



Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma  
MEM-TP

## ***ADDITIONAL MODULE 1. TARGET GROUPS***

### ***Unit 1: ETHNIC MINORITY GROUPS***

### ***INCLUDING ROMA AND SINTI COMMUNITIES, AMONG THEM THOSE WHO MIGRATE***

#### ***Guidelines***

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Migrants & Ethnic Minorities  
Training Packages



Escuela Andaluza de Salud Pública  
CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES



SERVIZIO SANITARIO REGIONALE  
EMILIA-ROMAGNA  
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## Unit 1. ETHNIC MINORITY GROUPS, INCLUDING ROMA AND SINTI COMMUNITIES, AMONG THEM THOSE WHO MIGRATE

### 1. Objectives and Methods

#### 1. Objectives and Methods

##### 1.1. Objectives

###### Objectives of the Presentation:

- To provide an evidence-based update on ethnic minorities' health.
- To identify major trends in the health status of ethnic minorities including Roma and Sinti communities, among them those who migrate.

###### Objectives of the Activity:

- To identify strategies for improving access to health care for ethnic minorities in your region / country, and prioritize these strategies according to their perceived relevance.

##### 1.2. Methods

Time	Objectives	Activities	Sources
30 minutes	<ul style="list-style-type: none"> <li>• To provide an evidence-based update on ethnic minorities health</li> <li>• To identify major trends in the health status of the Roma population</li> </ul>	Presentation	Projector, laptop, screen.
40 minutes	<ul style="list-style-type: none"> <li>• To identify strategies for improving access to health care for ethnic minorities in your region / country, and prioritize these strategies according to their perceived relevance.</li> </ul>	Activity in three parts: <ul style="list-style-type: none"> <li>• Presentation of the methodology</li> <li>• Small Groups: Nominal group technique</li> <li>• Plenary: Wrap up and discussion</li> </ul>	Projector, laptop, screen.  Cards, markers, flip chart, adhesive (spray), self-adhesive dots.

## 2. Presentation

**Slide 1** Title

**Slide 2** Outline on contents

**Slide 3** Introduction

The term "ethnic minority" covers a range of disparate groups. *This issue has already been addressed in Module 1. For the purpose of this training package in terms of health trends and*

*needs of ethnic minorities the discussion should be adapted to national contexts. Needs and frequent types of health problems of ethnic minorities are stressed in Module 2 and problems regarding data collection on ethnic minorities in Module 4.* Not all ethnic minorities in Europe are disadvantaged and very few are formally recognized by national legislation, but many ethnic minority populations around the world, including in Europe, are at risk of poverty and face discrimination. In terms of health trends and needs of ethnic minorities the discussion should be adapted to national contexts<sup>1</sup>.

Various criteria may be used to define an ethnic group in the following terms: ancestry or heritage (referring to genes or culture or both); region or country of origin; religion; language. Occasionally, indigenous or national groups may be legally recognised as vulnerable minorities.

Research investigating “ethnic differences in health” is usually based **either** on country of origin **or** self-ascribed ‘ethnic identity’.

1. These studies examine **migrants disaggregated according to their country of origin**. Such studies have the following weaknesses:

- They overlook the ethnic diversity which may exist in a single country of origin;
- They overlook ethnic groups (e.g. ethnic Chinese) which are found in many different countries;
- They exclude the *descendants* of migrants who are born in the host country.

Such studies often focus on migrants originating from a certain country or region who migrate to different European countries. Findings on their state of health are difficult to interpret. Because of post-colonial ties, a given migrant group may be familiar with the language and culture of one European country but not of others. The migration may have taken place in different periods and for different reasons. Health outcomes may be affected by the different conditions migrants experience in different countries, for example in the ease of accessing health care.

2. Other studies disaggregate populations in terms of **‘self-ascribed ethnicity’**: they ask respondents to choose the category they regard themselves as belonging to. One disadvantage of this method is that such self-ascriptions may not correspond to any ‘objective’ features of the respondent. However, from a human-rights viewpoint this is regarded as preferable to the imposition of ethnicity by someone else.

