with their appearance, suggesting that having a suntan is what young Traveller Community women 'strive to achieve' and going on to describe framing the risks of skin cancer in terms of physical attractiveness as opposed to health when discussing the use of sunbeds:

Sandra: we're like well you do know that in the long run you're probably gonna damage your skin and you might end up getting cancer skin cancer

which isn't gon- really gonna make you look lovely if you've got a big melanoma on your face (slight laugh) and erm you know explaining what that isn't very you know would need cutting away and that's not gonna make you look very pretty and it's just like just something to think about girls you know (laughs) no no don't panic over it but just be aware that there is a direct link

Contradictions were apparent in Sandra's narrative however, since elsewhere in the interview she described not 'sugar-coating' information and suggested that this was something that she had 'wanted to bring up'. This points to some difference between rehearsed descriptions of her approach and those illustrated through storytelling.

Becky also describes appealing to vanity when giving behavioural advice:

Becky: so you know for smoking you can say well you know if you carry on smoking you might get a few lines you know erm or eat this they're fantastic for your complexion erm you know this'll really stop you getting spots...if you do a bit of exercise its you know you just look healthy you look fantastic erm so yeah those things we realise work really well

This concern to hide health promotion within other agendas extended to the design of health promotion sessions. Practitioners spoke often about ensuring that health promotion was informal and about laughing and joking with community members. Some practitioners described efforts to ensure that health sessions and advice were delivered in an entertaining way to distract from the seriousness of health messages:

Becky: obviously beneath all the jokey jokiness and humour erm we do have you know we the the courses we've done we've we we have there are some serious messages behind it

In Becky's above quote, health advice is positioned as 'beneath' and 'behind' the more overt emphasis on humour during the sessions. Indeed, Becky also describes careful marketing of health sessions to provoke the interest of community members. She describes producing 'vibrant' and 'bright' table displays with colourful and fresh fruit, vegetables and herbs that are 'exotic and exciting and a bit different' for community members, and which resemble 'Ready Steady Cook' or 'Jamie Oliver'. Caroline similarly argued that there was sometimes a need to avoid badging things as health focused, since people can feel like they're 'getting a battering' all the time. Although articulating a philosophy of providing information to enable an informed but free choice, some practitioners also appeared to adopt strategies to cajole Traveller Community members' participation in sessions. Sandra described the importance of responding to Gypsy and Traveller community preferences for sessions and the benefits of interaction in and of itself, but she also suggested that community

members would inadvertently be absorbing health information whilst participating socially, and described the strategic organisation of activities to maximise engagement with health promotion advice:

Sandra: you know you create a buzz and an excitement about what you're doing and that hooks them in... we've got everything set out for cooking but we we know that if they just came and did the cooking they'd then leave so we have it all set up so they know what they're gonna do but then we'll do something for maybe half an hour or an hour first and then do the cooking so they know they've got to stay (laughs) it's a bit sneaky

Karen also described the need to 'package' health promotion issues by surreptitiously approaching these under the guise of alternative activities provided for the community:

Karen: we need to sort of maybe set up a sewing group and start you know talking to you know the women around you know again bringing the breast and cervical cancer awareness theme immunisations for your children you know all that sort of health stuff as a blanket or as a smoke screen almost you know we're doing this but we're doing that as well

Again, at times this practitioner noted the need for freedom of choice, yet on other occasions this person used language such as 'oh you've caught them now' implying an attempt to get Traveller Community members on side. Traveller Community members were presented as sometimes thwarting health advice, by smoking cannabis, and going out and getting fish and chips straight after a health education session for instance:

Karen: and then they all went out for fish and chips after there was like loads of fruit and veg on there it's like oh...
Researcher: (laughs)
K: fruit and veg and a joint and then they set the fire alarm off and it was like oh my god (laughs)

While Karen described not wanting to force reading and writing skills onto Traveller Communities and instead empower community members, on another occasion during the interview, she suggests that she would have 'made' Traveller Community members undertake a literacy course, even if this was in 'disguise'. A further attempt to enforce healthy behaviours was apparent in Becky's description of restricting the use of salt within sessions for instance:

Becky: they cook and they go 'oh wow yeah fantastic how does it taste it tastes shit or it tastes nice and you know what I mean so can I put a bit of salt in no you can't but what you do in your own house is up to you

However, it is also important to note that one practitioner adopted a different strategy, using her professional responsibilities to create in-roads to broaching health behaviours:

Nicola: now that I feel that I have a more trusted relationship and role within the community erm I can justify tackling those health behaviours that its part of my role you've let me in as a midwife now and as a midwife I now have responsibility to try and enable you to help you to develop more healthy lifestyle

This illustrates the ways that professional identity might be used when broaching lifestyle behaviour; namely by stressing that this is something that they must do in their jobs. Other practitioners described dimensions of their own identity such as age and experiences (e.g. such as motherhood) as influencing their ability to identify and engage with Traveller Community members. Practitioners highlighted differences in connections with Traveller Community members depending on age and shared experiences for example:

Sandra: we had a student called [name] who again loved her work...she got on really well with the particularly with the young girls cause she was only about erm 20 so she had a really good rapport with them she had a lot in common with them and erm tha- I feel like I've been erm probably taken on more by the the Mums you know because I'm a Mum and we can share experiences and stories so erm a- the they think its great that you've got a child they wanna know all about your family (laughs)

Practitioners therefore described multiple and often contradictory strategies in their narratives, both hiding health promotion within other agendas and providing forthright accounts of the facts in relation to health behaviour. This illustrates how practitioners drew on competing ideas when describing their work and roles. The multiple dimensions of identity along which practitioners saw sources of potential connection or dis-identification with Traveller Communities and which operate in complex ways during health encounters have also been highlighted.

7.4 Interpersonal interaction

7.4.1 A privileged position of acceptance

Practitioners' preferred identities as occupying a unique position in being accepted and able to work with Traveller Communities were reinforced in interpersonal interaction between myself and participants and my more general engagement in

the field. In informal conversation with Becky prior to undertaking the interview for example, the privilege she described in gaining insight into Traveller Community lives was extended to my own role as a researcher:

Becky added that it was also a privilege to get to know a community who we often only get to know otherwise through TV programmes (Extract from field notes)

Here, Becky draws a commonality between herself and me the researcher: we are both outsiders, who have been given a rare opportunity to observe an otherwise hidden community. Louise similarly appealed to the researcher as a fellow outsider with an interest in the community, describing herself as 'fascinated' by Traveller Community members' shared history and inviting my agreement when stating 'their language is interesting isn't it?'. These claims to a position as having gained access to an exclusive community may reinforce notions of Traveller Communities as 'hard to reach', further protecting the expertise of professionals in working with the community. In offering such statements, practitioners exoticise Traveller Community lifestyles, despite often explicitly criticising such representations in the media (such as 'Big Fat Gypsy Weddings'). Descriptions offered by Becky, that Traveller Community members have a 'lust for life' or a 'seductive culture' and of time spent with Gypsies and Travellers as 'exciting', 'exhilarating' and 'intoxicating' (the latter used three times during the interview) romanticise Traveller Community life. Though this was less evident in the accounts of other practitioners, confirmation of this issue was also provided throughout my engagement in the field more generally. Members of the Traveller organisation supporting the research conveyed their discomfort where practitioners suggest they are motivated in their work by curiosity or 'fascination' with Traveller Communities since this communicates a voyeuristic attitude. They also raised concerns where practitioners suggested that are 'friends' with Gypsies and Travellers or use phrases such as 'I get on with the Travellers'. This was due to the homogenising effect of these statements and as they were viewed as an attempt by practitioners to position themselves as interesting because of their work with Traveller Communities. Indeed, this research has shown that these forms of positioning seem to play a role in upholding the interests of practitioners by supporting their preferred identities, as opposed to those of community members necessarily.

7.5 Summary

In the context of discourses that position Traveller Community members as less time disciplined, fatalistic, and a community that is difficult to engage, providing advice about health behaviour was presented by practitioners as a delicate subject which threatened their status as liked and accepted within the community. The data therefore provides support for previous findings in the area of social welfare, which suggest that Gypsies and Travellers are not without power in interactions with practitioners since they have the potential to reject the overtures of health professionals or retreat from services (Vanderbeck, 2009). This study has highlighted the strategies through which this power is negotiated by practitioners in health encounters, namely by seeking to dress up health promotion in other agendas, downplaying professional or middle-class identities and instead adopting a more casual persona when engaging with community members. While Traveller Community members were found (above) to express a desire for more health information and greater medical scrutiny of their bodies to detect illness which may be hidden, practitioners often directed their attention to more superficial levels of the body when delivering health advice. This points to a potential mismatch in expectations between Traveller Communities and health practitioners regarding what constitutes health advice. Where advice is hidden in other agendas or couched in terms of wider benefits for physical attractiveness, this may feed the anxieties of Traveller Community members about the lack of health information received, and further entrench their position of vulnerability. Having discussed the extent to which practitioners seek to engage Traveller Communities in health messages, the following chapter examines the extent to which Traveller Community members themselves drew on fatalistic narratives and/or those of self-determination with respect to their health.

CHAPTER 8 - Touching wood and bucking up your ideas: Fatalism and personal responsibility in Traveller Community accounts

8.1 Introduction

This chapter details the ways in which discourses of fatalism, and that on the imperative of health co-exist in the accounts of Traveller Community members. Counter dominant presentations in existing literature, the chapter demonstrates that Traveller Community participants were not beyond the reach of health promotion doctrine and worked to construct identities as morally responsible health citizens. I examine the ways that Gypsies and Travellers upheld this preferred identity position through both the positioning of self and other actors in stories, and interaction with a health(y) researcher.

8.2 Discourses drawn upon and used

8.2.1 Fatalism

Traveller Community members sometimes referenced discourses of luck, fate or the role of higher powers such as God's will in explaining health and illness. In doing so, Gypsies and Travellers occasionally positioned themselves as having a lack of control over their health, resonating with portrayals of Gypsies and Travellers as fatalistic in existing literature. Numerous references to fate were evident in Brigid's narrative for example. When describing her present health as good, Brigid often used the phrase 'touch wood', or literally touched or knocked on wood; a superstitious practice used to avoid tempting fate after expressing positive expectations for the future:

Brigid: but this last few days two days to tell the truth I have been like everything's been alright so so far so good so I'm alright, touch wood

Sophia too drew on discourses of God and religion or tempting fate in her discussions of health or illness. Such references to fate were common in Brigid's account, indicating that this is a dominant discourse governing her explanations for health and illness. This was consistent with her emphasis on changes to health and

the body as mysterious and unpredictable, bolstered by stories about sudden changes in the health of relatives or wider community members:

Brigid: look at [name] a young mother thirty-three-year-old lost her life to cancer sometimes you think 'why is life so tragic?' it [name] was a fit person she never had an ail never had a pain in her life and that happened to her weird innit? Makes you think you know how life can go should be grateful every day God gives you innit? But what can you do? But like it's funny how like you can be sick one day maybe be the best healthy person one day and be next day...it shows you how your body can change don't it like how you can health how your body can go downhill up the hill

Brigid's quote encapsulates a fatalistic philosophy, positioning health and the body as beyond personal control. Her use of 'weird' and 'funny' position rapid changes to health as incomprehensible, providing support for the function of fatalism in managing uncertainty over future health articulated in existing literature (Keeley, Lanelle and Condit, 2009). However, Brigid's account also conveys some possible limits to the role of fatalism in this respect, since this explanation did not remove Brigid's fear of potentially sudden health changes:

Brigid: weird innit like how your body goes it frightens you how your body goes doesn't it how how your body can be normal one day and brugh (shudders)

Discourses of fatalism were also apparent in Patricia's narrative which was characterised by great struggle in living with a long-term health condition and little hope of improved future health:

Patricia: a lot of Travelling people don't go to doctors till they're really really sick you see I'm not a big believer in taking medication I mean I've suffered for years before I've gone over this till I've gone because I can't stick the pain and I am glad to take the pain killers now I'm waiting for the time to come and especially men and it aint always over bad experience it's just that they don't go and some go when it's too late when they're poorly there's a lot of people with mental health issues in Travelling people and they never go nowhere and they just take it as part of everyday life till some of em can't cope and they are hospitalised or sommat like that

Here Patricia describes how her own philosophy as reluctant to accept medication resulted in her experiencing pain for a prolonged period. This is contextualised by the suggestion that Traveller Community members in general have a fatalistic attitude in that they are reluctant to take control and access services before health issues reach a critical point. This outlook is attributed not only to negative experiences with services, but a cultural attitude among Traveller Communities, and particularly so in the case of men and mental health issues. Within the above

excerpt, Patricia's statement of 'I'm waiting for the time to come' is particularly bleak; appearing to signal resignation to her situation and position herself as waiting for death, as opposed to striving towards a fulfilling and healthy life.

Although Eleanor discussed her religious beliefs at length outside of the interview and indicated her faith in God to help resolve difficulties in a family relationship, there were surprisingly few references to fate or religion when giving an account of her health. While Eleanor, for the most part, emphasised personal control and influence over her health, like Patricia, she described a reluctance to seek help for mental health problems:

Eleanor: because Travelling people don't like to admit they're mentally ill Travelling people don't it's like a private thing to them you know and it was never something that...and it was never something that was talked about I've never ever in me life grown up ever hearing my parents talking about mental health issues or anything like that... so when I started experiencing things like that meself I didn't understand... I stuck it for a I- a good few year without going to the doctor and telling the doctor so- I- f- but I got that bad on me own and no-one knew about it I s- I said I'll have to go to- I said I'll have to go I didn't tell no-one about it

However, a reluctance to admit mental health issues among Traveller Community members is one among several reasons Eleanor cited for her hesitancy to seek help, with others including a lack of education around mental health conditions, stigma surrounding these issues, and fear that identifying herself as experiencing mental health problems would result in her children being removed. As such, numerous factors were noted to influence her decision about the uptake of services and a cultural reluctance to discuss and seek help for mental health conditions was not alone in determining uptake of these services. In addition, Eleanor explains her reluctance to take medication prescribed for depression by a desire to retain control, thereby complicating the notion of fatalism:

Eleanor: I dunno if I was imagining it meself making meself think it over taking taking the tablets cause I thought people that take tablets they're they're out of their own control but it's like I say Travelling people don't like to think that they're not in control of things

Eleanor's decision not to take up this treatment was not based on a reluctance to take control over health, but paradoxically motivated by a desire to retain personal control. As such, Eleanor's reticence to take up services does not reflect a fatalistic orientation but rather an agentic decision based on what she believed was best for

her mental health. This supports the findings of wider research which points to the potential for fatalism to co-exist with agency. Similarly to Eleanor, women from low socio-economic and ethnic minority groups in a study by Bell and Hetterly (2014) used fatalism to avoid medical intervention, connected with fear and mistrust as a result of historical experiences. This helps to explain Eleanor's narrative in which a combination of fear of consequences of seeking medical intervention and a desire to retain control inform her decision not to seek help. As such, it is important that different forms of agency (i.e. seeking help from outside services as well as personal control) are considered when making inferences of fatalism, or a lack of fatalism.

The accounts of some community members showed only traces of discourses of fatalism. Charlotte, too, lives with a chronic condition which significantly limits her ability to undertake everyday activities, yet fatalistic discourses around health were rare within her account. A minor and implicit reference to fate did occur where Charlotte described how her condition always seems to worsen after she makes any commitment:

Charlotte: I can't take permanent work on because I know I'm not reliable enough I might be OK for a week I might be OK for 6 months until I take some responsibility on and its usually as soon as I take the responsibility on I c- I get sick again and it come it can come on within hours I can be fine in a morning and then in the afternoon I'm not or the other way around

Similar trends are evident here to those reported in Brigid's narrative earlier. Charlotte describes it as bad luck that her health typically worsens precisely when she's agreed to take on any responsibility, as if she has tempted fate by making this commitment. In addition, her state of health is presented as unpredictable and liable to change quickly, giving a sense of health as beyond control. At times, Charlotte also presented her body as out of control:

Charlotte: it's like I've put the wrong legs on like I woke up this morning and put ones with the wrong shaped erm...there was one day walking around [shop name] a couple of year ago I'd been fine for weeks been fine just went for some not loads of shopping just a little bit for the tea or whatever and when I got to the doors to come back to me car I couldn't move me legs at all they wouldn't it it was like that was it they was like chair legs (smile) they just didn't they didn't bend there was no pain I had to call for somebody to come and get me (laughs) it didn't hurt it just and I couldn't push the trolley I could- cause the legs wouldn't go...they just decide they're not doing it (laughs)

The language Charlotte employs above serves to dissociate those body parts affected by illness from herself. By likening her legs to 'chair legs' and suggesting

'it's like I've put the wrong legs on', Charlotte describes her legs as if they were external objects. The use of 'the legs' as opposed to 'my legs', and the suggestion that 'they just decide they're not doing it' have a similar function; presenting her legs as having a mind of their own. At another point in the interview, Charlotte describes how her mobility often worsens on arriving home as 'your body just relaxes', again illustrating how the body can be deemed to be operating independently. Referring to body parts in this way seems to introduce humour, which may also function to distance self from illness and retain a sense of normality (something that appeared very central within Charlotte's narrative) as well as potentially reduce any burden for the listener.

Fatalistic expressions were almost entirely absent in Lucy's account of her health, which instead stressed individual responsibility for health. While Lucy does sometimes refer to God and luck (e.g. 'thank God' and 'it's a good job') when reporting her usual state of health, these phrases were used only in passing, and mentioned infrequently, appearing as figures of speech as opposed to dominant narratives for explaining health and illness. However, as in the case of practitioner narratives, Lucy did refer to the potential difficulties prioritising health, considering other concerns, when describing why other community members may have less healthy lifestyles:

Lucy: well there could be all different reasons maybe they're not getting encouraged to do things or they've maybe got problems in their life where they think oh we've got more problems than thinking about healthy lifestyles or illnesses that seems to be like the main cause people can't do it it's not that they don't want to its they can't

Elsewhere in the interview, Lucy suggested that for roadside Travellers, difficulty finding appropriate accommodation may impact on the ability to make healthy dietary choices. This again has some resonance with the suggestion by practitioners in the study that Traveller Community members may find it difficult to prioritise health when dealing with more pressing structural concerns. Indeed, narratives about a lack of ability to prioritise health were also evident in the account of Brigid, where she suggested that she hadn't noticed her health deteriorating at a particularly stressful time when she was experiencing difficulty finding accommodation. Some similarity was also apparent between practitioner portrayals and the presentations of self by Traveller Community members in respect to Traveller attitudes to time. During a group discussion at a conference I attended,

Traveller Community members suggested that they didn't want their lives to be interrupted repeatedly by researchers and were keen to move on with their lives once they had participated in research. Yet, while some parallel is evident here with the accounts of practitioners, it is notable that preferences articulated around engagement with researchers may differ from preferences for receiving health advice, especially considering community members' concerns about the lack of health information they received.

Hints at a fatalistic narrative were also apparent in Kelly's account where she describes her reactive approach to managing her health:

Researcher: you said that you don't go to the doctors very often so that's
Kelly: I dunno cause like I'd only go to the doctors if there was something wrong with me I wouldn't go for weekly check ups erm I dunno

Kelly explained this by a combination of factors which included the distance of accessible health services and her own lack of motivation to access them. However, while embodying some elements of a fatalistic approach, she too more often relied on discourses of personal determination over health, something that will now be explored in more depth.

