Summary of Findings: Cancer Awareness and Attitudes among the Traveller Community in Ireland

A co-designed study led by UCD in collaboration with Pavee Point Traveller & Roma Centre and the HSE National Cancer Control Programme (NCCP)

HSE National Cancer Control Programme, October 2025

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PAVEE POINT TRAVELLER AND ROMA CENTRE

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Abbreviations

AHPs	Allied Healthcare Professionals
AITHS	All-Ireland Traveller Health Study
GDPR	General Data Protection Regulation
GPs	General Practitioners
GPNs	General Practice Nurses
HCPs	Healthcare Professionals
HRT	Hormone Replacement Therapy
HSE	Health Service Executive
NCCP	National Cancer Control Programme
NCRI	National Cancer Registry of Ireland
NSCAA	National Survey on Cancer Awareness and Attitudes
NTHN	National Traveller Health Network
OCP	Oral Contraceptive Pill
PHCTP	Primary Healthcare for Travellers Project
PHN	Public Health Nurses
PPI	Patient and Public Involvement
PSG	Project Steering Group
SPs	Screening Professionals
SDoH	Social Determinants of Health
STSG	Sligo Travellers Support Group
TPHCWs	Traveller Primary Health Care Workers
THAF	Traveller Health Advisory Forum
THUC	Traveller Health Unit Coordinators
TVG	Traveller Visibility Group
UCD	University College Dublin
UV	Ultraviolet radiation

UCD Team

Principal Investigator
Dr Patricia Fox

Co-applicants
Professor Patricia Fitzpatrick
Associate Professor Kate Frazer
Dr Regina Joye

Associated Team
Dr Reuel Jalal
Dr Aela O'Flynn

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Also, a sincere thank you to the Project Steering Group for all their support, guidance and feedback in co-designing this study.

Please refer to Appendix I for a list of all those involved.

Contents

Contents

List of Figures and Tables

Figures

Tables

Summary of key findings

Quantitative cross-sectional survey of Travellers

A GDPR-compliant survey questionnaire based on the NCCP's 2022 National Survey on Cancer Awareness was developed with Pavee Point TPHCW. Data were collected by 12 TPHCW following training from UCD. A total of 483 surveys were completed by Travellers across the Republic of Ireland.

Experience of cancer

Overall, 97% of respondents knew someone who has been diagnosed with cancer,

with 42% saying it was a member of their close family.

36% say they themselves have been diagnosed with cancer,

with 3% of this group still undergoing treatment at the time of the survey.

Beliefs about cancer

Overall 35% agreed/strongly agreed with the statement "I would NOT want to know if I have cancer"

42% of respondents believed "A diagnosis of cancer is a death sentence"

The first three words that came to mind when they heard the term 'Cancer', were negative and included the words:

'Death'	'Fear'	'Disease'
60%	55%	39%

Taken as a whole, 63% agreed/strongly agreed with the statement "These days many people with cancer can expect to continue with normal activities and responsibilities"

while 71% agreed/strongly agreed that "Cancer can often be cured"

Females tended to hold slightly more positive beliefs about cancer compared to males.

Almost twice as many males (66%) compared to females (35%) believed that "most cancer treatment is worse than the cancer itself"

Risk factors for cancer

The majority of respondents agreed that there are actions they can take to reduce their cancer risk.

Overall, 77% agree with the statement “There are things I can do to reduce my risk of cancer”

Agreement levels are strongest amongst females and lowest amongst those aged over 65 years.

Smoking is well recognised as a risk factor for cancer, 96% of respondents citing it as a risk factor.

Overall, 36% of respondents identified as daily or occasional smokers.

Smoking prevalence was higher among men (44%) than women (32%).

Just 38% correctly agreed that “Drinking alcohol, even now and again, increases the risk of developing cancer” while 33% disagreed.

Additionally, 42% agreed that “Drinking alcohol can only cause cancer if you drink a large amount over a long period of time” while 36% disagreed.

Overall 59% recognised the link between overweight and cancer, one of the leading risk factors for cancer.

There was strong recognition of ultraviolet (UV) radiation from the sun and sunbeds as a risk factor,

with 92% identifying sunbed use

and 78% citing sunburn as a risk factor.

Use of sun protection measures (Using sunscreen of at least factor 30, wearing long sleeves, a hat, or sunglasses, and limiting time spent in the sun) is moderately high.

63% reported that they use sunscreen of at least factor 30.

76% state they would limit their child's time spent in the sun and

66% ensure their child would wear long sleeves, a hat or sunglasses.

Only 2% reported taking no sun protection measures for their children.

A minority of respondents recognised human papilloma virus (HPV) as a risk factor for cancer,

with 22% mentioning it spontaneously,

and a further 15% recognising it when prompted.

Physical activity was less commonly recognised as a cancer risk, with 26% spontaneously linking low physical activity levels to increased cancer risk.

Similar proportions identified processed (26%) or red meat (26%) consumption and inadequate fruit and vegetable (27%) intake as risk factors.

Only 9% spontaneously mentioned insufficient wholegrain consumption,

with an additional 11% recognising it after prompting.

Signs and symptoms of cancer

Spontaneous recognition of cancer signs and symptoms is generally low, with fewer than 50% of respondents identifying most symptoms,

except for an unexplained lump or bump (80%)

and a changing mole (55%).

Recognition of signs and symptoms was higher amongst females than males.

A majority of respondents, 60%, reported that they would speak to their doctor first if they noticed a physical sign of cancer.

A further 26% of respondents would discuss it with someone close to them first.

Barriers to acting on a potential sign or symptom of cancer include not wishing to discuss their symptoms with a doctor's receptionist (37%),

fearing the potential diagnosis (32%)

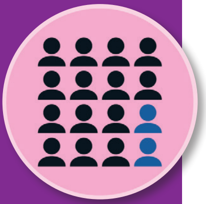
and the possibility of needing additional tests (31%).

Cancer screening

The key enablers for accessing cancer screening were speaking with the local Traveller Primary Health Care Worker (28%),

followed by receiving an invitation (27%)

and discussing with the general practitioner (GP) (18%).



TV, radio, newspapers, and social media platforms were noted to be the least effective enablers.

Qualitative interviews

Travellers	Health care professionals
Racism and discrimination significantly hinder Travellers' ability to adopt risk-reducing lifestyle behaviours, participate in screening, and access healthcare.	Healthcare professionals believe that racism and discrimination are root causes of the difficulties Travellers experience in adopting healthy lifestyle behaviours and engaging with the healthcare system.
Social determinants of health, including poor living conditions, low literacy, poverty, unemployment, and limited transport access further restrict engagement with healthcare.	Healthcare professionals identify social determinants of health—such as overcrowded or poor housing conditions, poverty, unemployment, and limited education—as having a significant impact on health outcomes.
Communication issues were identified which present unique challenges such as some Travellers not receiving post or having difficulty reading or fully understanding healthcare information. Concerns about privacy and confidentiality can delay help-seeking, while fear and fatalism about cancer are prevalent.	Travellers face specific barriers to accessing healthcare. These challenges include a lack of cultural appropriateness, difficulties attending appointments due to not receiving or being unable to read post, and the provision of jargon-heavy written materials that may be inaccessible to those with limited literacy. Travellers also face individual barriers to engaging with healthcare, including lack of childcare, limited transport, and fear or fatalism about cancer. Embarrassment or shame when discussing certain body parts or symptoms, and an intense need for privacy can further delay symptom recognition and help-seeking.
The development of the role of the Traveller Health Care Workers is viewed positively by Travellers and identified as a means to improve Traveller health.	Healthcare professionals highlighted the crucial importance of gaining the trust of Travellers and working with Travellers to develop health services that are culturally appropriate.

1. Introduction

1.1 Background

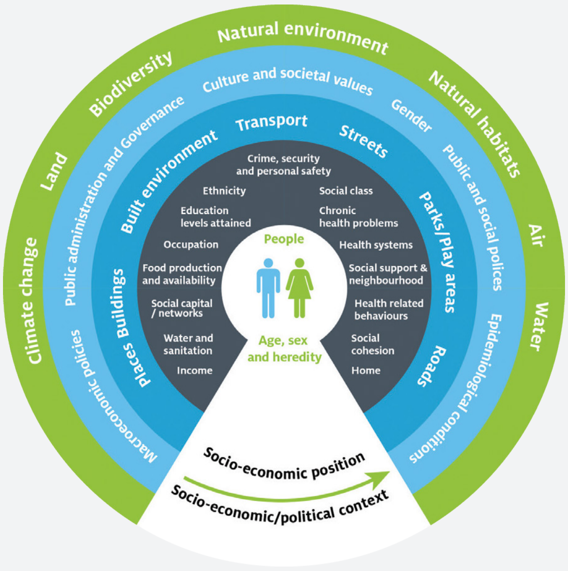
This report details the key findings of a nationwide research survey amongst the Traveller population living in Ireland the on the topic of cancer awareness and attitudes. The research was commissioned by the Health Service Executive's (HSE) National Cancer Control Programme (NCCP), carried out by University College Dublin (UCD) and Pavee Point.

The Irish Traveller population is a distinct minority ethnic group, with formal State acknowledgement since March 2017. Irish Travellers make up less than 1% of the population in Ireland, at just under 33,000 according to 2022 census data[1]. This may be an underestimate as the All-Ireland Traveller Health Study (AITHS)[2], found that the total number of Travellers living in Ireland was higher than recorded in the census at that time.

Travellers experience poorer health outcomes when compared to the general population[1,2,3], with clear evidence of poorer life[2] and health[4] expectancy. Overall, there is a gap of up to 13 years in life expectancy between Travellers and the general population. The social determinants of health (SDoH) have long been identified as having a significant influence on health and disease[5,6], a finding supported in the AITHS[2]. There is substantial evidence that sociodemographic factors such as employment status, income level, education, age, sex, ethnicity, gender, or disability status are key factors in determining the health of people and their communities[7].

Social Determinants of Health

(Adapted from Dalghren and Whitehead, 1991 and Grant and Barton, 2006)



The AITHS[2] found that cancer was one of the leading causes of death amongst Travellers, accounting for almost 20% of all deaths in the Traveller Community.

Ireland's National Cancer Strategy[8] underlines the importance of focusing on cancer prevention and early diagnosis to reduce cancer incidence, mortality, and morbidity. The National Cancer Registry of Ireland (NCRI)[9] estimated that in 2016, approximately 6,000 cancer cases were due to modifiable risk factors highlighting the importance of risk reduction initiatives.

Not all cancers are preventable[10], therefore early diagnosis is also an important priority, as stage at diagnosis is a key determinant of survival[8]. Patient factors that impact early diagnosis include knowledge and awareness of cancer signs and symptoms and their significance. Health literacy, defined as the ability to access, understand, and use health information to make informed health decisions, also plays a critical role. Additionally, attitudes towards cancer, which guide health-seeking behaviour, access to healthcare, knowledge of how to navigate health services, and socio-economic deprivation all impact the likelihood of early diagnosis. However, barriers exist at systemic (e.g. health care professional) as well as individual level. While there is a lack of disaggregated data on the basis of ethnicity, evidence suggests that members of minority ethnic groups are disproportionately diagnosed with late-stage cancer and face higher mortality rates compared to the majority population.

Deprivation impacts cancer incidence, stage at diagnosis and outcomes. According to the NCRI[7], there is a 7% higher risk for males and a 5% higher risk for females of developing cancer overall for people living in most deprived areas compared with those living in least deprived areas. Patients with cancer living in the most deprived areas experience lower five-year survival rates, on average, a 43% higher mortality risk within five years after diagnosis compared with those in the least deprived areas.

Travellers in Ireland experience persistent racism and discrimination resulting in poorer outcomes in health, education, employment and accommodation, as reported by various UN treaty-monitoring bodies, European institutions, and equality and human rights organisations. Racism acts as a key determinant in access to healthcare, participation in health care, and health care outcomes. High levels of racism and discrimination also negatively impact Travellers' engagement with health services[11] further compounding patient factors which influence stage of cancer diagnosis.

To inform public policy and interventions to reduce cancer incidence, morbidity and mortality amongst Travellers in Ireland, the HSE NCCP commissioned research on Travellers' cancer awareness and attitudes in line with previous research in the general population[12].

1.2 Aims

The aims of the research were to:

- Gain an understanding of cancer awareness and attitudes among the Traveller Community in Ireland.
- Identify any barriers and enablers to cancer risk reduction behaviours and early diagnosis of cancer.
- Provide baseline data to inform the development and delivery of effective cancer prevention and early diagnosis initiatives, monitor the impact of these initiatives, and support better understanding of policy priorities.

2. Method

This co-designed multi-methods study was developed and conducted in collaboration with Pavee Point Traveller & Roma Centre, University College Dublin, and the HSE NCCP, building on the methodology successfully developed for the AITHS[2].

Pavee Point and Traveller organisations worked in partenership with UCD, the HSE Traveller Health Advisory Forum (THAF) and the National Traveller Health Network (NTHN) which includes Traveller Health Unit Coordinators (THUC) and staff of the Primary Health Care for Travellers Projects (PHCTPs). These introductory meetings and subsequent guidance from Pavee Point facilitated partnerships with THUs and PHCTPs, supporting recruitment and data collection.

Pavee Point provided anti-racism and discrimination training for the UCD research team, an important first step in establishing trust and ensuring a partnership approach.

Ethics approval was granted by the Royal College of Physicians of Ireland on May 4th, 2023 (RCPI RECSAF 191). Approval was also received from the Pavee Point Research Advisory Committee and the UCD Data Protection Officer.

Data collection methods employed were:

a. Quantitative cross-sectional survey of Travellers, administered by peers
b. Qualitative interviews with a subset of Travellers (recruited from survey participants)
c. Qualitative interviews with HCPs

2.1 Quantitative survey of Travellers

A GDPR-compliant survey questionnaire based on the NCCP's 2022 National Survey on Cancer Awareness[12] was developed with Pavee Point TPHCW. The survey was amended to ensure wording was accessible and culturally appropriate for Travellers and to develop comparative data points. The survey was piloted and further amendments made.

Data were collected by 12 TPHCW following training from UCD using hard copy questionnaires in 2023. Written informed consent was obtained prior to the completion of each survey.

Each question in the survey was analysed to provide frequencies. Subgroup analysis was then performed by demographic variables (gender and age), and SDoH (literacy and for some variables, access to direct postal delivery). Literacy was categorised as yes vs no/don't know, (with missing and refusals omitted for all comparisons). Likert scales (with options of strongly agree, agree, neither agree nor disagree, disagree and strongly disagree) were recoded to provide a combined answer of agree and strongly agree. SPSS version 29 was used for statistical analysis.

A total of 574 surveys were distributed across 12 different Primary Health Care Traveller Projects in the Republic of Ireland; East (Pavee Point, Kildare, Ballymun, Clondalkin, Tallaght, Coolock); Longford; Cork; Sligo; Offaly; West Limerick and Meath. Of these, 84% were returned completed. The target sample size of 380 was exceeded with 483 (127%) completed surveys returned.

2.2 Qualitative interviews with Travellers

Travellers who completed the quantitative survey were invited to participate in semi-structured interviews. Interview topics guides were developed with the Project Steering Group. Interviews were offered face-to-face or online via Zoom and recorded with permission. 22 interviews were completed.

Braun and Clarke's[13,14] thematic analysis approach was used to analyse the qualitative data and key themes were identified by researchers.

After discussion and additional analyses, four thematic areas anchored in the data were confirmed, and consensus was reached.

2.3 Qualitative interviews with Healthcare Professionals

Participants with experience in caring for or engaging with Travellers were sought, through the PSG and through the PHCTPs. Interview topics guides were developed with the Project Steering group. 18 primary care healthcare professionals (HCPs), including general practitioners (GPs), general practice nurses (GPNs), public health nurses (PHNs) and screening professionals (SPs) were invited to participate in semi-structured interviews online via Zoom or by phone and recorded with permission. A total of 15 HCPs were interviewed.

Data analysis for the interviews with HCPs followed the same process as for the analysis of the Traveller interviews.

3. **Key findings** – Quantitative survey of Travellers

Percentages throughout this report may not sum to 100% as not all questions were answered by all respondents (e.g., missing responses) and some questions only refer to certain categories of respondents (e.g. CervicalCheck questions apply to people with a cervix aged 25-65). Accommodation was not analysed in relation to other variables as the small numbers in some accommodation settings precluded this analysis.

Throughout the survey literacy is defined by whether respondents answered 'yes' or 'no/don't know' to the question: 'Can you usually read and fill out forms you might have to deal with?'

3.1 Profile of respondents - Travellers

Total respondents - 483

Figure 1: Gender

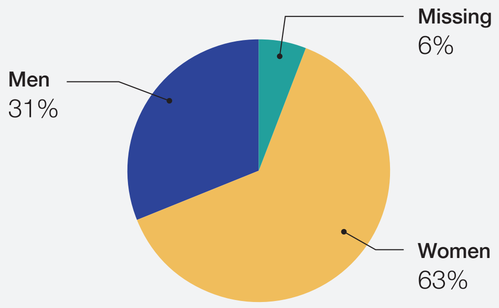


Figure 2: Age

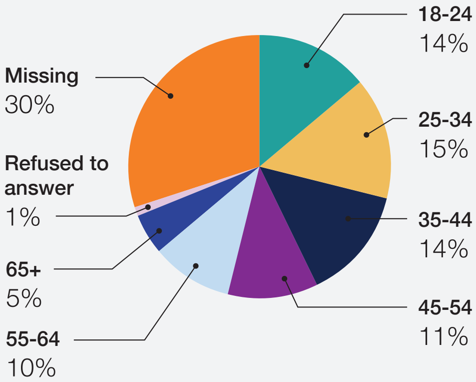


Figure 3: Region

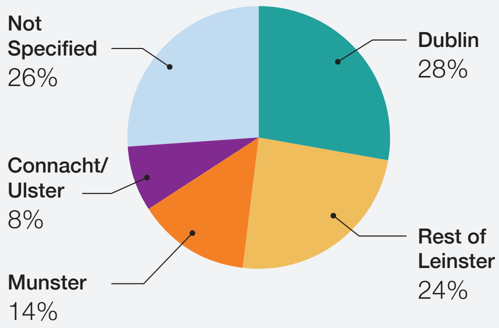


Figure 4: Education

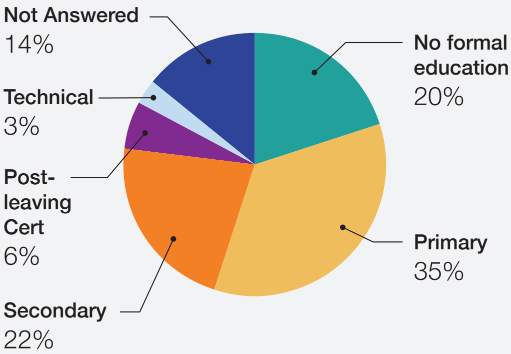


Figure 5: Working status

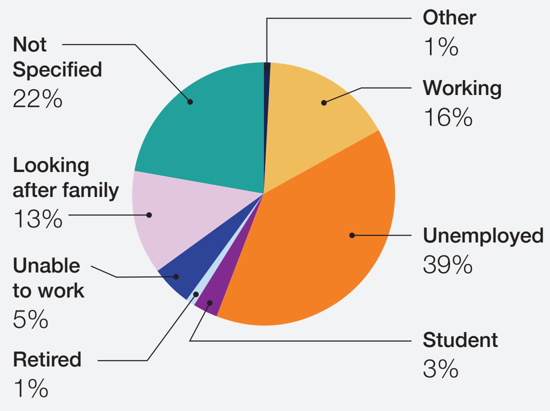


Figure 6: Fruit portion per day

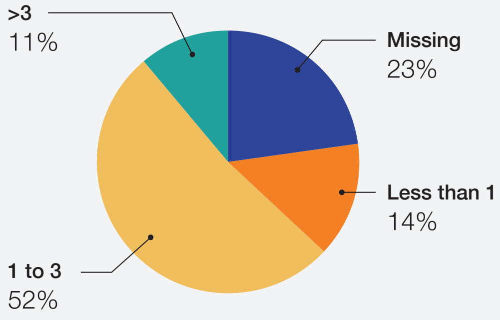


Figure 7: Vegetable portion per day

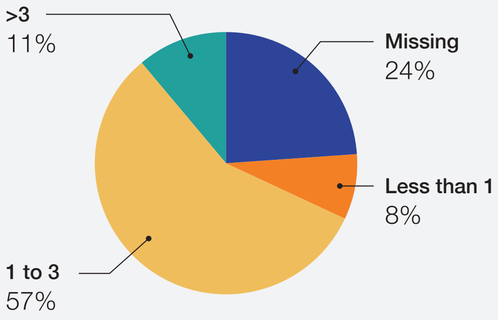
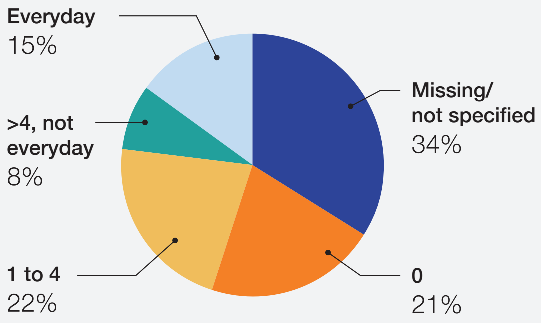


Figure 8: Days with exercise >30 mins past week



Smoking and vaping

Overall 36% of Traveller participants described themselves as daily or occasional smokers. The 2022 National Survey Cancer Awareness and Attitudes (NSCAA) among general population found 21% are current smokers. 44% of males were smokers, compared to 32% of females (Table 1).