Only a few countries disaggregate health data by ethnic categories in this way, and they all use different sets of categories. The UK has a long tradition of this type of research: however, it is not known whether findings from the UK are generalisable to other European countries, where ethnic categories may seem to be similar but in practice have quite different meanings.

#### **Slide 4 Needs and frequent types of health problems of ethnic minorities.**

*This information can also be found in Module 2 Unit 1*

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<sup>1</sup> Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. (2015a). MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen. Available at: [http://www.mem-tp.org/pluginfile.php/619/mod\\_resource/content/1/MEM-TP\\_Synthesis\\_Report.pdf](http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf)

- **Mortality and life expectancy**

Death certificates are not a reliable indicator of the prevalence of specific illnesses, because the causes of death are often oversimplified.<sup>2</sup> A Dutch study<sup>3</sup> found that life expectancy was longer than for native Dutch in seven out of ten non-Western migrant groups.

In the UK two major triannual studies into maternal mortality showed that women in minority ethnic groups were at significantly greater risk than the majority population<sup>4, 5</sup>. In particular Black African and, to a lesser extent, Black Caribbean women had significantly higher mortality rates than White women. Potential causes for these elevated rates included the later engagement with maternity services, and migration trajectories and circumstances of some Black African women who may have been newly arrived refugees or asylum seekers. Furthermore, many migrant groups experience higher diabetes mortality. The research on migrant mortality from diabetes mellitus in several European countries, conducted by the University of Amsterdam as part of the MEHO project<sup>6</sup>, found that rates were particularly high in migrants from North Africa, the Caribbean, the Indian subcontinent and countries with a low gross domestic product (GDP).<sup>7</sup>

- **Non-communicable diseases**

According to literature Surinamese and Antilleans have a higher risk of Cardiovascular diseases (CVD) mortality compared to the native population in the host country, while Moroccans have a lower risk<sup>8</sup>. However, differences found depend not only on the country of birth, but also on the destination country; similar findings were reported both in the original MEHO study on CVD<sup>9</sup>, and in a later extension of the study<sup>10</sup>. Much research currently focuses on the complex interaction of factors which may underlie the higher risks of CVD among certain migrant and ethnic minority groups<sup>11</sup>

As with all health problems, cancer rates for ethnic minorities vary by destination country as well as by country of origin, possibly reflecting differences in the accessibility and quality of health services (including screening programmes) for such groups.

- **Communicable diseases**

Tuberculosis notifications rate are higher in foreign born population than in native born population in Europe<sup>12</sup>. In the WHO European countries the average percentage of all cases

<sup>2</sup> Bhopal, R. (2014). Migration, ethnicity, race, and health in multicultural societies. Oxford: Oxford University Press.p. 142.

<sup>3</sup> Mackenbach, J. P., Bos, V., Garssen, M. J., Kunst, A. E. (2005). Mortality among non-western migrants in The Netherlands. *Nederlands Tijdschrift Geneeskunde*, 149(17):917-23.

<sup>4</sup> Ge, L. (2007). Saving mothers' lives: reviewing maternal deaths to make childbirth safer - 2003–2005. London: CEMACH.

<sup>5</sup> Centre for Maternal and Child Enquiries (2011). Saving Mothers' Lives: Reviewing deaths to make motherhood safer: 2006–2008. *BJOG*, 118(s1):1–203.

<sup>6</sup> Migrant and Ethnic Health Observatory (MEHO). Website: <http://www.meho.eu.com/> (temporarily unavailable)

<sup>7</sup> Vandenheede, H. et al. (2012). Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *European Journal of Epidemiology* 27, 109–117.

<sup>8</sup> Ujcic-Voortman, J.K., Baan, C.A., Seidell, J.C., Verhoeff, A.P. (2012). Obesity and cardiovascular disease risk among Turkish and Moroccan migrant groups in Europe: a systematic review. *Obesity Reviews* 13, 2–16.

<sup>9</sup> Bhopal RS, Rafnsson SB, Agyemang C, et al. (2011). Mortality from circulatory diseases by specific country of birth across six European countries: test of concept. *Eur J Public Health* 22:353-9.

