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“...it’s all the same no matter how much fruit or vegetables or fresh air we get”: Traveller women’s perceptions of illness causation and health inequalities

Margaret Hodgins^{a,*}, Michelle Millar^b, Margaret M Barry^a

^a*Department of Health Promotion, National University of Ireland, Galway, Ireland*

^b*Department of Sociology and Political Studies, National University of Ireland, Galway, Ireland*

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Abstract

This paper explores the perceptions of illness causation and health inequalities of Travellers, an ethnic minority group who experience considerable social and health disadvantages in Ireland.

In order to allow for subjective meanings to emerge, a qualitative methodology with purposive sampling was employed. Participants in the study were invited to respond to a vignette in a focus group setting. Forty-one Traveller women were recruited to the focus groups through community projects or adult education initiatives. The study not only illustrates the complexity of lay perceptions of ill-health and health inequalities, but raises important questions about the prevalence of depression and of domestic violence in the Travelling community. These Traveller women were very willing to discuss the structural factors that contributed to their health status, attributing ill-health to social and environmental factors, such as accommodation, hardship and discrimination. Further, they broadly rejected behavioural explanations of the heart disease described in the vignette. Traveller women’s understandings of health and the factors that determine it are deeply embedded in the social context of their lives and their ethnic identity. These findings are discussed in the context of social identity and ethnicity, and contribute to theoretical debates about the role of that identity in recognising inequality. The study revealed that Traveller women see many shortcomings in health service provision. They need service provision to be culturally sensitive and responsive to their needs.

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Introduction

Whilst considerable progress has been made in research activities concerning the measurement and explanation of health inequalities, as Blaxter (1997)

notes, how people themselves think about inequalities in health is rarely investigated. Advocates of lay consultation, such as Popay and Williams (1996) and Blaxter (1997, 2000) argue that investigations relating to individuals’ perceptions of health may be the missing link leading to a deeper understanding of health inequalities. Lay health beliefs are those views held by members of society who are not health professionals and it could be argued that lay

*Corresponding author. Tel.: +353 91 524411.

E-mail address: margaret.hodgins@nuigalway.ie
(M. Hodgins).

consultation may enable us to gain greater understanding of the complex myriad of factors involved in health inequalities. From existing research on lay health beliefs there is an emerging consensus that the study of people's definition and understanding of health and illness has a critical role to play in informing the development of effective health promotion practice and policy (Field, 1997; Pill, 1991). Insight into how these beliefs arise and change over time, how they vary between different social groups, and how they are related to health behaviour is now well documented (Blaxter, 1983, 1997; Calnan, 1987; Cornwell, 1984; Pill & Stott, 1985). The findings from these studies all point to a link between the living and working conditions of people and their beliefs about health and illness. However, the plethora of debates surrounding the causes and consequences of health inequalities in modern society rarely consult the "experts", those who know first hand what causes ill-health in their own lives and inequalities in the context of the wider society they inhabit. As with many areas of social complexity "the wearer of the shoe knows where it pinches most".

Popay and Williams (1996) identify three dimensions of lay expert knowledge relevant to the area of public health research and practice; lay understandings of the relationship between individual behaviour and life circumstances, lay theories about aetiology and the predictive power of lay knowledge. Blaxter's (1997) review of lay attitudes to health revealed ironically that those most vulnerable to disadvantaged circumstances were more likely to believe that social inequality in health does not exist, and thus when investigating health inequalities to approach the subject from the point of view of general ideas about health and illness causation. For a comprehensive analysis of lay perspectives on health and ill-health see Blaxter (2004).

The objective of this paper is to explore the perceptions of illness causation and health inequalities with Travellers, an ethnic minority group who experience considerable social and health disadvantages in Ireland. The study explores the complexity of lay perceptions surrounding health and ill-health and health inequalities. It also provokes wider questions about the prevalence of depression and domestic violence in the Traveller community, current health service provision to the community and social identity and inequality.

Irish travellers

Travellers are a small indigenous minority; although part of Irish Society for many centuries, their nomadic tradition gives rise to a particular lifestyle and culture, which sets them apart from non-Travellers or "settled" people. They are a distinct ethnic group by virtue of their shared history, value system, language, customs and traditions. It is estimated that there are approximately 24,000 Travellers in Ireland, which constitutes about 0.6% of the national population (Census, 2002). Travellers exhibit a population structure that resembles that of the settled population about 50 years ago. Those aged 0–14 years account for 42.2% of the Traveller population, but only 21.1% of the general population. Only 3% of Travellers live to be over 65 years compared to 11.1% of the general population (Pavee Point, 2004).