14% of males vaped compared to 12% of females, with vaping (the use of electronic cigarettes) being most common in the 18-24 age group (Table 1). Nearly twice as many people (18%) in this age range vaped compared to the 25-34 age group (9%), while 11% of those aged 35-44 years reported vaping.

Figure 9: Current smoker status

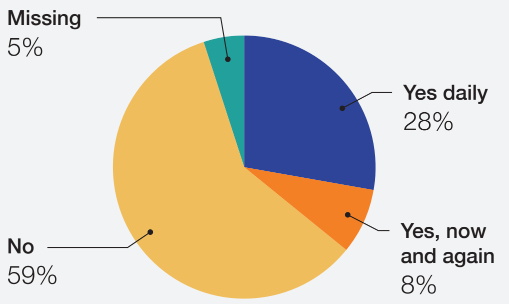


Figure 10: Past smoker status

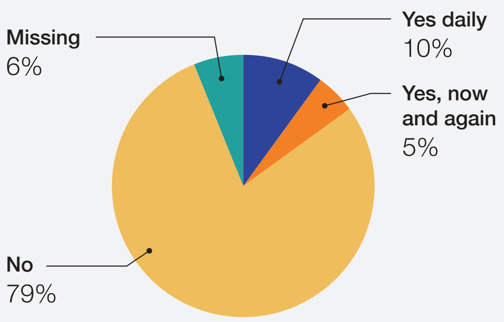


Figure 11: Vaping status

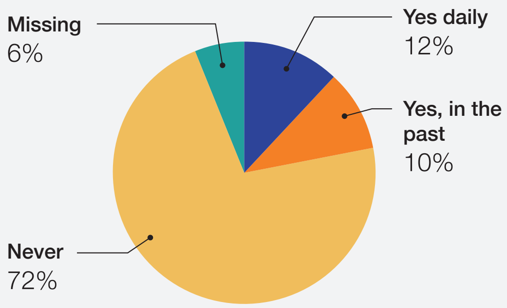


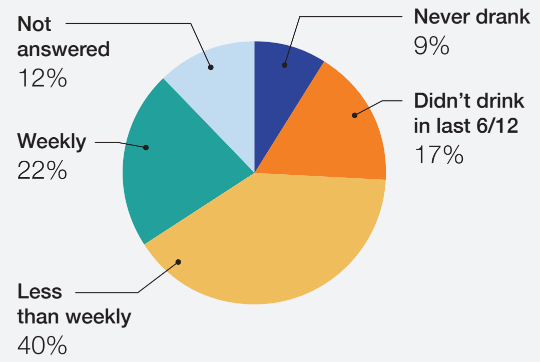
Table 1: Current smoking and vaping by gender and age group

	Gender		Age group					
	M	F	18-24	25-34	35-44	45-54	55-64	65+
Current daily/now and again smoking	44%	32%	26%	43%	44%	35%	28%	37%
Current vaping	14%	12%	18%	9%	11%	10%	10%	11%

Alcohol consumption

When asked about alcohol consumption in the past 6 months, 22% of Traveller participants reported they consumed alcohol at least once weekly, with 40% reporting less than weekly consumption. Traveller men drank slightly more often than women, with 9% consuming alcohol three or more days per week, compared to 7% of women.

Figure 12: Alcohol consumption in the last 6 months

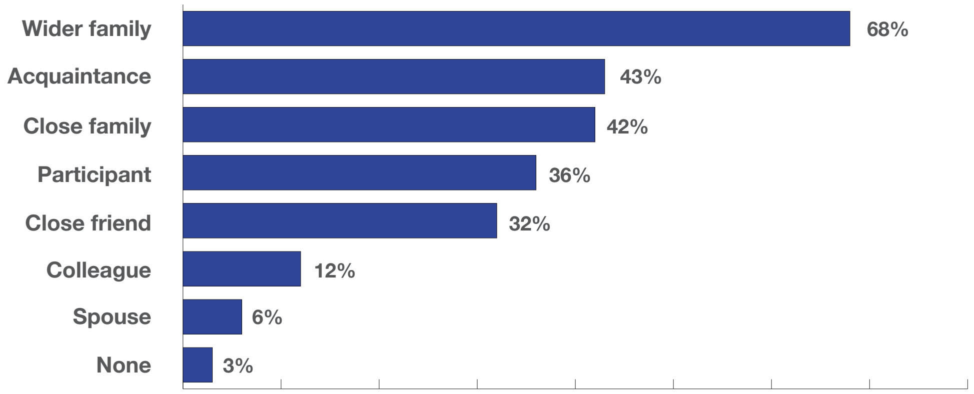


3.2 Experience of Cancer

Respondents were asked if they had a diagnosis of cancer or were currently receiving treatment for cancer, and then asked whether anyone in their family or circle of friends had ever been diagnosed with cancer (Figure 13). Among the respondents, 36% had been diagnosed with cancer. Of those who had been diagnosed with cancer, 3% of this group were still undergoing treatment at the time of the survey.

Overall, 42% of respondents reported having a close family member diagnosed with cancer, a figure consistent with the general population, where 42% of respondents in the NSCAA also had a close family member (parent, child, sibling) diagnosed with cancer. Additionally, 97% of respondents knew at least one person who had been diagnosed with cancer compared to 86% in the NSCAA.

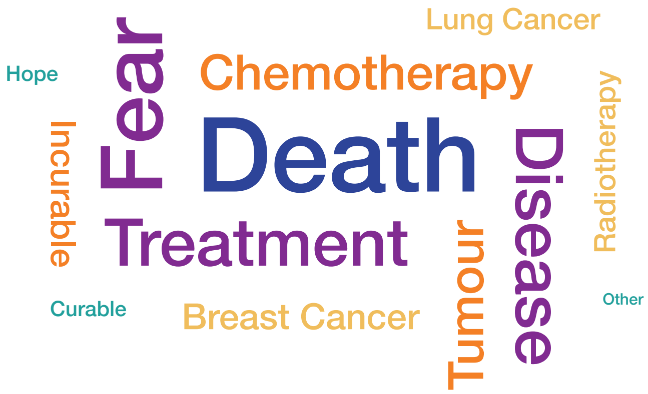
Figure 13: Personal experience of cancer



3.3 Beliefs and attitudes to cancer

Respondents were asked about their beliefs and were invited to share the first three words that came to mind when they heard the term ‘Cancer’ (Figure 14). The most frequently mentioned responses were negative and included the word ‘Death’ cited by over half of all respondents (60%), followed closely by ‘Fear’ (55%) and ‘Disease’ (39%). By comparison, when respondents in the NSCAA were asked the first three words that came to mind were when they heard the word ‘cancer’ the responses were ‘Fear’ (49%), followed by ‘Death’ (46%) and ‘Disease’ (40%)

Figure 14: Word association with cancer



Figures 15 and 16 show further exploration of the respondents’ beliefs about cancer. In terms of positive beliefs, 63% agreed /strongly agreed with the statement “These days many people with cancer can expect to continue with normal activities and responsibilities”, 71% agreed/strongly agreed that “Cancer can often be cured”, and 85% that going to the doctor as quickly as possible could increase the chances of survival. In contrast, 35% agreed/strongly agreed with the statement “I would not want to know if I have cancer” compared to 13% of respondents in the NSCAA general population.

On the other hand, 42% of Traveller respondents believed that “A diagnosis of cancer is a death sentence,” (Figure 16) while 25% of respondents in the NSCAA shared this view. Otherwise, there were few differences in attitudes towards cancer according to gender. Females tended to hold slightly more positive beliefs about cancer compared to males (Table 3). 66% of males compared to 35% of females believed that “most cancer treatment is worse than the cancer itself.

Figure 15: Attitudes to cancer

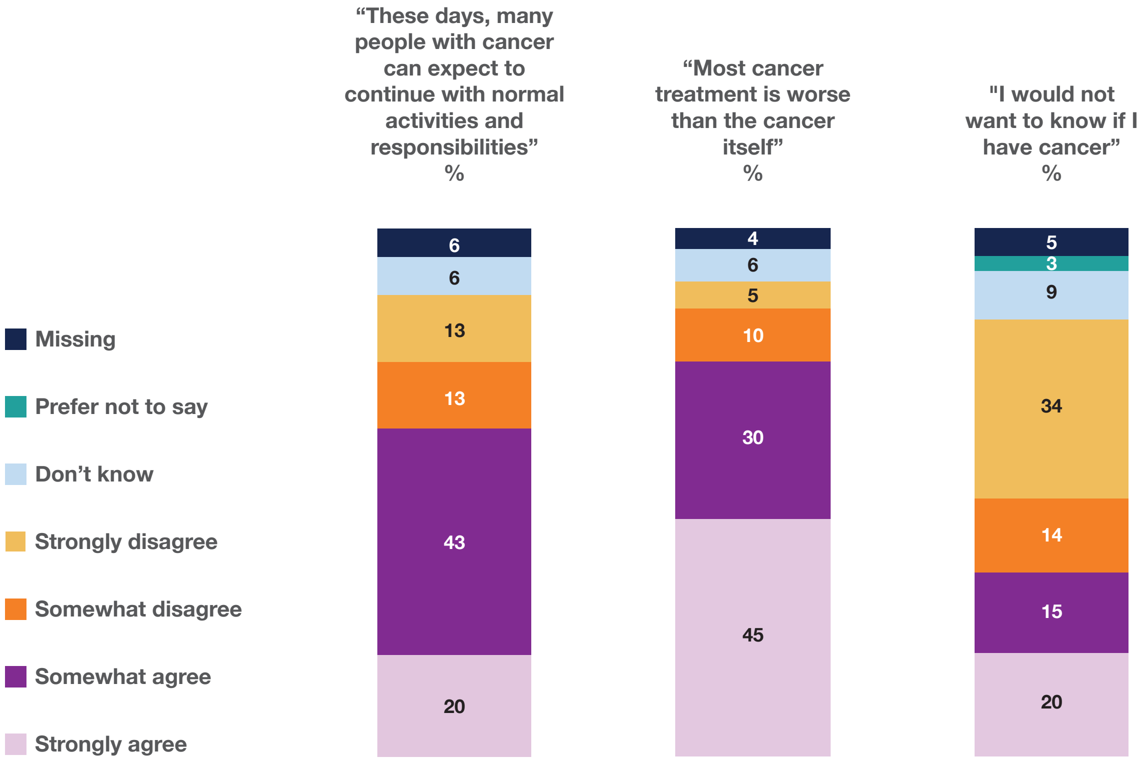
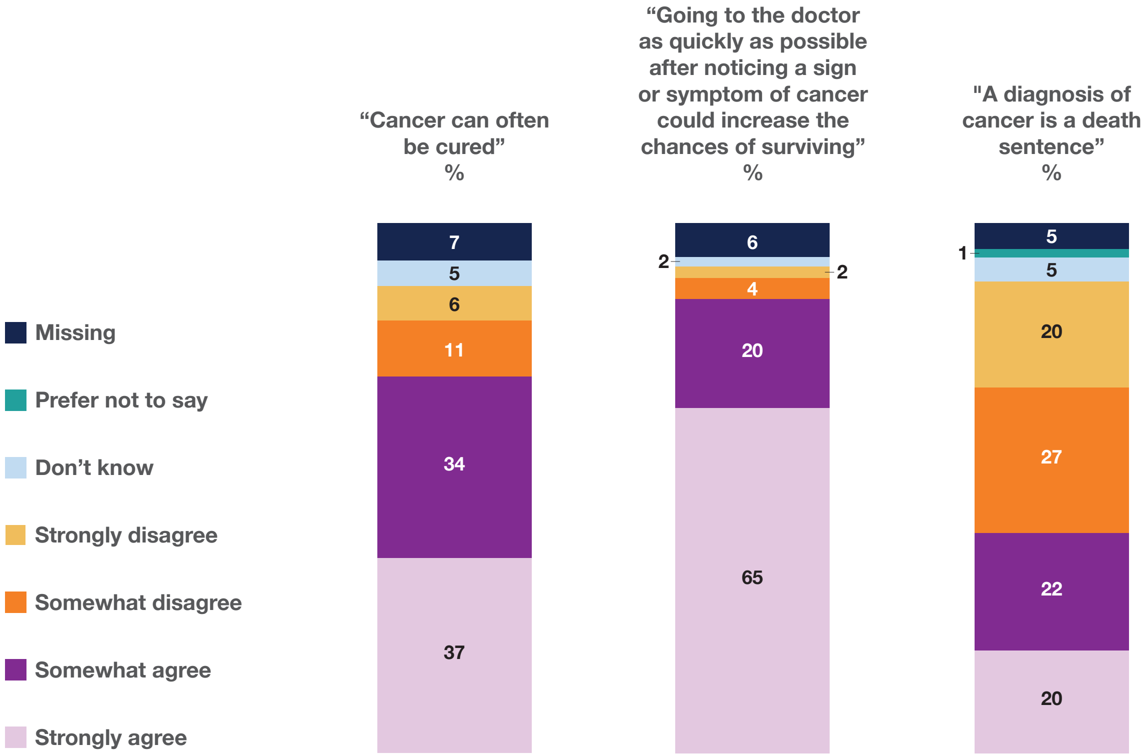


Figure 16: Attitudes to cancer



Those aged 65 and older tend to hold the most negative perceptions of cancer (Table 2). People aged 65 and older were more likely than other age groups to think that "most cancer treatment is worse than the cancer itself" (81%), and less likely to agree that "cancer can often be cured" (57%). 55% of this older age group agreed that "A cancer diagnosis is a death sentence", compared to approximately 40% of those aged 25-44 years and 28% of those aged 45-54 years.

Table 2: Attitude to cancer by age group (% agree)

	Age group					
Strongly agree/agree with statement	**18-24 n=87**	**25-34 n=81**	**35-44 n=94**	**45-54 n=78**	**55-64 n=60**	**65+ n=75**
These days, many people with cancer can expect to continue with normal activities and responsibilities	66%	62%	61%	63%	72%	53%
Most cancer treatment is worse than the cancer itself	75%	74%	76%	74%	78%	81%
I would not want to know if I have cancer	36%	37%	32%	21%	47%	36%
Cancer can often be cured	68%	72%	79%	74%	78%	57%
Going to the doctor as quickly as possible after noticing a sign or symptom of cancer could increase the chances of surviving	85%	83%	85%	86%	91%	91%
A diagnosis of cancer is a death sentence	41%	40%	40%	28%	48%	55%
Nothing can be done to reduce your risk of cancer	32%	21%	31%	23%	38%	39%

Females tended to hold slightly more positive beliefs about cancer compared to males. 66% of males compared to 35% of females believed that "most cancer treatment is worse than the cancer itself".

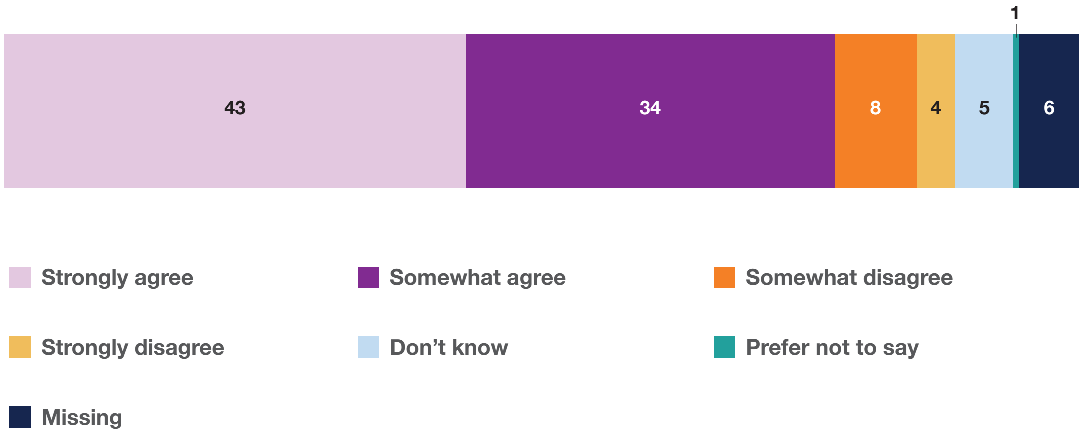
Table 3: Attitudes to cancer by gender

	Gender	
Strongly agree/agree with statement	**M**	**F**
These days, many people with cancer can expect to continue with normal activities and responsibilities	57%	64%
Most cancer treatment is worse than the cancer itself	66%	35%
I would not want to know if I have cancer	35%	35%
Cancer can often be cured	65%	75%
Going to the doctor as quickly as possible after noticing a sign or symptom of cancer could increase the chances of surviving	82%	88%
A diagnosis of cancer is a death sentence	44%	41%
Nothing can be done to reduce your risk of cancer	30%	31%

3.4 Attitudes to reducing cancer risk

Respondents were asked whether they agreed with the statement, “There are things I can do to reduce my risk of developing cancer.” Overall, 77% of respondents agreed, with 43% strongly agreeing (Figure 17). In comparison, the National Survey on Cancer Awareness and Attitudes (NSCAA) in the general population found that 90% agreed, including 55% who strongly agreed.

Figure 17: There are things I can do to reduce my risk of cancer (%)



There was little variation by gender. However, there are differences across age groups. The belief that actions can be taken to reduce cancer risk had the highest level of agreement among those aged 35-44 (86%) and the lowest among those aged 65 and over (69%) (Table 4).

Table 4: Attitude to reducing cancer risk by age

	Age group					
Strongly agree/agree with statement	**18-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**
There are things I can do to reduce my risk of cancer	71%	77%	86%	82%	83%	69%

3.5 Awareness of Cancer Risk Factors

Respondents were surveyed for spontaneous and prompted awareness of cancer risk factors. They were first asked to spontaneously name as many risk factors they could think of that could increase a person's chance of developing cancer. They were then presented with a list of 32 behaviours or exposures and asked whether each one could increase the likelihood of developing cancer. Most of the factors cited are associated with an increased cancer risk, though for some, such as mobile phone use and aerosol use, a definitive link has not been established. These were included to prevent respondents from answering yes to all items.