<sup>10</sup> Rafnsson, S.B., Bhopal, R.S., Agyemang, C., Fagot-Campagna, A., Harding, S., Hammar, N., Kunst, A.E. et al. (2013). Sizable variations in circulatory disease mortality by region and country of birth in six European countries. *Eur J Public Health*, 23 (4) 594 - 605.

<sup>11</sup> Bhopal, R. (2014, *op. cit.*),

<sup>12</sup> *ibid.*

that were found in people of foreign origin in 2008 was over 20%.<sup>13</sup> In some countries this was much higher<sup>14</sup>.

According to WHO Europe, “poverty and socioeconomic exclusion play a great role in the natural history of these infections. Exposure and transmission is accentuated in the poor, those who live in crowded and substandard housing, those with nutritional imbalances and those with limited education or access to preventive measures.”<sup>15</sup>

### **Slide 5 Live style**

According to literature<sup>16</sup>, there is a clear social gradient in smoking in the EU. A higher **smoking prevalence** is found in disadvantaged socio-demographic groups, whether defined by educational attainment, socio-economic status or other factors such as minority ethnic group. One of the mechanisms of the inequality in smoking might be difficulties in smoking cessation among these groups. Two studies from the UK<sup>17</sup> indicate a higher prevalence and difficulty quitting smoking among minority groups, although the variations in ethnic groups appear to be largely driven by variations in smoking among women.

- **Mental health**

A fundamental issue affecting research on the mental health problems of migrants and ethnic minorities is that **cultures vary in the way they conceptualise such problems**, the types that they recognise and the way distress and disability is expressed<sup>18</sup>. Whereas the presence or absence of physical diseases can be decided on the basis of objective biological indicators, psychiatric diagnosis has to rely on interpretation and judgement<sup>19</sup>. This involves taking into account relevant cross-cultural variations and the evidence base in this area is not well developed.

Depression and anxiety disorders, so-called “common mental illnesses”, are often hard to distinguish from “normal reactions to abnormal situations”. It is known that social disadvantage and lower SES are associated with depression, but it is not clear how many of the problems among migrants can be accounted for in such terms. Some studies<sup>20</sup> have shown that perceived discrimination or racism can increase rates of common mental disorders.

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<sup>13</sup> *ibid*

<sup>14</sup> More information is available in Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. (2015a ) Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen.

Mock-Muñoz de Luna C, Bodewes A, Graval E, Ingleby D. (2015b). Appendices I-VI, Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen.

<sup>15</sup> Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: Poverty and social exclusion in the WHO European Region: health systems respond. Copenhagen, WHO Regional Office for Europe

<sup>16</sup> Matrix Knowledge. Identifying best practice in actions on tobacco smoking to reduce health inequalities. European Union, 2014. Available at:

[http://ec.europa.eu/health/social\\_determinants/docs/2014\\_best\\_practice\\_report\\_en.pdf](http://ec.europa.eu/health/social_determinants/docs/2014_best_practice_report_en.pdf)

<sup>17</sup> Millward, D., & Karlsen, S. (2011) Tobacco use among minority ethnic populations and cessation interventions. *Better Health*; Karlsen, S., & Nazroo, J. Y. (2010). Religious and ethnic differences in health: Evidence from the Health Surveys for England 1999 and 2004. *Ethnicity & Health*, 15(6), 549-568. Cited in Matrix Knowledge. (2014)

<sup>18</sup> Bhugra, D., Gupta, S. (eds.) (2006). *Migration and Mental Health*. London and New York: Cambridge University Press.

<sup>19</sup> Horwitz, A.V., Wakefield, J.C. (2006). The epidemic in mental illness: clinical fact or survey artifact? *Contexts*, 5(1): 19-23.

<sup>20</sup> E.g. Karlsen, S. et al. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine*, 35:12:1795–1803

- **Maternal and child health**

Rates of stillbirth and neonatal mortality among groups of migrant origin also vary between different countries of destination, which may reflect differences between European countries in the accessibility and quality of health care for pregnant women in those groups.<sup>21</sup> With regard to screening for different types of cancer such as cervical and breast cancer, screening rates among different ethnic minority groups vary significantly.

