

Health and the Roma Community, analysis of the situation in Europe

*Bulgaria, Czech Republic, Greece, Portugal,
Romania, Slovakia, Spain*



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Presentation

The Roma community is the largest ethnic minority in Europe and is characterised primarily by the situation of social exclusion and wide-ranging poverty experienced by a significant proportion of its members. Inadequate access to housing, education, employment and other needs, along with the existence of barriers to Roma access to health services and an ineffective use of these services due to their lack of adaptation and even to discrimination, all contribute to a range of avoidable injustices suffered by this community with regard to their health situation. These health inequalities are not reflected in reliable and up-to-date statistics or data, a fact which further hinders the planning of targeted interventions designed to reduce and ultimately eliminate inequality.

The European project “Health and the Roma Community, Analysis of the Situation in Europe”, promoted by the Fundación Secretariado Gitano, was implemented in 2007 to analyse the health situation of Europe’s Roma community, to address social inequalities in the area of health and to suggest policies and actions based on reliable knowledge designed to improve the health status of Europe’s Roma community and to reduce inequality.

This project, funded by the European Union within the framework of the Public Health Programme, was implemented in seven European Union countries (Greece, Spain, the Czech Republic, Slovakia, Portugal, Romania and Bulgaria) with the participation of public and private entities from the different participating countries¹ and under the coordination of the Fundación Secretariado Gitano.

On 1 November 2007 the European project “Health and the Roma Community, Analysis of the Situation in Europe” was launched on the basis of the National Health Survey of the Roma population in Spain conducted in 2006 by the Ministry of Health and Consumer Affairs and the Fundación Secretariado Gitano. Four clear and concise objectives were pursued:

- To gather objective data on the health status of the Roma population living in the participating countries and their use of health-care resources.
- To make a diagnosis, based on objective data, of the health situation of the Roma community in each of the countries.
- To implement effective strategies designed to enhance the health of the Roma community and reduce inequality and to make recommendations in this connection at all levels.
- To raise the awareness of stakeholders (politicians, technical decision-makers, representatives of the Roma community, etc.) regarding the need to implement measures and strategies to improve the health situation of Europe’s Roma community and reduce inequality

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The work was based on a survey of the Roma population in Europe regarding their health status and access to health-care resources. A total of 7,604 Roma of all ages from the seven participating countries were interviewed. Information regarding households and household members was also gathered.

A group of experts was created in each country composed of professionals with different backgrounds: experts on health and the Roma community, representatives of public administrations, representatives of Roma organisations, experts in research and the interpretation of statistical data, etc. These professionals played an active role in the implementation of the project from the very beginning and, once all of the statistical information was processed (undertaken by the Spanish firm EDIS), they were entrusted with analysing the results obtained and preparing a report on the situation facing the Roma population in participating countries and, where possible, comparing it with that of the overall population. They also formulated recommendations for intervention based on the information gathered.

In order to provide a global overview of the health status of the Roma population in the countries that participated in the project, this document shows the main results of each of the seven national surveys conducted and draws comparisons between countries. As already mentioned, the ultimate objective of this document is not merely to generate knowledge on the health inequalities affecting the Roma population in Europe, but to contribute to their reduction. Therefore, this document makes a series of action proposals targeting each of the key agents involved in the health-Roma community nexus, focusing on correcting existing inequalities. Our wish is to raise the awareness of stakeholders as to the need to implement measures targeting health promotion among the Roma community and reducing inequality.

Lastly, it ought to be reiterated that only through the development of studies and research can we expect to accumulate sufficient knowledge of the reality facing the Roma population so as to be able to design and set up specific action programmes to palliate and ultimately resolve the inequalities that persist to this day between the Roma community and the European society as a whole.

**Health and the Roma Community,
comparative analysis of the situation
in Bulgaria, Czech Republic, Greece,
Portugal, Romania, Slovakia and Spain**



Introduction

The present analysis, elaborated on the basis of the information collected in the surveys realised in each one of the seven countries that participated in the European project “Health and the Roma Community: Analysis of the situation in Europe”, aims at shedding light on aspects that have been overlooked or neglected, at least in empirical terms, on the state of health of the Roma population at the European level.

The following chapters address the health of the Roma community from diverse angles. They endeavour to facilitate an understanding of the situation of Roma persons with regard to their health (both objectively and subjectively), their access to and use of the principal health services, prevalent diseases and prominent aspects of their lifestyles, by systematically comparing the data obtained in the seven participating countries. In this sense, it provides statistics that are comparable with existing data in the European Union (EU-27), in cases where information exists and is comparable.

Concretely, the analysis of the data is organised through four thematic and complementary areas. In the first place, data on socio-demographic aspects are presented, on the basis of which the particular situation of the Roma community is contextualised by taking into account the social determinants of health. Secondly, issues concerning the health status of the Roma are addressed by providing relevant information regarding perceived health, diseases, accidents, among others. The third theme of the report addresses the use of health services by the Roma, by providing data on consumption of medicines, visits to the physician, hospitalisations, emergency services, etc. The fourth and final thematic area focuses on the lifestyles of the Roma community in matters related to the consumption of tobacco and alcohol, physical exercise, rest, food, among others.

Methodology

Work was based on the collection of current, first-hand information obtained through a survey given to members of Europe's Roma population. This basically meant conducting direct or indirect interviews of 7,604 Roma of all ages and from seven European Union countries allowing us to subsequently extract statistically reliable data which can be extrapolated to the entire Roma community. The following are the technical characteristics of the survey.

Target population

Our target population was entirely composed of Roma from Bulgaria, Romania, Greece, Portugal, the Czech Republic, Slovakia and Spain. In this connection, as pointed out in the foregoing, information was gathered on the Roma population of all ages, both men and women.

In a research project of this nature seeking to obtain information on the situation of the Roma population, anyone who knows this population group can attest to the difficulty in acquiring the most accurate information possible in terms of real figures of the population in order to design a valid sample.

Serious difficulties were encountered in quantifying the size of the Roma population in all seven countries where the survey was conducted. The fact that "official" statistics do not exist in some of the countries studied and the discrepancy between such figures and estimates which are believed to better reflect reality, made our job more difficult. In order to quantify and locate our target population we used proportional figures provided by the groups of experts created in each of the countries where the study was conducted based on official figures and significant studies undertaken in this regard.

The following table shows the total volume of Roma population in each country comprising our target population. For further information on the process followed to calculate the target population, please refer to the individual country reports of each of the participants in this study.

Estimated Roma population by country

	Roma Population
Greece	125,000
Portugal	33,338
Czech Republic	230,000
Slovakia	320,000
Romania	1,050,000
Bulgaria	370,908
Spain	665,987
Roma Europe	2,795,233

The questionnaire

A personal door-to-door survey was carried out, i.e. face-to-face interviews conducted by an interviewer in the home of the interviewee using a structured and pre-coded questionnaire. On an exceptional basis only, the interview could be conducted outside of the home in cases where the person chosen could not usually be found at home at a reasonable hour.

The questionnaire was designed to collect information on the household, Roma minors (girls and boys) and Roma adults:

- **Questionnaire about the household:** The first part of the questionnaire gathers basic information from all members of the household: sex, age, relationship to the main wage earner, type of health-care coverage, difficulties encountered in everyday life, disability or chronic disease, etc. This part of the questionnaire also gathers information common to all members of a household: number of people in the household, habitual caretaker of minors, type of home, type of neighbourhood and whether social and health services are available in the area. All of this information is provided by an adult who is sufficiently familiar with the rest of the people living together in the home.
- **Questionnaire focusing on Minors:** This part of the questionnaire gathers information about all health aspects relating to minors, i.e. age 15 and under. These questions are answered by an adult on behalf of the selected minor; in principle the father or mother or, failing that, the child's guardian.
- **Questionnaire focusing on Adults:** A different questionnaire was likewise designed for adults to gather health-related information. In this case we focused on adults aged 16 and above who answered questions about their personal situation and directly gave their opinions in response to the questions posed.

Therefore, data analysis covers three different units: households, members of the household and individuals interviewed (either minors or adults).

Field work

Fieldwork was initially performed in Spain in 2006 and in the rest of the countries during the course of 2008. The following table gives more detailed information on fieldwork dates:

Fieldwork dates	
Greece	November / December 2008
Portugal	September / November 2008
Czech Republic	November 2008
Slovakia	September / November 2008
Romania	March / June 2009
Bulgaria	October / November 2008
Spain	September / October 2006

Generally speaking, only one person per household was interviewed (a minor or an adult). Therefore, each questionnaire gathered basic information about the household and all of its members and about the individual interviewed (a minor or an adult). This rule was followed in all of the countries with the exception of Romania where all of the members of the households were interviewed. The decision to change the fieldwork procedure was adopted by the Romanian team and was due to technical reasons. Further information can be found in Romania's national report.

The methodological shift in Romania does not have a significant bearing on the research or on the compiling of this transnational report. Information was gathered in that country on 659 households and 2,616 individuals, a sufficiently large sample to obtain reliable data. Notwithstanding the foregoing, the representativeness of the sample is affected owing to the fact that a sample with only one interview per household

is much more pervasive than one where all household members are interviewed. However, the household sample base is within acceptable parameters and there are countries with a smaller household sample than Romania and therefore this difference will not have too much of an effect on comparisons between countries. Even so, this methodological difference must be kept in mind because it could come into play when examining a specific piece of data.

Samples

Following are the sample numbers for each country. The following table illustrates the samples used, bearing witness to the enormous potential of the survey for statistical purposes:

Samples per country

	Households	Household members	Total interviewed	Minors interviewed	Adults interviewed
Roma Europe	5,647	26,058	7,604	2,784	4,820
Greece	641	3,492	641	215	426
Portugal	367	1,676	367	122	245
Czech Rep.	1,013	4,109	1,013	332	681
Slovakia	657	3,760	657	321	336
Romania	659	2,616	2,616	1,024	1,592
Bulgaria	814	3,947	814	266	548
Spain	1,496	6,458	1,496	504	992

Sample error

Based on the total population figure provided by each country, this being our target group for the survey, and using survey data, we were able to estimate the size of Roma households in each country and to determine the number of minors and adults. We can thus estimate the error margin for each of the groups focused on in this report. The number of households was calculated by dividing the total size of the Roma population by the average household size as determined in the survey. Similarly, to calculate the number of minors and adults we applied the percentage of minors and adults determined in the survey to the total number of Roma. The following table shows the overall figures for all of the participating countries:

Total numbers per countries

	Households	Roma Population	Minors	Adults
Roma Europe	623,589	2,795,233	1,728,086	1,067,147
Greece	23,105	125,000	67,937	57,063
Portugal	7,154	33,338	19,312	14,026
Czech Rep.	56,235	230,000	146,227	83,773
Slovakia	55,846	320,000	184,669	135,331
Romania	248,227	1,050,000	621,358	428,642
Bulgaria	76,319	370,908	253,977	116,931
Spain	156,703	665,987	434,606	231,381

Once the different target populations were quantified and our sample sizes known, we were then able to calculate survey error margins which are as follows:

Survey error margins ($\pm\%$)

	Households	Household members	Total interviewees	Minors	Adults
Roma Europe	1.30	0.60	1.12	1.86	1.41
Greece	3.82	1.64	3.86	6.67	4.73
Portugal	4.98	2.33	5.09	8.84	6.21
Czech Rep.	3.05	1.52	3.07	5.37	3.74
Slovakia	3.80	1.59	3.82	5.47	5.34
Romania	3.81	1.91	1.91	3.06	2.45
Bulgaria	3.42	1.55	3.43	6.01	4.18
Spain	2.52	1.21	2.53	4.36	3.10

Weighting of results

In light of the difference in sample sizes used in the different countries, we decided to weight each country's figures to make them comparable. Weighting means assigning different weights in accordance with sample tiers so that they correspond to the structure of the target group. Only then can one obtain representative results on the target population.^{1*}

In order to obtain representative data for the seven countries, weighting factors were applied to the data obtained so that the sample reflected the proportionality of the target group. In this case, different correction factors were applied depending on whether the focus was on households, household members or individuals interviewed.

Following are three tables, one for each unit of analysis and therefore each with its own weighting factor. Each specifies the size of the target group, distribution in each country expressed in percentage terms, the proportional sample per country obtained by applying the preceding percentages, the sample itself and the weighting factors applied.

Weighting factors: Households

	Households	Percentage	Proportional Sample	Sample done	Weighting factor
Greece	23,105	3.7	209	641	0.326053
Portugal	7,154	1.1	65	367	0.177112
Czech Republic	56,235	9.0	510	1,013	0.503455
Slovakia	55,846	9.0	506	657	0.770167
Romania	248,227	39.8	2,250	659	3.414264
Bulgaria	76,319	12.2	692	814	0.850123
Spain	156,703	25.1	1,421	1,502	0.946072

^{1*} If a sample is not weighted, all of the elements of the sample have the same unit value. However, in a weighted sample (the case of this survey) each element will have a determined value which will be greater or lesser than one. This value is assigned depending on whether the element is part of one or another tier and is calculated by dividing the sample used of a given tier by the proportional sample attributable to that tier.

Weighting factors: Household members

	Roma Population	Percentage	Proportional Sample	Sample done	Weighting factor
Greece	125,000	4.5	1,163	3,492	0.333047
Portugal	33,338	1.2	310	1,676	0.184964
Czech Republic	230,000	8.2	2,140	4,109	0.520808
Slovakia	320,000	11.4	2,977	3,760	0.791755
Romania	1,050,000	37.6	9,769	2,616	3.734327
Bulgaria	370,908	13.3	3,451	3,947	0.874335
Spain	665,987	23.8	6,197	6,407	0.967223

Weighting factors: Interviewees

	Roma Population	Percentage	Proportional Sample	Sample done	Weighting factor
Greece	125,000	4.5	340	641	0.530421
Portugal	33,338	1.2	91	367	0.247956
Czech Republic	230,000	8.2	626	1,013	0.617966
Slovakia	320,000	11.4	871	657	1.325723
Romania	1,050,000	37.6	2,858	2,616	1.092508
Bulgaria	370,908	13.3	1,009	814	1.239558
Spain	665,987	23.8	1,812	1,499	1.208806

Once the weighting factors were established to balance the sample at European level, we had to consider that each country has its own weighting to balance the sample internally. Therefore, in order to maintain the internal weighting of each country with a view to a comparative analysis, for each register we multiplied the sample balance factor calculated at European level (see tables above) by the internal weighting factor each had previously.

This is the only way to guarantee a database producing comparative results of the internal structure of each country while also obtaining information for the seven countries considered jointly. In light of this situation, we should be aware that the information furnished by the different countries in this transnational report could differ (albeit very slightly) from the data furnished by the different countries in their national reports and could even differ from the country summaries appearing at the end of this publication. In both cases, differences are minimal (tenths of a point in many cases) and do not affect the analysis and interpretation of the information.

Part 1. Socio-demographic characteristics

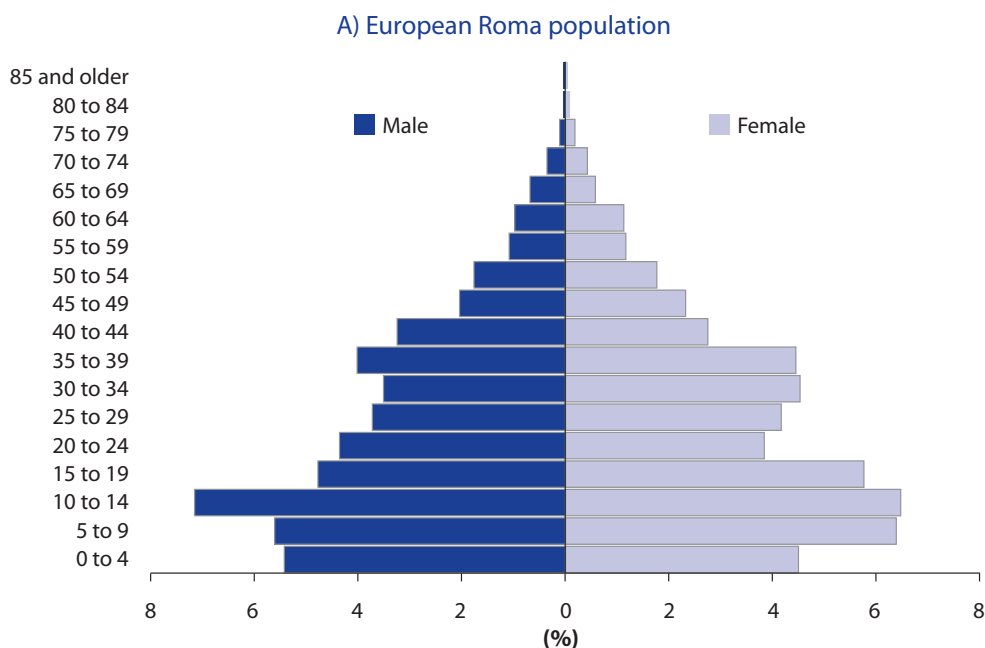
1.1. Baseline demographic situation

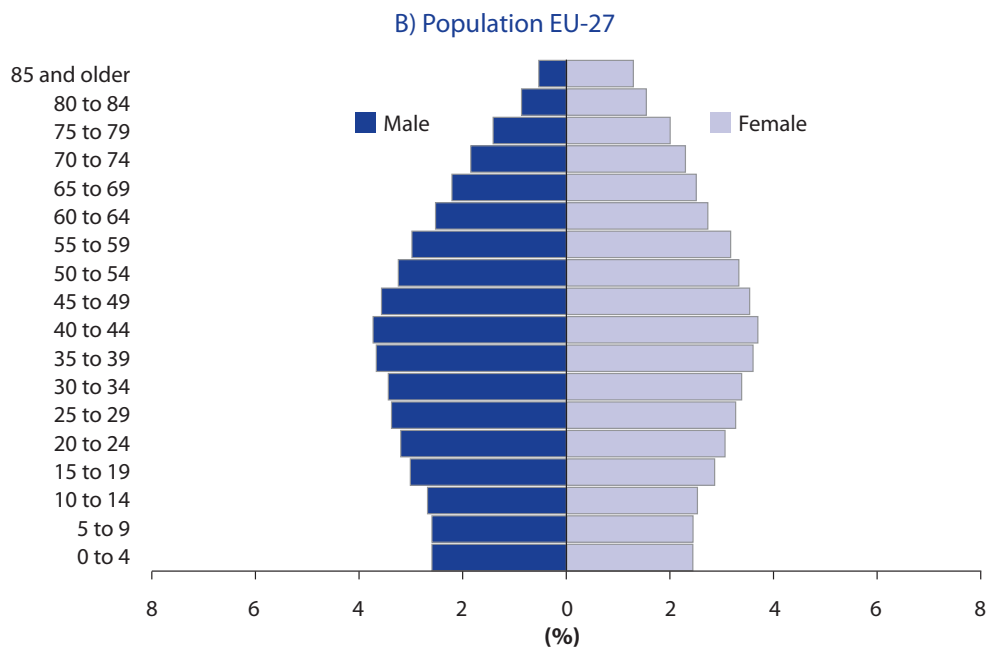
In the case of a research project such as this one, it is essential to begin with a socio-demographic description of the Roma population in comparison with the total population of the European Union. This may very well be the main social factor affecting health thus facilitating the interpretation of the social reality we are focusing on. We therefore begin our comparative study of the Roma community's health situation from a demographic perspective in order to view the different dimensions of health through characteristics of the population.

As already pointed out in the section covering the survey's methodology, there are three different levels or units of analysis to be considered when studying these results. The first focuses on households and results are based on a sample size of 5,647 households. The second focuses on the interviewee and in this case we have gathered information on 7,604 individuals. And lastly, basic information was collected on all of the members of the household, 26,058 people, this being the sample of focus for this section on demographic indicators.

We begin by showing the pyramid representing the Roma population of the participating countries considered jointly and that of the countries of the European Union (EU-27). This gives us a clear and concise idea of the differences between the two population groups. If we begin our analysis by looking at the base of the pyramids we observe the greater relative weight of minors in the Roma community in comparison with the pyramid representing EU-27 which rests on a relatively narrow base. This is a reflection of the declining birth rate for the last several years amongst the European population, especially EU-15 countries, as opposed to the Roma population where this has not been the case. However, the narrowing of the base of the pyramid representing the Roma population (up to age 9) in comparison with the group immediately above could indicate a slight decline in the birth rate of the Roma population. This could be an indication of new trends in terms of family planning in Roma homes.

Graph 1.1. Population pyramids in Europe: Roma community and the European Union





Another element characterising the Roma population and in contrast with the population at large can be found in the upper part of the pyramids. While in EU-27 the presence of the elderly is unmistakable indicating longer life expectancy, the same cannot be said of the Roma population. The Roma community is characterised by a more classic demographic structure (wide base and narrow apex) as from age 35 indicating a shorter life expectancy.

Having established the most significant differences illustrated by the population pyramids, we now want to delve deeper into our analysis looking at a set of demographic indicators taken from two basic demographic attributes – sex and age. This will enable us to identify possible contrasts between the countries taking part in this survey on Europe’s Roma population.

Our analysis is structured through a series of assertions comparing Europe’s Roma population with the overall EU-27 population and which can also be observed in the pyramids of the populations described in the foregoing. These assertions are as follows:

1. Balance of the female population vis-à-vis the overall population.

The data from the table of demographic indicators shows that the number of women is very similar to the number of men in both the Roma community and EU-27. Amongst the European Roma population we find a proportion of 103.5 women for each 100 men which is quite similar to the 104.8 women in EU-27. This holds true for the Roma population of all of the countries studied with the exception of Bulgaria where the proportion is 96.9 women to every 100 men. In contrast, the highest index is found in Portugal with 113.3 women.

2. Roma youth – aging Europe.

As was plain to see in the population pyramids, the Roma community is considerably younger than the overall European population. The average age of Europe’s Roma population is 25.1 in comparison with 40.2 for EU-27, a difference of 15 years. This attribute of the Roma population was found consistently in all seven countries with little difference between them. The highest average age was in Bulgaria (26.6) and the lowest in Greece (21.6).

This phenomenon is very clearly illustrated by focusing on the child and youth rates which are higher amongst Roma. 26.7% of the Roma population is between the ages of 15 and 29 (youth rate) compared to 19.3% in the case of EU-27. The child rate (population under age 15) of the Roma population is 35.7% compared to 15.7% for EU-27. Furthermore, the Roma population’s youth rate is

much higher than that of the European population. For every 100 people age 65 and over, the Roma community has 1,343 who are under the age of 15 in comparison with 92.1 in the case of EU-27.

In contrast, the elderly rate (proportion of the population age 65 and older) stands at 2.7% for the Roma population and 17.0% for EU-27. Having regard to the elderly rate, the adult and child populations are nearly balanced in the case of EU-27 while Europe's Roma community has 7.5 people age 65 or older for every 100 individuals age 14 or younger.

3. The European population lives longer than the Roma population.

This assertion is based on longevity and old-age indicators. The former focuses on the proportion of the population age 75 and over in comparison with the 65 and over group while the latter takes the proportion of people age 85 and over in comparison, once again, with those over age 64. Thus, the Roma population's longevity rate is 25.7% compared to 51% for EU-27 while the old-age rate is 4.5% for the Roma population as opposed to 11.2% for EU-27.

We would like to dwell for a moment on this assertion to establish some differences between countries. Only a small proportion of the Greek population reaches age 75 and older explaining the 16% longevity rate, the lowest of the seven countries. As for Portugal, although its longevity indicator is the highest (38%), its old-age rate is close to zero meaning that nearly the whole of the elderly population dies between the ages of 75 and 85. The Czech Republic has one of the highest longevity (37%) and old-age rates (6%) which indicates a higher life expectancy than the other countries.

4. Higher dependency rates for the Roma community, especially amongst minors.

A series of indicators have been devised in an attempt to measure possible dependency relationships between the two populations. This indicator basically measures the number of potentially inactive persons (under age 15 and over age 64) for every 100 potentially active people (between 15 and 64). The dependency rate of Europe's Roma community is 62 inactive persons for every 100 active ones as opposed to 48.7 for EU-27.

However, if we draw a distinction between minors and adults we see a clear imbalance between the Roma population and the overall population in terms of dependency. For every 100 Roma between the age of 15 and 64 there are 57.8 children under age 15 while in EU-27 this ratio stands at 23.3. In contrast, for every 100 potentially active Roma individuals we find 4.1 over the age of 64 in comparison with the figure of 24.9 for the European Union population as a whole.

5. Incipient fall in the Roma birth rate.

Here we are surprised to report a shift in the socio-demographic behaviour of Europe's Roma population. The progressive age structure shows that there are close to 82.7 Roma children under the age of 5 for every 100 children between 5 and 9 while this index for EU-27 is nearly 101. The fact that the indicator is under 100 for the Roma population means a fall in the replacement rate between the two youngest generation, a demographic situation which is repeated in all of the countries studied.

These figures could indicate a change in Roma birth rates, gradually mirroring the decline in Europe which took place several decades ago.

Table 1.1. Basic demographic indicators

Indicator	Definition	Greece	Portugal	Czech Republic	Slovakia	Romania	Bulgaria	Spain	Roma popul.	EU-27
Femininity index	Women per 100 men.	105.51	113.29	106.56	101.42	104.93	96.97	103.99	103.51	104.80
Average age	Average number of years lived per person.	21.56	23.75	25.85	24.02	26.50	26.63	24.97	25.09	40.24
Child rate	Percentage of the population age 14 and younger.	43.39	39.34	33.93	39.10	37.90	29.83	32.60	35.65	15.69
Youth rate	Percentage of the population age 15 to 29.	28.26	28.85	25.75	25.80	24.39	30.06	28.90	26.73	19.29
Elderly rate	Percentage of the population age 65 and older.	2.16	2.62	2.38	2.18	2.65	2.73	3.05	2.65	17.04
Longevity rate	Percentage of the 75 and over population divided by the 65 and over group.	16.00	37.50	37.25	23.08	26.25	20.21	26.98	25.65	51.02
Old-age rate	Percentage of the 85 and over population divided by the 65 and over group.	8.00	0.01	5.88	3.08	4.63	3.19	4.76	4.49	11.15
Youth index	Persons up to age 14 per every 100 persons age 65 and over.	2,008.00	1,500.00	1,423.53	1,795.38	1,429.34	1,092.55	1,068.25	1,343.04	92.07
Ageing index	Persons 65 and over per every 100 persons 14 and under.	4.98	6.67	7.02	5.57	7.00	9.15	9.36	7.45	108.62
Global dependency index	Potentially inactive persons (age 14 and under, 65 and over) per every 100 potentially active persons (15-64)	83.65	72.32	57.01	70.28	68.20	48.28	55.41	62.08	48.66
Child dependency index	Persons 14 and under per every 100 persons between 15 and 64.	79.68	67.80	53.26	66.57	63.74	44.23	50.66	57.77	23.33
Elderly person dependency index	Persons 65 and over per every 100 persons 15-64.	3.82	4.19	3.61	3.55	4.18	3.94	4.59	4.11	24.93
Progressive age structure	Children age 5 to 9 per every 100 children age 4 and under.	88.95	77.50	86.72	79.90	71.21	99.70	93.26	82.73	100.87
Replacement index	Persons 15 to 39 per every 100 persons age 40-64.	309.09	233.96	193.75	215.86	266.20	206.74	230.71	236.13	101.02

Source: EDIS S.A. European Survey on Health and the Roma Community 2009 and data obtained from Eurostat 2008 on EU-27

6. Population replacement assured in the Roma population.

The replacement index measures population replacement for the next 25 years. This indicator reflects the population between the ages of 15 and 39 per every 100 people age 40 to 64. According to this index, an indicator of over 100 guarantees demographic replacement. As the table shows, this indicator is above 100 both for the Roma population (of Europe in general and each of the countries analysed individually) and that of the European Union in general. However there is quite a difference – the replacement index for Europe’s Roma population is nearly 231 as opposed to 101 in the case of EU-27.

The country whose Roma population is most in line with the replacement index of EU-27 (despite being closer to the total Roma rate) is the Czech Republic with nearly 194. In contrast, the country with the highest replacement index is Greece (309) which makes sense considering that Greece is also the country with the highest child rate.

With this population replacement index we conclude this chapter which provides a comparative analysis using basic demographic indicators. As these statistics show, there are no noteworthy demographic differences between the countries where the Roma community survey was conducted. However, a comparison of the Roma population figures with those of EU-27 shows major differences in demographic trends.

1.2. Academic level

In this section we continue with an analysis of elements which allow us to characterise Europe’s Roma population both internally and with regard to the overall population. In this section we will focus on two variables which are of vital importance for the development of citizenship in all countries: academic level and enrolment rates of children in school.

Table 1.2. Distribution (in percentage terms) of the 16 and over Roma population according to academic level

	No studies	Primary	Secondary and beyond	Total	Base (N)
Roma population	43.6	32.8	23.7	100	(7,604)
Greece	83.2	15.1	1.6	100	(641)
Portugal	51.9	47.7	0.4	100	(367)
Czech Republic	20.4	70.3	9.3	100	(1,013)
Slovakia	25.4	47.8	26.8	100	(657)
Romania	37.4	26.9	35.7	100	(2,616)
Bulgaria	30.5	28.5	41.0	100	(814)
Spain	67.2	27.1	5.7	100	(1,496)

Source: EDIS S.A. European Survey on Health and the Roma Community.

44% of the total adult Roma population (over age 15) of the countries studied have not completed primary school studies. This means that approximately 465,000 Roma from these countries have failed to earn a school diploma. Moreover, not even a quarter of the population (24%) has attained at least a secondary level of education.

We would draw special attention to the “no studies” rates in Portugal (52%), Spain (67%) and particularly notorious, Greece (83%). In this latter country, only 1.6% of the Roma population reached at least secondary school. On the other extreme we would draw attention to the percentage of Roma students who did at least achieve a secondary level of education – Romania (36%) and Bulgaria (41%).

For comparison purposes, the following table shows data furnished by Eurostat on the whole of Europe’s population.

Table 1.3. Distribution (in percentage terms) of the 16 and over population (Roma community and EU-27) according to academic level

	Primary and lower	Secondary and higher	Total
EU-27 (*)	32.1	67.9	100
Roma Population (*)	75.5	24.5	100
Greece	98.3	1.7	100
Portugal	99.5	0.5	100
Czech Republic	90.4	9.6	100
Slovakia	72.3	27.7	100
Romania	63.4	36.6	100
Bulgaria	57.5	42.5	100
Spain	94.0	6.0	100

(*) EU-27: Population age 15 and over.

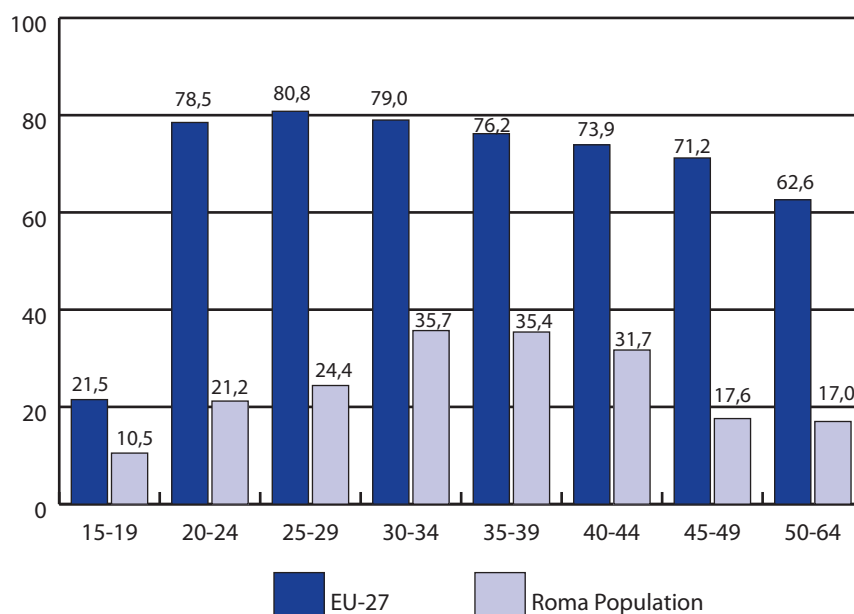
(*) Roma population: Population age 16 and over.

Source: EDIS S.A. European Survey on Health and the Roma Community and data on EU-27 from Eurostat 2008.

The figures from the above table speak for themselves. Only a very small proportion of the Roma population continues studying after primary school. In EU-27 just over two thirds of the population has at least a secondary level of education while this is true of only one quarter of the Roma population.

In other words, 2.8 individuals from the overall European population have achieved a secondary education for each Roma individual who can make the same claim. From these figures it can be deduced that approximately 1,300,000 Roma over the age of 15 have not progressed past primary school. These differences are clearly illustrated below by age group.

Graph 1.2. Percentage of the over 15 population with a secondary or higher level of education by age group



Source: EDIS S.A. European Survey on Health and the Roma Community, and data furnished on EU-27 by Eurostat 2008

The differences between EU-27 and the Roma population are self-evident featuring noteworthy gaps at all age groups. This gap is only significantly smaller in the age 15-19 group probably due to efforts being made by the younger generations.

Following are the school enrolment rates for minors.

Table 1.4. Percentage of minors (0-15) enrolled in school

	Minors	0 to 5	6 to 15
EU-27	79.8	45.2	99.6
Roma Population	67.2	22.5	87.0
Greece	34.9	8.8	56.0
Portugal	71.1	18.2	92.6
Czech Republic	72.1	28.6	94.1
Slovakia	71.9	20.3	96.4
Romania	67.6	9.9	86.9
Bulgaria	59.9	19.1	81.8
Spain	74.0	47.6	88.2

Source: EDIS S.A. European Survey on Health and the Roma Community and data furnished on EU-27 by Eurostat 2007

The most noteworthy differences are found in the 0-5 age group. While in EU-27, 45% of children at this age are already enrolled at school, in the case of the Roma community this figure is barely over one-fifth (23%) meaning that approximately 262,000 Roma children age 5 and under are not yet enrolled. This verifiable gap is what accounts for a difference of nearly 13 percentage points between the Roma population and EU-27 in the under 16 category.

The following table shows the student population among the 16 and over group:

Table 1.5. Percentage of the 15 and over population in school

	15 and older	15 to 24
EU-27	11.1	59.5
Roma Population	5.1	17.3
Greece	2.7	8.1
Portugal	1.8	5.6
Czech Republic	5.8	19.4
Slovakia	6.0	23.4
Romania	5.5	19.6
Bulgaria	3.8	14.8
Spain	4.7	14.3

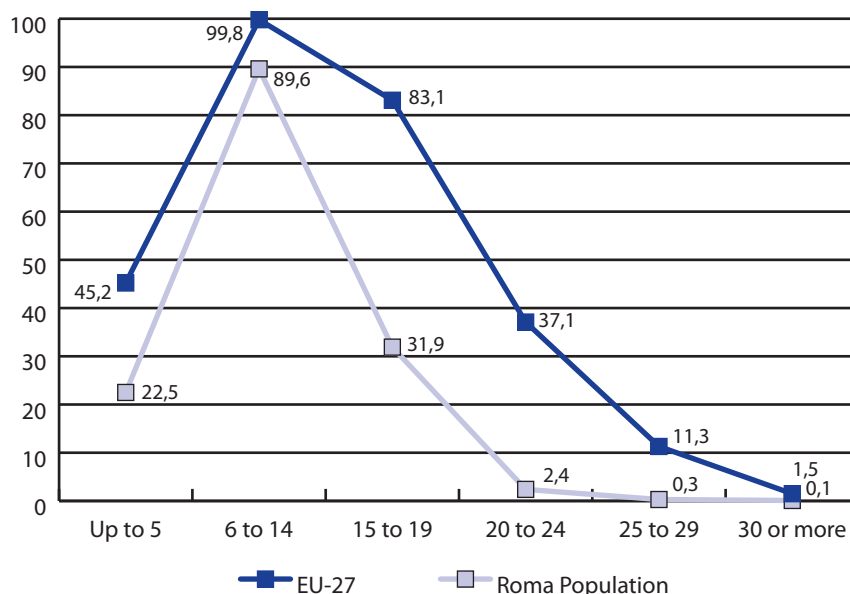
Source: EDIS S.A. European Survey on Health and the Roma Community and data furnished on EU-27 by Eurostat 2007

Although the gap in percentage terms is smaller among the adult population, it is still significant. Out of the entire 15 and over population, we find that the proportion of students in EU-27 (11%) is more than double that of the Roma population (5%). The gap is even larger if we limit the scope to the 15-24 age group where we find a student rate of 60% in the case of EU-27 which is 3.4 times greater than the proportion of Roma students at that age (17%).

As for individual countries, special mention should be made of the very low student rates in the 15-24 group in Greece (8%) and Portugal (6%).

The following graph clearly illustrates this comparison by age groups

Graph 1.3. Percentage of the population enrolled in school by age groups



Source: EDIS S.A. European Survey on Health and the Roma Community and data furnished on EU-27 by Eurostat 2007

This graph shows that fewer members of the Roma population enrol in school compared to the general population and also underscores early school leaving by the Roma population. Up to the age of 14, the school enrolment rate is significant, i.e. 90% of minors are in school. However, a great many leave school after that age.

1.3. Economic activity

This section analyses survey figures regarding the economic activity of the Roma population. A small clarification is in order before commencing: the data appearing here are based on the subjective perception of the interviewees and are therefore in no way comparable to the official figures compiled regularly in this regard.

Table 1.6. Economic activity (in percentage terms) of the adult population (16 and over) (self-classification)

	Employment	Unemployment	Inactivity	Total
Roma population	49.9	15.3	34.8	100
Greece	38.2	19.4	42.5	100
Portugal	60.8	9.8	29.4	100
Czech Republic	43.4	30.5	26.1	100
Slovakia	50.2	24.7	25.1	100
Romania	48.6	8.8	42.6	100
Bulgaria	61.9	7.1	31.0	100
Spain	48.3	19.7	32.0	100

Source: EDIS S.A. European Survey on Health and the Roma Community.

According to these figures, practically two-thirds of the Roma population are active and three-quarters of the latter are employed meaning that they are engaged in some sort of labour activity. This situation is illustrated in the following table.

Table 1.7. Activity and unemployment rates of the adult population (16 and over) (self-classification)

	Activity rate (Self-perceived)	Unemployment rate (Self-perceived)
Roma population	65.2	23.5
Greece	57.5	33.6
Portugal	70.6	13.9
Czech Republic	73.9	41.2
Slovakia	74.9	33.0
Romania	57.4	15.3
Bulgaria	69.0	10.3
Spain	68.0	29.0

Source: EDIS S.A. European Survey on Health and the Roma Community.

Special mention should be made of the inordinately high unemployment rates in three of the countries involved in our study: The Czech Republic, Slovakia and Greece. The first of these features an unemployment rate of 41% while in the other two it is in the vicinity of 33%. The case of Greece is especially noteworthy because this figure is associated with an activity rate of 58%. This means that in Greece more than six out of ten Roma are either unemployed or inactive, more than ten percentage points over the figure registered for the overall Roma population.

In addition to these figures, it is worthwhile to highlight a few others relating to employment. If we focus exclusively on the under 16 segment of the Roma population we find that 8.4% claim to “not do anything” (no studies or work) and 2.2% engage in some labour activity. This means that approximately 23,500 Roma under the age of 16 are working.

1.4. Place of residence

One of the most important aspects from a health perspective is the type of housing used by Roma families and its location, health conditions of the surrounding area and the availability (or lack thereof) of health and social services in the neighbourhood.

The data we provide in this regard reveal a great deal about this situation. 3.6% of the Roma population lives in shanty towns and nearly 27% in sub-standard housing, i.e. in homes featuring a number of deficiencies. In absolute terms, this means that approximately 852,000 Roma live in sub-standard housing or shanty towns.

A by-country breakdown of the data highlights the cases of Greece and Portugal where 22% and 31% respectively of the Roma population live in shanty towns. In Portugal and Slovakia the majority live in shanty towns or sub-standard housing as opposed to standard houses or flats and specifically in the case of Slovakia nearly half of the Roma population (47%) live in sub-standard housing and only 6% in shanty towns.

These data stand in stark contrast with those obtained concerning the Spanish Roma population where 92% of this latter group lives in standard flats or houses, 33 percentage points above the average for the countries considered jointly (69%).

As for the integration of residential neighbourhoods within the urban network we find that just over one-fifth of the Roma population (22.2%) live in neighbourhoods or areas which are distant or separated from the cities to which they are associated. However, the situation does vary from country to country and there are four where separation from urban centres is especially marked: Slovakia (41%), Portugal (44%), Bulgaria (47%) and Greece (54%).

The cases of Portugal, Bulgaria and Greece particularly stand out because not only does a large proportion of their Roma population reside in areas which are cut off from city centres but these countries are also the ones where we have recorded the largest proportion of the Roma population living in neighbourhoods characterised by unhealthy conditions. In Portugal close to half of the Roma population (47%) lives in areas

with poor health condition and the vast majority also lives in neighbourhoods which are distant from urban centres (39%). 55% of Roma in Greece live in areas with poor health conditions and 37% are also separated from urban centres. And lastly, in Bulgaria nearly two-thirds of the population (64%) live in neighbourhoods with poor health conditions and 34% in areas separated from the cities.

These are the same countries where we detected a greater lack of health and social services in the residential neighbourhoods of the Roma population. Portugal, Greece and Bulgaria were the countries where the highest proportion of the population lacks these services in their neighbourhoods, the figures ranging from 37% in the case of Portugal to 32% in Bulgaria. Also, in the Czech Republic and Slovakia nearly a quarter of the Roma population lacks health or social services in the vicinity of their homes.

In terms of these indicators, the Spanish Roma population finds itself in a relatively enviable position: 92% of that group has health and social services available to them in their home neighbourhoods.

Table 1.8. Distribution (in percentage terms) of the Roma population according to type and place of residence

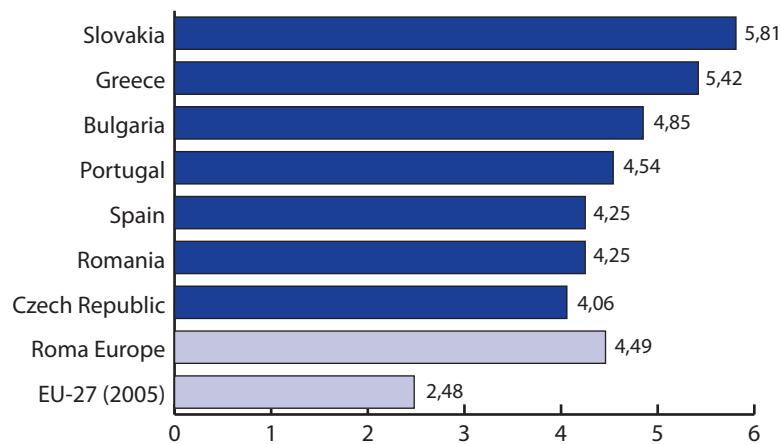
	Greece	Portugal	Czech Republic	Slovakia	Romania	Bulgaria	Spain	Roma popul.
POPULATION								
Total	100	100	100	100	100	100	100	100
Base (N)	(3,492)	(1,676)	(4,109)	(3,760)	(2,616)	(3,947)	(6,458)	(26,058)
Type of house								
Standard flat or house	52.6	46.2	62.5	46.5	65.8	70.6	92.4	69.5
Sub standard housing	25.5	23.3	32.8	47.3	33.5	25.0	6.6	26.9
Shanty town	21.9	30.5	4.7	6.2	0.8	4.4	1.0	3.6
Neighbourhood								
Integrated and good health	29.2	48.0	60.8	46.2	69.5	23.3	69.6	57.9
Integrated and poor health	17.2	7.9	22.9	12.6	22.4	29.9	13.9	19.9
Isolated and good health	16.2	4.9	5.6	25.7	6.7	12.8	9.3	10.6
Isolated and poor health	37.3	39.1	10.7	15.5	1.5	33.9	7.1	11.6
Health and social services								
With health and social services	64.5	63.1	76.9	76.3	97.9	67.8	91.7	86.3
Without health or social services	35.5	36.9	23.1	23.7	2.1	32.2	8.3	13.7
HOUSEHOLD								
Total	100	100	100	100	100	100	100	100
Base (N)	(641)	(367)	(1,013)	(657)	(659)	(814)	(1,4969)	(5,647)
Type of house								
Standard flat or house	52.4	47.6	63.6	51.2	64.9	73.1	93.0	71.1
Sub standard housing	25.2	22.2	31.9	43.8	34.0	22.4	5.9	25.6
Shanty town	22.3	30.2	4.6	5.0	1.0	4.5	1.1	3.3
Neighbourhood								
Integrated and good health	29.5	49.2	62.6	50.7	73.8	26.7	70.2	62.1
Integrated and poor health	17.9	7.9	21.6	11.7	17.9	28.8	13.0	17.7
Isolated and good health	15.0	4.8	5.5	23.1	6.9	11.4	9.5	9.7
Isolated and poor health	37.7	38.1	10.3	14.5	1.4	33.1	7.3	10.5
Health and social services								
With health and social services	64.3	65.1	77.9	79.0	97.5	68.7	91.9	87.5
Without health or social services	35.7	34.9	22.1	21.0	2.5	31.3	8.1	12.5

Source: EDIS S.A. European Survey on Health and the Roma Community.

1.5. Size of the household

This section focuses on another of the elements which differentiates the Roma population from the overall population of EU-27.

Graph 1.4. Average household size, Roma population and EU-27

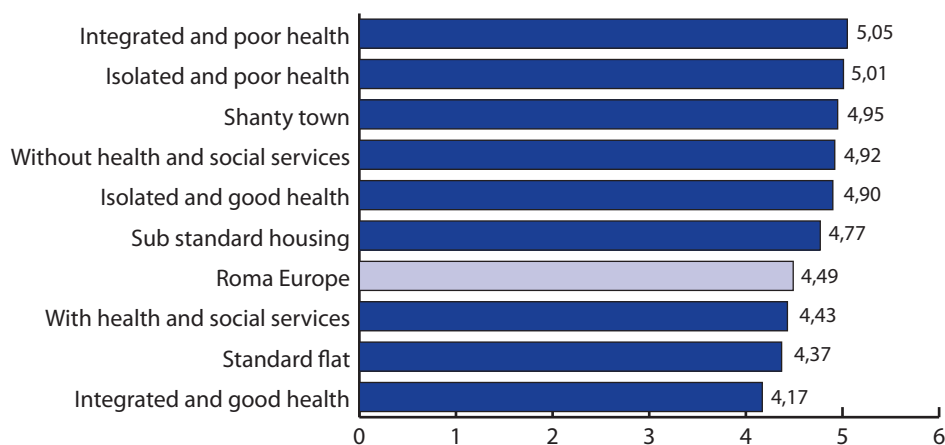


Source: EDIS S.A. European Survey on Health and the Roma Community and data furnished on EU-27 by Eurostat 2005.

The fertility patterns of Roma population households differ significantly from those characterising European households in general. On average, there are 4.49 individual living in the Roma households in the countries studied which is 2 points above the general average corresponding to EU-27. Four countries exceed this average for the Roma population, especially Greece (5.42) and Slovakia (5.81).

It is particularly interesting to observe how certain situations appear to have an important impact on household size. The figures shown in the following graph support this assertion.

Graph 1.5. Average household size of Europe's Roma population in accordance with different residence variables



Source: EDIS S.A. European Survey on Health and the Roma Community.

The graph shows that households associated with positive circumstances and situations are smaller than the overall average calculated for the Roma population: neighbourhoods integrated in cities and with good health conditions (average household size 4.17), standard flats or houses (4.37) and neighbourhoods or areas with available health and social services (4.43).

Households located in neighbourhoods featuring poor health conditions, a lack of social and health services or shanty town or sub-standard conditions are the ones with the highest number of members. In other words, the most numerous households are found in the most disadvantaged social contexts.

1.6. Care of dependent persons

We will finish this chapter by analysing the Roma population's degree of dependence and who tends to take responsibility for the care of people in need.

We begin by looking at Roma households with young children and focusing on the caretakers.

Table 1.9. Percentage of Roma households with minors (up to age 15) broken down by caretakers

	Greece	Portugal	Czech Republic	Slovakia	Romania	Bulgaria	Spain	Roma popul.
Mother	91.4	93.9	93.5	97.8	88.9	90.6	92.5	91.4
Father	19.1	11.9	50.7	72.2	43.8	35.7	20.7	39.3
Grandmother	27.7	13.9	34.3	38.3	24.9	35.5	20.8	27.3
Grandfather	5.2	2.3	8.1	3.8	4.7	6.3	2.7	4.6
Brother	1.3	0.6	3.8	5.2	0.9	0.6	1.9	1.8
Sister	5.7	20.3	7.7	10.5	6.5	3.1	13.2	8.3
Other relatives	4.8	7.4	8.9	4.7	4.9	1.9	6.0	5.1
Other relationship	0.5	1.9	1.3	0.7	1.1	1.9	1.1	1.2
Base (N)	(559)	(310)	(743)	(554)	(516)	(647)	(1,097)	(4,426)

Source: EDIS S.A. European Survey on Health and the Roma Community.

As the table shows, it is generally women, especially mothers, who are responsible for taking care of minors living in Roma households. In over 90% of the households with minors it is the mothers who assume responsibility for taking care of them, an occupation which, undoubtedly and over and above other considerations, has a direct impact on the likelihood of engaging in any sort of labour activity and is a factor accounting for why only 21% of the major wage earners of Roma households are women.

The following table shows the results obtained concerning Roma households where one of its members has difficulties carrying out everyday activities such as leaving the home, getting dressed, showering, eating, etc.

Table 1.10. Distribution (in percentage terms) of the Roma population according to difficulties faced in undertaking daily activities

	No difficulty	Moderate difficulty	Serious difficulty	Very serious difficulty	Total	Base (N)
Roma Europe	87.9	8.7	2.3	1.1	100	(25,961)
Greece	91.6	6.2	1.7	0.5	100	(3,418)
Portugal	93.9	4.9	1.0	0.3	100	(1,664)
Czech Republic	90.7	6.6	2.2	0.5	100	(4,109)
Slovakia	73.9	18.7	6.2	1.2	100	(3,759)
Romania	84.6	11.1	2.3	2.0	100	(2,616)
Bulgaria	94.5	4.0	1.3	0.3	100	(3,937)
Spain	94.3	4.1	1.3	0.3	100	(6,458)

Source: EDIS S.A. European Survey on Health and the Roma Community.

The figures indicate that 12% of the Roma population encounter some type of difficulty undertaking all or some everyday activities. In absolute terms, approximately 335,400 Roma persons residing in the countries studied encounter difficulties of this sort.

3.4% of the Roma population (approximately 95,000 people) encounter serious or very serious difficulties and therefore have a greater degree of dependence.

Table 1.11. Distribution (in percentage terms) of the Roma population encountering difficulties engaging in everyday activities broken down by help needed and received

	No help needed	Needs and receives help	Needs but does not receive help	Total	Base (N)
Roma Europe	40.8	54.4	4.8	100	(2,717)
Greece	33.7	60.0	6.3	100	(289)
Portugal	44.4	50.0	5.6	100	(98)
Czech Republic	43.4	52.0	4.5	100	(382)
Slovakia	62.3	36.4	1.3	100	(981)
Romania	35.8	60.0	4.2	100	(398)
Bulgaria	17.1	61.3	21.6	100	(218)
Spain	28.1	66.5	5.4	100	(351)

Source: EDIS S.A. European Survey on Health and the Roma Community.

This table reflects the percentages of Roma who encounter difficulties carrying out everyday activities and who also require the aid of another person. The data speak for themselves. Six out of every ten depend on the aid of another person but not all of them receive that aid: nearly 5% of the interviewees who claimed that they needed someone's help stated that they did not receive it.

This situation is especially worrisome. In Bulgaria the figures show that one-fifth of those who need the help of others do not receive such help.

The following table shows the people who are mainly responsible for taking care of dependent persons.