These behaviours were divided into eight categories:

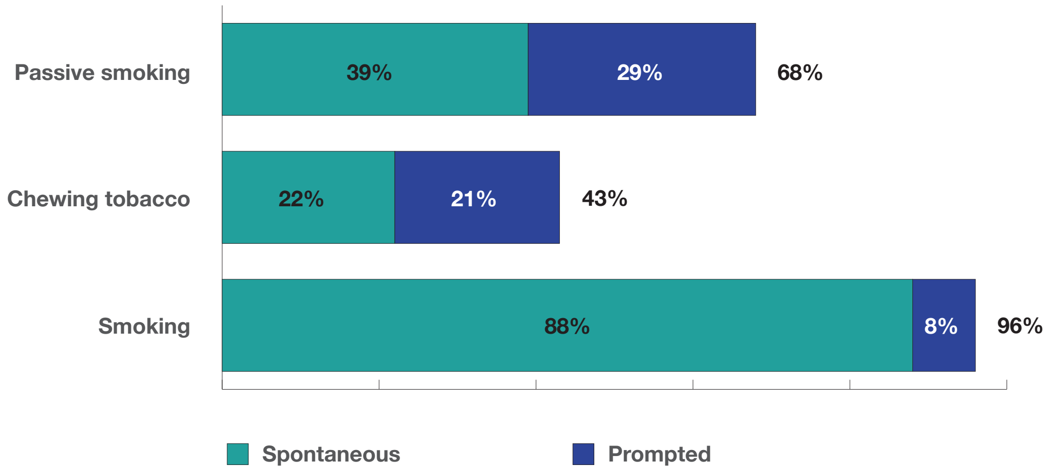
- Smoking tobacco
- Alcohol
- Ultraviolet radiation
- Environmental and occupational health
- Diet, physical activity & weight
- Certain medications including Oral Contraceptive Pill, Hormone Replacement Therapy
- Medical conditions and genetic risk factors
- Factors with no association with cancer

3.5.1 Smoking tobacco

Smoking tobacco was the most commonly mentioned risk factor. Almost all respondents (96%) agreed that smoking tobacco products increases the risk of developing cancer, with 88% mentioning it spontaneously and a further 8% when prompted (Figure 18). Additionally, 39% spontaneously mentioned exposure to second-hand smoke and a further 29% when prompted. Furthermore, 43% overall agreed that chewing tobacco could increase a person's chance of developing cancer, of whom 22% mentioned this spontaneously.

Similarly, the NSCAA found 98% of respondents agree that smoking tobacco products increases your risk of developing cancer, with 81% mentioning it spontaneously. 89% agreed that exposure to another person's smoking ('passive smoking') can cause cancer.

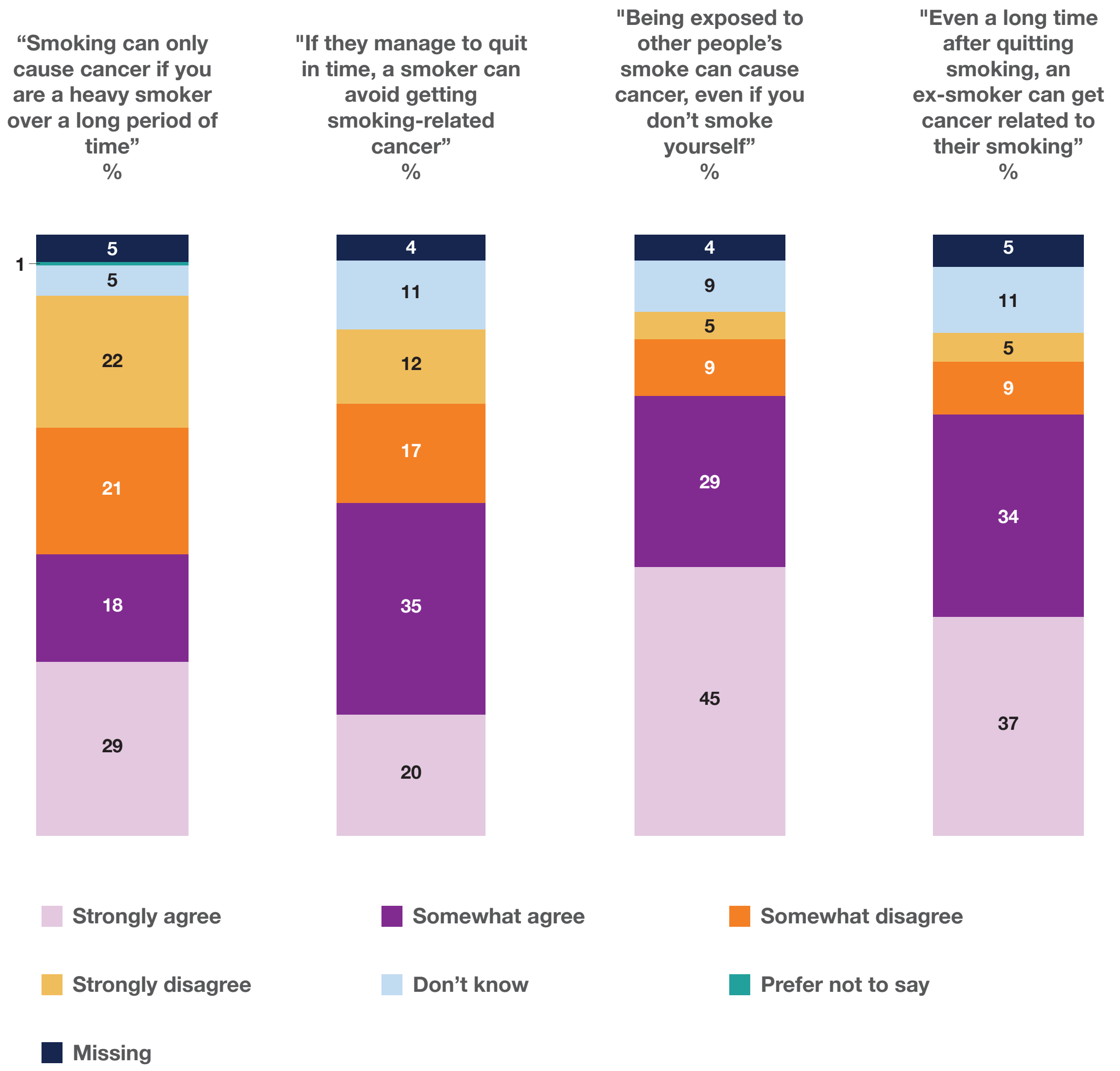
Figure 18: Awareness of cancer risk associated with smoking



Respondents were presented with statements concerning the connection between tobacco smoking and cancer and were asked to indicate their level of agreement or disagreement (Figure 19).

47% of respondents agreed/strongly agreed with the statement that “Smoking can only cause cancer if you are a heavy smoker over a long period of time,” while 55% agreed/strongly agreed that “If they manage to quit in time, a smoker can avoid getting smoking-related cancer”. 74% concurred with the statement that “Being exposed to other people’s smoke can cause cancer, even if you don’t smoke.” Similarly, the majority believed that “even a long time after quitting smoking, an ex-smoker can get cancer related to their smoking” (71%).

Figure 19: Link between cancer and smoking (% agreement)



Smoking and cancer risk awareness by gender and literacy

Overall, females demonstrated greater knowledge regarding smoking and cancer risk particularly in terms of the risks associated with passive smoking and the possibility of ex-smokers developing smoking-related cancers even long after quitting (Table 5). The most notable disparity in attitudes toward smoking and cancer risk between males and females was that 74% of females agreed that even long after quitting smoking, an ex-smoker can develop smoking-related cancer, compared to 63% of males.

Table 5: Link between smoking and cancer by gender and literacy (% agree)

	Gender		Literacy	
Strongly agree/agree with statement	**M**	**F**	**Yes**	**No / DK / Missing**
Smoking can only cause cancer if you are a heavy smoker over a long period of time	44%	50%	47%	46%
If they manage to quit in time, a smoker can avoid getting smoking-related cancer	51%	59%	58%	52%
Being exposed to other people’s smoke can cause cancer, even if you don’t smoke yourself	68%	77%	74%	73%
Even a long time after quitting smoking, an ex-smoker can get cancer related to their smoking	63%	74%	70%	70%

Smoking and cancer risk awareness by age

Among respondents aged 65 and over, 56% believed that smoking only causes cancer if one is “a heavy smoker over a long period” (Table 6). More Travellers in all age groups agreed that “even after a long time after quitting smoking an ex-smoker can get cancer related to their smoking” than agree that “if they manage to quit in time, a smoker can avoid getting smoking-related cancer”. High percentages in all age groups, but higher in older age groups, agreed that “being exposed to other people’s smoke can cause cancer, even if you don’t smoke yourself”.

Table 6: Link between smoking and cancer by age group (% net agree)

	Age group					
Strongly agree/agree with statement	**18-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65+**
Smoking can only cause cancer if you are a heavy smoker over a long period of time	44%	47%	50%	46%	37%	56%
If they manage to quit in time, a smoker can avoid getting smoking-related cancer	59%	56%	55%	55%	50%	59%
Being exposed to other people’s smoke can cause cancer, even if you don’t smoke yourself	67%	73%	71%	78%	80%	79%
Even a long time after quitting smoking, an ex-smoker can get cancer related to their smoking	67%	63%	73%	77%	77%	64%

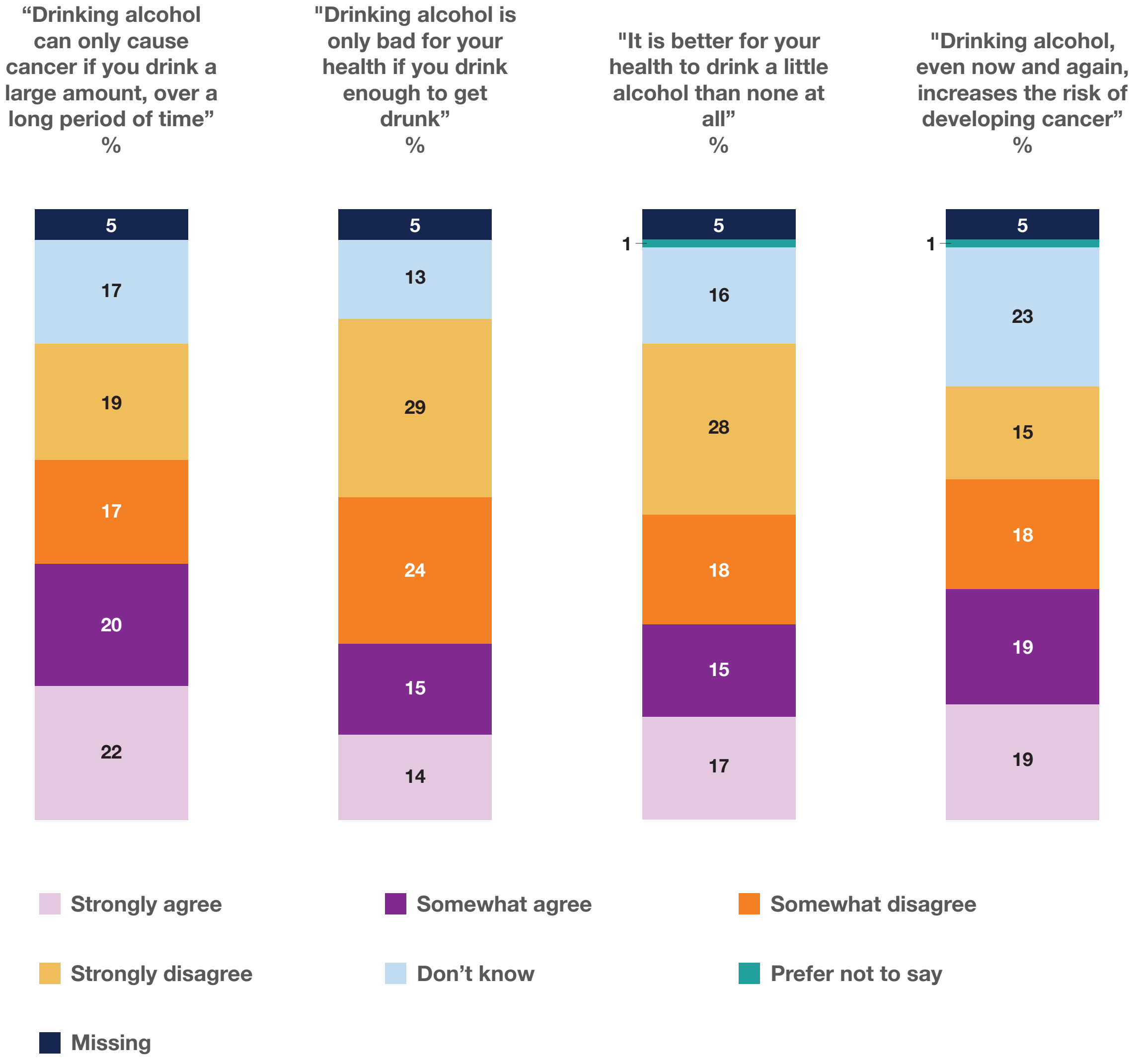
3.5.2 Alcohol

The survey findings indicate that just under half of respondents (49%) spontaneously noted the connection between alcohol consumption and cancer (Figure 25), whilst a further 16% did so when prompted.

The NSCAA found 42% spontaneously noted the connection between alcohol consumption and cancer, whilst a further 31% did so when prompted

The survey asked a series of questions to determine perceptions of the connection between alcohol consumption and cancer (Figure 20).

Figure 20: Link between alcohol consumption and cancer (% agreement)



Just under half of all respondents (42%) agreed/strongly agreed that “Drinking alcohol can only cause cancer if you drink a large amount, over a long period of time”. 32% agreed/strongly agreed “It is better for your health to drink a little alcohol than none at all”, whilst 46% disagreed, and 16% did not know. When it came to the statement “Drinking alcohol, even now and again, increases the risk of developing cancer”, 38% agreed/strongly agreed with this statement, whilst 33% disagreed/strongly disagreed and 23% stated that they did not know.

Link between alcohol and cancer by gender and literacy

There was some variation in awareness of the link between alcohol and cancer according to gender and literacy as illustrated in Table 7. 41% of females and 34% of males agreed or strongly agreed that “drinking alcohol, even now and again, increases the risk of developing cancer”; however, 44% of females and 39% of males agreed/strongly agreed that “drinking alcohol can only cause cancer if you drink a large amount over a long period of time”.

Table 7: Link between alcohol consumption and cancer by gender and literacy

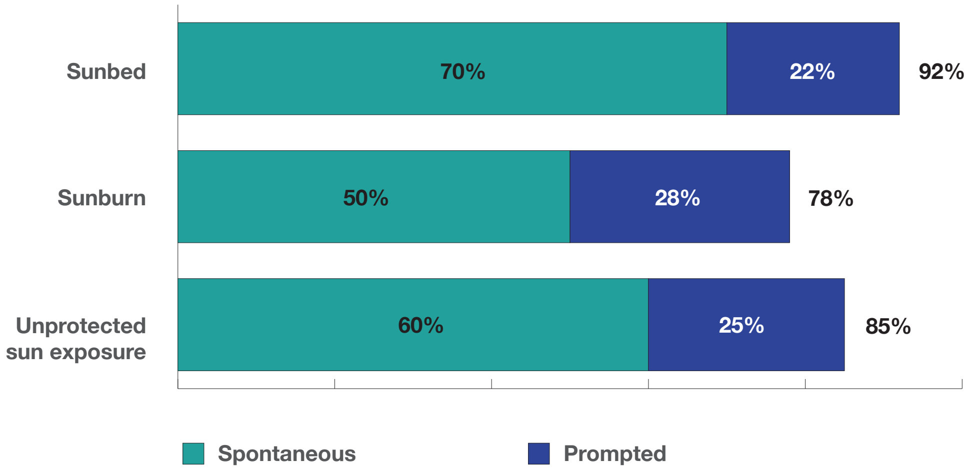
	Gender		Literacy	
Strongly agree/agree with statement	**M**	**F**	**Yes**	**No / DK / Missing**
Drinking alcohol can only cause cancer if you drink a large amount, over a long period of time	39%	44%	39%	47%
Drinking alcohol is only bad for your health if you drink enough to get drunk	27%	29%	30%	26%
It is better for your health to drink a little alcohol than none at all	26%	35%	32%	31%
Drinking alcohol, even now and again, increases the risk of developing cancer	34%	41%	36%	41%

3.5.3 Ultraviolet radiation

In total, 92% cited ultraviolet (UV) radiation from sunbeds as a cancer risk factor. In addition 85% reported unprotected sun exposure and 78% identified getting sunburnt as additional cancer risks factors.

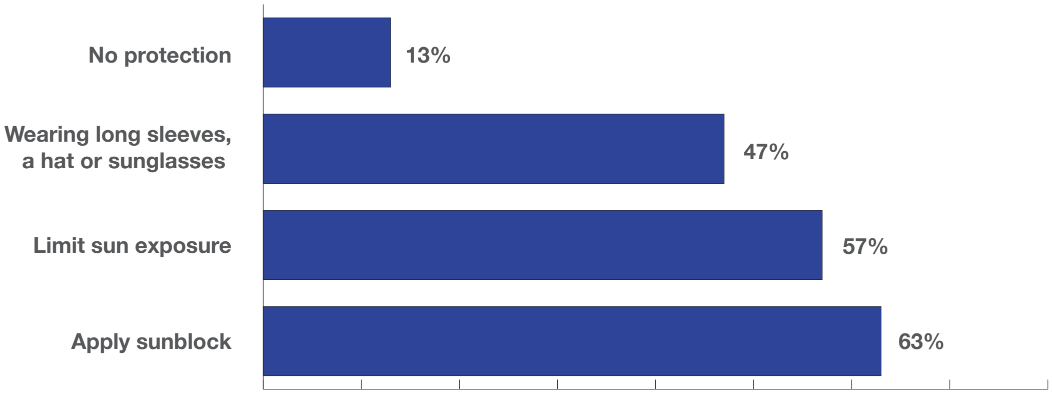
The NSCAA found 87% of respondents mentioned sunbeds as a cancer risk, unprotected sun exposure by 94%, getting sunburnt by 90%.

Figure 21: Awareness of cancer risk associated with ultraviolet radiation exposure



Respondents were asked to identify from a list which, if any, of the types of sun protection methods they use frequently during the summer in Ireland. As shown in Figure 22 the most commonly used measure of sun protection was to apply sunblock (63%), followed by limiting unprotected sun exposure (57%), and wearing long sleeves, a hat or sunglasses (47%). Just 13% reported using no sun protection.

Figure 22: Reported use of sun protection measures in Travellers during summer in Ireland



Sun protection measures by gender and literacy

In terms of gender, the largest disparity is in the use of sun protection measures such as wearing long sleeves, a hat or sunglasses with 51% of females reporting these behaviours, compared to 40% of males (Table 8). Females are also more likely to limit unprotected sun exposure, with 61% reporting this behaviour versus 51% of males. Additionally, more females (65%) use sun protection of at least factor 30 compared to males (58%). Conversely, males were more likely not to use any sun protection measures, with 15% reporting this compared to 13% of females. Individuals with low literacy levels were less likely to take proactive measures to reduce their risk of sun-related cancer.

Table 8: Types of sun protection measures by gender and literacy (% net agree)

	Gender		Literacy	
	M	F	Yes	No / DK / Missing
Limit the time spent in the sun	51%	61%	61%	50%
Wear long sleeves, a hat or sunglasses	40%	51%	51%	41%
Use sunblock of at least factor 30	58%	65%	69%	54%
None of these	15%	13%	11%	15%

Sun protection measures by age

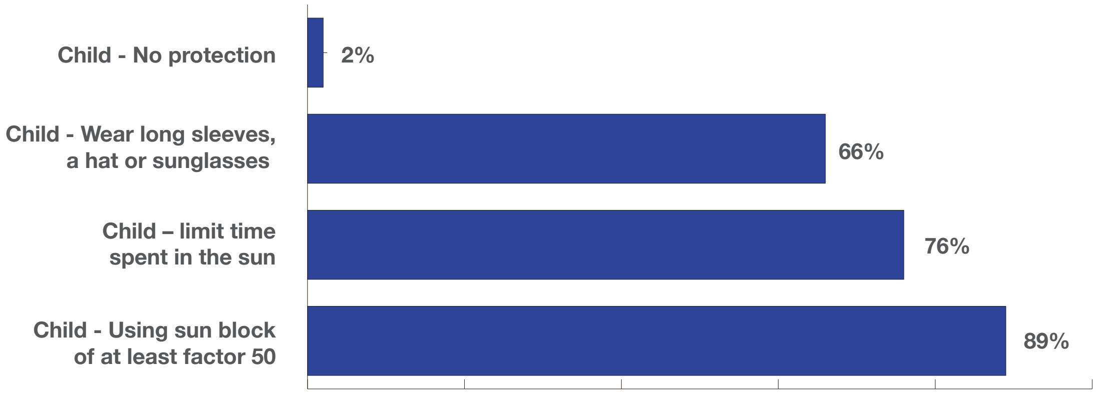
Those in the age group 18-24 were least likely to limit unprotected sun exposure and to wear long sleeves, a hat or sunglasses. They were also the age cohort most likely to use no protection. Use of sunblock is high among those in the age range 25 to 64 years, but lower in the 18–24-year age group and the over 65 age group (Table 9).