The health status of Travellers is significantly poorer than that of the settled community. The Travellers Health Status Study, published by Barry, Herity, and Solan (1987), is the most comprehensive analysis of Traveller health status undertaken in Ireland to date. This study revealed that Travellers have higher mortality rates for all causes of death, particularly accidents, metabolic disorders in children under 14, respiratory ailments and congenital problems. Traveller women experience poorer health than Traveller men, being at higher risk for death by accident, cancer, and cardiovascular or respiratory disease and thus can expect to live 12 years on average less than non-Traveller women. A fertility rate twice as high as that of the population is recorded within the Travelling community, an infant mortality rate 2.5 times the national figure, peri-natal mortality and still birth rates 3 times the national figures (Barry et al., 1987). The poorer health status has clear parallels with other nomadic groups. Comparative infant mortality figures and life expectancy for Irish Travellers, Canadian and Australian Aboriginal people and Italian gypsies are reported by O'Donovan, McKenna, Kelleher, McCarthy, and McCarthy (1995). For infant mortality, the rate for the nomadic group is substantially higher than the national average in each case, ranging from 1.5 times for Canadian Indians and 2.8 for Canadian Inuit and Australian Aboriginal peoples. Similarly, the national life expectancy is greater than that for each nomadic group, with differentials ranging from 9 to 20 years.

It is increasingly apparent that health status is influenced by a multiplicity of factors, most particularly “upstream” social and environmental factors such as economic position in society, living conditions, employment opportunities and working conditions.

It is difficult to disentangle the effects of culture, racism and socio-economic deprivation in the Traveller population. Travellers typically do not participate in the formal labour market, and therefore their socio-economic status cannot be measured by conventional means. They are usually economically active however, sorting and selling scrap metal, stripping old cars to re-sell parts, and horse trading. Levels of poverty or indeed wealth are difficult to assess although most commentators would agree that for many these marginal activities do not translate into self-sufficiency and there is considerable neediness in Traveller families. Traveller culture and way of life has not been recognised nor accepted, broadly speaking, in Irish society. Travellers are clearly a marginalised group, experiencing widespread discrimination and racism, both individual and institutional. Extremely negative attitudes to Travellers exist, and a serious deterioration in their position in Irish society over the past 20 years has been noted (MacGreil, 1996). This is evidenced by physical attacks on Traveller homes, organised resistance to the provision of Traveller accommodation, refusal to provide services to Travellers, and withdrawal of Traveller children from elements of mainstream activities in educational settings (MacGreil, 1996). Legislation and policy have been developed and implemented in many areas without taking account of the way in which they might impact on the Travellers (Fay & Crowley, 2001).

Non-acceptance of nomadism, combined with discrimination, has contributed to an accommodation crisis for Travellers. In 1995, 3100 units of accommodation were recommended, but by 2004, only 1000 of these had been provided (Pavee Point, 2004). The Housing (Miscellaneous Provisions) Act, passed in 2002, made trespass, previously a civil offence, a criminal offence. This means that Travellers living on the roadside are criminalised (Pavee Point, 2004), and is an example of the development of legislation without consideration of the potential impact on Travellers. Accommodation and living conditions clearly impact on Traveller health. Standardised mortality ratios are higher for unhoused Travellers (Barry et al., 1987), due mainly

to higher rates of accidents. Unhoused refers to Travellers living in either official halting sites and on the roadside. About 1000 (18%) Traveller families, at the present time, live on the roadside with no facilities (Pavee Point, 2004). Most others live on “official halting sites” which are few in number and are typically poorly serviced, poorly maintained and situated in unhealthy or dangerous locations.

Travellers exhibit a particular pattern of health service utilisation. The Travelling community tends to consult with services largely on an emergency basis—a high uptake of General Practitioner and Accident and Emergency services and a low uptake of preventative and educational services (O’Nualian and Forde, 1992; O’Donovan et al., 1995; Report of the Task Force, 1995).

Contemporary policy developments have sought to address some of these issues, through Equality legislation, the National Anti Poverty Strategy (NAPS) (1997), the National Health Strategy “Quality and Fairness” (Department of Health and Children, 2001) and a Traveller Health Strategy (Department of Health and Children, 2001). Further there has been a noted increase in participation in the political process in Ireland in recent years, seen in the inclusion of voluntary and community organisations as social partners in the drawing up of national partnership agreements, and the tendency to either directly include community organisations as advisory groups in policy development or indirectly, via invited submission.