Table 1.12. Distribution (in percentage terms) of the dependent population receiving care or aid from other people broken down by the principal caretaker

	Greece	Portugal	Czech Republic	Slovakia	Romania	Bulgaria	Spain	Roma popul.
Mother	43.3	12.5	25.7	34.3	51.6	10.5	21.3	38.8
Daughter	13.3	12.5	13.3	13.5	19.9	11.1	26.6	18.3
Wife or partner	16.7	25.0	18.6	19.0	11.9	20.4	25.4	16.3
Husband or partner	8.3	12.5	18.6	16.6	4.7	19.8	7.4	9.4
Another relative	8.3	12.5	8.0	10.0	6.5	16.7	6.6	8.2
Son	3.3	25.0	5.3	5.2	4.0	19.1	7.4	6.2
Other relationship	1.7	0.0	5.3	0.7	0.8	1.2	2.0	1.3
Social volunteer serv.	3.3	0.0	2.7	0.0	0.4	0.0	2.0	0.8
Grandmother	1.7	0.0	1.8	0.7	0.0	0.0	0.8	0.4
Grandfather	0.0	0.0	0.0	0.0	0.3	0.6	0.0	0.2
Father	0.0	0.0	0.9	0.0	0.0	0.6	0.4	0.2
Total	100	100	100	100	100	100	100	100
Base (N)	(185)	(47)	(216)	(364)	(229)	(187)	(236)	(1,464)

Source: EDIS S.A. European Survey on Health and the Roma Community.

Mothers, daughters and wives are the main caretakers of dependent persons. These three family member together cover close to three-quarters of the needs of dependent persons.

The main caretakers of dependent persons tend to be women regardless of whether we are referring to the Roma population or the entire European population. This situation is clearly illustrated in the following table.

Table 1.13. Distribution (in percentage terms) of the caretakers of dependent persons broken down by gender and country. *Roma population*

	Women	Men	Unknown
Romania	83.3	9.0	7.7
Greece	75.0	11.6	13.4
Spain	74.2	15.2	10.6
Roma Europe	73.8	16.0	10.2
Slovakia	67.5	21.8	10.7
Czech Republic	59.3	24.8	15.9
Portugal	50.0	37.5	12.5
Bulgaria	42.0	40.1	17.9

Source: EDIS S.A. European Survey on Health and the Roma Community.

The proportion of women as caretakers of dependent persons exceeds the average for the Roma population in three of the countries studied, the case of Romania being particularly striking.

Part 2. Health status

2.1. Perception of health status

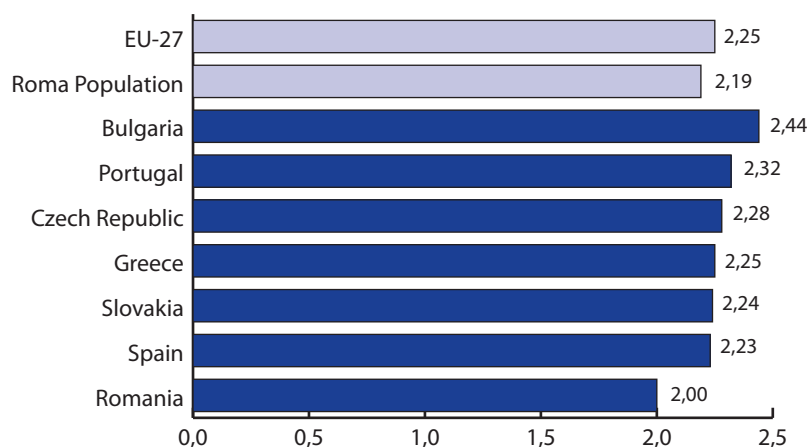
In this section we will thoroughly analyse the health status of the Roma population in the countries studied both in general terms and in comparison with the overall health situation of EU-27 (where data is available) in order to provide a more concrete and clear view of the health status of the Roma population.

Here we are presenting the subjective perception that different groups have of their health status. To that end, the Roma individuals who took part in the interviews were asked to rate their state of health on a scale of 1 to 5 during the 12 months immediately preceding the interview as follows:

- 1 Very good
- 2 Good
- 3 Mediocre
- 4 Poor
- 5 Very poor

The following graph shows the average scores (on a scale of 1 to 5) obtained for the overall Roma population interviewed and for each of the countries and the EU-27 Eurostat data.

Graph 2.1. Subjective perception of state of health. Comparison of averages (on a scale of 1 to 5) of the 15 and over population



Source: EDIS S.A. European Survey on Health and the Roma Community 2009 and Eurostat data on EU-27 (2008).

As shown in the graph, the averages for the two population group (Roma and EU-27) are in the vicinity of "2", i.e. state of health considered "good". However these figures must be analysed in context. The Roma population is basically young (average age of 25) while EU-27 is quite a bit older (average age 40). This 15 year difference linked to a negligible difference in health perception would appear to indicate a worse health situation for the Roma population.

In terms of the Roma population in the different countries, Romania has the best perception of its health with an average of 2.0 points while Bulgaria is the country with the highest average (2.4 points) and there-

fore the worst perceived health status which is consistent with its demographic situation being the country whose Roma population features the highest average age.

As alluded to in the foregoing, data analysis must consider the age of the population under scrutiny. This is the only way to identify differences in terms of health perception between the Roma community and the European population at large. The following table shows the distribution (in percentage terms) of the Roma population and the overall population of the European Union according perception of health broken down into age brackets.

Table 2.1. Distribution (in percentage terms) of the 15 and over population according to perception of health. Roma and EU-27 population age 15 and over.

	Very good/Good	Mediocre	Poor/Very poor	TOTAL	Base (N)
Roma population	68.0	23.1	8.8	100	(5,006)
15 to 24	86.9	11.1	2.0	100	(1,274)
25 to 34	83.1	13.7	3.2	100	(1,209)
35 to 44	65.9	25.0	9.1	100	(1,077)
45 to 54	45.4	41.8	12.8	100	(737)
55 to 64	22.7	48.7	28.6	100	(419)
65 to 74	12.4	51.8	35.8	100	(234)
75 to 84	23.7	28.9	47.4	100	(45)
85 and older	12.5	37.5	50.0	100	(11)
EU-27	66.0	23.6	10.4	100	--
15 to 24	91.9	6.7	1.4	100	--
25 to 34	86.7	10.8	2.5	100	--
35 to 44	78.4	17.3	4.4	100	--
45 to 54	64.3	25.8	9.9	100	--
55 to 64	51.2	34.2	14.6	100	--
65 to 74	38.0	41.3	20.6	100	--
75 to 84	25.8	42.5	31.8	100	--
85 and older	24.6	37.4	38.0	100	--

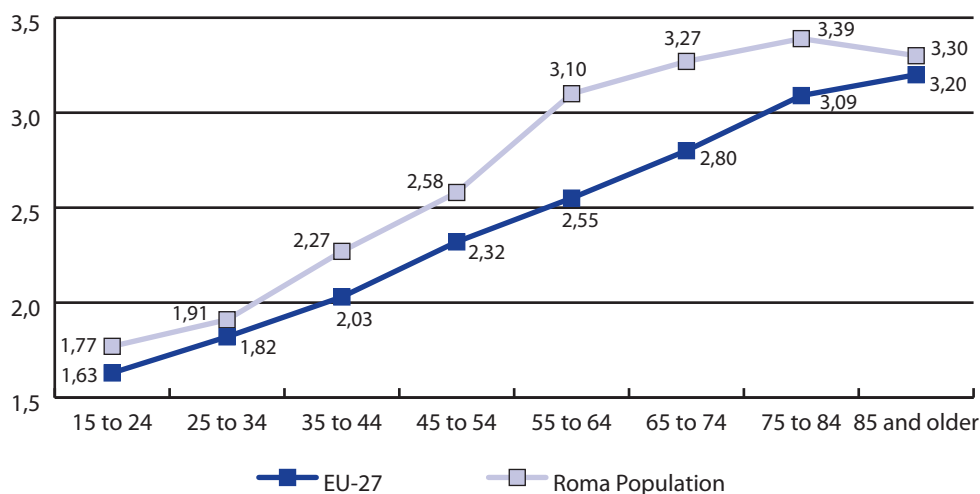
Source: EDIS S.A. European Survey on Health and the Roma Community 2009 and Eurostat data on EU-27 (2007).

This allows us to analyse this phenomenon within different generations. To this end we will focus on the proportion of the population rating their health as poor or very poor over the preceding 12 months. As the table shows, in both groups health perception is more negative as age increases which is as one might expect. Hence, despite a lower proportion of Roma persons with poor or very poor health (9% as opposed to 10% for EU-27), if we look at the different age brackets the percentage of Roma population in this health situation is higher than that corresponding to EU-27.

Furthermore, the gap between the two groups widens as age increases. 2% of the Roma population between the ages of 15 and 24 considers their health to be poor or very poor, 0.6 percentage points higher than the 1.4% registered for EU-27. However, this indicator reaches the 36% level for the Roma population between the ages of 65 and 74, 15 points over the 21% recorded for EU-27.

This same analysis is reflected in the following graph showing the average subjective perception of health on a scale of 1 to 5. Remember that 1 is for very good health while 5 means very poor, i.e. the lower the average score, the better perceived state of health.

Graph 2.2. Subjective perception of state of health. Comparison of averages on a scale of 1 (very good) to 5 (very poor). Population age 15 and over. European Roma and EU-27 population.



Source: EDIS S.A. European Survey on Health and the Roma Community 2009 and Eurostat data on EU-27 (2007).

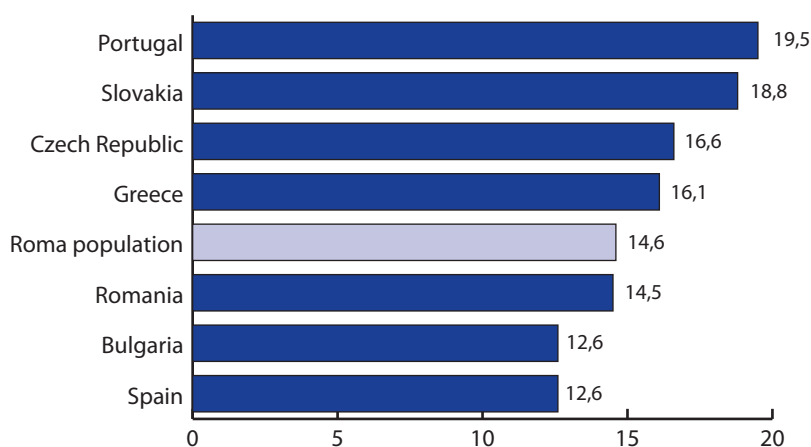
A close look at these data making a thorough comparison of the different age brackets shows that the Roma population actually has a worse perception of their state of health than EU-27 in all age brackets.

2.2. Disease and health problems

Having looked at state of health from the perception of the interviewee, this section focuses on health problems and disease suffered by the Roma population. Here we will highlight the proportion of the population suffering any sort of disability or chronic disease, information being furnished through the section of the questionnaire on all of the members of the household, i.e. a sample base for the overall European Roma population of 26,058 cases.

15% of Europe's Roma population suffers from some sort of disability or chronic disease which translates into 407,000 Roma. Exceeding this figure are Portugal (20%), Slovakia (19%), the Czech Republic (17%) and Greece (16%). The countries with a lower incidence of disability or chronic disease are Romania (15%), Bulgaria (13%) and Spain (13%).

Graph 2.3. Percentage of the Roma population suffering a disability or chronic disease



Source: Source: EDIS S.A. European Survey on Health and the Roma Community 2009.

It is surprising to observe how these results differ from the perception that individuals have of their own health. This is the case especially in Bulgaria (the most noteworthy case) and Spain where Roma individuals' perception of their state of health is quite a bit worse than the European average but if we focus on the reality of the diseases they suffer, this phenomenon is inverted. On the opposite end of the spectrum we have Slovakia and Greece. Despite expressing a state of health in line with the European Roma average, Roma from these two countries suffer from a higher incidence of disability or chronic disease.

Together with this information taken from the household questionnaire, interviewees were also asked whether a physician had diagnosed any of a series of diseases. Given that in this case the information refers only to those actually interviewed, the sample base is comprised of 7,604 cases. The following table shows the proportion of Roma population suffering from any of the chronic diseases listed, drawing a distinction between those referring to the entire Roma population and those exclusively referring to adults.

Table 2.2. Percentage of the population suffering from chronic disease by diagnosis

	Greece	Portugal	Czech Republic	Slovakia	Romania	Bulgaria	Spain	Roma Pop.
Minors and adults								
High blood pressure	9.3	6.5	11.3	10.2	10.3	22.6	10.6	12.0
High cholesterol	6.8	9.2	8.9	6.8	6.5	7.4	8.8	7.5
Diabetes	4.0	5.3	5.8	3.7	4.1	6.4	4.1	4.5
Asthma, chronic bronchitis	9.6	14.5	9.5	8.3	4.2	14.0	9.4	8.0
Heart disease	6.1	2.8	7.7	6.0	8.5	9.1	3.5	6.9
Stomach ulcer	5.8	3.0	7.9	3.9	3.3	6.6	5.9	4.9
Allergy	9.9	3.7	11.9	7.1	2.3	9.5	13.9	7.7
Depression (*)	7.7	3.6	10.7	2.8	--	3.3	8.8	4.1
Other mental illnesses	7.5	2.0	6.7	4.6	1.6	2.1	4.0	3.3
Migraines or headaches	10.4	5.4	21.7	10.3	7.5	14.5	22.2	13.5
Hernias	4.5	3.8	6.8	4.6	6.8	3.6	12.1	7.2
Only adults								
Poor circulation	8.2	5.8	9.1	8.0	9.1	4.3	17.1	10.3
Arthritis, rheumatism	5.4	3.8	10.6	7.3	10.6	15.2	14.5	11.7
Osteoporosis	0.5	1.9	4.3	4.4	1.7	2.8	3.6	2.8
Prostate problems	0.0	0.0	2.2	4.9	4.7	8.9	4.0	4.7
Menopause related probl.	8.6	0.0	9.9	7.0	6.8	11.6	8.1	8.1

(*) In Romania the question about depression was omitted.

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

In general terms, the ailments most frequently suffered by the Roma population both collectively and by country are migraines and headaches. The country with the highest number is Spain where 22% of the Roma population suffers from this ailment, followed very closely by the Czech Republic also with 22%, both quite a distance from the 13% average computed for the group of countries. In other words, approximately 380,000 European Roma suffer from migraines or headaches.

The second most prevalent ailment among the Roma population is hypertension. In this case, Bulgaria stands above the rest with 23%, far from the average of 12% for the countries considered jointly. Of the nearly 3 million Roma living in the seven countries studied, approximately 335,000 have high blood pressure.

As we progress down to the lower percentages, the results are more heterogeneous, indices varying considerably from one country to the next. The lowest prevalence observed amongst Europe's Roma population is for mental diseases in general (3%) followed by depression (4%) and diabetes (5%).

In terms of diseases specific to one or the other gender we find that Roma men in Romania have more prostate problems (9%) and the women of this same country are the ones most affected by menopause-related difficulties (nearly 12%).

In order to facilitate a more precise analysis of these data, the following table shows the prevalence of chronic diseases broken down according to whether they affect minors and adults.

The figures show that Roma minors suffer most commonly from asthma (8%) and allergies (7%). This translates into 153,000 Roma minors with asthma and 117,000 with allergies. Amongst the adult Roma population the most frequent are migraines and headaches (20%), hypertension (19% or 200,000 adults), arthritis and rheumatism (12% or 124,000 adults) and high cholesterol (12% or 122,000 adults).

Table 2.3. Percentage of the population suffering from chronic disease by diagnosis. Minors and adults

	Greece	Portugal	Czech Republic	Slovakia	Romania	Bulgary	Spain	Roma Pop.
Minors								
High blood pressure	0,9	0,0	1,2	0,0	0,0	2,3	0,7	0,5
High cholesterol	0,4	0,9	2,7	0,5	0,0	0,4	1,5	0,7
Diabetes	0,9	0,0	1,2	0,6	0,1	0,4	0,6	0,4
Asthma, chronic bronchitis	12,0	21,8	10,2	7,9	5,5	14,3	10,9	8,8
Heart disease	1,4	0,9	4,3	1,4	0,9	1,5	1,1	1,4
Stomach ulcer	0,5	0,9	1,2	0,0	0,4	1,1	0,2	0,5
Allergy	10,4	7,1	14,7	7,1	2,0	9,4	10,8	6,8
Depression (*)	0,5	0,0	6,1	0,5	--	0,8	0,7	1,4
Other mental illnesses	1,3	0,9	6,0	3,7	0,2	2,6	1,6	1,8
Migraines or headaches	3,6	1,5	12,6	1,3	1,0	4,1	5,1	3,3
Hernias		0,6	2,7		3,4	2,3	0,7	2,0
Adults								
High blood pressure	16,3	11,2	17,2	17,7	17,5	32,5	14,9	18,8
High cholesterol	12,1	15,2	12,5	11,3	11,0	10,8	12,0	11,5
Diabetes	6,7	9,2	8,5	6,0	6,9	9,3	5,7	7,0
Asthma, chronic bronchitis	7,7	9,2	9,0	8,6	3,3	13,9	8,8	7,5
Heart disease	10,1	4,1	9,7	9,3	13,7	12,8	4,5	10,1
Stomach ulcer	10,3	4,5	11,8	6,7	5,2	9,3	8,4	7,6
Allergy	9,4	1,2	10,2	7,0	2,5	9,5	15,3	8,3
Depression (*)	13,7	6,2	13,4	4,4	--	4,6	12,3	9,4
Other mental illnesses	12,8	2,8	7,1	5,3	2,5	1,8	5,1	4,2
Migraines or headaches	16,2	8,3	27,0	16,9	11,9	19,5	29,7	19,6
Hernias	3,2	3,1	2,7	1,4	3,8	5,1	7,9	4,7
Poor circulation	8,2	6,2	9,1	8,0	9,1	4,2	17,1	10,3
Arthritis, rheumatism	5,5	4,7	10,5	7,3	10,6	15,1	14,5	11,7
Osteoporosis	0,5	1,1	4,4	4,3	1,7	2,8	3,7	2,8
Prostate problems	0,0	0,0	2,2	4,7	4,8	8,9	4,0	4,8
Menopause-related probl.	9,0	0,7	10,1	7,0	6,9	11,7	8,1	8,1

(*) In Romania the question about depression was omitted.

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

A closer look at the percentage of minors with chronic diseases in each of the countries shows that asthma affects 22% of Roma minors in Portugal and migraines and headaches affect 13% of those from the Czech Republic. Special attention should also be drawn to the rate of hernias in Romania (3,4%) compared to the figure of 2% for the whole of Europe. As for the adult population, mention should also be made of the Czech Republic with regard to migraines and headaches as this is the country with the highest index in this regard affecting 27% of the adult population.

2.3. Accidents

We now move on to the information regarding accidents suffered by the Roma interviewees taking part in our study. The Roma population was specifically asked whether in the preceding 12 months they had suffered any sort of accident including aggressions, intoxications or burns. The following table shows that 11% of the population had suffered some sort of accident in the preceding year.

Table 2.4. Percentage of the population suffering an accident during the preceding year

	Total	Minors	Adults
Roma Population	10.6	10.6	10.7
Greece	15.6	18.1	13.0
Portugal	6.7	2.6	9.4
Czech Republic	11.2	10.9	11.3
Slovakia	11.0	12.3	10.1
Romania	7.4	6.5	8.0
Bulgaria	12.2	14.6	10.9
Spain	13.9	14.1	13.8

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

Greece is the country with the highest accident index (16%) followed by Spain with 14%. The lowest accident rate was recorded in Romania with 7%, four points under the average of the participating countries. The table also shows the accident indicator for minors and adults. The overall percentage of the population that had suffered an accident during the preceding 12 months was the same for minors and adults (11%).

However, accident rates in the different countries was very heterogeneous. The highest accident rate among minors was recorded in Greece with 18% followed by Bulgaria with 15% and Spain with 14%. The lowest rates were found in Portugal (3%) and Romania (7%). As for the incidence of accidents among the adult population the highest percentages were found in Spain (14%), Greece (13%), the Czech Republic (11%) and Bulgaria (11%), the lowest figures being recorded in Romania (8%) and Portugal (9%).

We now turn our attention to the places where these accidents occurred. To this end we asked the interviewees where the most recent accident had occurred.

As the table below shows, the most common accident site is the home accounting for 43% of the accidents. The second most common site was out on the street but not considering traffic accidents (20%) followed by traffic-related accidents (17%). The lowest accident rate was recorded at the workplace and school with 13% and the category called "other places" with 7%. The data broken down by country shows a high home accident rate in Romania (57%) and a high traffic accident rate in Spain and Portugal (29% and 24% respectively).

Table 2.5. Breakdown of the Roma population (in percentage terms) engaged in an accident during the previous 12 months by place of the most recent accident.

	At home, stairs, building entrance	Outside; a traffic accident	Outside; not a traffic accident	At work or school	Some other place	Total	Base (N)
Roma Population	42.8	16.5	20.3	13.3	7.1	100	(886)
Greece	39.6	18.9	17.0	9.4	15.1	100	(98)
Portugal	32.0	24.0	16.0	4.0	24.0	100	(25)
Czech Republic	42.3	11.3	26.8	11.3	8.5	100	(115)
Slovakia	38.0	6.5	33.7	20.7	1.1	100	(76)
Romania	57.1	6.1	9.4	17.5	9.9	100	(265)
Bulgaria	37.7	18.0	27.0	8.2	9.0	100	(99)
Spain	35.9	29.0	20.2	11.3	3.6	100	(208)

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

Women are affected much more by domestic accidents, including women who work outside the home. While 56% of women suffering accidents had their last accident at home, the same was true for only 32% of the men. Accidents outside the home, however, were suffered predominately by men, 24% affecting men as opposed to 16% affecting women, the same being true for labour-related accidents with figures of 16% and 9% respectively. These data are a reflection of socialisation whereby different duties, responsibilities and spaces are arbitrarily assigned to women and men.

Table 2.6. Breakdown of the Roma population (in percentage terms) engaged in an accident during the previous 12 months by place of the most recent accident. Gender and age groups

	At home, stairs, building entrance	Outside; a traffic accident	Outside; not a traffic accident	At work or school	Some other place	Total	Base (N)
Roma Population	42.8	16.5	20.3	13.3	7.1	100	(886)
Male	32.0	18.8	24.3	16.3	8.6	100	(472)
Female	56.1	13.5	15.5	9.7	5.2	100	(414)
Minors	42.2	9.0	25.2	15.9	7.6	100	(353)
Adults	43.1	20.9	17.5	11.7	6.8	100	(533)

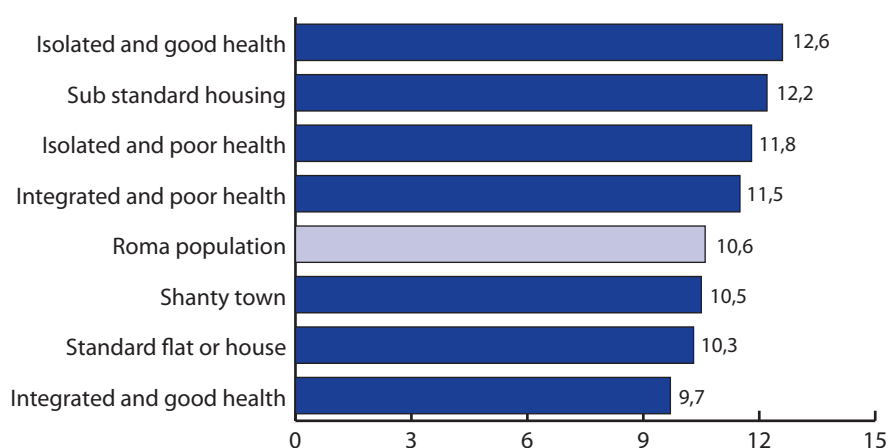
Source: EDIS S.A. European Survey on Health and the Roma Community 2009

Some noteworthy differences were likewise detected in the location of accidents between minors and adults. First of all, however, mention should be made of the high concentration of domestic accidents both in the case of minors (42%) and adults (43%). Traffic accidents mostly affect the adult population (21%) as opposed to minors (9%). Minors, however, suffer more accidents at school (16%) than their adult counterparts at the workplace (12%) and out in the street - 25% versus 18% for the adult population.

As for the consequences of the most recent accident in the last year affecting minors, we recorded bruises, contusions, sprains, dislocations and superficial cuts accounting for 58% of the injuries. The second most frequent consequence included fractures and deep cuts accounting for 23% followed by burns (16%), intoxications (4%), the last 10% being from the "other" category.

The survey also checked to see if there was a correlation between the type of neighbourhood or home and the number of accidents. The following graph focuses on the proportion of accident victims in the last year according to these variables.

Graph 2.4. Percentage of the population suffering accidents in the preceding 12 months according to type of neighbourhood and home.



Source: EDIS S.A. European Survey on Health and the Roma Community 2009

As the graph shows, social situations such as living in poorly integrated and unhealthy neighbourhoods or in sub-standard housing are key in explaining the high percentage of accidents suffered by the Roma population. Data show that the most determining factor is the low degree of integration of the neighbourhood of residence more than the type of home or health conditions. Less integrated neighbourhoods are the ones where the highest number of accidents was recorded, exceeding the European average for this same group by two points. As one would expect, the more integrated neighbourhoods featuring better health and housing conditions are where fewer accidents occurred.

2.4. Limitation of daily activity

In this section we show the results obtained regarding the situations keeping the Roma population from engaging normally in daily activities. To this end, European Roma were asked whether in the preceding two weeks they had to reduce or limit their main activity or free-time activity due to one or more pains or symptoms.

The following table shows the percentage of people affected by some sort of limitation in their daily activity broken down by country of residence and whether they are minors or adults.

Table 2.7. Percentage of the population which had to limit daily activities in the preceding two weeks.

	Total	Minors	Adults	Base (N)
Roma Europe	19.4	16.9	20.8	(7,604)
Greece	24.9	20.9	28.1	(641)
Portugal	10.0	10.5	9.4	(367)
Czech Republic	28.0	29.3	27.5	(1,013)
Slovakia	17.0	19.1	15.5	(657)
Romania	14.5	11.6	16.5	(2,616)
Bulgaria	27.7	27.1	27.9	(814)
Spain	19.9	14.8	22.2	(1,496)

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

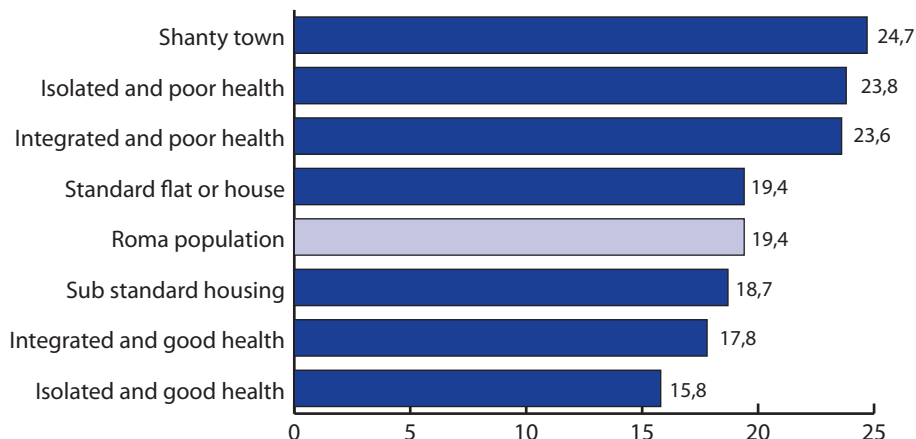
The table shows that 19% of the Roma interviewees had to limit their daily activity at some point during the two weeks immediately preceding the interview. The figures also show that this situation affected 21% of the adult population and 17% of the minors.

A by-country breakdown shows that the Czech Republic was where the highest number of Roma were limited in some aspect of their life, exceeding the average recorded for the Roma population as a whole by 8 points. This same country also has the highest child limitation index (29%), even exceeding the average for that area. As for adults, the highest percentages were found in Bulgaria (29%), Greece (28%) and the Czech Republic (28%).

The lowest figures were found in Portugal where only 10% of the minors and 9% of the adults were affected in their main activity by some limiting factor. The biggest difference between minors and adults was found in Greece (21% and 28% respectively) and in Spain (15% and 22%).

Once studying the breakdown of these indices by country and age group, we crossed them with the type of neighbourhood and housing variables to find out the proportion of people whose daily activities were limited and once again found that the population living in unhealthy neighbourhoods (24%) and those living in shanty towns (25%) were most affected.

Graph 2.5. Percentage of the population which had to limit daily activities in the preceding two weeks by neighbourhood and type of housing



Source: EDIS S.A. European Survey on Health and the Roma Community 2009

The conclusion reached is that the poorer the local health and housing conditions, the greater the proportion of people affected by this situation. In contrast, the areas where fewer people are affected are those neighbourhoods featuring good health conditions, once again demonstrating the link between social conditioning factors and state of health.

We also asked the Roma interviewees affected by some limitation in their daily activity about the causes of those limitations. Three factors stood out above the rest from among the different pains and symptoms. First on the list was sore throat, cough or cold suffered by 37% of the population facing limitations, the second was headache suffered by 36% and the third back or joint aches (34%). On average, the Roma population ticked 2.6 pains or symptoms as being responsible for those daily limitations.

However, data vary when the adult and minor populations are analysed separately. In the case of minors, the main symptoms have to do with sore throat, cough, cold or flu accounting for 69% of limitations in daily activities during the preceding two weeks. The second most common symptom identified in the case of minors is fever accounting for 42%. In the case of adults, there are two major causes: aches in bones and joints (49%) and headaches (45%).

2.5. State of teeth

The state of people's mouth, teeth and gums is an important factor when measuring the general state of health of a group. The Roma population was therefore asked about their dental health.

We will begin by describing the state of children's teeth, i.e. 15 or younger. As shown in the following tables, 6 out of every 10 minors have healthy teeth, the highest percentage being recorded in Romania (71%) and the lowest in Bulgaria (45%). In any case, in all countries the dominant category was that of healthy teeth.

However, it should be mentioned that 34% of all minors (360,000 children) do have cavities. Below this level we find Spain (33%), Romania (28%) and Greece (31%). In conclusion, cavities are the main dental problem affecting Roma minors in all countries.

Table 2.8. Dental health of minors (15 and under)

	S/he has cavities	S/he has had teeth removed	S/he has fillings in some teeth	Gums bleed	The child's teeth are healthy	Doesn't yet have teeth	Base (N)
Minors	33.6	13.5	18.2	7.4	60.9	8.1	(2,784)
Greece	31.1	12.7	11.4	14.1	59.4	12.0	(215)
Portugal	41.2	23.0	9.8	29.1	52.4	5.0	(122)
Czech Rep	40.7	27.2	35.8	12.4	53.8	21.7	(332)
Slovakia	46.1	24.4	27.0	8.4	51.8	9.3	(321)
Romania	27.7	7.7	12.8	2.5	70.5	3.7	(1,024)
Bulgaria	35.7	19.5	28.9	10.2	44.7	10.2	(266)
Spain	33.4	8.4	12.7	10.1	60.1	8.6	(504)

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

On the other end of the spectrum, bleeding gums is the dental problem which affects Roma minors the least (7%). 8% of the minors included in the sample were left out of this classification because their first teeth had not yet come in.

We also focused on the dental situation of the adult population. Data has been put into two different tables, one for minors and one for adults, each analysing shared problems and those which are exclusive to each age group. The following table addresses the problems affecting the over 15 group.

Table 2.9. Dental health of adults (16 and over)

	S/he has cavities	S/he has had teeth removed	S/he has fillings in some teeth	Gums bleed	Teeth are loose	Prostheses or false teeth	S/he is missing a tooth which has not been replaced	All teeth are natural	Base (N)
Adults	60.8	55.1	44.9	27.0	18.7	16.9	46.3	45.2	(4,820)
Greece	57.5	60.9	46.7	33.4	18.5	21.2	53.6	29.0	(426)
Portugal	54.4	64.5	45.6	39.1	23.4	22.8	51.7	17.7	(254)
Czech Rep	59.8	54.6	68.5	29.5	18.3	18.1	37.9	56.1	(681)
Slovakia	68.7	71.4	60.4	21.0	0.0	10.9	42.9	29.1	(336)
Romania	62.1	45.9	26.3	25.5	29.4	18.1	40.8	61.4	(1,592)
Bulgaria	63.0	61.1	63.1	31.8	21.9	18.2	48.7	35.6	(548)
Spain	55.8	56.6	46.1	26.6	10.2	15.8	55.1	35.3	(992)

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

The data show that the dental health of Roma adults is comparable to that of minors. As with children, the most prevalent problem is cavities affecting 61% of the 16 and over population, i.e. 1,050,000 adults. The second most important problem is the removal of a tooth affecting 1 out of every 2 adults. Also worth mentioning is that 46% of the adults (approximately 800,000 individuals) who have had at least one tooth removed have not had it replaced by a prosthesis

Once again, the country with the best dental health is Romania where the lowest indices in practically all of the categories affecting dental health were recorded. Romania has the highest percentage of adults who claim to "have all of their natural teeth" (61%), 16 percentage points above the average for the adult Roma population.

2.6. Hearing and visual characteristics

We conclude this descriptive section on the health status of the Roma community by offering some figures on hearing and visual characteristics focusing exclusively on the adult Roma population. The sample of interviewees is limited in this case to the 16 and over population but is still quite large (4,820 cases).

This information was gathered by posing two yes/no questions. Hearing limitations were detected by asking the interviewee if s/he could hear a television programme at a volume which others consider normal. As for visual characteristics the question posed was whether the interviewee could see well enough to recognise a person at a distance of four metres. The responses received allowed us to classify the population into four categories: no difficulties, difficulties seeing and hearing, only difficulties hearing and only difficulties seeing.

The following table shows the breakdown of the 16 and over Roma population in terms of hearing and sight and shows that 7 out of every 10 have no difficulty seeing or hearing.

Table 2.10. The adult Roma population and hearing and sight impairments

	No difficulties	Difficulties seeing and hearing	Only difficulties seeing	Only difficulties hearing	Total	Base (N)
Roma Population	67.4	7.2	7.8	17.5	100	(4,820)
Greece	77.2	7.1	7.6	8.2	100	(426)
Portugal	94.2	0.0	3.8	1.9	100	(245)
Czech Republic	81.0	5.1	6.3	7.6	100	(681)
Slovakia	82.3	4.6	6.0	7.1	100	(336)
Romania	48.6	9.2	5.9	36.4	100	(1,592)
Bulgaria	77.0	7.7	10.9	4.4	100	(548)
Spain	75.2	6.5	10.0	8.4	100	(992)

Source: EDIS S.A. European Survey on Health and the Roma Community 2009

However, one third of the Roma population from the countries studied exhibited some type of visual or hearing impairment, i.e. approximately 560,000 people. We should also point out that 7% of Roma adults (124,000 individuals) experience both hearing and visual impairments. Hearing problems are most prevalent affecting one out of every 4 Roma or 427,000 people.

Hearing impairments predominate over visual ones, at least among Europe's adult Roma population. Visual problems ranked second to hearing difficulties in all countries with the exception of Spain and Bulgaria where visual problems were more prevalent.

Part 3. Use of health-care services

3.1. Consumption of medicines

This section of the report focuses on the results obtained through this European survey concerning the use of health-care services by the Roma population.

This first sub-section analyses consumption of medicines even though this cannot strictly be considered use of services. Guaranteed access to medicines is, however, necessary for the treatment of disease and is one of the pillars on which the right to health-care is based. Furthermore, the use of medicines, together with health-care services, is indicative of the relationship which the Roma population has with the health-care system.

With that clarification we will now begin to describe and analyse consumption and self-prescription of medicines. In this regard, self-prescription means that the subject takes medicines without a physician's prescription whereas consumption refers to the taking of medicines with or without a prescription. These trends were quantified by asking Roma from the countries studied about the medicines they consumed during the two weeks immediately preceding the interview. If they answered in the affirmative to having taken medicines, we then inquired as to whether these had been prescribed by a physician or not.

The questionnaire listed a number of different medicines, 9 for minors and 19 for adults, the responses then used to calculate a series of indicators. We will begin with the data for the under 16 group and medicines taken, prescribed or not, to obtain consumption rates for the different types of medicines.

The table below shows that cold medicines are the ones most frequently consumed by Roma minors. 35% of the minors interviewed had consumed this sort of medicine and 34% had taken medicine to combat pain or fever, these two being the most frequently used in all of the countries studied. In the second group of most frequently taken substances we found vitamins and antibiotics, both with a 15% consumption rate among minors.

On the other end of the spectrum we found that laxatives were the medicine most infrequently employed in practically all countries with a rate of barely 1% on average. The exception in this regard was Greece with a consumption rate of 4%. Anti-nausea medicines and tranquilisers were the ones least consumed in that country.

Special mention should be made of the high 56% consumption rate of cold medicines in Portugal (21 percentage points higher than the average) and a 63% for anti-fever remedies (30 points above average). The consumption of tonics and vitamins is concentrated in the Eastern European countries and is much lower in Greece, Portugal and Spain.

Table 3.1. Percentage of minors who have consumed medicines in the preceding two weeks (with or without a medical prescription) according to type of medicine and country.

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Cold, flu	22.9	56.4	40.2	32.1	37.0	33.5	35.1	35.3
Pain and/or to reduce fever	28.4	63.8	35.1	39.2	33.2	29.7	32.0	33.6
Tonics such as vitamins and minerals	1.5	5.2	14.4	22.6	17.9	21.4	4.2	14.9
Antibiotics	10.9	11.1	14.7	20.2	15.2	15.8	10.1	14.6
Allergy medicine	4.5	5.7	9.9	4.6	4.1	3.8	6.8	5.1
Tranquilisers, relaxants, sleeping pills	0.5	3.0	7.9	5.1	5.8	3.0	1.8	4.5
Medicine to combat diarrhoea	3.3	7.2	3.6	3.5	4.9	3.8	2.2	3.9
Medicine to combat vomiting	2.3	5.0	2.9	3.7	2.8	10.5	2.9	3.8
Laxatives	3.5	2.1	1.2	2.1	0.2	2.3	1.2	1.1

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

A clear distinction needs to be drawn regarding how medicines are consumed because there is a big difference between taking medicines prescribed by a health-care provider and consuming medicines which the individual considers appropriate. It is therefore important to look at the percentage of minors taking unprescribed medicines.

The most commonly consumed unprescribed medicines are used to combat colds (29%) and pain-fever (24%). The second most prevalent group of medicines consumed without a physician's prescription are antibiotics (14%) and vitamins (10%). The self-medication rate is much lower for the rest of the medicines with indices under 5%.

We should also point out that the higher levels of consumption in Portugal of cold and fever remedies does not indicate a high self-medication rate. In fact, the percentage of minors who had consumed these medicines without a prescription is just under the average for the countries surveyed.

As mentioned above, the Eastern European countries consume greater amounts of vitamins and in this regard self-consumption was especially high in Romania and Bulgaria, both with 16%, in contrast with 7% in the case of Slovakia and 4% for the Czech Republic.

Table 3.2. Percentage of minors who have consumed medicines in the preceding two weeks without a medical prescription according to type of medicine and country.

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Cold, flu	17.8	27.4	24.9	20.0	33.4	30.5	27.3	28.5
Pain and/or to reduce fever	18.8	22.0	19.0	15.8	27.7	24.4	25.2	24.0
Antibiotics	10.0	10.0	14.5	20.0	14.6	15.8	9.5	14.1
Tonics such as vitamins and minerals	1.0	2.9	3.5	6.5	15.9	15.8	3.4	10.3
Allergy medicine	3.2	5.0	9.6	4.0	3.9	3.4	6.6	4.8
Tranquilisers, relaxants, sleeping pills	0.5	1.9	5.8	3.5	5.7	2.6	2.1	4.0
Medicine to combat vomiting	2.3	5.0	1.6	2.0	2.5	10.5	1.8	3.2
Medicine to combat diarrhoea	1.4	7.2	1.9	1.8	4.2	2.6	1.9	3.0
Laxatives	2.5	1.1	0.3	1.7	0.2	2.3	0.8	0.9

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Having described the situation concerning use of medicines and self-medication of Roma minors, we now turn our attention to the adult population (16 and over). The following table shows the percentages of adults who have taken medicines during the two weeks immediately preceding the interview broken down by the type of medication and country. As with minors, the most frequently consumed medicines were for colds and fever according to responses received from adults registering consumption rates of 35% and 31% respectively.

Table 3.3. Percentage of adults who have consumed medicines in the preceding two weeks (with or without a medical prescription) according to type of medicine and country.

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Pain and/or to reduce fever	37.6	58.9	41.5	42.1	31.2	29.2	35.6	35.0
Cold, the flu	20.4	55.0	32.7	22.2	39.9	27.7	25.8	30.6
Blood pressure medicine	11.0	7.8	14.1	15.0	21.9	25.2	10.9	17.1
Birth-control pills (women only)	3.1	19.2	16.5	3.5	26.9	8.8	8.2	15.2
Antibiotics	8.7	2.1	11.2	11.0	19.3	12.2	10.5	13.3
Tranquilisers, relaxants, sleeping pills	14.5	6.1	16.6	10.0	8.6	13.0	13.5	11.8
Tonics such as vitamins and minerals	5.8	2.8	13.0	13.4	14.7	14.4	5.3	11.1
Heart medicine	8.5	4.8	7.6	8.7	17.7	13.5	3.6	10.5
Medicine for rheumatism	3.0	6.1	6.4	3.8	16.5	9.5	4.9	9.0
Medicine for digestive tract problems	5.1	6.1	12.5	6.8	5.2	5.5	9.1	7.2
Medicines to reduce cholesterol	7.7	9.5	7.0	5.6	10.5	4.9	5.6	7.2
Medicine to combat diabetes	5.1	5.6	7.1	5.2	8.5	7.3	3.8	6.3
Allergy medicine	2.8	0.5	5.1	5.1	3.9	5.5	4.8	4.6
Anti-depressants	9.7	5.8	8.6	3.0	1.9	2.0	6.4	4.4
Medicine to combat diarrhoea	0.7	1.3	4.7	4.5	5.0	2.6	0.7	3.1
Laxatives	1.3	0.5	2.7	0.9	3.5	3.6	2.8	2.8
Medicine to lose weight	0.6	6.8	3.3	1.1	1.6	2.2	2.0	1.9
Hormone substitute medicines	0.7	0.4	2.9	0.3	1.2	1.6	0.8	1.2
Other medicines	6.1	5.8	13.9	9.1	14.0	11.5	6.7	10.5

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Here, special mention should be made of the 15% of Roma women who take birth-control pills. This means that approximately 138,000 Roma women use birth-control pills, a social phenomenon consistent with the timid decline in the birth rate detected in the demographic analysis conducted at the outset of this report.

As for comparison between countries, the first observation which stands out is the enormous heterogeneity in consumption patterns in the different countries. Once again, Portugal has the highest consumption rate of medicines to combat fever (59%) and colds (55%). Romania and Bulgaria feature the highest rate of blood pressure medicine users, in the vicinity of 25%. The use of birth control pills is high in Portugal (19%), the Czech Republic (17%) and is especially high in Romania (27%).

Another difference between countries is the higher consumption of vitamins in Eastern Europe. Also, more heart medicine is used in Romania and Bulgaria, Romania consumes more arthritis medicine and digestive tract remedies are among the favourites of the Czech Republic.

In addition to country differences in the consumption of medicines, we also want to highlight self-medication in the following table showing the percentage of adults using medicines without a medical prescription.

Data show that blood pressure medicines are the ones most commonly used without a prescription (17%) followed by medicines to combat fever and colds, both at 16%. Special mention should be made of the 14% of women who take birth control pills without a physician's prescription. Also, 11% of adults take self-administered antibiotics and 10% take heart medication without a prescription.

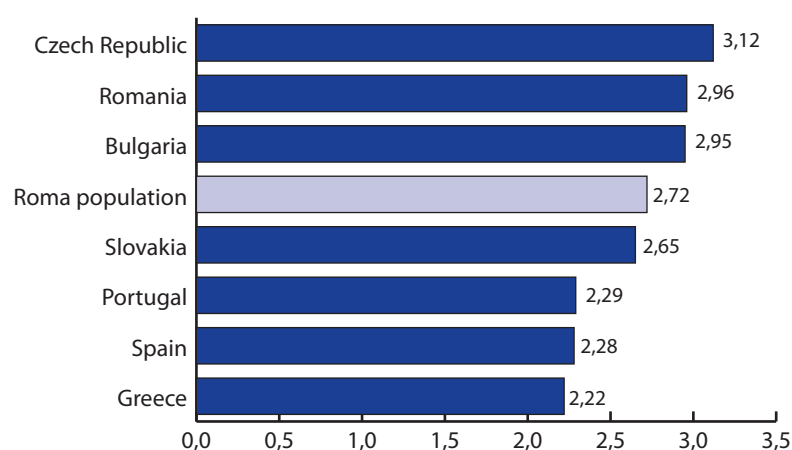
Table 3.4. Percentage of adults who have consumed medicines in the preceding two weeks without a medical prescription according to type of medicine and country.

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Blood pressure medicine	11.0	7.4	13.6	14.9	22.9	25.4	11.1	17.3
Pain and/or to reduce fever	14.9	11.6	14.5	10.3	13.7	17.5	21.3	16.3
Cold, the flu	10.7	13.2	14.6	9.6	22.3	16.2	14.0	16.0
Birth-control pills (women only)	1.0	19.2	16.0	3.5	24.3	6.4	7.2	13.5
Antibiotics	7.5	2.1	10.8	10.1	15.8	10.2	9.6	11.4
Heart medicine	8.5	4.8	7.2	7.7	18.7	13.3	3.6	10.4
Tranquilisers, relaxants, sleeping pills	12.9	5.7	11.9	5.7	8.7	9.9	10.6	9.5
Medicine for rheumatism	3.0	5.7	5.6	3.7	15.7	9.7	4.6	8.4
Medicines to reduce cholesterol	7.4	9.5	7.0	4.7	10.9	4.9	5.8	7.2
Medicine to combat diabetes	5.1	5.6	7.1	5.2	9.0	7.5	3.8	6.4
Tonics such as vitamins and minerals	4.0	2.8	2.6	3.4	8.0	8.4	3.9	5.6
Medicine for digestive tract problems	3.3	4.9	7.4	3.7	3.5	4.6	7.0	5.1
Allergy medicine	2.6	0.5	5.1	5.0	4.3	5.7	4.4	4.6
Anti-depressants	9.7	5.8	7.5	2.6	1.9	2.0	6.3	4.2
Medicine to combat diarrhoea	0.7	0.8	2.6	1.6	2.5	1.8	0.6	1.6
Laxatives	1.3	0.5	1.3	0.3	0.4	2.7	2.3	1.4
Hormone substitute medicines	0.5	0.4	2.9	0.3	1.2	1.8	0.9	1.2
Medicine to lose weight	0.2	1.7	2.1	0.1	0.5	1.6	0.6	0.8
Other medicines	5.6	4.9	9.7	5.5	9.5	8.6	5.9	7.6

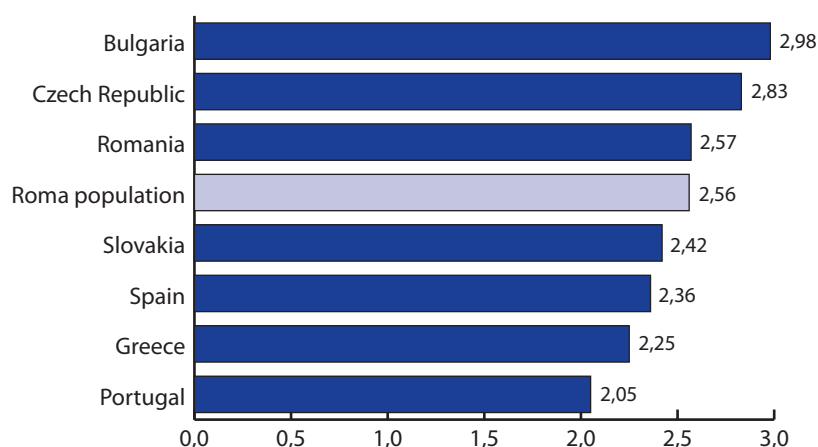
Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Together with consumption and self-medication rates according to the type of medicine taken, we also wanted to report on the average number of drugs taken by the adult Roma population. The following graph shows the average number of drugs consumed by the Roma community who took medicines during the two weeks immediately preceding the interview. This information was calculated based on responses to questions about 19 medicines.

According to the data, an average of 2.8 different medicines are consumed in the participating countries. In other words, the persons taking medicines ingested an average of nearly three different medicines. The countries consuming the greatest amount of medicines were the Czech Republic (3.12), Romania (2.96) and Bulgaria (2.95). Below the mean we find Slovakia (2.65), Portugal (2.29), Spain (2.28) and Greece (2.22).

Graph 3.1. Average number of medicines consumed by the adult consumer population

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Graph 3.2. Average number of medicines consumed by the adult population consuming self-administered medicines.

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

In addition to this information, it is also interesting to observe the average number of medicines taken by the Roma population without a medical prescription. The average for the surveyed countries was 2.6 which was exceeded by Bulgaria (3.0), the Czech Republic (2.8) and Romania (2.6).

3.2. Visits to the physician

This section describes physician visits made by Europe's Roma population. In order to better comprehend the results, it is important to bear in mind the type of health-care system in each country (universal public coverage, private, mixed, etc.).

In this section we describe when the most recent visit to the physician was made and the reason. This will shed light on the purpose of medical visits by the Roma population, i.e. whether routine visits are made or if physicians are only consulted in the event of an important health problem.

We begin with when the last visit to the physician was made. The following table shows the distribution of the Roma population according to the amount of time elapsed since the last visit to the physician.

A careful look at the data shows that this period is typically over one month but less than one year since the last visit. This holds true for practically all countries with an average of 36% except in Bulgaria where 46% of those interviewed had seen a physician in the last two weeks and Portugal where 47% had been to the physician during the last 15 to 30 days. In Romania however, we find the highest percentage of people whose last visit was over a year ago (19%) and Greece is where we find the highest number of people who have never been to the physician - 6% (4 points over the average for the whole of the Roma population).

Table 3.6. By-country breakdown of the Roma population according to the amount of time since the last visit to the physician

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
In the last two weeks	27.6	20.2	28.0	16.6	18.6	46.4	29.2	25.8
More than two weeks but less than a month ago	21.2	47.2	19.4	19.1	22.0	10.8	17.3	19.1
More than one month but less than one year ago	28.5	25.8	33.8	49.1	36.7	26.4	37.9	36.3
One year ago or more	16.8	5.6	17.1	14.3	19.2	13.9	14.8	16.4
S/he has never been to the physician	5.9	1.1	1.8	1.0	3.5	2.5	0.8	2.4
Total	100	100	100	100	100	100	100	100
Base (N)	(641)	(367)	(1,013)	(657)	(2,616)	(814)	(1,496)	(7,604)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

A breakdown of the overall information between adults and minors shows some interesting differences (see the following table). These data show that although visits to the physician are few and far between, there is more thorough control of children's state of health as evidenced by the higher percentage of children who had recently been to the physician. 48.4% of minors had seen the physician during the last month compared to 42.4% of adults. Moreover, nearly one out of every four adults (23.3%) had not been to the physician during the previous year or had never been compared to 11.2% of minors. However, we want to make it clear that 2% of adults have never been to the physician (approximately 41,000) and 21% have not been in the last year (361,000).

Table 3.7. Breakdown of the Roma population according to the amount of time since the last visit to the physician. European Roma population: minors and adults

	Minors	Adults	Total
In the last two weeks	26.2	25.6	25.8
More than two weeks but less than a month ago	22.2	17.2	19.1
More than one month but less than one year ago	40.3	33.9	36.3
One year ago or more	9.0	20.9	16.4
S/he Has never been to the physician	2.2	2.4	2.4
Total	100	100	100
Base (N)	(2,784)	(4,820)	(7,604)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Along these same lines, we now turn our attention to those who visited their physician in the previous two weeks to find out why. The following table shows the percentages of the Roma population who have seen their physician in the last two weeks according to the main reasons for that visit.