Table 9: Types of sun protection methods used by age

	Age group					
	18-24	25-34	35-44	45-54	55-64	65+
Limit the time spent in the sun	49%	57%	57%	68%	57%	59%
Wear long sleeves, a hat or sunglasses	30%	53%	56%	53%	50%	40%
Use sunblock of at least factor 30	53%	70%	69%	81%	50%	49%
None of these	22%	10%	13%	5%	18%	11%

Parents or guardians of children under 12 (n=169) were also asked about the types of sun protection they use for their children during the summer in Ireland (Figure 23). The majority (89%) reported using sunblock of at least factor 50, 76% stated that they would limit their child's time spent in the sun, and 66% ensured their child would wear long sleeves, a hat or sunglasses. Only 2% reported taking no sun protection measures for their children.

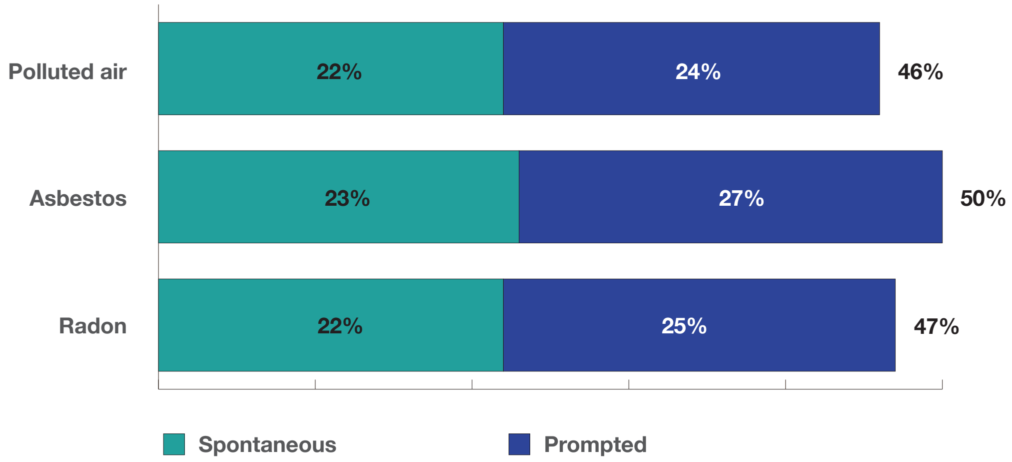
Figure 23: Reported use of sun protection methods in children under 12 years during the summer in Ireland



3.5.4 Environmental and occupational health

Other findings highlight respondents' awareness of environmental and occupational health risk factors (Figure 24). Less than one quarter spontaneously noted the connection between exposure to asbestos, radon or breathing polluted air and risk of cancer. After prompting, approximately a further 25% of respondents identified these environmental factors as risks for cancer.

Figure 24: Awareness of cancer risk associated with environmental or occupational health



3.5.5 Diet, physical activity and overweight

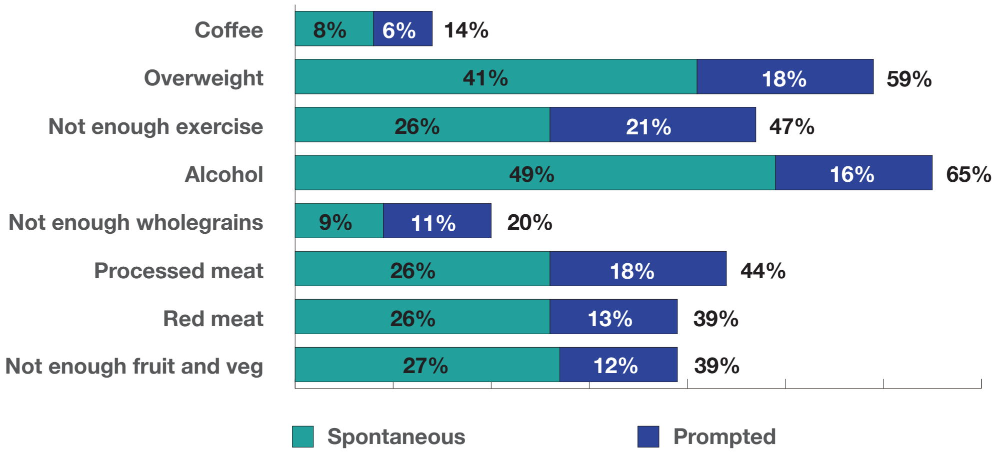
Overall 26% of respondents spontaneously linked lower levels of physical activity with cancer risk.

Similar percentages spontaneously identified processed meat, red meat consumption and inadequate fruit and vegetable intake as risk factors. 9% spontaneously noted the lack of wholegrain consumption as a risk factor for cancer, with an additional 11% identifying this after prompting.

Being overweight was recognised spontaneously by 41% with a further 18% acknowledging it when prompted (Figure 25).

In comparison, the NSCAA found that 25% spontaneously identified body weight and 33% cited physical inactivity as cancer risk factors, with an additional 47% and 39%, respectively, recognising these when prompted.

Figure 25: Awareness of cancer risk associated with diet, physical activity, and overweight

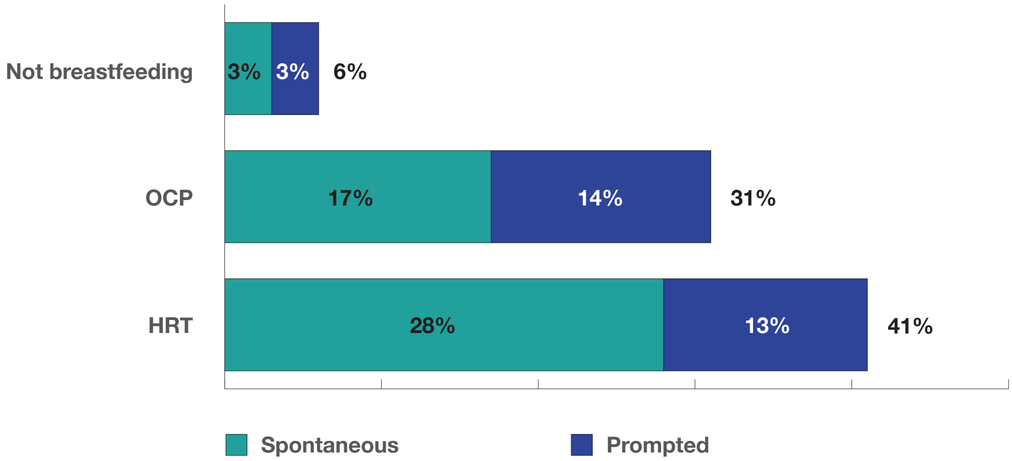


3.5.6 Female health including breastfeeding, OCP, and HRT

28% of respondents spontaneously linked hormone replacement therapy (HRT) with cancer risk, while another 13% agreed after being prompted (Figure 26). Additionally, 17% spontaneously associated taking the oral contraceptive pill (OCP) with cancer risk. Only a small number of respondents, either spontaneously or when prompted, identified not breastfeeding as a cancer risk factor.

The NSCAA found 9% respondents in total recognised not breast feeding as increasing risk of cancer.

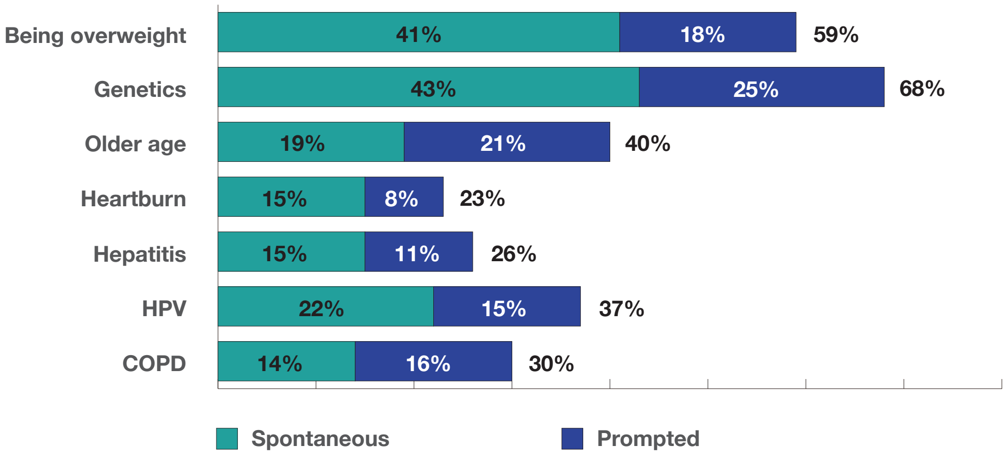
Figure 26: Awareness of cancer risk associated with breastfeeding, OCP, and HRT



3.5.7 Medical conditions and genetic risk factors

Among medical risk factors, genetics was the most frequently mentioned spontaneously as a contributor to cancer risk (Figure 27). A total of 68% of respondents acknowledged its role, with 43% identifying it spontaneously and 25% recognising it when prompted. This was followed by overweight, which was spontaneously identified by 41% as a risk factor for cancer and recognised by a further 18% when prompted. In contrast, only a minority of respondents recognised HPV as a risk factor for cancer, with 22% mentioning it spontaneously, and a further 15% recognising it when prompted. The NSCAA found 47% of respondents were aware of HPV as a cancer risk factor.

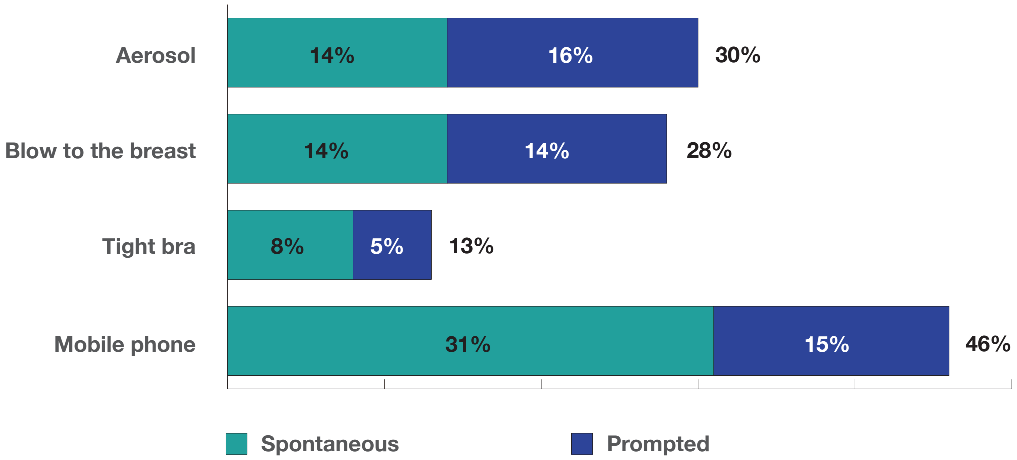
Figure 27: Awareness of risk factors associated with medical health



3.5.8 Factors with no established association with cancer

The proportion of respondents identifying factors with no established association with cancer, such as mobile phone use, aerosol use, a blow to the breast and wearing a tight bra highlight some of the misperceptions around cancer.

Figure 28: Factors with no established association with cancer



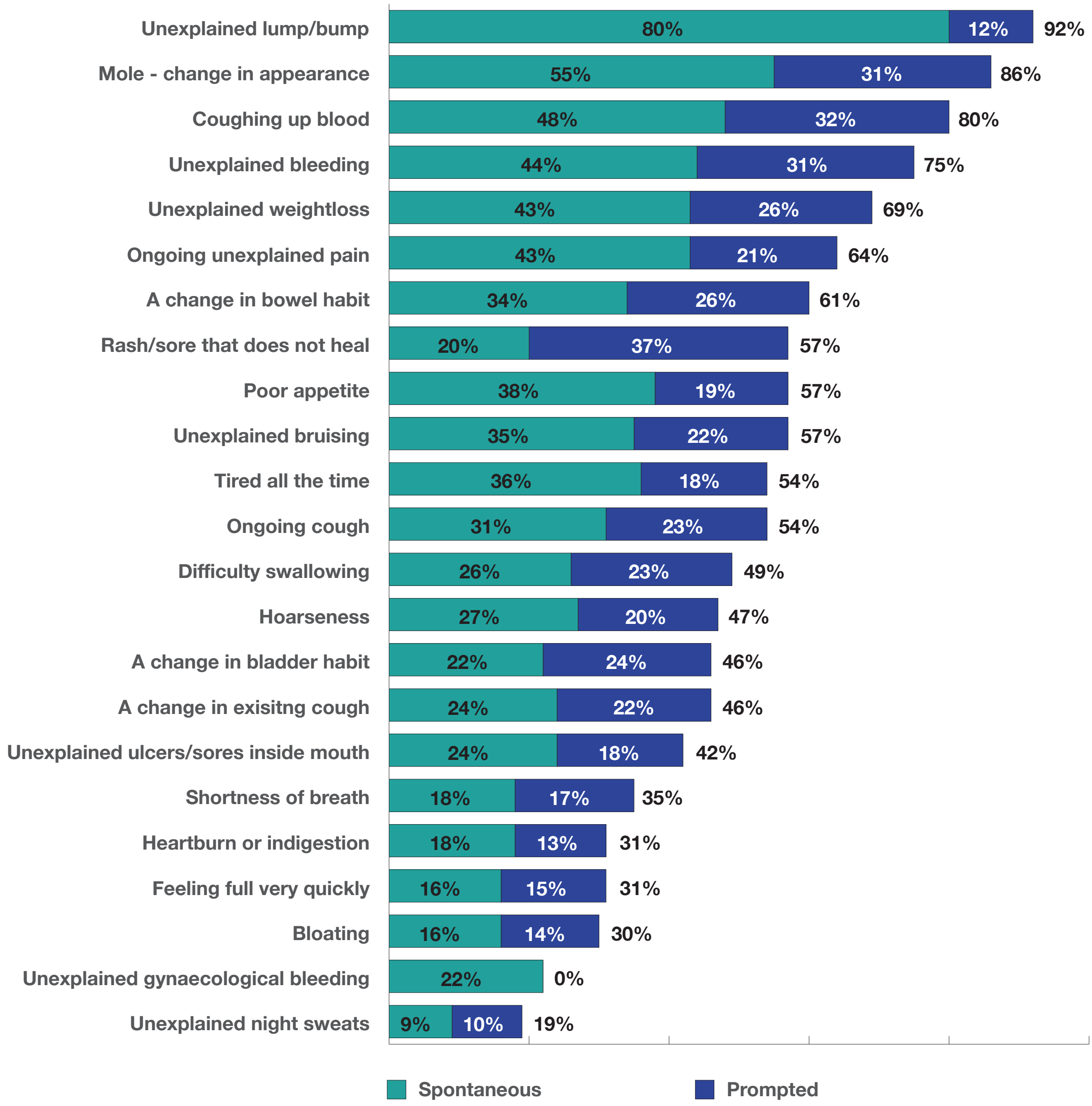
3.6 Awareness and Behaviours Regarding Cancer Signs and Symptoms

3.6.1 Awareness of cancer signs and symptoms

The initial question in this section prompted respondents to recall as many cancer signs and symptoms as they could. They were then provided a list of cancer signs and symptoms and asked whether they thought they could indicate cancer.

Figure 29 demonstrates spontaneous recognition of signs and symptoms is generally low and that most cancer signs are widely recognised when prompted.

Figure 29: Spontaneous and prompted awareness of different cancer signs and symptoms



Spontaneous recognition of signs and symptoms of cancer was highest for an unexplained lump or bump (80%) and change in a mole (55%). These were followed by coughing up blood (48%), unexplained bleeding (44%) and unexplained weight loss (43%) (Figure 29).

In terms of ability to spontaneously identify cancer warning signs and symptoms by gender, females were more likely males in correctly identifying many of the signs and symptoms of cancer (Table 10).

Table 10: Spontaneous awareness of different cancer warning signs and symptoms by gender

	Gender	
	M	F
Unexplained lump/bump	72%	88%
Ongoing unexplained pain	35%	48%
Unexplained bleeding (blood in poo, pee)	38%	49%
Unexplained bruising	28%	40%
Gynaecological bleeding	15%	28%
Ongoing cough	28%	34%
Hoarseness	24%	30%
Poor appetite	32%	41%
Feeling full very quickly	13%	19%
A change in bowel (poo) habit	29%	36%
A change in bladder (urine) habit	19%	24%
Difficulty swallowing	21%	30%
Mole – change in appearance	50%	58%
Rash/sore that does not heal	17%	23%
Unexplained weight loss	38%	47%
Bloating	13%	17%
Coughing up blood	49%	49%
Shortness of breath	16%	20%
Tired all the time	33%	38%
A change in existing cough	24%	24%
Unexplained night sweats	7%	11%
Unexplained ulcers/sores inside mouth	20%	27%
Heartburn or indigestion	14%	20%

Analysis by age revealed that individuals between 25 and 64 were more adept at spontaneously naming several signs or symptoms of cancer (Table 11). There was generally lower awareness of cancer signs and symptoms among younger age groups, with the exception of unexplained lump/bump, ongoing unexplained pain, moles and coughing up blood.

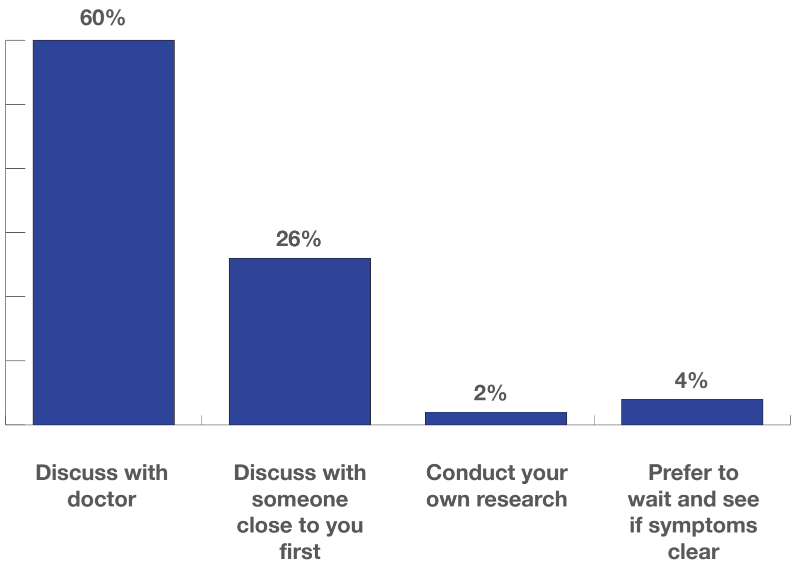
Table 11: Spontaneous awareness of different cancer warning signs and symptoms by age

	Age group					
	18-24 (n=80)	25-34 (n=67)	35-44 (n=75)	45-54 (n=65)	55-64 (n=53)	65+ (n=60)
Unexplained lump/bump	76%	80%	85%	81%	87%	75%
Ongoing unexplained pain	51%	46%	45%	45%	40%	28%
Unexplained bleeding (blood in poo, pee)	37%	46%	51%	50%	47%	37%
Gynaecological bleeding	9%	21%	27%	30%	28%	23%
Unexplained bruising	30%	31%	35%	42%	45%	29%
Ongoing cough	20%	32%	28%	37%	45%	32%
Hoarseness	17%	33%	22%	35%	37%	26%
Poor appetite	30%	31%	43%	40%	53%	33%
Feeling full very quickly	9%	20%	17%	18%	20%	15%
A change in bowel (poo) habit	33%	24%	42%	39%	45%	23%
A change in bladder (urine) habit	21%	24%	23%	21%	31%	15%
Difficulty swallowing	16%	22%	31%	33%	39%	21%
Mole – change in appearance	54%	58%	57%	47%	74%	39%
Rash/sore that does not heal	18%	28%	26%	18%	18%	17%
Unexplained weight loss	41%	41%	49%	35%	51%	44%
Bloating	9%	19%	25%	17%	14%	20%
Coughing up blood	52%	53%	43%	45%	67%	41%
Shortness of breath	21%	20%	20%	20%	20%	7%
Tired all the time	40%	37%	35%	37%	47%	19%
A change in existing cough	18%	28%	22%	31%	29%	13%
Unexplained night sweats	10%	12%	11%	9%	6%	4%
Unexplained ulcers/sores inside mouth	20%	26%	25%	30%	20%	21%
Heartburn or indigestion	9%	14%	21%	24%	20%	21%

3.6.2 Respondents' Behavioural Responses to Signs and Symptoms of Cancer

Respondents were asked what they would do if they noticed a physical sign suggestive of cancer. Figure 30 shows that the majority (60%) reported that they would first discuss it with a doctor, 26% said that they would talk with someone close to them first, 4% would wait to see if the symptoms cleared on their own and 2% reported they would do their own research.

