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The Experience of Pregnancy in the British Gypsy, Roma and Traveller Communities

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By Sophie Davies

Introduction

Gypsy, Roma and Traveller (GRT)1 women play a fundamental role within their communities and have distinct roles to men. Often seen as 'exotic outsiders,'2 GRT women have historically been seen as 'sensual, sexually provocative and enticing,'3 as well as 'passive objects, engaged in fortune telling and dealing with magical or medical potions.'4 Up-to-date literature describes GRT women's roles as being mainly based around homemaking and caring duties.5 It is fair to say that no other ethnic group of women has aroused such curiosity, mystery, hatred and fear in the UK6 Such interest continues to leave GRT women and their communities with wide-ranging inequalities7 including large disparities in health care.8

GRT communities are the most excluded in the UK and experience many barriers to health care.9 Women in these communities are also more likely to suffer regarding pregnancy, birth and access to perinatal services compared to women from non-ethnic minority groups.10 GRT communities are known

for having higher birth rates compared to non-GRT communities.[11] At the same time, a higher level of possible hazardous environmental conditions increases the potential for miscarriage and stillbirths, neonatal deaths and high rates of maternal death during pregnancy and after childbirth[12]

They are also 20 times more likely to experience the death of a child.[13] The unauthorised encampments where GRT women frequently live may be hazardous, for example, encampments next to canals risk waterborne contamination, rubbish tips may have rat infestations and waste ground can have an increased chance of fly-tipping. Moreover, there is often a lack of amenities such as clean water and cleaning and toilet facilities, as well as a higher risk of injury and illness in children compared to any other group.[14] It is estimated that '3000 families living roadside have limited or no access to basic water and sanitation.'[15]

Why is it harder for GRT women and their community to access health services?

GRT communities are rarely shown in a positive light by the media, local authorities and the government. They regularly experience harassment, direct and indirect discrimination and racism. This is a result of negative and incorrect stereotypes being systematically delivered via many different outlets. Many of the entrenched cultural prejudices go unchallenged and you are more likely to see racism against GRT communities on the front of newspapers and on social media. It is often seen as the last acceptable form of racism.[16]

Entrenched cultural prejudices not only have negative impacts on the GRT communities' carrying out their daily activities: they also impact their access to health care. Health reports continue to show stark inequalities in health problems and access to care.[17]

Indirect discrimination being carried out by the gatekeepers of health services and care increases the likelihood of GRT communities being unable to successfully gain access to them. Examples of indirect discrimination include GRT communities being wrongly denied the right to register with a new GP or dentist, due to not having ID or a permanent address, making it difficult to access or continue with regular health care due to evictions. Further, with no authorised short stay encampments and a lack of vital amenities such as clean water, toilets and cleaning facilities, GRT community members may have to cut their treatment short, miss appointments or give up treatment and care altogether.

How do cultural differences affect the experiences of prenatal and postnatal GRT women?

There are still conflicted ideals around women's bodies and how women should behave within the community, with female bodies needing to be covered up, especially around the opposite sex. Within the Roma community, the fear of being 'contaminated' by the female body, which leads to 'Marime,'[18] is still enforced, and discussing menstruation, pregnancy and birth can lead to dishonour,[19] though both males and females are capable of 'contaminating.'[20] However, the women of childbearing age have a stronger capacity to contaminate. As such, aprons are often worn from puberty in order to hide and avoid the

shame of bodily functions and female clothes, especially female underwear, which cannot be washed with male clothes and washing cloths and towels due to contamination.[21]

During pregnancy for Roma communities, the pregnancy must be announced and then not discussed thereafter. The pregnant women will now be 'impure' and now must be isolated from the community if possible and looked after only by women. There is often shame attached to pregnancy. Women will no longer be allowed to carry out domestic duties such as cooking and cleaning due to being 'Marime' and will be until the baptism of the child or after 6 weeks. This is due to the 'contamination' which 'Marime' women can cause to food and water.[22]

Research conducted by Edden et al[23] found that much of the research around 'Marime' was correct, yet outdated, with only extremely traditional families carrying out all the traditions and rituals to avoid 'Marime.' Further many of their participants varied in how they carried out their traditions and rituals. This can also vary from country to country.

Cultural practices in the GRT community are important and therefore need to be understood. Many GRT women will not use the toilet facilities within their trailers as it is seen as unhygienic. They will also often opt for cooking outside their trailer and many authorised encampments will have separate lodgings for cooking and cleaning tasks. Furthermore, such traditions in Romany culture mean that there are strict rules around cleaning kitchen items, which are cleaned in a ritualistic manner in order to avoid becoming 'Marime.'

Women may often prefer to use public toilets, for instance at petrol stations, and during pregnancy, they may drink less if they don't have close or easy access to these facilities. Research[24] found one woman being hospitalised for dehydration and being released from the hospital at 2 am once deemed fit enough. Local councils can authorise portaloos for women who are in the third trimester of pregnancy. However, many are denied this due to issues with accessing unauthorised encampments and thanks to evictions, portaloos are then not delivered to the new encampments.[25]

Many women may be living on unauthorised encampments whilst pregnant and experiencing frequent evictions by police using powers of eviction under Section 61 of the Criminal Justice Act[26] Research[27] has found that some pregnant women faced 3 evictions in the space of 2 weeks. Further, the evictions can cause stress and uncertainty, especially around being able to encamp somewhere close to a hospital. One woman expressed how she was due a visit from the midwife on the day of her eviction and the police would not allow her to wait.[28]

Even if GRT women have regular access to midwives, there may be further problems due to the midwife's lack of cultural and social understanding. Lack of training for midwives working with the GRT communities can lead to many GRT women expressing concerns about being treated differently by midwives.[29]GRT women often find their midwives cannot visit their encampments, as they cannot access them because of their rural location. Further, many midwives will overwhelm them with information and health literature when many cannot read or write.[30]

Frequently, evicted pregnant women express concerns about information-sharing from one hospital to the next. Many women will carry their hospital notes with them, as they have often found on arrival that the hospital has not received their notes or that vital information is missing.[31]

Support after the birth may be equally difficult to access. Further, if offered it will likely be declined.[32] GRT families are normally large, with some women having up to 10 children and parenting advice being passed down from generation to generation. GRT women take pride in being confident mothers and may not feel that they need further advice from health visitors.