The table shows that the vast majority of the Roma population (55%) saw their physician for a diagnosis and/or treatment and 28% for a medical check-up. In other words, 8 out of every 10 Roma who went to their physician during the previous two weeks did so for one of these two reasons. There are differences among the different countries. In Romania the same two motives prevailed but the proportions were reversed; 28% went for treatments while 54% went for checkups. In Greece, the second most common reason for seeing one's physician was to get a prescription and in Slovakia 77% of the Roma population visited their doctor for a diagnosis or treatment.

Table 3.8. Breakdown of the Roma population according to the reason for the last visit to the physician during the last two weeks

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Diagnosis and or treatment	68.8	66.7	56.3	77.3	62.0	27.8	62.9	55.0
Check up	3.2	22.2	27.6	9.2	25.9	53.5	18.7	28.4
Only to pick up a prescriptions	18.3	5.6	5.7	7.1	5.5	10.7	9.6	8.6
Sick leave form confirmation or sick leave form (only adults)	1.1	0.0	2.3	0.0	0.2	0.0	4.0	1.4
Some other reason	8.6	5.6	8.0	6.4	6.4	7.9	4.8	6.6
Total	100	100	100	100	100	100	100	100
Base (N)	(175)	(72)	(288)	(126)	(367)	(377)	(427)	(1,832)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

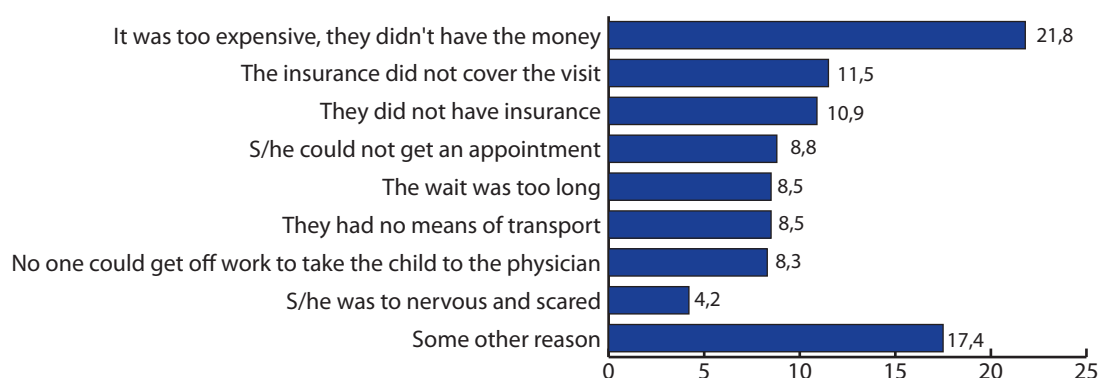
We also asked the Roma population if during the last 12 months they needed medical attention but did not receive it; in other words, a medical need unattended to. 8% claimed that they failed to receive medical attention when it was needed (approximately 210,000 individuals), the percentage varying between 7% and 8% depending on whether this involved minors or adults.

Table 3.9. Unattended medical needs. Percentage of the population that in the last 12 months needed medical attention but did not receive it

	Roma population	Minors	Adults
Roma population	7.5	6.7	8.0
Greece	17.1	13.0	20.5
Bulgaria	13.8	12.1	14.6
Czech Republic	8.1	8.3	8.1
Romania	7.3	6.8	7.7
Spain	4.3	2.7	5.0
Slovakia	3.8	4.3	3.4
Portugal	3.3	5.1	1.9

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Unattended medical need rates in two countries were far above the mean for the overall Roma population: in Greece 17% of the Roma population claims to have needed but not received medical assistance, the figure ranging between 13% for minors and 21% for adults, and in Bulgaria 14% of the medical needs went unattended over the last year, 12% in the case of minors and 15% for adults.

Graph 3.3. Percentage of the Roma population that failed to receive needed medical assistance due to lack of assistance

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

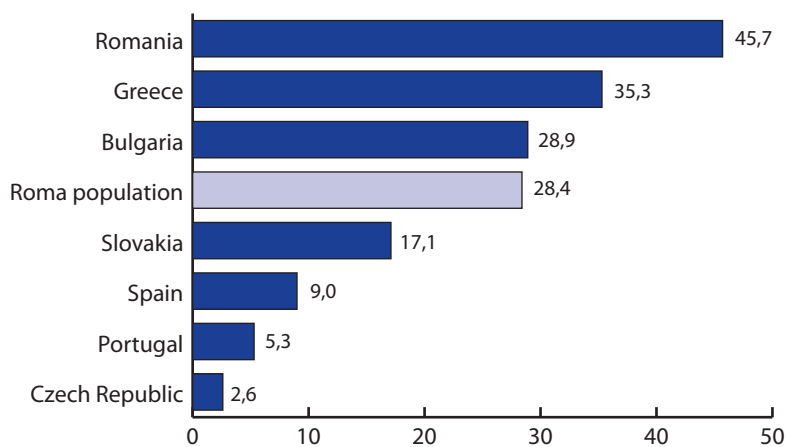
The main reason that the Roma population failed to receive medical attention had to do with their economic situation. 22% of the Roma population in this situation did not have sufficient funds to pay for the needed medical attention. At a distant second (12%) was that insurance failed to cover the visit and in third place (11%) the interviewee claimed to not have health insurance.

3.3. Children’s vaccination programmes

This section focuses on survey results relating to children’s vaccination programmes. We asked the parents and guardians of the surveyed minors if they adhered to the child vaccination programme.

The following graph shows the percentage of minors that failed to adequately follow the child vaccination programme. 28% of the children do not properly adhere to the programme which translates into approximately 300,000 children in the countries studied.

Graph 3.4. Percentage of minors who do not properly adhere to the vaccination programme.

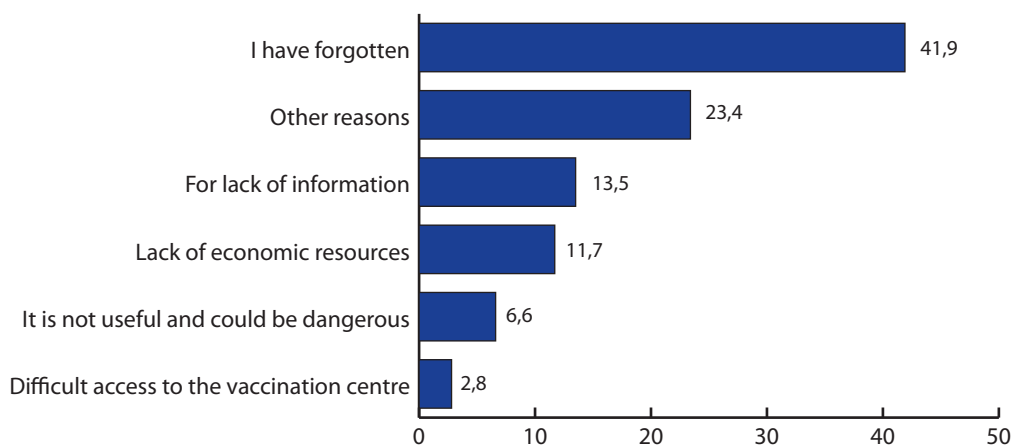


Source: EDIS S.A., European Survey on Health and the Roma Community 2009

The graph shows important differences between countries. Romania is the country where the largest proportion of minors does not properly follow the child vaccination programme (46%) followed by Greece (35%) and Bulgaria (29%). Under the mean for European Roma we find Slovakia (17%), Spain (9%), Portugal (5%) and the Czech Republic (3%).

It was also deemed important to find out why these children were not properly following the vaccination programme. That question was posed to the parents and guardians of children who did not adhere to the vaccination programme and the following graph shows the main reasons.

Graph 3.5. Percentage of minor who did not properly follow the vaccination programme according to the principal reason why



Source: EDIS S.A., European Survey on Health and the Roma Community 2009

In 42% of the cases where minors were not properly vaccinated, the parent or guardian claimed to have forgotten. Other reasons offered were lack of information (14%), lack of economic resources (12%), the opinion that vaccinations are worthless and could be dangerous (7%) and difficulty gaining access to the vaccination clinic (3%).

3.4. Dentist visits

Visits to the dentist are also an indicator of health care habits and therefore interviewees were asked when they last visited the dentist. 16% of the Roma population from the countries studied had seen the dentist in the three months immediately preceding the interview, 14% between four months and one year and 38% more than a year ago. One third of the Roma population had never been to the dentist.

Slovakia and the Czech Republic, where 8 out of every 10 Roma had seen the dentist on at least one occasion, are the two countries with the lowest proportion of the Roma population that had never been to the dentist. The next two countries are Bulgaria and Spain where 71% and 74% of the Roma population respectively had visited the dentist on at least one occasion. The countries the lowest proportion of the population having had at least minimal contact with the dentist are Greece (58%), Portugal (63%) and Romania (56%).

Table 3.10. By-country breakdown of the Roma population according to the amount of time since the last visit to the dentist

	Last 3 months	4 to 12 months	One year or more	S/he has never gone	Total	Base (N)
Roma population	16.1	13.7	37.7	32.5	100	(7,604)
Greece	15.4	7.1	35.5	42.0	100	(641)
Portugal	16.7	2.2	44.4	36.7	100	(367)
Czech Republic	18.9	18.5	45.1	17.5	100	(1,013)
Slovakia	20.1	13.3	46.6	20.0	100	(657)
Romania	13.1	15.4	27.3	44.3	100	(2,616)
Bulgaria	14.7	11.7	45.0	28.6	100	(814)
Spain	18.7	12.7	43.3	25.3	100	(1,496)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

The following table focuses on the amount of time since the last dentist visit of the adult population. Slovakia and the Czech Republic are the two countries where the highest proportion of adults had been to the dentist in the year preceding the interview (35% and 34% respectively), several points above the 29% average for European Roma.

Table 3.11. Breakdown of the adult population according to visits to the dentist.

	Last year	One year or more	S/he has never gone	Total	Base (N)
Roma population	28.9	50.5	20.6	100	(4,820)
Greece	23.1	52.2	24.7	100	(426)
Portugal	11.5	63.5	25.0	100	(245)
Czech Republic	35.3	55.9	8.8	100	(681)
Slovakia	33.8	60.0	6.2	100	(336)
Romania	25.7	40.7	33.7	100	(1,592)
Bulgaria	27.1	57.4	15.5	100	(548)
Spain	31.8	53.6	14.6	100	(992)

Spain was in third place (32%) in terms of the number of adults who visited the dentist in the last year. Below the European mean we have Portugal (12%), Greece (23%), Romania (26%) and Bulgaria (27%).

The table below shows the proportion of the Roma population (minors and adults) that claimed to never have visited the dentist. The proportion of minors is higher than that of adults for all of the countries studied. We should draw attention to the fact that 1 out of every 5 adult Roma (21%) have never been to the dentist which translates into approximately 356,000 people.

Table 3.12. Percentage of adults and minors who have never been to the dentist.

	Minors	Adults	Total
Roma population	52.5	20.6	32.5
Greece	62.6	24.7	42.0
Portugal	52.6	25.0	36.7
Czech Republic	33.0	8.8	17.5
Slovakia	38.8	6.2	20.0
Romania	59.6	33.7	44.3
Bulgaria	55.5	15.5	28.6
Spain	50.2	14.6	25.3

Differences among countries are apparent. As mentioned above, Slovakia and the Czech Republic are the countries where the Roma population (both adults and minors) most frequently goes to the dentist. 6% of Slovakian adults (the lowest percentage) and 9% of the Czechs have never been to the dentist. These figures contrast with 34% for Romania and 25% for Greece and Portugal.

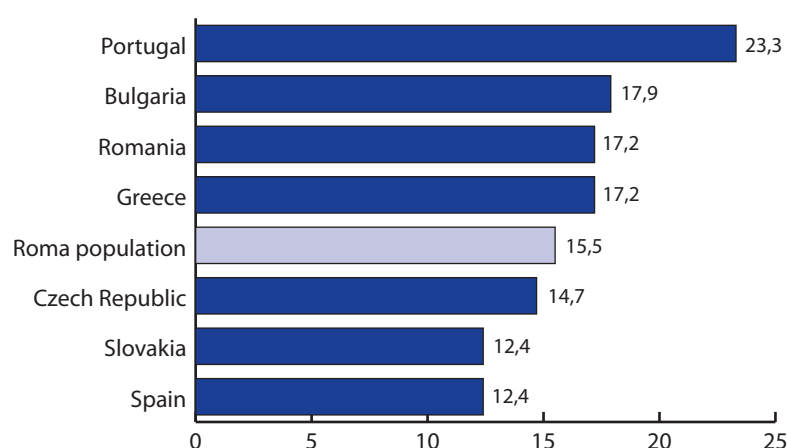
It goes without saying that less frequent use of dental health services is directly proportional poorer dental health. As was the case with health status, Greece and Portugal have the worst track record in terms of dental care with the lowest percentage of the adult population which has managed to keep all of their natural teeth, 29% and 18% respectively.

3.5. Hospitalisation

Another of the basic issues under scrutiny is the use made of hospital services by the Roma population. Here, information was gathered by asking the Roma population if, during the 12 months immediately preceding the interview, they had been hospitalised during at least one night and 16% of the population responded in the affirmative.

Greece (17%), Romania (17%) and Bulgaria (18%) are slightly over the mean while Portugal (23%) exceeds the average by a greater margin. The countries with the lowest percentages are the Czech Republic (15%), Slovakia (12%) and Spain (12%).

Graph 3.6. Percentage of the population hospitalised during the preceding 12 months



Source: EDIS S.A., European Survey on Health and the Roma Community 2009

It is also interesting to observe the percentage of the population hospitalised broken down into age groups.

Table 3.13. Percentage of the population hospitalised during the preceding 12 months by age group

	0 to 15	16 to 29	30 to 44	45 and over	Total
Roma population	13.6	13.7	12.1	27.3	15.5
Portugal	18.9	17.4	25.0	38.5	23.3
Bulgaria	20.6	14.7	12.1	23.8	17.9
Romania	14.3	17.1	11.3	37.4	17.2
Greece	16.2	14.9	17.2	25.6	17.2
Czech Republic	10.0	16.9	14.1	22.0	14.7
Slovakia	10.9	9.0	11.1	24.1	12.4
Spain	9.9	9.8	11.7	21.0	12.4

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

On average, the 30 to 44 group showed the lowest incidence of hospitalisation with 12% which was exceeded by Portugal (25%), Greece (17%) and the Czech Republic (14%). On the other end of the spectrum, the age group with the highest incidence of hospitalisation was the 45 and over group with 27%, exceeded by Portugal (39%) and Romania (37%).

It was also surprising to discover that an average 14% of Roma minors had been hospitalised during the previous year, figure exceeded by Bulgaria (21%), Portugal (19%) and Greece (16%). For the 16 to 29 age group the mean percentage was also 14%, exceeded by all countries except Slovakia (9%) and Spain (10%).

There were noteworthy differences between countries in terms of the average length of hospital stays. The average stay for the Roma population studied was 9.3 days with figures exceeding that number for Slovakia (16.9) Spain (12.1), the Czech Republic (11.1) and Bulgaria (9.8) while the shortest hospital stays were registered in Portugal (7.5), Romania (6.3) and Greece (5.4).

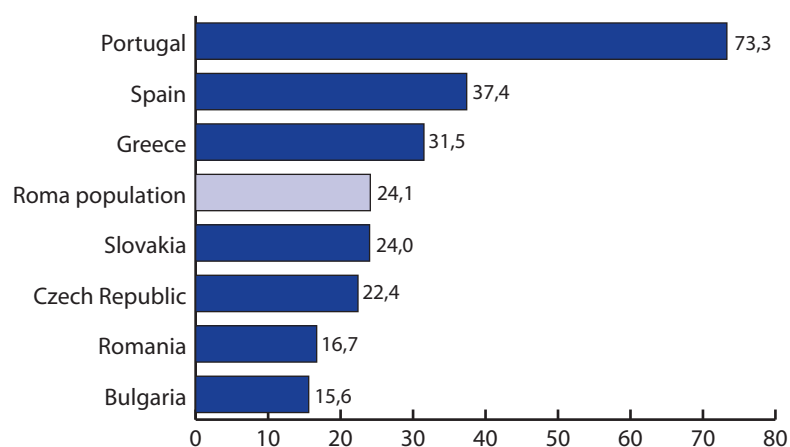
As for the reason for hospitalisation, special mention should be made of medical treatment without surgery accounting for 41% of the cases, medical studies for diagnostic purposes (22%), surgery (15%) and births (10%).

3.6. Emergency Room Services

This section focuses on the use made of emergency services by the Roma population. Interviewees were asked whether in the 12 months preceding the survey they had used emergency room services for any problem or illness.

24% of those surveyed answered in the affirmative meaning that approximately 673,000 Roma used some form of emergency service. This percentage is higher in Greece (32%), Spain (37%) and especially in Portugal where 73% of the Roma population used emergency room services.

Graph 3.7. Percentage of the population that has used emergency services during the preceding 12 months by country



Source: EDIS S.A., European Survey on Health and the Roma Community 2009

As with the case of hospitalisation, here it is also interesting to look at this indicator by age groups. 23% of all Roma minors have used emergency services which translates into 246,000 people. Exceeding this figure are Portugal (76%), Spain (35%), Greece (32%), the Czech Republic (27%) and Slovakia (26%).

The situation is similar for the 16 to 29 age group. The overall rate is 22% which is exceeded by a wide margin by Portugal with 67% and also by Spain (37%) and Greece (27%).

21% of the Roma population between age 30 and 44 used emergency services, the rate rising to 34% for the 45 and over population.

Table 3.14. Percentage of the population that has used emergency services during the preceding 12 months by country and age group

	0 to 15	16 to 29	30 to 44	45 and older	Total
Roma population	23.1	22.2	21.2	33.5	24.1
Portugal	76.3	66.7	75.0	75.0	73.3
Spain	34.8	36.8	34.9	45.1	37.4
Greece	32.0	27.3	31.0	39.5	31.5
Slovakia	26.1	20.5	19.3	29.5	24.0
Czech Republic	27.1	18.9	20.4	20.2	22.4
Romania	13.7	12.9	15.5	34.6	16.7
Bulgaria	20.3	10.6	11.6	18.2	15.6

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

We asked those who claimed to have used emergency services how many times they had used them during the 12-month reference period. The average number of times for the overall Roma population was 2.7 which was surpassed by Spain (3.3), Greece (3.1), the Czech Republic (3.0) and Slovakia (3.0). The rest of the countries were under the mean – Portugal with 2.6, Bulgaria with 2.5 and Romania with 1.8.

3.7. Preventive action taken by women

We round out this section offering information having to do with preventive practices by Roma women (visits to the gynaecologist, mammographies and pap smears). Here the survey pool includes interviewed women age 16 and over providing a total sample base of 2,521 cases.

The following table reports on visits by adult women to the gynaecologist according to the type of visit broken down into age groups.

Table 3.15. Adult women according to the type of visit to the gynaecologist broken down into age groups.

	16 to 29	30 to 44	45 to 64	65 and over	Roma pop.
She has never gone	26.8	6.6	10.3	22.1	15.9
She has never gone for reasons other than pregnancy	23.0	21.4	31.1	18.0	23.9
She has gone for reasons other than pregnancy	50.2	72.0	58.6	59.8	60.2
Total	100	100	100	100	100
Base (N)	(899)	(884)	(586)	(152)	(2,521)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

A relatively high number of women (16%) have never been to the gynaecologist (approximately 145,000 Roma women) and 24% (nearly one fourth) have only visited this specialist because they were pregnant. In other words, only 60% of Roma women, 545,000 in absolute terms, have gone to the gynaecologist for reasons other than pregnancy.

These percentages vary quite a bit from country to country. Special mention should be made of the Czech Republic and Slovakia where a significant proportion of Roma women had visited their gynaecologist for reasons other than pregnancy with rates of 83% and 76% respectively. These same two countries registered the lowest proportion of women who have never been to the gynaecologist.

On the other extreme we have Greece and Portugal where only 43% and 16% respectively of the Roma women reported having gone to the gynaecologist for reasons other than pregnancy. Furthermore, 22% of the Roma women in Greece and 24% in Portugal claimed to have never gone to the gynaecologist.

Table 3.16. Breakdown of Roma women according to the amount of time since the last visit to the gynaecologist.

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Has never gone	21.5	24.0	10.9	8.6	12.2	14.8	24.8	15.9
Reason other than pregnancy - less than 6 months	15.1	4.0	23.7	25.7	9.7	14.8	16.4	15.2
Reason other than pregnancy - 6 to 12 months	10.8	8.0	28.9	13.6	19.3	9.9	17.1	17.3
Reason other than pregnancy - 1 to 3 years	8.6	4.0	19.4	19.1	12.0	11.4	14.3	13.7
Reason other than pregnancy - 3 or more years	8.6	0.0	10.9	17.5	12.7	26.9	10.5	14.0
Has never gone for reasons other than pregnancy	35.5	60.0	6.2	15.6	34.1	22.2	16.8	23.9
Total	100	100	100	100	100	100	100	100
Base (N)	(227)	(123)	(375)	(170)	(834)	(266)	(526)	(2,521)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

A close look at this information by age group shows that 27% of the women between 16 and 29 and 22% of the 65 and over group have never been to the gynaecologist.

This survey also looked into the reason for the visit to the gynaecologist. The table below shows the percentages of women who visited the gynaecologist according to the reason (other than pregnancy) of the most recent visit. 38% of these women went to the gynaecologist for some type of problem related with this medical speciality, 33% for a periodic check-up and 12% for family counselling or planning.

Care must be taken when analysing the data by countries because the sample base was too small in Greece and Portugal and therefore not statistically significant. Therefore, eliminating these two countries from the analysis, the countries with the highest percentage of women with gynaecological problems are Slovakia (51%) and Bulgaria (48%). Romania is the country with the highest percentage who go for family planning reasons (18%) followed by Spain (13%). The highest percentages for periodic checkups were registered in the Czech Republic (50%) and Spain (46%).

Table 3.17. Percentage of women who visited the gynaecologist according to the reason for the most recent visit (other than pregnancy).

	Gynaecological problem	Counselling family planning	Periodic check up	Another reason	Total	Base (N)
Roma population	37.9	12.0	32.9	17.2	100	1,421
Greece	45.0	5.0	25.0	25.0	100	(94)
Portugal	25.0	50.0	25.0	0.0	100	(18)
Czech Republic	29.9	6.8	49.7	13.6	100	(312)
Slovakia	50.8	11.4	24.3	13.5	100	(126)
Romania	38.0	17.5	19.5	25.0	100	(409)
Bulgaria	48.1	3.4	35.6	13.0	100	(169)
Spain	29.1	12.7	46.0	12.2	100	(293)

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

We now turn our attention to Roma women who have been given gynaecological tests, especially two which are particularly relevant in terms of prevention: pap smears and mammographies.

Table 3.18. Percentage of adult women who have had a mammography or pap smear on some occasion by country.

	Mammography	Pap smear (cervix cell sample)
Roma population	21.6	28.6
Greece	8.4	31.9
Portugal	24.0	12.0
Czech Republic	24.1	27.6
Slovakia	14.4	13.2
Romania	20.1	18.6
Bulgaria	15.6	30.5
Spain	30.5	47.7

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Just over one fifth (22%) of Roma women have had a mammography at some point in their lives and close to three out of ten (29%) have undergone a pap smear.

Some important differences can be seen between countries. As for mammographies, Romania (20%), Bulgaria (16%) and Slovakia (14%) are under the mean and Greece is particularly startling with only 8% of Roma women having undergone a mammography at some point in their lives.

There are also four countries which perform fewer pap smears than the overall average of 28.6%: the Czech Republic (27%), Romania (19%), Slovakia (13%) and Portugal (12%).

Table 3.19. Percentage of adult women who have had a mammography or pap smear on some occasion by age group.

	Mammography	Pap smear (cervix cell sample)
Roma population	21.6	28.6
16 to 29	12.5	20.6
30 to 44	24.8	36.3
45 to 64	30.4	31.1
65 and more	32.8	24.2

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

A closer look at the data by age group shows a growing proportion of Roma women who have had a mammography at some point as they get older. 13% of the 16 to 29 group has had a mammography compared with 33% of the 65 and older group.

The highest percentage of women who have had a pap smear was registered in the 30 to 44 age group (37%). This figure is lower for the 45 to 64 group (31%), for the 65 and over group (24%) and also for the 16 to 29-year-olds (21%).

Part 4. Lifestyles

This section analyses different lifestyles of the Roma population living in the countries studied because these have a clear influence on health. The survey compiled information on the use of drugs, physical activity, sleep and eating habits. Regarding this latter point, information was also gathered on body mass index.

4.1. Tobacco and alcohol consumption

As explained further on, there are no drug use data for Romania because that question was not on the field work questionnaire for that country. Therefore, the substance use averages calculated for the overall European Roma population are based on only six of the seven countries studied. Also, the questions relating to drug use were only posed to the adult population (over age 15) meaning that the sample size was 3,228.

The following table shows the behaviour of the Roma population as concerns tobacco consumption by country. For this purpose, the following categories were established: daily smoker, occasional smoker, ex-smoker, non-smoker. The aim was to define behavioural types as concerns tobacco use.

Table 4.1. Tobacco use among the Roma population

	Greece	Portugal	Czech R.	Slovakia	Bulgaria	Spain	Roma pop.
Daily smoker	56.3	26.9	58.4	53.2	46.1	34.1	44.2
Occasional smoker	8.7	3.8	8.6	6.7	8.1	5.8	7.0
Does not currently smoke but did in the past	8.7	13.5	12.1	13.7	12.6	11.9	12.2
Does not smoke and was never a habitual smoker	26.2	55.8	20.9	26.4	33.2	48.2	36.6
Total	100	100	100	100	100	100	100
Base (N)	(426)	(245)	(681)	(336)	(548)	(992)	(3,228)

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

As the table shows, a high percentage (44%) of the Roma population smokes on a daily basis which means 486,000 smokers compared to 37% of the population that claims to not smoke and to have never been a regular smoker. There are relatively few occasional smokers (7%) meaning that most tobacco users are habitual consumers.

By-country analysis shows that the Czech Republic is the country with the highest percentage of daily smokers (58%) as opposed to Portugal at the other end of the continuum (27%). The gender breakdown of smokers reveals clear differences between countries; in the Czech Republic 64% of men and 54% of women are daily smokers (10 point difference) whereas in Portugal 50% of the men and only 4% of the women smoke (46 point difference).

Overall figures for the European Roma population show that 59% of men and 31% of women are habitual smokers.

Table 4.2. Percentage of daily smokers among the Roma population by gender

	Men	Women	Roma population
Total	58.8	30.6	44.2
Greece	66.3	46.8	56.3
Portugal	50.0	3.8	26.9
Czech Republic	63.8	53.6	58.4
Slovakia	62.6	44.7	53.2
Bulgaria	56.0	35.6	46.1
Spain	56.5	14.3	34.1

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Age is another element to be observed when it comes to tobacco consumption. As the following table illustrates, the highest percentage of consumers is in the 30 to 44 age bracket (47%) and the 16 to 29 group (45%). The 45 and over age group has the lowest percentage of smokers (40%).

The survey is further enriched by noting differences between countries. While in general terms the proportion of consumers is at its highest in the 30 to 44 age bracket, in Spain and Portugal the highest percentages are detected amongst the youngest members (16 to 29). In the Czech Republic and Greece percentages are very similar across all age groups.

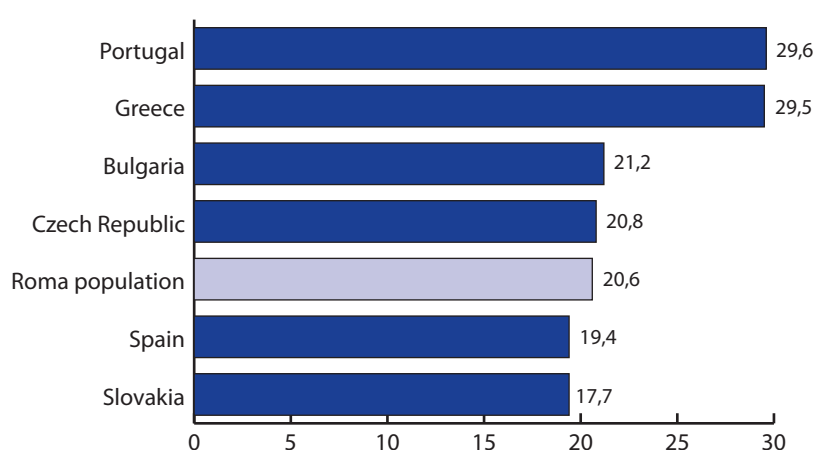
Table 4.3. Percentage of daily smokers among the Roma population by age group

	16 to 29	30 to 44	45 and older	Roma pop.
Roma population	44.7	47.3	39.9	44.2
Greece	55.2	59.6	56.4	56.3
Portugal	29.2	25.0	23.1	26.9
Czech Republic	57.2	58.5	59.6	58.4
Slovakia	53.3	58.5	47.3	53.2
Bulgaria	44.1	52.0	42.6	46.1
Spain	37.8	34.4	28.0	34.1

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

In addition to gender and age group, it is also important to know the amount of tobacco consumed. The following graph shows the average number of cigarettes smoked on a daily basis by habitual smokers.

Graph 4.1. Average number of cigarettes consumed daily by habitual Roma smokers



Source: EDIS S.A., European Survey on Health and the Roma Population 2009

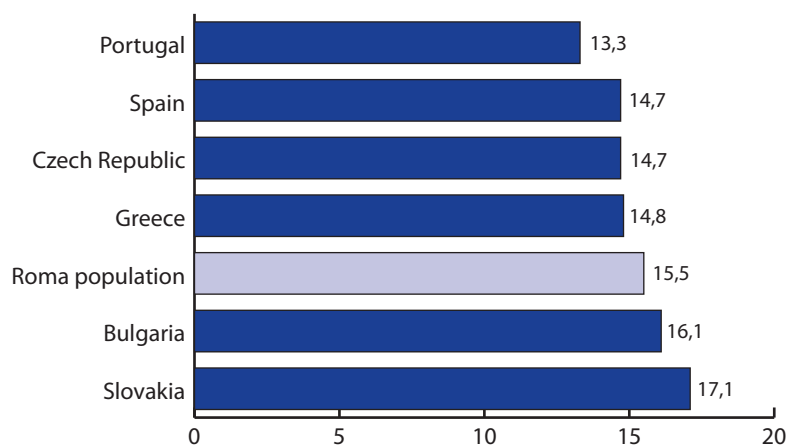
The above graph shows that the average number of cigarettes smoked daily is 20.8. Over that figure we find Portugal (29.6), Greece (29.5), Bulgaria (21.2) and the Czech Republic (20.8). Spain and Slovakia are below that average with 19.4 and 17.7 respectively.

Here we would like to highlight the situation found in Portugal where despite being the country with the lowest percentage of habitual smokers (27%), it has the highest average cigarette consumption rate (29.6). In this country we find that habitual tobacco consumers smoke excessively.

In addition to the above information, we also wanted to shed light on the average age at which tobacco users began smoking. This information is key if we are to prevent this unhealthy habit (especially at early ages).

As the graph shows, the Roma population begins to smoke on a daily bases at the age of 15.5. The Portuguese begin the earliest at age 13 which stands in contrast with the data indicating that Portugal is the country with the fewest young consumers in comparison with the rest of the Roma population.

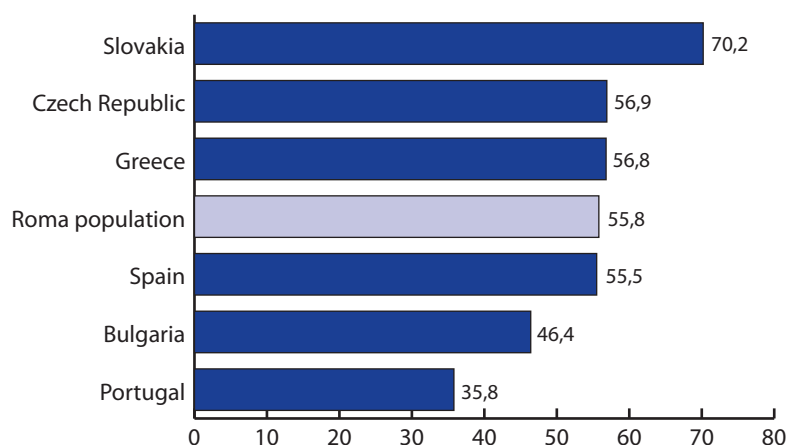
Graph 4.2. Average age at which Roma tobacco consumers begin to smoke



Source: EDIS S.A., European Survey on Health and the Roma Population 2009

In addition to tobacco, we also focused on the consumption of alcohol by Roma adults. To measure this, interviewees were asked if they had consumed any sort of alcoholic beverage in the previous 12 months. The following graph shows the percentages of the population of the different countries that had consumed alcohol in the year preceding the interview. We remind the readers that this information was not collected in Romania which is why that country does not figure in the graphs and tables.

Graph 4.3. Percentage of the adult population that had consumed alcohol during the preceding twelve months.



Source: EDIS S.A., European Survey on Health and the Roma Population 2009

As the graph indicates, 56% of the overall Roma population had consumed alcoholic beverages during the previous year which comes out to approximately 617,000 people. The highest consumption rate (70%) is found in Slovakia (14 percentage points above the average for the whole of the Roma population). On the other extreme we have Portugal where only 36% of the Roma population claimed to have consumed alcohol during the preceding 12 months.

Following is a more detailed breakdown of alcohol consumption by gender showing proportionately which of these two groups consumes greater amounts of alcohol.

Table 4.4. Percentage of drinkers among the Roma population during the preceding 12 months

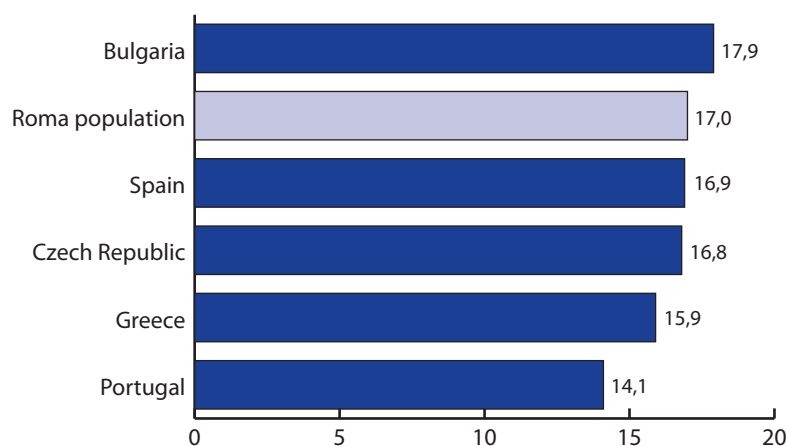
	Men	Women	Roma population
Total	73.1	39.6	55.8
Greece	77.3	38.5	56.8
Portugal	65.4	7.7	35.8
Czech Republic	67.6	47.6	56.9
Slovakia	83.0	58.0	70.2
Bulgaria	64.2	27.4	46.4
Spain	75.8	37.5	55.5

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

These data show a clear difference between men and women when it comes to alcohol consumption. 73% of the men, compared to 40% of the women had consumed alcohol during the previous year, a difference of 33 percentage points. The widest gender gap is found in Portugal and the narrowest in Slovakia and the Czech Republic. Even so, the gap between men and women is wide in all countries.

As mentioned in the foregoing, when studying and preventing the consumption of unhealthy substances it is extremely important to not only look at what and how much is consumed but also at what age people acquire this habit. To that end, those that had consumed alcohol during the preceding year were asked how old they were when they began to drink. This question was posed in all countries except for Romania and Slovakia. The average age was 17, ranging from 18 in Bulgaria to 14 in Portugal as shown in the following graph.

Graph 4.4. Average age at which those who consumed alcohol over the last 12 months began to drink



Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Breakdown of the data by gender shows that not only do fewer women consume alcohol but they also begin at a later age than men. While men begin drinking at the average age of 16, women start at the age of 18.

Table 4.5. Average age (by gender) at which those who consumed alcohol over the last 12 months began to drink

	Men	Women	Roma population
Total	16.2	18.5	17.0
Greece	15.2	17.1	15.9
Portugal	13.9	16.1	14.1
Czech Republic	16.4	17.4	16.8
Bulgaria	17.0	20.3	17.9
Spain	15.9	18.5	16.9

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Bulgaria is the country with the highest initiation age for women (20), the same holding true for the overall population (18). The Czech Republic is where the smallest difference is found between the initiation age for men (16) and women (17) which was also the case for tobacco.

If we look at the average age at which the Roma population begins to drink broken down into age groups we discover a trend towards alcohol consumption at increasingly earlier ages. Drinkers age 45 and over began to drink at the age of 18.1 whereas those in the 30-44 age bracket began at 17.5 and the youngest group at 16.

Table 4.6. Average age (by age bracket) at which those who consumed alcohol over the last 12 months began to drink

	16 to 29	30 to 44	45 and over	Roma population
Roma population	16.0	17.5	18.1	17.0
Greece	15.2	16.3	16.7	15.9
Portugal	13.9	15.0	13.2	14.1
Czech Republic	16.0	17.0	17.7	16.8
Bulgaria	16.3	18.6	18.9	17.9
Spain	16.0	17.4	18.1	16.9

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Once again, differences are found between countries. In Portugal the older sector of the population began drinking earlier (13). In Bulgaria we found a sudden drop in the average age of initiation from 18.6 for the 30 to 44 year old group to 16.3 in the case of the 16 to 29 year olds.

4.2. Problems with alcohol and other drugs

This section focuses on the problematic consumption of alcohol and other drugs given that the abuse of these substances has damaging consequences for the health of consumers and on the surrounding environment and, the more habitual and abusive, the more negative.

For that reason we asked the interviewees if they encountered problems as a result of consuming alcohol or other drugs. This topic was covered by the household questionnaire meaning that a qualified member of the household furnished information on all of its members. In this case the sample size was 19,682 Roma and 4,331 households. This question was not posed in Romania or Slovakia

The following table looks at Europe's Roma population according to whether or not they have alcohol or drug-related problems.

Table 4.7. Percentage of the Roma population with alcohol or drug-related problems

	Greece	Portugal	Czech R.	Bulgaria	Spain	Roma population
No problems	96.0	96.4	95.0	95.0	97.8	96.4
Problems with alcohol	3.0	2.9	3.0	4.8	1.1	2.6
Problems with other drugs	0.7	0.3	1.7	0.1	0.8	0.7
Problems with both	0.3	0.3	0.3	0.1	0.2	0.2
Total	100	100	100	100	100	100
Base (N)	(3,492)	(1,676)	(4,109)	(3,947)	(6,458)	(19,682)

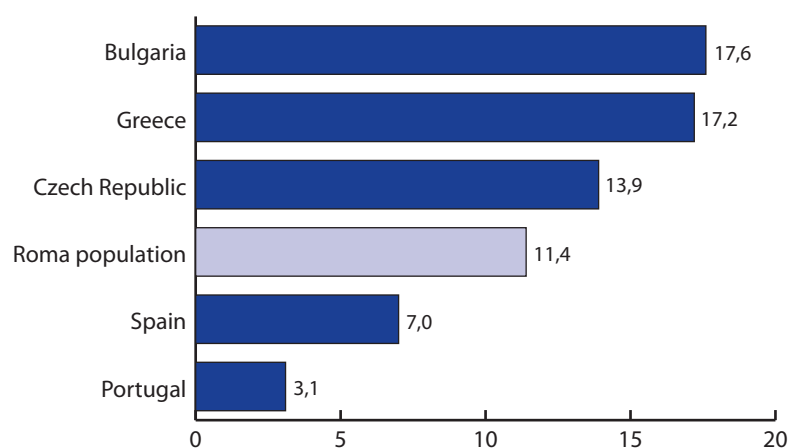
Source: EDIS S.A., European Survey on Health and the Roma Population 2009

The above data show that the overwhelming majority of Europe’s Roma population does not have any problems with these substances (over 96%). However, 2.6% of the population has problems with alcohol and nearly 1% has a drug problem. Hence, 3.5% of the population acknowledges having problems with alcohol or other drugs, approximately 38,000 individuals.

The Czech Republic and Bulgaria are the countries where the highest proportion of the population was found to encounter alcohol or drug problems, both countries at 5%. In Bulgaria, 4.8% of the population has a problem with alcohol while in the Czech Republic, 3% of the population has problems with alcohol and 2% with drugs.

Another way to analyse the information is to look at the number of households affected. In 11% of Roma households there is at least one member with an alcohol and/or drug problem which comes out to 71,000 affected households. Above this figure we find Bulgaria (18%), Greece (17%) and the Czech Republic (14%). Spain (7%) and Portugal (3%) are the countries where the fewest number of households are affected by this situation.

Graph 4.5. Percentage of households where at least one member has an alcohol and/or drug problem

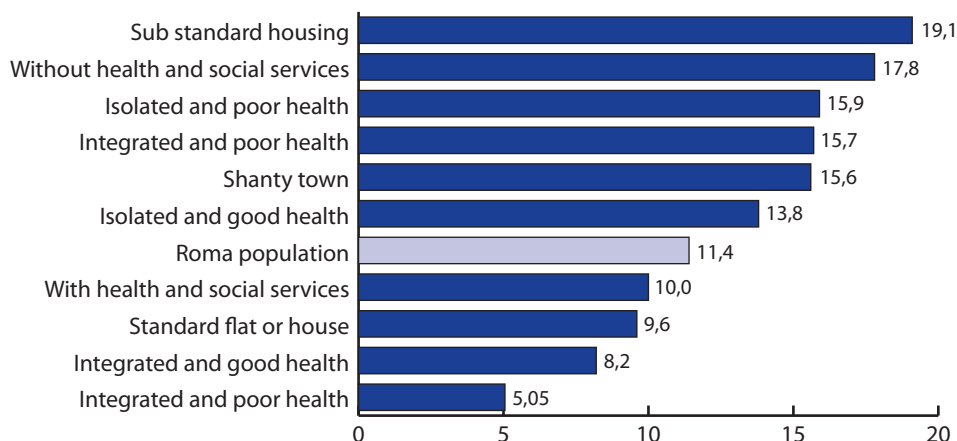


Source: EDIS S.A., European Survey on Health and the Roma Population 2009

The average size of the households affected by these problems is significantly larger (5.1) than that of households which do not suffer from them (4.4), the average being 4.5 members. Clearly, this situation is associated with a disadvantaged social context as we will see in the following.

The following graph shows that the households most affected by alcohol and/or drug abuse are those located in neighbourhoods or residential areas with poor health conditions and/or precarious housing arrangements. Hence, we find that 19% of the households living in sub-standard housing and 18% of those lacking social and health-care services close by have members affected by problems of this sort. And lastly we would point out that 16% of the homes located in neighbourhoods with poor health conditions, regardless of whether they are integrated into urban centres or not, and those located in shanty towns suffer from problems of this nature.

Graph 4.6. Percentage of Roma households with members encountering alcohol and/or drug problems as a factor of health-care and residential conditions.



Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Lastly, a certain correlation between living conditions and the ready availability of health-care and social resources and the number of households with members suffering alcohol and/or drug problems was confirmed. In contrast, the Roma population living in integrated areas with health-care services registered fewer households affected by these problems.

4.3. Physical activity and sleep

We will now analyse two essential aspects of everyday life having to do with a healthy lifestyle, i.e. the amount of time set aside for sleep and physical activity.

The following table shows the average number of hours that the Roma population in the countries studied sleeps each night. The overall average is 8.45 hours of sleep per night.

Table 4.8. Average number of hours of sleep for the Roma population

	Minors	Adults	Total
Greece	8.91	7.53	8.16
Portugal	8.35	7.68	7.96
Czech Republic	9.73	7.82	8.52
Slovakia	9.65	7.64	8.49
Romania	9.44	7.64	8.38
Bulgaria	9.22	7.61	8.14
Spain	9.46	8.45	8.76
Roma population	9.43	7.86	8.45

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

The under 16 group gets the most sleep (9.43 h) in contrast with 7.86 h for the adult population. The number of hours of sleep is inversely proportional to age.

We will now look at the breakdown of the Roma population in terms of physical activity during free time.

Table 4.9. Breakdown of the Roma population in terms of physical activity during free time.

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Does not take any exercise	70.4	33.3	62.8	53.4	61.5	69.6	54.9	60.3
Occasionally engages in physical activity or sport	18.7	45.2	30.1	41.4	26.7	26.4	28.7	28.9
Regularly takes exercise several times a month	5.4	20.2	4.7	3.8	9.8	2.9	11.5	8.1
Engages in sport or physical training several times per week	5.4	1.2	2.5	1.4	2.0	1.0	4.9	2.7
Total	100	100	100	100	100	100	100	100
Base (N())	(641)	(367)	(1,013)	(657)	(2,616)	(814)	(1,496)	(7,604)

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

60% of the Roma population of the countries studied claims to not engage in any sort of physical exercise during their free time. However, 29% occasionally take part in some physical activity or sport and 11% dedicate a significant amount of their free time to physical activity (8% work out regularly several times a month and 3% several times per week).

4.4. Eating habits and body mass index

Healthy eating habits is one of the main factors, along with physical activity, in staying healthy.

This section looks at the results obtained regarding the nutritional habits of the Roma population and their body mass indices (dividing a person's weight by height squared). This index and the person's age results in weight classification as normal, overweight or obese.

The following table provides details concerning the consumption frequency of certain basic foodstuffs (European diet) by the Roma population.

Table 4.10. Frequency of foods consumed among the Roma population.

	Daily	Three or more times per week but not daily	Once or twice a week	Less than once a week	Never or almost never	Total
Fresh fruit	27.8	23.7	22.8	17.9	7.8	100
Meat	24.8	33.0	28.4	11.4	2.5	100
Eggs	13.9	27.4	35.6	16.4	6.6	100
Fish	4.8	14.7	23.9	38.2	18.5	100
Pasta, rice	45.8	31.7	14.7	5.0	2.7	100
Bread, cereals	85.6	7.0	3.5	1.8	2.1	100
Vegetables	28.0	26.2	24.6	14.4	6.8	100
Legumes	17.1	30.8	29.2	17.6	5.3	100
Lunchmeat	20.9	24.8	25.4	21.2	7.7	100
Dairy products	47.3	25.0	16.5	8.7	2.4	100
Sweets	36.4	22.3	17.6	15.1	8.6	100

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

As the table shows, the most widely consumed foodstuff is bread and/or cereals which are consumed daily by 86% of the Roma population. 47% consume dairy products and 46% pasta and rice on a daily basis. We would especially highlight the fact that 36% of the population claims to consume sweets every day and only 28% vegetables and fruit.

Fish is among the most infrequently consumed foods in the Roma diet; 38% of the population eats fish less than once a week and 18.5% never eat it. Also, 18% of those interviewed eat fruit and vegetables less frequently than once a week and 14% consume vegetables less than once a week.

A country by country analysis of foods habitually consumed (three or more times per week) shows that Greece and Slovakia consume surprisingly little fish (8% and 10% respectively). As for meat consumption, Greece is the country with the lowest percentage of habitual consumers (39%). Slovakia also stands out for its low consumption of vegetables and legumes.

Special mention should also be made of the high consumption of less healthy foods such as sweets. This is especially the case among the Czech and Spanish Roma populations with 69% and 66% respectively.

Table 4.11. Percentage of the Roma population that consumes certain foodstuffs three or more times per week

	Greece	Portugal	Czech R.	Slovakia	Romania	Bulgaria	Spain	Roma pop.
Fresh fruit	43.8	81.9	54.2	46.1	44.5	43.2	65.0	51.5
Meat	38.9	91.1	68.6	66.7	39.4	51.1	80.6	57.7
Eggs	16.6	22.5	49.5	25.0	49.8	41.4	35.8	41.3
Fish	8.1	67.6	15.4	9.6	16.9	16.2	29.9	19.5
Pasta, rice	73.4	96.9	47.3	81.0	88.4	58.5	74.9	77.6
Bread, cereals	90.9	97.1	84.2	93.2	90.6	96.9	90.5	92.7
Vegetables	50.3	77.5	67.5	39.4	55.0	60.2	47.8	54.2
Legumes	28.9	73.3	30.1	26.8	57.9	50.4	46.1	47.9
Lunchmeat	26.2	71.9	42.9	40.3	32.1	57.4	63.6	45.7
Dairy products	60.1	80.8	80.1	57.3	65.9	70.4	85.2	72.3
Sweets	45.6	62.4	68.7	58.7	51.3	57.9	65.8	58.7

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Having analysed the foods consumed and frequency of consumption, it is interesting to analyse how these habits affect the health of Europe's Roma population. We will now look at the World Health Organisation's classification of the nutritional status of this group, i.e. body mass index.

Body mass index features three categories: normal, overweight and obese. Values under the overweight threshold fell into the category of "normal or sufficient weight".

Table 4.12. Distribution of the 2 and over Roma population according to body mass

	Normal weight	Overweight	Obese	No information	Total	Base (N)
Roma population	52.0	27.4	17.2	3.5	100	(7,388)
Greece	35.6	23.3	9.4	31.7	100	(629)
Portugal	39.5	40.7	14.0	5.8	100	(350)
Czech Republic	50.1	27.7	20.2	2.0	100	(984)
Slovakia	53.7	25.8	17.9	2.6	100	(639)
Romania	56.7	26.5	16.9	0.0	100	(2,554)
Bulgaria	57.7	27.5	14.2	0.6	100	(786)
Spain	44.8	29.5	19.7	6.0	100	(1,446)

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

It is first of all important to point out that just over half of the Roma population of the countries studied (52%) is within a weight range considered normal, 27% is overweight and 17% is obese.

Portugal is the country that has the highest proportion of Roma population with weight problems, nearly 55% (41% overweight and 14% obese). The country with the highest obesity rate is the Czech Republic with 20%.

We will now look at body mass index by gender and age bracket. As the following table shows, men have more weight problems than women (nearly 7 points higher) although the percentage of obese population is practically the same (17%).

Table 4.13. Distribution of the Roma population according to gender, age group and body mass

	Normal weight	Overweight	Obese	No information	Total	Base (N)
Roma population	52.0	27.4	17.2	3.5	100	(7,388)
Gender						
Men	48.5	30.6	17.1	3.8	100	(3,616)
Women	55.3	24.2	17.3	3.2	100	(3,772)
Minors and adults						
Minors	62.5	15.9	16.6	5.0	100	(2,585)
Adults	46.1	33.7	17.6	2.6	100	(4,803)
Age groups						
2 to 9	51.3	14.2	27.5	7.0	100	(1,297)
10 to 15	75.0	17.7	4.5	2.8	100	(1,286)
16 to 29	62.8	26.4	8.1	2.7	100	(1,700)
30 to 44	39.5	37.4	20.7	2.3	100	(1,662)
45 and older	29.9	39.6	27.6	2.9	100	(1,443)

Source: EDIS S.A., European Survey on Health and the Roma Population 2009

Significant differences are also detected between age groups. In general terms, Roma children have a more healthy body mass index than adults; 63% of minors are within the normal weight range compared to 46% of adults.

However, it is important to highlight different distributions according to age group. In the over 45 group, 70% of those surveyed have weight problems. Regarding children, 28% of the age 2 to 9 group are obese compared to only 5% of the 10 to 15 age group.

Summary and conclusions

Thanks to the European project “Health and Roma Community. Analysis of the situation in Europe”, we were able to acquire a snapshot of the health situation of the Roma population in Portugal, Greece, Spain, Romania, the Czech Republic, Slovakia and Bulgaria. It is our view that the results obtained in these seven countries are a representative sample of the situation facing the Roma population throughout the whole of Europe.