8.2.2 The imperative of health

Although there was evidence of Traveller Community members presenting health as beyond their control, this was not the only discourse at work in governing Gypsy and Traveller explanations for illness. Rather, Traveller Communities interviewed often demonstrated awareness of public health advice, monitored their own behaviour in accordance with such guidance, and emphasised personal responsibility for their health. Discourses on the imperative of health are most strongly apparent in Lucy's account, which is saturated with the need to monitor and avoid potential health risks, and with statements of self-determination in avoiding illness:

Lucy: I think it's better to feel fit and health in yourself so no I won't let meself get that far that I feel unfit and healthy

The phrase 'I won't let meself' (which also appears in a similar form elsewhere in Lucy's narrative), firmly situates health within the realm of personal control. Throughout her narrative, Lucy presents a coherent identity as healthy, spanning childhood through to imagined future selves. In the following excerpt, she lists those

behaviours that make her lifestyle healthy, seeming to perform her awareness of these to the listener:

Lucy: I think I've got quite a healthy lifestyle really erm I always go for a walk every day when I go home because I I'm always stuck behind the desk (laughs) while I'm at work erm I go swimming once a week always taking me dog for a walk erm and like me diet kind of lifestyle its quite healthy because I don't like sweets I don't like really I don't like really like crisps I'm not very keen on chocolate (laughs) cakes I don't really like pop I'm not a sweet eater at all I always have loads of fruit and veg erm so my lifestyle I think it's alright (laughs)

Lucy's account was peppered with normative statements indicating what 'should' be done in relation to one's health, and public health discourses were used in conjunction not only with behaviour, but Lucy's representation and treatment of the body:

Lucy: when they're smoking on the telly all that that they're taking into their bodies and how like people's alcohol all that what they're taking and drugs and what I think is I've got a friend she's about 27 or 8 but she works with people that's like bed ridden and people that is dying and things and I think well how can you be like yeah I know sometimes some of them has problems why they take drugs and alcohol and things but I think how can you be taking that into your body you are like a healthy person what's got maybe like at least 40 year of your life still to live and people that doesn't want to die but they've seriously ill and dy- I don't understand it I think how can you be wanting to take all that into your body you know destroying your body and things so yeah I think it's like got a very big impact on people they should be like (laughs) careful with what they take and what they have yeah and I think all like seeing it all the time it makes you more aware and know how important it is to keep like a healthy lifestyle and look after yourself

Lucy doesn't present the body as something that was beyond control but argues for the need to protect one's body by adopting the appropriate behaviour. She communicates a lack of understanding of why some people choose to pollute their bodies with substances that cause harm. Far from illustrating a lack of concern for future health, as was suggested by some practitioners in the study, Lucy's narrative makes a direct connection between current behaviour, future health and longevity of life, translating this into the recommendation that people should therefore be 'careful with what they take'.

Kelly's narrative was also almost entirely governed by a discourse of personal responsibility and agency with respect to health and health behaviour. Kelly was aware of public health messages such as those on the harms of smoking and

assessed her own health and behaviour in accordance with these guidelines. Yet, she differed from other participants in that she self-defined as unhealthy, and a lack of engagement with recommended behaviours formed a core element of her overall identity presentation:

Kelly: I wouldn't say I'm very healthy I smoke twenty fags a day so I'm not very healthy
Researcher: so you wouldn't say you were
Kelly: no I'm far from healthy

Elsewhere in the interview, Kelly also illustrates her awareness of other behaviours that are problematic for health, including drinking fizzy pop or red bull and eating high fat food. Thus, it is not the case that Kelly is unaware of public health doctrine on what constitutes healthy behaviour, but that despite this she exercises her choice to engage in behaviour such as smoking. Discourses around behaviour change for health promotion were also present in Eleanor's account. Like Lucy, Eleanor did not describe herself as having any current physical health conditions, and defined periods of health and lack of health solely by reference to her lifestyle behaviour. She too enacts her claim that she knows 'how to be healthy' to the listener by listing behaviours that she understands to be healthy or unhealthy, and clearly evaluated her own behaviour in accordance with public health doctrine:

Eleanor: I'm quite healthy nowadays erm compared what I used to be cause I used to be cause I used to smoke I used to smoke so but obviously I've give them up like a- a- lot of years ago now so but in the way of eating I'm not a very healthy eater I do eat a lot of junk food

Other smaller asides further demonstrate the imperative of health in Eleanor's narrative, including reference to role of health education in informing people of 'how they are supposed to be', as well as her use of public health or medicalised language such as 'binge drinking' and 'comfort eating'. The notion of a 'clean system' and the ideas that unhealthy behaviour can be a 'shock' to the system also introduces ideas around the polluting effects of unhealthy behaviour on the body, mirroring Lucy's narrative.

Perhaps unsurprisingly, the imperative of health was less prominent in the accounts of Brigid and Patricia, who were both living with long-term health conditions. This was particularly so where the overall narrative plot was one of struggling to cope with these conditions, as in the case for Patricia. However, even in these instances, discourses of personal responsibility were not entirely absent. Although it was more

difficult to get access to examples of Patricia's engagement in activities to promote her health, she was not unaffected by dominant health promotion discourses and described compliance with behavioural recommendations for the management of a family members' diabetes for example:

Patricia: She [daughter] knows because now she has to get up and do breakfast and things because he's been diagnosed with diabetes as well so he has to have things regular

When asked about advice she had received around how to improve her health, Patricia described her attempts to lose weight through exercising and eating healthily. Similarly, despite numerous references to fate in Brigid's account, her use of 'I'll get back to myself' in the below quote conveys a sense of self-determination with respect to her health:

Brigid: I was always fit I was never in hospital for anything weird innit like but then this there this last few mon- this last two three years though is everything's gone phew but I'll get back to meself

The discourse of individual responsibility for health is also communicated when Brigid describes a need to resume exercise, and when discussing her dietary behaviour:

Brigid: I used to eat a lot of fatty foods and I think I've gotta cut down because it's getting beyond a joke getting too fat I'll have to cut down all these bulges but no I do like I like fruit I eat a lot of fruit and vegetables...but like I think these takeaways and things like that aren't healthy are they the rare time I get a takeaway but I do eat a lot of fatty foods but what can you do life happens do you know what I mean I cannot eat at all wouldn't I

Brigid here demonstrates self-surveillance around how she 'should' be behaving with regard to her diet, as prescribed by dominant public health discourses. Consideration is perhaps needed around whether Brigid's account of her behaviour is as much the result of discourses reinforcing normative ideals of body size and shape as those on and promotion of health, given her remark that she needs 'cut down all these bulges' and her suggestion elsewhere that sometimes she is 'depressed' at the size of her stomach. However, health promotion discourses are themselves often entangled with those reproducing notions of idealised body image (Carlisle Duncan, 1994), and Brigid's use of the more medicalised term 'obese' (elsewhere in the interview) alongside everyday alternatives such as 'fat' confirm inscription by public health discourses. Indeed, Brigid's acceptance of personal responsibility is also evident in her monitoring of other health risks, for example,

when describing her hesitancy to bring her children into a GP surgery when they have measles in order to avoid spreading infection. The statements at the end of the above excerpt that 'life happens' and 'I cannot eat at all wouldn't I' seek to make the behaviour of eating unhealthily understandable by reference to the complexity of life and do convey some limits to possibilities of personal control however.

It was not always the case that experience of living with a long-term condition reduced the presence of health imperatives in the accounts of Traveller Community members however. In Charlotte's account, narratives about a lack of control over health sat alongside the importance of willpower and self-determination in managing a long-term condition. Throughout her narrative, Charlotte emphasises the importance of maintaining a positive outlook and the power of the mind over the body. These statements were supported with stories drawing on plotlines available in wider discourses about the possibility of fighting or triumphing over illness and defying illness trajectories:

Charlotte: because it I it's it's not helpful to just sit there erm they told me when I gorit cause I'm nearly I'm forty this year so I've had it ten year they said within ten year I'd be in a wheelchair which when I was at me half way point when I was poorly all the winters and couldn't stand up I thought it was true that was what was happening which it very possibly was (laugh) but I wa- I'd I'm more determined that I won't let that happen and even if it hurts I'll get up and I'll make meself do things erm

Within the above excerpt, the difference between actual and expected health status is not presented as the product of an inaccurate assessment about the progression of the illness. Charlotte describes how her health began to worsen and was reversed due to her own refusal to succumb to the illness and determination to keep going. This relates to Charlotte's frequent presentations of herself as independent, spanning back to, and bolstered by re-readings of events during childhood, and which mean that rupture to this identity may be particularly problematic. As such, Charlotte's narrative challenges linear medical narratives offered by practitioners which seek to quantify or label the degeneration of illness and reclaims control and authority over her own body. Presenting oneself as triumphing over illness and carrying on longer than had been expected, appears to help Charlotte to retain an identity as independent. Charlotte also presents herself as attuned to advice for promoting her health, 'reading up' and 'finding out about' information and as evaluating and regulating her own behaviour in response:

Charlotte: I I watch what I eat and I erm I very rarely sit down for a long time (laughs) and I I just try and keep mobile I have apps on me phone what tracks my activity levels or so that when it's in your pocket yo- kn- its picking up what you and when you don't when you check on it you think oh I must have been sat down a lot and you it I suppose it erm it gives you a cue to do a bit more or to try at least and I have apps to what so you can log what you eat and activities and things like that you do so you can kind of monitor your calorie intake a little bit so I try to do that erm and I s- I suppose it's just about reading up and finding out about what's what could be making things worse I've had to change what I eat a little bit I used to use erm like sunflower spreads and things like that which I thought was better cause in my family I've got heart disease so I didn't want to be eating erm animal fats and things like that so I but I discovered that sunflower oil potatoes and things like that make can make the arthritis in your hands and your fingers worse so I changed them from me diet... so now I don't eat as many potatoes but I do eat butter (laughs)

Fatalistic expressions therefore sat alongside discourses of self-determination and personal responsibility for health in the accounts of Traveller Community members. This finding supports previous research with the wider population which indicates that people tend to draw on a combination of fatalistic discourses and those on the importance of behaviour as predictors of health (Bolam *et al.*, 2003; Keeley, Lanelle and Condit, 2009). A clear contrast is evident between the narratives of Traveller Community members and the suggestions of some practitioners that Traveller Community members are not oriented to their future health, with many examples reported of community members moderating their current behaviour in order to minimise risk factors for future illness.

8.3 The positioning of self in relation to others

8.3.1 Avoiding judgment and blame

Discourse on the imperative of health connected with the potential for blame in the accounts of all Gypsies and Travellers, and particularly when describing engagement in 'unhealthy' behaviour. The ways that Gypsies and Travellers accounted for their health behaviour was therefore a key aspect in identity presentation, and the extent to which status as a morally responsible and healthy citizen could be claimed. For example, Brigid not only explicitly laid claim to a healthy identity by repeatedly suggesting that she was 'usually healthy', 'usually a healthy fit person' or similar, but also guarded against the potential health stigma associated with being overweight or 'obese':

- Brigid: since I got the chronic fatigue syndrome though I put on a lot of weight I noticed that me stomach I can't get rid of it I does exercise everything it's like a football it's that hard sometimes you can't weird but I went to the doctor at the hospital the other day and they said it could be the fatigue 's causing it you know like to not go down because it's your horm –mor-horn- whatever you all them hormones (laughs) hormones (laughs) but urh I mean like that's what's causing me stomach so big cause some days some days it's bigger than others some days it's out here some days it goes back in
- Researcher: right
- B: weird that innit [like?
- R: yeah yeah
- B: People says to me [name] first like you're not an over obese woman to have a stomach so big I'm not though cause like even the doctor said to me he said 'you're not you're legs is not big how old are you [name]?' I said 'I'm forty-three' he said you 'for a woman to have like your body's not an over obese to have a big belly' I said 'I know', 'do you drink?' I said 'no' the odd time I drink on very rare an occasion maybe a funeral or a wedding or something like that I drink but don't go out like drinking or anything so that's they call that a beer belly mine's not a beer belly is it

Brigid's statements that she is 'not an over obese woman to have a stomach so big' and the repetition of similarly worded phrases in the multiple occasions on which this story is told serve to provide evidence that she is not simply overweight, but that her enlarged stomach is the product of her health condition. In doing so, Brigid recognises and strives to counteract any potential judgement. Brigid also uses her account to discount lifestyle behaviours as potential explanations for her enlarged stomach, describing how her stomach hasn't changed despite exercise and ruling out other causes such as drinking alcohol. Reported speech is used to provide more 'objective' evidence, or to distance the teller from the message through removing their interpretation (Holt, 1996). By citing the voices of others, including that of a doctor, Brigid therefore lends support to these claims. That this story was relayed in a remarkably similar fashion both in conversation outside of the interview, and on another occasion within the interview, suggests that this is a well-rehearsed aspect of Brigid's health identity. It may also indicate the strength with which potential moral judgement over lifestyle behaviours permeates Brigid's account of her health.

The moral status entangled with health was also clearly apparent in Lucy's account, which was filled with value laden judgements of health behaviours, as seen below where she describes her plans for maintaining a healthy lifestyle:

Lucy: keep as active as possible all me life (laughs) try to keep as much active as I possibly can an try and keep like a healthy lifestyle always cause I think if you let it slip that'll just be it as you get older you think oh well get in these bad habits and bad I don't think that's any good try to make sure that you're always having your 5 a day veg always have fruit drink as much water as possible try to cut out on all the sugary fattening kind of foods all the time maybe just have a takeaway once a week and even though that I drive I do- I make sure that I'm always still walking about when I go home I always go for walks cause otherwise I think you're getting bad lazy habits (laughs) then you won't be able to get out and then when it won't do any good for your lifestyle at all yeah just try to keep active as possible all the time

The use of 'if you let it slip' communicates the need to keep one's health under tight control and as above, situates illness as a matter of personal responsibility, while the phrases 'bad habits' and 'bad lazy habits' clearly illustrate normative judgement operating around behaviours. Lucy's laughter also suggests some concern with impression management. Laughter has been noted to feature in interviews where self-image is at stake (Soilevuo Grønnerød, 2004), and as a mechanism through which participant's deal with gaps between ideals and realities; here between the reality of being 'stuck behind a desk' and the far-reaching ideal of staying 'as active as possible all me life'.

As in Brigid's account, an awareness of potential judgement over her lifestyle behaviour appeared to influence Patricia's presentation of self:

- Researcher: do they has the doctor ever said anything to you like that you should do something the same or different have they ever like said to you do this or that to improve health?
- Patricia: just to lose weight which I'm trying to very very hard because it () you know your bones which I know that meself cause but it's only this last few year couple of year that I have put weight on and I think it's put down to not being as active as I used to be what I can't d'ya know what I mean and I can't exercise like I used to do cause I used to walk a lot and I can't do it now...rain
- R: I know its miserable today isn't it? Erm I think that's erm I suppose it's just about yeah have there been any other people that have said to you to do different things or what's what else is helping you to do you know you said that they said to lose weight and you're trying to lose weight as well what stops you from being able to do those things and what helps you d'you know
- P: well the food part I do cut down I do do it I do do the food part but I cannot do the exercising sometimes I walk I went t' [name of shopping centre] with me daughter on not this weekend a couple of weekends before and we was gone for about an hour and a half and I was in bed for two days after I

could not move me legs cause I kept saying to her 'hurry up hurr-' 'ah you'll be alright mam' she thinks I'll get her out or whatever but I was in bed for two days and couldn't move I couldn't get up me legs were hurting me that much

Within the above extract, Patricia seems concerned that she may be judged for a lack of engagement in behaviour to lose weight. Through her statement 'I'm trying to very very hard' and the repetition of 'I do' when describing adapting her diet, Patricia appears to be stressing to the listener that she is trying to act in the 'right' way with respect to her health. The need to lose weight is presented as not only advised by the doctor, but something Patricia recognises herself. Reference to diagnosed illness appears to help guard against any potential judgement for not exercising more; it is not a matter of choice, but of being prevented from exercising due to the long-term condition. The flip into story mode to describe a concrete event supports these claims by helping to bring the listener in and create a more vivid picture of the difficulty Patricia experiences when attempting to exercise. Similar trends are evident in Lucy's account where she presents people as generally wanting to live a healthy lifestyle but being prevented from doing so due to circumstances or health condition:

Lucy: I suppose if you have health problems that's something that you can't actually do owt about

The suggestion that 'people can't do it it's not that they don't want to' again helps to avoid individual blame. This connects with the face-saving and sense making functions of fatalism identified in existing literature. The sense-making function of fatalism has been described as rationalising a lack of engagement in health behaviour on the grounds that the negative effects of previous behaviour are now impossible to reverse (Keeley, Lanelle and Condit, 2009). Here, fatalism as sense making seems to take a slightly different form however; the presence of a long-term condition enables participants to present an understandable account for an inability to lead a healthy lifestyle. A key difference is also evident here since those referred to above are unable to enact this behaviour, as opposed to rationalising a choice not to act based on the lack of impact this would have.

It was not only through claims of engaging in healthy behaviour that Gypsies and Travellers sought to position themselves as responsible and healthy citizens however. Another way through which Traveller Community members could demonstrate their health consciousness was by 'confessing' their unhealthy

behaviour and stating their intentions to be healthier within the interview itself. Cycles of guilt and sin (Kristensen *et al.*, 2010) in relation to health behaviour were prominent in Eleanor's account, with periods of engaging in an excess of unhealthy behaviour followed by a wholesale transformation of lifestyle to be healthier:

Eleanor: when I'm eating healthy I eat healthy but when I eat bad I eat bad so it's like it's like give and take sometimes I think right I've had enough of this junk food I'm gonna start and I will start and buy a load like I've got a lot of fruit in now but I always I'll just eat fruit and I'll eat all the healthy stuff I'll have a proper healthy diet but if I'm not bothering I can be very bad I can eat like take outs one day after another you know I can be very very bad so I go through phases for so many months I'll I'll I'll I'll be like a health- health person where's I'll drink water I'll drink er herbal teas I'll drink hot lemon and water for a- for probably two months solid and I'll nothing but healthy fish and chicken and fruit and vegetables and I'll eat no rubbish and bare skim of butter on a bit of brown bread and boiled eggs you know all proper healthy stuff what's good for you but then I get sick after a while after two months I phew I've had enough of all that and then I start eating rub- [rubbish] that is the truth

The repetition of the statement 'I can be very bad' again illustrates how moral imperatives of health permeate Traveller Community member's accounts and the ways that the interview acts as a forum in which individuals confess to their 'unhealthy' behaviour. Eleanor presented behaviours that are bad for your health as desirable and difficult to resist, but the uptake of these behaviours as followed by feelings of regret:

Eleanor: I mean fruit and vegetables is best thing you can eat to keep you healthy we- like know that but it's whatever it is we're just we're just get dragged to the horrible things it's like horrible things in the world is just so you wanna do erm you know they're bad for you but you still wanna do em and you know if you do you're not gonna be happy about but you still do it anyways but you know the good things that is good for you and they will benefit you you don't wanna do (laughs)
Researcher: it's true

The use of normative language here again illustrates the value laden nature of health talk, with those behaviours that are bad for you described as 'the horrible things in the world'. Eleanor's narrative reminds of a tension between pleasure and discipline in relation to health behaviour. The following extract further illustrates the ways that claims to health consciousness can be achieved through the role of confession and statements of intended self-improvement:

Eleanor: I thought when I do start deciding to buck me ideas up (laugh)
I'll go and see them [nutritionist]
Researcher: yeah so you're gonna go and see them are you [yeah]

Eleanor: I am yeah] definitely when I decide to when I decide to start eating but I have I have been I've been eating healthy you know but I can be healthier than what I can really you know but like I said it's just temptation is a very bad thing (laughs)

Reference to 'temptation' denotes issues of sin, as does the phrase 'buck me ideas up'. As for Lucy earlier, humour is employed in light of a 'problem revelation' statement, which indicates a gap between the presentation of 'real' and 'ideal' images (Soilevuo Grønnerød, 2004); Eleanor laughs when describing how she is not living up to ideal standards of health behaviour. The use of humour in these scenarios arguably helps people to minimise problems and demonstrate capacity to overcome them (Soilevuo Grønnerød, 2004), fitting the explicit narrative plot of reformation. Given the potential for moral judgement in the interview, participants appeared to use humour for impression management, to reduce the impact of statements deemed to be unacceptable (in this case statements contravening health advice) by demonstrating that they themselves recognised them as such (Soilevuo Grønnerød, 2004).