Figure 30: First action taken if noticed a physical sign suggestive of cancer

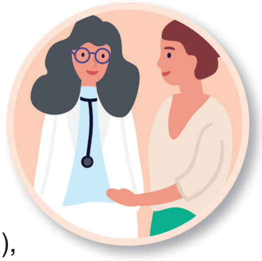


There were no major differences in reported responses to cancer symptoms by gender. A greater proportion of middle-aged respondents reported that they would prioritise discussing the issue with a doctor, while younger people were more likely to discuss it with someone close to them or do their own research (Table 12). Furthermore, there was little variation across age groups regarding those who would wait to see if the symptom clears on its own, although this response is slightly more common among those aged between 35-44 years.

Table 12: First action taken if noticed a physical sign suggestive of cancer by age group

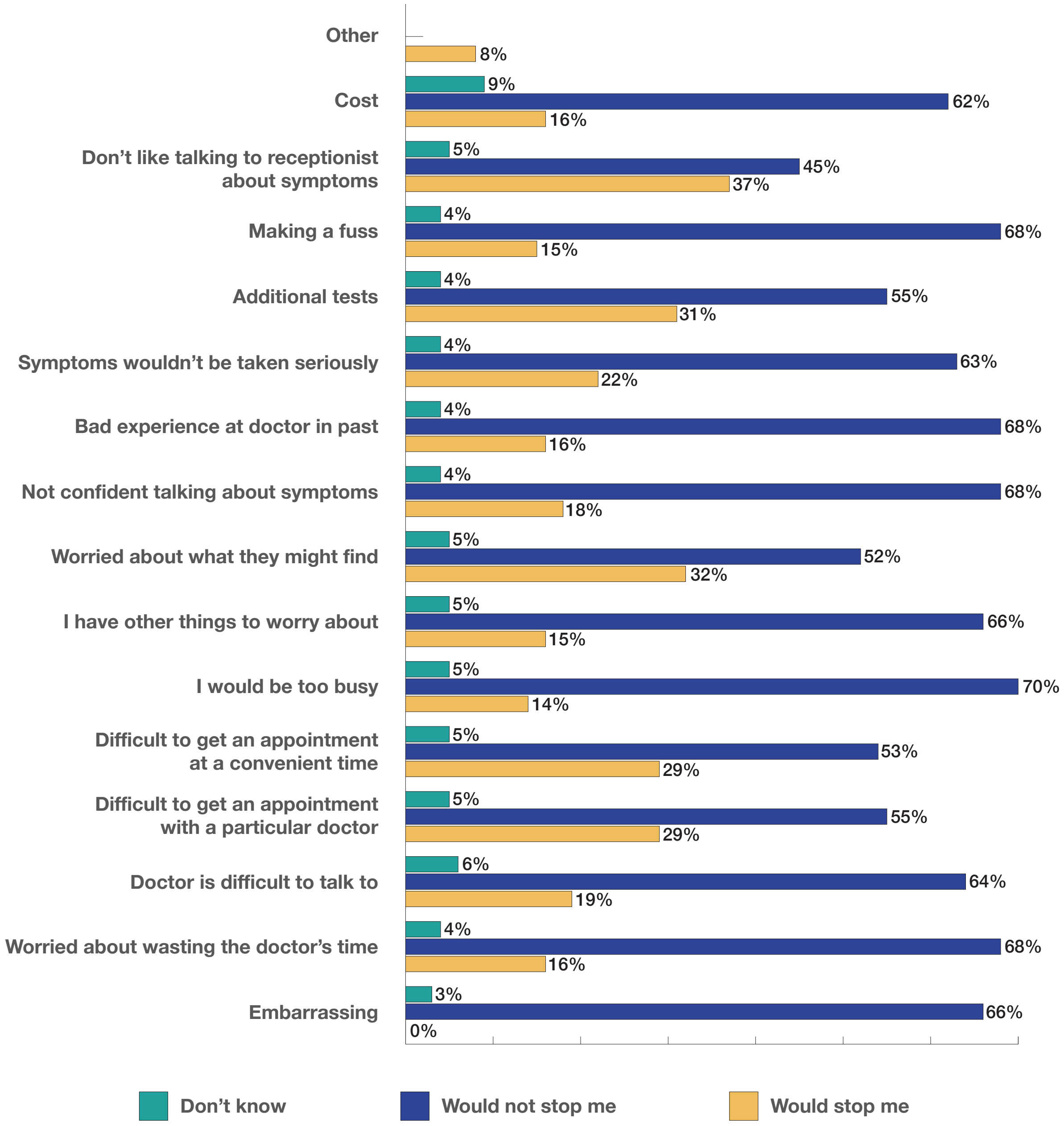
	Age group					
	18-24	25-34	35-44	45-54	55-64	65 +
Discuss with Doctor	44%	66%	61%	72%	69%	59%
Discuss with someone close	39%	22%	24%	20%	22%	23%
Do own research	5%	0%	5%	0%	2%	0%
Wait and see	3%	6%	6%	2%	2%	5%

3.6.3 Attitudes towards, and barriers to, visiting a doctor



The final part of this section examined whether, even if individuals want to attend a GP in response to cancer symptoms, they perceive barriers to doing so. Over a third of respondents indicated that discussing their symptoms with the receptionist (37%), fearing the potential diagnosis (32%) and the possibility of needing additional tests (31%) were deterrents to visiting the doctor.

Figure 31: Barriers to presenting to a doctor with signs or symptoms of cancer



There were few gender differences noted when assessing barriers to attending the GP, although more males reported feeling embarrassed (30%) than females (21%) when discussing symptoms with the doctor.

Table 13: Potential barriers to presentation (% who would be stopped from attending a doctor if noticed a sign or symptom of cancer) by gender

	Gender	
Potential barriers to presentation	**M**	**F**
I find it embarrassing talking to the doctor about symptom(s)	30%	21%
I would be worried about wasting the doctor's time	18%	17%
My doctor is difficult to talk to	18%	20%
I find it difficult to get an appointment with a particular doctor	28%	30%
I find it difficult to get an appointment at a convenient time	30%	29%
I would be too busy to make time to go to the doctor	15%	14%
I have too many other things to worry about	18%	15%
I would be worried about what they might find wrong with me	30%	33%
I wouldn’t feel confident talking about my symptom(s) with the doctor	22%	16%
I’ve had a bad experience at the doctors in the past	14%	18%
I would be worried the doctor wouldn’t take my symptom(s) seriously	21%	23%
I would be worried about what tests they might want to do	32%	30%
I don’t want to be seen as someone who makes a fuss	14%	17%
I don’t like having to talk to the doctor’s receptionist about my symptoms	43%	34%
The cost of attending the doctor	17%	16%

Among respondents aged 18-34 years, barriers to attending a GP were more prevalent. Specifically, nearly half of those aged 18-24 years (44%) expressed reluctance to discuss their symptoms with the doctor’s receptionist as a deterrent to visiting. Other obstacles cited in this age group included concerns about potential diagnoses (38%), apprehensions regarding necessary tests (36%), and difficulty scheduling appointments with a preferred doctor (36%). In contrast, respondents aged over 55 years were least likely to report barriers preventing them from visiting the doctor.

3.7 Screening

The survey included a set of questions aimed at measuring patterns of invitation and attendance at breast screening, cervical screening, and participation in bowel screening programmes.

a. Receipt of invitation and attendance at screening programmes

b. Barriers and enablers to participation in screening programmes

3.7.1 Receipt of Invitation and Attendance at Screening Programmes

Disparities in attendance and participation rates were observed across breast, cervical and bowel screening programmes.

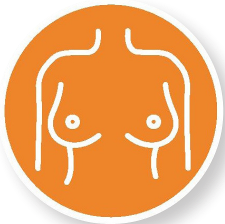
3.7.2 BowelScreen

A very small number of respondents were eligible for BowelScreen (n=36). Just 28% (n=10) of these received an invitation. 60% (n=6) of those who received an invitation participated. An analysis breaking down by gender is not feasible. Table 14 provides percentages of those who received an invite and participated. Nationally, 46.3% of people eligible for BowelScreen participate[15].

Table 14: Bowel screening receipt of invitation and attendance

BowelScreen (Females and males aged 60-69)	%
Invite received	28%
Attended (at least once) of those received invitation	60%

3.7.3 BreastCheck



73 respondents were eligible for BreastCheck. Of these, 86% (n=63) reported receiving invitations for breast screening with the BreastCheck programme. 84% (n=53) of all those who said they received an invitation attended. Nationally, uptake of BreastCheck screening is 70.3%[16].

Table 15: BreastCheck receipt of invitation and attendance

Breastcheck (females aged 50-69) n=73	%
Invite received	86%
Attended (at least once) of those received invitation	84%

3.7.4 CervicalCheck

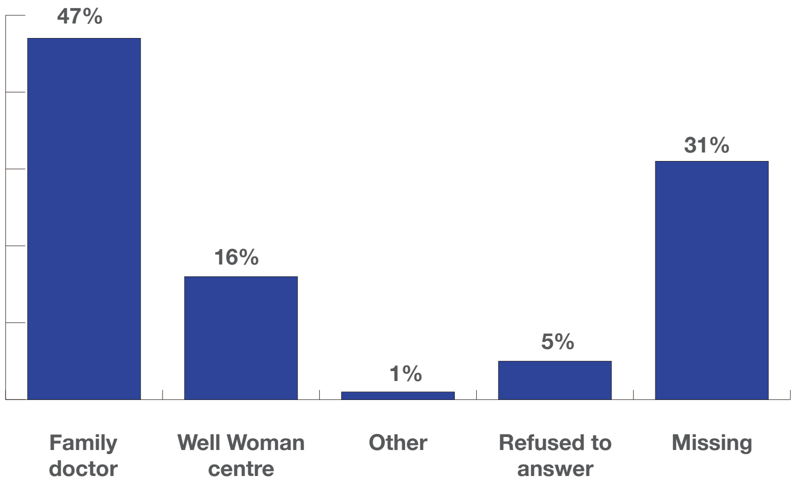
For CervicalCheck, 191 people with a cervix were eligible (aged 25-65 years). 74% (n=141) of the eligible population received an invite. Of those who said they received an invitation 88% (n=125) had attended at least once. Nationally, 75% of the eligible population participate in CervicalCheck screening[17].

Table 16: CervicalCheck receipt of invitation and attendance

CervicalCheck (females aged 25-64) n=191	%
Invite received	74%
Attended (at least once) of those received invitation	88%

Of those who had ever attended CervicalCheck 47% attended their family doctor, followed by 16% who visited a Well Woman centre.

Figure 32: Location of cervical screening for women aged 25-65 years.



3.7.5 Barriers and enablers to participation in screening programmes

As illustrated in Table 17, the primary barrier was embarrassment (21%), followed by fear of results (19%) and not receiving an invitation by mail (18%). The least reported barrier was lack of access to a doctor for cervical screening (4%).

Table 17: Barriers to Attendance at Cancer Screening Programmes

Barrier	%
Lack of time	9%
Feelings of embarrassment	21%
Fear of results	19%
Inconvenience (distance from screening centre)	5%
Lack of access to doctor (cervical screening)	4%
Didn't receive any invitations in the post	18%
I don't receive any post to my home	4%
Other	1%

The key enablers to screening participation were, speaking with the local Traveller Primary Health Care Worker (28%), receiving an invitation (27%) and discussing with the GP (18%) (Table 18). TV, radio, newspapers, and social media platforms, were noted to be the least effective enablers.

Table 18: Enablers to Attendance at Cancer Screening Programmes

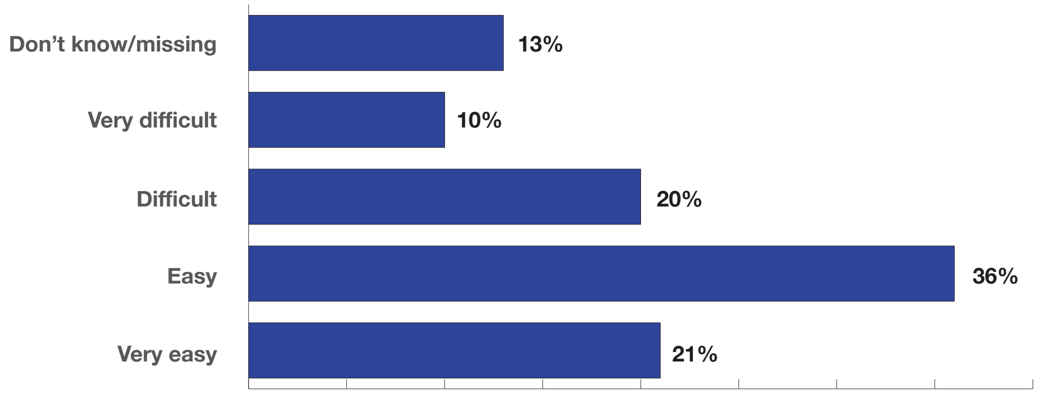
Enabler	%
Talking to the local Traveller Primary Health Care Worker	28%
Receiving an invitation	27%
Talking to my family doctor	18%
Talking to the public health nurse	9%
Heard from someone who had a test	6%
Information on media (TV, radio, papers)	3%
Information on social media	3%
Other	1%

3.8 Socioeconomic Data

This section of the survey aimed to determine social determinants of health that can affect respondents' awareness and access to cancer services.

3.8.1 Literacy

Figure 33: How easy or difficult would you say it is to understand the instruction leaflets that come with medicines?



3.8.2 Facilities

Figure 34: Direct or indirect postal delivery

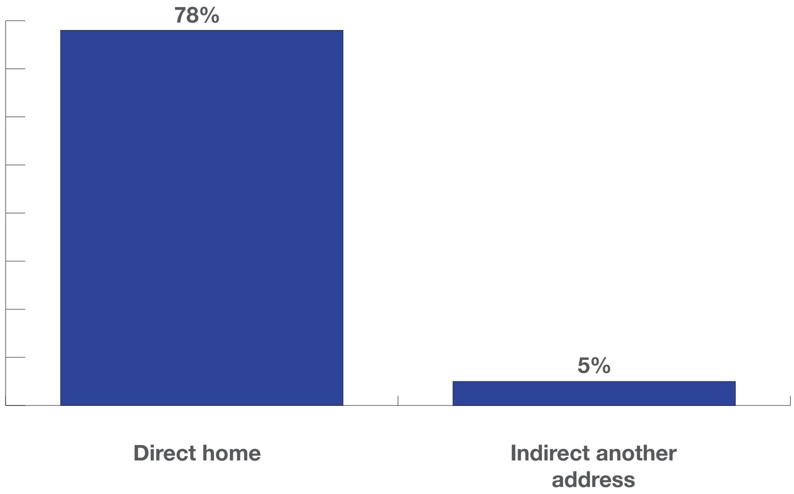


Figure 35: Access to toilet

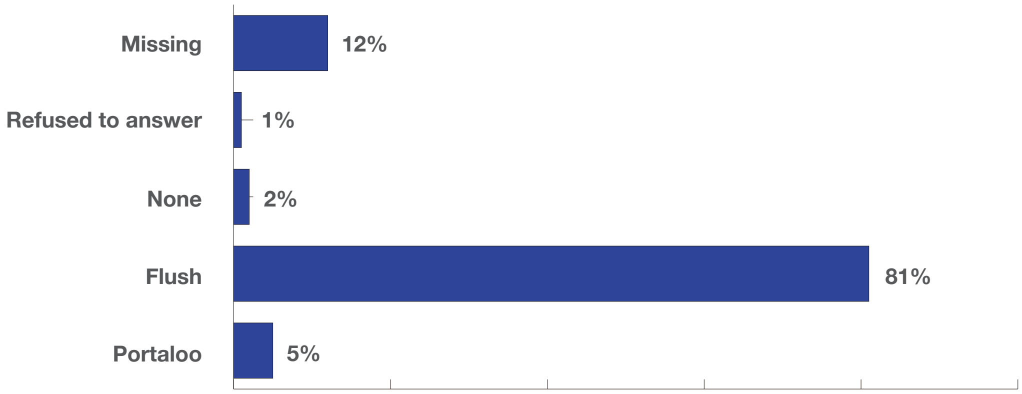
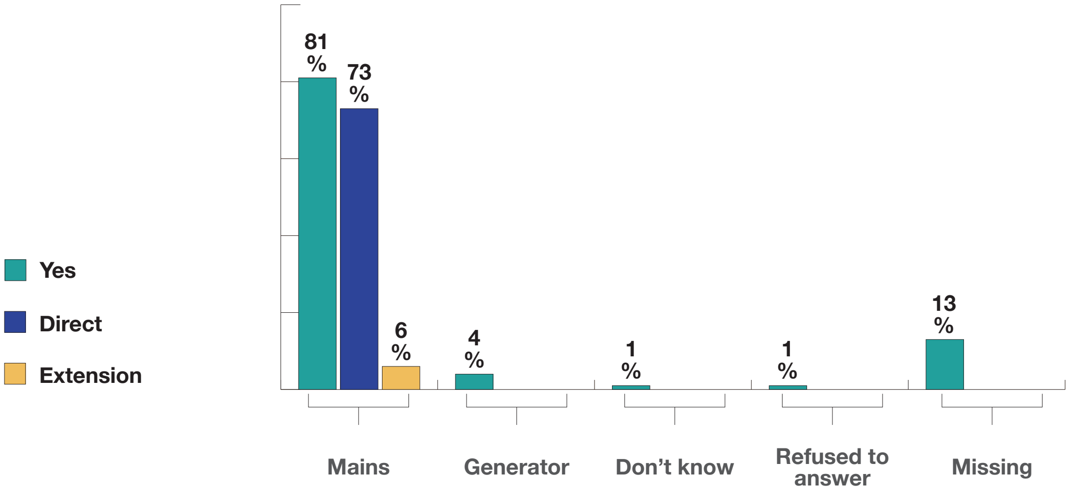


Figure 36: Type of electricity supply



4. Summary of key findings – Qualitative interviews with Travellers

Travellers are a diverse community with a unique culture. Many participants in this study expressed pride in being Travellers and a clear sense of belonging to something bigger, a family that extended beyond their immediate family members. Participants described how much they loved being Travellers and the significance they placed on their traditions.

This section presents the findings of qualitative interviews undertaken with Travellers to assess health-seeking behaviour and the factors that impact this, including barriers and enablers to accessing health services and engagement in cancer prevention/risk-reducing behaviours. A summary of the overarching themes and subthemes are outlined in Figure 37 below:

Figure 37: Summary of overarching themes generated from interviews with Traveller Community

Theme 1: Life is hard enough: This theme describes the challenges experienced in the everyday lives of Travellers and how this impacts their cancer awareness, cancer prevention and personal behaviours.

Subthemes:

1. Societal judgement, racism and discrimination
2. Competing demands to get through a day
3. Capabilities and motivation

Theme 2: Culture and cultural norms: This theme outlines the impact of Traveller culture and cultural norms on cancer awareness and cancer prevention in the community. Travellers are a diverse community with many beliefs and traditions that must be recognised and respected. Cancer care is generally affected by certain cultural factors that influence how Travellers experience diseases and seek and use health care services in the community and hospital.