The purpose of this chapter is to provide a systematised overview of the results and the main conclusions to be taken from them.

Summary

Socio-demographic characteristics

- **The European Roma population is younger than the overall European population.** The average age of the Roma community in the countries studied is 25.1 while the average age of the EU-27 population is 40.2.
- **The birth rate of Europe’s Roma population has started to decrease.** Statistics show that there are 82.7 Roma children under age 5 for every 100 children between the ages of 5 and 9. Despite the fall in the birth rate, population replacement is guaranteed for the next 25 years.
- **The European Roma population has a shorter life expectancy than the overall European population.** This assertion is based on longevity and old-age indicators. Thus, the Roma population’s longevity rate in the countries studied is 25.7% compared to 51% for EU-27 while the old-age rate is 4.5% for the Roma population as opposed to 11.2 % for EU-27.
- **44% of the adult Roma population has not completed primary school studies.** Approximately 465,000 Roma over age 15 from the seven countries that took part in this survey have not earned any academic diploma. Moreover, a lower proportion of the Roma population enrolls in school in comparison with the overall European population.
- **Three quarters of the active Roma population is employed.** We would draw attention to the unemployment rate in the Czech Republic (41%), Slovakia and Greece (approximately 33%).
- **3.6% of the Roma population living in the countries studied resides in shanty towns and nearly 27% in other forms of sub-standard housing.** This translates into approximately 852,000 who reside in sub-standard housing or shanty towns.
- **The average size of Roma households is 4.49 members, two points above the EU-27 average.** This figure is higher in the case of households located in neighbourhoods characterised by poor health conditions.

Health status

- **The Roma population views its own health quite similarly to the EU-27 population despite the fact that the Roma population in the countries studied is significantly younger.** 68% of Roma consider their health to be good or very good compared to 66% of the EU-27 population. However, if we break down data by age bracket we find that 2% of the Roma population between the ages of 15 and 24 rates their health as poor or very poor, 0.6 percentage points higher than the EU-27 population. This figure rises to 36% for the Roma population in the 65–74 age bracket compared to 21% for the EU-27 population in that same age bracket.
- **15% of the European Roma population has some sort of disability or chronic illness which translates into a total of 407,000 individuals.** The countries with the highest percentage of the population in these circumstances are Portugal with 20% and Slovakia with 19%.
- **The chronic illnesses most affecting the Roma population are migraines and headaches, hypertension, asthma and chronic bronchitis and high cholesterol.** Adults mostly suffer from migraines, headaches and hypertension while minors are most affected by asthma, chronic bronchitis and allergies.
- **12% of the Roma population encounters a certain degree of difficulty engaging in some or all daily activities.** Moreover, six out of every ten of these people need to be cared for by others.
- **11% of Europe's Roma population had an accident during the year preceding the interview.** Most accidents occur at home, accounting for 43% of the total followed by accidents outside the home (20%) and traffic accidents (17%).
- **19% of the Roma persons interviewed encountered some sort of limitation to their daily activity during the two weeks immediately preceding the interview.** People living in unhealthy neighbourhoods or shanty towns were the ones most affected by limitations to their daily activity.
- **The most pervasive dental problem among the Roma population is cavities.** 34% of Roma minors and 61% of the adults have cavities.
- **One third of the Roma population living in the countries studied (over age 15) has some vision or hearing difficulty.** This means that 560,000 people encounter difficulties of this sort. Hearing problems are most prevalent, affecting one out of every 4 Roma or 427,000 people.

Use of health-care services

- **The most frequently consumed medicines both in the case of Roma minors and adults living in the countries studied are those used to combat colds, pain and to reduce fever.** The consumption of blood pressure medicine and birth control pills among adults is also significant. Use of antibiotics among minors is likewise noteworthy.
- **With regard to self-medication, minors are mainly self-medicated with remedies to combat colds, pain and/or to reduce fever; antibiotics as well, but to a lesser degree.** Adults self-medicate with blood pressure medicine and pain, fever and cold remedies. It is also worth noting that 14% of the women who take birth control pills and 10% of those who take heart medicine, self-prescribe these drugs.
- **As for the frequency of physician visits, the highest percentage registered was for people who visited the physician more than a month but less than a year before the date of the interview (36% of those interviewed).**

- **The Roma population that visited their physician in the two weeks immediately preceding the interview did so mainly for a diagnosis and/or treatment (55%).** 28% of the Roma who visited their physician did so for a check-up, the second most common reason for the visit. In Greece, only 3.2% of those who saw their physician did so for a check-up. In contrast, in Bulgaria 53.5% last saw their physician for that purpose.
- **8% of the Roma population interviewed claimed to not have received medical assistance when they needed it (17% in Greece and 14% in Bulgaria).** The main reason that the Roma population failed to receive medical attention had to do with their economic situation.
- **28% of Roma minors do not properly adhere to the childhood vaccination calendar.** The case of Romania is particularly notorious with 46% of Roma minors failing to properly adhere to the child vaccination programme. In 42% of the cases where minors were not properly vaccinated, the parent or guardian claimed to have forgotten to take the children for their inoculation. We would also point out that in 12% of the cases, the reason was a lack of economic resources.
- **32.5% of the Roma population in the countries surveyed have never seen a dentist.** Moreover, 38% of those interviewed had not visited a dentist in the year prior to the interview.
- **16% of the Roma population has been hospitalised for at least one overnight stay in the year leading up to the interview.** The Portuguese made greatest use of hospital services (23%). The Slovaks and Spaniards frequent hospitals the least (12% in both cases). As for the reason for the most recent hospitalisation, medical treatment without surgery topped the list.
- **24% of those interviewed had made use of some emergency room services in the 12 months prior to the interview.** This percentage is higher in Greece (32%), Spain (37%) and especially in Portugal where 73% of the Roma population claimed to have used emergency room services. The 45 and over age bracket used emergency services more than any other.
- **Nearly 40% of Roma women age 16 and over have never been to the gynaecologist or went only because of pregnancy or to give birth.** In Portugal, 24% have never been to the gynaecologist and 60% have gone exclusively for reasons related to pregnancy or giving birth.

Lifestyles

- **44% of the Roma population (over age 15) smokes on a daily basis.** 59% of Roma men as opposed to 31% of Roma women are habitual smokers. In Greece, the Czech Republic and Slovakia, over 60% of the men are regular smokers.
- **The Roma population begins to smoke on a daily bases at the age of 15.5.** Portugal is the country where the habit starts the earliest (age 13) and Slovakia the country where the average starting age is the highest (17).
- **56% of those interviewed had consumed some alcoholic beverage in the 12 months prior to the interview.** Slovakia is the country where consumption was the greatest, exceeding the average by 14 percentage points (70%). The figures also indicate that the Roma population starts to drink at an increasingly younger age; while the 45 and older group started to drink at age 18, the 16 to 29 age bracket began at age 16.
- **The overwhelming majority of Europe's Roma population does not have any alcohol and/or drug related problems.** However, 11% of Roma households have at least one member with an alcohol and/or drug problem. In the case of Bulgaria this figure is 18%, Greece 17% and the Czech Republic 14%.

- **The households most affected by alcohol and/or drug abuse are those located in neighbourhoods or residential areas with poor health conditions and/or precarious housing arrangements.** 19% of the family units living in sub-standard housing have members undergoing this sort of problem.
- **60% of the Roma population of the countries studied claims to not engage in any sort of physical exercise during their free time.** Only 11% of the population engages in physical activity during their free time; 8% several times per month and 3% several times per week.
- **Only 28% of the Roma population consumes fruits and fresh vegetables every day.** Moreover, 18% of the population never eats fish. In contrast, 36% of the populations consumes sweets every day.
- **And lastly, 27% of the Roma population is overweight and 17% is obese.** Obesity levels are highest for the age 2 to 9 and 45 and over age brackets where the obesity index is 27.5% and 27.65% respectively.

Conclusions

A series of conclusions have been reached from an analysis of the results obtained which gives us a clearer view of the health situation of Europe's Roma population.

The first and most important conclusion is that this community is particularly vulnerable to the effects that social conditions have on health. Housing conditions, the type of employment that a portion of the Roma population engages in and the greater difficulties faced in achieving a suitable level of education are just some of the factors accounting for the precarious health situation characterising Europe's Roma community. Moreover, the health status of the Roma population living in run down neighbourhoods, sub-standard housing or shanty towns and those with less access to health-care and social services is even worse than that of the rest of the Roma population.

The adult Roma population (over age 15) has a worse perception of their own health status than the general EU-27 population. Also, nearly 20% of those interviewed claimed that in the two weeks immediately preceding the interview they had to limit their main activity or free-time activities due to one or several ailments or symptoms. Related to this figure and as shown in the survey results, the Roma population has a high prevalence of chronic diseases of which special mention should be made of migraines and headaches, hypertension and arthritis and/or rheumatism in the case of adults. As concerns minors, asthma, chronic bronchitis and allergies are particularly widespread. This situation is further exacerbated by the fact that the Roma population has poor dental health and a third of the population experiences difficulties seeing or hearing properly.

However, not only are housing, income and level of education closely linked to health. Access to and the use made of health-care services is likewise essential for good health. In this connection the health survey indicated that the majority of the Roma population had seen their physician during the preceding year with diagnosis and treatment being the main reasons for the visit. Despite this fact, 8% of the Roma population claimed that they failed to receive medical assistance when in need. While this figure is not excessively high, it is significant that the reason given by most of these people was that they did not have the money to pay for the medical visit, that insurance did not cover the visit or that they did not have medical insurance. In Greece, 20.5% of the adults needed but failed to receive medical assistance, the highest figure in this regard. In most countries it was found that people living in rural areas far from cities or in neighbourhoods isolated from city centres encountered the greatest difficulties gaining access to health-care resources.

As for the use made of health-care resources, special mention should be made of the disproportionate use of emergency services. This could be related to the immediacy of the service but can also be explained by the fact that these services are free in most countries. The national reports drafted by each of the participat-

ing countries also indicate that communication problems between the Roma community and health-care providers, mainly arising from prejudice and stereotypes, hinder the use of health-care resources.

Access to prevention services is insufficient. Over 25% of Roma children do not adhere to the vaccination schedule and over 40% of women over age 15 have never been to the gynaecologist for reasons other than pregnancy or labour. Also, 30% of the Roma population has never been to the dentist.

The community itself, with its habits and lifestyles, is also responsible for its own health. From an analysis of the data on tobacco and alcohol consumption, nutritional habits and physical activity, it can be deduced that a large proportion of Europe's Roma community has an unhealthy or very unhealthy lifestyle.

As already mentioned, the number of habitual smokers is very high, especially among men. The Roma population also begins to smoke at a very early age. As concerns alcohol, while the data collected do not directly indicate dangerous levels, it is safe to say that alcohol consumption is high among the Roma population and is being consumed at an increasingly early age.

Survey results concerning physical activity and nutritional habits are not encouraging either. The majority of the Roma population does not engage in any type of physical activity during free time and nutritional habits are poor, the latter being characterised by scant presence of fruit, vegetables and fish and excessive consumption of sugars. Considering these data, it should come as no surprise that a very high percentage Europe's Roma population is overweight or obese and this includes both minors and adults.

Thanks to the data obtained, we are now in a position to conclude that poor housing, inadequate education and difficulties encountered in gaining access to and using health-care services, together with deficient health habits, all contribute to the poor health status of Europe's Roma community the result of which is a high morbidity rate and lower life expectancy vis-à-vis other Europeans.

In light of these results, priority action needs to be taken in the following areas:

- Universal access to health-care services: Facilitate access to and use of health-care services among the poor Roma population and those living in rural areas and segregated neighbourhoods.
- Dental health: Facilitate access to and promote the use of dental health services.
- Use of prevention services. Promote the use of preventive health-care resources with a special focus on child vaccination and the prevention of gynaecological diseases.
- Acquisition of better health habits by the Roma population:
 - Implement actions targeting the prevention of drug use by young people and actions designed to reduce the smoking among men.
 - Promote and facilitate physical activity during free time, especially among young people.
 - Promote healthy eating habits.

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**Recommendations for the improvement
of the health situation of the
Roma Community and the reduction of
health inequalities in the European Union**



Recommendations for the improvement of the health situation of the Roma Community and the reduction of health inequalities in the European Union

Introduction

The national reports and the present transnational report on the health situation of the Roma in the European Union (EU) has allowed the analysis of comparable and representative data on the health situation of the Roma in seven EU member-states, by providing reliable and replicable indicators measuring the extent of the problem and helping to identify its causes. The results of these reports allow for a set of recommendations to be produced, which must be seen as functional elements of an integrated approach to the improvement of the health situation of the Roma in all national and local contexts. The health inequities lived by the Roma must be tackled with an understanding that Roma health is structurally determined (by the physical environment, the socio-economic conditions and legal status). Therefore, health is not simply a matter to be resolved by national health systems and health professionals but concurrently, in all social fields and by all stakeholders.

Having identified the key problems affecting Roma health, the present recommendations on the idea that recommendations contributing to the elimination of health inequalities require identifying the social agents involved in the health-Roma population nexus, and the responsibilities of each actor. However, the need for a holistic approach to the health inequalities lived by the Roma warrants the presentation of general recommendations, which are applicable EU-wide, in all national and local contexts regardless of their specificities and idiosyncrasies. Although this report, for a number of reasons, is based on seven EU member states rather than the entire EU community, its categories, indicators and recommendations may be generalised to the EU as a whole, with an understanding that 1) some national and local specificities may not be accounted for, and that 2) potential changes in the indicators used here will entail revising our recommendations. It must also be emphasised that the member states under study include Europe's largest Roma populations, in both absolute and relative terms, thereby increasing the validity and generalisability of the report.

This section begins by expounding the transversal principles that all agents should take into consideration in the financing, programming and provision of healthcare in the EU. It subsequently moves from the macro to the micro level of policymaking and implementation, and from state to civil society actors, by making respective recommendations to the EU, national and local governments, health professionals, and the Roma population.

General recommendations

We have identified a series of transversal recommendations, which must be taken into consideration by all institutions and actors when addressing any of the specific areas of intervention in healthcare and are to a large extent consistent with the 10 Common Basic Principles on Roma Inclusion, promoted by the EU's Integrated Platform for Roma Inclusion:¹

1. Tackling the structural determinants of health: inter-sectorial intervention in education, training, labour market inclusion, housing and health;
2. Involvement and participation of the Roma population in all processes of intervention;
3. Normalisation and strengthening of health programmes aimed at the Roma population: 'explicit but not exclusive targeting'.
4. Inclusion of a gender perspective;
5. Prioritising preventive healthcare by targeting Roma youth;
6. Continuation of data gathering and analysis, in order to deepen our understanding of the specific needs of the Roma population regarding healthcare, and to identify any changes of those variables conditioning the health situation of the Roma.

1. Tackling the structural determinants of health: inter-sectorial intervention in education, training, labour market inclusion, housing and health.

The circumstances under which persons are born, grow, live, work and age determine to a large extent their health situation.² These circumstances are conditioned by the distribution of resources and power, which are in turn shaped by policy choices. As pointed out by the WHO (2008: 1), the 'structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries'.³ Moreover, if the health situation of any population influences and is influenced by other social areas (housing, education, employment), this inter-relationship is particularly acute in the case of the Roma population. Social welfare is not the sum of different parts, but is rather conditional on integrated actions in all social fields, simultaneously and always with a consideration of the effects of a specific policy on other fields. A holistic approach, which seeks to redress geographical, national/ethnic and income inequalities EU-wide, should systematically and concurrently target education, professional training, employment, health and housing through effective and efficient fiscal and organisational instruments.⁴ Human health in particular should be a cross-cutting issue throughout the decision-making in different sectors and at different levels.

Holistic, inter-sectorial work should therefore entail a *shared* responsibility between all agents involved in welfare and employment, and the incorporation of health issues in all programmes aimed at the Roma population as well as other vulnerable populations. Inter-sectorial information sharing and coordination should be undertaken and sustained as a matter of principle.

¹ 10 Common Basic Principles on Roma Inclusion. 1st European Platform for Roma Inclusion (Prague, 24 April 2009): 10 Common Basic Principles on Roma Inclusion. Annexed to Council Conclusions, 8 June 2009. Available at: http://www.euromanet.eu/upload/21/69/EU_Council_conclusions_on_Roma_inclusion_-_June_2009.pdf. Accessed 10 September 2009.

² World Health Organisation (WHO), Sixty-second World Health Assembly, Resolution WHA62/R14. 22 May 2009. Available at http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf. Accessed 10 September 2009.

³ Commission on Social Determinants of Health (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health* (Geneva, WHO). Available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf. Accessed 10 September 2009.

⁴ Vladimir Špidla's speech at the Second European Platform for Roma Inclusion (Brussels, 28 September 2009), which is premised on the implementation of integrated policies, emphasised that: "... It is vital that policies for Roma education are not dealt with in isolation from those in employment and social affairs, housing and public health." Available at: <http://europa.eu/rapid/pressReleasesAction.do?reference=IP/09/1365&format=HTML&aged=0&language=EN&guiLanguage=en>. Accessed 2 October 2009.

2. Normalisation and stabilisation of health programmes aimed at the Roma population: 'explicit but not exclusive targeting'

Roma persons' equal access to health services must, however, be facilitated by compensating for existing social inequalities through programmes targeting the specific needs of the Roma defined by adapted and non-discriminatory attention. Given the need for explicit but not exclusive targeting, health programmes and medical attention aimed at the Roma should always tend towards normalisation and sustainability, i.e. the Roma population should be allowed and encouraged to be offered medical care by the same professionals and in the same resources as the rest of the citizenry.⁵ The central aim of these programmes should be to guarantee that the specific needs and peculiarities of the Roma population are included in the normal functioning of the resources and the actions of their professionals.

If interventions specifically targeting the Roma are implemented, they should be considered as temporary measures aimed at preparing the eventual incorporation of the Roma population into normalised resources.

The incorporation of the Roma population into normalised healthcare provision is a protracted and complex process involving the interaction between numerous social and individual factors, and can therefore not be achieved through ad hoc, temporary and intermittent programmes. Healthcare programmes aimed at the Roma should therefore be, whenever possible, strengthened and stabilised in the medium term. However, the long-term objective of programmes directed exclusively at the Roma should always be their eventual disappearance, in order to achieve the aim of healthcare normalisation, and to eliminate the potential stigmatisation that such specific programmes might involve if they rigidify over the long-term.

3. Involvement and participation of the Roma population in all processes of intervention.

It is of fundamental importance that the EU, national and local administrations as well as the NGO sector steer clear of lapsing into a paternalistic approach of health intervention. Therefore, the participation and whenever possible, the leadership of the Roma in all processes of intervention affecting them is recommended. The point is to secure the involvement of the Roma population as agents of their own development. Roma involvement implies changes of attitudes and habits that are unhealthy. The participation must take place in the phases of planning, implementation and evaluation, at both macro- and micro-levels of intervention:⁶

- Planning, implementation and evaluation:
 - diagnosis of Roma needs
 - definition of objectives and methods
 - implementation
 - evaluation.
- Macro- and micro-levels of participation:
 - Macro: Identification of strategic lines of action at the EU and national levels;
 - Micro: local implementation of these strategic lines of action.

⁵ This reflects principles 2 and 4, regarding 'mainstreaming' and 'explicit but not exclusive targeting', of the *10 Common Basic Principles on Roma Inclusion*. 1st European Platform for Roma Inclusion (Prague, 24 April 2009): *10 Common Basic Principles on Roma Inclusion*. Annexed to Council Conclusions, 8 June 2009. Available at: http://www.euromanet.eu/upload/21/69/EU_Council_conclusions_on_Roma_inclusion_-_June_2009.pdf. Accessed 10 September 2009.

⁶ The principle of Roma participation has been reiterated in EU resolutions. Council Conclusions on inclusion of the Roma. *2914th General Affairs Council meeting*. Brussels, 8 December 2008. 16862/08 (Presse 359). Available at: <http://register.consilium.europa.eu/pdf/en/08/st15/st15976-re01.en08.pdf>. See also principle 10 of *10 Common Basic Principles on Roma Inclusion*. 1st European Platform for Roma Inclusion (Prague, 24 April 2009). Both accessed 10 September 2009.

Such participation must involve diversified civil society interlocutors, in order to reflect the heterogeneity of the Roma population and diverse realities lived by Roma men and women:

- Associations that may represent one sector of the Roma population (but not others), and with which alliances can be built to work on determined areas of intervention (but not others).
- Roma mediators, who are in a position to provide valuable knowledge on the reality lived by Roma communities.
- Members of the Roma population who are not affiliated to any association or church, but who, thanks to their experience, training and sensitivity, may provide valuable contributions to the elaboration and evaluation of health policies.
- Users of the services, who through their relationship with healthcare staff or mediators may collaborate in all phases of planning and implementation.

Without the active participation of the Roma population in the planning, implementation and evaluation of policies, the legitimacy, transparency and effectiveness of policies are likely to be hindered.

4. Incorporating a gender perspective

Working towards a reduction of health inequalities requires the systematic integration of a gender perspective by all stakeholders, which takes into account the fact that health problems are more acute among Roma women.⁷ Roma women suffer a triple discrimination; for being women in a patriarchal society, for belonging to an ethnic minority that is affected by the most negative social perception and for belonging to a culture whose gender values have been associated almost exclusively to the function of mother and spouse. The opportunities available to Roma women are therefore limited in relation to men in their community and to society as a whole. In order to address this multiple discrimination, any policy aimed at reducing health inequities should focus particularly on the specific conditions and needs of Roma women.

It must be taken into account that the different health situations of Roma women and men are defined primarily by the distinct lifestyles (nutrition, consumption of tobacco, physical activity, etc.), which in turn are conditioned by their different social roles. The social norms that have traditionally governed the different roles and positions of men and women in the Roma population have a clear impact on the significant differences in the health situation of Roma men and women detected in the present study.

The roots of gender inequality, within the Roma population as in broader society, are socially constructed, and can therefore be modified, by Roma men and women. For this reason, and as already mentioned, all interventions aimed at improving the health situation of Roma women ought to be particularly sensitive to their particular situation.

The inclusion of a gender perspective is not only justified by the inequalities detected between men and women, but also by the multiplying effect of interventions aimed at women, for their pivotal role in the organisation of the family and the transmission of values and habits. Interventions should seek to promote a greater visibility (as mediators, educators) of and access to health resources by women. Furthermore, interventions cannot overlook younger Roma women and must bolster, through dialogue and reflection, a growing participation in society, which contribute to the creation of new meanings to Roma identity and convert themselves in referents for other persons of their community. Nevertheless, if we exclusively reinforce the responsibility and implication of women, we run the risk of contributing to the consolidation of gender inequalities.

⁷ *European Parliament resolution on the situation of Roma women in the European Union* (2005/2164(INI)). P6_TA(2006)0244. (1 June 2006). Available at: <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&language=EN&reference=P6-TA-2006-0244>. Accessed 15 September 2009.

5. Prioritising preventive healthcare by targeting Roma youth

Any reference to the Roma is a reference to an extremely young population, with close to half of the population under 20 years old and a traditional population pyramid (high birth rate, low life expectancy). Considering the determining effects of children's living conditions on their adult health and life expectancy, the need to target Roma children therefore becomes a vital necessity. In particular, preventive healthcare, which involves changes in habits and behaviours, may generate profound transformative processes by targeting children. It is therefore considered that Roma children and adolescents should be prioritised for information and education campaigns, in part because they are more permeable to any type of intervention. Furthermore, taking into account the characteristics of Roma teenagers and youth – defined by relatively early adulthood –, we urge that interventions be targeted at Roma boys and girls, in order to integrate concepts of preventive medicine and, in the case of drug abuse, before the first situations of consumption may occur.

Investing in sustained health programmes targeting Roma youth and adapted to their specificities will have the greatest probability of having a lasting positive impact on health equity and the health situation of the Roma population.

6. Continuation of data gathering and analysis, in order to identify any changes within or of key variables

We must emphasise the groundbreaking nature of the present report. The lack of studies and research on the health situation of the Roma population in the UE profoundly undermines the planning of specific programmes adapted to the reality and needs of the Roma.

- The present study should be replicated on a regular basis by using the same indicators and, if necessary, by adapting indicators to new empirical evidence, in order to establish a longitudinal analysis that allows for historical as well as geographical comparisons.
- More specific and in-depth studies should be undertaken, in part to redefine and 'funnel' the indicators used in the present report. Thematic examples include drug abuse, the use of emergency services, obstacles to the access and use of health care services.
- In order to take into account the territorial diversity of the Roma population, studies of specific localities and regions within each of the case studies analysed at the state level in this report should also be carried out.

Healthcare provision to the Roma population would be significantly improved by closer cooperation between researchers, policymakers and social workers. Gaps between the elaboration of the studies, the planning of policies and the development of intervention should be bridged in order to be more attuned and responsive to the needs of the Roma population.

From the macro- to the micro-level in healthcare provision

1. European level

The health situation of the Roma population is inadmissible with regards to the inspirational principles of the European Union (EU) and of the European social model. The principles of justice, equity and fundamental rights at the core of the European social model are trampled upon by the reality lived by the Roma. The EU must therefore undertake every effort to live up to its obligations, by addressing five central issues.

- EU leadership
- EU 2008-2013 Health Programme and the Roma population.
- Integrated policies
- Multilateralism
- Promotion of transnational networks

EU leadership

The Roma population is a European minority: The Roma population is present in the majority of the EU's jurisdiction and shares a situation of exclusion and discrimination in all member states. It is the largest minority in the EU and its demographic expansion signifies that the quality of its health is not a problem that can be ignored by the EU. Crucially, members of the Roma minority are European citizens entitled to the same rights, including the right to equitable healthcare, as the rest of the citizenry, as provided by EU treaties and other binding instruments such as the Council of Europe European Convention on Human Rights (1950) and Framework Convention for the Protection of National Minorities (1998), the United Nations International Covenant on Civil and Political Rights (1976) and International Covenant on Economic, Social and Cultural Rights (1976).

For this reason, we recommend that the promotion of health enters the political agenda of the EU. The EU must assume a political leadership position, in the sense of mobilising institutional and financial resources to articulate, coordinate and monitor measures aimed at the reduction of the health inequities experienced by the Roma.⁸

- **Transnationality and subsidiarity:** The health inequities lived by the Roma population must be considered as a transnational problem, because it is common to all countries under study to a greater or lesser extent. Transnational processes transcend and interlink domestic contexts and should therefore not be considered as matters that affect and are resolved exclusively by national administrations. New processes such as the large-scale migrations of the Roma populations from Eastern European member states to the rest of the EU increase the salience of the notion of transnationality with regards to Roma health. For this reason, the health situation of the Roma requires a European response. The transnationality of the issue of Roma health adds value to the coordination of national health policies aimed at the reduction of inequalities in Roma access to healthcare. Considering its capacity to address transnational issues and to coordinate the activities of multilateral, national and local institutions, the EU in particular ought to take a leadership role in the promotion of Roma health. EU leadership and initiatives should uphold and complement the authority of national states in the field of health provision in accordance with the principle of subsidiarity.⁹

⁸ The European Parliament "Reaffirmed the important role of the EU in fighting discrimination against the Roma, which is often structural and therefore requires a comprehensive approach at EU level, in particular with regard to the development of common policies, whilst acknowledging that the crucial competences ... of the Member States". Article 5. *European Parliament resolution on a European strategy on the Roma*. P6_TA(2008)0035. 31 January 2008. Available at: <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P6-TA-2008-0035&language=EN>. Accessed 1 September 2009.

⁹ Subsidiarity refers to the principle that central authority should have a subsidiary function, which signifies that social, economic and political issues ought to be handled by the smallest, lowest or least centralised competent authority. It is a fundamental principle of EU Law, enshrined in the 1992 Treaty of Maastricht. According to this principle, the EU may only enact legislation in cases where legal responses by individual member states cannot effectively address an issue. The transnationality of the issues affecting the Roma community entails that the EU would be the most appropriate institutional setting to plan, monitor and evaluate policy instruments improving Roma health.

- **Priorities and approach:** the elimination of the health inequities affecting the Roma population ought to be considered as a priority of all the institutions constituting the EU. The European Commission, Council and Parliament in cooperation with the Council of Europe must therefore show strong will and persistence to push the issue of equity in health onto the political agenda of national governments.
- On the one hand, the **European Commission** must respond to the mandate – of social inclusion and socio-economic cohesion, particularly with regard to the Roma population – assigned to it by the Council of the European Union¹⁰ and the European Parliament.¹¹
- On the other hand, the EU ought to consider the development of actions aimed at the promotion of Roma and other vulnerable groups' health as a priority within the framework of programmes of social inclusion and cohesion (European Social Fund [ESF], PROGRESS),¹² and of transnational cooperation (EU-Roma, European Grouping for Territorial Cooperation, Platform). The overwhelming preponderance of employment and professional training in these programmes potentially overshadows the implementation of integrated and inter-sectorial policies, and thereby hinders their effectiveness by overlooking the social conditions that underpin the development of a qualified and healthy workforce.
- In that sense and because the health situation of Roma persons is a structural issue, member states should be able to access Structural Funds to support national efforts to universalise and normalise healthcare provision (see below), in part by expanding the reach and quality of health resources in those areas that need it most, for instance by opening maternity and other primary care centres in areas with significant Roma populations.

The 2008-2013 EU Health Programme and the Roma population

With regards to the financing and actions aimed at the promotion of Roma health, the 2008-2013 Health Programme of the EU is considered as a particularly relevant instrument.¹³ The main objectives of the EU Health Programme are:

- To improve citizens' health security;
- To promote the reduction of health inequalities;
- To generate and disseminate health information and knowledge.

These objectives are particularly relevant to Roma health. In order to achieve these aims, it is of fundamental importance that the 2008-2013 EU Health Programme includes Roma health issues, and accordingly support actions that target specifically the Roma population.

In its second phase (2010-2013), the Programme should take into consideration the health situation of the Roma population and emphasise those aspects in which a greater inequality is detected. We suggest the incorporation of a **pilot project** aimed at Roma health in the Programme from 2010, and evaluated in 2012, in order for it to be scaled up in the following Health Programme (2014-2019). The pilot project would consist in the creation of a **team of experts on health inequality**, incorporated in the European Observatory on the Social Situation and Demography,¹⁴ with a particular focus on the situation of the Roma population. This team would be in charge of:

¹⁰ Council of the European Union, *Council Conclusions on Inclusion of the Roma*. 2947th Employment, Social Policy, Health and Consumer Affairs Council meeting. Luxembourg, 8th of June 2009.

¹¹ *European Parliament resolution on a European strategy on the Roma*. P6_TA(2008)0035. 31 January 2008. Available at: <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P6-TA-2008-0035&language=EN>. Accessed 2 October 2009.

¹² For information on the European Social Fund, see http://ec.europa.eu/employment_social/esf/. For information on the programme PROGRESS, see <http://ec.europa.eu/social/main.jsp?catId=327&langId=en>. Both accessed 18 August 2009.

¹³ European Parliament and Council, *Decision No. 1350/2007/EC of the European Parliament and of the Council establishing a second programme of Community action in the field of health* (2008-2013). 23rd of October 2007.

¹⁴ Information on the European Observatory of independent experts, established for the European Commission in 2005, is available at: http://ec.europa.eu/employment_social/spsi/european_observatory_en.htm. Accessed 10 September 2009.

- *Longitudinal, comparative analysis*: the expert team would replicate the present survey in time and if possible expand it to other member states. By undertaking long term data collection and analysis, the team would improve the accuracy and reliability of the present study's indicators, consolidate policy action paths and measure policy effects on the health situation of the most vulnerable populations, in particular the Roma population. This would be consistent with the EU Health Programme's aim of achieving the systematic collection, processing and analysis of comparable data for an effective monitoring of the state of health in the EU.
- *Maps of inequality and warning system*: the creation of a European map of health inequality between member states, built on the maps of inequality and warning systems developed by national health systems and to which we will return.
- *Good practice and information-sharing*: Identification and exchange of examples of good practice in the reduction of health inequalities, in collaboration with other European initiatives such as EU-Roma, the Decade of Roma Inclusion and the European Platform for Roma Inclusion.

By integrating Roma health as one of its priorities, the EU Health Programme 2008-2013 would contribute more fully to increased solidarity and prosperity in the EU.

Integrated policies

Intersectorality and the social determinants of health: As previously emphasised, whenever reference is made to the health situation of the Roma population, it is necessary to bear in mind the **social determinants of health**, because a significant proportion of the Roma population lives in a precarious socio-economic situation, which directly affects their health. In this sense, the EU will have to promote the implementation by its member states of **integrated housing, education, employment and other policies** aimed specifically at the Roma population, with a view to achieving **equity in health**.

Intersectorality within the EU: the 2008-2013 EU Health Programme ought to be coordinated with other programmes aimed at the social inclusion of the Roma population, in order to achieve the implementation of integrated policies. The need for integrated policies is a priority of the EU's Integrated Platform for Roma inclusion, as emphasised at its second meeting in September 2009 in Brussels.¹⁵

In order to achieve integrated and intersectoral policies, we propose that the use of the ESF for Roma health promotion be made through a more **systematic coordination between the Directorate-General (DG) for Education and Culture, the Health and Consumers DG (DG SANCO), and the DG for Employment, Social Affairs and Equal Opportunities**. Although joint projects exist, and meetings between staff in the DG take place to discuss Roma-related issues, they should be systematised through the elaboration of joint projects and actions. The EU also ought to be a model of intersectorality not merely by exchanging knowledge but by working together regularly and on a variety of projects. However, coordinative mechanisms should always be matched with the Commission's technical support of local administrations, because the latter play a fundamental role in the implementation and success of social inclusion policies.

For example, the **DG SANCO and the DG for Education and Culture** should jointly use the ESF to:

- Articulate a European-wide scheme that finances, through Structural Funds, health education programmes targeting schools and community organisations in impoverished and segregated areas, where disadvantaged groups such as the Roma are concentrated.

¹⁵ See EU Press Release, 'EU Platform for Roma Inclusion (Brussels, 28 September 2009)'. MEMO/09/419. Available at: <http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/09/419&format=HTML&aged=0&language=EN&guiLanguage=en>. Accessed 29 September 2009.

- Provide financial and logistical support to local administrations for health information campaigns adapted to the needs of Roma persons in order to achieve the transmission and acceptance of principles of preventive medicine, focusing for example on prenatal screening and the health behaviour and care of pregnant women. Women and children in particular should be targeted by campaigns, considering respectively their caretaker role and the more effective impact of information campaigns and education on youth. The promotion of a healthy lifestyle and a culture of prevention among Roma would be facilitated by developing attractive audio-visual materials for information campaigns.
- Positive training measures for Roma mediators and professionals in the socio-sanitary field, through bursaries and sustained training programmes.

Coordination between the **DG SANCO and DG Employment, Social Affairs and Equality of Opportunity** could take the form of:

- European intercultural training programmes for healthcare professionals, in order to improve their communicational abilities and to adapt their services to the needs of Roma patients.
- The two actions constituting the aforementioned pilot project, the creation of a European Health Ombudsman and of a team of Experts on Inequality in Healthcare within the Observatory of the Social Situation.

Multilateralism

In order to buttress the implementation of integrated policies, and with regard to our recommendation that the EU should assume a leadership role in the resolution of transnational issues – including the health inequalities lived by the Roma – , we also suggest that the EU should intensify its efforts to promote the development of a multilateral approach to health-related issues. Multilateralism, in contrast to unilateral or bilateral initiatives, refers to the principle that cooperative regimes based on sustainable consensus, joint answers to common problems, are more effective and legitimate ways of organising the resolution of international and transnational social problems.

The EU should strive to coordinate its health-related activities with relevant multilateral organisations such as the World Health Organisation, the Council of Europe and the Organisation for Economic Cooperation and Development (OECD), the United Nations Development Programme, as well as specialised agencies and initiatives such as the Decade of Roma Inclusion. The Decade in particular has acquired significant know-how related to health and the EU should take advantage of its expertise to the fullest extent possible.

We propose a coordinative mechanism between the EU and aforementioned organisations, similar to the EU's Open Method of Coordination, which already defines the relationships between EU member states.¹⁶ It would be based on the following principles:

- Alignment: common objectives.¹⁷
- Harmonisation: common quantifiable indicators.
- Coordination: identification of specific competencies of each institution. In this sense a clear division of labour between different organisations should be established, taking into account their respective capacities and roles, in order to implement effective and efficient health-related policies and to avoid the duplication of programmes. All organisations should coordinate their activities with na-

¹⁶ The Open Method of Coordination, defined as an instrument of the Lisbon strategy, is a framework of coordination allowing member states to elaborate a common strategy, based on common objectives, measurements and benchmarking (comparison of member states' performance and exchange of best practice, monitored by the Commission). More information is available at: http://europa.eu/scadplus/glossary/open_method_coordination_en.htm

¹⁷ This is consistent with Article 21 of the European Parliament's *Resolution on a European strategy on the Roma*, which "Urges the Commission and Council to align EU Roma policy with the Decade of Roma Inclusion and to make use of existing initiatives such as the Roma Education Fund, the OSCE Action Plan and the recommendations of the Council of Europe to heighten the efficacy of their efforts in this area". *European Parliament resolution on a European strategy on the Roma*. P6_TA(2008)0035. 31 January 2008. Available at: <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P6-TA-2008-0035&language=EN> . Accessed 5 September 2009.

tional and local authorities, while respecting the principle of subsidiarity. An example would be the coordination between the Observatory of the Social Situation (DG Employment) and the Observatory of National Health Systems (WHO).

- Exchange of information between aforementioned agencies should be transparent and systematic.

Promotion of transnational networks

In previous sections, we referred primarily to the relationships between multilateral organisations and between EU institutions. At this point, we should stress the need for transnational networks founded on the principle of an active participation of civil society stakeholders, governments and the EU, working together and jointly planning policies to improve the health situation of the Roma. Initiatives along that line already exist – including the planned Platform for Roma Inclusion – yet they remain embryonic and must be further developed and structured.¹⁸ The point is to avoid the creation of phantom projects which marginalise civil society actors from the decision-making process and undermine the legitimacy of policy actions.

Such transnational networks will help the construction of a public service-civil society partnership that will achieve a greater degree of accountability, while ensuring that actions launched are fairer. In this sense, public institutions should reach out to Roma organisations and individuals, as well as other vulnerable collectives of all member states, for the elaboration, implementation and monitoring of healthcare policies.

The leadership of the EU, referred to earlier, should facilitate such public-civil partnerships, **via three existing networks of monitoring and exchange of best practices** set up at the European level: the EURoma network, the Open Method of Coordination and the Platform for Roma Inclusion.

In order to ensure the input and feedback of Roma civil society actors, as well as the transparency of the actions affecting the health situation of the Roma population, we recommend the creation of an independent mechanism of supervision of Roma inclusion in the national health systems as well as in the institutions of the EU, via the Platform for the Inclusion of the Roma.

2. National, regional and local authorities

National, regional and local authorities, on their side, should

- Take actions on the **social determinants of health**.
 - Launch public policies that have a positive incidence, at all levels, on the living conditions of the Roma population
 - The policies of the different public administrations must be complementary to promote health and increase healthcare equity
 - Ensure that health and healthcare equity becomes a value shared by all sectors.
- Evaluate the effects of all public policies on the health situation of the most excluded and marginalised populations, including part of the Roma community. To this end, support should be sought from aforementioned instruments (transnational state-civil society networks, Observatory of Social Situation, Observatory of the national health systems of the WHO).
- Wherever this agency is lacking, create a **Health Ombudsman**, following the example of the Parliamentary and Health Ombudsman in the United Kingdom, and the *Defensor de los Usuarios del Sistema Sanitario* in some autonomous communities of Spain. The Health Ombudsman would:
 - Undertake independent investigations of complaints and accusations against health services based on discrimination and inadequate services.

¹⁸ Council Conclusions on Inclusion of the Roma. 2947th Employment, Social Policy, Health and Consumer Affairs Council meeting. Luxembourg, 8 June 2009. Available at: http://www.euromanet.eu/upload/21/69/EU_Council_conclusions_on_Roma_inclusion_-_June_2009.pdf. Accessed 15 September 2009.

- Provide legal support and litigation strategies for both European citizens and residents, in issues of discrimination and racism in health services.
- Participate actively in the Open Method of Coordination in order to exchange good practices in relation to the healthcare system, and accept the need to reduce the inequalities between groups and regions in the quality of healthcare services, taking into consideration the fact that all member states share common challenges: fiscal pressures, aging and dependent populations, access to all patients to new health technologies, and existing exclusion of groups such as the Roma population.
- Take advantage of all instruments of the EU at their disposition to elaborate and implement policies sustained in time and aimed at the Roma population in the area of health.¹⁹ These instruments include:
 - Financial support (ESF, European Regional Development Fund, Instrument for Pre-Accession)
 - Technical and coordination support (EURoma, Open Methods of Coordination)
 - Legislative support (Race Equality Directive, Framework Decision on Racism and Xenophobia), which will require significant effort and, whenever necessary, a change of institutional 'culture' to implement effectively EU directives in the field of non-discrimination and equal treatment.

On their side, local administrations must work directly with the Roma population in order to resolve its most immediate needs (with the initiation of specific and temporary services for this purpose), but at the same time, and in parallel, it is necessary to create bridges bringing the Roma population closer to normalised programmes/services and in order for the Roma population to be assisted in a way that takes into account their social and cultural differences. Normalised resources have to be flexible enough to provide a response to populations characterised by social and cultural differences.

It must be reminded that the **universalisation of healthcare** is consistent with the objectives of the European Health Programme 2008-2013 and the Lisbon Agenda, with regard to a competitive and healthy workforce.

3. National health systems

With regards to national health systems, emphasis should be placed on:

- **providing universal healthcare** and guaranteeing equal access to health services, which are founded on the principle of equity.
- **including and embracing difference** in the organisation and functioning of health systems.
- Healthcare systems founded on **primary care, disease prevention and health promotion**.
- The creation of **alarm systems for health inequality**.

Universalisation of healthcare and equal access to health services founded on the principle of equity

Although the precarious health situation of a significant proportion of the Roma population is largely due to their living conditions, their health situation is determined by the access and use of healthcare resources. For this reason, universalisation and equitable access should be considered fundamental principles of healthcare provision. The Roma population should be allowed to have access to the same services as the rest of the population and under similar conditions, in function with their needs and independently from their social position, residence and income. Health systems should strive to identify and eliminate all existing barriers to access (based on ethnicity and gender, economic, institutional, geographical, cultural and legal²⁰).

¹⁹ See Council of the European Union, op. cit.

²⁰ European Parliament's Committee on Employment and Social Affairs (EMPL), *Social situation of the Roma and their improved access to the labour market in the EU*, INI/2008/2137, pp.18-21. 11th of March 2009.

The EU should consider access to healthcare by all residents as a matter of right, regardless of their economic or legal situation.²¹ Following the examples of Scandinavian states, Spain and the United Kingdom, all member states should strive to achieve the universalisation of healthcare and an equitable access to health resources, if possible through minimum standards for access to public health services set by the EU.

The current period of worldwide economic crisis reveals the fact that universal healthcare constitutes a salient instrument of social cohesion and stability. The EU must urge governments to undertake no trimming of public health, emphasising that any kind of cutback in this field, while producing short-term savings, will likely produce a multiplication of costs in the longer term. The universalisation of vaccination, dental, ophthalmological and gynaecological care as well as preventive medicine, for instance, have proven positive indirect effects on labour productivity and help to lower costs by preventing more expensive treatments in the long run.²²

Although universalisation may initially generate inequities by virtue of the fact that persons with easier access to information and to health centres/hospitals will take advantage of public services more quickly and easily than vulnerable groups, it eventually reaches the rest of the population and establishes itself as a social norm.²³

Embracing difference in the organisation and functioning of health systems

Furthermore, one of crucial challenges is the inclusion of difference in the organisation and functioning of health systems, considering the principle that the Roma population must be attended by the same professionals and the same services as the rest of the population. It is of crucial importance that the inclusion of difference be effected by upholding the principle of equal treatment.

There is strong evidence that a communicational barrier persists in undermining close and collaborative relationships between national healthcare systems and the Roma populations. Entrenched misunderstandings have been primarily caused by:

- **A lack of adaptation of the messages and information that are conveyed to the Roma.** This adaptive deficiency is primarily caused by the language used and the means used to convey information and to communicate. In the case of health professionals, the primary communicational tool is written text, whereas oral communication – especially in areas with high illiteracy rates – is generally preferred by the Roma.
- **Diverging criteria for the evaluation of healthcare.** In the case of the Roma minority, the quality of healthcare is assessed in terms of the time dedicated to medical attention as well as the conduct of health professionals (the personal treatment of patients, the perceived empathy shown by the professional, as well as specific non-verbal messages). These criteria are understandably difficult to fulfil in existing healthcare systems. It will be difficult to increase the time dedicated by doctors to each patient, and verbal explanations would assist in facilitating an understanding of time constraints by Roma patients. At the same time, training in communicational abilities for professionals (demonstrations of empathy, non-verbal messages) would help them to generate more positive perceptions of healthcare quality by Roma patients.

²¹ We concur with the WHO Commission on the Social Determinants of Health's analysis, which bases its recommendation of publicly funded, compulsory universal health care on the following evidence: "Higher private sector spending (relative to all health expenditure) is associated with worse health-adjusted life expectancy ... while higher public and social insurance spending on health (relative to GDP) is associated with better health-adjusted life expectancy ... Moreover, public spending on health is significantly more strongly associated with lower under-5 mortality levels among the poor compared to the rich ... The Commission considers health care a common good, not a market commodity". Commission on Social Determinants of Health (2008). *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health* (Geneva, WHO), p.95. Available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf. Accessed 10 September 2009.

²² Ministerio de Sanidad y Consumo and Fundación Secretariado Gitano (2008) *Comunidad Gitana y Salud. La situación de la comunidad gitana en España en relación con la salud y el acceso a los servicios sanitarios. Conclusiones, recomendaciones y propuestas* (Madrid: MSC and FSG), p.21.

²³ *Ibid.*, p.21.

- **Mutual prejudices**, which often provoke defensive and mistrustful relationships. These prejudices carry deep-seated emotional components that make them particularly difficult to modify. Underlying fears and misunderstanding have been constructed through:
 - **Entrenched historical prejudices**, cemented by centuries of conflicts and that continue to define the relationships between Roma populations and the rest of society.
 - **Negative personal experiences**, which fuel these historical prejudices by converting anecdotal evidence into generalisations, often through negative rumours diffused by other members of the community (*snowball effects*). In contrast, positive experiences rarely alter such prejudices because they are lived as exceptions to the rules.

Existing inequalities affecting Roma access to healthcare, however, entail the application of positive actions to compensate for existing disadvantages and accelerate the universalisation and equalisation of health provision.

The following specific measures would help to effectively break down these barriers:

- Inter-cultural mediation and education among equals.
- Training in diversity for healthcare staff.
- Adaptation of material for educational and information-sensitisation campaigns.
- Launching of specific interventions.

Inter-cultural mediation and education among equals

One way of breaking down communication and cultural barriers is the incorporation of inter-cultural mediation and the development of educational programmes founded on the principle of cultural equality.

Inter-cultural mediation is a fundamental resource for bridging differences between the Roma and the rest of the population. It promotes constructive change in their relationships by:

- Facilitating communication between healthcare professionals and the Roma, by promoting the latter's equal access to healthcare resources;
- Advising and informing Roma patients about their rights as patients and about aforementioned issues (time allocation for medical services), in order to promote an understanding of constraints on medical care.
- Advising health professionals for the provision of care adapted to the needs and interests of the Roma population;
- Providing personal support for Roma patients, including for preventive medicine.

In order to achieve these aims, **inter-cultural mediators** should become a perennial figure in primary health centres and hospitals. Mediators favour the recognition of the Other and mutual understanding, thereby preventing the aggravation of cultural conflicts and allowing the search for alternative strategies for the resolution of problems derived from cultural differences.

It must be borne in mind, however, that the presence of mediators can be ineffectual if health professionals have an unclear understanding of the mediator's functions, and resulting in:

- delegating all the weight of the intervention to the mediator.
- delegating all activities that healthcare professionals dislike, i.e. street intervention, to the mediator.
- Using the mediator's service exclusively in situations of conflict.

Therefore, a number of requisites should inform the actions of mediators:

- Clear definition of their role and functions;
- Adequate training;
- Recognition and support by administrations and healthcare professionals;
- Coordination of their work with healthcare professionals;
- Conditions allowing for stable and durable interventions, considering that high staff turnover discomforts patients and undermines the credibility of the mediator.

With regards to the Roma-to-Roma approach developed by the OSCE and embraced by the EU, the training of mediators should emphasise **education among equals**.²⁴ Education among equals is an important instrument for the elimination of mutual prejudices. Its methodological underpinning is the training of members of the Roma community, which would allow them to provide health education and training to other members of their community. The professional training of Roma individuals would not only facilitate dialogue and access to health services, but would also undermine existing prejudices against the Roma by the rest of the population.

Training in diversity for healthcare staff

Another way of breaking barriers consists in the training of the healthcare professionals in regular contact with the Roma population. Training is an essential prerequisite for quality and effective healthcare. Regardless of the quality of existing curricula, compulsory educational systems have scarcely addressed the need to develop the communicational abilities that subsequently become valuable for particular professions. Furthermore, healthcare curricula do not promote communicational abilities nor impart knowledge in medical anthropology, which are indispensable for the provision of effective healthcare to immigrant and Roma populations.

Training in medical anthropology, communicational abilities, conflict resolution and multiculturalism should be introduced in curricula for all healthcare staff in order to provide adequate and flexible medical and preventive care to Roma patients and families.

The inclusion of these components ought to take place at all levels of training:

- Prior to employment, at the undergraduate level
- Specialised and practical training.
- Ongoing training during employment.
- Such qualification, initially aimed at active health professionals, should be preceded by sensitisation efforts, so that it avoids being perceived as a burden. For this reason, training initiatives should include the following messages:
- The point is not to work more but to work better.
- The point is not to be trained in caring for the Roma community but to be able to deal with difference through healthcare, taking into consideration the specificities of the Roma community.

Adaptation of material for educational and information-sensitisation campaigns

In order to foster intercultural understanding, **materials for educational and information-sensitisation campaigns** should be adapted, whenever appropriate, to the cultural codes of the Roma population. Furthermore, it has been emphasised by Roma respondents that existing information campaigns rarely strike a chord with the Roma. In order to achieve a positive identification by the Roma, it would be advised to devise information campaigns aimed specifically at the Roma, which would complement campaigns aimed at the general population. The **participation of both Roma** and other citizens in the elaboration of these cam-

²⁴ European Parliament resolution on the situation of the Roma in the European Union. P6_TA(2005)0151. 28 April 2005. Available at: <http://www.europarl.europa.eu/sides/getDoc.do?type=TA&reference=P6-TA-2005-0151&language=EN>

paings and educational materials, using attractive audio-visual materials adapted to the codes of the Roma, would also promote education between equals and the elimination of mutual prejudices.

Information campaigns along with education between equals should focus primarily on the need to break the dichotomy health-disease that tends to inform Roma conceptions of a healthy lifestyle. A large proportion of Roma respondents understand health as the absence of disease, whereas disease is in turn associated with death. They also tend to understand health and disease as determined by factors external to their persons, rather than lifestyles (such as physical exercise or nutrition, for example).

Such a conception of health has detrimental consequences:

- Health preoccupations emerge solely with the manifestation of conspicuous and invalidating symptoms, thereby undermining the impact of preventive medicine.
- Once disease is manifest, the Roma consider that action must be immediate and resolute, due to the direct relationship that is construed between disease and death.
- Diagnoses generate ambivalent responses when invalidating symptoms are not yet manifest. Sometimes, diagnoses are even perceived as instigating a disease that was previously non-existent.
- If symptoms are no longer manifest as a result of the treatment, the therapy tends to be abandoned because it is believed that the disease disappeared along with the symptoms.