Examples of confession to unhealthy behaviour were found across participants. This is seen earlier where Brigid is careful to correct the potential misinterpretation that her lifestyle is completely healthy when she says 'don't get me wrong...I do eat a lot of fatty foods'. The acceptance of personal blame for health is also displayed where, rather than attributing her tiredness to her long-term condition, Brigid suggests she has become 'lazy' now that she has stopped living on roadside and has settled on an authorised site. Issues of confession were also evident in the ways that Charlotte positioned herself:

Charlotte: I've not been going to the gym cause I've been in pain all the time and probably what I really need so is if I'm going to the gym somebody to go right why haven't you been d'you know like to put some responsibility on it rather than just leaving it on me going well go if you can well no I can't actually (laughs) so I know like none of it I can't do really if it's just do what you can I can't actually do mo- most of it

Although the pain caused by Charlotte's condition is often prohibitive of engagement in physical activity, self-determination is again emphasised, with the solution cited as having someone to hold her to greater account for not exercising. Charlotte laughs when suggesting that if she was accountable to herself alone she wouldn't push herself to go to the gym and would decide 'well no I can't actually' with humour again used when positioning oneself in relation to an unmet ideal. Like in the

accounts of earlier participants, Charlotte therefore accepts a level of blame for not engaging more in exercise, confessing that she could do more to the listener. Indeed, the acceptance of blame occurs often in Charlotte's account when discussing a deterioration in her health and condition:

Charlotte: I didn't think I had measles but I did but I wa- it was at the same time I was on [medication] and I just thought I was ill with it being winter erm and so I wasn't really going to the GP that much apart from to get prescriptions an' and so I i- I kind of I suppose I let meself get into situations with my health because of me arthritis erm that maybe other people would probably go to the GP straightaway with

In using the statement 'I let meself get into situations', Charlotte positions herself as culpable for her ill health. Elsewhere in her narrative, Charlotte also explicitly describes herself as at 'fault' for forgetting to take her medication, and for not pushing more to get access to health services. Thus, even where participants reported disengagement in behaviour to promote their health, by showing recognition of this and stating one's intention to be healthier in future, they sought to demonstrate self-surveillance and retain some semblance of identity as 'responsible' with regard to their health.

While demonstrating compliance, or at least intended compliance with health advice was one route through which Traveller Community members could cultivate positive health identities, Traveller Community members also took care to avoid positioning themselves as overly concerned with their health. Lucy fitted the caricature of the 'worried well' in that she constantly monitored and responded to potential health threats, clearly taking up those responsibilities prescribed by public health discourses. Lucy's commitment to living a healthy lifestyle therefore meant that she was less vulnerable to potential judgement with respect to her behaviour than was demonstrated earlier for some participants. However, Lucy's conscientiousness with respect to her health also opened up the possibility for judgement. Within this extract, Lucy presents herself as soaking up health information at any given opportunity, both for herself and family members or other sections of the community. However, her suggestion that she may be a hypochondriac points to some tension in relation to the presentation of oneself as health concerned:

Researcher: where are the main sources of information about health for you?
Lucy: from the doctors or even like if you go to hospitals they always have like big posters and leaflets up don't they all about

health and things or like I'll even I'll google it (laughs) you know find out all the different problems or just talking to people like they'll tell you and things you get like leaflets sent out and things to you so yeah yeah I get loads of information (laughs) oh sometimes I think I'm a hypochondriac (laughs) ooh that might be wrong with me do you know when you're reading it all yeah I get loads of access and loads of information but I think it's good to be informed ()yeah and now me [family member] well she works in a nursery so she has loads and loads of books on from like infant to about 9 and 10 year old you know telling you about all the health problems and things so I know all that for like with small children (laughs) and when I go to doctors and things and listening I know for the older ones as well yeah so I do get loads of information

Being a hypochondriac is something which has a negative status attached to it in society, and Lucy appears attuned to the risk that she is viewed as too focused on her health. The use of 'you' where Lucy says 'do *you* know when you're reading it all' helps to avoid this judgement, presenting the tendency to self-diagnose or over worry about health issues after looking online as something that I would also recognise. The statement 'I think it's good to be informed' also helps to avoid any potential criticism by reframing this tendency more positively. Smaller asides in Lucy's narrative also hint at possible judgement attached to being too healthy. For instance, her laughter following her earlier suggestions that she doesn't like sweets, crisps and chocolate, foods commonly seen as 'treats' in society suggests some self-consciousness around her rejection of these. In addition, the laughter which follows Lucy's labelling of some behaviours as 'bad lazy habits' in her earlier extract also seems to indicate some discomfort in criticising these behaviours. Brigid's description of her sister as a 'fitness fanatic', as well as the presentation of healthy behaviours as 'boring' by Eleanor (and the health practitioner Sandra) further point to the potential undesirability of identity as someone that has become too absorbed with their health. This aspect of the narratives resonates with the tension between enjoyment and longevity of life identified by Becky (a health practitioner in the study) and help to contextualise the more general concern of practitioners with making health advice more interesting to community members. However, it is important to note that this concern formed only a small part of the narratives of Gypsies and Travellers, with a desire to present as healthy forming a much more prominent identity position for Traveller Community members involved in the study.

Kelly's account provides a useful counter example to those of other Gypsy and Traveller Community members presented so far, in that she appeared to be more resistant to the moral pressures surrounding health. As for others, discourses of personal responsibility were evident in Kelly's account, and there is also evidence of the moral evaluation of behaviour when Kelly describes herself as 'very bad' for engaging in behaviour such as the consumption of energy drinks and greasy food, that is harmful to health. However, she did not strive to present a positive health identity in the same way as other participants, and was more outwardly rejecting of, and resistant to health messages. For example, despite recognising that smoking is bad for her health, Kelly explicitly states that she has no intention of quitting:

Kelly: it's not very good for you is it smoking twenty fags a day can't be good for you really
Researcher: and what what do you think about what do you feel about that do you worry about it or do you does it cross your mind very often or not?
K: no not at all I have no plans on giving up so no

Kelly described her decision to stop drinking fizzy pop as driven by necessity ('I had to') due to becoming unwell, and therefore as a reactive rather than preventative choice. She presents herself as having a high degree of agency with respect to choices over her health behaviour, describing her resistance to attempts by family members to influence her smoking behaviour:

Researcher: and what do they [relatives] say about your smoking do they give you advice about that or?
Kelly: no cause they smoke too like me Mummy tells me to give up all the time but
R: does she when she says that you're to give up what why does she say that she wants you to give up like what reason does
Kelly: cause obviously she knows it's bad for you ()
R: and what do you say when she says that?
Kelly: I just tell her to shut up (laughs)

Resistance to health advice forms a consistent thread throughout Kelly's presentation of her health identity both within and outside of the interview. While on one occasion in the interview she appears to make more of a claim to be healthy, the conversation then shifts back toward her lack of engagement with behaviour to promote her health:

Researcher: would you say that you've been quite healthy in the past or?
Kelly: I dunno like I wouldn't say unhealthy person but I dunno
R: what kind of things do you do that mean you're not unhealthy?
K: what do you mean

- R: like what things do you do in life like to try and stay healthy?
K: what do you mean like?
R: like some people might do I dunno they might eat certain things they might drink certain things
K: no I just eat whatever I want

The statement 'I wouldn't say unhealthy person' appears to imply the presence of a healthier identity. However, Kelly's later comment that 'I just eat whatever I want' continues to point to an overall absence of health consequences in guiding her behaviour. On reflection, my phrasing of the question 'what kind of things do you do that mean you're not unhealthy' in the quote above may have closed off the potential for Kelly to stipulate alternative 'healthier' selves by presuming a behavioural explanation and shifting the discussion into the present and away from the time point at which Kelly described herself as not unhealthy. A better question may have been 'what makes you describe yourself as not unhealthy then?' However, as Kelly presents herself as unhealthy consistently throughout the interview and in response to more open questions, it is unlikely that this presentation of self is the result of the phrasing of the question alone.

8.4 Interpersonal interaction

8.4.1. Confession and resistance to a health(y) researcher

Interviews and wider interaction with Traveller Community members during fieldwork acted as a microcosm of the discursive conditions discussed above and provided occasions on which the performance of preferred health identities played out. Radley and Billig (1996) describe how the accounts of people experiencing illness might be influenced by the fact that they are narrating this to a 'healthy researcher'. It is possible that, as someone researching health, I was also viewed as advocating healthy behaviour and as judging participants for their own approach to health. The preferred identities of Traveller Community members were often echoed in my interactions with them outside of interviews. For example, both immediately before and after the interview (as shown in the below extract), Kelly made me aware that she was going for a cigarette:

- Researcher: I think that's all the questions I've got to ask you but erm is there anything else you think I haven't covered or like you wanna say about health that I haven't asked about or thought about

Kelly: I can't think of nothing anyways
R: no that's really useful to speak to you really helpful thank you
K: you're alright that's grand I need a (smoke)

Such demonstrations of engagement in 'unhealthy' behaviour to the researcher may function as a form of enacted resistance to health doctrines about smoking perceived to be upheld by the researcher, in keeping with Kelly's explicit identity presentation as unconcerned about her health. On another occasion when I was giving Kelly a lift back to the Traveller site during fieldwork, I realised as we were arriving on site that she was not wearing a seatbelt. This came to my attention when a police car passed by and Kelly reached for and pulled the seatbelt across her to give the illusion that this was fastened. At this point I expressed my surprise, asking if she hadn't had this on during the trip and she replied that she hadn't. I was shocked and said that she should wear a seatbelt. On reflection, I noted that dictating how I thought someone should behave is usually something that I would avoid when engaging with research participants. That I did so on this occasion was perhaps the result of the interaction taking place in my car (which can be conceived of as an extension of my own personal space) and my surprise that Kelly was not wearing a seatbelt (which I had viewed as a taken for granted practice). This demonstrates how Kelly's overt identity claims as resisting health discourses were recreated in the interaction between Kelly and myself as health researcher. Other instances during interaction with community members also reflect this dynamic, for example when I was unsure whether to accept a can of Red Bull that had been bought for me by a community member. An interaction in which a young Traveller told the rest of the group that I had brought a salad for my lunch highlighted the potential that community members were projecting a healthy identity onto me. Reported motivations for adopting certain lifestyle behaviour also hints at the ways that a health researcher may be positioned by participants as someone upholding ideas about what people should or shouldn't do in relation to health. For example, Eleanor used the honesty statement 'to be truthful with you' for example when describing how she had quit smoking to prevent this forming a barrier between her and her children, as well as due to financial motivation, as opposed to reasons strictly related to health. In doing so, Eleanor appeared to be 'owning up' to the researcher for not quitting smoking for 'right' reasons. These examples illustrate how my own position as a health(y) researcher appeared to contribute to interviews and outside interactions taking on the quality of a 'confessional', through which power

relations associated with public health doctrine continue to be exercised in the interaction between the researcher and participants.

Connected with this apparent concern with being judged by the researcher, I experienced a similar tension to that identified by practitioners around maintaining acceptance while asking about health behaviour. I often found it difficult to introduce questions about what people did to maintain their health, for fear that I would be seen as judgmental. On occasion, this resulted in my unintentional reinforcement of fatalistic discourses. This was most apparent in my interaction with Patricia, whose discomfort discussing health behaviour was evident in the interview. During this exchange, Patricia diverted conversation away from health behaviour, shifting the focus to acknowledge the weather. When trying to draw the conversation back to the topic of weight loss my own uneasiness is evident in my muddled phrasing of questions, as I search for a way to ask about this in a non-judgemental and acceptable manner. See for example the following excerpt:

Researcher: erm have there been any times where you've you've maybe done something to try and be like to try and improve your health or whether yeah like if there's been any times where you've done anything to try and obviously there's some things you can't change but can you think of any times where
Patricia: no not really, no not as I can think of no I've just got on with things and done whatever I've had to do

My question is jumbled and tentative, as indicated in the use of 'maybe' and the stop-starting and trailing off of my phrasing. When listening to Patricia's struggle to live with a debilitating long-term condition, and her lack of hope for improved health, asking about things she did to improve her health seemed insensitive. My statement of 'obviously there's some things you can't change' actually proposes a fatalistic perspective to Patricia. This dynamic was also present in other interviews. In Brigid's interview for instance, she often appeared to solicit my agreement with her viewpoints around the mysterious nature of illness, for instance, when she says, 'weird that innit?' and 'it frightens you doesn't it' and assumes commonality in our perspectives. During the interview and when Brigid touched wood to avoid tempting fate, I often felt compelled to join her in doing so, as if to communicate that I too hoped that Brigid's current state of health would continue. This demonstrates some convergence in narratives of health between myself and Brigid, but as for Patricia, again illustrates the ways that I may have reinforced narratives of fatalism. Similar trends were apparent in my interview with Eleanor, when I strived to avoid any

sense of judgement and offer understanding for her actions by suggesting that it is indeed difficult to sustain healthy behaviour, and when I confirm her feelings around the gratification gained from unhealthy food by suggesting 'it's true'. Again, hypersensitive to the risk of that Traveller Community members feel they are being placed under scrutiny, I seek to make understandable the difficulties Eleanor reports in adhering to lifestyle advice by suggesting that her difficulties are mirrored in my own experiences. Reflections on my interpersonal interaction with participants lends support to the idea that fatalistic statements are entangled with potential blame and 'face saving' which has been suggested in previous literature (Bolam *et al.*, 2003). Here we see this from a different direction however, as I as the researcher sought to ensure that participants were not blamed for a lack of engagement in healthy activity by pre-empting a fatalistic response.

8.5 Summary

While a degree of overlap in Traveller Community and practitioner narratives was evident with respect to Traveller orientations to time, the overt and bold nature of practitioner claims in this regard were not matched within Traveller Community accounts. There was some evidence of fatalistic narratives within Gypsy and Traveller Community accounts, for instance in the use of discourses of luck, fate or the role of higher powers such as God's will when explaining illness. However, these were not the only discourses at work in governing Traveller Communities explanations for illness. Seminal work which put the case forward for fatalism in Traveller Communities was based on qualitative research with Traveller Community members who were living with illness (Van Cleemput *et al.*, 2007). The present research, which involves Gypsies and Travellers experiencing a wider range of circumstances has highlighted much evidence for alternative or at least additional stories to those of fatalism in Gypsy and Traveller Community accounts of their health. Counter to representations within existing literature and in practitioner narratives, Traveller Community members did not appear to be beyond the reach of public health discourses on the imperative of health. Furthermore, Gypsy and Traveller Community members do not utilise fatalism as a 'global outlook' when describing their health, and discourses of fatalism intersected with those on the moral imperative of health. This supports findings from previous research with parallel groups that suggest fatalistic explanations tend to be combined with

behavioural explanations for health (Bolam *et al.*, 2003; Keeley, Lanelle and Condit, 2009). In contrast with practitioner presentations of Traveller Community members in relation to time, there were also examples whereby Traveller Community members bought into linear notions of time advocated by public health, and the idea that action now can prolong or improve one's health later. In addition, while Traveller Community members sometimes presented fatalistic attitudes as generalisable to Traveller Communities as a whole, there were also examples whereby individual Gypsies and Travellers interviewed distanced themselves from those beliefs presented as held by the wider Traveller Community members. This was evident in the language used, with shifts in the use of 'I'/'we'/'they' when discussing approaches to health and uptake of services. This is not to say that discourses on the imperative of health were uncritically accepted, and as Kelly's account shows, some individuals may use their agency to resist or reject health promotion discourse. However, as we also see from Kelly's narrative, a lack of adherence to healthy behaviour was not always underpinned by arguments about a lack of control over health, but a more explicit rejection of health advice. This demonstrates the potential danger of inferring that Traveller Community members' health practices necessarily result from fatalistic beliefs.

Where fatalistic narratives were used, this chapter has helped to understand the possible functions this has for the expression of health identities by Gypsy and Traveller Community members. Support was found for the function of fatalism in managing uncertainty around illness (best exemplified by Brigid's account) (Keeley, Lanelle and Condit, 2009). There appeared to be very little in the accounts of Traveller Communities to suggest that Traveller Community members used fatalism as a form of stress relief. Some Traveller Community members described their fear of the potential for health to change. This perhaps relates to the anxiety described by Traveller Community members in Chapter 6 with respect to the potential for illness to go undetected. While fatalism may absolve some worry and stress about how to promote or maintain one's health, there still appears to be a level of general worry about how quickly health can change. There were some examples of fatalism being used in a sense-making capacity, to help explain the impossibility of engaging in healthy behaviour when living with a chronic illness. While the potential role of fatalism in saving face has been pointed to in existing literature, methodologies and forms of analysis which focus purely on explicit expressions of fatalism have meant

that this is not always shown. The use of a narrative approach, which considers not only what Gypsies and Travellers say, but how they construct health identities through the positioning of actors in the stories told, and their interaction with the researcher, has given further insight into the potential role of fatalism in face saving. As interviews have shown, this was a two-way process in which I, the researcher sometimes proposed a fatalistic orientation to participants to try to avoid being seen as judgemental. While fatalism was sometimes used by Traveller Community members to save face with respect to their poorer health, this was not the only way in which they did so. In fact, it often seemed that Traveller Community members avoided potential judgement by identifying where their behaviour needed to improve or by stating their intentions to make changes to their current lifestyle. In this way, the interview itself seemed to take on some of the qualities of a confessional in which Traveller Community members demonstrated self-surveillance of their behaviour, and compliance with health advice.