English, Welsh, Scottish and Irish Travellers are very unlikely to take up breastfeeding.[33] Numbers are extremely low, with a study finding 3% taking it up for the first 6 weeks.[34] Breastfeeding is not seen as part of the culture and can be viewed as an 'immodest act,' whereas in Roma culture, breastfeeding is very much a part of the feeding process. However, breastfeeding needs to be done in complete privacy, which can be extremely hard to achieve in the community.[35]

The family are largely involved in the upbringing of the children, with many of the older siblings looking after their younger siblings whilst the mother cleans or runs errands. As such, many older siblings will see themselves as very experienced in raising children.[36] This is also the same in Roma communities, where everyone has a responsibility in raising the child.[37]

That is not to say that no English, Welsh, Scottish and Irish Travellers will take up breastfeeding given the correct support and advice. However, health visitors may have set views about the women they are supporting and may wrongly assume that they will not accept such advice. Therefore, they may be reluctant to explain the health benefits of breastfeeding and to offer support.[38]

Research found[39] that all the women they interviewed described a 'minimal service with little routine contact beyond the immediate post-natal period,' which also included support around breastfeeding. Many described how their health visitors were unable to understand the cultural and social differences.

It was further found that trusted relationships with health visitors that were built up over a period of time led to higher success rates in women taking up breastfeeding. Adequate social and cultural training for health professionals with predisposed views being challenged and changed will enable them to confidently support GRT women and build trusting relationships.[40]

How can UK health services, local services and local government improve access to health care for GRT women?

Unfortunately, it is not enough for the UK to have an open-door policy to health care if it is in fact closed to those who do not know how to access it or who have had little or no previous relationship with it. Many GRT women will also be unaware of such services existing. Further, due to frequent evictions and lack of knowledge about new areas they move to, many will face further barriers. Those confident enough may try to access such service with little success. Friends, Families and Travellers[41] found that 'almost half of doctors and one third of dentists wrongfully refused to register Gypsies and Travellers if

they had no fixed address or proof of identification.'

However, there are many services out there supporting GRT communities to gain access to health care. These are mainly GRT-based charities that are involved in policy changes, as well as in educating and training staff in health care settings. Many local authorities have carried out research on health inequalities and have recorded their failings. This has resulted in them taking steps to improve access with new funded projects to help reduce health inequalities; some local authorities, such as Bristol, now have dedicated GRT-trained health visitors and education leads.

In Cornwall, Travellerspace,[42] a charity supporting GRT communities in Cornwall and the South West, have set up a flagship midwifery project based at Teyuva Centre in St Day. The project includes newly appointed midwives and Travellerspace project staff.

Kernow Maternity Voices Partnership spoke to the community of the Wheal Jewel Traveller site about their experiences of maternity services. Feedback from the community was poor. This highlighted the need for a more 'bespoke, personalised, family centred approach' where their cultural needs could be met.[43] A partnership was formed that allowed for joint discussions, cultural training for midwives and even new logos for uniforms. There are now two culturally trained midwives who care for the women at the Wheal Jewel Traveller Site in St. Day, and they also work closely with other agencies to make sure the women's needs are met.

Are GRT communities really protected under the Equality Act 2010 and can it be improved?

GRT communities are protected under the Equality Act 2010 and public authorities should be thinking about how their policies protect GRT communities under this act. It is important for them to consider if their services or policies directly or indirectly exclude GRT communities from accessing services that are rightfully accessible to them. Friends, Families and Travellers[44] have created 'practical solutions' to help improve access to health services for both local authorities and GRT communities.

Firstly, local authorities and health services should understand the social and cultural needs of GRT communities. Not only can this improve the health outcomes of pregnant women within the community, but research has also found that this can lead to 'significant long-term cost savings for health and care services.'[45]

Secondly, they should be equipped to support pregnant GRT women. Has there been basic training for health staff to understand that members of GRT communities do not need ID or an address to register at a GP surgery or a dentist and should therefore not be turned away? Are they aware of trusted organisations who act as a 'care of' address? Are they aware of low-level literacy skills among these communities and can they offer discreet help with filling in forms and producing accessible health literature?

Thirdly, midwives and health advisors should be empowered to work across organisational lines. For

example, do they seek advice from charities supporting GRT communities? Can they travel across geographic boundaries to deliver care to women who have been evicted? If not, can midwives contact midwives from other areas for them to continue the care they were once providing?

These practical solutions are not radical or difficult to implement; local authorities do not need to be examined on how to practically apply them. Large research reports being carried out by town and city councils will not be enough to end the disparities in the health care being received by GRT communities if basic training on social and cultural differences is not delivered at local levels or if such reports go unread. If cultural and social differences are ignored in local health settings, the disparities in the delivery of health care will continue, leaving GRT communities vulnerable and excluded from health care that they are rightfully entitled to.

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