In order to break such a dichotomy, the conception of **preventive medicine** should be systematically incorporated into inter-cultural mediations and information campaigns. For example, we urge the launching of adapted campaigns aimed at the prevention of sexually transmitted diseases, and more specifically HIV.

Launching specific interventions

On occasion and in order to address particular situations, it is necessary to launch interventions that are specifically aimed at the Roma population. These interventions should be temporary, coordinated with normalised healthcare resources, and always aim at mainstreaming Roma health.

Healthcare systems founded on primary care, disease prevention and health promotion

It has been demonstrated that the effectiveness of health systems increases significantly when they are based on primary health care.²⁵ Primary care, premised on community participation and empowerment, implies acting on the social determinants of health and “comprehensive, integrated, and appropriate care, emphasising disease prevention and health promotion”. It involves quality frontline care by multidisciplinary medical teams, which undertake systematic information-sharing with the community and effective upwards referral.²⁶ In this sense, we recommend the development of basic local health resources in geographical areas with significant Roma populations, aimed at disease prevention and health promotion. However, these resources should complement the facilitation of access to medical treatment by the Roma.

Education for the development of healthy lifestyles as well as for the rational use of health services ought to be considered as key objectives for the real and effective improvement of Roma persons’ health.

An initial focus on youth and women would be appropriate, by promoting prenatal screening and improvements in the health behaviour and care of pregnant women.

Maps and warning systems for health inequality

Healthcare systems must introduce maps geographical health inequalities (within and between regions) and ‘warning systems’ alerting on emerging inequalities. Such maps and warning systems would survey indicators such as vaccinations, the incidence of determined illnesses, gynaecological attention, or occurrences of conflicts in health centres. The maps, disaggregated by income, gender and ethnicity, would al-

²⁵ Commission on Social Determinants of Health, op. cit., p.96.

²⁶ Commission on Social Determinants of Health, op. cit., pp.96-97.

low patients and professionals to observe the geographical areas and populations that are most affected by health inequalities. These maps should be used as a basis to redirect resources and investment towards the most disadvantaged areas and groups, in accordance with the principle of equity and with the aim of systematically emulating areas where excellence prevails.

Whenever situations of inequality become manifest, healthcare systems must contemplate a number of responses:

- Active engagement of patients and street intervention.
- Adapted information strategies.
- Targeted subsidies for activities and habits having a positive impact on health – for example sports.
- Inter-sectorial coordination with social and educational centres, NGOs and Roma organisations for flexible, rapid and adequate investments.

Aforementioned maps and warning systems ought to be elaborated at both micro- and macro- levels, in coordination with the expert research team on health inequalities incorporated in the European Observatory on the Social Situation and Demography referred to previously.

4. Roma community

The aforementioned recommendations made reference to Roma participation in all processes of intervention, yet focused primarily on initiatives and actions aimed at the Roma by institutions and organisations which are not controlled by the Roma. With regards to health, the Roma community should also assume responsibility for its own health care. Participation and inter-cultural exchange signifies that responsibility for the reduction of health inequalities cannot fall exclusively on public administrations. As mentioned earlier, Roma involvement entails changes in attitudes and lifestyles, as well as a change in the ways Roma organisations are internally organised and relate to the rest of civil society and public authorities.

In this sense and with regards to the need for the Roma population to increase its awareness of the situation of health inequity it faces, Roma persons should:

- Make an effort to break the communicational barriers that exist with health professionals.
- Understand and internalise the importance of acquiring healthy habits (balanced diet, quitting tobacco consumption, physical activity) and preventive behaviour (regular gynecological visits, prophylaxis – including vaccines and to prevent sexually-transmitted disease).

The Roma community should also take the initiative to pressure public authorities for the implementation of aforementioned recommendations. In this sense, the existence of an associative Roma movement, which is currently raising the awareness of the EU and national governments on Roma needs and rights, is an important instrument for the empowerment of the Roma community. Its active participation in the planning, implementation, monitoring and evaluation of policies will contribute to the generalisation of fairer practices.

Participation, awareness-raising and exchange will require:

- The social participation of youth and women, both within the Roma associative movement and through other organisations (public and civil human rights and anti-discrimination organisations, women organisations) that allow them to struggle for the defense of Roma rights.
- Training and educational advances, to advance a process of professionalisation of Roma associations.
- The democratisation of Roma associations.

Summary and conclusions

The health situation of the Roma requires urgent responses, which must be defined by a holistic approach translated into sustainability and mainstreaming. In order to effectively reduce the health inequalities experienced by the Roma, inter-sectorial policies in education, training, labour market inclusion, housing and health must be implemented; the Roma population must actively participate in all processes of intervention; health programmes targeting the Roma population must be normalised and strengthened they must adopt a gender perspective and prioritise Roma youth. Crucially, all actions must rely on well-defined indicators, which in turn require longitudinal and periodic research to understand the specific needs of the Roma population regarding healthcare, and to identify any changes of those variables conditioning the health situation of the Roma. As such comparative data gathering must be pursued and, if possible, expanded to other EU member states and accession countries.

Universal and high quality health coverage, founded on inter-cultural exchange and the guarantee of the right to equitable access to health services

The economic crisis cannot be used as an argument to avoid investing in measures that correct inequalities and protect the rights of persons. We must take on the challenge of increasing social protection and guarantee public services through four key elements:

- Universal healthcare.
- Active social inclusion relies on the following prerequisites:
 - Sufficient services for all.
 - Services adapted to persons with specific characteristics and needs.
 - Efficient and effective services.
- It is an obligation of public authorities to remove any obstacle to an equitable access to services.
- Indubitably, the Roma population must also change many practices and habits but this does not exempt public authorities from fulfilling their obligations.

Tackling the three dimensions of the health cycle and acting on the social determinants of health

The three dimension of the health cycle (prevention – care – risk reduction) are complementary and must therefore be tackled concurrently.

- *Prevention*: emphasis must be placed on habits, on lifestyles, on behaviours, on the perception of the health system, and on supposedly 'cultural' factors. What is detrimental to health is detrimental to culture.²⁷
- *Care*: healthcare must be universalised, i.e. it must reach all and be adapted to specific needs (mediators, information campaigns, sensitisation of health professionals, solutions to transport problems).
- *Risk reduction*: in the case of determined situations that cannot be resolved in the short-term, all stakeholders should focus on reducing risks.

Although substantial improvements may be obtained by acting in those three dimensions of the health situation without undertaking structural transformations, this is not a sufficient condition to address the health inequities experienced by the Roma: the social determinants of health ought to be tackled through an integrated approach and inter-sectorial coordination.

²⁷ José Manuel Fresno, *Concluding speech of the Summit on Health and the Roma community*, Madrid 1-2 October 2009.

Breaking the targeted VS mainstreaming dichotomy

The debate targeted VS mainstreaming approaches as alternative, mutually exclusive options is misguided, because it opposes actions which should be regarded as complementary. The second principle of the EU's Platform for Roma inclusion refers to the need for explicit but not exclusive targeting of the Roma: "Explicit but not exclusive targeting of the Roma is essential for inclusion policy initiatives. It implies focusing on Roma people as a target group but not to the exclusion of other people who share similar socio-economic circumstances. This approach does not separate Roma-focused interventions from broader policy initiatives. In addition, where relevant, consideration must be given to the likely impact of broader policies and decisions on the social inclusion of Roma people".²⁸ In some cases, targeted actions are necessary, but they should always lead to normalisation.

Roma health as a transnational challenge requiring EU leadership

The study has demonstrated that the issue of Roma health is transnational. It is common to all member states and is accentuated by large-scale migratory processes. For this reason, The EU must assume a position of leadership in the coordination of actions aimed at the promotion of health by member states and multilateral organisations.

All stakeholders must, with systematic EU support, undertake a qualitative shift from mutual knowledge to mutual exchange and learning must be undertaken (by sharing tools, platforms, working methods), while the issue of Roma health must be systematically incorporated into the Open Method of Coordination and the Platform for Roma inclusion.

Considering the fact that the Spanish Presidency of the EU (first semester of 2010) aims at placing the issue of Roma inclusion among the key priorities of the EU's social agenda, and at advancing the monitoring of health inequalities, there is an unprecedented opportunity and use the present study's results to involve all stakeholders involved in the health - Roma community nexus in order to achieve an effective impact on the health situation of the Roma.

This chapter has been elaborated by Dr. Andreas Tsolakis (Department of International Relations of FSG) based on the recommendation made by health experts participating in the project and compiled in the national reports.

²⁸ 10 Common Basic Principles on Roma Inclusion, op. cit.

Annexes.
Executive summaries of the
national reports on health
and the Roma Community.



Analysis of the situation in Bulgaria

Author: Ilona Tomova

Roma, Europe's most numerous minority, have been victims of prejudice, stigmatization and discrimination for centuries. They are especially vulnerable during times of important social transformation and crises. Mass unemployment and poverty affected between two thirds and three fourths of Roma households during the post-Communism period.

The transition from a planned state economy to a free market was extremely long and painful in Bulgaria. An entire Roma generation was virtually excluded from the mainstream labour market for almost twenty years. The community's geographical isolation increased, affecting approximately 80% of Roma (in the late 1980's fewer than 45% of Roma lived in segregated neighbourhoods). Geographical segregation had an adverse effect on Roma's ability to find jobs during times of crisis and especially affected the socialization process of young people. Many Roma neighbourhoods turned into ghettos. Most of the institutions abandoned these *mahali* and Roma access to administrative, medical and other services became very difficult. A large number of young Roma dropped out of school. Ensuing functional illiteracy has hampered labour market integration and led to poverty extending over generations. Serious mass poverty was the plight of at least two thirds of the Bulgarian Roma population until just recently and will probably rise again due to the current global crisis. All of this has had a negative effect on Roma health and their access to medical services.

Access to health services depends on different factors that have cumulative negative effect on Roma health.

The quality of medical services depends on the macroeconomic situation and on state policies specifically targeting health. Total per capita expenditure on health is very low in Bulgaria and Romania. This means that Bulgarian and Romanian citizens have more restricted access to quality health services and that the package of health services in these countries is very meagre. Government curtailment of spending on health services has the greatest effect on the poor. Bulgaria has the highest share of out-of-pocket expenditure on health. Private medicine accounts for two fifths of the total expenditure on health in Bulgaria and 96.3% of that is paid out-of-pocket. If patients need surgery or long or permanent treatment, the share of out-of-pocket payment may increase significantly. Financial difficulties are extremely severe for the poorer social classes and are unbearable for more than two thirds of Roma people.

Bulgaria had quite a good physician, dentist, hospital bed and medical centre ratio but due to low salaries, thousands of nurses and midwives left the country and now the nurse:physician ratio is only 1.2:1. This had led to a deterioration of the quality of medical services and adversely affects care provided to the most vulnerable groups: i.e. newborns, young children, the elderly, the chronically ill and the disabled. The Roma community has the highest proportion of newborns and young children and their perinatal, neonatal, infant and under five morbidity and mortality rates are the highest in the country. The Roma infant mortality rate in 2001-2004 was 25.0 per 1000, while that of ethnic Bulgarians was 9.9. The insufficient number of nurses and midwives has an even greater negative effect on Roma because of communication difficulties between physicians and people with lower levels of education.

Another problem that hits Roma harder than the rest of the population is the uneven distribution of physicians and medical centres. The highest number of patients per physician is found in the regions with a high proportion of Turks and Roma. This means that the people in these regions, especially rural areas, endure

lower quality medical services, spend longer time waiting in physician's offices and travel longer to visit specialists, medical laboratories or hospitals.

More than two thirds of adult Roma have abandoned the legal labour market and many now work at temporary, seasonal or informal jobs mainly in the grey economy. This sort of work is often associated with health problems due to lack of insurance. According to the survey *Health and Roma Community: Analysis of the Situation in Europe*, 26% of adult Roma (18% of the entire population) have no health insurance. As a result, Roma rely more on emergency services, physician's altruism and on pharmacists' advice when purchasing medicines without a physician's prescription.

The mortality rate of those who have undergone successful surgery in hospital emergency rooms is very high because of the poor hygienic conditions in many Roma neighbourhoods or because of the lack of medical care when they return home after a short stay in the emergency unit. Those who survive often have chronic health problems or become disabled as a result of lack of proper care, diet and medication. Insufficient paediatric care may also account for part of the high infant mortality rate, especially in isolated rural settlements.

Stiff regulation of pharmacies by the Bulgarian health system, especially the most recent reform of regulations governing prescriptions for chronically ill patients, put many pharmacies out of business or prompted them to simply refuse to work with the public health system. The sale of medicines on the grey market increased and these can now be purchased in cosmetic stores or the offices of advertising firms. There is no health control regarding the storage of medicines or their quality. According to the survey *Health and the Roma Community...* four fifths of adult Roma consume medicines without a prescription. If the trend of bankrupt pharmacies and medicines being sold by people without proper training as pharmacists continues, the lives of thousands of Roma will be at great risk.

Another factor hindering Roma access to health services is their lack of confidence in physicians. Many Roma (especially those with lower educational levels or who are illiterate) are convinced that physicians and nurses are biased against them on ethnic and social grounds. Many of the problems between Roma patients and physicians could be described as communication problems. The majority of physicians and nurses working in Roma neighbourhoods or in settlements where many Roma reside are not prepared to deal with people with a different culture or who are severely impoverished and or who face social exclusion.

Another significant factor contributing to bad health and a high early mortality rate is poor living conditions. According to the Bulgarian National Statistical Institute, almost half of the Roma population lacked potable water in their homes in 2001 and were forced to use water from street pipes or wells. Most Roma neighbourhoods have damaged sewerage systems or none at all and this increases the risk of hepatitis and gastrointestinal disease.

Overpopulation in Roma neighbourhoods and homes is the norm. NSI data show that one fifth of Roma people live in homes where they have less than 4 sq. m. per capita. Another two fifths have between 4 and 8 sq. m. floor space at their disposal. Often more than three generations live under the same roof. Overpopulation in Roma neighbourhoods and homes fosters the spread of disease and is also a cause of everyday distress – intimately related to high morbidity.

Local governments fail to look after hygienic conditions in Roma neighbourhoods. In some cases this is the result of narrow unpaved streets but, generally speaking, there are no cleaning or garbage collection services in some parts of settlements. This lack of proper hygiene and overpopulation are the cause of infectious disease and epidemics.

A sociological survey conducted in eight large Roma neighbourhoods in city centres in 2007 showed that in most some repairs or enlargement of the sewerage system had taken place during the previous 2-3 years. The problem is that in half of these cases, engineering or technical mistakes were made and contaminated water floods houses, yards and streets. Hundreds of Euros have been wasted and hygienic conditions for many families have deteriorated.

Most municipal authorities have left Roma neighbourhoods and now there is no control over illegal construction and use of sidewalks and streets there. In many places streets are blocked by illegal buildings or they are so narrow that cars cannot go down them. Ambulances cannot reach large sections of Roma ghettos and physicians are unable to find the homes of their patients.

Roma have suffered the difficulties of the transition to a market economy more than anyone. For the majority of men who found themselves permanently excluded from the mainstream labour market, their only chance to gain higher social status and self-respect was illegal activity and control over women. Social exclusion has caused Roma to become increasingly closed off into micro-groups in their homes and ghettos. This sparked a return and enforcement of the role of conservative pre-modern patriarchal forms of social and cultural life in the Roma community, especially in large Roma ghettos. The cult of physical male strength and violence, control over women, restricted possibilities for human development, mass inclusion of young people in deviant forms of behaviour – characteristics of all poor urban ghettos all over the world – spread among Roma. In some marginalized groups the survival of the family is always at the expense of women and children who are exploited or at the expense of long-term goals like obtaining a good education or qualification or taking good care of one's health.

The Roma community is the one which marries the earliest in Bulgaria. The Roma fertility rate from 2001-2004 was 26.7 per thousand in comparison with 6.9 per thousand among ethnic Bulgarians. Bulgaria has Europe's highest teen-age pregnancy rate and it is highest among Roma women – 10-12 times higher than that of ethnic Bulgarians. Teen-age pregnancy is a risk factor due to the low birth-weight of newborns, higher neonatal, perinatal and infant mortality and morbidity and higher mortality rate for women giving birth. All of these problems have likewise been observed during this sociological survey.

The survey *Health and the Roma Community...* defined the major characteristics and changes in the social status and family life of rural Roma and those of them who live in large towns and cities in 2008:

- Roma with stable employment increased in 2007-2008. One third of Roma adults were employed in 2008 and received their health insurance through their job. Despite this improvement, the Roma employment rate is still extremely low.
- Roma women depend on their work and own incomes much less in comparison with Roma men and with ethnic Bulgarian women. Moreover, most employed Roma women work at seasonal or temporary jobs. This type of employment does not provide its employees with social or health insurance thus putting them in a vulnerable position in times of crises or bad weather conditions.
- 14% of children age 7-15 are early school leavers and 1.1% of them work full time to provide for the family.
- Roma men hold the main authority positions in the family and play a major role in providing for the family (thanks to their own work or through organizing the exploitation of women and children). Men were characterized as the 'head of the household' or the main provider in nine tenths of Roma households.
- In 85% of the households young couples and their children live together with the husband's parents. Most young families depend entirely on their parents' financial support during the first 10 years of their marriage as a result of early marriages and the high level of youth unemployment in the Roma community. Two thirds of Roma children age 0-9 depend on the financial support of their grandparents rather than their own parents. Only in the 10-15 year old group is the percentage of those who depend on their parents' incomes equal to those who depend on their grandparents' incomes. Dependency on the husband's parents and on the grandfathers' financial support perpetuates the patriarchal model and the authority of men and mothers-in-law.
- Sons, much more often than daughters, depend on their parents' financial support and help in raising their children.

- No less than 18% of Roma live in households where three or more generations live under the same roof.
- There are more grandmothers than grandfathers in the extended Roma family given women's longer life expectancy. They help more in raising the children but their incomes are much lower than those of men. Older women are often chronically sick or disabled and this contributes to the financial difficulties of extended Roma families.

Roma have been suffering severe and extended exclusion from the labour market and from other main social spheres. They have no political party with the power to protect their economic, social and cultural interests in Bulgaria. Neither do they have access to the social networks engaged in transforming social capital from the former regime into economic capital in the new market society. The only legitimate power resource they possess is that of male dominance over women in the family and in the community as a whole. Women are the main means of exchange and the accumulation of power in Kaldarash, Lovara, Thracian tinkers, and among some Muslim Roma groups. The honour and dignity of the *pater-familias* and all the men in the family depend on the merits and worthiness of their women, especially soon-to-be-wed daughters. That is why control over girls and women's bodies in most of Roma groups is so strong and brides' virginity is valued so high. But this exaggerated focus on pre-marital virginity is one of the reasons behind teen-age marriages in traditional Roma sub-groups: if girls marry in their early teens, the risk of casual sexual contact is extremely low. The other very important reason for early marriages is to keep young people in the community and thus "protect" them from the evils of the outside society. Elders go as far as to encourage even the best Roma students to drop out of school early in order to preserve the community.

Total male control over women is considered necessary for a wide array of reasons. Roma boys will only be considered full-fledged men when they marry and father a child. This accounts for the strong family and group pressure for early marriage and parenthood. All relatives expect the first child to come within the first year after the wedding. A good wife is one who serves her husband by fulfilling all of his desires and who shoulders a large part of the housekeeping burden from her mother-in-law. Her work and that of her children, or the social benefits she receives if she is an unemployed mother, often cover the household's expenditure for food and other goods. The family's economic survival is often secured at the expense of women's (reproductive) health (and sometimes of that of her children as well).

Young women often say they favour modern birth control methods but do not use them because of their husbands. They often blame their mothers-in-law for perpetuating an old-fashioned attitude towards sex and reproductive health.

The Roma community is the youngest one in the country. Two thirds are children and youth – almost twice as many young people as among ethnic Bulgarians. But this does not mean that theirs is the healthiest community.

As a whole, those surveyed assessed their health and that of their relatives positively: more than half of the Roma over 16 assessed their own health as good or very good. According to 70% of them their children's health is also (very) good as is that of their family members (67% gave positive answers). One third of those surveyed gave ambivalent answers concerning their own health, 12% claiming it was (very) bad. One fourth said the health of their children and/or that of other family members was not very good and 6% declared that their children or other family members were in a bad health.

The most positive self-assessments were given by Roma age 10–44. The decline occurs immediately after age 45. Less than one fourth of Roma above that age assessed their health positively, one half offering ambivalent answers and 28% claiming their health to be bad. The most frequently declared maladies diagnosed by physicians were high blood pressure, migraines or headaches, arthritis and rheumatism, asthma, chronic bronchitis, chronic obstructive lung disease, heart diseases, menopause-related problems, allergy, high cholesterol, stomach ulcers and prostate problems.

Very serious problems in Roma neighbourhoods are linked with infectious diseases. The overpopulation of Roma settlements and households makes it more difficult to isolate virus carriers and diseases frequently

turn into epidemics. Some cultural peculiarities also contribute to the spread of disease. One of these is the empathy norm and commitment to the sick implying frequent visits, taking care of them and emotional support throughout. This norm is compulsory for relatives, friends and even neighbours. Poor diet, everyday distress connected with long-term unemployment, poverty, uncertainty and discrimination all reduce the organism's resistance to virus and bacteria and contribute to longer duration of diseases and greater complications. Also, nearly four fifths of Roma complain that they do not have enough money to buy needed medicines, especially in the case of prolonged diseases. As a result, many diseases that usually do not have dire consequences on the health of Bulgarians in general become chronic for a large number of Roma or have a negative impact on other organs.

According to the data from the comparative survey *Health and the Roma Community: Analysis of the situation in Europe*, 28% of those surveyed suffered some type of indisposition such as a cold, virus or some other disease forcing them to reduce their main activities in the two weeks preceding the interview. This is a very high number and is just one more indicator of the severe morbidity situation facing the Roma community. The elderly and children were the most vulnerable age groups: 39.6% of Roma over 45 and 38.2% of children aged 0-9 had been sick. Type of housing seems to be a significant factor accounting for higher morbidity: the proportion of people suffering from different symptoms in the two weeks leading up to the interview was highest among those who lived in sub-standard housing (36%) or in shanty towns (32.4%). Children most frequently suffered from the common cold, flu and cough. Adults suffered more symptoms indicative of different diseases: heart disease, bone and joint disease, kidney problems, nervous system disorders or viral diseases.

This survey showed that 12% of the entire Roma population (including children) suffers from some type of disability or from a serious chronic disease. One peculiarity which is characteristic of the Roma community is early disability and widespread chronic disease as early as middle-age. One third of men and two fifths of women age 45-60 have partially or entirely lost their ability to work due to poor health. The proportion of those suffering from chronic disease or disability in the over 65 group rises to 70%. Three fifths of the men and three quarters of the women claimed they have some chronic disease or are disabled.

The survey showed that the size of settlements, the area of residence (integrated or isolated) and housing type are also significant factors leading to higher levels of disability. Some of these factors also entail other significant processes such as poverty, poor education and poor access to medical services. Rural populations face many difficulties in gaining access to medical services and suffer higher levels of long-term unemployment and poverty. The proportion of people who suffer from chronic illness or who are disabled is highest among rural Roma. In contrast, Roma living in Sophia have a better chance to be diagnosed and obtain a disability certificate. That is why the proportion of disabled among this latter group is the highest and the proportion of those who suffer from chronic illness but are not categorized as disabled is lower.

Many different obstacles are faced in obtaining a medical disability certificate. A serious problem is that sick people have to submit to a huge number of medical examinations which are expensive and are not covered by the Public Health Service. This financial problem is particularly critical in the case of the poor who face permanent and high expenses for life-support medicines. Another problem is connected with the administrative organization and bureaucracy surrounding medical services acting as a particular barrier to the illiterate and, once again, the poor. The third problem is that in many places the regional medical centres have closed down and sick people have to use the services of what is known as the Expert Physicians Commission in Sophia or other distant cities. Because of this, the poorest sick people cannot obtain a disability certificate and are therefore deprived of social pensions and a series of other benefits provided for people who cannot ensure their income because of health problems.

Accidents in the Roma community are commonplace. During the 12 months immediately preceding the interview, 12.2% of all those surveyed had suffered an accident. This figure was double (21.3%) in the case of older children (10-15 years of age). Particularly surprising was the fact that more women than men fall victim to accidents. About half of the injured women and children had suffered domestic accidents. This is an indirect indicator of the spread of domestic violence in this community.

One of the most shocking findings made through the survey *Health and the Roma community...* is that a huge amount of the medicines that Roma consume or give to their children are not prescribed by a physician for the health problem in question. Many medicines are bought without a prescription and are given to children and these are not only common medicines such as aspirin, paracetamol and some other widely used painkillers but also antibiotics, allergy medicines, tranquilizers, sleeping pills and others. Over half of the Roma population is inclined to self-medicate with non-prescription medicines on different occasions and women engage in this sort of self-treatment more frequently than men. The proportion of Roma consuming self-prescribed medicines increases with the age. The progression is unmistakable: one third of the young are inclined to take non-prescribed medicines rising to 50% among the 30-44 age group and over three quarters of the Roma population people over 45 consumed at least one of the listed medicines without any prescription in the two weeks preceding the interview. Three quarters of the men who self-medicate take two or more unprescribed medicines as opposed to two thirds of the women.

This practice explains the frequent deterioration of patients' health, the high proportion of people suffering from chronic disease and accounts for part of the high premature death rate in the community. There are no other surveys monitoring self-medication and therefore we cannot compare Roma behaviour with that of other ethnic groups but the results are very disturbing nonetheless. Physicians with many Roma on their patient lists and neighbourhood-based Roma health mediators must immediately be made aware of this practice. Health institutions and the media also need to join forces to inform the society about the problems and dangers connected with the self-treatment.

A new survey covering the entire population should be conducted to monitor the self-medication situation throughout the country and to determine just how much medication is being sold outside of pharmacies. The institutions must take immediate initiatives to keep pharmacies within the legal market and help them from going out of business. The Bulgarian population traditionally trusts the advice received from pharmacists concerning minor ailments mild traumas, typical problems related to menopause or other common conditions. The search for medical advice from pharmacists grew as a result of the bureaucratization of the health system, increase in the compulsory fee for medical examinations and the rising number of people without health insurance over the last several years. This custom is not likely to change quickly and if pharmacists with medical education and a license for the sale of medication are replaced by uneducated traders the consequences for human health, especially among the poor, will be catastrophic.

According to the data gathered from the *Health and the Roma community* survey, last year 14% of Roma who were ill, indisposed or pregnant failed to receive the health services they needed. This happened slightly more often with adults than with children. People without health insurance are exposed to greater risk – 21% of them did not receive the medical service they needed. Residents of isolated Roma neighbourhoods, especially those with poor hygienic conditions, often failed to receive the medical services they needed. Lack of health insurance was most likely the major obstacle. There are, however, other factors such as poverty, low level of education, lack of communication skills limiting interaction with representatives of different institutions, men's tendency to become verbally aggressive in frustrating situations, etc. In the presence of some (or all) of these conditions, the risk of conflict and refusal of the physician to provide the required services or to forego negative stereotypes, prejudices and discriminating attitudes towards the patient increases.

Data from the present survey show that immunization problems affecting Roma children have not yet been overcome. In almost one third of the households with children the parents declared that their children have some immunizations but they are not sure if they have all of them. Girls are more often left unvaccinated than boys. Children in isolated neighbourhoods are two and a half times as likely to be unvaccinated than those living in integrated neighbourhoods. Young children are more likely than older ones to have gaps in their immunization calendar. According to physicians, this could partly account frequent indispositions observed among the youngest children in the Roma community.

Poor diet, insufficient oral hygiene, lack of prevention and seeing the dentist when it is already too late are the reasons underlying the poor dental condition of Roma children as from a very early age. One fourth of

the youngest age group experience many teeth and gum problems. 12.5% of the children up to age 9 and 28% of those between 10 and 15 had at least one permanent tooth extracted. Adult Roma also have very poor dental health despite being a very young population. Two thirds have cavities or pulpitis; three fifths have had at least one tooth extracted; and half have not undergone treatment to replace missing teeth. One out of every three suffers from bleeding gums and one out of every five had a loose tooth/teeth.

According to data obtained, one fifth of those surveyed stayed in hospital at least one day during the year immediately preceding the survey. Small children have the highest hospitalization rate (one third) followed by the over 45 group (one fourth). The proportion of hospitalized women is higher than that of men due to the longer life expectancy of women with health problems. Access to health institutions is more difficult for the poorest Roma. Only 13.5% of those who live in the most dire conditions – shacks constructed of whatever is available – had been hospitalized. A proportion of the sick people from the shanty towns were probably unable to cover private hospitalization expenses.

Roma spend more time in hospital than the rest of the population. Assuming that average hospital stays in 2008 are comparable to those of 2006 (the last year for which we have National Health Centre data), the average duration of hospital stays for Roma was 2.6 days longer than that of the rest of the Bulgarian citizens. Comparison of data for the whole population shows that:

- in the case of surgery, Roma spend more time in hospital than the rest of the population;
- Roma children often enter hospital with multiple symptoms indicative of an advanced stage of different diseases which means that many medical examinations need to be conducted in order to determine the right diagnosis and medication;
- Roma children often need ongoing treatment of already contracted diseases before operation;
- adult Roma often need to stay in hospital longer because of the severity of the many diseases they suffer and/or because of the general poor health condition of the patients who recover slowly.

According to survey data, hospital expenses in the case of 71.5% of hospitalized Roma during the last 12 months were covered completely by the National Health Fund. The Health Fund covered absolutely all expenses of hospitalized Roma related to medical examinations aimed at more precise diagnosis and treatment of the diseases without surgical intervention. The families had to cover all expenditures or to make additional payments for surgical procedures in most of the cases.

The survey data support the conclusion that more Roma use free hospital services compared to the rest of the Bulgarian population. This is easy to explain – a large proportion of the Roma population is included under one or more categories of people whose medical treatment is completely covered by State funds: the number of children in the Roma community is two and a half times higher than that of the Bulgarians; a substantial number of Roma are registered as poor and are therefore exempt from paying consumer fees and out-of-pocket treatment expenses; and disability occurs at a young age in this community. Many Roma without health insurance mainly use emergency room services.

According to survey data, in 2008 16% of the Roma population used emergency room services – one fifth of the children and one seventh of the adults. Roma lacking health insurance frequent Emergency Room facilities nearly two times more often than those with health insurance. For most of them, especially the poorest, this is the only way to receive qualified medical assistance, three-day hospitalization and even an emergency operation. Last year 22.4% of Roma without health insurance received medical services through Emergency Rooms compared to 12.5% of those with regular health insurance.

Half of the people that used Emergency services during the last year did so only once. One fifth used Emergency services twice during the year. One out of every nine women and children received Emergency services five or more times.

Roma women in Bulgaria visit the gynaecologist quite regularly. One fourth of them visited this specialist during the last year for reasons other than pregnancy. Young Roma women go for gynaecological checkups for reasons other than pregnancy three times more often than those over 45. Breast and uterine cancer prevention in the Roma community is insufficient. Women between the ages of 30 and 44 submit to pap smear tests more frequently than younger women – almost half of this age group had this test. Those who live in Sophia and other large cities have an easier time gaining access to this examination (54% underwent the test) but only 25.6% of rural Roma women had a pap smear. One fourth of Roma women examine themselves for breast cancer. Women from the villages had mammographies 2.8 times less frequently than those living in capital cities.

The National Council for Cooperation on Ethnic and Demographic Issues acquired mobile laboratories for uterine and breast cancer screening through a PHARE project in 2008. Tens of thousands of Roma women will be able to undergo these examinations for free if the Ministry of Health provides the required financing to keep the screening program in operation. The amount of money needed is not great at all and it is unacceptable to halt the program at such an early stage. Many physicians working on this project are afraid that it will be shut down and the expensive equipment will be privatized.

One fifth of the Roma population has sight problems (18.6%) and one ninth (12.0%) have auditory difficulties. These are most prevalent among the elderly. There are no statistical data broken down by gender for these health problems.

Poverty and poor living conditions are not the only factors that influence Roma health. Quite a lot of them have an unhealthy lifestyle. Over half of the Roma men and one third of the women smoke on a daily basis. On average, men smoke 24 cigarettes daily while women smoke 17. The highest proportion of heavy smokers is in the 30-44 year old group where 52% smoke on a daily basis.

In 17.4% of households at least one member has a problem with alcohol or drugs. These problems are more frequent in households located in poor, run-down buildings (21%) and in isolated neighbourhoods (22%). The access of addicts to medical care is minimal due to the fact that many of them lack health insurance.

Over four fifths of adult Roma have sedentary lifestyles. This is due to a lack of sport facilities and open spaces for recreation purposes in their neighbourhoods, but also because, in general, sports and keeping in shape are simply not a priority. Roma do not engage in physical activities or sport during free time more frequently than the country's other ethnic groups. Ninety percent of the Roma population over 30 do not practice sport or do any physical exercise. The problem is especially serious for women who spend most of their time engaged in passive activities and whose daily routines are physically less demanding than those of men.

The daily diet of Roma is unbalanced towards bread, starchy foods and sweets. A quarter of the population eats fruit only once or twice a week and one third consumes fruit occasionally or never. Fish is extremely rare in their diet and they do not eat a sufficient quantity of vegetables.

The diet of children and women is even more unbalanced compared to that of adults and men. Children consume fruit, dairy products, pasta, rice and potatoes more often than adults but they also consume many more sweets. Meat, eggs, fish, vegetables and salads are consumed only rarely. The main difference in the diet of men and women is that women eat sweets more often than men and consume less meat, fish and vegetables.

General recommendations

A combined effort involving many institutions is required (Ministry of Health, Council of Ministers, National Council for Cooperation on Ethnic and Demographic Issues, Ministry of Labour and Social Policies, Ministry of Finance, local authorities and civil society structures) to overcome the negative health trends affecting disadvantaged ethnic minorities.

Government spending on healthcare needs to be increased. In 2005 it totalled only 444 \$ PPP per capita. Everything possible should be done so that hundreds of thousands Bulgarian citizens with chronic diseases or who need cancer surgery do not have to discontinue medical treatment due to financial difficulties. Physicians warn that Public Health funds earmarked for cancer and diabetes medication will only cover half the needs of those suffering from these maladies.

An urgent change is needed to end the established practice of patients having to pay two-fifths of the cost of treatment out-of-pocket which leads to poverty even for families whose incomes are above the national average. The Ministry of Health and the Health Fund should examine the experience of Greece and other countries as concerns institutional and family insurance which takes the burden off the family budget in the event of disease or surgery.

More aggressive measures must be taken to reduce the severity of poverty among Roma. Poverty and limited access to medical services are the major factors underlying poor health.

Roma inclusion in neighbourhoods must be accelerated in the general town planning of all settlements with separate Roma neighbourhoods and comprehensive development plans need to be made to enable the construction of technical infrastructure there, to legalize homes in an acceptable state of repair and to tear down those which are life and health threatening and those which impede the construction of roads, water pipelines, sewerage systems, and electricity and telephone lines in the neighbourhoods.

The construction or renovation of utilities in Roma neighbourhoods needs to be accelerated to rehabilitate a significant number of dwellings and to build new inexpensive municipal housing for the homeless and for those living in very poor conditions and for families whose homes will be demolished for the building of utility infrastructures in the neighbourhoods. Every home must be provided with clean drinking water with a view to improving local hygiene.

The streets and alleyways between houses in Roma neighbourhoods should be cleaned more often. Regular rat extermination, control and disinfection of the dog population in the neighbourhoods and more strict control of the conditions for raising domestic animals in Roma neighbourhoods and villages, are also needed.

More collaboration is needed between the Ministry of Health, the Ministry of Education and Science, the Health Fund and the media (especially the electronic media) to ensure permanent improvements in the health and reproductive culture of the population.

Recommendations to reduce maternal mortality

Projects focusing on improving sexual culture and family planning will only be successful if they are aimed both at young women and men and at mothers-in-law in the Roma community. The only possible way to bring about change in the reproductive behaviour of the community is through improving the educational level of young Roma and implementing significant changes in their lifestyle. Such changes are related to their inclusion on an equal footing in the labour market and in civil society in general. Only the offering of a wide range of opportunities for the successful employment and social development of Roma men and women will lead to a gradual rethinking of patriarchal values.

GPs, gynaecologists and health mediators must become more actively involved in a variety of projects and activities to improve the reproductive health and culture of Roma women. Their efforts should be aimed at:

- optimizing maternal health;
- early monitoring of pregnant women and at regular intervals during pregnancy and timely hospitalization of women in labour;
- improving the health culture and reproductive health knowledge of young people, especially of girls and women;
- systematic work focused on men and older women to overcome the negative attitude towards modern family planning methods and change attitudes towards abortions which should be seen as a permissible way of regulating the number of children in the family;
- Prevention of unwanted pregnancies, abortions and sexually transmitted diseases and promotion of hygiene and adequate family planning.

Some of the problems related with the cruel sexual exploitation of a significant proportion of young Roma women are beyond the control of physicians. Civil society organizations, schools, the media and the judicial system must get more actively involved in activities aimed at increasing control over the inclusion of minors and women in high-risk jobs. This will probably lead to a reduction in sexually transmitted diseases, violence against women and will ensure their full equality.

Recommendations for reducing child mortality

- Free compulsory tests of the foetus during pregnancy to prevent hereditary diseases, including women without health insurance;
- Improve the technical equipment of hospitals and paediatric units that provide health services to children;
- Improve the quality of childbirth and neonatal care.
- Prohibit the segregation of women in labour in maternity wards based on ethnic origin;
- Health education for rational child upbringing;
- Raise the quality of paediatric care;
- Increase the scope of vaccinations.

Improving health status and reducing premature mortality

- Reduce the incidence of infectious and parasitic diseases - tuberculosis, viral hepatitis, echinococcosis and others. Implement screening programs, early diagnosis and prompt treatment;
- Reduce the incidence of some widespread socially significant diseases leading to premature death - hypertension, cardiovascular and cerebrovascular diseases. Implement screening programs, early diagnosis and prompt treatment;
- Provide better healthcare and better quality of life for patients with chronic illnesses and the disabled through better public funding for medication, rehabilitation and diet;
- Reduce the incidence of hereditary diseases leading to early disability and premature death among some endogamous minority groups;
- Conduct selective genetic screenings, neonatal screenings and prenatal diagnoses.

Provision of effective equal access of Roma to health services and health information

- Open the health system to meet the needs of the poorest and most vulnerable groups and communities;
- Confirm the position of health mediators as an interlocutor between health care institutions and minority groups and communities and develop a network of health mediators;
- Constantly raise the qualifications of general practitioners and nurses working with disadvantaged minority communities and train them in a spirit of tolerance; acquire the knowledge and skills needed to work with patients of different cultures and lifestyles; increase the number of nurses and clinical psychologists;
- Improve the technical equipment at pre-hospital medical services;
- Improve the quality of specialized medical care to rural and mountain populations, to the poor and other disadvantaged groups by providing effective systems to control the quality of medical services and the equitable distribution of financial resources for public health; provide free, voluntary and informed choice of health services and show respect for patients, privacy and their convenience;
- Develop innovative programs to reduce poverty and help poor families and develop initiatives and implement policies and programs aimed at ensuring a level of consumption that meets the basic needs of poor and vulnerable groups, families and individuals, and especially children.

Analysis of the situation in the Czech Republic

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Roma population in the Czech Republic

During the period from 1945 to 1990 Roma were not considered a separate minority in the Czech Republic and for census purposes they were either forced to declare membership in some other recognised ethnic group or were included in the “other” category. The 1970 and 1980 census included a statistical survey of the Roma population which was conducted without the knowledge of the persons being counted (Table 1).

Table 1. Roma population in the CR according to censuses, 1970 to 2001

Census year	Absolute number	
1970	60 279	Persons identified as Roma
1980	88 587	Persons identified as Roma
1991	32 903	Declared ethnic group
2001	11 746	Declared ethnic group

Source: Censuses

No declaration of ethnicity was made in the 1970 and 1980 census but certain persons were identified as Roma. The census commissioner based this identification on national committee records and his own assessment of characteristic features. Despite objections to this method of identification, the results of both censuses do provide a statistical source which was apparently fairly reliable and provided information on structural characteristics as well as the overall Roma population.

In the 1991 and 2001 censuses the list of designated ethnic groups was expanded substantially and, **for the first time since the end of World War II, Roma were allowed to declare their Roma nationality and indicate Romani as their native language. However, this option was used by only a part of the Roma population meaning that the 1991 and 2001 censuses only include those who were willing to declare themselves as members of the Roma ethnic group. As for the actual number of Roma in the population, however, this information is incomplete and data do not reflect the real number of Roma.** In the 1991 and 2001 censuses it was also possible to indicate Romani as a native language and the number of people considering Romani their native language did not change substantially over those years, remaining just under 25 000.

Demographic and statistical experts, as well as most others in the different disciplines, are surprisingly consistent in their estimates. According to them, the number of Roma at the beginning of the 1990s was around 150 000 and by the turn of the century that number had risen to between 180 000 and 210 000. Similar results were also obtained from forecasts based on 1970 and 1980 census results. However, the question remains whether these numbers reflect the emigration of Roma after 1989. Estimates of the number of Roma who left the country again differ greatly and range between 35 000 and 70 000.

Based on estimates made by experts and considering estimates used by mass media, we can safely say that at present approximately 200 000 Roma are living in the Czech Republic. The minimum number, considering the substantial number of Roma who emigrated, is around 150 000 and if we omit extreme values the maximum

estimate of the current population is around 250 000. We should expect a rise in the Roma population in the future; in the 2010 to 2020 period numbers are expected to range between 250 000 and 280 000.

Estimates of the current age structure of the Roma population and its geographic dispersion are based on data from censuses and, in the case of regional breakdown, also on data from the 1989 National Council records. Age structure evolution from 1970 to the present is in line with expected changes in overall demographics, i.e. a gradual decline in birth rate and improved mortality rate. The territorial distribution of Roma has not changed substantially over time according to census results and National Council records. While the estimated total number of Roma cannot be substantiated by any census, estimated structural characteristics are based on census data and, in the case of age structure, were verified by an international comparative survey.

Description of the background situation

The requirement to reduce health inequalities in the Czech Republic has yet to be addressed, the health insurance payment system only making allowance for age differences. Moreover, systematic attention is not paid to identifying inequalities in health and attitudes to health among Roma citizens and members of other ethnic minorities. Conducting targeted research in this field is very complicated given that epidemiological studies seeking to monitor the health of ethnic minorities have to first of all define the ethnic group or minority in question. This leads to ethical, methodological and disciplinary problems and differences of opinion. The most hotly debated question is probably the very identification of an ethnic minority as a group. No less important is the fact that in the course of a society's development, different segments of ethnic minorities do not undergo an identical process of change – there are differences in the degree of cultural, economic and social integration. Lastly, the fact that it is not possible to identify an individual's ethnic group unless that individual volunteers such information is another serious problem. One important research initiative looking into the health of the Roma population was the SASTIPEN survey which was conducted with the cooperation of the Government Council for Roma Community Affairs.

As in any other field, here too Roma citizens are at greater risk of prejudicial treatment and face greater reluctance on the part of healthcare providers when providing services and may even be subjected to discriminatory practices which could ultimately damage their health. Healthcare providers are not adequately prepared to communicate with Roma patients. For example, they are unfamiliar with their customs and specific needs (e.g. openness to more frequent ward visits by extended family members), which is why we recommend that vocational schools training future health workers should include care for members of ethnic minorities in the curriculum and that this subject should be part of the lifelong learning process for healthcare staff. These educational activities should be implemented by accredited educational facilities using alternative forms of instruction (learning by experience). Health policy at both national and local level should include campaigns to raise awareness of healthy lifestyles and the consequences for Roma citizens if they fail to engage in such healthy lifestyles.

Unfortunately, health standards are influenced by a number of associated problems linked to social exclusion such as run-down housing where damp and mould and various disease-transmitting pests are often rife. Health standards are also affected by extended periods of physically demanding work, sometimes in an unhealthy environment and, last but not least, by the incidence of socio-pathological phenomena linked to serious infectious diseases and substance abuse; mainly addiction and prostitution. Stress caused by everyday worries and sometimes even the very struggle to survive in an environment of exclusion also contributes to the incidence of illness. Moreover, quality healthcare is not available in every municipality, especially in rural areas, and this is even more true today as we see the number of hospital beds being reduced and a several medical facilities being closed down (especially acute care facilities).

Principal findings

The international comparative survey entitled *“Roma and Health”* provided a relatively wide range of information about the health of the Roma population in the Czech Republic. When using this information, however, the specific features of this kind of research affecting the nature of its outputs should be kept in mind. One methodological problem, for example, is the selection of respondents and the representativeness of the sample. The fact that the Czech Republic does not possess reliable statistics on which to base the selection of representatives of the Roma population should be taken into account. The fragmented nature and different methodologies employed in producing records means that data on the number of Roma citizens and their structural characteristics are imprecise. Given that reliable official data simply do not exist, qualified estimates based on analysis of statistical data and demographic trends should be used in sample-based surveys of the Roma population. This is the most reliable foundation available but we must remember that they are merely estimates. An estimate of the number of Roma per region was used to select respondents in the said survey. Specifically, we used the middle estimate of the number of Roma in the Czech Republic at the start of the 21st century.

The willingness of the Roma population to take part in the survey and answer the questions also has an impact on the nature of the output. Willingness to respond to open questions is already a filter of sorts determining the type of person taking part in the survey but this is a general problem with all sample-based surveys and does not only affect the Roma population. Nevertheless, in the case of Roma citizens, characteristics linked to the willingness to take part in research are more complicated and may have a greater impact than in the case of sample-based surveys of the majority population.

Also, a typical feature of Roma respondents is to answer in the way they think they ought to or are expected to. Their effort to present themselves in a socially acceptable light is the result of a mix of socio-cultural norms and their notions about the majority society's expectations. Experience with surveys of Roma citizens shows that this tendency is not displayed to the same degree for all topics and it is not easy to detect it in the survey results. It requires good knowledge both of Roma issues and of empirical research.

A certain lack of representativeness, a tendency to try to give expected replies and other specific features are in no way a reason to disregard the significance of empirical surveys among the Roma population. We simply want to highlight the fact that a prudent approach should be taken when working with the findings of these surveys. The results of surveys such as these are very useful and in a certain sense irreplaceable. They should not be interpreted in isolation, however, their true value coming from comparison with other data. In the case of this particular survey, the other data in question is from medical documentation on Roma citizens, the experiences of doctors and health workers and information on the health of the majority population. This also applies to the subsequent list of principal findings.

Viewed as a whole, the survey data on the health of Roma citizens appears relatively favourable as indicated by the subjective feelings of the Roma citizens themselves. The majority consider their state of health to be very good or at least good (two-thirds of adults and more than four-fifths of minors). On the whole, data on diagnosed illnesses and health problems are not alarming either. Almost half of the adults (46%) are free of all of the illnesses scrutinised in the survey; just under a fifth (15%) have been diagnosed with one of the illnesses or health problems addressed in the survey, figures being somewhat higher for Roma minors which comprise the vast majority of the population. Hearing and sight problems are also the exception among Roma citizens (according to the criteria used in the survey, slightly more than 10% of Roma adults have hearing and sight problems). Obesity may be something of a risk in the Roma community, but in this case as well the survey data do not suggest it to be widespread. According to the data on body weight and height, the vast majority of Roma citizens are either of normal weight (half of adults and roughly 70% of minors) or fall under the category of “overweight” posing only a small health threat (27% of adults and 10% of minors).

Despite these relatively favourable data, there is one group of Roma whose health is below mean values. Depending on the criteria used, the size of this group ranges from one-tenth (individuals who perceive

their health as bad or very bad) to a quarter (persons diagnosed with three and more illnesses); in some age categories of the Roma population the relative size of the group is significantly larger, however.

The relatively pronounced trend displayed among Roma in relation to the link between health status and age is one of the negative characteristics of the health situation in the Roma population. While deteriorating health as age increases is natural, the fact that below-average health status is already apparent in the 45-59 age bracket and that this situation is very pronounced among the over-60 group is a warning sign. This is evident both in the respondents' subjective perception of their own health (perception of health as bad or very bad is twice as frequent in the 45-59 age group and four times as frequent among those over 60) and in the accumulation of multiple ailments (the proportion of those suffering from three and more illnesses or health problems in older middle age is almost double the average, and two-and-a-half times higher among those age 60 and over). The same trend can be observed with hearing and sight problems.

The relatively frequent deterioration of health and the considerable proportion of persons suffering from health problems among generations of post-productive age is not the only negative phenomenon worthy of attention; dental health among the Roma population is another such phenomenon. Dental problems are very widespread among Roma; four or more defective teeth is by no means exceptional (found in almost two-fifths of Roma individuals and almost half of those in the upper middle-age category). An incomplete set of teeth is symptomatic. Roma individuals tend to lose their teeth very early (20% of the 16-21 year olds and one third of those between 22 and 25 do not have all their natural teeth). By the time Roma move into the upper middle-age category a significant majority do not have all their natural teeth (60% of those between 45 and 59 and 70% of the next higher age group). This problem is compounded by a relatively low interest in replacing lost teeth (between 40 and 50% of Roma who have lost teeth have not had them replaced).

Some negative trends are linked to lifestyle and health-related behaviour of Roma individuals. This is the case of smoking. Survey data clearly show that anti-smoking measures, awareness campaigns and debate of recent years have not had much of an impact on the lifestyle of the Roma population. Smoking is very widespread among Roma. According to comparable data for the Czech population as a whole, the proportion of full-time smokers among the Roma ethnic group is several times higher (60% of Roma age 16 and over smoke every day and 10% are occasional smokers). Moreover, Roma are also fairly heavy smokers and start very young, frequently during childhood (30% of today's full-time smokers started at age thirteen or younger).

Alcohol consumption is less easy to accurately define from survey data. The criterion for identifying a tendency to consume alcoholic beverages was defined in a way that makes it difficult to determine whether the 40% of Roma who admit to having consumed alcohol during the last six months, including on exceptional occasions, represents a problem or not. The fact remains that if alcohol consumption is a problem, then it affects men twice as much as women and hard liquor is consumed as well.

Lack of exercise, characteristic of a large majority of Roma age 16 and over (70% have no leisure activities and spend almost all their free time engaged in sedentary or completely passive activities), appears to be a relatively clear-cut problem. Minors evidently do better in this regard but the problem of lack of exercise should not be underestimated in their case either (affecting 40% of minors).

Survey data point to a major socio-cultural component in the health of the Roma population. This is evident in the perception of the importance of health and attitudes towards illness. In general, two attitudes concerning health can be distinguished: an active, participatory attitude and an attitude that can be denoted as instrumental. Each of these is linked to a different kind of health-related behaviour. According to the instrumental attitude where health is perceived as the absence of illness or health problems, interest in one's own health focuses mainly on the use of healthcare and similar. The participatory attitude to health is not primarily linked to illness but rather to staying healthy and prevention as a prerequisite for a full life and integration into society.

Health-related surveys have shown that the relative weight of the participatory attitude to health is growing in majority society. Healthy lifestyles and a priority on prevention is catching on as a kind of cultural norm today. According to survey data, however, Roma citizens buck this trend; the vast majority have an

instrumental attitude towards health with all of the associated features (lack of appreciation for or failure to perceive the importance of prevention and healthy lifestyles). This specific characteristic distinguishing Roma from the majority society plays a very important role influencing both the health status of the Roma population and their upward social mobility and integration into society.

The survey identified the factors shaping the health of the Roma population:

- 1. Socio-cultural characteristics** (myths, moral norms, value systems and their focus) and the resulting attitude to one's own health as something of value as well as the attitude to the health of those around them and its value);
- 2. Different lifestyle vis-à-vis the majority population;**
- 3. Different nutritional habits and diet;**
- 4. Different attitudes to illness and disease prevention** – with the resulting different behaviour when illness strikes;
- 5. Influence of socio-professional status** – in most cases unskilled, physically demanding work performed under high-risk conditions. Healthcare for ethnic minorities is not a problem confined to the Czech Republic, however. It is a pan-European problem mainly requiring political solutions with the active cooperation both of the state and its institutions and representatives of minority groups. It is one of the aspects affecting minority integration and the latter's active participation in addressing their own problems is a crucial prerequisite.