Subthemes:

1. We are a diverse population
2. Fear and fatalism
3. Religiosity and privacy

Theme 3: Systems-level barriers in healthcare, cancer prevention and management: This theme illustrates the impact of structural barriers that crosscut the very existence of Travellers' lives and the adverse effects of living conditions, education and literacy levels on engaging with health services and personal living and working conditions and of racism and discrimination through whole-of-life interactions.

Subthemes:

1. Gender
2. Fragmented, delayed and rushed health services
3. Impact of the gatekeeper on access
4. Communication
5. The living, social and economic conditions

Theme 4: Achieving self-determination in healthcare, cancer prevention and management. This final theme presents enabling factors that exist to support cancer awareness, prevention and healthy lifestyles using a strengths-based lens to foreground best practices.

Subthemes:

1. Building on existing strengths
2. Further develop Traveller existing systems, supports and programmes
3. Co-designing anti-racism training and education programmes

4.1 Study participants

In total, 22 members of the Traveller Community participated in this arm of the study; 16 females and 6 males (Table 19). A majority (n=18) of participants worked in Traveller organisations. The majority of participants were female (n=16) and aged 28 to 50 years (n=15, 68%). Demographics of participants are outlined in Table 19.

Table 19: Demographic Characteristics

	Total (n)
Age	
28 to 50 years	15
Over 50 years	7
Location (County)	
Dublin	7
Longford, Meath, Limerick, Cork, Sligo	15
Total	22

4.2 Findings

4.2.1 Theme 1: Life is hard enough

This theme describes the challenges experienced by Travellers in their everyday lives, and how these impact their cancer awareness and lifestyle behaviours. Although many Travellers indicated personal awareness of cancer symptoms and screening programmes, they experience challenges in their daily lives that adversely impact their health behaviours and health outcomes. These challenges are underpinned by racism and discrimination.

This theme has three subthemes (1) Societal judgement, racism and discrimination, (2) Competing demands to get through a day (3) Capabilities and motivation.

1) Societal judgement, racism and discrimination

Participants detail the experiences and difficulties that occur in their day-to-day lives and across their life span. These challenges are underpinned by racism and discrimination, commencing in childhood and continuing through whole-of-life. Travellers describe systemic and individual experiences of racism and discrimination in various settings, including when accessing health care services and in interactions with individual health care professionals.

> "I can go into a hospital or go into an environment where there is doctors or nurses or whatever, like in a GP if my own local doctor is not there. It could be another doctor, and they look at you as if you're just someone that you're after coming in off the street. I just find that some people just look at us as if we're dirt; we're nobody. What's the point coming in, you're going to die anyhow. I just get that, me personally." (Participant 5).

> …but I also think there's an issue maybe around, you know, the fear of, you know, being discriminated against by the doctors, by the staff in the surgery. So I think it's, yeah, I think it's a fear of discrimination at one level (Participant 2)

2) Competing demands to get through a day

Social determinants of health (SDoH) impact everyday life for Travellers. The added demands of day-to-day life as a Traveller lead to reduced focus on self-care, and prioritisation of the family's welfare. This is especially the case for Traveller females who may place less emphasis on their own health and wellbeing, and focus instead on children and family. Participants suggested that because Traveller females prioritise family first, their ability to attend their own appointments is limited. Due to the need to manage childcare, school collection times and other caring roles, the date and time of appointments may be unworkable for them. These factors, including, in some cases, inability to drive, impact their ability to prioritise their health.

> "…You just put it off like that. And a lot of Traveller women, I think women in general they put themselves last, they put like the family would be first or the children would be first ... Like if the appointment just say was at 2 o'clock and they'd to collect their children at 2 o'clock, well then they wouldn't go to the appointment." (Participant 6).

SDoH - specifically sub-standard housing and lack of basic amenities- are cited as increasing personal stress, downgrading self-care, and focusing attention on others. Individual behaviours can also be explained by affordability, arising from persistent poverty, a consequence of reduced employment opportunities, lower educational attainment, and experiences of racism and stigma.

> “So I think there are environmental factors as well and financial factors. And I think also discrimination and racism, you know, I think you know, contribute to ill health in many …”(Participant 2)

Participants shared real-world personal examples of the daily consequences of current living on their mental health and wellbeing. They described the reality of Travellers experiencing poverty and having to choose between heating a home or buying food. If another issue arises [medical or otherwise], they are in ‘survival mode’.

> “We can say housing, but the poor housing, poor accommodation, contributes to so many factors and the result of their health.” (Participant 21)

Participants noted that females often bear the burden of care within the family, such as encouraging males to seek medical advice and participate in cancer screening programmes.

> “… the women has to do it all for them, do you know make their appointment and try and get them to it. Because they (Traveller males) don’t want to go to the doctors..”. (Participant 7).

3) Capabilities and motivation

Participants described the factors that impact the capability and motivation of Travellers to engage in cancer prevention behaviours and report potential cancer symptoms. Fundamentally, participants felt that difficulties in this area were a consequence of discrimination in everyday life, that growing up while experiencing whole-life judgement, racism, and discrimination erodes personal capacity, capabilities, and motivation. For some, living with persistent negative external experiences manifests in their personal choices.

Understanding the context in which Travellers live helps to explain their capabilities, motivations, and opportunities.

> “…. a lot of discrimination regarding Travellers, regarding any minority person or community. But look at the accommodation, look at our social, look at their employment, around their mental health. And mental health can affect their physical health…. We would work an awful lot around the terms of health, like your employment, your education, your accommodation, your social outlets. All of that plays a part on physical and mental health. And until that improves Travellers’ health is not improving.” (Participant 16).

Specific examples of factors that impact capability and motivation included the source of health information, and literacy skills. Literacy, whether personal or within a family, is an enabler of individual cancer awareness and prevention.

> “…unfortunately, there are many other Travellers out there who cannot read and write very well. So a lot of the material is not very accessible” (Participant 2).

> “…there is still young Travellers that actually cannot read because of the education system…they would have sent to school, but they were left probably at the back of the class. I know young girls now can barely read and write in 2023; I’m talking about young girls. So that can be an issue sometimes for Traveller families.” (Participant 3).

Literacy challenges were especially acknowledged for older Travellers.

> "…for the older Travellers, 50 plus, it certainly is an issue. The lack of literacy and being able to, not just being able to read and understand the instructions on medication but when you actually see a doctor or a health care professional there's also a barrier there that they may not necessarily understand their language, their vocabulary" (Participant 2)

Similarly, awareness may be higher for Travellers with increased education and higher literacy skills while poor education and literacy skills impeded cancer prevention and early diagnosis.

> "I don't think the Travellers is aware, I'm aware of screening tests but there's a lot of the Travellers is not, not aware of it. No awareness of it; again, as I said, it has to go out there again. More education out there. It's all coming back to education the whole time." (Participant 15).

4.2.2 Theme 2: Culture and cultural norms

This theme outlines the impact of Traveller culture and cultural norms on cancer awareness and cancer prevention in the community. Travellers are a diverse Community with many beliefs and traditions, and cancer care may be affected by cultural factors that influence how Travellers experience disease and seek and use health care services in the community and hospital. This theme has three sub-themes (1) We are a diverse population and not a label (2) Fear and fatalism (3) Religiosity and privacy

1) We are a diverse population

Travellers are not an homogenous population, and individual skills, knowledge, and cancer awareness vary.

> Again I think it's a generational issue….I see a lot of the younger Travellers actually taking better care of themselves. And you know don't smoke, don't drink, exercise, go to gyms, walk, cycle. So yeah, there is a generation issue; I think the younger generation are much, much more health conscious than the older ones. (Participant 2).

> it depends on the person, the person might find it easier to talk to their doctor. Or they might find it easier to talk to the primary health care workers, depends on the person their selves, do you know. (Participant 11).

2) Fear and fatalism

Participants suggested that Travellers often don't want to engage with cancer healthcare services due to fear and fatalistic attitudes toward cancer. Travellers believe that events in life are predetermined and inevitable. There is a widely held belief that health and illness are 'given' to you, that you are born with it, and therefore, Travellers have no control over their lives and destiny, including a cancer diagnosis. This perpetuates a feeling that one has no control over one's life and the inevitability is only 'death'. Often, this fatalistic culture and fear may prevent engagement with health promotion and early cancer prevention. Participants suggest the word cancer itself inspires personal fear and can deter people from seeking an early diagnosis.

> People believe that you are born with it, and it only takes some kind of thing for it to come out. (Participant 20).

> "You see some people find a lump or they find something that's not right with them, they think of death straight away, they think it's a waste going to the doctor". (Participant 10).

> "Some Travellers out there that won't even say the word cancer. Because they are afraid of what it might bring and what it might implement. It's terrifying." (Participant 18).

3) Religiosity and privacy

Personal privacy is essential to Travellers. Challenges can arise when attending GP appointments due to multiple Travellers registering with the same GP within a locality. This is often not a choice, but a consequence based on a lack of access and options due to discrimination. When a GP is trusted and known to be welcoming to Travellers, many Travellers will register with their practice. Potentially, this can impact privacy when attending appointments.

> "Travellers, in general, are very private about their health." (Traveller 6).

> "There's too many Travellers for the one doctor. Because they can't get no one else so one doctor takes a lot of Travellers on. But sometimes a lot of Travellers want a bit of privacy or whatever. So some Travellers are afraid sometimes that this doctor is going to discuss your problems with them or if the receptionist at the desk is talking on the phone, you're kind of afraid to talk to her because there might be someone in the waiting room… a lot of people want to be kept private or do private stuff, but unfortunately, you can't when you can't get many doctors out there that will take Travellers on" (Participant 1).

Religion plays a role in Traveller culture and Traveller response to cancer and cancer symptoms.

> "A lot of the Travellers and especially the older Travellers when they find out about cancer, that they have cancer or that a member of the family has cancer, they do, they turn down the religious road. They go to all these pilgrims, and they could be a different country, Medjugorje or Lourdes, all of these places. They go to all the priests around the country, they'll go to all these places and to me this is burying their heads in the sand" (Participant 7).

4.2.3 Theme 3: Systems- level barriers in healthcare, cancer prevention and management

This theme outlines the system-level barriers that cross-cut Travellers' lives, such as racism, discrimination, poor living conditions and low levels of literacy. These barriers have an adverse impact on their health, and their engagement with health services. Participants highlight that despite wanting to report cancer symptoms, the journey into mainstream services is difficult for Travellers due to inherent system factors and the adverse day-to-day life challenges faced by Travellers.

Participants explained the impact of the two-tier system within Irish healthcare services and how access is improved with the ability to pay. The multiplicative effects often result in a personal coping mechanism [default] of withdrawal from services: 'it's not worth the hassle'. This theme has five sub-themes: (1) Gender (2) Fragmented, delayed and rushed health services (3) Impact of the gatekeeper on access (4) Communication (5) The living, social and economic conditions

1) Gender

The impact of gender is evident. Fear causes Travellers to use euphemisms such as ‘women’s problems’ rather than mention the word ‘cancer’ as it can invoke painful memories of family members who have had cancer or died.

> “If a woman had cancer there, she wouldn’t tell it. The Traveller woman wouldn’t tell it because they’d be too embarrassed for to tell it. So, like a Traveller woman went to hospital, she was a friend of my daughters, she was a very young woman, and she had all this; she had to get her womb and get everything taken away. But when anybody said to her like is it cancer, no it’s women’s problems, when actually it was cancer” (Participant 7).

> “Traveller women would tend to want a female health people to do the test on them rather than having males to do them. So you know just to be aware of all that, be aware of the culture regarding that and be aware of the literacy definitely.” (Participant 16).

Males were identified as being particularly reluctant to acknowledge symptoms or seek health information.

> “Traveller men they’re hard, even to go to a doctor. You have to keep shoving them to get their bloods taken and all that. They’re hard work at times they are.” (Participants 12 and 13).

> “Men when we talk about all the different types of cancer screening there is for men, some of them won’t go because it’s in relation to an intimate level of themselves. They won’t do it. And it’s only then when they get very, men of a certain age get aches and pains because the prostate they go then at that stage. But even at that, the wife or the girlfriend or whoever nearly has to bring them in. Because they don’t want to go, they do need to go, but they don’t want to go. (Participant 21).

2) Fragmentised, delayed and rushed health services

Difficulties in mainstream services and systems, specific and structural, contribute to reduced awareness and knowledge of cancer and prevention within the Traveller community. Many Travellers do not have the expertise to navigate the health system alone and to request alternative appointments. Participants described postal and appointment delays and noted that many Travellers are unaware that non-attendance could result in removal from an appointment system or waiting list. Travellers are unaware of the limitations inherent in current mainstream services and require education to enhance their participation. Participants also highlighted the challenges posed by Ireland’s two-tier healthcare system, where those unable to afford private care may face delays in accessing care.

> “But then you might have a doctor that just wants you out faster……Just rush. Rush you… That you’re in there for maybe a minute or two and they just want you in and out fast. You tell them your symptoms, and they just can’t wait to get you out. So I think a doctor should give that Traveller person more time. Because over the lack of education, they have. And do clearer words for them. Give them a better understanding.” (Participants 12, 13).

> And it's hard to get appointments, as before you could walk into your doctor and you would be seen as soon as they could, like. But now it's all appointments. And I think that's really impacting on the Travellers health. And then when they can't get an appointment, they say they won't bother doing it. (Participants 12, 13).

> A person who couldn't afford to go privately could be dead within the frame of time it takes to see the doctor or it could progress to a stage where it's no longer you know you might find it at a stage where it could be treatable but because you can't get an appointment with the doctor until a certain time, that person could be signing their death warrant because they haven't got the money to go private. I think they are the things that need to be prioritised because they are life threatening rather than sitting and waiting, sitting and waiting because of money. It shouldn't be a case that you can't afford to live. (Participant 18).

3) Impact of the gatekeeper on access

Travellers expressed a dislike of disclosing health problems that are 'a private matter' in a public way. This can affect their decision-making about whether to attend their GP or not. For example, Travellers do not wish to discuss their problems either on the phone or in person with non-clinical personnel [receptionists/secretaries]."

> "I'm just annoyed by that; when you go to make an appointment, and they say to you, well, what's the problem. And you say I want to tell my problem to the doctor, not you. So how can you tell your problems, especially private problems, to a secretary, not the doctor. So you have to tell the secretary to get through to the doctor". (Participant 15).

> You'd have a fight to get past the receptionist because they tell you they wouldn't let you make an appointment. The doctor, we're not taking on no new patients. But this would be without asking a doctor or something like that. So we put it down to because we were Travellers. The doctors themselves, some of them wouldn't take on Travellers. It has improved a bit but not much. (Participant 7).

4) Communication

Participants highlighted situations when information is provided in ways that are culturally inappropriate for Travellers, information remaining inaccessible to Travellers due to the method of communication used (e.g. in writing/medical jargon). Due to low literacy, Travellers may miss medical appointments, for example, because they are unaware of the information in the letter. There are additional challenges in receiving mail.

> "…. They're coming out no wiser like. Because, like, they could go to a doctor and they come out a lot worse because they've been given all those big wordings and things. And names and things. ….. So maybe some doctors wouldn't, you might have a doctor who might have a great time for a person and explain everything properly". (Participant 12 &13)

> "...there is not a lot of information there like with leaflets it's not Traveller appropriate, it's not how important it is to a Traveller to look after their own health." (Participant 5).

5) The living, social and economic conditions

Finally, participants reinforced the impact of day-to-day living conditions that adversely impact Travellers' health, cancer awareness and prevention. The reality of daily living cannot be overstated, and it is evident that although cancer awareness and prevention are important to Travellers, their social and economic conditions limit their capacity to engage. Specific examples included transport and postal delivery.

> "…A lot of sites where Travellers live, there's no real public transport, so if you're not driving you're kind of, you're in a bit of trouble there because you probably have to walk to the doctors sometimes and then you're kind of saying to yourself look it's not worth the hassle. I won't even bother going to the appointment today."(Participant 1).

Difficulties receiving mail have significant repercussions for Travellers. Current cancer screening services include posting test kits to home addresses, which is a substantial barrier for many Travellers.

> "You mightn't get the post for weeks and then, or you mightn't get the post for a few days, and then when you do get it, you realise that you've missed an appointment. So that's another struggle that we have, that Travellers have…"(Participant 1)

> "…because if you are in like an unofficial halting site or an unofficial camp not getting maybe any mail. If you are in a site maybe that's overcrowded, all your letters could be thrown into one area,"(Participant 16).

> "…Yeah, the facilities, the Traveller accommodation for someone that's living in it, they wouldn't have gas, or they wouldn't have, the electricity is gone, and so again this all goes back to the easy option where we'll go and get takeaway food. But they can't cook meals because the accommodation, they haven't got the facilities to do it". (Participant 1).

> "…you have the caravan, and it's a torpedo of gas which is a hundred euros every two weeks to heat because it's only tin" (Participant 21).

4.2.4 Theme 4: Achieving self-determination in healthcare, cancer prevention and management

Travellers are motivated to engage with health services despite the challenges caused by social determinants of health. This final theme presents enabling factors that exist to support cancer awareness, prevention and healthy lifestyle behaviours using a strengths-based lens to foreground best practices. Many developments are Traveller-led and situated within Traveller Health Projects. This theme has three sub-themes (1) Building on existing strengths, (2) Further develop Traveller existing systems, supports and programmes, (3) Co-designing anti-racism training and education programmes

1) Building on existing strengths

Participants described opportunities to enhance health services to promote cancer screening and awareness. The role of the Traveller Primary Healthcare Worker was highlighted as particularly impactful and beneficial in providing information to enable them to speak up and chat in a variety of ways to embed health information.

Travellers also highlighted opportunities to enhance health that extend outside of health services. Examples of such opportunities include initiatives already underway within the context of sports activities, and initiatives using informal chats and conversations. These examples illuminate the Traveller Community's innovative strengths and highlight further opportunities for development.

> "We have a lot of Primary Health Care workers that work with Traveller families out in the local areas. And I would get the information from them. But also probably from my sports clubs or if I'm involved in sport. I get it from my trainers or whatever about healthy living, healthy eating, all that kind of stuff". (Participant 1).

Participants described the positive impact of Traveller Primary Health Care project workers who are drawing on local strengths to collaborate and communicate with their community.

> "…the Primary Health Care workers really do fantastic work in producing information and material and resources that is very easy to understand and very accessible. And I think that's really important." (Participant 2)

Participants highlighted the positive engagement with charities, including the Marie Keating Foundation and the Irish Cancer Society, in supporting cancer awareness in Travellers.

> "… the Irish Cancer Society, the Marie Keating Foundation, I think they're doing a lot of work, but I think they should be doing more, working with the Primary Health Care workers to come out on site maybe and work with Travellers directly and give them that information. Now, what the Primary Health Care workers are doing, they're doing a lot of that stuff, but I think more needs to be done." (Participant 1)

2) Further develop Traveller existing systems, supports and programmes

Participants described positive impacts from engagement with health care professionals, specifically public health nurses who engaged with Travellers directly and with Traveller Health Projects. However, there are opportunities to embed the Traveller Health Project activities further.

> "..the older generation, if you like, they will tell you that most of their information actually comes directly from Traveller organisations. Not from mass media, not from the health care sector, but from Traveller organisations, you know, producing, as I said earlier on, very accessible, easy to read, easy to understand material around health issues" (Participant 2).

> "… the Primary Health Care Workers have a very important role; they go out to the homes and advise people of all different things, like healthy eating, smoking groups, non-smoking groups and all that, advising people that wouldn't get out. They actually go to their homes and tell them about it….. sometimes, the Primary Health Care Workers here call out to the homes, and they invite people for breast checks and screening and all that." (Participant 11).

The role of PHCW in breaking down communication barriers was evident. Several examples were cited where Traveller PHCW were accessed by members of the Traveller Community to help bridge the gap to healthcare.

> "And since the men's worker has come on board it's just brilliant because you see more engagement from men. It's just fantastic." (Participant 3).

> "So we were liaising; we were the middleman, between the Traveller and the GP that time as well. Because we done a lot of stuff with GPs because there was only, there was only three GPs in X at that time who would take on Travellers." (Participant 8).