The problem of health inequalities in Ireland is recognised in the NAPS. NAPS endorses a partnership approach to tackling inequalities acknowledging as it does the importance of consultation with and involvement of the voluntary and community sector, users of services and those with first hand experience of poverty. In a review and updating of the NAPS targets the government states that its overall objective is to reduce the inequalities that exist by making health and health inequalities central to public policy and thereby proposing a multi-sectoral approach to alleviating health inequalities. (Department of The Taoiseach, 2002). As part of the review, a NAPS and Health Working Group was established to develop health targets and an associated implementation and monitoring framework, which included Traveller representation. The targets proposed involve reducing the gap in health between rich and poor, promoting equity of access to health services and developing new ways of working to address the

main factors that link poverty and ill-health. Included in these targets was the aim to reduce the gap in life expectancy between the Travelling Community and the whole population by at least 10% by 2007 and the monitoring of the life expectancy and health status of Travellers so that targets can be reviewed and revised for Travellers, by 2003. (Department of The Taoiseach, 2002).

Both the Employment Equality Act (1998) and the Equal Status Act (2000) outlaw discrimination and equality issues in employment and the provision of goods and services on nine grounds, which include those of race and membership of the Travelling Community.

The current health strategy “*Quality and Fairness*” (Department of Health and Children, 2001) acknowledges that poverty, unemployment, education, access to health services and environmental factors all play important roles in determining the health of individuals. The strategy also aims to take initiative to eliminate barriers for disadvantaged groups to achieve healthier lifestyles. The year 2002 also saw the publication of the Traveller Health Strategy, developed in partnership with Traveller organisations, which focuses clearly on responding to the inequalities in health status between the Travelling community and the general population, listing over 100 actions aiming to improve the health of Travellers.

Whilst the Irish government is clearly committed to tackling health inequalities in Ireland the implementation of these policies is as yet to be completed or evaluated. At present a question mark looms over the future of the health strategy, as many of its own deadlines have failed to be met (Millar, 2004). The ability of the current strategy to effectively tackle health inequalities may be determined by finances as opposed to the ability of policy-makers to effectively implement the strategy. However, for the first time in Ireland there is evidence of a multi-sectoral approach, a move towards greater inclusiveness, and clear government commitment to narrowing the gap in mortality rates amongst socio-economic groups.

Most published research on the Traveller community has involved measurement of health status and utilisation of health services. Travellers’ own perceptions of health or ill-health, and causes of and social construction of health and ill-health and health inequalities, have not to date, been explored. This study aimed to explore these issues with Traveller women. A qualitative methodology was

employed, in order to allow for subjective meanings to emerge.

Method

Purposive sampling was employed. Travellers were recruited through pre-existing community projects or adult education initiatives. In one health board region, one training programme or group project was selected, for each of the three constituent counties of the board, by the regional Traveller Health Care Unit.¹ Care was taken not to select from projects with a particular health focus. Twenty women attended this set of focus groups. In the second health board region, all participants were recruited through a Traveller Training Centre, utilising three pre-existing groups within the training programme. Twenty-one women attended this set of focus groups, yielding a total of 41 women in the study.

Fifty-one per cent of the women were between 20 and 29 years of age, with a further 20% between 30 and 39 and 15% between 15 and 19 and 14% over 40. One-third were married with a further 15% cohabiting and 15% separated. The mean number of children was 3. Only two women had completed secondary education, and two had no schooling.

Participants in the study were invited to respond to a vignette in a focus group setting. The vignette depicts a woman, Brigid, who was experiencing depression, was feeling particularly unwell in recent months and now exhibits signs of heart disease (see Fig. 1). The text was modified from the vignette developed for a study of perceived health inequalities in low-income women (Hegarty, 2000). The vignette was employed to facilitate discussion by providing a concrete example, rather than an abstract concept. Vignettes are also useful when the subject matter is sensitive as it allows a process of distancing. This may be important in relation to health inequalities, as we cannot expect low-income respondents to identify their own inequality (Blaxter, 1997). The method is described by Finch (1987) as one which acknowledges that meanings are social and it provides a means to express them that does not restrict the respondent to choices which may be

¹A partnership organisation, developed at regional health board level, to meet the challenge of improving Traveller health, as recommended by the Task Force on The Travelling Community (1995).

Let me tell you about Brigid. She is in her early 40s and is a member of the Travelling community. Brigid generally finds life a struggle. She has experienced depression on and off over the last few number of years. She has been feeling particularly unwell over the last few months, experiencing tiredness, loss of energy, headaches. More recently, she has had fairly severe pain and tightness in the chest on a few occasions. Brigid went to her doctor who told her that she was suffering from angina. The doctor explained that while the pain can be relieved by drugs, it is a sign of heart disease, and a warning that a heart attack could occur.

Fig. 1.

contrary to their belief, as can happen in survey methods. The vignette method has been used previously in the Irish context, for example to explore implicit beliefs concerning mental health problems (Barry, Doherty, Hope, Sixsmith, & Kelleher, 2000).