The following factors affecting the quality of healthcare were identified:

- 1. a cultural barrier hindering the doctor/patient relationship** (different traditions, customs, habits, lifestyle, attitude to the illness itself);
- 2. culturally conditioned way of displaying and presenting difficulties and highly emotional accompaniment;**
- 3. problems of differential diagnosis and therapy when there is no knowledge of the social background of illness.**

Healthcare measures should primarily be targeted at raising the Roma population's awareness of healthy lifestyles, patients' rights and how the healthcare system works in general. Awareness campaigns should also cover the issue of family planning. The root causes of poor health should likewise be tackled, including poor housing conditions, socio-pathological phenomena in excluded localities and illegal work in unhealthy working conditions.

In terms of direct work with clients, a programme involving social workers trained in health matters is used to improve health standards in Roma communities. The aim of these social workers is to actively seek out groups or individuals whose health is at risk either because of high-risk behaviour or for some other objective reason. Implementation of the programme is supported by the Ministry of Health. Unfortunately, this effective measure is not available in all socially excluded localities.

Ideas for measures to be adopted

There is no doubt that measures affecting the health of Roma citizens can only be effective if they are part of an overall strategy targeting this sector of the population. A second important factor is the lack of data and qualified information on which to base health policies. In this regard, survey data represent just one source of partial information that needs to be compared and contrasted with other data, primarily with data available on the health of the non-Roma population and data from the medical files of Roma citizens. It is also necessary to verify and delve deeper into survey findings by means of follow-up surveys focusing on selected topics that have proven to be important but were not explicitly scrutinised by the survey or were merely touched upon in passing. The most important topics appear to be the availability of healthcare for Roma citizens, the reasons for ignoring prevention and the lack of appreciation for healthy lifestyles, communication barriers and doctors' and health workers' readiness to understand the specific features of the health-related behaviour of the Roma population and to respond to them appropriately.

The survey confirmed that launching health-awareness activities with a broad spectrum of information, with the overarching goal of improving the prerequisites for raising Roma health standards, should be one of the priorities. This principal objective is derived from a whole series of other goals, the main ones being:

1. Ensure that relevant information is available for all groups of Roma citizens. One suitable way to create an information system that would be comprehensible and easily accessible for Roma is to set up information centres in Roma localities and, where necessary, enhance socio-medical services in the field to provide information for Roma citizens in their home environment.
2. Raise interest in prevention and healthy lifestyles. Failure to focus on this way of improving health has deep socio-cultural roots in the Roma community and making the greatest possible number of Roma aware of the importance of this is no easy task. This work should be preceded by the aforementioned surveys and discussions with experts on communication and Roma issues.
3. Improve Roma individuals' ability to behave appropriately and take effective action when illness or health problems strike the family. The purpose of this is to prevent medical complications requiring more demanding treatment because Roma patients have inadequate information or insufficient social skills.
4. Improve Roma citizens' understanding of the healthcare and health insurance systems. Experience gained from empirical surveys has shown that understanding the principles and basics of socio-medical concepts is insufficient in the majority society as well. It is safe to say that this is even more true in the case of the Roma population.
5. Minimise risk behaviour. This would involve an educational programme targeting the Roma community to improve their awareness of the consequences of phenomena such as non-payment of health insurance, failure to follow physicians' orders, etc.
6. Improve self-assuredness and prevent discrimination of Roma citizens in healthcare. The goal here is to raise Roma patients' awareness of their rights and options.
7. Improve communication and remove barriers and prejudices affecting Roma in health-related situations. This would involve an educational programme focusing on members of majority society, most importantly healthcare and medical services providers.

Description of households and sample selection

1. **Basic sample:** Roma population in the CR – the middle alternative of the estimated number of Roma in the Czech Republic, see Table 5.
2. **Sample size:** Upon agreement with the steering centre, the size of the selected sample was stipulated at 1 200 households (800 adults, 30% of whom live in socially excluded localities; 400 minors 30% of whom live in socially excluded localities).
3. **Regions:** The numbers of households and respondents in individual regions were determined from the estimated number of Roma indicated in Table 5.
4. **Groups based on municipality size:** Based on expert estimates, quotas were established for three groups based on municipality size.

– regional city (capital)	50% of households
– towns from 10 000 to 50 000 people	31% of households
– towns from 1 000 to 10 000 people	19% of households

The specific localities were chosen depending on the regions where we managed to establish cooperation with one of the Roma organisations (associations) active in the given region.

5. **Selection of households:** The final selection of households was made by the interviewers according to instructions given them. During selection, they were to observe the structure indicated in Tables 7 and 9. Approximately 30% of households were to be chosen from socially excluded localities.
6. **Selection of respondents in households:** Two questionnaires were completed in each household; the household questionnaire and the questionnaire for adults **or** the questionnaire for minors. The criteria for selecting the person to complete the household questionnaire was **“the person earning the household’s main salary.”** The questionnaire for minors was completed by the same person if possible. If the person selected refused to cooperate, the second choice was the adult who could best describe the entire household. Adult respondents were chosen based on the rule **“the next birthday following the date of the visit to the household.”**

Household members were considered to be those who live permanently in the household visited and who participate in running the household.

Selection of regions and categories of municipalities

Region	Number	%	Total	N.33% N	NSV.30%	D.66%	DSV.30%
Central Bohemia	24 200	12.1	145	44	16	101	30
10 000 - 50 000		66	100	33	11	66	20
1 - 10 000		33	50	17	5	33	10
Moravia-Silesia	30 600	15.3	184	61	13	123	41
Ostrava		50	92	30	10	62	20
10 000 - 50 000		31	57	19	6	38	13
1 - 10 000		19	35	12	4	23	8
Zlín Region	7 400	3.7	44	15	4	29	10
Zlín		50	22	7	2	15	5
10-50 000		31	14	5	1	9	3
1 - 10 000		19	8	3	1	5	1
South Moravia	10 800	5.4	65	22	7	43	14
Brno		50	33	11	4	22	7
10 - 50 000		31	20	7	2	13	4
1-10 000		19	12	4	1	8	3
Prague	11 200	5.6	67	22	5	45	15
Liberec Region	10 400	5.2	62	21	4	41	14
Liberec		50	31	10	3	21	7
10 000- 50 000		31	19	6	2	13	4
1 - 10 000		19	12	4	1	8	2
Hradec Králové Region	12 200	6.1	73	24	5	49	16
Hradec Králové		50	36	12	3	24	8
10 - 50 000		31	23	8	2	15	5
1-10 000		19	14	4	6	10	3
Olomouc Region	14 800	7.4	89	29	9	60	20
Olomouc		50	45	15	5	30	10
10 - 50 000		31	28	9	3	19	6
1-10 000		19	16	5	1	11	4
Plzeň Region	10 200	5.1	61	20	7	40	12
Plzeň		50	30	10	3	20	6
10 000 - 50 000		31	19	6	2	13	4
1 - 10 000		19	12	4	1	8	2
Vysočina Region	4 400	2.2	26	9	3	17	6
Jihlava		50	13	4	1	9	3
10 000 - 50 000		31	8	3	1	5	2
1 - 10 000		19	5	2	1	3	1
South Bohemia Region	10 400	5.2	62	21	6	41	14
České Budějovice		50	31	10	3	21	7
10 000 - 50 000		31	19	7	2	12	4
1 - 10 000		19	12	4	1	8	3
Karlovy Vary Region	12 800	6.4	77	25	6	52	17
Karlovy Vary		50	38	13	4	25	8
10 000- 50 000		31	24	8	2	16	5
1 - 10 000		19	15	4	1	11	4
Pardubice Region	8 200	4.1	49	16	5	33	10
Pardubice		50	25	8	3	17	5
10 - 50 000		31	15	5	1	10	3
1 - 10 000		19	9	3	1	6	2
Ústí nad Labem Region	32 400	16.1	194	65	20	129	39
Ústí nad Labem		50	97	32	10	65	20
10 000 - 50 000		31.1	60	20	6	40	12
1 - 10 000		19.1	37	13	4	24	7
	200 000	99.9	1198	395	110	803	258

Data collection did not take place for technical reasons (161 households)

Legend

Number	Middle variant of the estimate of the size of the Roma population
%	Estimate of the percentage of the population of regions and categories of municipalities where Roma reside.
Total	Total number of respondents in regions and categories of municipalities
N33%	Percentage of minors (0-15 years of age)
NSV30%	Percentage of those living in socially excluded localities
D66%	Percentage of adult respondents (16 years and over)
DSV30%	Percentage of those living in socially excluded localities

Analysis of the situation in Greece

Authors: Angeliki Tseva & Evgenia Zarokosta

1. National Health System of Greece

The Greek Health Care System can be described as a mixed system: the health care branches of the various social insurance funds co-exist with the National Health System (ESY- Ethniko Systima Ygeias).

In 1983 ESY (NHS) established guarantees for free health care for all residents of Greece. The system covers the entire Greek population without any special entitlement conditions regardless of professional category or region. Health care services are also provided to EU and non-EU citizens on the basis of multilateral or bilateral agreements.

Furthermore, within the ESY (NHS) context, primary health care services are provided through rural health centers and provincial surgeries in rural areas, the outpatient departments of regional and district hospitals, the polyclinics of the social insurance institutions and specialists in urban areas.

Secondary care is provided by public hospitals, private for-profit hospitals and clinics or hospitals owned by social insurance funds.

Medical Treatment Options

Emergencies

Emergency treatment can be obtained through the emergency departments at major hospitals (see hospitals and clinics).

Ambulances (EKAV) provide immediate medical attention and emergency transport to hospitals free of charge to people who have registered with the ESY (NHS).

Medication

Medicines are available from the chemist shops (pharmacies) divided in two main categories depending on whether or not a prescription is required.

In case you need medicine available by prescription only, public or private doctors will consider your situation and provide you with the prescription allowing you to buy the appropriate medicine from the pharmacy.

Additionally, if you have a health care card issued by the appropriate National Insurance Fund, you will pay a reduced price for prescription drugs.

Hospitals and Clinics

Public Hospitals and Clinics

Public hospitals and clinics differ in terms of size and specialization and, in general, are very well equipped, especially in major cities. Located throughout Greece, these provide a wide range of high quality medical care free of charge including services such as emergency care, surgery, cardiology, radiology, etc. Smaller

public hospitals, usually found in smaller cities or villages, may not offer all medical services. However, if the treatment you need is not available you will be referred to another hospital.

Private Hospitals and Clinics

Private hospitals and clinics are usually located in large towns and cities. These hospitals usually provide a number of in-patient services similar to those offered by public facilities. If you need medical treatment and choose a private clinic, it is advisable to join a private health insurance fund to help pay costs as ESY tends not to cover the cost of private hospital accommodation.

Doctors

If you need a doctor and it is not an emergency, you can go to a family doctor. You may choose your own doctor -specialisation- from a list provided when you register with ESY (NHS).

Dentists

You should register with ESY (NHS) in order to pay a reduced price for public dental services.

However, there are private dentists who will charge a fee for their service.

Health Insurance

Public Insurance

Health insurance in Greece is offered through hospitals, private clinics and doctors as long as you have been registered with a social insurance fund. Registration with such institutions requires part or full time employment.

Private Insurance

There are an important number of citizens which have subscribed to a private insurance organization. However, the cost and types of coverage vary widely.

2. Health in Greece: Mainstream Population

- Total Population: 10.934.097 (Census 2001)
- Male: 5.413.426
- Female: 5.520.671
- Ages 16-29: 4.257.000 (approximately)

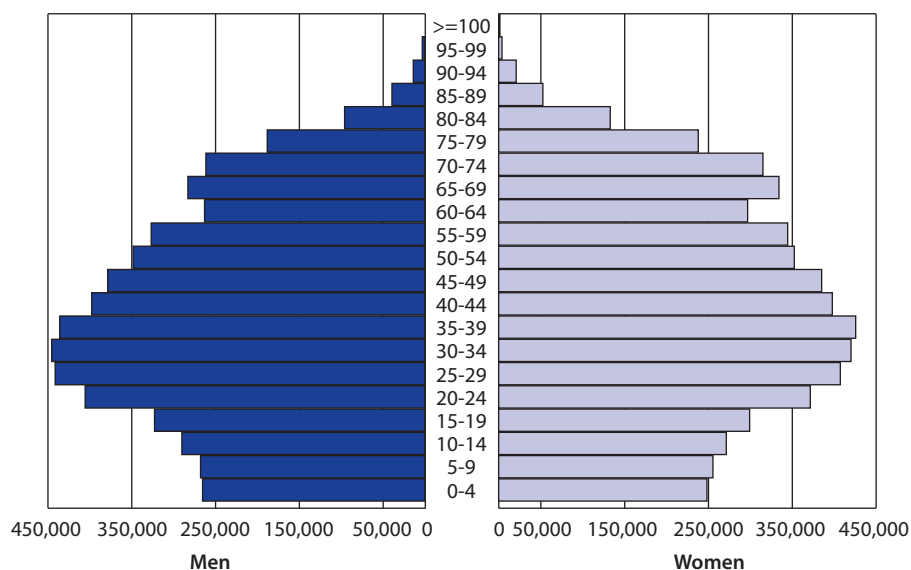
Proportional distribution according to gender and age:

- According to data available, there are more females than males in the mainstream population.
- The highest percentage of the population is in the 16 to 29 age bracket.

Characteristics of the mainstream population

- The vast majority 99,5% lives in standard flats or houses.
- The majority live in areas with social and health- services but a large percentage lives in areas without health-care services.
- Data show that only 0.1 are not integrated into the educational system. Labour statistics indicate that employers account for 10% of the labour force, employees 60%, family business 18% and unemployment stands at 9.2%.
- 0.03% lacks basic literacy skills but in the 65 and older age bracket this percentage increases to 65%.

Mainstream Population pyramid



Data show that ages 0 – 49 account for the majority of the mainstream population but fail to reach 92.1% mark of the Roma pyramid.

Health situation. Diseases

- 74% of the population considers their health to be good or very good. Percentages are higher for males and decline as age increases.
- 35% claim to suffer from chronic diseases (39% female and 30.7 male).
- Most common diseases: hypertension 16%, hypercholesterol 9.1%, osteoarthritis 6.1%, diabetes type I and II 6.4%, stress 4%, heart problems 3.1%, ulcers 2.8%, ischaemic heart disease 1.7%, asthma 1.6%, depression 1.5%, chronic bronchitis or emphysema 1.1%.

Accidents

- 8% of the population suffered some sort of accident.
- Most accidents are suffered by males (45.84%); Females: 12.96%.
- Ages up to 75 (85%), 15-29 (42%), 60-74 (40%), 30-44 (35%), 0-14 (8%).
- Most accidents are traffic-related and others include falls, poisoning and drowning.

Consumption of Medicines

- Type of medicines mainly taken without a medical prescription are those to relieve pain and/or to reduce fever (15%).
- 25% have unused drugs at home.
- Adults consume 75% of all medicines used and females consume more than males.

Dental visits

- Only 1 out of 10 have healthy gums.
- Almost all (99.7%) of those in the 35-44 age bracket have cavities and 2 out of every 3 suffer from bleeding gums.
- 35% visit the dentist in a regular basis.
- 50% do not have dental insurance.

Hospitalisation

- 20% of the population has been hospitalised.
- Main reasons for hospitalisation are: circulatory system, tumours, digestive system, nervous system, etc.
- The majority of the population is hospitalized between 1 and 7 days.

Preventive action taken by women

- The majority (70%) has never had an osteoporosis test.
- 46% have never had a breast test.
- 56% have never had a mammography.
- Mean age for the first child is 29.2.
- The majority has never had a pap smear.

Auditory and visual characteristics

- The overwhelming majority has no auditory and sight problems. Only 18.7 of the population encounters hearing and sight difficulties.

Lifestyles: tobacco and alcohol consumption

- 40% of the populations are daily smokers; 49.9% male and 30.8% female. 4 out of every 10 smokers smoke up to 20 cigarettes daily.
- 44.3% of young people between the ages of 18-34 smoke daily.
- 24.6% of the 14-17 age group smoke daily.
- The mean number of cigarettes consumed annually is 2,457.17 per person.
- More than 20,000 Greeks die each year from smoking.
- 42% of the population consumes alcohol.
- 1 out of 5 drinks daily.
- 8.6% of the 12-64 population has used drugs once or more in their life (13.3% male / 3.9% female).
- 12.2% in the 18-35 age bracket.
- 10% of the 14-17 age group has used drugs one or more times.

Lifestyles: physical activity, rest and nutrition

- 25.3% of the population *suffers from insomnia*. More females than males.
- 34.5 % of the male and 44.7% of the female population do not engage in any sort of physical activity.
- Nutrition is relatively balanced although not up to par with the Mediterranean diet.
- 1 out of every 3 do not have breakfast.
- 52% have breakfast half the days of the week.
- Meat and sweets are preferred over cereals and vegetables.
- 57.7% are overweight.
- 14.3% male.
- 18.3 female.

3. Research Methodology

Aims and Objectives

The main objective of the work was to put together a representative sample and gather information on the current health situation of the Greek Roma population and compare the outcomes to the other EU countries participating in the project.

A number of different aspects emerged providing pertinent information on the status of the Roma people with regard to:

- general health status, identification of the main problems encountered (chronic illness, aches and pains, limitations in terms of activity, aid, accidents etc.);
- knowledge of the degree to which health services are used;
- preventive practices followed;
- frequency of habits which could endanger or benefit health.

These main aspects formed the basis of the approach followed in this project. Given that the fundamental aim of the research was not only to gain insight into the health status of Greek Roma but also to compare the situation of Greek Roma with that of other population groups, the methodological approach also aims to generate official health statistics in Greece. It is also in compliance with the research design by the leader of the project (Fundación Secretariado Gitano).

Methodological approach

To achieve these objectives, the project gathered current, first-hand information by means of a national survey. This basically meant conducting direct and indirect interviews with a representative sample of Greek Roma households all over the country so that we could subsequently extract statistically reliable data which can then be extrapolated to the entire Roma community. The technical characteristics of the survey were as follows.

Target population

The statistical target population of the study was the entire **Greek Roma population** and therefore information was gathered from Roma of both sexes age 0 and older. In terms of age, the group was divided into two categories, minors and adults. In the case of minors (0-15 years) information was collected indirectly while in the case of adults (over 15) it was collected directly.

The total theoretical sample envisaged 660 interviews of Roma households. Each of these interviews gathered detailed information on the health status and habits of 440 adults and 220 minors (in a 2:1 ratio). In the case of the former, information from each household was collected first-hand from a randomly selected adult, while in the case of the minors it was provided by an adult directly responsible for and familiar with the situation of the minor. Those interviewed also provided information on the home and all of the members residing there.

In order to acquire a representative sample, data from a previous survey¹ was used. Information concerning the following variables was used for the first phase of this survey:

1. Geographical distribution of Roma settlements nationwide
2. Type of houses (construction material: e.g. tent, apartment, shack, etc.)
3. Number of households per settlement
4. Estimation of the number of inhabitants in the community/demographic data
5. Type of residence (permanent or seasonal)

Information was gathered from 162 settlements in 116 Municipalities. The total number of members of was 27,000.

¹ Special Service for the Implementation of Actions Co-Financed by the European Social Fund - Ministry of Employment (2008). Current situation of Roma in Greece, Review of actions and Preparation of action plan for the 4th Programming Period.

Sample design

The sample was designed in stages. At stage one, data concerning territorial (regional) distribution and number of settlements per region from the above mentioned study was used.

The following considerations were taken into account in attaining a nationwide sample:

1. Sample size per settlement divided by 3 [module (N,3)=0] in order to achieve a 2:1 ratio.
2. The size of the sample per region and per community had to be large enough to make additional estimates per region.
3. Availability of human resources (such as existence of local social / medical centers, qualified interviewers) in order to reduce the no-response rate.
4. Autonomous communities recorded (table 1)

Table 1. Communities per region and sample of households

	Region	Autonomous communities/settlements (not all in Greece)	Sample (households)
1	East Macedonia and Thrace	28	129
2	Central Macedonia	23	117
3	West Macedonia	2	-
4	Epirus	3	-
5	Thessaly	11	111
6	West Greece	47	150
7	Ionian Islands	5	-
8	Central Greece	17	33
9	Peloponnesus	13	-
10	Attica	9	93
11	Crete	2	27
12	North Aegean	1	-
13	South Aegean	1	-
	Total	162	660

Thus, the final sample can be regarded as disproportionate.

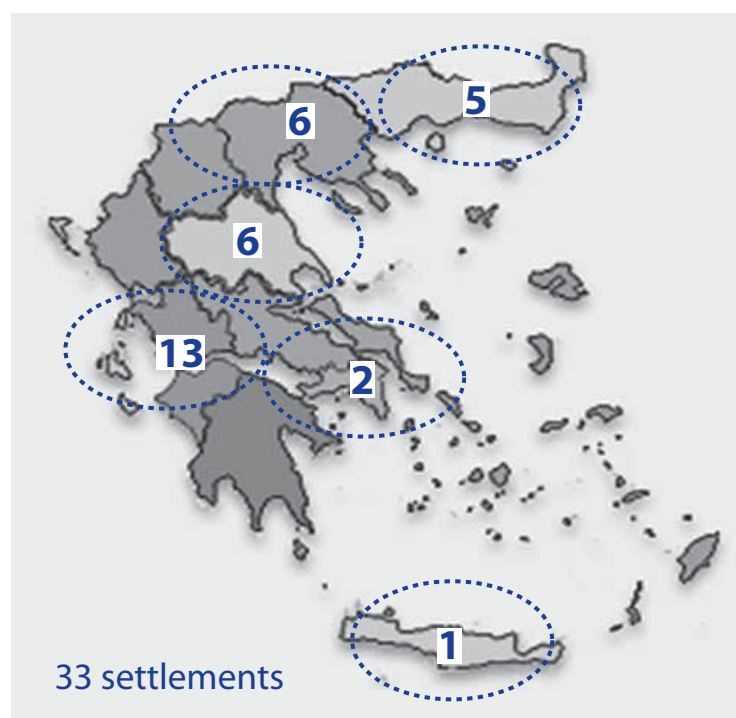
According to the Spanish (coordinator) sampling design, the final sample should reflect a 2:1 adult to minor ratio. It was decided that a sample of 2.4% of the households (namely 660) would be adequate, taking parameters like budget, time, human resources and territorial dispersion into account. This means 660 people were scheduled for interviews. Therefore, of the 660 Roma, 220 were minors (up to age 15) and 440 were adults (15.1 and older), broken down by gender and age group.

Sampling

In general the sampling method used can be described as multistage, disproportionate, non probability-judgmental method at the preliminary stages and simple random selection for the interviews of minors and adults.

The first stage entailed the selection of the first units which, in this case, were the regions where settlements were known to exist (table 1).

Specific settlements were selected at the second stage (Table 2). The main criterion was the existence of a social-medical center providing support to the target population and type of housing (equally balanced).

Table 2. Settlement areas

Once we had identified and located the areas where our target population lived, we proceeded to select the units of the third stage, i.e. households.

At the fourth stage, within each household, a minor (0 to 15) for the minor's questionnaire or an adult (15.1 and older) for the adult's questionnaire was selected.

In selecting the sampling units, we considered breakdown by sex and age bracket as illustrated below (Table 3).

Table 3. Distribution of the target group (designed)

Minors				Adults			
Age	Male	Female	Total	Age	Male	Female	Total
0-6	54	52	106	15.1-30	113	130	243
6.1-15	60	54	114	30.1-45	56	50	106
				46 +	43	48	91
Total	114	106	220	Total	212	228	440
%	51.8%	48.2%	100%	%	48.2%	51.8%	100%
	Total male: 326				Total female: 334		

In no case were both an adult and a minor of the same household interviewed. In each household only one adult **or** one minor was interviewed in addition to collecting information regarding the household in general. The interviewers had to follow certain guidelines provided by the coordinator. In selecting a minor or adult to be interviewed, interviewers were instructed to choose the member of the family whose upcoming birthday was closest to the survey date in order to attain a random selection.

This design was used to reach 645 households. We were unable to reach the planned sample of 660 due to a number of reasons and obstacles. Also, 4 questionnaires were rejected at the final screening. Thus the final sample was 641 households containing a total of 3,485 individuals, 2.79% of the estimated Roma population.

Table 4. Final sample (acquired)

	Male	Female	Total
Minors	109 (50.7%)	106 (49.3%)	215 (33.5%)
Adults	199 (46.7%)	227 (53.3%)	426 (66.5%)
Total	308	333	641

As the above table shows, the percentage distribution of the final sample is very close to the original design and the 2:1 ratio was likewise achieved (66.5%:33.5%)

A total of 3 485 people were living in the 641 households, i.e. 5.4 persons / household (very close to the 5.24 from the previous study).

The distribution of the nationwide sample by region, municipality, area and type of settlement/community is presented in Appendix 1.

Field work

Field work was conducted between November and December 2008.

A strict set of rules specifically designed to account for the characteristics of the target group was established to ensure the quality of field work, a vital part of any research project of this nature.

All of the people taking part in the collection of data received specific and detailed training at a meeting held in Athens. In addition to the criteria and operational mechanics typically transmitted to the interviewers responsible for a survey, in this case they were also provided with a series of very important specific rules in order to minimise possible bias and ensure the accuracy of the data collected.

4. Health and the Roma Community: Analysis of the situation in Greece

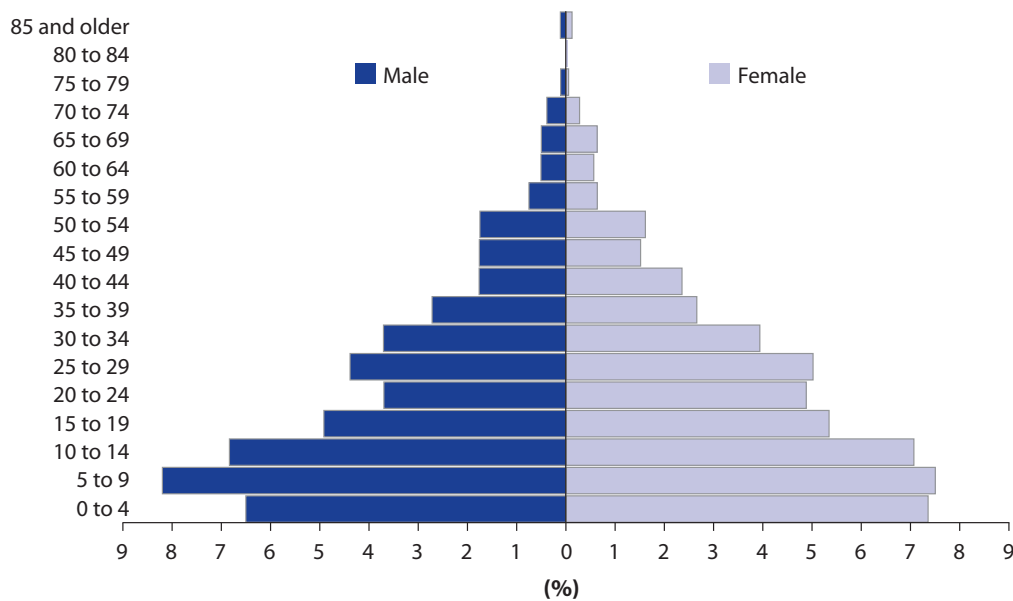
Proportional distribution according to gender and age:

- According to data collected, the 16 to 29 age bracket is the most numerous (accounting for 26% of the total). Females outnumber males by 2.5%.

Characteristics of the country's Roma population

- The majority (52.6%) live in standard flats or houses and 25.6% in sub standard housing. 22% live in shanty towns.
- 53.5% live in isolated neighbourhoods and 54.5% in neighbourhoods characterised by poor health.
- While 65% live in areas with social and health services, a significant percentage (35%) live in areas with no social or health services.
- 17% of the minors are enrolled in school, girls to a lesser degree than boys.

Population pyramid



- Data show that the 0–49 age bracket accounts for 92.1% of the Roma population. The average age of the Roma population is 21.56.
- **Self employment is the main occupation** with entrepreneurs accounting for 12.6% of workers, seasonal and temporary salaried workers 8.4%, permanent salaried workers 3% and those engaged in family businesses accounting for 1.8%.
- **Unemployment** stands at 61.7%. Most women (64.1%) are housewives.
- 41.5% of adults are illiterate, 13% can only read and write, 15.7% did not complete primary school studies, 9.7% completed primary studies, 3.6% did not complete secondary studies, 0.8% completed secondary studies, 0.6% have a university degree and 0.2% have a post graduate degree.

Health situation. Diseases

- 90% of the population assesses their health status as good or very good with no gender differences but significant differences (reaching 60%) between age brackets.
- Most of the population (over 90%) does not suffer from any chronic disease, migraines or headaches, allergy or high blood pressure. Menopause-related problems suffered by women are the most common diseases.
- 98% of the under 45 population is free of disabilities and chronic disease.

Accidents

- Most accidents occur between the ages of 0–29 (53.6%) and most occur at home (40%).
- Victims are mainly female (66%) and typically result in bruises, sprains or superficial cuts (68%).

Limitation of daily activities

- The daily activities of the Roma population are not limited due to ailments. Only 40% of the over 45 age bracket have to reduce activities due to illness or injury.
- Symptoms affecting the main activities of the Roma population are mostly observed in cities with populations of 100,001 to 250,000 (48%) and those living in standard flats or houses (28%).
- The type of neighbourhood and whether social services are available or not does not have a bearing on limitation of everyday activities.
- Minors have to limit their main activity due to sore throat, cough, cold or flu (49%) whereas bone, back or joint pain (44%) are the ailments limiting adults.

Consumption of medicines

- 51.3% of minors take medicines for cold, flu, pain and/or to reduce fever.
- Cold and flu remedies and medication for pain and fever (without a medical prescription) are the ones most typically taken by minors (36.6%).
- These same medicines are likewise the ones most frequently taken by adults without a doctor's prescription (58%).
- 14.5% of adults take tranquilisers, muscle relaxants and sleeping pills.
- The medicines mainly taken by adults without a prescription are for colds, flu, pain and/or to reduce fever (25.6%).
- 12.9% of adults take tranquilisers, muscle relaxants and sleeping pills without a prescription.
- Adults consume 68% of the medicines taken, and women take more than men (76.4 compared to 58.7%). The over 45 bracket accounts for 86.3% of all medicines consumed.

Medical consultations

- 1 out of every 2 minors and adults visit a physician once a month whereas the rest of the population visits a physician once a year. 5% have never visited a physician.
- The majority (over 60%) of minors and adults (both sexes) visit medical centres and out-patient departments or emergency rooms of hospitals.
- The main reason (70%) for doctor's visits is diagnosis and or treatment.
- The majority of minors and adults (63%) visit National Health System physicians.
- 17.2% of minors and adults needed but did not receive medical assistance.
- The main reason for failing to receive medical attention was economic (60% of the cases), the reasons being "could not get off work", "too expensive", "no means of transport", "did not have insurance".
- 65% of minors adhere to the vaccination calendar and 35% are not properly vaccinated.
- Significant gender differences were found in vaccination programmes. In some cases, twice the number of girls failed to adhere to the vaccination calendar.

Dental visits

- The majority of minors 63% have never gone to the dentist independent of gender whereas 25% of adults have never gone to the dentist.
- The majority (54.8%) use National Health System dentists and 35% visit private dentists.
- Minors have good teeth in 75% of the cases. Boys between the ages of 10 and 15 exhibit the most problems.
- 50% of adults do not have good teeth, 18% do not have teeth at all and 21% have prostheses or false teeth. The most serious problems are observed in women age 45 and older.

Hospitalisation

- 17% of the population has been hospitalised, the largest group from the 45 and older bracket (26%) and are mainly men (20%).
- Most (73% of minors and 85% of adults) are hospitalized between 1 and 7 days. The highest percentage is found in the 16-29 age group (92%) and no gender differences were observed.
- The main cause for hospitalisation (50%) is medical treatment.
- 95.3% were not put on a waiting list for hospitalisation.
- 47.6% use the National Health System to finance hospital stays.

Use of emergency services

- The majority (70%) do not use emergency services regardless of age, gender, town size, the existence of social and health services or area of residence.
- An average of 4.1% of adult women and 2.82% of adult men used emergency services.
- The majority (92%) of those using emergency services prefer national hospitals regardless of gender, age group or size of the town.

Preventive action taken by women

- 84% of women are mothers and 88.5% of them are completely illiterate.
- 21% of women have never gone to the gynaecologist and 35.6% have never gone for reasons other than pregnancy.
- The overwhelming majority (92%) has never had a mammography regardless of age or town size.
- 68% of the women have never had a pap smear.

Auditory and visual characteristics

- 15% have hearing problems regardless of gender or age bracket.
- A higher percentage (32%) of the 45 and over group have hearing problems.
- 15% have sight problems regardless of gender or age bracket.
- A higher percentage (37%) of the 45 and over group experience vision difficulties.
- The overwhelming majority (77.5%) have no hearing or vision problems regardless of gender or age group except for the 45 and over group where the incidence of vision and/or auditory problems stands at 20%.

Social support

- More than the half population has sufficient social support regardless of age.
- Women outnumber men when it comes to lack of social support. The main shortfall in this regard is in response to the survey question “invitation to go out with others for fun” (57% versus 35%).
- 68.2% of the population has sufficient social support whereas 31.8% is lacking such support.
- Social support facilitates daily activities.

Lifestyles: tobacco and alcohol consumption

- 56.5% are habitual smokers whereas 9% smoke occasionally.
- 66.5% are male compared to 47.2% who are women.
- On average, boys begin smoking at age 14 and girls at age 16.
- The majority (98%) smokes cigarettes.
- 57% of the population consumes alcohol, males (77%) and females 39%. Males 45 and over is the group most prone to drinking. Drinking begins at age 15 for boys and at 17 for girls.
- 0.7% of the population has drug problems and these are mostly found among males age 30-44.
- Drugs Problems are more prevalent in households living in sub-standard housing, isolated and in poor health and in locations lacking health and social services.

Lifestyles: physical activity and rest

- 91% of minors and 48% of adults sleep more than 8 hours per day.
- No gender differences were found in this regard.
- Most minors (56%) and the vast majority of adults (82%) do not take any exercise. Females are less prone to exercise (81.8%).
- The vast majority of minors (90%) watch television every day.
- The vast majority of minors (90%) watch television between 1 and over 3 hours daily.

Lifestyles: nutrition

- The majority (57%) of infants up to 6 weeks were breastfed with no gender difference.
- The majority (65%) of minors eat breakfast whereas the majority of adults (85%) have coffee/tea or nothing at all. There are no differences gender differences in this regard.
- 88.2% consume bread and cereals on a daily basis.
- 73.5% consume pasta and rice either daily or more than 3 times a week.
- 60.5% consume dairy products either daily or more than 3 times a week.
- 52% consume vegetables either daily or more than 3 times a week.
- 45.1% consume meat once or twice a week.
- 22.4% never consume lunchmeat, 19.8% never consume fish and 17.1% never consume eggs.
- 23.4% of the Roma population is overweight.
- 9.5% of the Roma population is obese.
- 45.9% of them are in the 45 and over age bracket.

5. Recommendations

- Enforce all legislative regulations that already exist in favour of integration and to combat all forms of discrimination against Roma;
- Use all financing mechanisms and funding possibilities;
- Create synergies which could develop out the Roma Decade;
- Highlight good practices from past experiences and disseminate them;
- Mainstream Roma and include them in all ongoing policy cooperation mechanisms at EU and national level, especially with regard to social inclusion, employment, education and health;
- Involve Roma civil society in both the design and implementation of policies and projects;
- Be consistent in combating negative stereotypes of Roma at all levels;
- Focus on Roma issues during the upcoming 2010 European Year for Combating Poverty and Social Exclusion;
- Involve the Roma community at local level in the improvement of their daily life, especially regarding issues like housing, education, employment and health;
- Continue to research and monitor the situation of Roma in terms of racial prejudice and human rights violations against Roma which lead to Romaphobia;
- Create Policy Groups in the sectors of employment, education, health, housing, culture, etc.;
- Renew processes and abandon ineffective approaches and adopt others that take different dimensions of the issues and lessons learnt into account;
- Combat barriers affecting Roma such as: lack of education and training, lack of language skills, lack of recognition of skills and qualifications, lack of access to professions, lack of integration policies, stereotypes, prejudices and negative attitudes, discrimination, lack of information, labour market competition and grey market labour;
- Raise awareness of civil society and the mass media regarding discrimination faced by Roma;
- Map and assess human rights violations suffered by Roma;
- Map Good Practices regarding Roma Health issues;
- Establish a long-term research program on Roma Health at European level;
- Establish a European Roma Health Observatory;
- Run workshops and training programs for social service and health care providers working with the Roma community;
- Set up an Ombudsman to protect the human rights of Roma;
- Take positive steps to encourage Roma to seek employment and use health services (scholarships, training and retraining).

Analysis of the situation in Portugal

Author: Maria José Vicente

Introduction

The Roma Community comprises Europe's largest ethnic minority and is generally characterised by persisting poverty and social exclusion. It is important to acknowledge and promote the Roma culture in order to fight the discrimination they suffer from and the negative social image based on stereotypes and prejudice that the mainstream society has of this community. All these issues are vital for well-being and individual quality of life but have never really been addressed.

Health is one of the main basic social needs and a fundamental right playing a crucial role in social exclusion/inclusion processes. Health is a key element to access other resources, services and rights that create social "opportunities" and social cohesion.

Thus, health care inequalities and access to health services are two of the main factors contributing to the social exclusion of this Community. Despite being obvious, their health condition is not backed up by statistics or reliable updated data since there are no studies on this subject¹ in Portugal.

In this context, a diagnosis was developed to obtain reliable data and objectives on the health status of the Roma Community and to guarantee the latter's access and use of the existing health services and resources. This diagnosis was developed at national level within the scope of the Project *Health and the Roma Community: analysis of the situation in Europe*² (2007-2009), funded by the European Union in the framework of the Public Health Programme – PHEA – Public Health Executive Agency.

Therefore, this document seeks to report the main conclusions of the diagnosis, identifying the real needs and defining priority actions. Its recommendations must be capable of influencing the design of measures aiming to reduce the inequality faced by the Roma Community and to promote the latter's effective social inclusion.

¹ There are only studies on sepecific territories, without a national scope.

² This Project is developed by Rede Europeia Anti-Pobreza within the framework of a transnational partnership involving Portugal, Spain (Project promoter), Romania, Czech Republic, Bulgaria and Greece.

1. Methodology

In a study of these characteristics seeking to obtain information on a specific subject - health – as regards Roma Communities and where it is very difficult to come up with basic indicators with which to typify these communities, the construction of any type of representative sample (of an unknown universe) is an extraordinary adventure. An important premise must be borne in mind: the information available on this ethnic group is very poor³ making it difficult to obtain reliable data on Roma Communities in Portugal. This lack of information also makes it impossible to put together a representative sample of a universe which, in fact, we really don't know. Based on the collected data, REAPN defined the sample as follows:

- **360 questionnaires were administered** covering **12 districts**: Aveiro; Beja; Braga; Bragança; Coimbra; Évora; Faro; Lisboa; Porto; Setúbal, Santarém e Castelo Branco;
- Of the 360 questionnaires, **120 were administered to children** and **240 to adults** (120 to female and another 120 to male adults);
- **30 questionnaires** were administered in each **district** selected and were broken down **as follows: 10 children, 10 male adults and 10 female adults.**

In order to carry out the diagnosis and to achieve the stipulated objectives, the main part of the work consisted of administering a questionnaire to a sample of Roma Community members by conducting direct (to adults) and indirect (to children) interviews to a number of selected households throughout the country.

The field work was carried out between July and November 2008. In the first two months (July/August), a pre-test was applied to check whether the data matrix and the questionnaire contents were suited to the target group. As a result of the field work, 367 questionnaires were administered (164 to men and to 203 women).

Table 1. Sample of the Roma Community

	Age distribution of interviewees	Male	Female	Total
Minors	0 - 4	11	16	27
	5 - 9	12	27	39
	10 - 15	20	37	57
	16 - 29	54	58	112
	Sub-Total	97	138	235
Adults	30 - 44	28	33	61
	45 - 64	32	23	55
	65 and older	7	9	16
	Sub-Total	67	65	132
Total		164	203	367

It is worth highlighting that through 367 questionnaires we were able to cover 1,673 Roma Community members.

2. The Portuguese National Health System

The Portuguese Health System integrates three co-existing systems: the National Health Service (NHS) funded through general taxation and available free to all citizens through public health services (hospitals and health centres where patients pay a “symbolic” fee); health subsystems where special social/health insurance schemes cover certain professions; and lastly, voluntary private health insurance. The National Health Service provides universal coverage. About 25% of the population is covered by the health subsystems, 10% by private insurance schemes and another 7% by mutual funds. The main objective of the NHS is

³ There isn't a sociological study or any type of scientific approach to the characterization of these communities in Portugal. If it is true that many studies on Roma Communities had been produced in Portugal, it is also true that they are partial and based on different methodologies, not allowing a reliable overview.

to allow the State to meet its responsibility to protect health through integrated health care services such as: health promotion and prevention, diagnosis and treatment of diseases and patients' social and medical rehabilitation. The NHS offers universal coverage and according to the Portuguese Constitution, all citizens have the right to health services which are "tendentiously" free⁴.

The National Health Service includes all public health care providers:

- Hospitals;
- Local Health clinics;
- Health Centres;
- Health Centre Groups.

Patients have to pay a small fee for medical appointments, treatments and surgery. However, there are some groups that are exempt from these payments such as those with low income and disability pensions. These payments are called moderating taxes and, in essence, are small amounts of money paid by patients for a medical appointment or other health care service. By law, health care services are "tendentiously" free based on users' economic and social situation. The main aim of the fees is to moderate, streamline and regulate access to health services and to strengthen the social justice principal within the National Health System.

Table 2. Charges according to the type of service

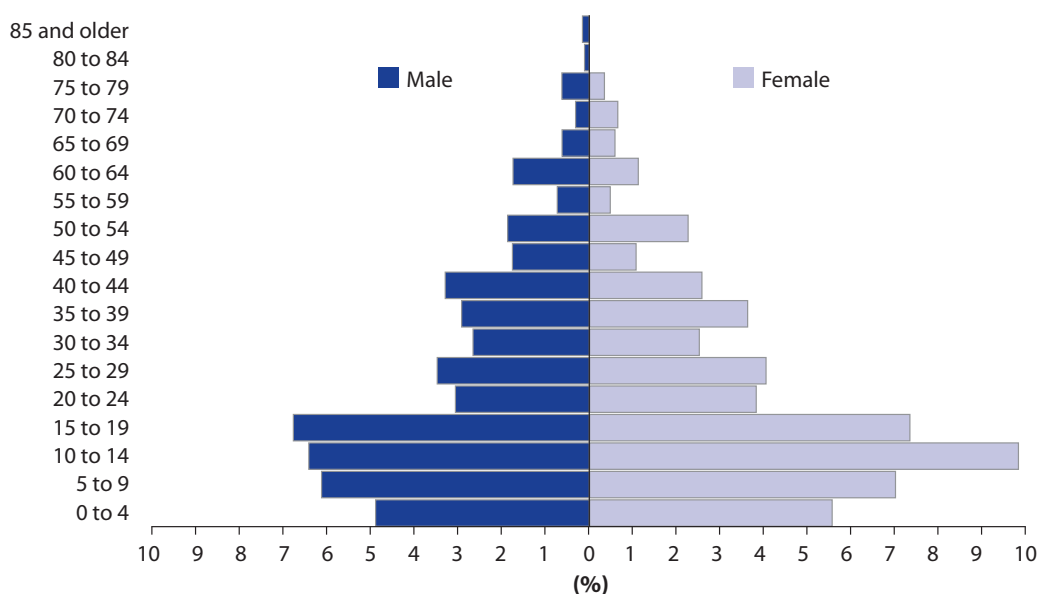
Type of Health Service	Charge
Medical Appointments	
- Central Hospitals	4.50€
- District Hospitals	3.00€
- Health Centres	2.20€
Emergencies	
- Multipurpose emergency	9.40€
- Basic and medical-surgical emergency	8.40€

3. Characteristics of the surveyed Roma population

As for demographics, the population is characterized by an over-representation of women (885, 52.9%) and an under-representation of men (791, 47.1%) out of a total of 1673 Roma Community members. This imbalance is understandable considering the relative weight of the female population in the overall Portuguese population. It is also plain to see that the Roma population is young. 60% are between 0-24 and 39.7% are children under 15. It is also worth mentioning that approximately 40% of the population is over 25. This distribution indicates that the Roma community has a much younger population when compared with the rest of the Portuguese population characterised by an inverted pyramid with a greater concentration of the population in the older age groups.

⁴ Article 64, point 2 a) of the Portuguese Constitution: The right to health protection is carried out through general, universal health services, taking into account citizens' social and economic conditions they are "tendentiously" free.

Figure 1. Population Pyramid



The same does not apply to the Roma population which is characterised by a normal population pyramid (Fig. 1) with a higher concentration of young people. This fact could be explained by the high birth rate and scant presence of the elderly which could be related to the lower life expectancy of this population. It is also important to point out that this situation can also be associated with the poor **housing conditions** in which the Roma community lives and which has a bearing on their health status. The Roma Communities continue to live in poor housing with insufficient sanitary and hygiene conditions which increases their social exclusion. In fact, most Roma families live in sub-standard housing (52.50% out of a total of 367 households).

As regards **education**, Roma communities have low academic qualifications. 52.3% of the interviewed population (48.2% of adults and 4.1% of minors) had not attained any short of academic qualification and from this sample, 36.9% (33.9% of adults and 3.0% of children) were completely illiterate. It should be noted that just 38.3% of the adult population completed primary school studies and only 0.4% completed secondary studies. This low level of education makes this community more vulnerable to social exclusion.

As concerns **the labour market situation**, the majority of the Roma population is inactive. 91.6% are inactive, 44.3% are unemployed or working in the informal economy and 27.4% are living on pensions or other social benefits. We would also point out that 8% are engaged in family businesses associated with sporadic activities such as street markets and street vending. The remaining 8.5% of the Roma community form part of the active population, 4% are self-employed and 2.4% are salaried workers. There are communities that make their living from “traditional” activities and a small number which is integrated into the formal job market. The vast majority live from what they make on street vending and street markets. Some of these enjoy what they do mainly because these activities involve a degree of *nomadism* which is associated with this ethnic group. For others, however, these are the only activities they have access to due to their low academic level.

The data collected show that one of the elements contributing to the vicious circle of poverty and social exclusion is the Roma community’s lack of access to the formal labour market. This situation leads many members of the Roma community to engage in precarious activities and informal work and to become recipients of the Social Insertion Income. However, it is important to mention that this scenario is beginning to change since 66% of the children are currently in the school system acquiring knowledge and qualifications which will facilitate their future integration into the labour market.

As for **health** care, most of those interviewed were covered by the Social Security National Health System. Although this issue will be addressed in more detail in the following chapter, it should be mentioned here

that this is one of the major problems faced by Roma communities. Previous studies (and this diagnosis) demonstrate that the poor social and economic conditions of Roma Communities have a negative impact on their health status, including lower life expectancy, poor nutrition and disease when compared to the mainstream population. Roma health patterns directly influenced by low educational levels and limited access to healthcare services. Discriminatory and prejudiced attitudes are key factors that lead to segregation and exclusion of Roma from public health campaigns and programs. Cultural differences may create barriers between Roma communities and health care providers.

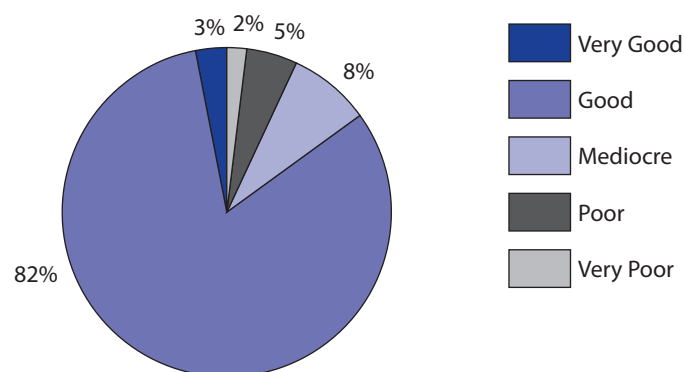
4. Health and the Roma Community

In order to acquire a general idea of the health status of the Roma Community and based on the outcomes of the diagnosis, we should stress the following main characteristics of these communities.

The Health Status of the Roma Community

Most individuals consider their health to be *good* (82%). However, 15% believe that their health status is between the *mediocre* and *very poor*.

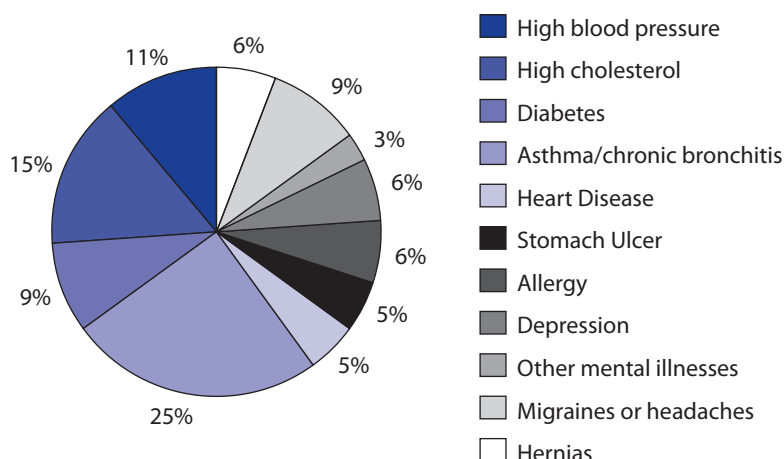
Figure 2. Breakdown of the surveyed population according to their perception of their health status over the last 12 months



This perception is more prevalent among younger age groups where the vast majority consider their health to be very good. In contrast, amongst older age groups we find a higher number of individuals who perceive their health as *good*, *mediocre* and *very poor*. This is more evident within the over 65 group where the following percentages can be found: *good* – 57.7%; *mediocre* – 25.0% and *poor* 13.5%. This situation could be due to the fact that older people have poorer health due to their physical condition and because they are part of a more vulnerable age group. It is still important to point out that as age increases, negative health perception also rises.

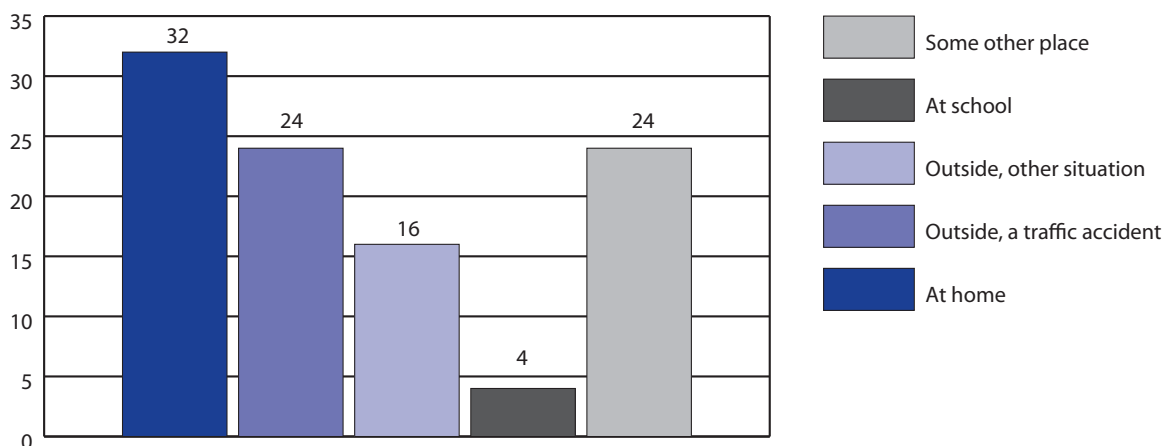
The most prevalent diseases among those interviewed were respiratory illnesses such as *asthma* and *chronic bronchitis* (25%) followed by diseases such as high *cholesterol* (15%) and *high blood pressure* (11%). If we compare these data with the general population, we don't find the same prevalence of disease. The disease having the greatest effect on the general population is *high blood pressure* and respiratory maladies are not at all significant.