3) Co-designing anti-racism training and education programmes

Once again, the role of the PHCW, and their expertise in developing resources is valued by Travellers. Their awareness of racism, literacy, and endemic challenges within their community are strengths that can help them build resources.

Participants described positive and valued interactions with health care professionals who were invited to meetings with Travellers locally as part of a project activity – a local setting was not intimidating for Travellers.

The creation of safe spaces, both in terms of gender of HCP [depending on the topic being discussed], and provision of information within Traveller health projects was considered important and beneficial, further highlighting the need for a targeted, Traveller-centered approach.

> "…we don't get our health information from nowhere, doctors that's the only place. But without that we gets no health… Primary Health Care [workers] will give us information, we look for information Primary Health Care will give it to you. But there, again, there's a lack on that as well. There should be more open out with information, especially with Travelling Community. Some have no education, more has, so the ones with no education it's hard for them, it's very hard for them." (Participant 15).

> "… Like in the kind of leaflets we would build up. Like we would make sure that they'd understand what would be on it. So, in other words, understanding as well can be a big thing for Travellers when it comes to certain things like….. I think it could yea, have some kind of workshops or something on those awareness. Would help bring awareness there to people" (Participants 12, 13).

> ….. A lot of the older Travellers wouldn't, a visual sometimes that they can see is very good. A lot of them wouldn't, we'll say, be able to read maybe certain stuff. So we keep the language very plain and simple. For the older generation and I suppose again it's running little workshops, it's getting them involved in a chat. And I suppose the way how you plan a thing. If you say we're doing training on this, straight away, oh, I'm not going to that, because you're worried you're signing up for something. We don't want to sign them up. We need to ease them into it. So it's a workshop but it's the chats; it's more informal, does that makes sense. And that's what this is all about, it's not going into a massive building where there's fear. So having hubs within different areas all over the country to make that investment. So we have the workers coming in where they feel safe. Like Traveller organisations, specific Traveller organisations in all the different areas. We don't have a specific Traveller organisation here in [xx] for instance. (Participant 3).

5. Summary of key findings – Qualitative interviews with healthcare professionals

This section presents the findings of the qualitative interviews undertaken with healthcare professionals (HCPs) to explore their perceptions regarding the barriers and enablers for Travellers concerning healthy lifestyle behaviours, cancer screening participation, and timely reporting of cancer symptoms.

A summary of the overarching themes generated by this interview process is shown in Figure 38 below.

Figure 38: Summary of overarching themes generated from interviews with healthcare professionals

Theme 1: Social Determinants of Health (SDoH): SDoH impact lifestyle behaviours, cancer prevention, screening, and timely reporting of cancer signs or symptoms for Travellers particularly for those living on halting sites.

Subthemes:

1. Discrimination and racism.
2. Sub-standard accommodation, overcrowding, and poor environmental conditions.
3. Poverty, unemployment and poor education.

Theme 2: Health system barriers: Health system barriers include challenges related to accessing health services and lack of cultural appropriateness within the health system

1. Challenges in accessing health services
2. Lack of cultural senstivity, and discrimination within the health system

Theme 3: Individual and/or cultural barriers: Individual and/or cultural barriers impact cancer prevention, screening, and timely reporting of cancer symptoms.

1. Fear and Fatalism
2. A Wish for Privacy,
3. Gender roles

Theme 4: Enablers: Enablers to the uptake of healthy lifestyle behaviours, cancer screening participation and timely reporting of cancer symptoms among Travellers need to be developed and supported at a national and local level.

Subthemes:

1. Addressing SDoH as a priority
2. Health services working in close collaboration with well-resourced Traveller organisations including PHCTPS
3. Importance of trusting relationships with culturally sensitive, well-resourced health services and HCPs.

5.1 Study participants

15 HCPs participated in interviews (Table 20). This included six PHNs, five GPs, two GPNs and two screening professionals. This is a small selction of health care professionals. Most participants were female (n=13). Geographical spread displayed in Table 21.

Table 20: Demographic Characteristics

Occupation	Total n (%)
PHN	6/15 (40%)
GPs	5/15 (33%)
GPN	2/15 (13%)
Screening Professionals	2/15 (13%)
Total	15

Table 21: Demographic Characteristics

Location	Total n (%)
East	6/15 (40%)
West/Northwest	5/15 (33%)
South/Southwest	4/15 (27%)
Total	15

5.2 Findings

5.2.1 Theme 1: The Social Determinants of Health

According to most HCPs, SDoH impact all aspects of Travellers' ability to engage in healthy lifestyle behaviours for cancer prevention, cancer screening and early detection.

Theme 1 is presented under three subthemes: (1) Discrimination and racism, (2) Substandard accommodation, overcrowding, and poor environmental conditions, and (3) Poverty, unemployment, poor education.

1) Discrimination and racism

HCPs described the impact of societal and HCPs racism and discrimination on the uptake of healthy lifestyle behaviours for cancer prevention, screening, and timely reporting of cancer symptoms for early diagnosis. The impact of intergenerational racism and discrimination on health outcomes was noted and comparisons were made to other minority ethnic groups.

> "….it's not about individual choice, it's about that, they're a discriminated population … I mean, they're an exceedingly discriminated against group within our society … and we tolerate that. We tolerate very poor, em, life expectancy, very poor health throughout their life… they're very clearly affected by the discrimination that they, they get within our society, and that's, that's inter, that sort of generational. It comes down through, you know, I mean, there are a classic minority group, classic sort of indigenous population. I suppose, if you think of it like that, em, they're our native Americans, they're our Māori" (HCP 2, SP)

It was noted that the extent of racism and discrimination against Travellers could not be overstated.

> "I think Travellers are discriminated against in life, in society, in policy, in investment, in service design" (HCP 12, GP).

Racism and discrimination were deemed to be significant barriers, in addition to deprivation, to the uptake of healthy lifestyle behaviours.

> "But yeah, that would be the biggest barrier, I think their social situation and the discrimination that is, you know thrown at them all the time. And that sense of being 'othered' by the rest of us. I think that's a huge barrier" (HCP 13, GP)

Discrimination impacted cancer screening when post was not delivered to the halting sites.

> "…many of the sites don't get post. So, the postmen are afraid to go in … And like, you know, because it's out ruling a whole population of people from their post including, like, they're not getting their medical appointments or any important post they need. So, the post, apparently were giving different excuses over the years. But the current one was that there was dogs, really, dogs on the sites and the postmen were afraid. (HCP 7, PHN)

Prior negative experiences with health services also had the potential to raise concerns about trust. It was noted that some HCP's also engaged in racism and discrimination on an individual, interpersonal and systemic levels towards Travellers.

> Always within the class [student PHNs & midwives] when you would discuss Travellers and Travellers health, there would always be a group who would be anti-Traveller, who already when they were young and young healthcare workers starting out on careers and they already had prejudice and bias (HCP 14, PHN)

> They still feel some stigma and discrimination. Because they're Travellers they're treated a bit differently, and if any, if they feel anyone looks down on them, then that's another reason they don't want to present to doctors or hospitals (HCP 7, PHN)

Racism and discrimination in the educational system had negative downstream consequences, particularly among older Travellers who did not feel empowered to articulate their health concerns to HCPs.

> I suppose they have probably been in my mind anyway it's that they've such a poor experience in school where teachers would have told them to "just shut up and you know nothing". And "you can't do anything; you sit at the back of the classroom". That they've never learnt how to actually open their mouth and ask a question. I think that's a lot of it, especially in the older ones (HCP 15, PHN)

2) Sub-standard Accommodation, Overcrowding and Poor Environmental Conditions

HCPs described the challenges for Travellers in adopting healthy lifestyles when they had unmet basic needs.

> "…they're living in such sub-standard accommodation that you can't even start to think about anything else that it affects you from the moment you wake up in the morning to the last thing at night. It affects your engagement to the outside world. It affects your mental health, it affects your physical health" (HCP, 12, GP)

Preparing healthy meals is challenging due to lack of basic facilities such as electricity, particularly for those living in trailers. This results in a tendency to opt for convenience foods over home-cooked meals.

> "You try planning nutritious meals that aren't calorie-laden in a caravan [trailer] with a tiny fridge and… intermittent electricity". (HCP, 6, GP)

Outside of personal accommodation, neighbourhood characteristics, including the availability of recreational spaces, and safety concerns in some halting sites, also influence lifestyle choices.

> "…there would be a limited exercise in, you know there would be because of the sites, and then they they're not conducive to you know, to, to walking around on they're like cluttered, there's a lot of large like large debris. There's a lot of like cars abandoned in different places, and so there may not be a straightforward route around just to get exercise. [Some sites] are just based off one of the motorways. So, it's not. There's no, there's nowhere really safe to just go outside your front door and go for a walk. And so, they're kind of limited. They're constrained by their environmental (HCP 11, PHN)

Postal delivery emerged as a challenge to participation in screening. Travellers living on the roadside may not have any access to post, there may be damage to post, there may be damage to post boxes, or post may be delivered to the sorting office rather than directly to the sites. However, it was noted that, more recently, some appointments would be sent and received via text message.

> "In terms of where the environment and where they live like it's one of the, the big things is them not receiving post, not receiving their, and not receiving appointments, and I would get a lot of that like a lot of my time would be following up to check to see did they get appointments that I would be aware that they would, they would have; have they attended them? (HCP 11, PHN).

Early diagnosis of cancer was also impacted by sub-standard accommodation and poor living conditions as it was not a priority for some Travellers given the other issues they had to deal with.

> “She got quite a late diagnosis, too, but again, her housing was just her main thing... So, when she had X cancer symptom, I think she just, it wasn’t her main concern. It was trying to get a house for herself … so she just kind of, I suppose, buried it away, and didn’t think about it until it just got so [symptomatic] that she had to ask someone. And at that point it had already spread” (HCP 7, PHN). [Some details withheld to maintain confidentiality].

Lack of personal privacy emerged as a potential barrier to early diagnosis of cancer. Self-examination for early signs of cancer, for example, was considered close to impossible for some Travellers living in overcrowded trailers.

> “They don’t, they don’t have a room to stand up in front of a mirror, they don’t have locks on their doors, so how are they going to stand up and check their breasts when there’s ten people living in the house including two grandchildren, three sons, two sons-in-law, like how would you know that nobody is going to see you …” (HCP 15, PHN)

3) Poverty, Unemployment, and Poor Education

Poverty, unemployment and poor education were identified as contributors to the difficulties Travellers face in adopting healthy lifestyles.

> “Well, what else is there for me to do? I don’t have money much to change my life, but I if I have a cigarette… and the despair of that particular site drags you down, and even on the sunniest day you’re looking and there would be you know, a, a group of males there and they’re drinking non-stop. I think it’s the utter despair…” (HCP 8, PHN)

Attaining and maintaining health was further down the priority list in the context of poverty and unemployment.

> “Like Maslow's hierarchy of needs. So, a lot of the ones I go to see, there’s so much poverty that they can't really focus on their health, because their other things are impacting them so much …” (HCP 7, PHN)

The financial costs associated with maintaining a healthy lifestyle were highlighted.

> “… sometimes it’s cheaper to buy the cheap and nasty food because buying a thing of sausages and chips or a takeout, you know from a chipper, is sometimes just easier and you get the kids to eat it as opposed to cooking proper food” (HCP 3, GP)

Some HCPs noted the impact of poverty on screening participation as some Travellers did not have cars to drive to appointments or had difficulty affording car fuel or money for bus fares. A lack of transportation also contributed to some Travellers with cancer missing hospital appointments because of being too unwell to travel by bus and being unable to afford a taxi.

Poor literacy and health literacy were seen as particular barriers.

While the negative outcomes related to poor education and literacy levels were outlined, it was acknowledged that education and literacy were improving considerably among many younger Travellers and this was leading to positive outcomes.

> "I do think it's changing with regards to the more educated younger generation but the ones who have the kind of education and a bit more sort of assertiveness I suppose are not in the age group that would be thinking about cancer yet" (HCP 13, GP)

While all the HCPs were keen to highlight the importance of education, one PHN noted that Traveller females sometimes raised large families despite having poor literacy and living in deprivation.

> "… you will have a group of people, say mothers, who might have poor literacy, who have managed to raise X amount of children, to have budgeted, to have done X, Y, and Z in extremely difficult times, in, in poverty and therefore they are highly intelligent" (HCP 8, PHN).

5.2.2 Theme 2: Health System Barriers

Theme 2 is represented by two subthemes: (1) Challenges in accessing health services and (2) lack of cultural sensitivity, and discrimination within the health system.

1) Challenges in Accessing Health Services

This subtheme describes system-level barriers including the availability, timeliness and length of primary care appointments, issues with medical cards, and shortages in HCPs and allied healthcare professionals (AHPs). Invariably, challenges in this context impact Travellers' access to HCP for the provision of guidance and support on the uptake of healthy lifestyle behaviours for cancer prevention, cancer screening, and timely reporting of cancer symptoms. While acknowledging that challenges in obtaining a GP appointment are not exclusive to Travellers, several HCPs highlighted the difficulties they face in particular.

> "Yeah, and just getting an appointment is so hard. There's another GP in X that does have a big Traveller cohort, but I know myself even trying to get through, you'd be ringing, maybe for an hour before someone would answer the phone" (HCP 7, PHN)

The ability to attend was a challenge for younger females Travellers who were due for cervical screening.

> "And then the girls don't have the lift that day and it gets put off and they are waiting. So, by the time they actually get their appointment they have forgotten even why they wanted it" (HCP 15, PHN)

The length of appointments due to busy caseloads in general practice was also noted.

> "Like I don't know about you, but if I need now when I go to the GP to have a list of actually the things that are actually bothering me or maybe causing me discomfort or whatever … having your bloods done for something or whatever, and then you forget and a bit of chat happens and the GP is very busy. I mean they are, they really only have, they only have ten minutes" (HCP 14, PHN)

The move to online appointment systems was seen as an efficient approach, but might not be suitable for people who were not digitally literate, including some Travellers.

> "Our Travellers would never have an appointment if we were do that, except for some of the younger ones, you know" (HCP 6, GP)

2) Lack of cultural sensitivity, and discrimination within the health system

Under this subtheme, HCPs described a lack of appreciation within the healthcare system of the impact of the SDoH on Travellers regarding healthy lifestyle behaviours and their engagement with health services. Some HCPs felt there was also a lack of understanding of Traveller culture. Finally, it was noted that there was an inability to determine Travellers' health services engagement/screening uptake when there was no ethnic identifier. It was suggested that health policy had overlooked the impact of the SDoH on certain marginalised groups such as Travellers.

> "…that sort of societal approach to inequalities has really fallen out of favour, in the, in my opinion, in the way that the "Healthy Ireland", has, has sort of taken over the world as a "just don't do it" sort of approach, you know. We'll give you smoking cessation. We'll do this. Go on a park run. You know all those things are fine for healthy people. They're not fine for, they're not fine for Travellers or migrant populations or whatever" (HCP 2, SP2)

It was highlighted that there was a misconception that marginalised people who do not participate in health services are not interested in their health.

> "And there's one thing that the misconception quite often is, that people that don't engage don't care and what I've learned from my 10 years of working kind of with marginalized groups is most of the time they care. They care as much, if not more, sometimes, than, than the average person on the street" (HCP 12, GP)

There was a belief that HCPs sometimes made assumptions about Travellers' ability to engage in healthy lifestyle behaviours such as being able to cook and afford healthier foods. One of the key concerns regarding the lack of cultural sensitivity and discrimination was the health system's limited recognition of poor literacy/health literacy particularly (although not exclusively) among older Travellers.

For some HCPs, the use of medical jargon was particularly problematic given it may deter Travellers from returning to follow-up appointments.

> "…the medical jargon can be a barrier, I think, too. They don't fully understand, and they're very conscious of not wanting to sound silly or sound uneducated. If they don't understand, sometimes, when they do go in, they come away feeling like they don't know really, you know, fully, and or they don't fully understand what's been said, and it puts them off going back" (HCP 7, PHN)

Regarding interventions like cancer screening, it was deemed important to engage on a deeper level and to avoid assuming that Travellers had a clear understanding of what was involved in screening.

> "…says, when there's a free programme it's open to everybody it's out there. It's as easy to get to and yet they don't show up but that's not, it's not as, eh, as simple as that … Here's what it's involved. Here's how it works …" (HCP 12, GP)

It was also asserted that there was a limited understanding of the underlying SDoH issues for Travellers who missed their healthcare appointments.

> “… there’s no consideration at all for what hardships they are under to try and get to appointments and to try, and then they are just discharged for not attending. And I’m like how can you discharge somebody who is still clearly sick? You can’t discharge somebody who is sick. They are on medication, you have discharged them because they didn’t come to an appointment”(HCP 15, PHN)

This limited understanding among some HCPs of the impact of the SDoH on Travellers was exemplified by a PHN who reported the response she received when a male Traveller with cancer was unable to attend his appointments due to a lack of affordable transport as he was too unwell to get public transport.

> “And when I contacted the hospital, they weren’t very sympathetic towards him. His consultant basically said to one of the nurses, “If he’s not bothered to come in for treatment, then why should we bother to try anymore?”” (HCP 7, PHN)

The lack of prioritisation of Traveller Health and the impact of the SDoH on their health in medical training and education was seen as a contributory factor in HCPs’ limited understanding in this context.

> “Trying to get training around Traveller health into GP training schemes is another big challenge and not uniform across the training schemes…there’s huge layers to education and training needed around attitudes and assumptions” (HCP 6, GP)

Not having access to a medical card was seen as particularly problematic.

> I come across a lot of patients, as well, haven’t got medical cards even, or that mightn’t even have a GP, so sometimes it might be just something really acute happens, and that’s when they go to seek medical attention. But then they don’t have a medical card, so they can’t even get an X-doc [out of hours] appointment. (HCP 7, PHN)

5.2.3 Theme 3: Individual and/or cultural barriers

Under this theme, HCPs identified several individual and/or cultural barriers which they believed negatively impacted cancer prevention, cancer screening, and the early diagnosis of cancer among Travellers. These barriers included fear and fatalism around cancer (particularly among older male Travellers), privacy, fear of being judged within their Community, and embarrassment and shame related to certain symptoms/health conditions. Some HCPs noted that there was still an element of patriarchy in the Traveller Community, which they considered to be a barrier to adopting healthy lifestyles and attending appointments in some instances. Finally, although keen to note that it was not exclusive to the Traveller Community, misinformation was highlighted as a barrier particularly in the context of cancer prevention. This theme has three subthemes: (1) Fear and Fatalism (2) A Wish for Privacy, (3) Gender roles

1) Fear and Fatalism

According to some HCPs, Travellers' fear of cancer resulted in a tendency to avoid discussing the subject.

> "But often times I find that they don't really want to discuss cancer. There's a lot of fear behind it" (HCP 5, GPN)

A sense of fatalism was believed to hinder engagement in health promotion and cancer prevention in some instances.

> "I think in particular around cancer they have a very fatalistic view about cancer. Some Travellers that I've spoken to feel that cancer, that it's in there already when you're born and that something will bring it out. So, they don't perceive themselves as having any control over their health" (HCP 13, GP)

For one PHN, there was potential for a self-fulfilling prophecy as fear of cancer resulted in delayed presentations to HCPs with more advanced disease stages and poorer survival which relayed a message back to the Community that cancer and attending hospitals were to be feared, thereby creating a vicious cycle.

> "I think that there's a lot of fear around going to hospitals and going to doctors. And yeah, I think that's basically a fear and prevents them from going and I think it makes it worse." (HCP 7, PHN)

2) A wish for privacy

Privacy concerns and fear of judgement by other members of the Community were also considered to be barriers to prevention, screening, and the early detection of cancer among Travellers. Shame and embarrassment also emerged as barriers in some instances and as these barriers are interrelated, they are discussed alongside privacy where relevant.

Interventions to support health behaviour change were sometimes thwarted by privacy concerns, shame, and fear of being judged by others.

> "you know it's a very small community that are always judging each other" (HCP 13, GP)

There were instances where privacy was of such importance that even some family members were unaware of health issues.