CHAPTER 9 - Discussion

9.1 Introduction

This chapter draws together the accounts of practitioners and Traveller Community members which have previously been presented separately. It highlights areas of congruence and dissonance between them and considers the relationship of findings to existing literature and theory. The chapter is structured in three sections. The first centres around the embodied nature of claims to evidence and authority surrounding the health status of Traveller Community members and work with these groups. Applying sociological theory on 'body work' (McDowell and Court, 1994) and emotional labour (Hochschild, 1983), this section discusses the key tension between practitioners' attempts, through the management of their own bodies, to moderate the professional gaze, and Traveller Community members' demand for greater levels of scrutiny of their health and bodies. The second section considers the discrepancy between practitioner and Traveller Community accounts regarding the extent to which Gypsies and Travellers were seen to accept personal responsibility for health and comply with behavioural advice. Narratives of differential time preferences are argued to be central to this issue and utilising poststructuralist theory, this section demonstrates the significance of time and space in how relations of power and resistance 'play out' between Gypsies, Travellers and health practitioners. The final section of the chapter returns to the concepts of 'race' and 'whiteness', positioning Gypsy and Traveller health inequalities as a racialised but also classed and gendered issue. It revisits the dialectic identified in the literature around whether Traveller Community health is to be categorised as a cultural or structural problem and finishes with a critical reflection on the potential for narratives to entrench binary subject positions of Travellers as needy victims and practitioners as white saviours.

9.2 Body work in interaction between practitioners and Traveller Community members

While work on the sociology of the body has long shown that bodily presentation can be integral to one's occupation, the embodied nature of trust between clinicians and patients is a more recent research endeavour and has tended to focus on clinical settings (Brown *et al.*, 2011). While building and maintaining trust between Traveller Community members and health practitioners is emphasised in the literature

(Lhussier, Carr and Forster, 2016; Mcfadden *et al.*, 2016), this discussion has remained largely disembodied. Throughout this thesis, body work was identified as significant in the development of relationships between Traveller Community members and health practitioners, and in the constitution of their identity positions. This study thereby contributes an understanding of the embodied nature of trust with a different group of health professionals: those working in a public health capacity within community, clinical and local authority settings.

The literature on body work has been divided into a number of areas, including: 1) the impression management work individuals undertake on their own body; 2) the management and display of one's own emotions and the emotions of others; 3) direct and physical work on the bodies of others, as in caring occupations or the beauty industry for instance; and 4) the material effect of work on the bodies of employees (Gimlin, 2007). Most practitioners in the current study had limited if any involvement in health work performed directly on the body, instead being responsible for providing health advice, or working in a more strategic, public health capacity. Midwives involved in the study whose roles do involve more direct and intimate body work on others did not largely reflect on this aspect of body work, likely due to the focus of the research on their public health work with Traveller Community members. It is the first two aspects of body work that emerged as most important in this study and which will now be discussed further: 1) work by practitioners on their own bodies; and 2) the management and display of emotions. Practitioners' representations of Traveller Community members' attitudes to their own bodies also emerged as important from the data and are explored throughout.

9.2.1 Performing identities as 'in touch' with the community

Findings chapters suggested that an ability to win the trust of, be liked by, or knowledgeable about Traveller Communities was one way through which practitioners could lay claim to specialist expertise about these groups and carve out positive identities for themselves in their talk. As was the 'othering' of middle-class colleagues who were presented as less attuned to the lives of disadvantaged groups. Discourses on the health of Traveller Community members as having to be seen to be believed, and of Gypsies and Travellers as unlikely to trust 'outsiders' underpinned practitioner claims to this expert and privileged position.

Practitioners' preferred identities as privileged in their relative closeness to, and expertise in engaging with marginalised groups such as Traveller Communities was reflected in their reported body management practices. Practitioners described undertaking body work to downplay any 'professional' status and communicate a working class, down-to-earth identity, which they identified as important in establishing relationships with community members. This was evident for instance, where Sandra refers to an absence of body markers that signify professional status, such as a 'white jacket' or 'stethoscope', as important in facilitating engagement with Traveller Community members. It is also apparent in Linda's reference to not wearing a uniform, taking off her shoes, and adopting body language which signified informality such as sitting cross legged on the floor when working with Traveller Communities. In adopting these techniques, Linda, Sandra and other practitioners may gain an ability to more readily identify with community members, but with this comes the potential loss of other identity positions, such as their ability as women to claim identity as a 'professional'. It is unlikely that other professionals (GPs or surgeons for instance) would be expected to cast off their professional identity in this way, therefore highlighting the differential demands placed on various sets of practitioners. Body appearance is also referenced by Becky who makes explicit claims about body erosion and marking when she suggests that peer educators more readily establish rapport with Gypsies and Travellers as they 'wear their history on their faces', with history here referring to their 'deprived' or 'brutalised' backgrounds. Body conduct was also important in communicating respect for Traveller Community culture during health encounters, and in attempts to re-balance power in health interactions, with both Nicola and Linda describing their work to convey, through their presentation of self, the more everyday identity position as a 'guest' when visiting community members' homes.

In some cases, practitioners described themselves as emphasising an identity position which was stable and pre-determined, as was the case where Becky suggests that she and most other workers in the organisation were from 'white collar backgrounds'. However, some aspects of practitioners' presentations of self appeared to be more contingent or unstable. Becky for instance, draws explicitly on the metaphor of performance when describing her role as 'like a stand up', 'like being on stage', and 'like being in character'. Indeed, Becky explicitly draws attention to the capricious and evolutionary nature of her self-image when describing

her need to adapt and change her use of language to match that of the specific group, and when she suggests that 'you're a bit like a creature...you know you develop a tough skin for when it's really hot'. These expressions chime with those of 'adopting a different sense of myself' and 'building up a shell' used by women working in merchant banks in the study by McDowell and Court (1994). Gregson and Rose (2000) note the different analytical perspectives from which performance has been approached; those based on the work of Goffman on the one hand which presume an agentic performance of a pre-existing identity position, and that informed by the work of Butler, which views subjectivities as performed into being, within a given discursive field and set of power relations. In keeping with the latter perspective, it is here suggested that practitioners were not intentionally performing a pre-decided identity in order to engage with Traveller Community members. Rather, body work undertaken by practitioners to downplay any professional associations must be understood to be both an enactment of discourses which present Traveller Community members as unlikely to be accepting of practitioners as well as constitutive of these discourses and their associated identity positions.

Comparing the accounts of practitioners and Traveller Community members suggests important differences in representations of Gypsy and Traveller bodies and the level of medical scrutiny of the body which is seen as appropriate. Existing literature on body work focuses on a) work undertaken by employees to manage their own body appearance or emotions, b) the work they perform on the bodies of others, and c) the legacy work leaves on the material bodies of employees. This study illustrates the usefulness of also considering the ways practitioners represent the bodies of those they work with in their talk. Practitioners often reported promoting advice based on its benefits for physical appearance rather than for health improvement. Indeed, some appeared to suggest that Gypsies and Travellers would be more concerned with physical attractiveness than other sections of the population and therefore more likely to respond to this strategy of delivering advice. This connects with broader portrayals of Traveller Communities as materialistic and concerned with image in popular media, as seen in the Big Fat Gypsy Weddings programmes for instance. The accounts of Traveller Community members provided no evidence however, that concerns about physical appearance were prioritised over concerns about health. Rather, Gypsies and Travellers often articulated a desire for greater medical scrutiny of their bodies. This included a preference by

participants for being physically examined during GP appointments, as has been noted by Van Cleemput et al. (2004), but also greater access to other forms of medical screening, testing or classification of their bodies. Likewise, community members often stressed the importance of receiving health information and communicated their frustration where this was not provided. Findings therefore point to a potential lacuna between, on the one hand, the expressed wishes of Traveller Communities to receive professional and thorough medical investigation, and on the other, the body work undertaken by many health practitioners to downplay their 'professional identity' due to concerns that they may be seen as 'over-professional'. The tendency to direct health promotion advice at superficial levels of the body, by emphasising the benefits for physical appearance may also exacerbate community members' concerns that they are not receiving sufficient health information and that health issues are undetected, particularly since Gypsies and Travellers were aware of their lower than average life expectancy as a group.

9.2.2 Emotional labour

The management of emotion emerged as another core element of body work undertaken by health practitioners working with Traveller Communities in the current study. Returning to Hochschild's (1983) distinction, practitioners sometimes described engaging in surface acting, suggesting that they worked to portray a different emotional state to community members than that they actually experienced. Sandra described the requirement in her role to challenge Traveller Community members as contrasting with her innate personality of shying away from conflict for instance. This is also implied in Becky's statement of the need to develop 'a tough skin' which implies a guard to protect one's underlying feelings. Aspects of surface level acting were also seen in Karen and Sandra's descriptions of the importance of disguising any shock at the circumstances of 'disadvantaged' groups that threatened to show through facial expression, in order to gain the trust of community members. Aspects of deep acting were also evident in accounts, whereby practitioners rationalised instances of aggression from Traveller Community members when accessing or receiving services by reference to barriers to in accessing care such as discrimination, or personal trauma, that generate this behaviour. Here they report engaging in deep acting since they alter any potential judgement toward community members for their behaviour through making this understandable.

However, like the responses of social workers in the study by Winter et al. (2018), on many occasions practitioners did not suggest that they were involved in surface or deep acting with regard to their emotions, but stressed that their care for community members was authentic. Though the language used to describe practitioner relationships with Traveller Community members varied from that conveying strong personal feelings such as 'love', to less intense expressions of 'enjoyment' of working with these groups, many practitioners did not characterise their relationships with community members as ones that are emotionally detached. Indeed, some work in this area has challenged the idea that emotions are commodified in nursing and healthcare professions, suggesting that this overlooks the satisfaction that practitioners take in the provision of care and their ability to offer emotional support as a gift to patients rather than this being forced upon staff by institutions (Bolton, 2000). Personal and emotional connections with health practitioners were also valued by Traveller Community members. Kelly commented positively on a service in which they had got to know the individuals delivering the service over time for instance. Likewise, Patricia stressed the importance of practitioners taking the time to sit, chat and have a cup of tea with community members. In addition, practitioners who were valued by community members were often referred to by personal descriptors such as 'lovely' or 'nice'. This thereby illustrates some cross-over between practitioner and Traveller Community accounts regarding the importance of emotional connection in building trust and ensuring satisfaction with health services.

9.2.3 The institutional, classed and gendered nature of body work

Applying existing theory on body work helps place that reported by health practitioners in the wider organisational and social context within which they work. As has been found in other employment sectors (Hochschild, 1983; McDowell and Court, 1994), and parallel health professions (Brown *et al.*, 2011; Riley and Weiss, 2016), practitioners in the current study identified aspects of bodily performance and emotion management as forming an integral part of the service they provide, and their role in engaging with 'disadvantaged' groups in particular. Previous literature highlights the differential involvement of professionals in body work according to status, with male staff in senior roles less often involved in direct labour on the bodies of others (Twigg, 2000). While practitioners in the current study were not, for the most part, involved in physical work on the bodies of others, this distinction is

nonetheless conceptually useful in understanding practitioner techniques to downplay a 'professional' identity and their emphasis on the ability to closely observe Traveller Community bodies. Those practitioners who had moved into more strategic roles that involved less direct or hands-on work with communities often lamented their distance from community members. This is apparent in the suggestion by both Louise and Karen that public health is seen as where individuals go to settle down and is therefore viewed with some distain. This highlights the significance of closeness to, or distance from the community for how health practitioners articulate and differentiate between professional identities, and its role in the status of practitioners. We see here a reversal of the relationship between status and distance from body work previously articulated in existing literature; a position as close to the bodies of disadvantaged communities enabled claims to a different type of status, as 'street smart' and in touch with Traveller Community members and other disadvantaged groups. As seen in the account of a midwife involved in the study, body work was not straightforwardly associated with professional role, and through the management of one's appearance, practitioners could cast off signifiers that betray one's 'professional' identity.

Practitioners did not explicitly describe body rules stipulated by their employers or formalised in guidelines for practice. However, in cases where practitioners from the same organisation were interviewed, it was clear that the relative merits of these practices had been deliberated between colleagues. Hochschild's (1983) concept of 'feeling rules' assists in understanding the connections between emotional performance and institutional and social structures. This points to the potential costs associated with an inability to express one's emotions, or the requirement to alter emotions in accordance with institutional expectations for their management. This PhD research contributes greater understanding of the 'feeling rules' that operate in different types of health institutions, looking at the emotion work undertaken not only by those in clinical, professional occupations such as midwifery, but those in public health and community roles. The research has shown the different 'feeling rules' that appeared to be operating depending on the different sectors that practitioners belonged to. Those working in community sectors appeared less regulated in regard to their expression of personal emotions toward Traveller Community members and their work with these groups. By contrast, practitioners in more professionalised roles and working at a greater distance from the community less often couched their

relationship to Traveller Community members in such strong terms. Louise, exemplifying the latter category for example, described her sadness at the unmet needs among Gypsies and Travellers and in response, a desire to re-train in a role in which she could herself work more pragmatically and directly with the community and just get on with addressing the issues she saw. It is perhaps significant that Louise ties this to her background as a nurse, a profession which centres around hands-on care. That she corrects this initial response, describing this as irrational however, suggests that she is concerned she has allowed her emotion to temporarily get the better of her professional and objective judgement. Nicola also appeared to relinquish her professional role to a lesser extent, and on one occasion during her interview amends her initial selection of the term 'fears' to instead use 'anxieties' when describing her concern about working with a teenage Gypsy Traveller woman; the former term appearing to convey a strength of emotion that might be deemed to be at odds with the detachment required in her professional role. The emphasis on neutrality, objectivity and the upholding of boundaries between practitioners and clients in professional codes of conduct appear to prevent those working in more formalised professional roles from the performance of emotion. Indeed, it has been argued that capacity for emotional expression has been depleted as a result of a more general trend toward the increasing bureaucracy and rationality of organisations which has seen greater divisions between public and private spheres and an emphasis on efficiency and adherence to rules rather than social relationships (Gimlin, 2007; Hingley Jones and Ruch, 2016; Winter *et al.*, 2018). While there is now a move towards greater personalisation and individualisation in health services (Bennett, 2014), this too is at odds with some of the approaches articulated by practitioners, since the rationale for personalised working with Traveller Communities was often articulated on the basis of assumptions about Gypsy and Traveller group identity.

This study points to narratives among practitioners that, by definition, civil society⁷ employees should shoulder a greater amount of the emotional burden of working with people who are characterised as 'vulnerable' or 'disadvantaged' than those in clinical NHS roles for example. While recognising the specific contribution of civil society organisations, this claim is troubling in its positioning of this sector as solely

⁷ A term used to refer to organisations who operate separately from government (e.g. public sector) and for-profit sectors

(or at least) predominantly responsible for those experiencing the greatest inequity or particularly challenging circumstances, thereby taking the focus away from the duties of statutory forms of support. In assuming that civil society organisations and staff are, by definition, more able to tolerate emotional distress associated with this work, this risks a lack of understanding and appropriate resourcing of the work that employees in these sectors perform. It may also prevent the implementation of rules that afford the same protections to workers as staff in other sectors and generate inequality in working conditions. This research therefore points to the commodification of emotion work in not only clinical health care settings, but also within the civil society sector, and perhaps to an even greater extent given suggestions that workers in this sector should be particularly responsive to and understanding of the 'problematic' behaviour of 'troubled' groups.

Findings also suggest that class intersects with notions of professional distance and closeness to the community in informing emotion management. Sandra suggests that those who are 'middle-class' are less accustomed to the lives lived by disadvantaged groups, and more likely to show shock or disgust to community members. This points to the role of emotion work in again enabling practitioners to project an identity as working-class, and non-judgemental of disadvantage, helping to establish trust with Traveller Communities.

Previous work on emotional labour points to the differential emotion work carried out in male dominated occupations, such as paramedics, in which the suppression of emotion is encouraged (Williams, 2013). Hochschild (1983) suggests that men and women are called upon to perform different types of emotion work. Women are more likely to work on the frontline, directly interacting with and dealing with people's emotions, while men are suggested as more often employed in middle and upper social work roles, at a distance from community members and therefore less likely to express emotions such as 'love' (Winter *et al.*, 2018). Findings from the present study contrast with those of previous studies in regard to the influence of masculinity on emotion work undertaken by practitioners. Indeed, the strongest expression of strong personal connection to Traveller Communities was that expressed by the one male participant in the study. This is perhaps explained by this individual's position in working directly with community members. While the distancing undertaken by medical practitioners is often connected with gender norms in professions (Williams,

2013; Riley and Weiss, 2016), this study suggests that there is a need for caution in assuming that engagement in emotion work is prescribed by one's gender alone. Rather, closeness to the community appeared to interact with and potentially even supersede gender in generating rules of emotional labour. Support was therefore found for Schilling's (1993: 122) point that differences in the forms of emotion work undertaken by men and women may not be an absolute split, and that they may perform similar emotion work where in similar roles. In addition, practitioners do not perform emotions in isolation, but rather, in response to the emotional field they are presented with, here referring to work with Traveller Communities. As such discourses in operation with respect to the propensity of Traveller Communities to accept or reject health workers may also have influenced the emotional performances of practitioners.

9.3 Un-disciplined bodies?

The degree to which Traveller Community members are presented as culturally compliant or resistant to health promotion advice is a fundamental tension which underpins narratives of Gypsy and Traveller health generated in this study, and indeed, the wider literature in this area. Although varying in its overtness, a discourse of Gypsies and Travellers as differently oriented to space and time is key to understanding this tension in the accounts of practitioners in the study. This included representations of Traveller Community members as less time-disciplined, chaotic, disorderly, and less tolerant of structure or environments resembling a classroom. These portrayals are in keeping with representations of Gypsy and Traveller relationships to time in existing literature, which point to potential incongruity between highly structured, rule-governed cultures of educational and health service provision, and the greater spatial and temporal freedom associated with Traveller Community life (Peck, 1983; McCann, 1987; Lehti and Mattson, 2001; Levinson, 2005, 2008; Dion, 2008; Bhopal, 2011). Depictions of Traveller Communities as lacking boundaries, or as somehow operating outside the rules or conventions of majority society, echo broader discourses which construct the nomadism of Traveller Communities as a threat to geographical, spatial, and social order (Bancroft 2000; Clark & Campbell 2000; Halfacree 1996; Morris 2000; Richardson 2006; Turner 2000). These narratives also chime with romantic ideas about the freedom provided by a nomadic lifestyle, and nostalgia directed at

'traditional' or 'simple' modes of living that are associated with images of Gypsy and Traveller Communities in society (Holloway, 2005). Pragmatic implications that follow from this discourse, such that Traveller Community members are often described as unlikely to respect the fixed times of health care appointments (Lawrie, 1983; Raper, 1986; McCann, 1987; Feder, Salkind and Sweeney, 1989; Goward *et al.*, 2006), were also found in the narratives of some practitioners in the present study.

Traveller Community members were not only treated as undisciplined with respect to their conduct in health promotion sessions, but as present rather than future oriented, and as therefore affording little priority to the prevention of future ill health. Explanations for this attitude were varied, sometimes appearing to suggest that this was a collective outlook or philosophy among Gypsies and Travellers and at other times connected with structural constraints such as level of education or inability to afford to adopt healthy lifestyles. One practitioner (Becky) suggested that Traveller Community members' expectations regarding their lower life expectancy fostered an attitude of enjoying the present rather than planning for the future. Again, these representations of Traveller Community members echo existing suggestions that Traveller Communities are fatalistic (Van Cleemput *et al.*, 2007; Dion, 2008), and lacking self-regulation with respect to health behaviour (Dion, 2008). The present study therefore shows that previous assertions of Traveller Community members as less time disciplined persist in health practitioner narratives. However, findings from this work provide greater detail on how practitioners report managing this supposed tension around time in their work with Traveller Community members, and in health settings specifically. Applying Foucault's theory of disciplinary power and Deleuze's concepts of smooth versus striated space, this section of the chapter further interrogates the significance of time and space in constructions of Traveller Communities regarding health, and the operation of power and resistance in health interaction between practitioners and Traveller Community members. It does so by looking specifically at two areas: 1) the temporal and spatial organisation of health advice and sessions, and 2) the future-oriented principles of public health.