Figure 3. Percentage of those interviewed suffering from chronic disease by diagnosis



With regard to **accidents**, we found that only 7.1% of the interviewees claimed to have suffered accidents during the preceding 12 months. However, adults are more inclined to suffer accidents than children (9.4% and 3.9% respectively), and the number of accidents is higher among men (9.4%) than women (5.1%). The 30 to 44 age group suffers the greatest number of accidents. Most accidents happen at home (32%) followed by car accidents (24%).

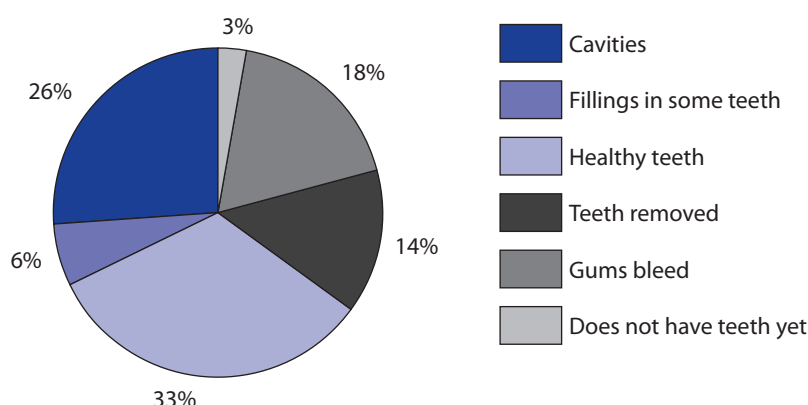
Figure 4. Distribution of the interviewed population according to the type of accident



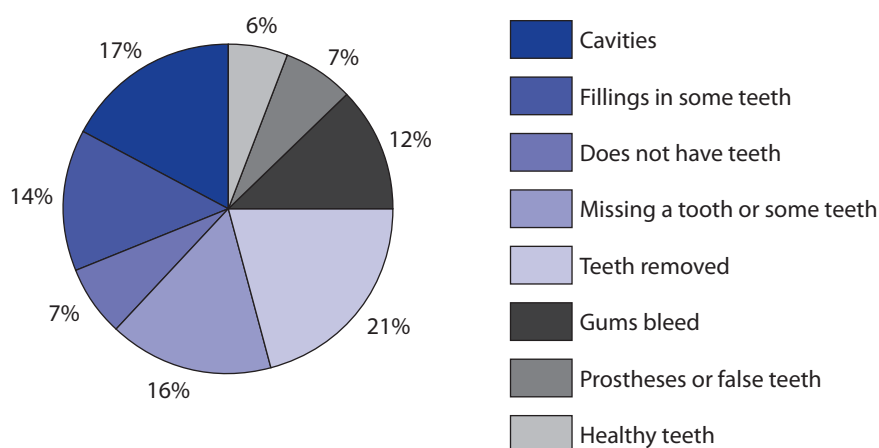
Regarding limitations in pursuing daily activities, only 10% of the interviewed population found themselves in a situation where they had to reduce their main activity during the previous two weeks. The highest incidence was among minors (10.5%). We also found that the percentage of temporary incapacity is higher among women (10.3%), being more prevalent in the over 45 age group. In light of available data, a higher percentage of the majority population is on temporary leave than among the Roma community. The figure for the majority population is 12%⁵ compared to 10% of the Roma population. The main reasons causing Roma people to reduce their main activity was headaches (37.5%), nervousness, depression and difficulty sleeping (33.4%), and bone, spinal cord or joint pain (32.2%). In the case of minors it was mainly due to fever (69.4%), followed by colds, pain and sore throat (30.6%).

Regarding **dental health**, 64% of the children are affected by the condition of their teeth and 26% have cavities.

⁵ INE – 4º Inquérito Nacional de saúde – 2005/2006

Figure 5. Breakdown of minors by teeth condition

95% of the adults interviewed claimed to have dental problems. The most frequent situations are *teeth removed* (21%) and *cavities* (17%). These figures are of some concern showing that dental health is deficient.

Figure 6. Distribution of Roma adults by the condition of their teeth

As for **auditory and visual acuteness**, 10.5% of the adults interviewed have hearing difficulties. The percentage is higher among men (12.4%) than women (8.6%). The same is applies to *sight problems* (only 11.33% of the Roma population has vision difficulties).

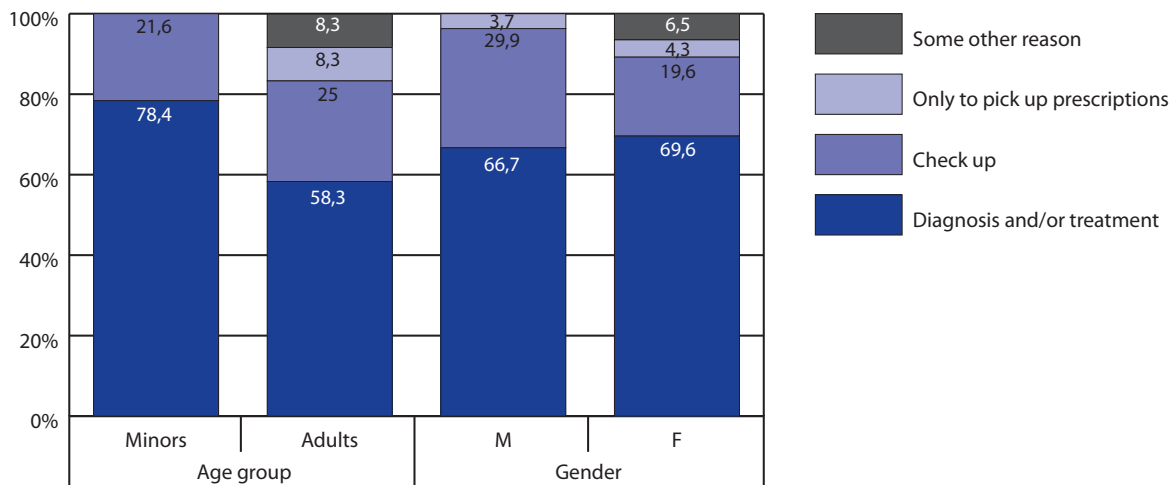
4.2 – Use of Health Services

As for **use of medicines**, the study showed that *cold/flu* remedies and medicines to reduce *fever and/or pain* are widely used by both children and adults. In the case of children the consumption of antibiotics and medicines for diarrhoea is equally high. Here it is important to mention that most antibiotics and medicines for flu, fever and pain are not taken under a physician's prescription. The same is true for adults in terms of self-prescribed medication (medicines for *colds/flu*, *fever* and *pain*). However, there are other medicines not prescribed by doctors but nonetheless consumed by Roma communities such as birth control pills followed by medicines to reduce *cholesterol* and combat *diabetes*. We have a high self-medication rate (55.8% of the adult population *takes medicines without a physician's prescription* compared to 44.2% that only take *medicines with a doctor's prescription*).

The Roma community does see physicians regularly. The frequency of physician visits is highest in the category of *more than two weeks and less than a month ago* (43.8% of minors and 48.6% of adults) followed by the annual visit to the physician – *more than one month but less than one year ago* (25.5% of minors and 26.4% of adults). Medical appointments *in the last two weeks* are also significant, especially for minors (24.2%).

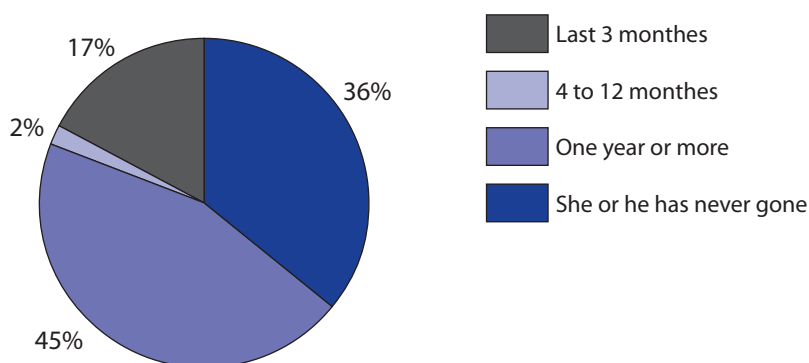
While the Roma population turns to hospital emergency rooms when they have a health problem, medical checkups usually take place at the Health Centre followed by outpatient hospital consultations. This situation could have to do with the fact that interviewees are covered by the National Health System. The need for a *diagnosis and/or treatment* is the main reason to see the physician. Percentages are significant both for adults (58.3%) and minors (78.4%), and for both genders (66.7% of men and 69.6% of women). Men have more checkups than women.

Figure 7. Main reason for the last visit to the physician, by age group and gender



45% of those who answered that a year or more had gone by since they last visited the dentist were adults between 30 and 44. The greatest percentage of Roma community members who answered that they had never gone to the dentist (36%) was in the 0 to 15 age bracket, the same group which had gone most frequently to the dentist in the last three months (17%). This could be the result of the dental health programs established jointly by the Ministries of Education and Health for school students. In contrast with regular doctor visits which take place within the scope of the National Health System, most dental services are provided by private doctors (63%). This explains the lack of access these communities have to dentists for lack of economic resources.

Figure 8. Time elapsed since the last dental visit

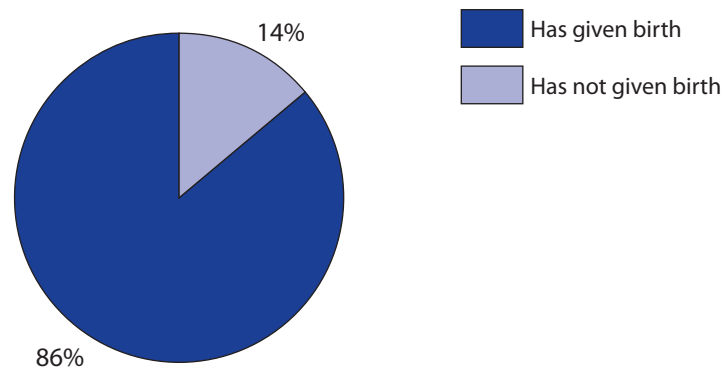


Regarding **hospitalisation**, the majority of the Roma population hospitalised during the course of the previous year did not spend more than a week in hospital. The main cause of the hospitalisation was *treatment without surgery* (66%). This percentage was equally high in adults and minors but more significant in this latter group. Over the last 12 months about 73% of Roma people had requested **emergency services** (at Health Centres and/or Hospitals). Of these 73%, a significant proportion (33%) had used these services

twice over the previous 12 months and 29% only once. The percentage of the population that had used emergency services more than 5 times was considerable (11%). In contrast to what happens with medical consultations, whenever an emergency arises the majority of those interviewed (90%) answered that their first choice is to go to the hospital emergency room.

A high percentage of women had recently given birth. This was particularly true in the 16 to 29 age bracket and shows that early pregnancies are common among Roma but this situation is changing.

Figure 9. Percentage of women who have borne children



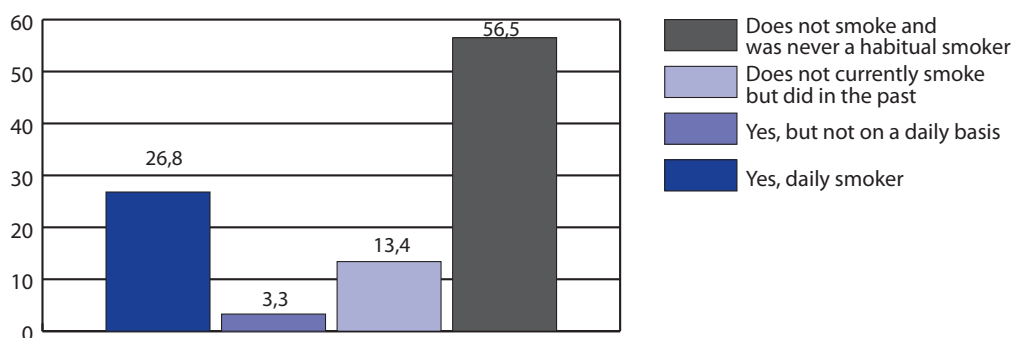
However, although teenage pregnancies are common in Roma communities, we found that women do not have regular **gynaecological checkups**. 24% of the women interviewed said that they had never had a gynaecological checkup. This is especially true for the 16 to 29 age bracket. Most women only see a gynaecologist when they are pregnant. Here it is important to point out that most pregnant women had only had one checkup throughout the entire pregnancy (43%) and only 22% reported having checkups every 2 months.

Following up on the above analysis, 19% of Roma **women have been to the gynaecologist for reasons other** than pregnancy and these reasons are: counselling family planning (43.8%), a gynaecological problem (31.3%) and periodic checkup (25%). Counselling and family planning is essentially sought by women between the ages of 16 and 29. This shows that the youngest women are more aware of the need for family planning whereas older women only go to the gynaecologist if they are experiencing problems or for periodic checkups and these are often linked to symptoms of gynaecological disease and difficulties associated with menopause. An absence of preventive gynaecological practices is evident considering that 76.8% of women have never had a mammography ordered by a specialist and 87.1% have never had a Pap smear test.

Lifestyles

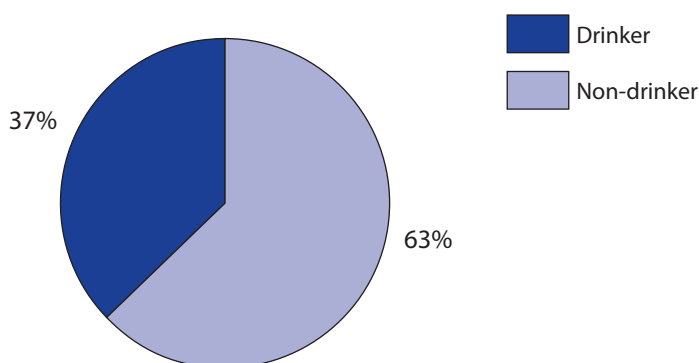
Regarding **tobacco consumption**, 30.1% of those interviewed are *smokers*, 3.3% of whom are only *occasional smokers*. Tobacco consumption is high among the male population and the younger age brackets and a decrease in consumption can be observed in the older age groups probably due to the onset of disease amongst those that started smoking very early (essentially from age 30 onwards). This situation is different amongst the majority Portuguese population where the highest proportion of smokers is concentrated between the ages of 35 and 44.

Figure 10. Breakdown of the adult population by tobacco consumption



As for **alcohol** consumption, most of those interviewed hadn't consumed alcoholic beverages during the last 12 months, only 37% answering affirmatively to this question. However, evidence shows that they start drinking very early – between the ages of 12 and 14. For men the starting ages is earlier (around 13 years old) when compared to women (16). However, those in the 30 to 44 age bracket started drinking later than those in the 16-29 and over 45 groups.

Figure 11. Breakdown of the adult population by alcohol consumption



As for **television viewing**, most children (82%) watch television regularly - between 1 and 2 hours per day. This is especially the case for girls between 10 and 15. This could be because boys prefer other types of entertainment such as football and girls spend more time at home.

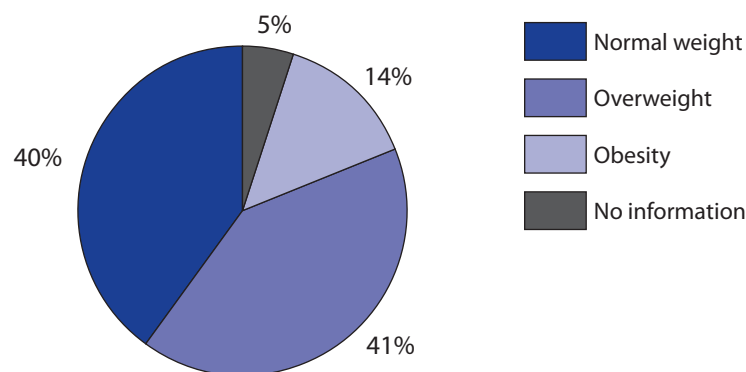
Most of the Roma population (78.4%) engages in little or no **physical activity** during free time. 33% of those interviewed does not take any type of physical exercise and only 45.4% occasionally engage in physical activity or sport. Children have higher levels of physical activity than the over 16 population. This may be because children are still in school and have physical education as part of the school curriculum. In the older age groups there are a small number of individuals who engage in physical activity or sport.

As for **nutrition**, breakfast foods typically consumed by Roma consist of a combination of bread/cereals (95.6%), coffee with milk (73.4%) or tea and milk (71.6%). Eggs, cheese, ham, bacon and sausages are foods that are not traditionally part of this meal (the same can be said of the majority population). Regarding the **type of foods consumed**, bread/cereals head the list (89.8%) as well as pasta and rice. However, few vegetables are consumed (18.3%), legumes (12.9%) and fish (3.4%). More meat (9.3%) than fish is eaten. The lack of vegetables, legumes and fish in the Roma diet may account for the incidence of diseases such as high *cholesterol* and *blood pressure*.

Table 3. Percentage of those surveyed who consume different foods

	Daily
Fresh fruit	16.4
Meat	9.3
Eggs	0.8
Fish	3.4
Pasta, rice	84.7
Bread, cereals	89.8
Vegetables	18.3
Legumes	12.9
Ham	46.9
Dairy Products	38.1
Sweets	18.4

In terms of **Body Mass Index**, 41.4% of those interviewed is overweight, 39.7% are in the normal range and 13.7% are obese.

Figure 12. Breakdown of the Roma population by body mass index

There is a gradual tendency to put on weight as from age 16, the highest percentage (57.7%) coming from the over 45 group. Overweight leads to obesity which is frequently due to the eating habits of this population and the lack of daily physical activity.

A look at the main problems affecting Roma communities shows that deficient education, inadequate housing and exclusion from the labour market are important factors that influence the well-being and the quality of life of Roma populations. Bearing in mind the indicators⁶ scientifically set to identify health inequalities, it is plain to see that the Roma community's health status is poor when compared to the majority Portuguese population. Summing up, we would stress five elements which stand out in this diagnosis:

- Roma Communities experience poverty and social exclusion that affect their state of health. Respiratory diseases are particularly prevalent among Roma communities because there is a close relationship between these and poor housing conditions. It is therefore necessary to invest in intervention to bring about change in underlying⁷ conditions so that interventions are able to achieve intended results in the area of health;
- A lack of preventive practices (basically in areas such as family planning, gynaecological disease, dental health, etc.) as Roma communities conceive health as the absence of disease. Therefore, they

⁶ The indicators are as follows: mortality rate, morbidity rate, perceived health, health related behaviour, activity limitation and access to and use made of health-care services.

⁷ In 1985 the WHO defined underlying health conditions such as peace of mind, adequate nutrition, adequate housing conditions, participation in social life, etc.

only use health services in the presence of very dramatic symptoms and incapacitating consequences thus making it difficult to approach the concept of prevention;

- Lack of health education to modify behaviours and attitudes. Predetermined ideas prevail as regards one's body, illness, health and sexuality. This situation could be rooted in cultural customs and traditional habits which hinder behavioural change;
- Absence of healthy lifestyles, as for example, in the field of nutrition (inadequate food consumption, unbalanced nutrition) and a lack of regular physical activity which is reflected in the high percentage of individuals who are overweight and/or at risk of obesity. Thus, it is important to carry out training sessions on health education. These must be part of a process of information dissemination and people must be held accountable for acquiring the knowledge, habits and attitudes which contribute to health promotion and prevention.
- Finally, we would point out that there is a clear situation of inequality between the Roma population and the majority population. In addition to what has already been said, attitudes and health habits must change and this will only be possible with the contribution, involvement and joint work of Roma Community members and health care providers.

5. Recommendations for Action

Analysis of the main conclusions led to the identification of the Community's real needs and helped to outline a set of **action strategies** to put an end to health inequalities among Roma populations. However, it is important to underline that these strategies should be cross-cutting since Roma communities need a mainstreamed intervention (education, health, housing, employment, etc). They likewise need strategies to improve the access to and quality of health care through the gradual empowerment of Roma communities to take care of their own health and develop proximity and pro-active attitudes taking cultural diversity into account.

Thus the main action strategies are:

- **Studies and Research** – Before policy can be defined it is essential to become acquainted with the target population (in Portugal there are no sociological studies on these communities). This makes the phenomenon virtually invisible to the different decision making bodies and in terms of the instruments developed through existing social policies. Lack of information also leads to unsuited policy measures and actions aimed at social inclusion and the elimination of discriminatory practices. Roma populations have not been considered as a priority target group in the National Action Plans for Inclusion.⁸ Therefore, one of the first strategies is to conduct a diagnosis of the reality of the Roma community. Any intervention in these communities has to take their cultural, social and economic characteristics into account in order to obtain a deeper understanding of this population and consequently take more effective action. With regard to health, it is urgent to carry out studies to provide information on the needs and behaviours associated with health and the Roma community such as:
 - Specific studies on the incidence of HIV, DST, and hepatitis B and C, alcohol and tobacco consumption and other addictions;
 - Risk evaluation and behavioural studies;
 - Analysis of the factors that influence and make it difficult for these communities to access health care in order to define measures to overcome these barriers;
 - Monitoring of data regarding specific health issues affecting these populations.

⁸ Until 2008 the NAPsinc – National Action Plan for Inclusion did not consider the Roma Community as a priority target group

- **A Mainstreaming Strategy for the Roma Community** – It is important to define policies and more active social inclusion measures that are not confined to single and fractional policies and projects lacking continuity or that are unsustainable. Therefore, integrated and overarching policies addressing different areas are called for (education, health, housing, justice, employment and professional training, etc.) as part of a strategy targeting the Roma community. We are talking about the need for an integrated national plan for Roma communities that effectively facilitates access to basic goods and services and to the exercise of full citizenship. To this end the following measures can be defined:
 - Measures to promote access to education especially aimed at eliminating direct and indirect segregation or assimilation practices in schools;
 - Measures to promote better housing conditions and to end segregated and disadvantaged neighbourhoods with a high concentration of Roma population;
 - Measures to promote access to basic goods and services, specifically health care services;
 - Development of strategies to integrate the Roma community into the labour market through vocational training and follow up to monitor integration;
 - Awareness raising actions to “encourage” employers to hire members of the Roma community. The success of labour market integration must be “publicised” in order to end prejudice and raise the self-confidence of Roma community members and to show that labour integration is possible.
- **Fostering the Participation of the Roma Community** – It is important to support the participation of Roma community members in the design, development, implementation and evaluation of policy measures. We have to work with and not for the Roma community. Cooperation is essential for more effective action tailored to the needs and experiences of the target group. The Roma community must be active in its inclusion process. To this end we recommend involving Roma associations, local institutions and the Roma community in order to obtain a collective perception of health education.
- **Networking/cross-sector work, systematic and a continuous follow up of previously implemented initiatives** – Investment must be made in networking and cross-cutting actions. We must join forces and invest in networking involving stakeholders and institutions with broad experience in this area to promote the inclusion of cultural and ethnic difference and diversity. In this sense, the health area must always be present in the different initiatives and projects in order to gather specific data on Roma communities enabling work on important issues. In other words, this means that we should take advantage of the inter-sectoral collaboration of professionals from different fields through partnerships including the different health structures and sectors (Ministry of Health, High Commissioner for Health, coordination for the infection of the HIV/AIDS, Ministry of Education, Roma associations and other organisations that work with and for Roma communities).
- **Intercultural mediation** – Mediation is a resource bridging the gap between the Roma community and the majority society in order to promote constructive change in relations between the two. Cultural mediation in health services will make it possible to work with the Roma population on aspects related to health education and the proper use of health services. Therefore, it is important to continue to invest in the training of mediators to work in health care services.
- **Training in cultural diversity for health care professionals** – Proximity is a key element in effectively working with Roma communities and must be promoted between health professionals and these communities in an attempt to create trust and empathy with a view to eliminating prejudice and stereotypes. Therefore, it is important to carry out ongoing awareness raising work aimed at health care professionals through multicultural training. Issues to be addressed in this training should include respect for difference and cultural diversity and background knowledge of Roma culture. This is essential training for health professionals during their academic and professional lives in order to make health care provision compatible with Roma culture.

- **To identify health professionals to ensure follow up and establish a solid relationship** – With a view to creating trust, health care providers should be of the same gender as the patient in order to facilitate communication and avoid uncomfortable situations. It is also important to share experiences within health professional team in order to tackle the gender issue since some Roma women feel uncomfortable with male doctors.
- **Information and Public Awareness Raising Campaigns** – In this context the following actions may be developed:
 - Promote the credibility of services through guided visits supplemented by information brochures on the different health services in order to overcome the lack of knowledge between the Roma community and health services;
 - Carry out campaigns adapted to these communities involving their members both as key agents and target groups (use key community members such as women and Roma associations);
 - Involve associations, local institutions and the Roma community in awareness raising actions on health related issues;
 - Use health education to work on the following areas: oral and general hygiene, nutritional habits, accident prevention, the importance of check ups, the adoption of healthy lifestyles, etc.;
 - Create working groups/fora for reflection and debate among professionals in the social-health care sector who work with the Roma population with a view to reviewing professional practices and promoting access to health care services by this community.
- **Alternative means of information/dissemination** – Tailored material should be created for Roma communities to make sure that information is correctly understood and assimilated. Therefore, these strategies cannot be based solely on printed information since this community has low academic skills. It is important to use more appealing and understandable tools.
 - These materials/instruments should include the organization of different health services and medical specialities.
 - Provide easily understandable information on diseases, treatments and preventive practices, avoiding extremely technical language.
 - Draft technical documents suited to cultural diversity.
 - Install temporary mobile health units adjacent to Roma settlements in order to inform, guide and to create rapport and trust between health care providers and members of the Roma community.
 - Develop information initiatives targeting Roma communities on the mechanisms and operation of health services, explaining primary health care, what health services are available, access procedures, etc.
- **Measures for specific health areas** – In addition to the measures mentioned above, it is important to define other specific ones for some health sector areas. Following are some possible strategies:
 - **Family Planning:**
 - a. Organize sessions to reduce the number of teenage pregnancies while respecting Roma culture in relation to maternity, the use of birth control methods, the need for checkups throughout the pregnancy and cancer tests;
 - b. In gynaecological consultations it is important: i) that regular gynaecological diagnoses are made by a woman physician; ii) to pay attention to the caretaker-patient relationship; iii) to create an atmosphere conducive to trust and understanding; and iv) to respect cultural issues when it comes to sex and reproductive functions;
 - c. Information sessions on menopause since many women are unaware of this process, especially changes to their body/organism.

- **Child health:** Health education training sessions using games and entertaining activities in order to work on the following areas: the importance of vaccinations, oral and corporal hygiene, nutritional habits, accident prevention, etc.
- **Lifestyles:** Awareness Raising campaigns to adopt healthy lifestyles (balanced diet, physical activity, etc.) and the importance of prevention adapted to these communities with the help of Roma community members and health care professionals.

The fight against poverty, social exclusion and health inequalities that affect Roma communities “demand incremental policies/strategies. Policies must be tailored to the context where they will be implemented and to the people they target. In this context, social change takes place from one generation to the next, building up victories, recognizing and evaluating defeats and sometimes moving back two steps and starting all over again”⁹.

Bibliography

- Caritas de Aveiro; *Estudo de Caracterização Sócio-Demográfico das Comunidades Ciganas no Concelho de Aveiro*, 2008
- Castro, Alexandra; “Dos Contextos Locais à Invisibilização Política: discussão em torno dos ciclos de exclusão habitacional dos ciganos em Portugal”, in *Revista Cidades: Comunidades e Territórios*, nº. 15, Dezembro de 2007
- European Commission Against Racism and Intolerance; *Second Report on Portugal*, Adopted on 20 March 2002, Strasbourg, 4 de November 2002.
- European Commission Against Racism and Intolerance; *Terceiro Relatório sobre Portugal*, Adopted on 30 June 2006, Strasbourg, 13 February 2007.
- Instituto Nacional de Estatística, “4º Inquérito Nacional de Saúde – 2005/2006”, in *Destaque*, Agosto de 2007
- Instituto Nacional de Estatística, *Anuário Estatístico Regional*, 2007
- Rede Europeia Anti-Pobreza-Portugal; *Actuar com a Comunidade Cigana – Orientações para a Intervenção em Toxicodependência a partir dos serviços de assistência*, 1999
- Rede Europeia Anti-Pobreza-Portugal; *Guia para a Intervenção com a Comunidade Cigana*, 2007
- Rede Europeia Anti-Pobreza-Portugal; *Manual de Sensibilização para a Elaboração de Políticas de Inclusão Social das Comunidades Ciganas*, 2004
- Silva, Luísa Ferreira et al; “A Comunidade Cigana e o Etnocentrismo da Instituição Médica de saúde Comunitária”; in *IV Congresso Português de Sociologia*, Coimbra 2000.
- SOS Racismo; *Sastipen ta li – Saúde e Liberdade, Ciganos – Números, abordagens e realidades*; Lisboa, 2001

⁹ Sérgio Aires, in Prefácio, *Estudo de Caracterização Sócio-Demográfico das Comunidades Ciganas no Concelho de Aveiro*, Caritas de Aveiro, 2008

Analysis of the situation in Romania

Authors: Marius Wamsiedel & Cristina Jitariu

Scope and context

The report *Health and the Roma Community: Analysis of the Situation in Romania* is based on a descriptive and exploratory quantitative research project aiming to identify health conditions within the Roma community. The research should be used to identify policies to combat inequalities and improve the living conditions of the target group. The questionnaire gathered information about the characteristics of the Roma population (demographic structure, social environment, household, and education), self-perceived state of health, access to and use of medical services, use of medicines and lifestyle. The diversity of the questions allows for a better understanding of the overall health status of Roma in Romania and the difficulties they face in accessing health services. The inherent drawback of this approach is the partial or complete omission of some relevant phenomena for assessing the health status of Roma. For example, operational access to healthcare was based on three dimensions – the existence of health centers in the proximity of Roma settlements, the possibility of accessing medical services offered by these facilities and the effective use of such medical centers. However, the research failed to consider how effective these medical services are and insufficiently covered the limitations of medical insurance, discrimination faced and racism on the part of medical staff. These topics need to be addressed by future studies in order to get an even more accurate image of this phenomenon.

This research project was conducted as part of the project “Health and the Roma community. Analysis of the Situation in Europe”, and is implemented simultaneously in six countries through national organizations working to improve the living standards of the Roma community: Health of Roma Foundation in Bulgaria, Office of the Council for Roma Community Affairs (RVZRK) in the Czech Republic, EXFINI POLI in Greece, Rede Europeia Anti Pobreza in Portugal, The Roma Center for Social Intervention and Studies (Romani CRISS) in Romania, and Partners for Democratic Change (PDCS) in Slovakia. The project coordinator is the Fundación Secretariado Gitano (FSG) from Spain, which previously conducted similar research with the financial support of the European Union in the context of the Public Health Program.

The specific aim of the project was to collect real data concerning the health status of the Roma population and then to use these data to develop a general diagnosis of Roma health and to analyse research findings. The data gathered will likewise serve to develop strategies and recommendations to improve current policies.

Methodological aspects

The research was conducted on a representative sample of the Roma population in Romania (759 households). The questionnaire was administered through face-to-face interviews conducted at the respondent’s residence by a trained team of interviewers. Due to the lack of data regarding gender and age breakdown of the population, the research team decided to apply the questionnaire to every member of the household. Hence, information was collected on approximately 2616 persons. The entire team of interviewers was Roma so as to avoid reluctance or refusal on the part of respondents to speak openly and frankly.

Data was collected on 12 topics by means of the questionnaire: self-perceived health status and disease; accidents; limitations on everyday activities due to health problems; medicines used; visits to the doctor's office; visits to the dentist; hospitalization; use of emergency healthcare services; preventive health measures taken by women; social support; amount of physical activity and rest; and nutrition. During the process of adapting the international questionnaire to the specific characteristics of Roma communities living in Romania, the research team decided to eliminate a section assessing tobacco and alcohol use. Romani CRISS believes that such a topic requires a slightly different approach combining quantitative and qualitative research methods in order to correctly assess how much tobacco and alcohol Roma people consume and what the underlying reasons for that. The questionnaire contained 73 questions and was 15 pages long. In order to facilitate administration, it was divided into five smaller questionnaires, one of them intended to identify Roma households (the selection questionnaire), and the others to collect data about the subjects: the household questionnaire (H12, H13, H14, and H15), the personal file (H1-H7, H9, and H11), the questionnaire for minors (M1-M52), and the questionnaire for adults (A1-A73). The study may have had two limitations. In the absence of reliable information about the structure of the Roma population in terms of housing, we run the risk of including disproportionately few subjects living in poor conditions. The second limitation was the tardiness of the team conducting fieldwork in the Western part of the country, the number of surveys conducted there being fewer than initially foreseen.

Findings and recommendations

Perceived state of health

The sample gave a positive assessment of health status. 79.8% of the respondents declared their health to be either good or very good whereas only 4.6% considered they were in a bad or very bad state of health. Positive self-assessment of health status is a common trend in quantitative studies focusing on the Roma population. Similar previous research conducted in Romania (Cace și Vlădescu 2004:26, UNDP 2002:63), Bulgaria, Czech Republic, Hungary, Slovakia (UNDP 2002:63), and Greece (Trichopolou 2009:4) are consistent with our study in this respect. However, qualitative studies (in Romania, Fleck and Rughiniș 2008:88-103), as well as the analysis of objective indicators of health status such as life expectancy and infant mortality, contradict these self-assessments (UNDP 2002:64) and point to a series of structural problems preventing access to quality health services (OSI 2005).

The prevalence of optimism regarding health status in Roma communities from several geographical and cultural areas suggests a different cultural concept of health and disease. A report published in Spain revealed that "a large percentage of Roma conceive health as the absence of disease, and disease as an incapacitating phenomenon linked to death" (FSG 2005:13). A disease is not considered to exist unless it shows some clear symptoms that prevent the individual from undertaking daily activities or endanger his/her very physical existence. Once symptoms have vanished the person considers himself/herself healthy again. The World Health Organization takes a completely different approach to health based on Western thought. The WHO considers that "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."¹ Therefore, it is safe to say that a large percentage of the Roma respondents who claimed good overall state of health do not consider asymptomatic problems or ailments which do not interfere with the performance of daily activities as disease.

The health status identified by the respondents should be understood within the cultural context of the Roma population and compared with other indicators. Our research found that over half of the population age 45 and over, with no gender difference, suffers from disabilities or chronic disease; over 60% of adult men and women have cavities; one out of every two adults is either overweight or obese. Diet is unbalanced with consumption of meat, eggs and fish below the recommended levels, and most subjects perform little if any physical activity outside work. On the other hand, the study shows that the incidence of

¹ Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

disabilities and chronic diseases in the population age 5 to 29 is less than 4.2%; fewer than one out of every ten subjects suffered an accident in the preceding 12 months; medicines are widely used once a disease has been identified; and 96.5% of those surveyed made at least one visit to the doctor. In conclusion, respondents' optimism regarding their health status is partially justified; however, there are some important problems that need to be addressed in order to improve Roma health.

Lack of information

The study did not assess Roma access to healthcare information. Nonetheless, the answers given to some questions indicate a widespread lack of knowledge concerning the rights Roma people are entitled to within the National Health System, regardless of insurance. For example, 45.7% of the minors in the sample did not receive all the vaccines required by the National Immunization Program in spite of the fact that they are mandatory and provided free of charge. Moreover, half of them did not receive even one single vaccination. Children living in neighborhoods and areas isolated from towns were particularly at risk of not completing the required immunization program. In 9.1% of the cases, parents claimed they were not been aware of the immunization program. That percentage is likely to be higher if we consider that a further 9.4% of the minors didn't get the mandatory vaccines due to lack of economic resources. While there is an indirect cost associated with vaccinations (including transportation to and from the healthcare center and, in some cases, informal payments), it is safe to say that at least some of the parents in this category had not been correctly informed about the rights they are entitled to under the Romanian healthcare system. The parents of 47.9% of the children who failed to receive mandatory vaccinations claimed they forgot to go to the doctor's office. The high number of people in this category suggests that at least part of the responsibility lies with the authorities. The National Immunization Program was unsuccessful in publicizing the usefulness of the vaccination program, the optimal period for completing it or the existence of mandatory vaccines provided free of charge.

Concern over health

Concern over health is difficult to define given the different concepts people have of health. For communities where traditions play an important role in the social life of the group, assessing concern over health should cover not only the attitudes and behavior of the subjects regarding modern methods of prevention, control and disease treatment, but also attitudes and behavior regarding traditional ways to stay healthy. It was beyond the scope of this study to look into the ideas and practices surrounding health, the traditional preventive and curative measures, the use of medicinal plants and thaumaturgical practices aimed at healing and avoiding disease (such as incantations and protection against the evil eye). This research project focused solely on the interest shown by members of the Roma community towards modern methods of prevention, control, and treatment of medical disorders. Concern for health was measured in terms of use of medicines, frequency of visits to the doctor and dentist and infant nutrition. Inevitably, we are dealing with an incomplete representation of interest taken in health.

62.8% of the sample had taken medicines in the two weeks prior to the interview and significant differences were observed in terms of gender and age brackets. Among adults, three out of four women and one out of two men had taken medicines and consumption increases with age. Those over 45 consume the most medicines (83.5%). The medicines consumed correspond to the symptoms identified by the subjects suggesting that in the Roma community health problems tend to be treated with drugs. As for minors who had to reduce their activity for medical reasons in the previous 12 months, 83% had sore throat, cough, cold, or flu, and 52.9% had fever. In terms of medicines consumed, minors most frequently used cold and flu remedies followed by antipyretics, vitamins, and minerals. One out of every five minors had taken antibiotics.

The study also proved self-prescription of drugs to be a widespread practice among Roma. One out of every two users of cold or flu remedies and six out of every seven antibiotic users take these drugs without ever consulting a doctor. The self-administration of drugs is practiced by minors as well as adults. Self prescription becomes prevalent at age 7. However, a methodological aspect should be mentioned here. The self-prescription rate was based on the use of medicines without a medical prescription but no information

was collected regarding the existence of a prescription obtained in the past for similar symptoms. From the information collected in the study, it was impossible to identify the mechanism underlying the self-administration of drugs, the types of situations requiring visits to the doctor's office and the kind of situations where self-treatment is considered more appropriate or the degree to which prescribed drugs are combined with self-administered drugs. Self-administration of drugs (especially antibiotics) is potentially dangerous to users. The treatment could be inappropriate for the medical condition, the dosage could be wrong, it could interfere with the treatment of some other ailment and, in the case of antibiotics, can create bacteria resistant to treatment (Grigoryan *et al.* 2007:153).

Most subjects make at least one visit to the doctor each year. Only 2.3% of minors and 3% of adults declared they had never been to the doctor's office whereas 47.6% of minors and 29.1% of adults made at least one visit in the month prior to the interview. Most subjects went to the doctor for diagnosis or treatment (50.4%) or follow-up (31.6%).

Fewer people go to the dentist as compared to the doctor. 44.3% of the subjects declared they had never been to the dentist. Persons living in areas or neighborhoods isolated from towns and with poor health are most likely to have never gone to the dentist whereas those living in integrated areas with good health are the most likely to have made a visit to the dentist. In the three months preceding the interview, a higher proportion of minors than adults had gone to the dentist but, on average, adults made more visits than the rest of the population during the same period.

Concerning nutritional habits, breastfeeding is the most common form of infant nutrition. 98% of the children in the 6 weeks to 3 months age group were given only breast milk. After that age nutrition diversifies. 93.8% of the children 3 to 6 months old continue to rely on breastfeeding, but 54.7% are also given other foods. The World Health Organization recommends that "infants should be exclusively breastfed for the first six months of life to achieve optimal growth, development and health" (WHO 2009).

Two conclusions can be drawn from the use of medicines, visits to doctors and dentists, and infant nutrition: first, the Roma population displays a real concern for health; and second, this concern is not always expressed in medical terms.

Health problems

The study does not reveal any ethnic-specific pathology for the Roma population. Cardiovascular pathologies and nutrition-related diseases are the most common health problems among adults; children suffer from respiratory disorders. 4 out of 5 minors had to curtail their regular activities in the two weeks preceding the interview because they had throat troubles, cough, cold or flu; 1 out of every 2 minors had fever. In the same period, 57.6% of adults had headaches, 52.3% experienced bone, spinal cord, or joint pain and 34% suffered chest pain. Breakdown of symptoms by gender shows some differences. Bone, spinal cord, or joint pain was more frequently encountered among women; the same tendency was found for chest pain. On the other hand, a smaller proportion of the women in the sample showed symptoms related to the respiratory system and nervousness, depression or sleep-related troubles.

Improper nutrition and its immediate consequences and overweight and obesity combined with insufficient physical activity are major risk factors for the health of Roma in Romania. Subjects have a relatively varied diet but it is calorically unbalanced. Bread, cereals, and similar products are consumed on a daily basis by 86.9% of the population; the second category of food products in the ranking is pasta and rice which are consumed daily by 63.3% of the population. The heavy consumption of cereal-based products accounts for excess weight. The study also showed relatively low consumption of fish, eggs and meat leading to a deficit in animal protein, saturated fatty acids and phosphorus. These nutrients are important for the normal development of children.

Access to and use of healthcare services and facilities

The World Health Organization identified three dimensions characterising an efficient healthcare system: access, utilization, and efficiency. Access was defined in terms of availability, accessibility, affordability and acceptability. Utilization was the combination of access and personal health behaviour. Effectiveness was considered a function of several variables including efficacy, inputs (amount and quality of resources), quality assurance mechanisms (process of service delivery, provider performance), patient compliance and health behaviour, and external factors (environmental, biological, social, etc)." (HSPA: 126)

Our research focuses especially on access to and use of health services. To this end, the following indicators were used: the existence of medical centers serving the population included in the study; the time it takes to get to and from healthcare centers; and the likelihood of getting an appointment. The existence of medical insurance or access to the services it provides (for those receiving benefits without having to pay the cost of the insurance such as children, the unemployed and the retired) is a meaningful way of assessing access to healthcare. However, the way the question related to insurance was posed makes it impossible to use in the case of Romania. The use of medical services is estimated based on the number and frequency of visits made to doctors' and dentists' offices, the use of emergency services and the rate of hospitalization.

The existence of healthcare centres to serve the population was assessed through the combination of two indicators: the number of persons who made visits to the doctor and the average time it takes to get from one's home to the medical center. Only 2.8% of the population had never been to the doctor, the percentage being higher in the case of people living in shanty towns. The average access time to a medical facility is about 30 minutes and the most common response from subjects was 20 minutes.

Regarding appointments, out of the 178 subjects who did not receive medical care in the previous 12 months despite needing it, only 6.7% mentioned the difficulty of obtaining an appointment as the cause. Another 10.7% mentioned that the waiting list was too long. It is worth noting that the absence of insurance and insurance benefits as well as lack of transportation have also been mentioned as obstacles in gaining access to medical services.

Based on subjects' responses, the medical infrastructure serving Roma communities is generally adequate and accessible. Despite this, the use of medical services is unbalanced, dental care facilities being used significantly less than general medicine services. 44.3% of those surveyed had never gone to the dentist and here an important distinction can be made according to housing. 78.5% of those living in neighborhoods and areas isolated from towns and with a poor state of health had never been to the dentist compared to only 35.5% of those living in integrated areas with a good state of health. The limited use of dental care facilities may be due to cost; most dentist offices are private and insurance only rarely covers dental work.

The economic barrier

It is impossible to measure the impact of economic level on access to medical services given that the questionnaire did not cover the economic status of the households and individuals. However, it is likely that scant economic resources translates into limited access to medical care. One out of every five subjects who needed health treatment in the twelve months preceding the interview but could not obtain it considered that either medical services were too expensive or they could not afford them. Another 47% did not go to the doctor because they lacked insurance or the insurance did not cover the services they needed. Moreover, the parents of 9.4% of the minors who failed to complete the immunization program claimed poor financial situation as the reason.

Recommendations

- 1.** Develop good practice guides for integrated community services with the involvement of all health system stakeholders: family doctors and their assistants, community nurses and Roma health mediators. The aim should be to swiftly and consistently meet the health needs identified in each community.
- 2.** Organize information campaigns and communication programs to modify behavior and encourage healthy lifestyles with emphasis on high priority problems and determinants of health. These campaigns/programs could have greater impact if addressed to younger people (including pre-school children), if ongoing (including all generations) and if they include elements of the target population's culture.
- 3.** Implement continuous training of healthcare providers working with the Roma community based on an accredited curriculum: community nurses and health mediators for Roma communities.
- 4.** Establish mobile medical services to address high priority public health issues: care for mothers and children (including immunization); screening for uterine cancer; medical assistance for the elderly or persons with disabilities, etc. These services should be established in remote areas, areas with a high number of uninsured Roma and areas with a shortage of qualified medical staff. Financial support for these mobile medical services could be provided by the Romanian Ministry of Health (infrastructure and personnel) and the communities (covering the utilization costs).

Analysis of the situation in Slovakia

Authors: Petra Szeghy & Miroslav Popper

Characteristics of the Roma population in Slovakia

In terms of demography, Slovakia ranks among countries with the highest proportion of Roma population. Different sources offer different numbers ranging from around 320,000 to 500,000 Roma living in Slovakia accounting for 8 to 10 % of the country's population. However, these data are only estimates because in Slovakia it is not possible to collect or maintain information specifically on Roma due to an unclear interpretation of laws regarding the collection of ethnic data. According to the most recent census done in 2001, only 89,920 Slovakian citizens declared themselves to belong to the Roma ethnic minority. Geographically, the highest number of Roma lives in Eastern Slovakia – approximately 60 %.

The Roma minority is characterized by different long-term reproduction patterns and permanent population growth. Also, life expectancy is lower than that of the majority population and mortality higher among both children and adults. The Roma population has a different age structure and a higher proportion of children and youth than the majority population. One persistent negative phenomenon is the considerable number of teenage mothers. Almost half of the Roma population in Slovakia is under age 18. In this context, the “youthful nature” of the Roma population will, in the near future, cause an increase of the relative proportion of Roma children in comparison to the majority population.

In Slovakia there are over 1000 Roma settlements. Around 150,000 Roma live in segregated places which are unfit for a proper lifestyle and have a negative impact on the health of the population. A significant number of these dwellings are not equipped with any utilities, they lack sewage and people living there encounter more difficulties gaining access to health care. The situation is even more complicated because government policy contributes to furthering this segregation by implementing the lower-standard apartment construction program with the vast majority of these apartments being built in remote areas removed from the majority population.

Key determinants of health no doubt include not only housing but also drinking water. In numerous settlements, there is just a single well serving all residents. Quality of water is not monitored regularly and people using the water often learn about its possible contamination only after infection spreads.

The main results of social and economic transformation that the Roma had to face after 1989 included loss of jobs for many of them - causing significant damage to the social status of this minority and deepening marginalization. To this day, large segments of the Roma population are long-term unemployed and the unemployment rate in some isolated settlements even reaches 100 %.

The major cause of unemployment is the extremely low level of education of the Roma minority. Under the current educational system as many as 12.4 % of Roma children fail in schools. Schools for students with special needs is a separate issue. Readiness for school tests and other performance tests do not take the social deprivation of Roma pupils into account and hence Roma students often fail those tests. It is not unusual to find children enrolled in special schools even though they have no physical or mental disability but are only socially disadvantaged.

Stereotypes and prejudice against Roma are a major factor influencing their status in society and leading to open and covert discrimination by the majority population. Attacks by right-wing extremists occur regularly and occasionally result in the death of the victim. Discrimination is often institutionalized. In addition to the above-mentioned housing construction program, there are recorded cases of police violence against Roma minority members. A great number of criminal offenses against Roma are evaluated by the police as attacks with no racial motivation. As a result of this policy, Slovakia ranks among the countries with a low official number of racially motivated criminal offenses.

Characteristics of the health care system in Slovakia

Slovakia has a mandatory public health insurance system where every person with an income and permanent residence in Slovakia must make monthly insurance payments for health care. The state makes these insurance payments for minors, students, the unemployed, welfare beneficiaries, the elderly and other persons specifically listed in the Health Insurance Act, Law 580/2004. Non contributory insured persons are provided with immediate health care.

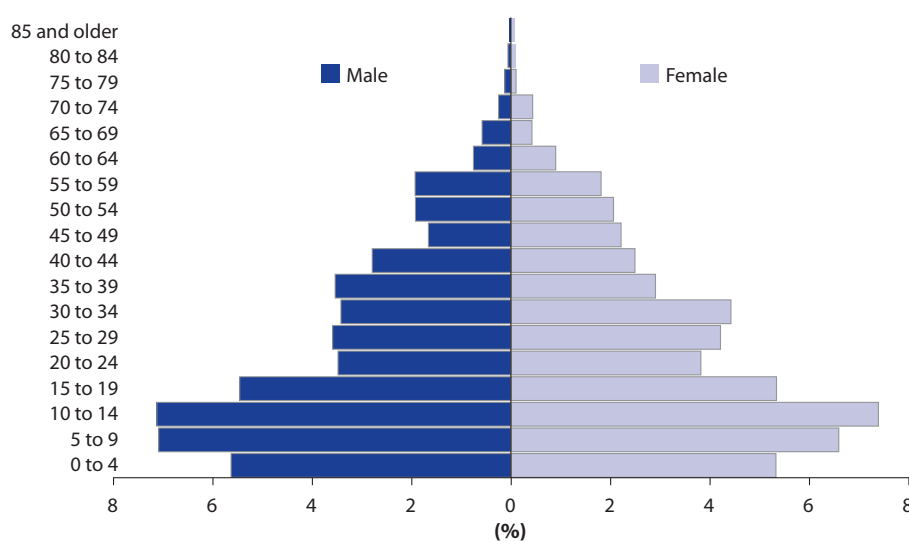
Under this insurance system, most health care procedures are provided free of charge. Visits to physicians, stays in hospital, and emergency health care are also provided free of charge. Drug prescriptions are charged at a rate of € 0.17 each, visits to emergency room € 1.99 each and transportation by ambulance € 0.07 per kilometer. Some types of medication are not covered in full by the health insurance company and in those cases the patient is required to pay the amount set by the company. Everyone age 18 and older is required to undergo a preventive health check-up every two years by a general practitioner and once a year by a dentist and women are required to see a gynaecologist once a year. In the case of pregnant women, examinations are required each month and once during the first six weeks following childbirth. Minors must undergo preventive health checkups once a year by a general practitioner and twice a year by a dentist (scope of the Health Care Act, Law No. 577/2004). In 2008, the national healthcare budget accounted for 5.05% of GDP (INEKO, 2009).

Research outcomes

Demographic indicators

Research outcomes confirm that the Roma population in Slovakia is relatively young when compared to the population in general both in regards to age structure and average life expectancy.

Figure 1. Age structure of the research sample of Roma population (N=3 760).