Standard protocol was followed for conduct of focus groups. A copy of the vignette was passed to all participants at the start of the focus group and then read aloud to the group, due to possible literacy difficulties.

A thematic content analysis was undertaken. Transcripts from focus groups were read and coded independently by two researchers. The key questions addressed in the focus group were used as a framework for analysis. Inter-rater reliability was established through a consensus approach, based on discussion of the data and interpretation of the emerging themes (Silverman, 2000).

Results

The Traveller women clearly and rapidly identified with “Brigid” in the vignette. In three of the six focus groups the immediate response to the scenario was that it was typical for a Traveller woman. They felt that she was worried about things “going on in her life” (FG6) and that “she feels she has no support, that there is no one there for her” (FG5).

I think it’s typical... you could say the same thing about a lot of Traveller women. That goes for all Traveller women of all ages. (FG1)

In all groups they perceived Brigid to be weary, fed up, depressed and stressed. A participant in focus group 4 poignantly stated:

I feel I understand this story and I see the way Brigid is going and I feel I am going that way as

well and I don’t like knowing that, I might get a heart attack. That’s the way I feel about life. It’s always a struggle. In fact it gets too much sometimes. (FG4)

Perceived causes of ill-health

The Traveller women in this study clearly saw ill-health to be complex and multiply determined. A number of attributions emerged in their discussions of Brigid’s situation that reveal the intricacy of health representations in their community. Hardship generally and the daily struggle was plainly a dominant theme for these women. This was in part due to just being a woman and in part due to being a Traveller woman.

The Traveller women in this study considered their role as a woman and especially as a mother to inherently compromise their health. For some the fact that mothers are expected to be solely responsible for children and that children depend on them was stressful, as the following exchange shows:

Children always depend on their mother.

The main worry are the children, are they alright... mothers worry, fathers can walk off or go away. (FG1)

Just having children, and trying to keep them well was considered stressful. The demands of motherhood—the time required to mind and mother children, the strain associated with getting around with several children in tow, not having a car, keeping going, cooking and cleaning—was seen to contribute to ill-health. Further many of the groups perceived women to compromise their own health in respect of that of their children and husband. They thought that women typically put the family first and neglect themselves.

When you're not taking care of yourself you're not eating right, your not looking after yourself. Then you just run yourself down into the ground....I don't think we eat right. I don't look after myself either. I have to think of other people before I think of myself. (FG4)

...a woman mightn't get the chance herself to go to the doctor ...over the children ..that she'd want to be very sick before she do go to the doctor herself. (FG1)

It was acknowledged that as a Traveller mother Brigid “probably has a load of kids” (FG4), although the more general implications of Traveller life as a risk factor for ill-health were discussed at greater length. In all focus groups, the Traveller way of life was seen as tough and difficult:

because we're Travellers...it brings on an awful lot of the depression in your life. (FG3)

It was thought that Brigid was doing too much, and that her everyday struggle with the stress and hard work was relentless. The hardship of life had a number of components; specifically poor living conditions and the discrimination experienced as an ethnic minority were seen to each contribute directly or in combination to ill-health and to create stress. They talk about exhaustion and finding it hard to keep going. Not only do large families pose a burden, but raising them in situations where there may no running water, shared toilets, leaking roofs and no washing machine adds substantially to that burden. Trying to mother in the face of inadequate physical resources and in a social climate seen as hostile, clearly compromise health.

Travellers referred frequently to the pervasiveness of discrimination. They described it as something that is everywhere and an everyday experience; “against ourselves and our families, our children” (FG2). The stereotyping process was described very simply:

People think that once you have a big bun in the head and the big earrings that you are going to rob left right and center. (FG6)

Living conditions were seen to contribute to ill-health; living on the roadside with no running water, being “all cramped up, on top of each other” was “not a right way to be” (FG6) and not conducive to good health.

The conditions you live in. Some of the places are desperate, like rain coming in through your roof. (FG5)

I'm telling you, washing clothes on a board all day is no joke, she is stressed. She has to be. Anyone would. (FG4)

Stress and worry were seen as a significant contributor to ill-health in Brigid's life. Traveller women plainly perceived themselves to be a group of women with considerable stress and worry. They felt that “a lot can be put down to stress” (FG6). Stress and worry were linked to ill-health generally, being associated with tiredness, not eating properly or not eating at all, headaches and loss of energy. Stress was also linked quite specifically to both heart disease and depression:

People have a lot of worry, a lot of stresses and can develop heart disease or heart attacks... to live with the burden of worry. (FG3)

Well I think that what brings on depression is worry...anyone who worries an awful lot will bring on depression. I often heard that before. (FG1)

For some there was a pathway from stress to depression to heart disease: “Yes (depression) it could cause pains in your chest. If you're worried you could get pains in your chest. There must be a reason for it” (FG6).