9.3.1 The temporal and spatial organisation of health advice

In the transition traced by Foucault (1977) from crude and absolute forms of power (exemplified by public displays of punishment performed directly onto the body), to

disciplinary forms of power (which operate through the habitual training of the body), time and space take on particular significance. Indeed, for Foucault, 'power is articulated directly onto time; it assumes its control and guarantees its use' (1977: 160). It is noteworthy for the present study that the shift to a disciplinary society is attributed by Foucault to demographic changes in the eighteenth century that saw an increase in the 'floating population', and that 'one of the primary objects of discipline is to fix; it is an anti-nomadic technique' (1977: 218). Thus, we see in Foucault's work the clear suggestion that nomadism poses a threat to power, and that disciplinary regimes of power arose in part due to their increased capacity to manage this threat:

That is why discipline fixes; it arrests or regulates movements; it clears up confusion; it dissipates compact groupings of individuals wandering about the country in unpredictable ways; it establishes calculated distributions. It must also master all the forces that are formed from the very constitution of an organised multiplicity; it must neutralize the effects of counter-power that spring from them and which form resistance to the power that wishes to dominate it: agitations, revolts, spontaneous organisations, coalitions – anything that may establish horizontal conjunctions (Foucault, 1977: 219)

This focus on the disciplining of individuals in time and space, particularly by way of managing the potential threat to social order posed by nomadism has clear application to findings from the present study, which pointed to orientations to time and space as a potential source of conflict between practitioners and Traveller Community members. Applying Hall's (1994) distinction, Gypsies and Travellers were characterised by practitioners (though not explicitly) as adhering to polychronic or process-driven orientations to time. Such orientations to time counter the highly structured monochronic systems guiding health promotion sessions as usual, as well as the requirement to exercise restraint and self-control in order to resist 'unhealthy' behaviours, or at least limit these to "relatively safe, approved, ritualistic expressions of release in socially designated times and places" (Crawford, 1994, p. 1359). It is, in part, through the meticulous arrangement of bodies in space that discipline is achieved. This includes techniques not only of enclosure or confinement, but the segmentation and assignment of specific spaces to individuals. In doing so, this creates a space that is functional, insofar as it enables individuals to be monitored:

One must eliminate the effects of imprecise distributions, the uncontrolled disappearance of individuals, their diffuse circulation, their unusable and dangerous coagulation; it was a tactic of anti-desertion, anti-vagabondage,

anti-concentration. Its aim was to establish presences and absences, to know where and how to locate individuals, to set up useful communications, to interrupt others, to be able at each moment to supervise the conduct of each individual, to assess it, to judge it, to calculate its qualities or merits. It was a procedure, therefore, aimed at knowing, mastering and using. Discipline organises an analytical space (Foucault, 1977: 143)

Discipline is also argued by Foucault to be accomplished by controlling activity through timetables that allow the partitioning of time into ever smaller units, supervision, and the removal of distractions and which maximise the productivity of time. Power is exercised through the prescription of movements, their pervasiveness and regularity leading to internalised habits and the 'correction' of individuals. In Foucault's terms, this form of power enables:

a hold over others' bodies, not only so that they may do what one wishes, but so that they may operate as one wishes, with the techniques, the speed and the efficiency that one determines. Thus discipline produces subjected and practised bodies, 'docile' bodies (Foucault, 1977: 138)

There was some evidence in practitioner accounts of attempts at such spatial and temporal regulation of Traveller Community members. When suggesting that the use of salt on food was allowed in one's own home, but not within the confines of health sessions, Becky attempts to create an *enclosed* health promotion space, with a line drawn between behaviour that is acceptable within sessions, and that which, if one chooses to engage in it, should be performed away from the gaze of the health practitioner. Likewise, instances of community members displaying 'unhealthy' behaviours in close proximity to or within health sessions were met with a degree of dissatisfaction by practitioners, as was the case where Karen remarked that Traveller Community members kept 'nipping out for joints' during the session and described how after the session: 'there was fruit and veg there and they went out for fish and chips'. This demonstrates at least an attempt to ensure some enclosure of health promotion sessions.

However, for the most part, findings from the current study highlight a relaxation of the rules, structure and formality of health promotion when working with Traveller Communities, to mirror the polychronic and process driven approaches to time that practitioners perceived these groups as adopting. This is illustrated by Becky's extended account of the chaotic nature of health sessions for example, in which multiple activities can be undertaken at once (e.g. participants are not asked to turn their phones off), interruptions to the core business of health promotion are

accommodated (e.g. for participants to 'go and see their kids'), activities are undertaken when the time feels appropriate, rather than according to pre-set timetables (e.g. 'they can have a sandwich when they want') and at a speed that is dictated by Traveller Community members themselves. Practitioners distinguished their own approaches from those adopted by authoritarian figures such as 'teacher' (Sandra), 'preacher' (Sandra, Becky) or 'judge' (Karen, Caroline, Becky, Linda) and their associated spaces of the 'pulpit' (Linda) or the 'classroom' (Becky). The efforts of many practitioners to dissociate health education from modes of education associated with a classroom, reflect narratives of structured learning environments as ill-adapted to Traveller Community culture, or vice versa, and for preferences of Traveller Community members for real-life learning and freedom to pick things up at your own pace (Levinson, 2005). Indeed, not all health promotion spaces could accommodate this unstructured approach, with Becky also highlighting challenges where venues were un-used to Traveller culture and orientations to time and space, suggesting that Travellers 'can be incredibly messy like a lot of the communities we work with' and that 'we always had something that had gone wrong you know the kids were running around or the somebody in the centre had complained'.

Aside from the examples noted, of attempts to create enclosed health promotion spaces, hallmarks of disciplinary regimes of power which strive for the avoidance of 'uncontrolled disappearance', 'diffuse circulation' and the precise location of individuals in space (Foucault, 1977), were curiously absent from these interactions. Indeed, Becky's suggestion that 'if they don't wanna listen they just walk walk out' even positions Traveller Community participants as able to avoid health promotion completely if they wish to. The simultaneous relaxation of the rules within health sessions and of some attempted sanction over Traveller Community members' behaviour therefore suggests a combined approach of control and leniency in regard to health behaviour and conduct within health promotion encounters.

Previous research has highlighted the significance of temporal structure in the exercise of power in the colonisation of Aboriginal Communities (Nanni, 2011). Within the present research, time took on a similarly important role in the signification and operation of power and resistance. Like Aboriginal Communities, Traveller Community members were characterised as resistant to attempts to control their conduct (here in relation to health advice and sessions) by definition of their attitudes to time and space. However, in contrast to the efficacious use of time

as an apparatus of control in colonisation (Nanni, 2011), the narratives of practitioners in the study are those of having had to relinquish forms of temporal and spatial regulation commonly employed in health promotion when working with Gypsy and Traveller Communities. Thus, practitioners in the study articulated little support for a view that they occupied positions of power in relation to Traveller Community members.

9.3.2 Future-oriented principles of public health

Traveller Community members were not only seen by practitioners as contravening the monochronic ordering of everyday health promotion interactions and sessions, but also the future-oriented principles of public health advice. The discipline of public health is premised on principles of causality that are underpinned by linear and monochronic notions of time, operating on the understanding that it is possible to influence the future (at least in part), through our past and present action. In keeping with the commodification of time in society, whereby 'one block of time may be traded for another which is seen as more valuable' (Fox, 1999: 1317), individuals are expected to spend time in the present engaging in healthy lifestyle behaviours, in order to 'buy' future time by preventing poor health and ultimately prolonging life. As has been argued for social work (Juhila, Gunther and Raitakari, 2015), public health also embodies a linear approach to time in its emphasis on positive change, and progressive journeys of self-improvement. This approach to time forms a further device for the operation of power. In disciplinary power, the fixed position of individuals in space is less important than the rank or position they occupy in relation to others (Foucault, 1977). It is therefore not only through the physical arrangement of spaces that power proceeds, but through processes of assessment and ordering of individuals in hierarchies. It is through this technique that power succeeds in simultaneously governing both the group or population and the individual. Disciplinary time is linear time; it divides up time into a series of consecutive periods, following which individuals can be assessed, and arranges these time slots into an overall course. In its orientation of individuals towards an ultimate goal, this system ensures the endurance of systems of power, since subjects are ensnared in an extended sequence of categorisation in relation to others, a given trajectory and to regular intervention. Through their suggestions that Traveller Community members are oriented to the present and fatalistic regarding their future health, practitioners positioned Gypsies and Travellers as having

attitudes to time that stand in contrast with the linear view of time advanced by public health, and as therefore potentially resistant to attempts to control individuals by mapping their progress against such linear milestones. Practitioners relayed stories of Traveller Community members resisting their attempts to draw them into 'future talk' regarding their health. Some reportedly did so by refuting suggestions that current action could guarantee future health, as seen in Sandra's story of encountering attitudes of 'what will be will be'. In some cases, Traveller Community members were noted to shift discussion to the past, as in Karen's story of a community member who avoided engaging with a discussion about cancer prevention and instead focused on memorialising the death of a family member, 'the star in the sky'. While these narratives sometimes sat alongside counter examples, and were not articulated by all practitioners, the fixation of Traveller Community members in the present or the past nevertheless formed a strong narrative in practitioner accounts. Although communicating respect for the choice of community members regarding how far they engage with advice about promoting their future health, practitioners also appeared to express some frustration where these messages were not engaged with, or at the very least communicated the sense of challenge they experienced in trying to get these messages heard. Karen for instance, communicates her surprise at the reluctance of this community member to discuss cancer despite two years having passed since the death of her relative from the disease. The ambiguity and sense of tension regarding whether to accept or strive to change the supposed orientations of Traveller Community members in relation to time and health is also encapsulated in Becky's statement of 'oh I don't really want to you don't really wanna change it but they have a very kind of erm intoxicating philosophy of you only have today you can't control tomorrow'. A reluctance to shift into future talk therefore appeared to be experienced by practitioners as a form of resistance to their attempts to broach behavioural advice and was presented as a potential source of conflict during health communication.

Practitioners experienced a challenge therefore in balancing what they identified as community priorities with the need to address health behaviours as part of their professional role, or personal values. It is puzzling that despite practitioner suggestions that Traveller Community members were less oriented to the future, health advice was often delivered with the suggestion that this would improve physical appearance, since this would involve the same trade off in terms of present

and future time. The priority that practitioners judged Traveller Community members as affording physical attractiveness appeared to offset the belief that Traveller Communities were less able to delay gratification in this way. This points to the interaction of discourses on time orientation with those on Traveller Community members' greater concern with their appearance in informing the ways that practitioners broached behavioural issues.

Narratives reported in the literature on the fatalism and different time perspectives of Gypsy and Traveller Communities (Van Cleemput *et al.*, 2007; Dion, 2008) were reflected in the accounts of practitioners in the current study. What this study adds however is insight into the ways practitioners report traversing the intersections of these competing discourses in their everyday practice. Representations of Gypsies and Travellers as giving less priority to their future health have been shown through the study to lead to a tendency to reduce the intensity of intervention around health behaviour and in some cases a reticence to address these issues. This was reflected in findings which illustrate the adoption by practitioners of a less formal or less prescriptive approach to working with Traveller Communities compared to work with other groups. Sandra's description of not delving in detail around what changes Traveller Community members had made to their health behaviour, but to keep this more 'casual' is illustrative of this approach for example. Another illustration is provided by Becky's suggestion that structured tools for goal-setting and monitoring behaviour change (such as reflective logs, defined outcomes, and use of metrics such as BMI, weight, lung capacity, and lung age), as well as accreditation for the completion of community health education courses were not employed in work with Traveller Communities. The various efforts of practitioners to create a 'smoke screen' (Karen) to disguise or entice participation with more serious health promotion messages, or avoid participants feeling like 'they're getting a battering all the time' (Caroline) also hints at the efforts of practitioners to, at least partially, provide a forum in which participants experience 'fun' and some freedom from life's pressures. As for the temporal and spatial organisation of health sessions discussed above, there appeared therefore to be a relaxation of usual techniques of power and surveillance such as the identification of health promotion goals and the assessment of individuals against the incremental steps for achieving these. This is despite practitioners having identified health behaviours as particular issues among Gypsy and Traveller communities.

9.3.3 Smoothing out spaces of health promotion

Foucault's (1977) theory of disciplinary power does not apply straightforwardly to reported interactions between practitioners and Traveller Community members. The accounts of practitioners suggest Traveller Community members were in fact subject to very little attempts at discipline, though there were a few instances of more forceful attempts cited to control Traveller Community behaviour reported earlier. The refusal to monitor and document the health of Traveller Community members within routine monitoring systems, as well as a reticence to apply more individualised forms of health assessment shown through the present study, points to the absence of instruments of power such as 'the examination', which 'places individuals in a field of surveillance and situates them in a network of writing; it engages them in a whole mass of documents that fix and capture them' (Foucault, 1977: 189). Tactics evident in study findings are more reminiscent of negative and repressive forms of power, of 'projects of exclusion' (ibid: 199) which function through the 'binary division between one set of people and another' rather than via 'multiple separations and individualizing distributions' (ibid: 198). Foucault (1977) suggests that these two forms of power combine; the binary categorisation of groups as normal/abnormal enables them to be singled out for individualising techniques of surveillance and correction, which in turn, support the categorisation and exclusion of groups. However, such techniques of power were, for the most part, not discernible in the accounts of practitioners in the study. It is possible that this is indicative of a subtle and hidden form of power which Foucault acknowledges is key to modern forms of power.

The work of Deleuze and Guattari, in particular their concepts of smooth versus striated space (Deleuze and Guattari, 1986) assists in understanding why practitioners interpret Traveller Community orientations to time (at least as practitioners perceive them), as strategies of resistance to the delivery of health advice, as well as the potentially hidden functioning of power in interactions between practitioners and Traveller Community members. Striated space is associated with the apparatus of the State, which divides and draws boundaries in space through techniques of measurement and quantification. It is space that is characterised by hierarchy, order, stasis and homogeneity, and which is oriented towards occupation and sedentarism. Smooth space on the other hand is an open space (symbolised by the desert or the steppe) which is free from the lines and codes imposed upon state

space. Smooth space is facilitative of a freedom of movement, and associated with the nomad, who does not occupy a fixed and bounded territory, but flows across this smooth and open space. The relationship of Nomads to the state symbolised resistance for Deleuze and Guattari (1986). They conceived of a nomadic war machine which through perpetual movement and resistance to becoming fixed, can escape capture or codification by the State. Read through this lens, practitioner perceptions of the unpredictability of movement of Traveller Community members in relation to time and space is akin to a nomadic war machine operating in a smooth space and is interpreted as a form of resistance to the striated spaces of health promotion. While in striated space 'all movement is subordinated to points or positionings; beginnings and ends; states of being' (Malins, 2004: 486), movement within smooth spaces follows no set patterns and runs in many different directions rather than toward fixed points or destinations (Malins, 2004). This helps to explain practitioner stories whereby Traveller Community members were presented as having resisted attempts to shift discussion to the future, to plot out and work toward fixed destinations in terms of future health outcomes, and the preference to avoid being fixed in space within health promotion sessions.

Deleuze and Guattari (1986) also describe the potential for smooth space, and the State to appropriate the nomad war machine for its own ends, using nomadic pathways or routes as a method of communication. Faced with an expectation of resistance to their attempts to broach health behaviours, practitioners sought to appropriate the characteristics of smooth space in health promotion settings (e.g. enabling freedom of movement in sessions, avoiding attempts to fix the focus only on health promotion, and facilitating autonomous learning, which enables Traveller Community members to pick things up on their own pace), co-opting and reproducing Traveller styles of interaction and communication for the delivery of health advice. Some practitioners' attempts at control within sessions, e.g. capitalising on people's reluctance to refuse a blood pressure test during opportunistic health interventions and punctuating other 'fun' activities with health messages, reflect tactics of surprise or unpredictability that characterise the nomad war machine. However, these sat alongside attempts at regulation through a more absolute or fixed manipulation of space, suggesting that a combination of techniques of power were in operation during health promotion with Traveller

Communities. This helps to unmask the forms of power, and conceptualisations of resistance that were in operation in health promotion sessions.

9.3.4 The contrasting stories of Traveller Community members

Discourses found in existing literature, of Traveller Community members as fatalistic and less time disciplined with respect to their health (Van Cleemput *et al.*, 2007; Dion, 2008), were also reflected in the narratives of health practitioners in this study. These representations potentially reinforce images of Gypsies and Travellers as groups who reject the preventative foundations public health and the moral responsibility to promote one's health. A key and novel finding of the current study has, however, been the demonstration that Traveller Community members do not position themselves as wholly fatalistic or beyond the reach of public health doctrine and associated technologies. While at times discourses of fatalism featured in the accounts of Traveller Community members, they co-existed with narratives of personal responsibility and control over health in Gypsy and Traveller accounts. Indeed, for the most part, Gypsies and Travellers were clearly striving to construct preferred identity positions as responsible health citizens. In the one narrative account in which a Traveller Community member displays a high degree of resistance to health promotion advice (Kelly), this orientation was underpinned not by a discourse of fatalism, or the rejection of an ability to influence future health, but one of personal responsibility. Kelly accepted the premise of lifestyle behaviour as a cause of illness but stressed her agentic and decisive decision not to adopt this behaviour which she knew to be beneficial to her future health.

Findings also highlight an important discrepancy between Traveller Community and practitioner narratives around the nature of Traveller Community members' attitudes to time. Previous research on Traveller Community member orientations to time and space appears to accept a degree of cultural difference in this regard (Levinson, 2005, 2008; Bhopal, 2011), with this suggested as underpinning the maintenance of distinct identities and reinforcing boundaries between Traveller and settled society. By these readings, the outsider status of Gypsies and Travellers results from the fact that this diversity is not recognised or valued. Similar interpretations of Traveller Community attitudes to time were evident in the accounts of health practitioners involved in the study. Practitioners suggested that Traveller Community members' awareness of their shorter life span, and fatalistic beliefs resulted in their greater

orientation to the present and reduced focus on future consequences. However, when talking about their health, Gypsies and Travellers participating in the study often shifted into a future 'time tense' (Roberts, 2004) and articulated an acceptance of linear notions of time advanced by public health. As such, the notion that Traveller Communities are less future oriented in regard to their health seems to have become an engrained truth that does not reflect the range of storylines available in the talk of Gypsies and Travellers themselves.