Housing

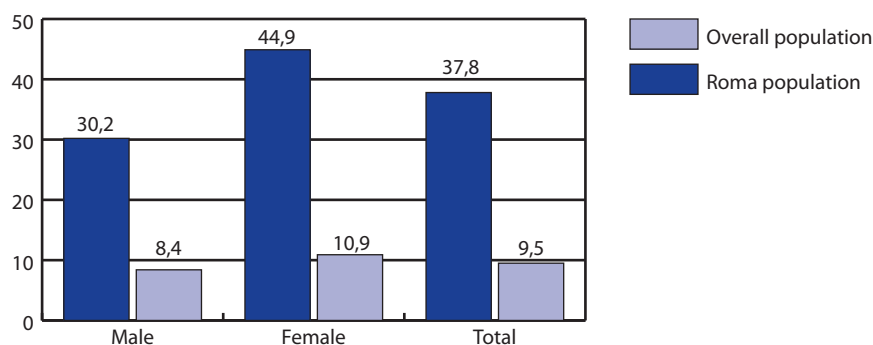
Research results showed that less than half (46.5 %) of the Roma community in Slovakia lives in standard housing conditions. The largest sub-group (47.3 %) lives in substandard housing or shacks (6.2 %). However, the pool of housing used by Roma (number of households) is mostly composed of standard housing units (52.6%). Sub-standard dwellings account for 42.4% and shacks for only 5.0% of the total housing pool. This difference in the figures means that, on average, a higher number of Roma individuals live in sub-standard housing units. Of the sample of households included in this research, 46.2% live in dwellings integrated in towns with good health conditions for their household members; 12.6% live in dwellings integrated in towns but with poor health conditions and another 25.7% of families live in dwellings isolated from the town but with good health conditions. The remaining 15.5% of the family units live in isolated dwellings with poor health conditions. Approximately three quarters of household members have access to a health care centre and less than one quarter face difficulties gaining access to a health care centre.

Employment

The most frequently reported main activity in the case of adults is temporary or seasonal employment including what is known as “activation work” (28.5%). Only 16.6% of adults have permanent work contracts.

While permanent employment was reported as the main activity by as many as 26.5% of men, among women this figure was only 7.2%. Taking care of the household was reported as the main activity by 18.6% of women but 0% of the men claimed this as their main activity. This finding underscores the traditional division of gender roles in the family and the patriarchal structure among Roma.

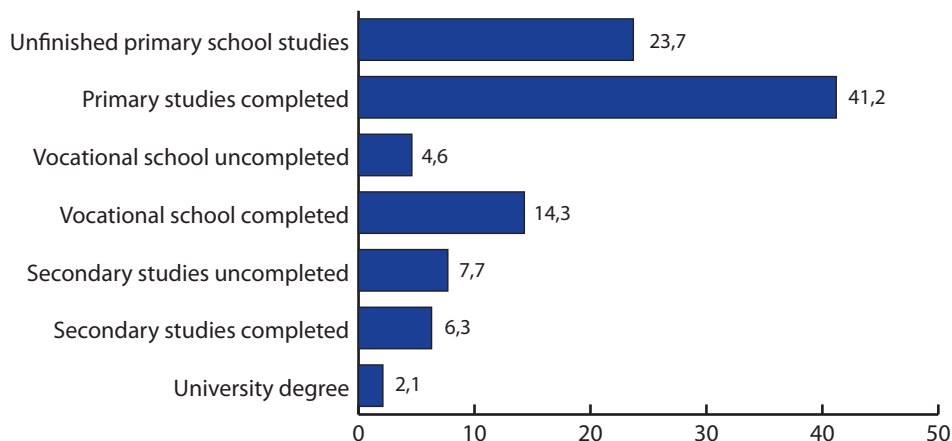
Figure 2. Comparison of unemployment figures for the Roma population and overall Slovak population in 2008 (in percentage points)



The above figures indicate the prevailing long-term trend of high unemployment among Roma. The difference between the Roma and general populations would be even greater if the unemployed also included those with seasonal employment performing “activation work” – accounting for 28.1%. This would bring the number to 65.9% which is closer to the estimates of 60 to 80% unemployment among Roma and 100% in some isolated settlements.

Education

Figure 3. Structure of Roma population (in percentage points) by completed level of education.



This table clearly shows the low level of education of the Roma population. The largest group among adults surveyed (41.2%) completed their primary education. Secondary education (passing final examinations) was completed by 6.3% of the population, technical vocational school by 14.3% and university by 2.1%. From these figures it can be inferred that only 22.7% of the population is able to engage in skilled labour, i.e. those having completed secondary education. Along with discrimination, low level of education among the Roma is the main cause of high unemployment and related negative effects such as poverty, social exclusion, extremely low mobility and poorer living conditions. Increasing educational levels is the key starting point in improving Roma living conditions.

Health condition and illness

Subjective perception of health status

The Roma population assesses its health condition more positively than the general population of Slovakia. Of the overall population, 23.1% perceive their health condition as “very good” while for the Roma sample this figure was 29%. The difference was even larger for those who assess their own health as “good” - 29.1% of the general population and 41.2% of the Roma population sample. Poor health was reported by 13.1% of the overall population and by only 8.1% of the Roma population. Since this self-assessment does not correspond to the reality as determined by experts, the two groups probably use different reference frameworks to evaluate their health condition.

Illness

The most frequent illnesses include hypertension (10.2%), migraines and headaches (10.3%), asthma and bronchitis (8.3%) and poor blood circulation (8%). Surprisingly low is the prevalence of diabetes (3.7%), which among the general population is in the vicinity of 8% (DG Health and Consumer Affairs, 2007) and is considered and underestimate. Overall morbidity appears quite low in contrast to the general population. For example, according to the MONIKA survey (Baráková, 2002) and the CINDI survey (Avdičová, 2005), as many as 30% suffer from hypertension, 10 to 72% from high cholesterol (depending on age) and 28.3 % from circulation disorders.

In some cases the prevalence of illness is gender-related: women suffer more frequently from migraines and headaches (14.7%) than men (4.8%), from arthritis and rheumatism 11.3% vs. 3.2% in men, from osteoporosis 6.2% vs. 2.2% in men and from diabetes 4.6% vs. 2.8% in men. Morbidity generally appears to be lower for men with a slightly higher percentage only in the case of heart disease.

In the case of young adults, illness is less prevalent among the Roma population than in the general population. As age increases, however, the health situation of the Roma community deteriorates and this is most

visible among the elderly. While the highest prevalence reported among the general population is 68% (EU SILC, 2006), this figure goes as high as 85.7% for Roma.

The relatively low prevalence of chronic disease found in this survey most probably does not serve as evidence of better health of the Roma population but rather of a lack of awareness of their own health condition and a large number of undiagnosed diseases. The prevalence we found is more like the tip of the iceberg than objective reality. Presumably, these were cases diagnosed in areas with better access to health care or cases where the diagnosis was made at an advanced stage of the disease on the basis of serious symptoms which made the patient decide to see a physician.

Limitation of everyday activity

Difficulties in performing common everyday activities are a reliable indicator of the health status of persons with assumed limited access to health care. As many as 26.1% of the respondents suffer from some health problem which limits their everyday activity in some way. Mild health difficulties were reported by 18.7%, relatively serious difficulties by 6.2% and very serious difficulties by 1.2% of the surveyed population. Difficulties were reported more frequently by women (mild 20.1%, relatively serious 7.2% and very serious 1.3%) than by men (mild 17.2%, relatively serious 5.2% and very serious 1.2%). Difficulties were more frequently encountered by adults (34.4%) than by minors (14.2%).

The prevalence of health problems and their severity increases with age among the adult population. Mild difficulties were reported by 25.3% of the respondents age 30 to 44 but by 43.1% of those between the ages of 45 and 64. Serious difficulties were reported by 20.2% of respondents age 45 to 64 but by 43.0% of the 65 and older group. Very serious difficulties were reported by 10.1% of the respondents from the oldest age category.

Limitation of the main activity

The fact that a relatively high proportion of the Roma population had to limit their daily activities for health reasons in the previous two weeks does not coincide with the subjective perception Roma have of their own health (generally positive) nor with overall morbidity results which are lower according to our research than for the general population (EU SILC, 2006). The reported results do correspond, however, with data on difficulties in performing everyday activities which are also relatively high. It would seem that the question on limitation of activity is a better indicator of the health status of Roma than the question on diagnosed chronic diseases or subjective evaluation of health condition.

In the two weeks preceding the survey interview, 19.1% of minors and 15.5% of adults had to limit their main activity for health reasons. Gender breakdown showed this to be the case for 14.7% of the men and 19.4% of the women. As for age groups, 21.6% of children aged 0-9 had to limit activities as did 22% of adults over 45. This presumably has to do with greater vulnerability to common illnesses in early and late phases of life.

Based on the analysis of the need to limit activities due to health problems it is safe to say that more attention should be paid particularly to persons at the early and late stages of life and to improving the health and social conditions of people living in lower-standard dwellings and in isolated areas with poor health conditions.

Consumption of medicines

As for the types of medicines used, children most frequently use pain killers and medicines to reduce fever (39.2%), cold and flu remedies (32.1%), vitamins and minerals (22.6%) and antibiotics (20.0%). Except for antibiotics, they often use these types of medicines without a doctor's prescription. There are no significant differences between boys and girls in the consumption of medicines. The proportion of children age 0-9 who use tranquilizers, relaxants and sleeping pills (7.8%), 2.6% without a prescription, was quite alarming. Sources of qualitative information such as interviews with Roma assistants indicate that this is a common practice used by some parents to calm children down when parents want a break from them.

Adults most frequently use pain killers and medicines to reduce fever (42.1%), cold and flu remedies (22.2%) and high blood pressure medication (15%). The most frequently used medicines without a prescription are pain killers and medicines to reduce fever (31.8%) and cold and flu medicines (12.6%). According to information from field health workers, Roma women especially use pain killers regularly and in large quantities. They solve their health problems exclusively with ibuprofen, panadol and other analgesics. Health education in this respect should make information available that such an approach is harmful.

As for gender differences, women use somewhat more medicines than men for nearly all types of illnesses. The greatest difference between women and men has to do with the use of antibiotics (women 14.8% and men 7%). There is also a significant difference in the use of antidepressants (women 4.9%, men 1.0%). The most important exception, however, is heart and artery problems for which men use more medicines than women (10.3% vs. 7.2%). Men also use more medicines than women to reduce blood cholesterol levels.

Eyesight and hearing

Problems with hearing were reported by 11.7% of those surveyed, 13.2% men and 10.3% women. The proportion of persons with hearing problems increases with age showing a significant jump as of age 45 where it rises to 25.8%. Sight problems were reported by 10.7% of the Roma population with no significant differences observed between men and women. Again, there is a significant increase in the incidence of sight problems as from age 45 reaching proportions of 26.8%.

A relatively large proportion of the Roma population suffers from hearing and eyesight problems which complicates everyday life but often these disorders or diseases are left undiagnosed and untreated. Direct screening of these diseases in the field is needed to improve this situation.

Accidents

Accidents in the preceding 12 months were reported by 11.1 % of the respondents which is in line with estimates for the general EU population (EU Injury Database, 2007). The highest number of accidents (13.9%) was recorded in the 10 to 15 age group. Incidence of accidents is somewhat higher for minors (12.3%) than adults (10%). Among adults there is greater difference between genders with accidents happening to men at a rate of 13.5% compared to only 8.8 % for women.

As for location, most accidents happen at home (38%) and outdoors but not counting traffic accidents (33.8%). Traffic accidents, among the most serious and with the greatest consequences, affected only 7% of the Roma population. This number is low because more than one third of the survey sample lives in isolated dwellings where the risk of traffic accidents is virtually zero.

Dental health status

Regarding the frequency of visits to the dentist, 6.3% of adults and 10.6% of children age 10 to 15 do not ever visit the dentist. The causes of this situation should be given more attention, particularly considering that all children in Slovakia see the dentist twice a year as part of their mandatory schooling. The most frequent indicators of children's dental health include the incidence of cavities (approximately one half), tooth/teeth extraction (one quarter) and fillings (also approximately one quarter). Dental health is considered good for about one half of the children regardless of their age or gender. In adults, the most frequent are cavities (68.7%), extracted teeth (71.4%) and tooth fillings (60.4%). Almost half of all adults have lost one or more teeth. Only one third of the respondents have all of their original teeth.

Access to health care

Visits to the physician

In terms of type of dwelling it is safe to say that the worse the housing standard, the lower the percentage of residents who sought health care over a span of less than one year meaning that people living in the lowest standard housing visit the physician least often. These data presumably indicate the existence of barriers between potential patients and physicians or that health conditions are being neglected or are seen as less important. The main barriers include: lack of money for transportation and sometimes the at-

titude of health care providers and of other patients towards Roma patients, particularly those who come from low standard dwellings.

Overall, health care facilities can be reached on average within 45 minutes. A more detailed look, however, shows, that while from the majority of locations health care facilities can be reached in approximately half an hour, an inordinately longer period of time is needed to reach a doctor for those living in isolated areas with poor health conditions (83.01 minutes on average). People living in areas with no health care facilities needed three times the time (99.21 minutes) to travel to the doctor compared to those living in locations with a health care facility (33.57 minutes).

Health care not provided

Overall, 3.8% of those surveyed did not receive medical care during the previous year when they needed it. This figure is higher than that corresponding to the general population of Slovakia where the problem of care not being provided affected 2.8% of the population (3.5% of the women and 2.0% of men, Eurostat 2009).

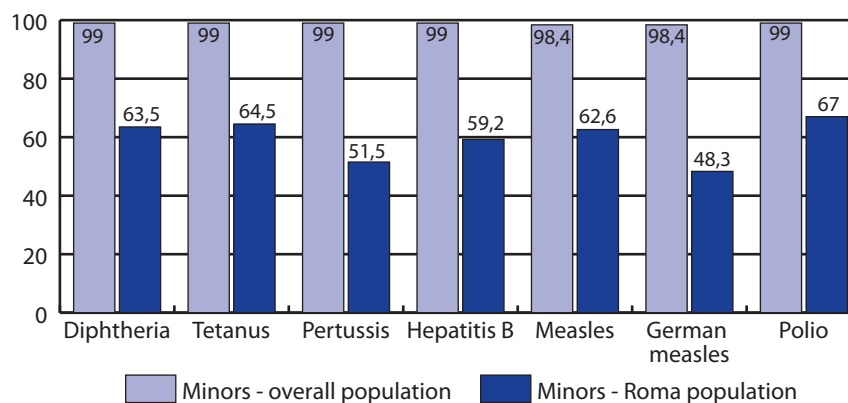
In terms of housing, the situation is worse for people living in isolated areas with poor health conditions where 11.6% did not receive care and for people from locations without health care facilities (7.6%).

The most frequent reasons for failing to receive medical care include lack of money (42.3%) and lack of transportation (15.4%). Lack of money actually refers to money for transportation or medicines since in Slovakia basic medical care is provided free of charge.

Vaccination of minors

A relatively high percentage of Roma children are not vaccinated in accordance with the official vaccination program. If we compare survey data with vaccination data for the whole of Slovakia in 2006, it is safe to say that the Roma receive significantly fewer vaccinations against basic diseases.

Figure 4. Percentage of vaccinated Roma children compared to other children in Slovakia in 2006 (World Health Organization Regional Office for Europe, 2009).



The vaccination program is the least effective in integrated neighbourhoods with poor health conditions (35.5%) but also in isolated areas with poor health conditions (21.1%) and in locations without a health care facility (25.8%).

Use of emergency health services

In the preceding year emergency room or ambulance services were used by approximately one quarter of those surveyed. Emergency room visits are most frequent in the case of minors age 0-9 (30.9%) and adults 45 and over (30%), i.e. the most vulnerable segments of the population in terms of age.

On average, emergency services are used by minors and adults approximately three times a year which is a relatively high number. Women use these services almost twice as often as men.

In terms of housing location, emergency services are used almost twice as often by people living in locations without health care facilities (35.1%) than by people living in locations with health care facilities (21.1%). Because areas without health care facilities do not create the structural conditions necessary for preventive and systematic health care, local residents probably visit physicians only after their health condition has deteriorated significantly.

Prevention by women

From the point of view of prevention, it is alarming to see the high percentage of women who have never visited a gynaecologist for reasons other than pregnancy (15.4%) or who have never visited a gynaecologist at all (8.7%). The situation is equally critical for two types of cancer screenings since such examinations are obligatory and must be performed regularly starting at a certain age. Pap smears (cervix cell samples) were performed on only about 20% of women over 30 and only 24.5% of women aged 45 and over have had a mammography.

Lifestyle

Tobacco consumption

The study showed more than double the proportion of daily male and female smokers in the surveyed sample as compared to the general population (HIS, 2004). Consumption of tobacco products exceeded the average by 50% in all surveyed age groups and in both genders.

Consumption of tobacco products is significantly higher in men (77.8%) than in women (52.5%). Relatively low tobacco consumption was reported for the over 45 age group where we find a higher proportion of ex-smokers. Men consume more cigarettes and begin at a younger age than women. On average, Roma begin to smoke at 17.09 years of age and Roma men smoke an average of 19.60 cigarettes a day while for women that figure is 15.23. The number of cigarettes consumed daily rises with age.

Consumption of alcohol

To the question of whether they had consumed alcoholic beverages at least once in the past year, 70.30% answered in the affirmative. Only 17.20% of men and 42.30% of women had not consumed any alcoholic beverages during the previous year. Considerable differences in consumption patterns were reported for men and women: about one half of the men (51.90%) consume alcohol most frequently during visits with family or friends, over one quarter in pubs and less than one fifth at home. On the other hand, women typically do not consume alcohol in pubs at all, only 13.60% drink at home and an overwhelming majority (82.70%) when visiting with family and friends.

Physical activity

According to this survey, most of the adult Roma population does not practice sports. Over two thirds of the respondents say they do not play any sport or take any exercise at all, one third do but only occasionally and only 1.1% on a regular basis. The situation is different for Roma children: 31.5% do not play any sport or take exercise at all, 31.5% do occasionally and only 10.7% practice sports regularly.

Normal daily physical activity for adults includes "walking, carrying some weight and moving frequently without any great physical exertion". The second most frequent answer given by men is "undertaking tasks requiring significant physical exertion" and by women "sitting for most of the day".

Television viewing among minors

Roma children watch too much TV. 93% of the children watch television every day. Children between 10 and 15 typically spend more time watching TV than the 0-9 subgroup. 67.2% of the older children (10 to 15) watch television for over 2 hours a day as opposed to 48.7% of younger children (0 to 9) and only 11.9% of children (total) watch TV for less than one hour per day.

Breast-feeding of Roma children

Roma mothers breastfeed their children more and longer than mothers from the general population. Over four fifths of Roma children receive mother's milk from 6 weeks to 3 months of age while this is the case for only two thirds of the general population. 37.3% of the Children age 3 to 6 months from the general population are nourished with mother's milk while this is the case for 62.7% of Roma Children.

Eating habits

The most prevalent foods are bread and cereals which are consumed daily by 86.5% of those surveyed. Less than half of the respondents consume pasta or rice every day. Approximately one third consume sweets on a daily basis, milk products or meat. Only about one fifth consume fruit each day and only about one seventh consume vegetables on a daily basis. Meat is consumed at least once a week by 65.6%, eggs by 64.5% and sausages by 57.5% of the respondents. The least preferred category is fish which is never or almost never consumed by 27% of the respondents.

53% of the children consume sweets daily and 28.9% consume them three times a week. Only 5.6% of the children eat sweets less frequently than once a week. Fresh fruit is consumed daily by one third of the children and vegetables by only 13.3%. Vegetables are consumed less than once a week by approximately one fifth of the children.

Conclusions and recommendations

The survey shows that the Roma population is not on a par with the majority society. The most critical areas of inequality are education, housing, employment, and health. As for Roma health, it is necessary to start systematically addressing several interconnected problems due to the complex nature of the issues. The causal chain begins with a low level of education giving rise to high unemployment, dependence on the social support/assistance system, and poverty. Due to a number of factors (segregation, discrimination, forced relocation and poverty), a segment of the Roma population lives in rural areas and on the outskirts of towns with poor infrastructure, often in conditions typical of temporary housing. This is how so-called Roma settlements have developed – isolated enclaves with no social mobility and where it is impossible for residents to overcome their condition of poverty and isolation and receive adequate education and subsequently raise their social status. It is therefore necessary to understand and to take the comprehensive nature and interconnectedness of the causes for the current situation as a starting point when formulating policies and creating strategies.

Almost all monitored indicators of Roma health clearly show that the greatest health problems (frequently viewed as less important) concern people living in lower-standard housing, in isolated and also in integrated locations with poor health conditions and in locations with no access to health care. People from these areas need greater support and assistance in order to improve their health.

With respect to health and health care, attention needs to focus particularly on the following areas:

Prevention – it is necessary to address the entire Roma population and work more systematically with the most vulnerable groups living in conditions that pose immediate risk to their health. These are people living in very poor quality housing (shacks) and/or in isolated areas with poor health conditions which are characterized by limited or no access to drinking water, i.e. safe water, no sewage and the ensuing low standards of hygiene. Within this population group, women, children and the elderly are particularly vulnerable.

Prevention should focus predominantly on these **areas**:

- 1. Environment:** In the case of marginalized Roma communities suffering from an unsuitable basic standard of living, remedies must be ensured in the form of active assistance and provision of missing resources. Any efforts to improve housing and infrastructure, if they are to be effective and have long term effects, require the direct involvement of the target groups thus increasing the responsi-

bility of Roma for their environment. An important starting point is the definition of social housing, development of a social housing strategy and tools for its implementation.

- 2. Information dissemination:** It is necessary to make easy-to-understand and easy-to-apply information on health available to the entire Roma population, including information on healthy lifestyles.
- 3. Accessibility to health care:** A situation must be reached where primary prevention prevails over secondary care, i.e. prevention of disease and health complications rather than having to address acute cases. To achieve this mental barriers must be broken down and fear and distrust of regular medical examinations must be overcome.
- 4. Elimination and reduction of the spread of infectious disease:** In addition to the above-mentioned structural changes, it is necessary to ensure that all minors are included in the vaccination program regardless of where they live or their ethnic background.
- 5. Limit misuse of medicines:** It is important to inform people about the negative impact of freely using prescription medicines and encourage them to go to a health care facility if symptoms develop.
- 6. Discrimination:** It is also important to introduce mechanisms for the effective prevention, removal and unequivocal punishment of all forms of discrimination in accessing health care and to raise Roma awareness of legal recourse and provide legal assistance.

To achieve these changes, it is important to take advantage of the potential of the target community, to address gender inequality and to lead discussions among experts and activists, governmental agencies and non-governmental organizations, Roma mediators and other relevant stakeholders at local and national level. It is equally necessary to create fora and initiate public discussions on health issues and problems. Last but not least, it is necessary to sensitize the majority society as to the needs and problems of the Roma minority.

The following recommendations are addressed predominantly to the Ministry of Health Care of Slovakia as the leader of needed measures. We believe that they will provide inspiration to all those involved in improving the standard of living of the Roma population and will serve as suggestions to the Office of the Government Plenipotentiary for Roma Communities:

- 1.** Based on the 2006 government program, "The Government continues to maintain resolution of Roma issues as its priority. For implementation, it will support all developmental programs designed to improve the lives of the Roma and the integration of the Roma community into society while using financial resources efficiently and in a targeted manner in the areas of education, culture, health and social care, infrastructure, and housing". This statement should also include reference to the creation of suitable conditions to solve the health problems of the marginalized Roma community. A balance needs to be struck between *de jure* and *de facto* conditions (i.e. between legislation and its real and practical implementation).
- 2.** An advisory body composed of experts dealing with Roma minority issues working in cooperation with relevant institutions must be in place to support more actively systematic solutions to remove inequalities against marginalized groups of population in gaining access to health care and to make health prevention programs more functional.
- 3.** Include the profession of health assistant in the catalogue of professions and increase the number of these workers to ensure ongoing and systematic work in locations with a high percentage of Roma population. When creating employment positions for health assistants, workers from the target community should be supported.
- 4.** Develop an action plan based on the health support program for disadvantaged Roma communities and ensure it is backed up organizationally and financially.

5. In cooperation with competent institutions, develop a system for the collection of ethnic data to allow for an accurate evaluation of the health condition of the Roma population. Support the implementation of research activities (qualitative and quantitative research) related to health with an emphasis on sexual and reproduction health. The goal should be to design higher quality and more effective programs to improve the quality of health of Roma women and men, to increase their awareness of planned parenthood and to provide health care without discrimination, including sexual and reproductive health services.
6. Find a way to encourage citizens, and particularly marginalized groups, to undergo regular preventive medical checkups and for minors to comply with the vaccination program e.g. by sending invitations to see the physician.
7. Develop a health support system (health care contributions) for socially disadvantaged groups with an emphasis on prevention and chronic and other diseases. There is a particular need to lend financial support to socially weak groups, particularly for dental and other services which require payments by patients.
8. In coordination with the Ministry of Education of Slovakia, a preventive and awareness-raising program designed to improve the health situation of Roma should be included in the school curriculum for socially disadvantaged groups. This requires the development of suitable methodological materials.
9. Develop a support system for physicians working in areas where there is a high concentration of marginalized Roma communities. This should be designed to encourage physicians to actively care for Roma patients by implementing educational and prevention-related activities directly in the field. Emphasis also needs to be placed on increasing marginalized groups' responsibility for their own health.
10. Create an effective, coordinated and functional communication system among the individual entities involved in providing services to marginalized Roma communities. The Slovak Office for Public Health and the regional offices for public health need to more effectively coordinate with non-governmental organizations and implement different health-related programs targeting Roma communities as part of the Roma Decade 2005 – 2015.
11. Support the development of accredited programs which focus on Roma health ensuring the continuing education of health care staff (physicians, health care professionals) through educational institutions and by developing supervision mechanisms (of physicians' attitudes towards patients).
12. Actively support cooperation between private and non-profit sectors in the sense of furthering corporate social responsibility by funding Roma health programs.

Sources

- Health Insurance Act no. 580/2004 and amendments and additions to the Health Insurance Act no. 95/2002 and amendments and additions to other legislative Acts.
- Medical Care Act no. 577/2004 on payments for services related to the provision of health care
- Institute for Economic and Social Reform: The Government Fulfils One Quarter of its Promises, 2009, <http://www.ineko.sk/> (access on 16th July 2009)

Analysis of the situation in Spain

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Introduction

The situation of the Spanish Roma population, in terms of health, was virtually unknown until now. Despite the importance of the Spanish Roma community, estimated to total approximately 500,000 to 700,000 people, it has been invisible in the National Health Surveys [Encuesta Nacional de Salud de España (ENSE)] that the Ministry of Health and Consumption, initially with the Centre of Sociological Research, and today, with the National Statistics Institute, has been producing in order to determine the health situation of the Spanish population as a whole.

In 2006, the first National Roma Health Survey took place, developed in the context of the Collaborative Agreement signed by the Ministry of Health and Consumption and the *Fundación Secretariado Gitano* (2003-2008). The questions included in this survey on the health situation and lifestyles of the Roma population in Spain as well as their use of health services coincide with the questions that the Ministry of Health and Consumption and the National Statistics Institute used in their National Health Surveys of 2003 and 2006. This has allowed, for the first time, a direct comparison between the health situation of the Roma population and that of the population as a whole in Spain.

The information obtained thanks to this survey will be of great use for the development of policies tending towards the reduction of the inequalities suffered by the Spanish Roma population in the area of health, and in order to facilitate its social inclusion.

Methodological notes on Spain's National Roma Health Survey, 2006

The analytical target of this survey is the totality of the Spanish Roma population (except the Roma population of the Canary Islands, the Balears, Ceuta and Melilla). After analysing different studies, adjusting and revising statistical methods, and correcting different deviations, the total size of the population was estimated at 667,987 Roma individuals.

With a view to achieving the objectives set, a questionnaire was devised for a total of 1,500 Roma individuals with Spanish nationality. Detailed information was collected on 1,000 adults and 500 minors (up to 15 years of age). Interviewed individuals also contributed information on their household and household members, so that in determined aspects information was obtained on 6,458 Roma persons.

As already mentioned, the elaboration of the questionnaire followed to a large extent the contents of the National Health Survey, with the aim of achieving comparable final results. The final questionnaire contained 217 variables structured into three blocs: households, youth (less than 16 years old) and adult population.

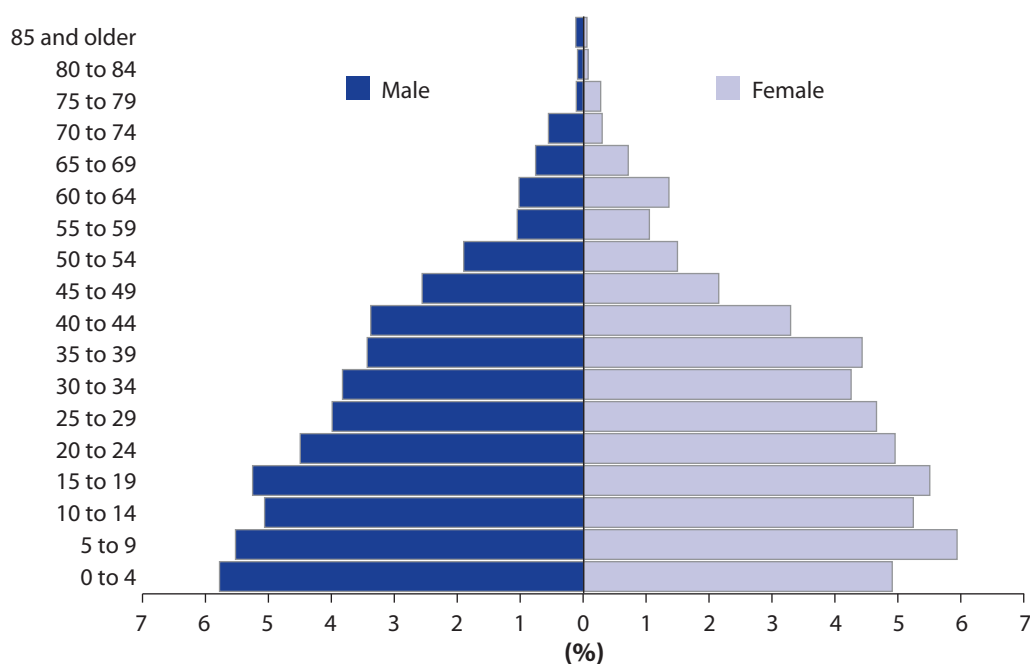
The fieldwork was developed for the most part between September and November 2006.

Characteristics of the surveyed Roma population

It is useful to describe the characteristics of the interviewed population in order to better compare the statistical data emerging from the respective surveys of the Roma population and of the general population in the National Health Survey, as well as the representativeness of the sample obtained in relation with the Roma population. On the basis of the situational data, we can observe if there is a high or low social distance between the target populations.

With regards to age distribution, the surveyed Roma population is significantly younger than the general population surveyed in the National Health Survey of 2006.

Figure 1. Population pyramid. Spanish Roma population. 2006



Source: Elaboration EDIS S.A, on the basis of the Roma National Health Survey, 2006

With reference to the distribution of the Roma population according to the type of housing and the location of the neighbourhood, normalised situations tend to predominate (normalised housing, in neighbourhoods with access to health services, integrated and in good conditions). Only 7% of the Roma population lives in sub-standard housing or shanty towns.

However, the surveyed population is concentrated in urban municipalities. 74% of the Roma population lives in towns of 25.000 or more inhabitants.

With regards to occupation, in the case of Roma men temporary contracted employment predominates, followed by self-employment, unemployment and retirement. In the case of Roma women, the proportion of women engaged in remunerated work is higher than that of women dedicated to non-remunerated household tasks. High unemployment rates affect both Roma men and women.

The surveyed population demonstrated a low educational level, in particular among women. 70% of Roma women did not complete their primary education, in comparison with 60.8% of men. The sample shows that 2.7% the population had higher education qualifications.

In the case of the youth, the most noteworthy fact is that 8.5% of the young population between 6 and 15 years old is not enrolled in schools.

Regarding the household, in the case of men, 68.3% of those interviewed are heads of households (“that household member who makes the largest contribution to the domestic economy, which sustains the said household”). Only 1.5% of men are husbands of the household head. In the case of women, 50% are spouses of the household head and 24.1% are household heads. Another frequent occurrence is that interviewed persons declare to be the son or daughter or the household head.

These figures are relevant to the extent that they allow an assessment of the type of Roma population included in the sample. In the absence of reference data for the population, it is impossible to estimate the possible bias of the sample. In any case, it seems that the sample consists primarily in an urban Roma population, in normalized housing, and constituting small households. The educational levels, the central role of the interviewees, the proximity of households to the nuclear model, the levels of occupational insertion all indicate, in addition to the indicators applied to the selection of the sample that a possible sample bias would tend towards a Roma population sample defined by indicators that are closer to those of reference population. This signifies that such a hypothetical, a priori bias would produce in any case an underestimation of the health inequalities affecting the Roma in Spain.

Summary of the findings of the comparative study between the National Health Survey of the Roma population and the general population and main recommendations

Health status

- Differences were observed in the comparison between the Roma population and the general population and these persist upon comparison of the results broken down by social class, level of education and type of housing.
- The percentages of some diseases and cardiovascular risk factors found in these surveys are higher for the Roma population than for the general population.
- Important differences were found in some of the comparisons drawn with the general population and in the case of some indicators this gap persisted even compared to the segment of the general population in a worse socio-economic situation (ENSE class V, households whose main wage earner is employed as an unskilled manual labourer) and increases considerably in comparison with social groups in a better socio-economic situation (ENSE social class I, administrative posts and professions associated with a full university degree).
- In the case of Roma women the study seems to indicate that they suffer more health problems in comparison to Roma men and when compared to women of the general population.
- Health differences between the Roma population and the general population are greater amongst the older segments of the population.

Table 1. Health status. Some noteworthy results:

Perception of health

- Only 10.5% of Roma women over age 55 describe their health as good or very good compared to 38.2% in the general population. In social class V this figure is 32.8% and in class I 59.6% for women of the same age.
- 33.4% of the Roma men over age 55 describe their health as good or very good compared to 52.3% in the general population. In the general population these figures are 44.6% for social class V and 73.2% of men in social class I.

Health problems

- Differences in health problems can also be observed depending on the type of housing or level of education:
 - Roma women who live in sub-standard housing or shanty towns have a greater tendency to describe their health as bad or very bad in comparison with those who live in standard housing. They likewise refer more frequently to problems such as hypertension, asthma, cardiovascular disease, hearing problems, dental problems (loose teeth), accidents and use of tobacco. They also show a greater tendency to have had to curtail their main activity or to have used emergency room services more frequently.

Differences are also observed among Roma men depending on their type of housing. Those living in sub-standard housing or shanty towns report a greater number of hernias, hearing problems, accidents, depression and other mental illnesses.
 - The Roma population with a higher level of academic studies have a better perception of their health status and are less inclined to hypertension, asthma, eye problems and tobacco consumption (the latter only applying to men).

In the case of women, higher academic level is also associated with less obesity and fewer cavities and more frequent preventive practices (mammography's and smear tests).
- Of the wide range of health problems studied in the survey (cholesterol, depression, stomach ulcers, migraine headaches, etc.), Roma over the age of 35 (both men and women) suffer these in greater proportions than the general population. In some cases this is also true of younger age groups as well. Examples:
 - 13.6% of Roma men report having high cholesterol levels compared to 9.6% from among the general population.
 - Migraines are more prevalent among Roma women and men (37.1% and 20.7% respectively) than among their counterparts in the general population (9% and 3.9% respectively).
 - 16.4% of the Roma women reported allergy problems compared with 10.9% of the rest of the population.
 - The depression rate for Roma women stands at 17.6% compared to 7.7% of women of the general population.
 - The asthma rate for Roma children is 13.3% compared to 5.4% in the general population.

Dental problems

- 54.6% of Roma men reported having cavities compared to 41.1% of men from social class V and 17% of the men from social class I. For women these figures are 56.3% (Roma population), 34.2% (class V) and 18.7% (class I).

Lifestyles

- A higher percentage of Roma women refrain from consuming alcohol and fewer smoke in comparison with Roma men and with the general population.
- According to ENS data however, Roma men smoke more both percentage wise and in terms of number of cigarettes and there are fewer non-drinkers in comparison with the general population. Also, Roma begin smoking and drinking at an earlier age than their counterparts among the general population.
- The percentage of overweight and obese Roma women is higher than for the general population.
- The Roma population (both sexes) is characterised by less healthy eating habits: lower daily consumption of fruit and vegetables, higher consumption of sugars and animal fats, less tendency to eat a complete breakfast.

Table 2. Lifestyles. Some noteworthy results:

Smoking

- Roma men smoke more than their counterparts in the general population (54.9% as opposed to 31.6%). 20.7% of social class I and 36.6% of social class V of the general population are daily smokers.
- The gap amongst youngsters is even bigger. 56.2% of young Roma between the ages of 16 and 24 smoke regularly as opposed to 30.5% from social class V and 12.4% of social class I. On average, Roma smokers begin at age 14.4 compared to age 17 among the general population.
- There is a lower percentage of Roma women who claim to smoke on a regular basis in comparison with the general population (14.7% compared to 21.5%). On average, Roma women smokers begin at age 16.7.
- Average tobacco consumption is higher for Roma men who smoke 20.8 cigarettes per day as opposed 16.4 among general population smokers. Roma women smokers consume the same number of cigarettes as women from the general population (between 13 and 14 per day).

Consumption of alcoholic beverages

- Roma men start drinking at an earlier age than men of the general population (age 16 compared to age 18).
- Roma women consume fewer alcoholic beverages than women from the general population. Roma men drink less wine on a daily basis than the general population and consumption of beer and other alcoholic beverages is similar. Survey data does not reflect volume of consumption and therefore no conclusions can be drawn in terms of risk behaviour.

Eating habits

- The percentage of Roma boys and girls who do not eat breakfast (5.5% and 8.4% respectively) is higher than for the general population (1% of the boys and 2.1% of the girls).

Exercise

- Data gathered on physical activity is insufficient to properly identify frequency and intensity and therefore it is not possible to determine whether exercise levels are suitable although significant levels of inactivity have been observed.

Overweight and obesity

- According to the ENS, 19.2% of under 18 Roma girls are obese. This percentage is higher than for general population social class V (10.1%) and four times higher than for social class I (5.2%).
- 35% of Roma men compared to 39.1% of men from the general population (not a significant difference) are within the recommended body mass index for adults (between 18.5 and 24.9 kg/m²). In contrast, this difference is statistically significant among Roma women (40.4% as opposed to 52% of women in the general population).

Access to the health system

Here we encounter two different situations:

1. Universal health care has meant an improvement in Roma population access to general medical services, hospitals, emergency rooms and access to medicines. The comparatively worse health status of this sector of the population sometimes implies more frequent use of these services in comparison with the general population.
 - The public health system absorbs the bulk of medical visits and hospitalisations of the Roma population.
 - The percentage of cases where the Roma population needed medical attention and did not receive it is very similar to that of the general population.
 - General medical checkups, however, are less frequent among the Roma population, the latter more frequently turning to physicians for the diagnosis or treatment of more acute pathologies.
2. Access of the Roma population is lower in the case of services not covered by the National Health System or prevention (as opposed to direct treatment of ailments): dental health, prevention practices among women, access to hearing aids or eyeglasses.

Table 3. Access to the health system. General medicine, hospitalisation, emergency room and medicines. Some noteworthy results:

General medicine

- 26.3% of Roma men had been to their general practitioner within the previous two weeks compared with 25% of social class V and 19% of social class I from the general population. In the case of women these percentages were 33.5% (Roma population), 39.6% (social class V) and 26.2% (social class I).

Hospitalisation

- 11.6% of the Roma men had been hospitalised during the previous year compared with 10.4% of the men from social class V and 8.3% from social class I.
- For women (with the exception of births): Roma population (12.2%), 10.9% (class V) and 5.4% (class I).
For older sectors of the population, hospitalisations of the Roma population double those of the general population.
- The percentage of hospitalisations grows very swiftly with age in the case of the Roma population.

Emergency room

- Of the Roma population under age 16, 29.8% of the boys and 40.4% of the girls had used emergency room services during the previous year.
- Use by Roma boys is lower than that of boys from the general population (38.6%)

Use of medicines

- The Roma population consumes more medicines than the general population: for example, 28% of Roma men and 42.9% of Roma women report having consumed medicines for pain and/or to reduce fever in the previous two weeks (compared to 14.7% and 24.9% for men and women respectively of the general population).
- The Roma population receives takes more prescription medicines than the general population.
- Self-mediation is a problem shared by the Roma population and the general population, especially when it comes to medicines for cough, flu, sore throat and bronchitis and those for pain or fever.

Table 4. Access to the health system: prevention practices among women, dental health, and access to hearing aids or eyeglasses. Some noteworthy results:

Prevention practices among women

- 25.3% of Roma women over the age of 16 have never gone to the gynaecologist compared with 17.6% of the general population (25.2% class V and 9.2% class I).
- A higher proportion of Roma women see the gynaecologist for some gynaecological problem. The percentage of women reporting that their last visit to the gynaecologist was due to some gynaecological problem is 30% in the case of Roma women, 20.8% for class V dropping to 10.2% for class I.
- However, a lower percentage of Roma women see their gynaecologist for regular checkups, this being the reason for the most recent visit to the gynaecologist in 44.2% of the cases of Roma women, 69% for class V and 84.2% in the case of class I.
- Mammography's are recommended between the ages of 50 and 64. Of Roma women over the age of 55, 59.2% had had a mammography compared with 72.1% of women from the general population.
- As for pap smears, 47% of the Roma women had undergone the test compared with 52.4% of the women from social class V and 81.1% from social class I.

Dental health

- 49.5% of Roma boys and 51.4% of Roma girls have never gone to the dentist compared with 39% and 38.4% respectively among the general population.
- Dental work such as extractions, fillings, caps, bridges or false teeth is less frequent among the Roma population in the case of women and men and children and adults. For example, 42% of Roma men report having fillings compared with 43.8% in class V and 71.6% in class I.

Sight problems, with correction (glasses or contact lenses) if applicable

- 14.2% of Roma men report vision impairment compared to 3.7% of the general population (4.5% of class V and 2.4% of class I).
- The figures for women are 19.7% (Roma population) compared to 6.6% (general population). In the general population, the percentage varies from 9.4% for women from class V to 3.7% for class I.

Hearing impairment, with correction (hearing aid), if applicable

- 42.8% of Roma men over the age of 55 reported hearing problems as opposed to 24.4% of the general population. The figures for women are 34.4% for the Roma population and 20.5% for the general population.

Principal recommendations for action

In some of the areas addressed in the survey, the gap between the Roma population and the general population can be reduced by refocusing health services.

Life-long health promotion, especially among children and adolescents

- Important health gains can be made if appropriate action is taken in the areas of: nutrition, exercise, tobacco and alcohol reduction, etc. The most profound changes will be brought about through comprehensive and long-term health promotion.

Disease prevention

- Preventive action for women:
 - Mammographies and pap smears at the prescribed age (via active recruitment).
 - Enhanced access to gynaecological services.
 - Improved monitoring of pregnancies.
- Cardiovascular disease:
 - Improve prevention and monitoring of cardiovascular risk factors (hypertension, cholesterol, overweight and obesity, lack of exercise).
- Sight and hearing impairments:
 - Facilitate access to eyeglasses and hearing aids to correct these problems.

Healthcare / health-care system

- Access to the health-care system:
 - Work towards health equality by decreasing existing barriers (accessibility) even though access is universal.
- Use of medicines:
 - Reduce self-medication (consumption of medicines without a physician's prescription) and over-medication (abuse of medical prescriptions) and improve follow-up of medicated patients.
- Dental services: Improve access

Particular attention needs to be paid to children both in terms of promoting health and health-care and preventing disease.

Public policies and intervention

Policies and actions should be devised to improve the situation of inequality facing the Roma population in some areas which were identified in this study and the inequalities observed among the lower socio-economic sectors of the population. Reaching these objectives would certainly be a major step forward in fulfilling the constitutional and legal commitment associated with universal health-care services. Strategies should adhere to the following steps:

1. Identify the different health services and needs of the Roma population and quantify inequalities in terms of care and the results they produce.
2. Design specific objectives to reduce inequality and attend to diversity in standard National Health System services. (Although special services are not needed, existing services *do* need to be adapted to accommodate differences.)

3. Adapt resources to cultural differences as needed and train health-care personnel in the art of inter-cultural mediation.
4. Implement active measures to guarantee that the Roma population benefits from the different health programmes (including active recruitment initiatives) when deemed necessary.
 - a. In this connection, enforcement of Law 16/2003 of 28 May 2003 on the Cohesion and Quality of the National Health System is called for.

“Article 3(2) – The Public Administrations shall focus health initiatives by incorporating active measures preventing discrimination against any population group for cultural, linguistic, religious or social reasons or because of special difficulty gaining effective access to the health-care services of the National Health System.
 - b. European Council Directive 2000/43/EC of 29 June 2000 on enforcement of the equal treatment principle for persons regardless of their racial or ethnic origin and the latter’s transposition in Chapter III of Law 62/2003 of 30 December 2003 is likewise applicable.

“Article 30. Affirmative action measures concerning racial or ethnic origin. To guarantee full equality in terms of racial or ethnic origin in practice, the equal treatment principle shall not preclude the maintenance or adoption of specific measures in favour of certain groups for the purpose of preventing or compensating for disadvantages suffered by reason of their racial or ethnic origin.”
5. Promote the collaboration and participation of the Roma population and their associative fabric in all intervention processes.
6. Promote inter-sectoral work and action.
7. Place particular focus on children, adolescents and young people and include the gender perspective in all interventions to reduce health inequalities in light of the greater prevalence of health problems amongst Roma women. Through these interventions, work should be done to make Roma men and women co-responsible as health agents

Following is a reminder of the “General Recommendations” included in the document compiled by the State Council of the Roma People, the Ministry of Health and Consumer Affairs and the Fundación Secretariado Gitano, regarding *Health and the Roma community* in 2008 and earlier years.

General recommendations

- *Participation of the Roma community in all intervention processes.*
- *Inter-sectoral work.*
- *Move forward and delve deeper in research.*
- *Train health-care workers to be sensitive to diversity.*
- *Foster intercultural mediation and peer education.*
- *Adapt teaching material and information-awareness-raising campaigns.*
- *Make headway in the universal offering of health-care benefits.*
- *Reiterate the importance of health in certain sectors of the Roma community.*
- *Steer programmes focusing on health and the Roma community towards mainstreaming.*
- *Stabilise programmes focusing on health within the Roma community.*

Partnerships for health

Improving the health of the Roma population implies the establishment of strategic partnerships with the National Health System throughout the entire country and with other institutions. This entails:

1. Including objectives focusing on the Roma population in the different strategies of the Ministry of Health and Consumer Affairs and the Autonomous Communities, specifically:
 - National and regional strategies to combat cancer, ischemic cardiopathology, diabetes, mental health, palliative care, strokes and chronic obstructive pulmonary disease;
 - NAOS strategy, i.e. action promoting healthy diet and exercise;
 - Domestic accident prevention plan;
 - National Drugs Plan;
 - Children's dental plan;
 - Initiatives to prevent alcohol abuse;
 - Actions to prevent smoking (see the NASTIS campaign run by GazKalo and the Regional Government of Navarre)¹;
 - Programmes facilitating access to sexual and reproductive health services.
2. Improving health information systems at local, regional and national level to raise awareness as to the health-care needs of the Roma population;
 - A periodic National Health Survey targeting the Roma population similar to the National Health Surveys (INE, MSC) in order to assess compliance with inequality reduction objectives. In order to guarantee the comparability of the results we would recommend coordination among those responsible for the two surveys (INE, MSC and the undertaking awarded the contract) in terms of the training of and instructions given to field personnel, agreements concerning dates, questionnaire changes and sample design.
 - Health information systems allowing for the detection of health-service problems attributable to inequality. For example, monitoring of population-targeted mammography programmes, active recruitment programmes, etc.
 - Implementation of sentinel and monitoring systems to report on health inequalities suffered by the Roma population.
 - Draw up communication and dissemination plans to address observed inequalities.
3. Coordinating action with other entities and action plans:
 - With the Directorate-General for Traffic Control to design specific strategies to prevent traffic accidents among the Roma population;
 - With the Ministry of Education and the regional departments of education to design schools which take stock of these results and promote health.
 - With the Spanish Network of Healthy Cities to incorporate the objective of reducing health inequalities affecting the Roma population.
 - With Spain's 2008-2010 National Action Plan for Social Inclusion and the 2008-2010 (2009-2012) Action Plan for the Development of the Roma Population.
 - With the Council for the advancement of equal treatment and non-discrimination of persons for reasons of racial or ethnic origin provided for in Law 62/2003 whose objective is the promotion of equal treatment and non-discrimination of persons for reasons of racial or ethnic origin in the area of health and others.

¹ Federation of Roma Associations in Navarre "Gaz Kalo" (2005), NASTIS campaign to reduce smoking. Pamplona: Regional Government of Navarre, GazKalo Federation of Roma Associations of Navarre.

Need for research

The study conducted does not contain sufficient information or does not allow for a direct comparison with the situation of the general population in certain areas which could be especially relevant for the health of the Roma population such as:

- Compliance with vaccination schedules;
- Nursing and child development;
- Frequency, amount and intensity of physical activity;
- Consumption of drugs and the dangerous consumption of alcoholic beverages;
- Experiences of discrimination in the use of health-care services;
- Social and cultural capital of the Roma population to maintain and enhance its health status.

The following additional research needs have been detected:

- Qualitative research: survey-based information can be supplemented through specific qualitative research on some especially relevant topics (concept of health, nutritional practices, perception of hazards and accidents, perception of the health-care system, communication/relationship between health-care personnel and the beneficiary population, medication, etc.).
- Monographic studies: owing to their synthetic nature, National Health Surveys cannot provide sufficient information on some topics and therefore supplementary information is needed through monographic studies (on the use of health services, on cardiovascular risk factors, drug consumption, sexual and reproductive health, nutrition, etc.).
- Complementary methodology: in National Health Surveys, the interviewee is the only source of information. However, in a more comprehensive study of health, lifestyles and access to health services, other sources of information are needed. In addition to those arising from the use of qualitative techniques already mentioned, specific research design can be included: based on diagnostic tests, indicators relating to the use of services, epidemiological monitoring systems, sentinel networks, etc.

Bibliography

- *Hacia la Equidad en Salud. Disminuir las Desigualdades en una Generación en la Comunidad Gitana. Estudio comparativo de las Encuestas Nacionales de Salud a población gitana y población general de España.* Madrid: Ministerio de Sanidad y Política Social, Fundación Secretariado Gitano, 2009.

Bibliography

- Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva: World Health Organization, 2008.
- *Health and the Roma Community*. Ministerio de Sanidad y Consumo y Fundación Secretariado Gitano. Madrid: Ministerio de Sanidad y Consumo, 2005.
- *Hacia la Equidad en Salud. Disminuir las Desigualdades en una Generacion en la Comunidad Gitana. Estudio comparativo de las Encuestas Nacionales de Salud a poblacion gitana y poblacion general de Espana*. Madrid: Ministerio de Sanidad y Política Social, Fundación Secretariado Gitano, 2009.
- Vicente, M^a Jose. *As Comunidades Ciganas e a Saúde: um primeiro retrato nacional*. Madrid: FSG, 2009.
- Wamsiedel, Marius. Jitariu, Cristina. Barbu, Simona. Cnab, Tiberiu. *Sănătate și comunitatea romă, analiză asupra situației din Romania*. Madrid: FSG, 2009.
- Ζαρόκωστα, Ευγενία. Τζάνας, Κωνσταντίνος. Τσεβά, Αγγελική. *Υγεία και κοινότητα των Ρομά: Ανάλυση της κατάστασης στην Ελλάδα*. Madrid: FSG, 2009.
- Nesvadbova, Libuše. Šandera, Jiří. Haberlova, Vera. *Romska populace a zdravi Česka republika – Narodni zprava*. 2009. Madrid: FSG, 2009.
- Popper, Miroslav. Szeghy Petra, Šarkozy Štefan. *Romska populacia a zdravie: Analyza situacie na Slovensku*. 2009. Madrid: FSG, 2009.
- Томова, Илона. *ЗДРАВЕТО И РОМСКАТА ОБЩНОСТ, АНАЛИЗ НА СИТУАЦИЯТА В ЕВРОПА ПРЕДВАРИТЕЛЕН НАЦИОНАЛЕН ДОКЛАД – БЪЛГАРИЯ*. Madrid: FSG, 2009.



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