In focus group 2 the interaction of various factors was expressed:

An awful lot of it comes from bad accommodation and discrimination. I keep sayin' those two words an' I know well it's those that are causing' the most problems. Causin' heart problems and depression. (FG2)

Worry, stress, depression, bad accommodation and probably the lack of many things...I don't know. The Travellers' health is going down and that is the reason...all of this... the depression an' discrimination an' all of that. (FG2)

The Travellers associated smoking and eating behaviours with ill-health but considerably less frequently and with less enthusiasm than environmental or social causes. It was pointed out, for example, that “Eating the wrong foods contributes to heart disease” (FG4). Some reckoned that Brigid was a smoker and that smoking plays a role in heart disease. However, the benefit of smoking for health

in the broader context of a stressful life was identified:

..... I smoke an awful lot. I have to slow down a bit, I just feel unwell to be honest. I feel that I'm that way because I smoke too much but I need the fags to relax me. (FG4)

More generally, however, the women clearly saw the limitations of the behavioural approach to understanding and alleviating heart disease.

Smoking is always the cause of everything according to the doctors. Even when you hear of someone dying of cancer, they always say its because they smoked. They never tell you it calms your nerves and it does. There are people who die of cancer who don't smoke and don't drink. Many peoples dies of cancer that doesn't smoke or drink. (FG6)

And perhaps most plaintively:

...I'm tired and Maggie is always tired....and it's all the same no matter how much fruit or vegetables or fresh air we get. (FG2)

Perceived adequacy of health services

In the main, comments about health services were very negative. One woman stated that she had “no faith in doctors—they do nothing for ya anyway” (FG5). Another claimed that “they would have to be very, very bad before they'd go to a Doctor” (FG2), a sentiment echoed in other focus groups. There was a general reluctance to engage with health professionals. The Traveller women discussed a number of general shortcomings in service delivery. They felt that they had inadequate information on available services and that services were inequitable and poorly delivered. Incidents were recounted in which, in the speaker's opinion, a doctor gave the wrong information:

I went to the doctor when I was depressed and the doctor gave me tablets...I was pregnant at the time...if I had taken those tablets, and I didn't know this, if I had taken those tablets then I wouldn't have my child today because they would have killed my child..... I went to a doctor in England when I got depressed again and he asked what I was on and what tablets I was given...he told me that those tablets could have mentally and physically retarded my child...it'll tell you about going to doctors... (FG1)

The Traveller women were clearly dissatisfied with what they perceived as a lack of thoroughness on the part of doctors. A number of experiences were recounted and discussed in each of the focus groups. It was felt that doctors do not listen, do not examine children properly, and do not give enough time. As one woman stated “they run you in and out” (FG1), and are often quick to dispense prescriptions or tablets without further discussion:

She (Brigid) was probably told “ah you'll be ok” and sent off home. She needs to be sent to the hospital. They do all the tests there. A doctor won't sit down and explain all that (risks) to her. She would probably just give her tablets and let her take these and hope for the best. Probably say she has a chest infection (laugh). Yeah. That's what happens. (FG4)

They just give ya tablets when they could talk to ya and give some advice.....They give you a prescription and goodbye. (FG5)

The Travellers perceived this tendency to be due to doctors wanting to get rid of them and perhaps perceiving them to be stupid. In one of the few statements that praised a health professional, it was due to her willingness to explain the advantages of immunisation.

She was very good with Travellers. She explained things us...she was interested in us. (FG3)

In focus group 6 the women expressed dissatisfaction about the way in which health professionals communicate with Travellers. They felt that “Travellers are treated different by doctors”. In focus group 6 the women referred to instances in which they were talked down to or criticised by health professionals. These women spoke of feeling insulted, and “given out to”. They expressed frustration at this treatment and yet seemed to feel powerless to challenge it. The treatment they described amounted to negation of their role as a mother, and understandably was a significant contributor to their poor mental health.

Sometimes they do give out to you. The nurse came to me and told me I shouldn't have any more kids cause they might get neglected

If the nurse sees you holding the baby wrong they'd be down your neck

They do check them like, they weigh them and look to see if they are abused. (FG6)

Not surprisingly, the women expressed difficulties in being open with doctors, and with asking questions:

It's as if they think you're stupid or somethin'...and then you get ashamed to ask, so you don't. (FG6)

It's hard to discuss anything with them. Cause they think they know it all and we know nothin. (FG4)

She (Brigid) mighten be able to explain it to a doctor. I could go in with a bad pain and as soon as I get there I clam up. (FG5).