Poverty often limits access to reproductive health services and health prevention and promotion programs (screening, diagnosis care, prenatal and obstetrical services), and thus increase the risk of adverse outcomes<sup>22</sup>.

The obstetric complications associated with female genital mutilation or cutting (FGM) also present challenges to health service providers. They require specialist knowledge about the potential health risks to mother and child, the legal and ethical frameworks surrounding this issue, and the most effective ways of meeting the health needs of the women subjected to or at risk of this procedure. This is in order to ensure qualified and effective preventive measures against FGM, and coping with the effects of the mutilation.

### **Slide 6 Descendents of migrants**

Integration outcomes of the children and later descendents of migrants can vary greatly. In a tolerant society it may be possible for them to create a 'bicultural' ethnic identity, maintaining ties both to their origins and to the host country. Alternatively they may maintain ties only to their own group, or only to the host society, or to neither. None of these outcomes is by definition 'good' or 'bad' for their position in society.

Unfortunately there is only a limited amount of research into the 'second generation' (i.e. the first generation of descendents of migrants, born in the host country). Most of it concerns the educational and employment outcomes of the children of the 'guest workers' who came to Europe in the 1960's and 1970's. Though some children in this group may show strong upward mobility and the average level of achievement is higher than that of their parents, the group as a whole remains disadvantaged in relation to the majority population. Rates of unemployment, for example, tend to be much higher than among majority youth.

There is however very little research available on the health of this group. Epidemiological studies using 'country of origin' as a proxy for ethnicity are by definition concerned only with migrants, while studies using self-ascribed ethnicity usually make no distinction between generations. Most research studies are therefore one-off surveys based on specially recruited samples. Patterns of health tend to reflect the social position of those studied. In some cases, health outcomes can be even worse than among the first generation. Other studies, however, contradict this picture with outcomes that may be even better than those of ethnic majority citizens.

Some of the main findings from available research<sup>23,24, 25,26</sup> are the following:

<sup>21</sup> Villadsen, S.F., et al (2010). Cross-country variation in stillbirth and neonatal mortality in offspring of Turkish migrants in northern Europe. *European Journal of Public Health*, 20(5):530–535.

<sup>22</sup> WHO (2010). op cit

<sup>23</sup> DASH Study - Determinants of young Adult Social well-being and Health (previously Determinants of Adolescent Social well-being and Health) <http://dash.sphsu.mrc.ac.uk>

<sup>24</sup> Veling, W., Selten, J. P., Veen, N., Laan, W., Blom, J. D. & Hoek, H. W. (2006). Incidence of schizophrenia among ethnic minorities in the Netherlands: a four-year first-contact study. *Schizophr.Res*, 86, 189-193.

<sup>25</sup> Selten, J. P., Laan, W., Kupka, R., Smeets, H. & van Os, J. (2011). Meer kans op depressie en psychose bij allochtonen. *Ned Tijdschr Geneesk*, 155.

- Blood pressure rose faster over time for ethnic minority children (UK).
- Adolescent boys from ethnic minorities tended to report better mental health despite coming from poorer families and neighbourhoods. Positive factors identified were caring parents, doing things together as a family and having friends from different ethnic groups (UK).
- Experiences of racism had a negative effect on mental health in all ethnicities (UK).
- Second generation of non-Western migrants are more diagnosed as “psychotic” than the majority population (Netherlands)
- Rates of risky behaviour in the second generation not always converge towards the rates found in the majority population. This is the case in alcohol consumption.
- In relation to smoking in men and overweight and physical inactivity in women rates of risky behaviour have converged. Male descendants who reported to be daily smokers were slightly higher than migrants in general, and significantly higher compared to the majority population. In adolescence, girls from some ethnic groups were more likely to be overweight than participants from other ethnic groups. Contributory factors included skipping breakfast, drinking too many carbonated soft drinks and not eating enough fruit and vegetables (UK, Netherlands, Denmark).
- Rates of physical activity were higher among all migrants compared to Danes, and among descendants aged 18-39, rates of physical activity were significantly higher.
- Considering self-perceived health, the older the migrants and their descendants, the greater the differences in perceived health when compared to the majority population (Denmark).