> "They would hate for anything to get back into their community, and even within their own families they're still so private" (HCP 7, PHN)

Concerns around privacy appeared to be particularly problematic to the early diagnosis of cancer and GP receptionists' requests for information while triaging calls were perceived as a notable deterrent in this context.

> "I find there's a lot of barriers, because the Travellers don't want to tell a secretary, you know, their problem, because maybe they're going with something that's very private, and they find it hard enough to say it" (HCP 4, PHN)

It was noted that this was a particular issue in reporting pelvic organ symptoms.

Concerns around reporting pelvic organ symptoms were not only confined to discussions with GP receptionists. While acknowledging that it was not just limited to the Traveller Community, HCPs identified a reticence among Travellers to discuss these symptoms with GPs who were of the opposite sex.

> "And if you have a trust again if the GPs are male, or a females. So, for example, cervical bleeding, I could be saying on you need to see your GP …no, no, no, for he, it's a he! And there's no woman there. And it it's simple as that" (PHN 8)

Similarly, there was a concern about the tendency for male Travellers to avoid discussions around male pelvic cancers with PHNs.

> "...And again men will be embarrassed about this.., you know, they'd be very embarrassed" (HCP 8, PHN).

3) Gender roles

Some HCPs noted the impact of gender roles within the Traveller Community, and it was suggested that females were primarily tasked with managing the family and taking the lead on health issues.

> "Traveller males I think live behind the scenes. Anything to do with the family or anything it's the woman is forward. So, she's the woman who actually is the brunt of most discrimination. Because she's the one who attends to the school, goes to the GP, asks the GP, goes to the hospital and the clinics" (HCP 14, PHN)

In some instances, it was suggested this patriarchal backdrop may impact on the ability of females to engage in healthy lifestyle behaviours and decision making around family. Family and community are highly valued, with experiential knowledge and advice being shared inter-generationally, often under the guidance of matriarchs.

> "… it's still a very patriarchal society or it's a society where the mother-in-law is in control. 'Why, you out walking? Why, you aren't you cooking for my brother, my son a dinner? Why don't you give them more children?' It's very hard for young females …" (HCP 8, PHN)

5.2.4 Theme 4: Enablers

Theme 4 is represented by three subthemes: (1) Addressing SDoH as a priority, (2) Health services working in close collaboration with well-resourced Traveller organisations including PHCTPS and (3) Importance of trusting relationships with culturally sensitive, well-resourced health services and HCPs.

1) Addressing the SDoH as a priority

Under this subtheme, HCPs pointed to the critical need to address SDoH upfront given the detrimental role these play in Travellers' physical and psychological health and their ability to engage with lifestyle interventions, screening and the early detection of cancer as outlined under Theme 1.

HCPs felt there was a need to address societal discrimination against Travellers.

> “Fundamentally, we need some societal change, and I don’t ... I have no idea how you do that ... I’ve no idea how you, em, how get rid of that discrimination, em, that’s so ingrained over many generations” (HCP 2, SP 2)

According to one PHN, it was essential to make people accountable for discriminatory statements and/or actions and to implement a zero-tolerance policy around discrimination of Travellers.

> “If you do something that is offensive and wrong if it’s in education, if it’s in health, if it’s in housing, we should be … there to be a no, there should be a zero tolerance. Sorry you don’t treat people like that… we should be just all accountable” (HCP 8, PHN)

2) Health services working in close collaboration with well-resourced Traveller organisations including PHCTPS

Under the second subtheme, HCPs were keen to highlight that for any initiatives concerning Travellers, Travellers should be front and centre and taking the lead. Given the poor literacy among Travellers, HCPs highlighted the need to consistently partner with Traveller organisations to co-design and develop accessible health information materials and approaches that were clear and understandable.

> “Yeah, absolutely to have a meaningful discussion where they are the real partners, and everything we do, the Traveller Community should be the lead agency” (PHN 8)

HCPs discussed the positive impact of the PHCTPs on the TPHCW themselves and on other Travellers through the TPHCW engagement with the wider Community.

> “[X PHCTP] it’s, it’s transformative in terms of particularly cancer diagnosis or probabilities, because they are on top of their smears. They go for their mammograms. They know what altered bowel habit means, like passing blood is not a good thing” (HCP 6, GP)

Male TPHCW were also acknowledged as a knowledgeable and valuable resource.

> “They’re very good. They’re, they, they’re really, I mean, when you meet them, they’re very knowledgeable, and they, they know their stuff. They’re good. I met one recently, a man, can’t remember his name now, but he was, his area was mental health, and presumably directed at men and he was really good. He, he had both a great way about him, but also he was very knowledgeable” (HCP, 6, GP)

PHNs liaised with PHCTPs and TPHCW on the ground when providing education on cancer prevention by highlighting cancer risk factors such as the use of sunbeds and underlining the importance of vaccination.

> “… they (TPHCWs) would have a couple of sites that they would go and visit, and they’ll try and disseminate all the health promotion information, you know. They’ll often bring out information on vaccines … “(HCP 7, PHN)

HCPs also discussed the role played by the PHCTPs and TPHCWs in encouraging participation in cancer screening and early detection of cancer.

Interventions by TPHCWs were considered particularly effective in improving participation in bowel screening, where involvement was initially perceived as "quite poor."

> "…the good thing about the Traveller projects like X, where they do, the healthcare workers to go out and make it that bit more accessible or easy for them. They will, they will do it. A lot of them just wouldn't have ever heard of bowel screening or have a clue what it's about. Or you know, they might be a bit disgusted when they find out, so they really need, like that, people coming out to explain what it is and how to do it" (HCP 7, PHN)

The TPHCWs may be the first port of call for Travellers concerned about cancer symptoms.

> "…there is an older man, he has X condition, and he has a lump … So, X PHCTP actually rang me about him as well to see would I go out because he was just, he mentioned it to one of their health care workers…"(HCP 7, PHN)

According to another PHN, collaboration with the PHCTP in her area was quite limited.

However, the suboptimal engagement may be due to the limited hours the TPHCW were allowed to work each week. It was suggested that a solution to this could be to facilitate more hours while retaining the TPHCW' social welfare benefits.

> "They only work twelve hours a week so I can't see how they can get much out when they have to be in training as well." (HCP 15, PHN)

Overall, the HCPs indicated that the PHCTP model was key to cancer promotion and early diagnosis, but more funding and resourcing were needed in this area.

> "I mean the primary health care work, you can support it more, you could fund it more. You could, you know, there's lots of things you could integrate it more with health service … you could have more people within the health service that work in this space".(HCP 2, SP)

Also, the need to involve more young people and male TPHCW was suggested.

> But with men… you know, the age group that you should be … the young ... they're gonna live forever ... they'd be highly embarrassed if I came in and told them [about testicular cancer] eh do I talk to the males … Should there be, you know, for the male health workers. Should there be a little course done for them, so they can come out, go out and promote, you know, any lumps or bumps or swelling" (HCP 8, PHN)

3) Importance of trusting relationships with culturally sensitive, well-resourced health services and HCPs.

This subtheme highlights the importance of good relationships with health services and HCPs and the provision of culturally appropriate care, employing flexible, innovative approaches around cancer prevention, screening, and early diagnosis of cancer. The need to provide additional resources to public and private health services who work with Travellers was also underlined.

Establishing and maintaining trusting relationships between Travellers and health services and HCPs was seen as a critical enabling factor for the uptake of healthy lifestyle behaviours, cancer screening participation and timely reporting of cancer symptoms among Travellers.

> "I think a lot of it comes down to the relationship and the longitudinal relationship or the continuity of care in the primary care team" (HCP 12, GP)

Conversely, when trusting relationships were not established, engagement on both sides was likely to be poor.

> "… then their experience of engaging with services. So, you know, if they, some of them do get a good GP and they will go to them, and that's fine, but if they've got a bad relationship, and you know they may not go and do that either" (HCP 2, SP)

Some HCPs emphasised the importance of being pragmatic when considering alternative formats to written health information, suggesting the use of videos that could be easily shared and viewed on smartphones, given their widespread use among Travellers.

> "there's a lot of literacy issues within the Traveller community still, but that a lot of them they, they use phones a lot and, and apps and stuff. So, you know, get it on their phone and in a video and things, and they'll get it" (HCP 2, SP)

Regardless of the format, all health information should be provided respectfully.

> "… I suppose that as health professionals and general practitioners that we know how to get the message across in a respectful way that is culturally sensitive, respectful way". (HCP 5, PHN)

It was acknowledged that health service appointment times were unlikely to suit certain groups including Travellers and alternative options should be considered.

> So there, there's kind of busy people and a, at a busy age, and you're trying to get them to slot into what suits me. And remember most GP practices are where the first level of screening for CervicalCheck happens, most of them are open office hours. So, there's no evenings, there's no weekends in terms of flexibility around getting this done. Yeah. So there, there's a couple of barriers, some that affect across the board and some specific to the to the women from the Traveller community who we would meet (HCP 12, GP)

The importance of cultural competence for HCPs was highlighted.

> "Maybe for healthcare professionals, that maybe we need to be taught a little bit more how to tailor messages or how to, you know, find out from people from the Traveller Community that work within health promotion, and so on, how we can get that message out better. And adjust our ways of our consultations, and kind of putting on a different hat and looking at it from a different way" (HCP 5, PHN)

The need to provide additional resources to public and private health services that work with Travellers was underlined. According to some of the HCPs, additional funding was required for GP practices with high numbers of patients from the Traveller Community to ensure adequate time and support are allocated to addressing multiple physical/psychosocial issues while making time for health promotion advice and avoiding missing cancer screening and evaluation of cancer symptoms.

GPs spoke about the increasing workload and complexity of cases in general practice in recent years and the impact this was having on the provision of care including cancer screening.

> "So, the days of me having somebody in front of me who's in for I don't know …say acne, or they're worried about the skin issue and me saying, have you got a minute? I'll, I'll do your smear while you're here, I see it's overdue. Those days are gone because primary care and practice has gotten so busy" (HCP 12, GP)

6. Conclusion and next steps

The aims of this research were to understand Travellers' awareness of cancer risk factors and signs and symptoms, to identify barriers and enablers to cancer risk reduction and early diagnosis of cancer, including access to health services and engagement with cancer prevention/risk-reducing behaviours, and finally, to assess the impact of the social determinants of health (SDOH) on health-related behaviours. This is the first study of its kind to be undertaken in Ireland.

Next Steps

It is imperative that the results of this survey be used to inform initiatives to improve cancer outcomes in the Traveller Community. Results will be utilised by the NCCP Cancer Prevention and Early Diagnosis functions to inform further implementation of the National Cancer Strategy 2017-2026[9] recommendations, specifically:

Recommendation 2: 'The NCCP will develop a cancer prevention function, working in conjunction with the broader Healthy Ireland initiative, and will lead in relation to the development and implementation of policies and programmes focused on cancer prevention.'

and

Recommendation 7: 'The NCCP and the HSE Health & Wellbeing Directorate, in partnership with the voluntary sector, will develop a rolling programme of targeted multi-media based public awareness and education campaigns, aimed at the early detection of specific cancers and with particular focus on at-risk populations'.

In addition, findings will inform further implementation of the Department of Health and NCCP National Skin Cancer Prevention Plan 2023-2026[16].

Social determinants of health have a significant impact on Traveller Health. To overcome these, and to improve Traveller Health, it is important that Ireland's National Traveller Health Action Plan (2022-2027)[17] and National Action Plan Against Racism (2023)[18] are implemented. The NCCP recommends the urgent implementation of an ethnic identifier to accurately identify Traveller-specific health needs, monitor access to services, and measure the impact of targeted initiatives. Without disaggregated data, it is not possible to ensure equitable health outcomes or address the systemic barriers experienced by the Traveller Community.

The following are specific actions for the NCCP to work with the Traveller Community to reduce cancer risk and enable earlier diagnosis.

Actions

1. Disseminate and promote findings from survey	The NCCP will disseminate and promote the findings from this survey. To address the key findings, the NCCP will disseminate this survey to key stakeholders. The findings of this survey will be shared directly with the Traveller Community, with organisations that work with the Traveller Community, with the HSE National Social Inclusion Office and with relevant national groups implementing Traveller-related health strategies, to help inform their work and initiatives. The report will be shared with organisations working in the area of cancer risk reduction and early diagnosis to inform their work with the Traveller Community. The survey findings will be shared with healthcare professionals through NCCP networks, highlighting both the challenges and enabling factors influencing the Traveller Community's engagement with healthcare.
2. Education	The NCCP will use the survey findings to inform education of healthcare professionals, with a particular focus on the barriers and enablers experienced by the Traveller Community in engaging with cancer risk reduction behaviours and timely health-seeking to facilitate early cancer diagnosis. This will include promoting relevant HSeLanD training, e.g. the Intercultural Awareness e-learning programme.
3. Community engagement	The NCCP will host a workshop with Traveller Primary Health Workers to explore the survey findings, with the aim of strengthening existing activities and developing new initiatives. Findings will also inform current and future community engagement activities with the Traveller Community by regional HSE Senior Health Promotion and Improvement Officers-Cancer Prevention, and members of the Irish Cancer Prevention Network.
4. Awareness raising with Traveller Community	The NCCP will use the survey findings to support cancer risk reduction and early diagnosis messaging, aligning with the community engagement activities outlined in Action 3. This will include the development of culturally appropriate health education materials in collaboration with the Traveller Community. By working directly with Travellers to co-create these resources, the NCCP will aim to ensure that information is both meaningful and relevant, supporting individuals to make informed decisions about their health.

Appendix I: Acknowledgments

We wish to acknowledge all those involved in the development of the project, data collection, analysis of the data and compiling the report.

UCD Team

Principal Investigator

- Dr Patricia Fox

Co-applicants

- Professor Patricia Fitzpatrick
- Associate Professor Kate Frazer
- Dr Regina Joye

Associated Team

- Dr Reuel Jalal
- Dr Aela O'Flynn

Pavee Point Traveller and Roma Centre

- Co-ordinator: Mary Brigid Collins
- Molly Collins
- Missy Collins
- Bridget Collins
- Sheila Reilly
- Maggie McDonnell
- Nancy Collins
- Julie Joyce
- Pauline McDonnell
- Helen Collins
- Valery O'Leary
- Mary Collins
- Winnie McDonagh
- Winnie Collins
- Bernadette McDonagh
- JulieAnne Collins

Thank you also to Rebecca Gorman (Current Traveller Health Coordinator (THC), Jenny Liston, & Doireann Crossan (Previous THC))

TravAct (Northside Traveller Support Group), Coolock

- Co-ordinator: Kathleen McDonnell
- Mary Collins
- Mary Tyrrell
- Kathleen Ward
- Margaret McDonagh
- Lisa Mc Donnell
- Winnie Collins

Cork Traveller Visibility Group (TVG)

- Co-ordinator: Tehmina Kazi
- Biddy McDonagh
- Eileen Burke
- Nora Cash
- Patrick McDonagh
- John O'Sullivan

Longford Traveller Healthcare Project

- Co-ordinator: Mary Nevin
- Martin Nevin
- Lisa Joyce
- Teresa McDonnell

West Limerick & Rathkeale PHCTP

- Co-ordinators: Treasa Sheahan, Valerie Foley & Denis Robinson
- Hannah Hehir
- Myra O' Brien
- Winnie Harty
- Bridget Quilligan
- Bridget Harty
- Margaret Harty

Kildare Traveller Action, Kildare

- Co-ordinator: Liz O'Brien (PHC Co-ordinator) & Petra Daly (Manager)
- Bridget Dooley O Brien
- Bridget Cawley
- Brigid O' Brien
- Louise O' Brien

St Margaret's Traveller Community Association, Ballymun

- Co-ordinator: Winnie McDonnell
- Sandra Collins
- Mary Collins
- Ellen Mongan
- Nancy McDonnell
- Mary McDonagh
- Helen Stokes

Tallaght Travellers Community Development Project, Tallaght

- Co-ordinator: Colette Spears
- Nancy McDonnell
- Sandra Collins
- Ellen Mongan
- Mary Collins
- Helen Stokes
- Mary McDonagh

Sligo Travellers Support Group (STSG)

- Co-ordinator: Bernadette Maughan
- Terry Comiskey
- Michael Ward
- Marie Ward
- Cliona Ward
- Dana Stokes
- Cheryl McGinley
- Kathleen Ward

Offaly Traveller Movement

- Co-ordinator: Leona McDonagh
- Sarah McDonagh
- Brigie McInerney
- Mary McInerney
- Caroline McDonagh
- Geraldine Ward
- Celine McInerney
- Leona McDonagh
- Sorcha Lewis

Meath Healthcare Project for Travellers

- Co-ordinator: Eileen Gilsenan
- Mary McDonnell
- Nathanya McDonagh
- Julie Power
- Lisa McDonagh
- Mary Joyce
- Brigid Collins
- Pauline Doyle
- Sharon Nevin

Clondalkin Travellers Development Group, Clondalkin

- Co-ordinator: Andrea Malone
- Nora Mc Donagh
- Mary Maughan
- Sylvia Conroy
- Leanne Dunne
- Michael Lawrence
- Elizabeth Connors

Project Steering Group

Name	Organisation
	UCD
Dr Patricia Fox	Principal Investigator, UCD
Prof Patricia Fitzpatrick	Co-applicants, UCD
Assoc. Prof Kate Frazer	Co-applicants, UCD
Dr Regina Joye	Co-applicants, UCD
Dr Reuel Jalal	Associated Team, UCD
Dr Aela O'Flynn	Associated Team, UCD
	Pavee Point
Lynsey Kavanagh	Co-Director, Pavee Point
Doireann Crosson	Primary Health Care Project Coordinator, Pavee Point
Mary Brigid Collins	Primary Health Care Project Coordinator, Pavee Point

	NCCP
Áine Lyng	Cancer Prevention Officer, NCCP
Dr Triona McCarthy	Director of Public Health, NCCP
Maria McEnery	Cancer Prevention Officer, NCCP
Dr Una Kennedy	GP Advisor, NCCP
Dr Heather Burns	Consultant in Public Health Medicine, NCCP
Louise Mullen	National Lead for Cancer Survivorship, NCCP
Dr Niamh Bambury	Aspire Fellow in Cancer Intelligence, NCRI and NCCP
Dr Celia O Hare	SpR Public Health Medicine NCCP
Dr Fiona McGuire	SpR Public Health Medicine NCCP
	HSE
Michelle Kearns	Project Manager, HSE National Social Inclusion Office
Brigid Quirke	Project Manager, HSE National Social Inclusion Office
Muireann De Paor	SpR Public Health Medicine, HSE

Project Advisory Group

Name	Organisation
Triona McCarthy (Chair)	Director of Public Health, NCCP
Áine Lyng	Cancer Prevention Officer, NCCP
Maria McEnery	Cancer Prevention Officer, NCCP
Una Kennedy	GP Advisor, NCCP
Heather Burns	Specialist in Public Health Medicine, NCCP
Louise Mullen	National Lead for Cancer Survivorship, NCCP
Allison Deane	SpR Public Health Medicine, NCCP
Paul Brosnan	Health and Wellbeing Programme, Department of Health
Noreen Murtagh	Patient/public representative
Claire Collins	Director of Research & Innovation and Director of People & Culture, Irish College of General Practitioners
Deirdre Murray	Director, NCRI
Helen Deeley	Interim AND, HSE Health & Wellbeing

Lynn Swinburne	Senior Health Promotion Officer, National Screening Service
Kathleen Bennett	Head of the Data Science Centre RCSI / Associate Professor of biostatistics
Brigid Quirke	Project Manager, HSE National Social Inclusion Office
Muireann De Paor	SpR Public Health Medicine, HSE
Grainne Begley	Project Manager, Social Inclusion / Public Health, HSE
Fiona Mansergh	Assistant Principal, Health and Wellbeing Programme, Department of Health
Anna Gavin	Consultant in Public Health, Director NI Cancer Registry & Professor, Queens University Belfast
Doireann Crosson	Primary Health Care Project Coordinator, Pavee Point
Lynsey Kavangh	Co- Director, Pavee Point
Mary Brigid Collins	Primary Health Care Project Coordinator, Pavee Point
Niamh Bambury	Aspire Fellow in Cancer Intelligence, NCRI and NCCP

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