What Brigid needs

In each focus group, Brigid's needs were discussed at some length. She was considered to be primarily in need of health services. Suggestions to go to the doctor or the clinic were made in the context of her heart disease:

She needs to be sent to the hospital to get an ECG done by qualified doctors. (FG6)

Brigid was clearly seen to need support. Her family was mentioned in all focus groups but chiefly in the context of giving her practical support, for example "they could give her a hand like, for a while. That would relieve her if she was tired" (FG4). In all focus groups Brigid was described as needing someone to talk to, someone she could trust. Family and friends were mentioned in this context but with caveats:

...ya need your family.

Sometimes you mightn't have your family.

Sometimes you can do without your family—sometimes your family are worse. Your friends are better than your family. I manage better with my friends than my family. Your family can run you down. (FG5)

Friends....all they can do is feel sorry for me. (FG2)

In five of the six focus groups Brigid's need for counseling and professional support "more than family" (FG4) was articulated. Counseling was described as "...better than medication cause it helps you cope with depression in the home situation" (FG6), although it was also acknowledged that:

if you're suffering from depression you are better off to have the medication, it helps ya until you

are back up on your feet. If you do need them you have to have them. There is people that does need it. (FG5)

Wealth and health

In five of the six focus groups, the Travellers initially reacted to this question by saying that money cannot buy health. They quickly pointed out that you could have a nice house, a big car, and a holiday and still experience sickness or still experience discrimination. However, they did also identify specific benefits that money could confer if one did fall ill. It was acknowledged that a "holiday might help" (FG 2) and that if you were living in a house "with heating an' all that you wouldn't be a victim" (FG6). Similarly:

Like at least you would have your own toilet. It's not nice sharing a toilet with other families cause they might not keep it clean like and then you don't like usin' it or letting the childer near it. If you have somewhere to wash life is so much easier. (FG6)

The possibility of securing better services was accepted. If Brigid had money she could buy her way into "loads of services....and have "somethin' done right away" (FG2). It was perceived that she would not have to struggle so much and would be happier in herself. The Travellers recognised that not only did resources create choice, but could afford greater respect in wider society, something that they felt was absent from their lives:

You have to have money to be treated proper in this world. If you don't it's tough luck. (FG6)

The women, however, also pointed to some of the health risks that wealth carries. They mentioned drugs and anorexia, which they suggested could lead to heart disease.

Prominence of domestic violence

Finally, in addition to the main themes explored with the focus group protocol, one unexpected theme arose. Domestic violence was discussed spontaneously and openly by the Traveller women in four of the six focus groups and plainly was part of the hardship they perceived in their lives.

Living with violence was described clearly as fostering ill-health, but in most groups being subjected to violence was discussed as a direct cause of depression. It was thought that Brigid's husband could be giving her a hard time, "putting her down" or that he could be "violent and box you when he has a few pints (FG5)". She could be ill from "the strain like of not knowing what was goin' to happen next", one woman suggested (FG4). Women were seen to worry about drinking husbands and "*getting a beating*" (FG4). The link with depression is clear from the following exchange that took place in Focus Group 6.

Maybe she has a husband that drinks and so has no money...

Maybe she's worried that he's going to beat her
If she has a husband and he's givin' her a hard time that could make her depressed

You don't feel good about yourself and you don't feel like doin' anything and then you get depressed

In both focus group one and five some analysis of the causes of domestic violence took place. The women saw men's need for power and control to be a key factor, and described how this extends throughout home life:

If you do the least thing wrong you will be corrected for it, and ...that will be rough. (FG1)

Jealousy was also mentioned frequently men being described as "having bad minds on their wives" (FG1) and one woman cautioned:

You'd better believe though that he has people watching you and if you talk to another fellow they will be back and give ya a bad beating. (FG5)

Discussion

This study conducted with a small number of Traveller women not only illustrates the complexity of lay perceptions of ill-health and health inequalities, but raises important questions about the prevalence of depression and of domestic violence in the Travelling community.

Perceptions of illness causation were clearly elaborate for these women. Not only did they identify a number of causes, both structural and behavioural, but they discussed the interactive nature of these causes. Discrimination, poor quality

accommodation and "*living rough*" generally were all identified and discussed in the context of Brigid's ill-health generally and in some cases as specific triggers for either depression or heart disease. The women reflected on the hardship of life on the road, with large families and often unsupportive husbands. They saw these various aspects of life combining to result in high stress levels, which in turn led to depression, heart disease or both. Brigid's ill-health was no surprise, giving the struggle she goes through, and will continue to experience. For these women, life is a constant struggle, and the demands placed on them as wives and as mothers, extract a real cost, physically and mentally. The women understand their own ill-health in this social context. The data provided by Traveller women in this study give voice to the realities which lie behind findings from previous studies on Traveller life. In a study of Traveller families in a part of Dublin, 55% had no water. Fifty per cent had no access to working toilets, 60% to a washing machine, and 66% to working showers (Howley, 2001). Nearly one quarter of Traveller families live on the roadside.