Findings from the current study show a strength of personal responsibility for health in Traveller Community narratives that has not been displayed in previous literature. This finding is likely explained by the different approach taken in the present study. Many studies of Gypsy and Traveller health start from the position that essential cultural differences underpin the differential health status of these groups. That studies starting from this premise produce findings on the distinctiveness of Traveller Community health beliefs and behaviours is unsurprising. By contrast, the adoption of a poststructuralist informed narrative approach enabled such dominant, taken for granted discourses to be exposed as only one among many possible constructions of Traveller Communities. This approach has allowed more marginal discourses to be brought to the fore, illustrating that the health identities of Gypsies and Travellers are more complex than previously assumed, highlighting oscillation between identities as engaged with and resistant to health advice. This is consistent with recent theoretical work that cautions against a view of resistance to health advice as characterised by wholesale rejection of services or behaviours and which points to the more subtle and nuanced nature of resistance (Armstrong and Murphy, 2012). The potentially complex permutations of resistance were also indicated in the ways that Traveller Community members' challenge of medical practitioners was rationalised not on their rejection of medical authority but rather on the basis that the treatment was not performed with what they understood to be the appropriate level of medical or scientific rigour.

It is important to consider why such strong and persistent claims about the different orientations of Traveller Community members to time and health are found in practitioner accounts, even despite evidence of counter narratives in the accounts of Traveller Communities with whom these practitioners worked. It is possible that Traveller Community members were more inclined to express identities as morally

responsible health citizens in interviews with a health(y) researcher than in interactions with practitioners. However, similar concerns with impression management are likely to operate in communication between Traveller Community members and health practitioners, potentially to an even greater degree given practitioners' explicit remit of improving health.

While the above discussion of practitioner approaches illustrates the relaxation of power within health sessions, in the form of temporal and spatial control in health interactions with practitioners, Traveller Community members were clearly subject to public health techniques of normative judgement, surveillance and risk categorisation which operate at the broader population level to produce self-regulating and docile bodies. This thereby creates a paradox whereby a broad awareness of the need to regulate one's behaviour in response to dominant discourses on moral responsibility for health was not always reflected in the support that Traveller Communities suggested they received, nor the approach of practitioners, who described a reluctance to broach health behaviour directly for fear that this would alienate Gypsies and Travellers. This tension is amplified for Gypsies and Travellers given the combined effect of discourses on the imperative of health and those which position Traveller Communities as a group who is particularly 'at risk' regarding health. Structural difficulties in access and narratives of being fobbed off when accessing services further compound this scenario. Calkins' (1970) classic study on the different values attached to time, depending on people's circumstances, help in understanding this dynamic. For instance, an overabundance of time may lead to approaches to using time such as 'passing time', 'waiting', 'doing time', 'making time', 'filling time', or 'killing time' for example (Calkins, 1970). Understood in this way, an awareness of the lower life expectancy of Traveller Communities overall, and difficulty getting access to health services required to detect illness, could be considered as giving rise to the experience of time-pressure rather than an abundance of time. Yet, counter to suggestions in the literature and in practitioner narratives, this sense that time is short or that one is living on borrowed time did not translate into narratives about living for the day, but rather gave rise to anxiety that health issues were present but going undiagnosed. This study therefore highlights the discourses underpinning the urgency with which Travellers may approach health services (Lehti and Mattson, 2001). Indeed, narratives about the

requirement to be 'pushy' to get access to services and of treatment having been received 'in the nick of time' were common in Traveller Community accounts.

9.4 Race, culture and structure in narratives of Traveller Community health

The introduction to this thesis highlighted a dearth of attention to the racialisation of Gypsies and Travellers, owing to their position as white minority ethnic groups (Bhopal, 2011; Goodman and Rowe, 2014; Rowe and Goodman, 2014; Garner, 2017). A small body of work explicitly applies the concepts of racism and racialisation to Traveller Communities, focusing on the media (Morris, 2000), education (Bhopal 2011), and place, space and the planning system (Holloway, 2003; Garner, 2017). However, very little consideration has been given to the racialisation of Gypsies and Travellers in the arena of health, with the literature in this area more often employing the concepts of ethnicity and culture. Given Garner's (2017) observation that the category of 'race' is 'immediately more conflictual' than ethnicity, a neglect of the concepts of race and racialisation in research on Gypsy and Traveller health may form an important blockage to recognising and de-normalising the inequities and discrimination experienced by these groups. This PhD research did not ask about race or racism directly, but allowed Gypsies, Travellers and health practitioners to draw on frames such as race, class and gender as they saw fit, when narrating their experiences. This approach provides an opportunity to comment on the extent to which the concept of race was used overtly by participants when discussing Gypsy and Traveller health, as well as attending to more subtle processes of racialisation, including cultural racism. Indeed, a key motivation for undertaking this thesis was to critically interrogate the dominant, taken for granted and benign status that has often been afforded to cultural explanations for Gypsy and Traveller health inequalities. By speaking to both health practitioners and Traveller Community members themselves, the work adds understanding not only of the ways practitioners racialise Gypsies and Travellers by attributing certain characteristics to these groups, but also attempts at 'reflective racialisation' (Garner, 2017) by Gypsies and Travellers themselves. That is, the ways that these groups may emphasise shared group characteristics to facilitate solidarity and counter stereotypes imposed upon them by those from outside the community.

Mirroring literature on Gypsy and Traveller health, explicit references to race or racism were rare in the accounts of both practitioners and Traveller Community members when making sense of health inequalities experienced. Of the practitioners interviewed, only Linda referenced racism directly. When describing differences in the experiences of Roma and Romany Gypsies or Irish Travellers, Linda initially appeared uncertain regarding whether the concept of racism was relevant to the latter two communities, substituting the term racism for assumptions and stereotypes and indicating that stigma was more of a problem for Roma communities than other Traveller Community groups. Linda later acknowledges the racism experienced by Traveller Community members when discussing policing, but still appears unsure over the use of this term when she comments: 'I think there's probably I don't know I might be wrong I think there's probably a bit of racism as in racism because they're a different ethnicity'. Likewise, most Gypsies and Travellers described their differential access to and experiences of health services because of their ethnicity. Yet, community members rarely labelled these experiences as racism (with only Catherine and Bernadette using this term). Both practitioners and Traveller Community members more commonly referred to prejudice, or to assumptions or stereotypes made about Traveller Communities. This points to similar ambiguities regarding the extent to which Gypsies and Travellers can lay claim to experiences of racism in relation to health to those found in parallel areas (Bhopal, 2011; Rowe and Goodman, 2014). A hierarchy of racial inequality was, however, implied in accounts. Caroline, another practitioner in the study described differences in terms of the acceptability of prejudice toward Traveller Community members compared with other ethnic groups, directly attributing this to their whiteness:

you wouldn't do that to somebody black they're [colleagues] not racist but because Gypsies are White suddenly you know it's open season

Indeed, some Traveller Community members described their comparatively poorer treatment relative to other minority groups, echoing the oft-cited Traveller rights mantra that prejudice toward Gypsies and Travellers constitutes the 'last respectable form of racism' (BBC, 2004). While this narrative seemingly assists in drawing attention to the stark and often unquestioned prejudice that Traveller Community members experience, it may also undermine possibilities for solidarity to challenge racism in all its guises and reinforce division by pitting minority groups

against one another. While the Whiteness of Traveller Communities could potentially disguise racism against these groups, in some cases it appeared to facilitate Traveller Community members in aligning themselves with a white majority, as seen in the cases of Catherine, Bernadette and Brigid who drew on their British nationality when articulating their entitlements to services. This again reinforced notions of hierarchy however, positioning those who have migrated to the UK as less deserving of services than others.

Perhaps unsurprisingly given that race was a relatively unspoken issue in relation to Traveller Community health, processes of racialisation which draw on biological attributes were relatively absent in participant accounts. Exceptions were, however, apparent in Linda's suggestion that Gypsy and Traveller women have shorter gestational periods than other women, and in Hazel's description (and albeit dismissal of) a colleague's Lamarckian belief that the poor hearing of previous generations of Travellers (caused by the noise of caravan wheels on roads) has subsequently become a genetically inherited trait. Claims to fundamental biological or genetic differences of Traveller Communities were not drawn upon and used by community members in the current study however.

While the racialisation of Gypsies and Travellers was not accomplished through emphasis on the biological characteristics of Traveller Communities, it was apparent in processes of cultural racism. Practitioners were clearly assigning cultural characteristics to Traveller Community members that were not always matched in the narratives of community members themselves (such as the different orientations to the body and to time discussed above). Though not biological, some reference was made to visible and embodied characteristics of Traveller Communities, as seen in practitioners' presentations of Traveller Community members as particularly concerned with their appearance. One Traveller Community member involved in the study suggested bodily markers of physical appearance were used by settled community members to distinguish Gypsies and Travellers, with those individuals who were identifiable as belonging to these groups particularly vulnerable to discrimination. This is also suggested in Kelly's account where a voice which is recognisable as belonging to a Traveller Community member leads some GP receptionists to disconnect phone calls. Traveller Community members also showed an awareness of their racialisation as groups who are disengaged from their health.

This is reflected in comments by Patricia and Catherine that practitioners assume Traveller Community members are less intelligent and therefore withhold information.

For the most part, there was little evidence of a coherent and distinct cultural outlook of Traveller Community members around health and health behaviour. Gypsies and Travellers did not present themselves as any less concerned about or engaged with their health than other groups. There was variation in the preferred health identities that Traveller Community members in the study claimed for themselves, from active health citizens to conscious resisters, with competing and shifting outlooks also demonstrated in the accounts of individual Traveller Community members. Spivak (1990) coined the term 'strategic essentialism' to refer to the ways that minority groups may present unified identities to facilitate collective mobilisation for one's rights. There were some instances of self-racialisation and strategic essentialism by Gypsies and Travellers in the data, with this assisting community members in reclaiming more positive identities for themselves. A clear example of this was where Gypsies and Travellers members stressed the emphasis on caring for children within their communities. Catherine's suggestion that child abuse and the placement of children into care does not happen in Traveller Communities forms an extreme illustration of strategic essentialism. While not fitting the definition of self-racialisation or strategic essentialism, there were also some examples of approximation of these techniques in the accounts of practitioners, who sometimes imparted positive generalisations of Traveller Community members as 'lovely' or 'intelligent' and who appeared to feel less need to qualify blanket statements where these were positive. This study has pointed to the complicated operation of race as a category when making sense of Gypsy and Traveller health entitlements and identities, with the concept of race appearing to be used both to promote and obfuscate Gypsy and Traveller rights to health and access to services.

The literature review highlighted a tension between cultural and structural explanations for the health of Traveller Community members. Reflecting existing literature, strong claims about the distinctive culture and lifestyles of Traveller Communities were exemplified in the accounts of practitioners in the study. However, discourses around culture were often cited alongside structural explanations for Gypsy and Traveller health inequalities, such as poverty or

discrimination. In some cases, these explanations were presented as superseding cultural influences and at other times, as interacting, for example where poverty was suggested as giving rise to fatalism, or a low prioritisation of health. Class appeared to be operating as strongly as race in practitioner accounts, both in explanations for the health of Traveller Community members, and as a factor affecting practitioners' interaction with these groups. When describing their work with Traveller Communities, practitioners often aligned Traveller Community members with the broader subject position of disadvantage as opposed to identity as a Traveller Community member. One-dimensional portrayals of Traveller Communities as disadvantaged or excluded, along with claims to specialist expertise in working with such groups, were used as a form of currency or means of attaining status by some practitioners. This outlook echoes the wider media genre of 'poverty porn' (Lissner, 1981) and the dominant cultural narrative of the 'White saviour', which depict those who are 'in need' according to shallow victim stereotypes, and give the impression that they are wholly dependent on Western intervention. Indeed, Karen used language that explicitly mirrors the common charitable trope when suggesting that she was motivated to work with Gypsies and Travellers due to a desire to help those that were 'less fortunate than' herself. She also draws a comparison to charitable work undertaken overseas when describing the need to enable Traveller Community members to help themselves rather than rely on external support. The visit and tour of the Traveller site by health practitioners so that they could see the conditions on the site for themselves is also reminiscent of a 'poverty porn' approach. The phrase 'White saviour' may be misleading in this context, as I am referring to White health practitioners helping a White ethnic group, and since practitioners often positioned themselves alongside rather than at a distance from the community. However, this concept nevertheless captures the construction of Traveller Community members as 'in need' of intervention, as well as helping us to consider the interests certain group representations serve not only for communities, but for practitioners and organisations working with these groups.

Portrayals of Traveller Community members as disadvantaged by definition, and suggestions that such circumstances can only truly be understood by health practitioners with the right aptitude are perhaps driven by a desire to ensure work is undertaken with the required sensitivity. Practitioners described working-class identities or their familiarity with the complexity of circumstances experienced by

'vulnerable' community members as important in finding a point of connection with community members. While assisting practitioners in identifying with Gypsies and Travellers, this representation itself points to assumptions that Traveller Community members are inherently disadvantaged and always from working class backgrounds, thereby overlooking the social stratification of these groups. This demonstrates how practitioners may reinforce popular discourses depicting Traveller Community members as 'other', even while working toward their inclusion. It is also important to note that gender appeared to form an additional dimension in the operation of a White Saviour complex, with female practitioners particularly concerned to assist Traveller Community women, who they judged to be potentially oppressed, isolated and as having low 'aspirations', with this sometimes suggested as tied to practitioners' own cited values regarding female empowerment. Although prejudice experienced due to one's position of belonging to a Traveller Community formed a dominant narrative in making sense of experiences, some Gypsies and Travellers also drew on wider identity positions in their talk, referring to the influence of poverty/wealth on the health services received. This is illustrated in the connection Bernadette makes between high rates of cancer in Traveller Communities, and the low incidence of cancer in those that are 'well to do', or 'rich'.

These findings connect with discussion in previous literature around the potentially stigmatising effects of discourses on the structural influences on health. In the current study, the reconciliation of competing discourses which on the one hand advocate the imperative of health and on the other describe Traveller Communities as unhealthy by definition, appeared to pose a key identity tension for participants which needed to be accounted for in interviews. To the best of my knowledge, this is the first such study to have highlighted the influence of this dynamic on the identities expressed by Gypsy and Traveller Communities. Findings contrast with those of Hodgins (2006) which suggest Traveller Communities are more willing to acknowledge the structural determinants they experience than other groups (Cornwell, 1984; Blaxter, 1997) and are less concerned that doing so would 'devalue their identity' (Hodgins, Millar and Barry, 2006). Hodgins et al. (2006) interpret these findings as stemming from differences in the articulation of class and ethnic inequality, suggesting that the heightened attention to the health of Gypsies and Travellers means these groups are more willing to:

see themselves as needy, requiring intervention and assistance rather than looking to themselves and within their own community for strength to surmount difficulty (2006: 1988)

Some convergence in findings is evident in findings reported here and those of Hodgins et al. (2006), in that Traveller Community members involved in the present study did draw readily on structural and material explanations for their poorer health status. However, while this was the case, findings of the present study do not support the acceptance of an identity position as 'needy' by community members and in fact, highlight the potentially stigmatising effects of such discourses. Traveller Community members in the current study were obviously aware of the potential moral judgement that was attached to their poorer health and lower life expectancy and there was evidence of associated attempts at impression management within interviews. Indeed, drawing attention to the experience of structural inequality was connected with this potential blame and was one way through which community members could mitigate this. Unlike in the study by Hodgins et al. (2006), in which Traveller Community members rejected behavioural explanations for health, in favour of structural or material determinants, Gypsies and Travellers in the current study positioned themselves as personally responsible for, and active in promoting their health. The difference in findings reported here, and those of Hodgins et al. (2006) is likely to be explained in part by the contrast in study methods. The use of vignettes by Hodgins et al. (2006) introduces a degree of distance between participants, the study topic and the researcher. On the other hand, the use of narrative interviews to discuss people's personal health experiences in the current study is likely to have created a greater requirement for participants to account for their position to a health(y) researcher. Findings reported in this thesis suggest that the acknowledgement of health inequalities does not necessarily equate with the acceptance of a 'needy' or stigmatised identity. They point to the potentially damaging effects of narratives which position these groups as passive victims, given that Travellers too are subject to broader discourses on the imperative of health. Likewise, it identifies a need to avoid assumptions of a lack of personal responsibility for health among Traveller Community members. The emphasis of practice expertise in working with 'vulnerable' or 'disadvantaged' groups has been shown here as potentially stigmatising to community members and suggests the need to balance presentations of need with recognition of the healthy aspects of self-presented by Traveller Communities.

9.5 Summary

This chapter has brought together the narratives of practitioners and Traveller Community members around three key areas: 1) body work and emotional labour; 2) the role of time and space in positioning Traveller Community members as disciplined by or resistant to health promotion; and 3) the use of race, culture and structure in understanding Gypsy and Traveller health. Throughout these discussions, consideration has been given to the identity positions of practitioners and Traveller Communities which are circumscribed and enabled, along with associated implications for how Traveller Community health is broached. This chapter has added to understanding not only around the narrative accomplishment of Traveller Community members' and health practitioners' preferred identities, but the embodied nature of these identity positions, and the operation of trust and relationships between these actors which have been hitherto unexplored. It has been argued that, in response to discourses that position Traveller Communities as an excluded and disadvantaged group, the body and emotional work of practitioners was reportedly key to the establishment of trust and the ability to engage this group. It has drawn attention to the different rules governing how practitioners present and conduct themselves depending on the sector in which they work and connected with class. Specifically, it has argued that civil society organisations and practitioners working in community roles are expected to engage to a greater extent in managing the emotions of those who are 'vulnerable'.

Representations of Traveller Community members as having a distinct sense of time, and as more focused on the present than the future have been shown as a further way through which the health 'otherness' of Traveller Communities is established. Drawing on poststructuralist theory, the chapter has argued that orientations to time and place are key mechanisms for understanding attempts at controlling the health behaviour of Traveller Community members, as well as interpretations of resistance. Somewhat surprisingly, practitioners appeared to be relinquishing many strategies of temporal and spatial discipline in health interactions with Traveller Communities. Instead, it was argued that practitioners approached health education by mimicking and co-opting what they deemed to be usual channels and styles of communication used by Traveller Communities. That health education is largely hidden was suggested to create a paradox given that Traveller Communities do not position themselves as present rather than future focused, but

as receiving a lack of health information or advice to support them towards these aims. A cycle therefore seemed to be apparent whereby discourses on the moral imperative of health, combined with awareness that Traveller Communities as a group have poorer health than others then intensifies concern that health needs are going unmet and entrenches identities of Traveller Community members as 'in need' and vulnerable.

The chapter finally reflected on the use of race, culture and structure in narratives about Traveller Community health. While participants rarely used the concepts of race and racism, it was argued that health is a further arena for the racialisation of Gypsies and Travellers. This was accomplished through depictions of Traveller Community members as less concerned with their health (connected with the positioning of Traveller Communities as more concerned with superficial aspects of their bodies, or as having different time preferences). Examples of self-racialisation of Traveller Community members were also apparent, notably, by drawing attention to the greater protection of children in Traveller communities and which helped these groups generate more positive representations of their culture. Processes of racialisation intersected with notions of disadvantage, class and gender in accounts, with class forming a key frame used by practitioners when discussing their ability or lack of ability to engage with Traveller Communities. Together, these discourses could lead to concrete effects. Reinforcement of practitioner identities as specialist in working with Traveller Communities may potentially lock out Gypsies and Travellers from some forms of health advice or from interacting with a wider range of health practitioners.