### **Slide 7 National ethnic minorities**

Research on **national ethnic minorities** is quite limited, in part due to the fact that many of these minority groups are not recognised and not all groups experience inequalities.

**The Sami**, an indigenous minority group in the north of Norway, Finland and Sweden however, has been the subject of numerous studies. Findings on self-reported health from the **project SAMINOR** (a population-based study of health and living conditions in areas with both Sami and Norwegian inhabitants in Norway) indicated that Sami respondents reported to be in worse health than Norwegian respondents, and Sami women more so than men. Additional findings included experiences of discrimination in encounters with health services (especially reported by Sami women), and language barriers.<sup>27</sup>

For the **Sami**, research has shown, that while their health differs little from that of the majority population, one significant risk factor is their livelihood, namely reindeer herding. This activity can be hazardous and leads to the observed higher rates of injuries from herding accidents.<sup>28</sup>

**Slide 8 Roma population** is much larger than any other ethnic minority in Europe (10-12 million). Roma, described by the Council of Europe<sup>29</sup> as “a mosaic of diverse groups”, are considered to have descended from groups which left Northern India around the 11<sup>th</sup> century and migrated westwards, reaching Europe at the end of the 13<sup>th</sup> century and spreading out in many directions. In most of the countries where they attempted to then settle they were

<sup>26</sup> Singhammer, J. *et al* (2008). Etniske minoriteteters sundhed. Partnerskabet for undersøgelse av etniske minoriteteters sundhed, Center for Folkesundhed.

<sup>27</sup> Hansen, K., Melhus, M., Lund, E. (2010). Ethnicity, self-reported health, discrimination and socioeconomic status: a study of Sami and non-Sami Norwegian populations. *International Journal of Circumpolar Health, North America*, 69.

<sup>28</sup> Sjölander, P. (2009). What is known about the health and living conditions of the indigenous people of northern Scandinavia, the Sami? *Global health Action* 4.

<sup>29</sup> Council of Europe (undated) Defending Roma Human Rights in Europe. <http://bit.ly/1nUJway>



subjected to systematic persecution, enslavement and exclusion, ‘ethnic cleansing’ and genocide.

Roma experience an extreme degree of social disadvantage and discrimination. UNDP Human Development Report <sup>30</sup>, “*the situation of Gypsy, Roma and Traveller groups must be seen as a scar on the human development record of European nations*”. Their disadvantage extends to the fields of education, health, employment, housing and political participation.

**Slide 9** The 2014 EC **Roma Health Report** included a part dedicated to data collection, which includes an overview of what actions countries and supranational bodies are taking to improve data collection on the health of Roma, followed by a series of recommendations for how to improve data collection and coordination.<sup>31</sup>

In terms of data collection on Roma communities in Europe many obstacles have been identified:

- In many cases legislation is being put forward as forbidding collection of ethnic data, despite international human rights entities disproving such interpretation and calling for the need for such data.
- Ethnic minorities may rather not self-identify (when there are such options in surveys) as of particular ethnicity to avoid stigmatisation.
- There is a lack of agreement regarding the terminology and definitions used when referring to Roma minorities.<sup>32</sup>

The greatest numbers of Roma within the EU live in Central Eastern Europe – Romania, Slovakia, Bulgaria, Hungary, and the former Yugoslavia. Less than 20% of Roma in Europe are nomadic. **Figure 1 EU member states with the largest Roma and Traveller populations**<sup>33</sup>

**Slide 10 Figure 2 Mortality and life expectancy**<sup>34</sup>

Using the average for the EU-27, the European Roma population has an average age of 25.1 in comparison with 40.2 for the non-Roma population.

**Slide 11 Figure 3 Population pyramids in Europe: Roma community and the European Union**<sup>35</sup>

Roma population is mirroring the decline in birth rate that took place in the European non-Roma population several decades ago.