What is curious about this study is how it contrasts with conclusions drawn from other studies on perceived illness causation, and health inequalities in disadvantaged population. For example, Blaxter (1997) found that people have been found to view health as being dependant on behaviour and responsibility for health and illness to be in the individual's own hands. Further, causes of health and ill-health outside the individual's control—such as housing, environment, poverty or prosperity—are rarely mentioned particularly by those who are socially disadvantaged. She concludes that "those who are in the lowest social classes or have the least education, are most likely to confine their explanations to behavioural causes. The idea that the socially fortunate may be healthier is often flatly resisted" (Blaxter, 2000, p. 201). MacIntyre, McKay, and Ellaway (2004) report similar findings more recently.

Travellers would generally be seen as a very disadvantaged group in Ireland. Although levels of poverty are not easy to measure, and many are economically active, extremely low levels of formal employment and very low levels of educational attainment are recorded. Almost all Travellers are in receipt of medical cards (O'Donovan et al., 1995), often considered a proxy for economic and social disadvantage in the Irish context. These Traveller

women were very willing to discuss the structural factors that contributed to their health status, attributing ill-health to social and environmental factors, such as accommodation, hardship and discrimination. Further, they broadly rejected behavioural explanations of Brigid's heart disease, commenting in a way reminiscent of Graham's working class women (Graham, 1992) that smoking in fact offers a route to relaxation, and may reduce stress; "You could be up in a heap and a fag would calm you down".

The anomaly may be explained in part by the methods employed here and in other studies. Survey data, for example, may not yield a considered or contextualised account of perceived causes of ill-health since questions are designed to elicit the causes of health for society in general, in an abstract rather than a personal setting. Qualitative accounts, on the other hand, reveal the complexity of lay perceptions (Blaxter, 1997). In this context it is worth noting that much of the research reviewed by Blaxter, particularly the survey data, asked specific questions about health, in the abstract, whereas these Traveller women were discussing ill-health using a concrete example, as illustrated by the vignette character in a focus group situation. This interpretation is supported by the finding, in a very similar study of Irish women from lower socio-economic groups, of a diversity of perceived causes of ill-health, including social, psychological and lifestyle factors (Hegarty, 2000).

Previous studies suggest that working class women reject the idea of social inequality in health and the majority consider money to have nothing to do with health (Calnan, 1987), yet the women in this study did concede that money was important, at least insofar as it could allow one to minimise some health risks. The findings again mirror those of Hegarty (2000), who found in her study that while wealth was not seen to make one more or less susceptible to ill-health, it was important in determining resources to cope with health difficulties. The women in both studies acknowledged that money could buy better services. This finding no doubt reflects the inherent inequity in the Irish two-tiered health system and may be specific to the Irish health services.² However, it was also acknowledged that money could ease hardship, by allowing one to

access basic facilities, a holiday, and as one woman perceptively noted "...you wouldn't be a victim".

Previous studies on lay perceptions of health and ill-health have found that typically, disadvantaged people will talk about not "giving in" to illness, and about the importance of "mind-over-matter". (e.g. Blaxter, 1997; MacFarlane, 2000). The moral aspect of lay accounts of health and illness is a consistent theme; the requirement to resist disease and not fail in one's moral duty to rise above it. Such moral dimensions were notably absent in these Travellers' accounts. While Brigid was not seen as morally weak nor lacking in spirit, there was little evidence of these Traveller women having a sense of agency, or the belief that they had any power to improve things. There was a general sense of helplessness, perhaps best exemplified in the comments:

What chance do we have? I'd love to have a good start in life. I don't have any chance. All that's ahead is a struggle with no help. (FG4)
everyone is always giving out to us. (FG6)
..you have the talk (at the Women's group) but when you go home it's all there. You're back to square one again. (FG2)

What emerges clearly from the data is the extent to which these women express few positive expressions of self worth, of enablement, of hope, in relation to Brigid or indeed to themselves. The women portray an image of a Traveller mother as a woman who is physically and emotionally exhausted from the demands of caring for a large family in an uncompromising physical environment, who puts others first, is at risk of violence in her own home, is either ignored or insulted by health professionals in the face of trying to raise children in these circumstances, and is disliked or even hated by society at large.