CHAPTER 10 - Conclusion

10.1 Introduction

This thesis responded to what was identified as a contested territory surrounding the 'problem' of Gypsy and Traveller Community health. Various narratives, often advanced by those outside of Gypsy and Traveller Communities, compete to define how these groups *are* in relation to their health and explain the inequalities they experience. Rather than using data collected from Traveller Communities to support interpretations *about* these groups, I have tried to create a space within this research whereby community members and health practitioners can give accounts of themselves and each other, and to bring these accounts into dialogue.

Specifically, the thesis examined how Gypsies and Travellers are constructed as groups in relation to health, and how health is constructed in relation to Traveller Communities. It also addressed questions around the preferred identities claimed by Traveller Community members and health practitioners, where these identity positions collide and coalesce, and the associated implications for approaches to improve Gypsy and Traveller health.

This chapter first reflects on the methodological approach taken for the study. I here assess the value of poststructuralist informed narrative inquiry in meeting the research aims and set out the limitations of the current study. The second section reflects on the extent to which I, as a settled researcher, can hope to redress unequal power relations and achieve change through the research. It distils the implications of the findings for future research and practice in the area of Gypsy and Traveller health and outlines my (modest) plans to maximise the impact of this work.

10.2 The research story: methodological reflections

10.2.1 Contribution of a poststructural narrative approach

The use of poststructuralist narrative inquiry provided a number of benefits for this research. The commitment within poststructuralism to avoiding producing essential representations of groups helped avoid, as far as possible, an approach of reproducing further global definitions of Traveller Communities and their health beliefs and practices. By adopting this approach, the focus of inquiry could instead

be shifted onto the discourses in circulation *about* Traveller Communities and health practitioners, and their constitutive role in shaping practice and health interactions. The poststructuralist emphasis on identity as multiple and fluid, along with the commitment in narrative inquiry to individuals' biographies, over time and context, helped avoid the privileging of ethnicity in participant accounts. This helped examine how wider identity positions such as those of healthy citizens, nationhood, motherhood, class or disadvantage could be drawn on alongside or intersect with those of race or ethnicity in participant accounts.

The adoption of this theoretical and methodological approach in the current study has brought voices and plotlines into the fold that have hitherto been marginalised by the predominance of cultural explanations in the field. Key here was the demonstration of the co-existence of healthy and unhealthy selves, fatalism and agency, and compliance and resistance to health promotion ideals, both across and within the accounts of Traveller Community members in the study. It also highlighted the role of these competing discourses on the identities claimed by Traveller Community members, with discourses that position Travellers as having poor health on the one hand, and which advocate the imperative of health on the other, combining to stigmatise these groups. While previous criticisms of cultural explanations have countered this argument by emphasising structural influences, this too may risk entrenching a narrative of the powerlessness of Traveller Communities and downplay the agency of Gypsies and Travellers. The approach taken in the current study examines the ways that Travellers may be trapped in regimes of power and limited by the discourses to which they are subject, but also how they can enact resistance in relation to the discourses to which they are subject, thereby capturing such moments of struggle. Likewise, the work also enabled attention to the ways that narratives about the 'vulnerability' of Traveller Communities were instrumental in the identities produced for health practitioners, their claims to expertise and the ways they practice with these groups. These practices in turn, often reinforced a position of Traveller Communities as 'other' and disadvantaged. The joint focus on the constructions of both practitioners and Traveller community members forms a key strength of this study, helping work towards a scenario whereby the preferred identities of practitioners and Traveller Communities complement one another.

10.2.2 Study limitations

While the methodological approach adopted has been shown to be of value in generating a novel perspective on the topic area, it is also important to highlight the limitations of the research.

10.2.2.1 Study sample

Limitations stem first and foremost from the sample of participants involved in the study. Participants were recruited from one geographical location and drawn from a network of community members and practitioners who were, predominantly, known to each other. In keeping with the poststructuralist underpinning of the study, I do not aim to produce universal truths. It is nevertheless important to note the potentially contextually specific nature of the discourses drawn upon within the current study and acknowledge the possibility that other modes of talking about Traveller Community health may be drawn upon in alternative areas. The presence of an organisation working for Gypsy and Traveller rights in the area, therefore ensuring at least some representation of these groups in public health provision, is one factor that may have influenced the discourses in circulation, for instance. This may also have contributed to the finding that, in comparison to prior studies (Van Cleemput *et al.*, 2007), Traveller Community members cited their low average life expectancy relative to other groups. That said, reflections from broader engagement in the field, including involvement in conferences, other events and conversation in the areas of both public health and Traveller Community rights indicate that many of the discourses articulated within the current study are also expressed outside the study area.

It is also important to stress the relatively homogeneous sample of Traveller Community members involved in the study. Of the diversity of groups encompassed under the category of 'Traveller Communities', this study involved only Romany Gypsies and Irish Travellers. In addition, given the crucial role of the local Traveller Community organisation in providing support to community members in the area, it proved difficult to locate community members who were not known to the organisation. The study sample included Gypsies and Travellers who live in housing and those living on a local authority site and did not include representation from community members currently living on roadside or private sites. Finally, as described earlier, while I had aimed to recruit Traveller Community men to the study, I was not successful in doing so. However, given that health practitioners and

initiatives encompassed in the study focused almost exclusively on Traveller women, this facilitated the comparison of practitioner and Traveller accounts by enabling the collation of different narratives about events or interactions held in common. Overall, while the relative lack of diversity among the Traveller Community sample therefore placed limits on understanding the variety of identity positions that connect with those of ethnicity and health, this brought benefits in enabling attention to nuances in how overarching discourses are taken up and used, and potential variation in representations of self in response to similar events and experiences.

There were a limited number of health practitioners in the area working in a public health capacity with Traveller Communities, and the research was successful in recruiting most of those who did so to the study. One weakness of the practitioner sample however, was the omission of GPs from the study. A decision was made to avoid recruiting GPs, since their roles have been traditionally weighted toward clinical rather than public health work, and as including GPs was deemed as likely to sway the focus more towards issues around service accessibility and provision for Gypsies and Travellers, something that is already very well documented in the literature. However, as might be expected given the challenges that Gypsies and Travellers face in this area, access (or lack of access) to GP practices and other health services were discussed frequently in Traveller Community accounts, as was the treatment received through these services. Indeed, given the limited amount of preventative health advice received by Gypsies and Travellers in the area, it would have been very difficult to focus only on those instances of health interaction in interviews. It is important to acknowledge therefore that Traveller Community accounts of accessing care, when referring to GP services, are not always compared with accounts from practitioners in the corresponding profession, and this is something that has been born in mind during the analysis process. This did not, however, impact on the ability to explore similarities or differences in the preferred identities expressed between practitioners, and where referring more generally to health promotion advice, to compare corresponding accounts from Traveller Communities and health practitioners.

10.2.2.2 Stories and their limits

The focus on generating stories through the research was appealing for its ability to encompass the breadth and complexity inherent in participants' lives, and the ways

that participants positioned themselves in relation to others. This was also beneficial due to pragmatic and ethical considerations. Traveller Community members are suggested to have a rich tradition of storytelling (French, 2014), and this method shifts the balance of control for constructing accounts about one's experiences to the participant and away from the researcher. It was thereby judged as a useful way of rebalancing potentially un-equal power relations within the research. However, I experienced several challenges in the application of this approach. Firstly, this method did not shift the balance of power in interviews with Traveller Community members as far as I had anticipated. Traveller Community members often deferred to me to check that their responses were in keeping with the type of information required for the research and slipped out of storytelling mode to ask what else I wanted to know. This is potentially related to the difficulty in narrating instances of health as opposed to illness, or other significant events. It was often when recounting encounters with health practitioners that had been unsatisfactory in some way that Traveller Community members gave accounts that most closely match typical story structures (Labov, 1982). Likewise, I found variation in the extent to which practitioners engaged with telling stories during interviews, with most seeming more comfortable talking in generalised and abstract terms about their work with Traveller Community members. This gave rise to considerable anxiety throughout the research in terms of whether I was generating the form of data that was required for narrative analysis, since participant accounts combined general insights and the use of bounded stories in support of their claims. However, this form of data is accommodated in the small story approach to narrative adopted in the study which analyses all aspects of participant accounts rather than limiting analysis to circumscribed stories in the data. As a result, this restricted insights into potential patterns in the structuring of stories about Traveller Community health. Another limitation stems from the limited actual interaction of the narrative voices of Traveller Community members and practitioners throughout the research. I considered presenting example statements from each party to one another, to generate cross-fertilisation of narratives. However, this approach was rejected due to the potential harm this may cause to established relationships in the field, and as this would conflict with the aim of the research to allow participants to construct their identities as they saw fit. As such it must be acknowledged that it is the researcher's process of translation and interpretation (albeit informed by engagement and observation of

the field) that allows narratives from the different 'sides' to speak to one another, and potential implications to be drawn for health communication.

10.2.2.3 Broad and exploratory approach

Given the exploratory nature of the current study, a decision was made to focus on health in a broad sense, rather than examine the identity presentations of participants surrounding a particular health promotion issue (such as immunisation, cervical screening or breastfeeding). This brought advantages in ensuring that sufficient practitioners could be recruited to the research, and in allowing open-ended exploration of the construction of health by participants. It also prevented Gypsies and Travellers from being defined or self-defining in relation to a single issue, allowing participants to define as both healthy and unhealthy. I believe this work has been useful in demonstrating that portrayals of Traveller Community members as disengaged with preventive health or fatalistic do not reflect all aspects of Gypsies and Travellers' self-presentations. However, it is possible that presentations of self in relation to health generally may differ from those articulated in relation to specific health issues, services or interventions.

10.2.2.4 Embodying health identities

A third issue, connected with the nature of stories and the broad research focus, concerns the distinction between talk and practices. This research focused predominantly on the ways participants constructed identities through talk. The research did involve some informal observation during visits to the organisation, including participation in health sessions being delivered with Traveller Community members. However, this was undertaken primarily with the aim of understanding the extent to which stories and identity presentations may vary or be held constant outside of interviews, as well as to inform reflections on how participants may be positioning me. Although I have incorporated some reflections on how my own and participants' bodies were implicated in identity relations, I gave greater attention to talk than bodily conduct in these interactions. Similarly, findings about the significance of the body and the temporal organisation of health sessions were not anticipated at the outset of the research but emerged through the data generated. As such, greater orientation during the research to the embodied and spatial nature of interactions during observation of health sessions would have improved the depth of insights provided on this issue.

10.3 A (provisional) ending: distilling the moral of the stories

In this final section of the thesis, I reflect on the extent to which I can effect change through the study, in light of my position as a settled researcher. The need to consider this issue was reinforced when I discovered the following comment, made in response to a blog post analysing the limited success of the Decade of Roma Inclusion, and which gives a scathing analysis of the contribution of academics from outside of Gypsy, Roma and Traveller Communities:

The main reason the decade led to little improvement for the Roma is that although inclusion was the manifest aim the latent purpose of this initiative (just like all of them) is that it was about creating a lot of nice jobs for middle class gadje bureaucrats, policy wonks and academics/ researchers to cry false tears over the Roma while securing their own cushy jobs and good salaries. So long as the Roma have these parasites riding on their backs they will never achieve inclusion because the parasites need them to be excluded and marginalised to justify their own careers (Dave, 2015)

While perhaps indicating an extreme stance, the above comment relates to longstanding debates in the field around whether research focusing on the processes through which groups are excluded simply reinforces the status quo (Sibley, 1998). This statement also connects to concerns that presenting groups as 'in need' fosters dependency on external sources of support and perpetuates the requirement for external services and interventions (McKnight, 1995). Indeed, this chimes to a degree with arguments I have myself made in this thesis around the potential othering of Traveller Communities where practitioners make claims to expertise based on an understanding of, and ability to engage with disadvantaged groups. Given that such criticisms may also be directed at researchers who articulate an interest in groups who tend to be overlooked within mainstream services, it is appropriate to consider my own stance on this issue.

On first reading the above quote I felt profound guilt that I might be reproducing or even personally benefiting from the inequity experienced by others. On reflection however, I feel that both 'gadje' and Roma, Gypsy and Traveller people need to work together to secure inclusion and that change would be difficult to achieve where members of 'majority' populations don't also work towards this end. As has been argued by Bignall (2008), a refusal to speak for others may result the continued silencing of groups who, historically, have not had their voices heard. While I do not see my role as one of speaking *for* Traveller Community members (and practitioners), I aim to use my positionality (for instance, as a researcher, as

someone involved in public health lecturing in higher education, and as a settled community member) and the opportunities these various positions afford, to provide a channel for the narratives of Gypsy and Traveller Community members.

Throughout the research, I have taken a number of steps to manage the power dynamic inherent in the risk of capitalising on the circumstances of community members for personal ends. I have remained alert to any potential to reinforce the otherness of Traveller Community members through the research and have actively tried to destabilise stereotypes of Traveller Community members as exotic or hidden which might otherwise be employed to give greater appeal to my research (Forster and Jones, 2018). The close relationship with and backing received from the Traveller organisation supporting the research has also helped to ensure the relevance and utility of this work to existing practice in the field.

Poststructuralist approaches often shy away from offering concrete truth claims or recommendations, since to do so would simply re-establish an alternative relation of knowledge/power. However, in the interests of ensuring that the research not only describes but also attempts to challenge existing narratives and question existing structures of power where possible, I here depart slightly from poststructuralist tradition, to consider the implications of findings. Following the distinction drawn by Bauman (1987), I understand my role not as that of a 'legislator' who offers definitive judgements about the 'correct' course of action, but one of a 'moral interpreter', acting in a translational role to facilitate exchange between different standpoints, in this case between Traveller Community and health practitioners. Based on the insights gained by placing Traveller Community members' and health practitioners' narratives alongside one another within the current study, a series of suggestions for practice and further research are now outlined. This is with the aim of identifying shared stories that can guide efforts to improve health and reduce health inequalities among Gypsy and Traveller Communities.

10.3.1 Implications for practice

Counter to many of the existing narratives about Traveller Community health, this work demonstrates that Gypsies and Travellers are not 'beyond the reach' of dominant health promotion discourse on the moral imperative of health, and that these groups draw on remarkably similar definitions of health to those found in wider populations. The research also questions global attributions of fatalism directed at

Traveller Communities, instead highlighting the co-existence of fatalistic and agentic health discourses in Gypsy and Traveller accounts. Findings therefore highlight the importance that practice does not operate from the assumption that Gypsies and Travellers are, by definition, 'disengaged' in, or unable to prioritise their health. Such assumptions were shown to have concrete effects on practice, closing off dialogue about aspects of health. A reluctance to broach health behaviour, strategies of disguising behavioural advice by instead focusing on its benefits for physical attractiveness, or dissociating oneself from formal health professional roles through bodily representation helped practitioners negate the potential risk to trust of appearing judgemental. However, findings also show that this strategy is likely to have unintended consequences in exacerbating Traveller Community concerns about the lack of advice and information they receive about how to promote their health. The diversity evident across Gypsy and Traveller Community accounts highlights the importance of attending to individual differences in outlook with respect to health.

Existing recommendations in this area tend to offer pragmatic solutions for alleviating structural barriers to service access, or focus on bridging difficulties in health provision arising from a lack of awareness of Gypsy and Traveller culture. Indeed, cultural awareness training for health care professionals is often a core strategy for increasing the accessibility of health services to Traveller Community members. While both of these perspectives are undoubtedly useful, the former may not provide insight into the narratives that underpin structural barriers and the latter may risk reinforcing notions that Traveller Communities are different from other groups and promote the need for specialist knowledge. This thesis demonstrates that, in addition to recommendations in these areas, attention should be paid to the ways that communication between practitioners and Traveller Community members may breakdown as a result of discrepancies in the preferred identities that these actors claim, as well as those that they cast for each other.

Findings from this study suggest that Traveller Community members experience their poorer health status as stigmatising and are concerned to uphold identities as morally responsible, healthy citizens. Potential for conflict was identified between these identities, and practitioner representations of Traveller Community members as differently oriented to future health, and articulations of their own identities as

expert in working with 'disadvantaged' or 'excluded' groups. The pursuit of such 'white saviour' identity positions potentially works to preserve the structural inequity experienced by such groups, for instance, by reinforcing the notion that health provision for Traveller Communities is the preserve of only 'specialist' services or individuals. This work lends support to the potential usefulness of approaches that recognise the strengths or assets of community members and which offer some challenge to the assignment of a 'victim' role to Gypsies and Travellers. In addition, I suggest that education for health practitioners might usefully focus not only on the culture of Traveller Communities, but also question common taken for granted narratives about these groups in relation to health. Training is required which prompts self-reflection around how we understand ourselves in relation to our work with Traveller Communities, the potential interests served by these understandings and presentations, and the potential effects these give rise to.

The research has given insight not only into how health practitioners position themselves in relation to Traveller Community members, but also how they do so in relation to other health practitioners. This highlights the different expectations for emotional work depending on employment sector and practitioner role. Those working in civil society organisations and interacting closely with Traveller Communities were expected to engage in emotional labour to a greater degree. Systems for commissioning health services for socially excluded groups have been recognised as providing very little attention to relational aspects of delivery, such as trust (Wemyss, Matthews and Jones, 2015). This work underscores the need for recognition of the varied forms of work undertaken by different types of organisations and workers, as well as greater consideration of the expectations of staff regarding emotional labour and how these are best supported and resourced.

10.3.2 Recommendations for further research

This exploratory study has suggested a number of avenues for further research. Having examined the preferred identity positions of Romany Gypsy and Irish Traveller Community women with regard to their health, further research could usefully be undertaken to explore whether Traveller Community members in a more diverse range of positions (e.g. according to Traveller Community sub-group, gender, sexuality, accommodation type) draw upon similar or different narratives. In addition, further work should unpick how Traveller Community members and health

practitioners may present themselves differently in response to specific health issues and services.

Traveller Community members in the current study were clearly concerned about and accepted the moral responsibility to promote their health. However, they often described themselves as lacking access to the appropriate tools (in terms of information and services) to be able to fulfil these aims. Further research is needed which examines more precisely community members' preferences in terms of the forms of information desired and most appropriate methods of delivering this information. Research in this area could use participatory methods to work with community members to design and implement health promotion materials.

This work has pointed to the significance of the body and space in health interactions between Traveller Community members and health practitioners. Further work that looked specifically and in more depth at the embodied nature of building and managing trust and relationships with Traveller Community members would be beneficial. This could include the use of an ethnographic approach to explore how Traveller Community members and practitioners conduct themselves within different health spaces. This would help to understand how identities and health communication between these actors are shaped not only in talk, but also in interaction with objects and places.

Discussions of the emotional labour undertaken by health practitioners was an unanticipated finding of the research. At present, the emotional work of health practitioners has been undertaken in relation to a limited range of occupations, less often encompassing those in community and civil society roles. This study has hinted at the potentially differing feeling rules that operate for those in these sectors, connected with dimensions of identity such as proximity to the community, class and disadvantage. This indicates the potential of further research in this area for enriching analysis of the differential social requirements for the performance and management of emotions in a range of health institutions or settings, and the possibilities and limits these create for relationships, identities and practices.