**Slide 12 Roma Health Status**

Existing studies confirm that compared with the non-Roma population in Europe, Roma have poorer health. Roma populations in Europe are also frequently socially excluded, suffer discrimination and consequently face barriers accessing good quality housing, health care and

<sup>30</sup> Stewart K. (2010). Human Development in Europe. New York, United Nations Development Programme (Human Development Research Paper 2010/7)

<sup>31</sup> European Commission (2014). Roma Health Report.

[http://ec.europa.eu/health/social\\_determinants/docs/2014\\_roma\\_health\\_report\\_en.pdf](http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf)

<sup>32</sup> Kallayova, D., Bosak, L. (2012) Improvement of health services for Roma communities in Slovakia. In: Ingleby, D. et al (eds.) Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity. Antwerpen: Garant Publishers.

<sup>33</sup> OSF, 2010. No Data—No Progress. Country Findings. Data Collection in Countries Participating in the Decade of Roma Inclusion, 2005–2015. <http://osf.to/1uyswGX>

<sup>34</sup> Roma Health Report. European Commission, Health and Consumers.

[http://ec.europa.eu/chafea/documents/health/roma-health-report-2014\\_en.pdf](http://ec.europa.eu/chafea/documents/health/roma-health-report-2014_en.pdf)

<sup>35</sup> Roma Health Report. European Commission, Health and Consumers (2014) *op cit*

education. UNDP survey data from 2004 and 2012 on Roma show that<sup>36</sup>:

- *“One third of Roma respondents aged 35 to 54 reported health problems limiting their daily activities. (2011)*
- *Approximately 20 per cent of Roma respondents were not covered by medical insurance or did not know if they were covered. (2011)*
- *66 per cent of Roma said they could not afford prescription drugs compared to 29 per cent of the majority population. (2004)*
- *15 per cent of Roma children under the age of 14 are not vaccinated compared to four per cent of children from non-Roma households. (2004)”*

Other relevant data<sup>37</sup>:

- *The adult Roma population (over age 15) has a worse perception of their own health status than the general EU-27 population.*
- *44% of the adult Roma population has not completed primary school studies.*
- *Approximately 465,000 Roma over age 15 from Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain 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 (the unemployment rate in the Czech Republic is 41%, Slovakia and Greece approximately 33%).*
- *3.6% of the Roma population living in Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain 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*

### **Slide 13 Health determinants**

The WHO Commission on Social Determinants of Health (CSDH) regards processes of social exclusion as the major cause of health inequalities among migrants and ethnic minorities. In this context **health is not considered only as health care, but also includes disease prevention, health promotion** and efforts to address concerns in the wide range of health areas – i.e. nutrition, physical activities, alcohol, and tobacco – as well as in other policy sectors - i.e. employment, housing and environment<sup>38</sup>.

Even though there are substantial limitations in the comprehensiveness and quality of the available European or nationwide data on the Roma population, the evidence demonstrates that the Roma population has considerably shorter life expectancy compared to the non-Roma population<sup>39</sup>. Studies suggest that in some Roma groups, higher rates of infant mortality appear to be associated with poorer living conditions, housing, lower educational and labour opportunities, further exacerbated for migrant Roma.

<sup>36</sup> Kallayova, D., Bosak, L. (2012) *op cit.*

<sup>37</sup> Health and the Roma Community, analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain report. Fundación Secretariado General Gitano, 2009 Available at: [http://ec.europa.eu/justice/discrimination/files/roma\\_health\\_en.pdf](http://ec.europa.eu/justice/discrimination/files/roma_health_en.pdf)

<sup>38</sup> WHO Regional Office for Europe (2008). The Tallinn Charter Health Systems for Health and Wealth. Copenhagen, WHO Regional Office for Europe. Available at [http://www.euro.who.int/\\_data/assets/pdf\\_file/0008/88613/E91438.pdf](http://www.euro.who.int/_data/assets/pdf_file/0008/88613/E91438.pdf)

<sup>39</sup> Regarding Roma life expectancy years compared to non-Roma by country, data is available at *Roma Health Report*. European Commission, Health and Consumers (2014).