The inconsistency with previous findings may be best explained with reference to the concept of social identity. Blaxter (1997) argues that as accounts of health and illness are essentially accounts of social identity: people do not label their own inequality as it would devalue that identity. She is making this point in the context of research on working class people. Inequality as a function of social class may be very different to inequality as a function of ethnicity. For Travellers, membership of the Traveller community is generally central to their identity. Perhaps this, combined with increased politicisation

²For a more detailed description of the two-tiered aspect of the Irish Health Services, see Millar (2004).

within some quarters of the Traveller community allows them to label their “inequality” more openly than working class people, and similarly allows them to see themselves as needy, requiring intervention and assistance, rather than looking to themselves and within their own community for strength to surmount difficulty.

The rapidity with which the women identified with the character in the vignette lends further support to the use of this method with sensitive subject matter. While the women all identified with the situation “Brigid” found herself in it was primarily with the depression she was experiencing, rather than the heart disease. Their estimation of how Brigid might feel was almost exclusively consistent with the symptoms of depression—weariness, low in energy, strained, and feeling fed up. Depression was seen as stigmatising, shameful and something that might not be disclosed. With depression you “get into a routine of hiding it, protecting it...other people don’t know, they don’t see it...only the person themselves knows it when they are at home by themselves...” (FG1). “The shame of it” (FG2) prevented people from seeking appropriate help, as it may lead to “the asylum”. Depression was seen as being prevalent for Traveller women and to have sudden onset:

Depression can come upon you at any stage. You could be walking down the street and depression can come upon you. (FG1)

In the absence of data on the prevalence of depression within the Travelling community, it would appear that depression might be perceived as very common in this group. Their lives, both by objective standards and by their own account, places them at high risk. Internationally, prevalence rates for depression are higher in women (Carr, 2001), there is evidence of high rates of mental ill-health generally among some nomadic groups, and specifically of depression and suicide in Aboriginal people in Canada (Health and Welfare Canada, 1992). Further, not being in paid employment, having a young child under the age of six, and poor support from husbands or friends are all listed as risk factors for depression in adult women (O’Connor, 1998). Being a full-time mother, as many of these women were, of itself exacts a psychological cost (O’Connor, 1998).

Both social and material hardship and violence are reported to have a precipitating effect on depression in adult women (Bifulco & Moran,

1998). In this group both factors possibly combine and reinforce one another. Indeed, the manner in which these women discussed domestic violence merits further investigation. Intimate partner violence is increasingly recognised as being very common, with prevalence rates of 10–69% reported in countries around the world (WHO, 2002). There is evidence that the effects on women’s health are wide-ranging and persistent and include stress, anxiety, depression, and poor physical health. (VicHealth, 2004; WHO, 2000). Extreme sensitivity would be required to explore this topic further, identifying responses and supports in partnership with Traveller women and their representative organisations.

The study revealed that Traveller women see many shortcomings in health service provision. Their comments were almost exclusively negative, which is consistent with other studies of the Travelling community and the health services (e.g. Hodgins, McMahon, & Kelleher, 2002; O’Donovan et al., 1995). Travellers have a substantial interest in health issues, in particular the health of their children. However, if they continue to perceive health professionals as unwilling to respond to their needs, the potential for health gain via interactions with health professionals is compromised. Clearly, there is a need for service provision to be culturally sensitive and responsive to their needs. From the Traveller perspective this includes being generous with time and interest at consultations and an awareness on part of the provider of the challenges Traveller life poses to health maintenance, especially with regard to literacy difficulties and crowded halting site or roadside dwelling (Hodgins et al., 2002). They are seen as demanding by many service providers, but this has to be viewed in the context of the high levels of morbidity and infant mortality in their population. Anti-discriminatory training for health professionals, open dialogue with Traveller women and cultural exchanges may improve relationships. There is a need to explore extended delivery of Primary Care Projects, in which Traveller women undertake training and are employed as peer support workers, thus reducing negativity in both service providers and within Travelling community (Quirke, 2001).

At a broader level the question is raised as to whether the Travellers have, in their comments about the interactions with health professionals, internalised negative stereotypes about what constitutes

good mothering and thus their capacity to be “good” mothers. Certainly this would explain both their reluctance to visit Doctors, and the apparent lack of agency around challenging health professionals.

What these data show is the myriad of factors which contribute to the ill-health of women, many of which concern factors such as motherhood and marriage and material circumstances which many low-income women experience. The effects of living conditions and discrimination particular to the Traveller community in Ireland points to the need for research and practice attention to ethnicity in addition to gender and class, and the employment of culturally sensitive research methods. If we are to fully understand why health inequalities persist we must consult with those most affected by them.

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Further reading

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