Lastly, I earlier noted a need for education and rights awareness training initiatives targeted at practitioners to encourage reflection on the different interests and

motivations which underpin this work, and the representations of communities that they themselves advance. This is particularly in regard to the potential entrenchment of the disadvantaged position of Gypsies and Travellers, and the ways that work with these communities may be used as a form of currency to establish one's own expertise. Research is needed which explores the methods through which this form of reflection might be encouraged.

10.3.3 The next chapter

In this final section of the thesis, I detail plans for taking the research forward, with the aim that findings are made available for wide use (beyond only academia) and may foster (modest) change that contributes to improving conditions for Traveller Community members. As discussed earlier, the comparative approach adopted in this research presents opportunities to inform communication between Traveller Community members and practitioners. In seeking to maximise the impact of the research in this regard, I am inspired by examples which use creative arts such as graphic novels and forum theatre to challenge the stereotypes of Gypsy and Traveller Communities that impede their access to services. The Minority Ethnic Carers of People Project (2014) book 'Two Sides of the Same Story', provides a particularly instructive example of an approach to challenging narratives commonly heard among service providers that create barriers in access to support services among Gypsy and Traveller people. I also take inspiration from the recent 'We Are All So Many Things' campaign, which embodies an intersectional approach to counter Gypsy and Traveller Community members being viewed only through the lens of their ethnicity. Following in the footsteps of these examples, and based on the findings of this thesis, I aim to develop, in collaboration with community members, a graphic novel or alternative form of creative engagement to prompt reflection among those who work with or may work with Gypsies and Travellers. The narrative nature of the data adopted through the research lends itself well to these aims. Although the precise format for sharing findings will be decided in conjunction with community members, this is potentially envisioned as presenting Gypsy and Traveller, and practitioner narratives about health, alongside one another, making clear where divergence or convergence in these narratives may impede or facilitate communication. It could also involve, in the spirit of the Traveller movement campaign (London Gypsies and Travellers, 2017), showing the many aspects of health as they interact with wider roles for fictionalised case studies of Gypsies and Travellers based on research findings. More ambitiously, it could involve the

generation of short theatre performances depicting common health scenarios. That the vehicle for communicating findings is developed in collaboration with Gypsies and Travellers themselves is essential, providing a way of sharing research findings back with participants, and ensuring that community members have a say in how these findings are taken forward and used. In doing so, and to borrow from Terry Pratchett (2011), I aim to finish the research by returning the rights of Traveller Community members to author their own lives, as opposed to simply becoming 'a part of someone else's story'.

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Appendices

Appendix 1: Interview guide for Traveller Community members

Icebreaking questions

How long have you lived here? How often do you travel/have you travelled in the past? Do you have any family who live nearby?

Stories of health

In terms of health, how would you describe yourself at the moment?

Follow up:

- *What makes you describe yourself/health in that way? What else?*
- *When did you first realise that your health is that way? / When during the daily life do you notice most/least that your health is that way?*
- *What is going on in your life that stops you from/helps you to be healthy? Which of these are most/least important?*
- *How does attention to your health fit in with other parts of everyday life (things like to do, responsibilities etc.)*
- *How healthy are you compared to other people you know?*
- *Who is the most/least likely to have the same view about your health at the moment as you do? Follow up on time when you saw that most clearly*
- *Who has been helping you with your health, or who has hindered you with respect to health?*

Can you tell me about a **time in your life which stood out when you've felt more healthy** (even if it was just for a very short window/no matter how long ago)?

Follow up (as above)

Or time when you felt like you were **nearly there/on the right track towards becoming healthy?**

Follow up (as above)

Time when you **felt like you were less healthy?**

Follow up (as above)

Is your health **better when you're in some places than others?**

- *Can you tell me about a time that displays that at its most clearest?*
- *What was it about being there then that meant you felt particularly healthy?*

Can you tell me about a time when you **did something to improve your health**?

- *What led to that?*
- *What thoughts were going through your mind when you did that?*
- *How did you go about doing that?*
- *Was there anything else going on for you at the time that influenced you making that change? Which of these were most/least significant?*
- *Who helped you to make a change to your health, or who hindered you?*
- *Did anyone notice the change? What did they say about it?*
- *What happened after that? What impact did that have on you?*

Have you got any **hopes/plans for the future** in relation to your health?

Stories about experiences with health service/professionals

Can you think of a time when you were on the receiving end of someone giving you health advice that was a good experience?

- *What happened first? What happened next?*
- *Who was there? What did they do/say?*
- *What were your reactions? What thoughts did you have/what sense did you make of that?*
- *Did you talk to anyone else about it at the time?*
- *How did it turn out?*
- *What happened afterwards? What impact did that have on you?*
- *Why might other people have behaved in the way they did?*

Can you tell me about a time when you had a particularly **bad experience**?

Follow up (as above)

Appendix 2: Interview guide for health practitioners

Stories about work with Traveller Communities

Could you tell me your story about how you first came to be working with Traveller Communities and the work you've been involved in over that time?

- *What happened first? What happened next?*
- *Who were you working alongside?*
- *What motivated you to work with Traveller Communities?*
- *What were your expectations for the work? How did your expectations turn out?...How did your views about the work change if at all?*
- *Who have you worked alongside? Who has the most/least similar views of Traveller health to you?*
- *Have you found yourself working differently at different times throughout your work/as you work in different settings? – Examples*
- *Are there any differences in the way you work with Traveller Communities compared to how you work with other groups? If so, how?*
- *Is there anything about you personally or your role that influences the work you do with Travellers? Follow up for specific times.*

Can you tell me about a time in your practice with Traveller Community which you think went **particularly well**?

- *What happened leading up to this? What happened first? What happened next?*
- *Did you have an idea of what you wanted to achieve? How did you introduce that?*
- *When did you first think to yourself that it was going well?*
- *What were your feelings about what was happening? What sense did you make of it?*
- *Who else was there/involved? What did they say/do?*
- *Did you talk to anyone else about what was going on? What were other people's reactions to that?*
- *How did it all end?*
- *What impact did that have for you? Did anything change for you in your work after that?*
- *What else was going on for you at the time that might have contributed to the encounter going well?*
- *What made you choose that particular time?*
- *How would other people involved describe it?*

Can you tell me about a time in your practice with Traveller Community **when you got stuck**?

Follow up (as above)

Can you tell me about a time which was **significant in changing your approach** to working with Travellers?

- How did that start? When did you first realise that you wanted to change your practice? What was going through your head at the time?
- What happened next?
- Who else was there/involved? What did they say/do?
- Did you talk to anyone else about what was going on? What were other people's reactions?
- What else was going on for you at the time that might have influenced you in making this change?
- How did it all end? What impact did that have for you in your work? What changed for you after that happened?
- What made you choose that time in particular?

Appendix 3: Observation record for Traveller Community members and practitioners

Participant ID:

Date of interview/conversation:

Duration of the interview/conversation:

Participant's gender:

Age:

Notes on who referred to study by and relationship to person who made the referral (if relevant):

Notes on researchers' knowledge about/expectations/preconceptions of participant prior to interview, preparation for interview, how the interview came about, and what prior knowledge participants had of the researcher:

Notes on initial contact/conversations with participant, first impressions, possible motivations for/concerns expressed about participating in the project, questions about the research/researcher, indications of differences/similarities drawn with the researcher:

Notes on context of interview – where were initial conversations/interviews held, was anyone else around at the time of the interview, were there any other events going on for the participants/community at the time:

What reactions were evoked in me as a researcher by the stories told at different points during the interview:

Notes on conversation after the interview – did the participant express new or different views once the tape recorder had been switched off:

Suggestions for other potential participants and their relationship to the person interviewed:

Any other comments:

Appendix 4: Analytical framework to guide narrative analysis

Interpersonal level

- What interaction occurred prior to making contact with participants, e.g. how did the researcher imagine the participants, prepare for interviews, work through potential interview scenarios? What preconceptions of interview participants did the researcher have? How did the particular interview come about? What happened before and after the interview? What prior knowledge did participants and interviewers have about one another?
- What happened between first contact with a participant and the actual interview episode? E.g. what first impressions may have been formed? What hidden goals or imagined future roles in the project may have been operating?
- How might the person have expressed particular identities in response to perceptions of the researcher? What similarities and differences were there between researcher and participant and how might this have influenced the stories told? How did the participant relate to the researcher? Were there any explicit descriptions of, or overtures to the researcher by participants?
- In what ways do participants present themselves as having sufficient credibility to talk about the topic? What does this tell us about assumptions made about the researcher?
- Did participants make a distinction between talk within the interview and more informal communication e.g. expressing different viewpoints after the recorder was switched off, or asking the researcher for personal advice?
- How did the context, historical experiences and beliefs of the researcher affect the responses to the stories told? How might this in turn have shaped the participant's narrative? E.g. was there anything the researcher felt uncomfortable asking, or was drawn to ask? What verbal and non-verbal cues might the researcher have given the participant about their reactions to the story?
- How might the participant be directing their stories to imagined audiences (which may be entangled with the imagined position of the researcher or against which the researcher may be enlisted alongside the narrator?) And how does the participant position the audience?

- What seems to remain unsaid? How might the stories have been told differently to a different audience?
- How might stories have been influenced by the social spaces in which they were told?
- What assumptions do I make? How do I position people through the questions I ask?

Positional level

- How does the person position themselves within particular instances of social interaction?
- Were different identity positions employed throughout the interview or depending on the social situation described? Did participants relate to others differently at different points in the story?
- What might participants' positioning of others (through explicit descriptions, engineering particular plots, drawing on readily recognisable characters) imply about the participants themselves? How might participants use others in the story to express versions of themselves? E.g. do participants compare self with others, or have others comment on themselves or their actions?
- Do participants describe their current self by evaluating their former selves?
- What conversations occur between 'different voices', such as between the voices of Travellers and health professionals?
- What can be learned from examples of reported speech with others?
- Is there any use of dramatization or mimicry of other voices?
- How do people position different characters in relation to one another and self?
- Pay attention to use of verbs that may frame action as voluntary rather than compulsory and or grammatical forms that intensify vulnerability – e.g. victims of one circumstance or another. Who do they give the power to initiate action? Do people position themselves as having agentic control over some events/actions or suggest having purposefully initiated and caused actions in some circumstances and not others?

Discursive level:

- Are there examples of key stories throughout a narrative or narratives which appear fluent and well-rehearsed which provide insight into more static identities and dominant discourses that inscribe participants?
- Alternatively, are there moments when participants demonstrate greater effort to explain or present an account or contradictions in accounts indicate stories which are told less often or have not been expressed previously, and which might act as transformative or self-reflective moments which disrupt or contest the relations that constitute identity?
- What is taken for granted, privileged or treated as common sense in narratives?
- How do participants draw on dominant discourses, policies, social conventions?
- Are there any examples of participants challenging particular discourses or adhering to discourses that are alternative to those that are dominant?
- How do participants draw on notions of class, gender, age or ethnicity or other social categorisations in their accounts?
- What is the cultural context driving examination of narrative or what are the problems solved by a narrative or the problems it creates?

Appendix 5: Participant information sheet for Traveller community members

Research project exploring Gypsy and Traveller health stories Information sheet for Gypsies and Travellers

You are being invited to take part in a research project that I am doing as part of my study at the University of Edinburgh. Before you decide whether or not to take part, it is important that you understand why the study is being carried out and what taking part will involve. Reading or talking through this leaflet with me, and discussing it with others will help you to decide whether or not to take part in the study. Please contact me or my supervisor if you would like to ask any questions or find out more information about the study and take time to make a decision.

Thank you for sparing the time to consider joining the study.

What are the aims of the study?

The study aims to find out how Gypsies and Travellers tell stories about or describe themselves in relation to health and accessing health services. It will look at how Gypsies and Travellers' descriptions of themselves and their own health may compare with health professionals' descriptions of Gypsy and Traveller health to find out what might lead communication about health to go well, or to breakdown, and how it might be improved.

Why have I been chosen as someone who might take part?

Your views and experiences about health are important and can help us to learn more about how to improve communication between health practitioners and Gypsies and Travellers. The research wants to involve Gypsies and Travellers who have and who have not had experience with health services and to include Gypsy and Traveller men and women who live in different kinds of accommodation.

Do I have to take part?

No. It is up to you whether or not you would like to take part. If you decide to take part in the study, you may stop being involved at any time up until 31st Dec 2015 without giving a reason. If you decide to stop your involvement, all information that you have provided will be destroyed and removed from project materials. Deciding not to take part in the study will not affect the quality of services that you receive in any way.

What will participation involve?

If you take part you will be given a CD recording of this information and/or a copy of this information sheet to keep and will be asked to sign a consent form, or give verbal consent that you agree to take part in the study. You will be asked to take part in 2 or 3 interviews about how your health is at the moment, other times in your life when you have felt healthy and unhealthy, times when you have done something to improve your health, times when you have received health services, and how you

imagine your health will be in the future. It is expected that each interview will last between 1 and 2 hours. The interviews would be organised at a date and time convenient to you and can be split across different days or times if you prefer. You are free to stop the interviews at any time point and you do not have to answer any questions that you do not wish to. With your permission, the interviews will be audio recorded and the researcher will also make some notes during the interviews and about conversations before and after the interviews. This is to ensure that your views can be represented as accurately as possible and also so I can examine my own performance as a researcher.

Will my taking part in the study be kept confidential?

Yes. The recordings of the taped discussions and a typed up version of these discussions will only be viewed by myself and my supervisors and will be kept in locked storage and destroyed 3 years after the study is complete. As part of the presentation of results from the study, small quotes of your own words may be used in written form in reports or presentations. Your name will be removed from the information presented and any information that could lead to you being identified will not be included. However, if you were to share any information that suggests you or others are at risk of harm I may need to tell somebody else in order to keep you safe.

What are the benefits of taking part in the study?

You may not benefit directly from taking part in the study. However, your views will help understand more about how Gypsies and Travellers and practitioners talk about Traveller health in order to learn how communication may be improved. Some people find talking about their experiences a useful process in itself.

What are the disadvantages of taking part in the study?

You will be asked to give up some of your time to take part in the interviews. You do not have to talk about anything you do not wish to and are able to withdraw from taking part in the research, without giving a reason, at any point prior to the 31st Dec 2015.

What will happen to the results of the study?

The research findings will be shared with Gypsies, Travellers and practitioners who took part in the study. Publications developed from the research findings will also be shared with other practitioners, Gypsy and Traveller organisations and researchers in order to inform their future practice.

Who has reviewed this study?

Before this study was carried out, permission had to be granted from the University of Edinburgh Research Ethics Committee. They reviewed the plans for how the study would be carried out in order to protect your interests.

**Thanks very much,
Natalie**

Contact for further information:

Natalie Forster (researcher)

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Tel: 0131 650 6642 (office hours

Wednesdays 11am-1pm)

Appendix 6: Participant information sheet for health practitioners

Research project exploring stories about Gypsy and Traveller health Information sheet for health professionals

You are being invited to take part in a research project that I am undertaking as part of my study at the University of Edinburgh. Before you decide whether or not to take part, it is important that you understand why the study is being carried out and what taking part will involve. Reading or talking through this leaflet with me, and discussing it with others will help you to decide whether or not you take part in the study. Please contact me or my supervisor if you would like to ask any questions or find out more information about the study and take time to make a decision.

Thank you for sparing the time to read and consider taking part in the study.

What are the aims of the study?

The study aims to find out how health professionals describe the health of Gypsies and Travellers and how they describe themselves in relation to the work they do with Gypsies and Travellers. It aims to compare the accounts of Traveller health offered by health professionals and Gypsies and Travellers in order to find out what might lead communication about health to go well, or to breakdown, and how it might be improved.

Why have I been chosen as someone who might take part?

As professionals working with Gypsy and Traveller Communities, your experiences are really important in helping us learn more about how to improve communication between health practitioners and Gypsies and Travellers. The research aims to involve health public health professionals working with a public health remit and who have a range of experience of working with Traveller Communities.

Do I have to take part?

No. It is up to you whether or not you would like to take part. If you decide to take part in the study, you may stop being involved at any time up until 31st December 2015 without giving a reason. If you decide to stop your involvement, all data that you have provided will be destroyed and removed from project materials.

What will participation involve?

If you take part you will be given a copy of this information sheet to keep and will be asked to sign a consent form. You will be asked to take part in between 1 and 3 interviews about how you came to be working with Gypsy or Traveller Communities; what health means in the context of your work with Traveller Communities; times in your practice that a) you felt went particularly well or; b) when you might have felt stuck; and about times that were significant in changing your approach to working with Traveller Communities. It is expected that each interview will last around 1 hour. The interviews would be organised at a date and time convenient to you and can be split across different days or times if you prefer. You are free to stop the

interviews at any time point and you do not have to answer any questions that you do not wish to. With your permission, the interviews will be audio recorded and the researcher will also make some notes during the interviews and about conversations before and after the interviews. This is to ensure that your views can be represented as accurately as possible, and also so that I can examine my own performance as a researcher.

Will my taking part in the study be kept confidential?

Yes. The recording of the taped discussions and transcription of these discussions will only be viewed by those directly involved in the research and will be kept in locked storage and destroyed 3 years after the study is complete. As part of the presentation of results from the study, small quotes of your own words may be used in written form in reports or presentations. Your name will be removed from the information presented and any information that could lead to you being identified will not be included. However, any information that you were to share that suggests that you or others are at risk of harm may have to be disclosed.

What are the benefits of taking part in the study?

You may not benefit directly from taking part in the study. However, your views will help in understanding more about how Gypsies and Travellers and practitioners talk about Traveller Community health in order to learn how communication may be improved. Some people find talking about their experiences a useful process in itself.

What are the disadvantages of taking part in the study?

You will be asked to give up some of your time to take part in the interviews. You do not have to talk about anything you do not wish to and are able to withdraw from taking part in the research, without giving a reason, at any time prior to the 31st December 2015.

What will happen to the results of the study?

The research findings will be shared with Gypsies, Travellers and practitioners who took part in the study. Publications developed from the research findings will also be shared with other practitioners, Gypsy and Traveller organisations and researchers in order to inform their practice.

Who has reviewed this study?

Before this study was carried out, permission had to be granted from the University of Edinburgh Research Ethics Committee. They reviewed the plans for how the study would be carried out in order to protect your interests.

**Thanks very much,
Natalie Forster**

Contact for further information:

Natalie Forster (researcher)

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Tel: 0131 650 6642 (office hours
Wednesdays 11am-1pm)

Appendix 7: Participant consent form

Research project exploring stories of Gypsy and Traveller health Participant consent form

Participant

Please tick boxes

I confirm that I have read and/or discussed and understood the information sheet for the above study and have been given the opportunity to ask any further questions about the research.

I understand that participation in the study is voluntary and that I am free to withdraw from the study at any point before 31st Dec 2015 without giving a reason.

I agree to take part in the study.

I agree to my interviews being audio recorded.

I agree to the use of anonymised quotations in publications developed from the research.

Researcher:

I agree to keep all information provided by participants confidential, with the exception of information that suggests that participants themselves or others are at risk of harm.

I agree to remove any details from publications of the study which could lead to participants being identifiable as individuals.

I agree to keep the transcripts and recordings of participants in locked storage and to destroy them 3 years after the study.

Name of participant

Date

Signed

Name of researcher

Date

Signed

Contact details for the researcher:

Natalie Forster

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