According to research, Roma have low levels of education and skills, often leading to long-term unemployment and increasing levels of poverty.<sup>40</sup> Roma generally lack adequate living conditions, with the most severely overcrowded accommodation reported in Slovakia and Hungary.<sup>41</sup> Many Roma are found to live in marginalised communities with limited access to basic services.<sup>42</sup> Roma children especially, face many barriers when trying to access health care.<sup>43</sup> The discrimination, racism and exclusion faced by this community is also a strong determinant of health. Based on these known factors, recommendations have been made for more integrated, multi-sectoral solutions.<sup>44, 45</sup>

Work towards addressing the social and economic exclusion lived by many ethnic minorities and especially the Roma, has focused on combating discrimination based on gender, racial or ethnic origin, religion or belief, disability, age or sexual orientation (e.g. the **Decade of Roma Inclusion**). Strategies to increase labour market participation and participation in social, cultural and political life are at the centre of European initiatives for social protection and social inclusion (e.g. the Treaty of Lisbon, from 2009, reaffirmed the importance of combating social exclusion and discrimination).

#### **Slide 14 Prevalence of major infectious diseases & immunisation uptake**

There is no country-level evidence of systematic collection on comprehensive data or evidence of Roma health status for the major infectious diseases. The available data indicates Roma are disproportionately affected by communicable diseases. This impact can be linked to:

- social determinants such as living conditions,
- limited inclusion in prevention programmes such as immunisation programmes,
- entrenched discrimination,
- health perceptions and life style.

Poor living conditions related to disease and ill health:

- At household level depends on poor condition of housing, overcrowding (more than 2.5 people per room), no indoor access to sanitation, use of wood-burning stoves.
- At camp/settlement level conditioned by presence of water stagnating because of ruined paving or inappropriate drainage systems, size of the camp (number of people; size of the camp/ square meters), camp overcrowding (less than 25 m<sup>2</sup> per person), presence of rats in the camp, lack of running water, sanitation, electricity heating, and prolonged stay in the camp.

*“Roma health literature focuses mostly on infectious diseases and genetic disorders as the major causes of differences in Roma health. However, it has been argued that ‘the focus on communicable disease may reflect less a concern about the health needs of the Roma but more those of the majority population’. Indeed, historically, Roma have been perceived and often*

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<sup>40</sup> Matrix Consulting (2014).

<sup>41</sup> *ibid*

<sup>42</sup> Kallayova, D., Bosak, L. (2012). Improvements of health services for Roma communities in Slovakia. In: Ingleby, D. et al (eds.) Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity. Antwerpen: Garant Publishers.

<sup>43</sup> Rechel, B. *et al* (2009). Access to health care for Roma children in Central and Eastern Europe: findings from a qualitative study in Bulgaria. *International Journal for Equity in Health*, 8: 24.

<sup>44</sup> *ibid*.

<sup>45</sup> Masseria *et al* (2010).

*stigmatised as a source of contagion. Poor hygiene and sanitation continue to be viewed to be the main causes of the relatively high rates of infectious disease in Roma”<sup>46</sup>*

The fact that Roma are far behind the vaccination level of the majority population is likely to be a result of more difficult access to general health services. Besides this there is also lack of information and awareness on the importance of vaccination. According to literature<sup>47</sup>, 28% of Roma minors in Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain 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. In 12% of the cases, the reason was a lack of economic resources.

The low levels of immunisation amongst Gypsy Traveller children are indicative of a range of factors shaped by their culture and lifestyle such as: (i) involuntary mobility as a result of eviction from sites, (ii) difficulties in registering and accessing GPs and, (iii) a lack of information regarding community health.

Evictions of Roma settlements has had, beyond all other negative impacts, a significant impact on the health of the population, as the organisation of healthcare and of public health actions became more difficult e.g. for those who have been diagnosed and are being treated for tuberculosis, there is no continuity of care resulting in poor compliance with medication and a lack of effective monitoring and follow up. This is a matter of great concern, since incomplete treatment can lead to multi-resistant TB and worse outcomes.

Regarding HIV, epidemic has severely impacted on some segments of this population with high prevalence of IVDU (Intravenous Drug Use). The percentage of Roma within new diagnoses of HIV infection has significantly decreased along the years, as IVDU has become a less predominant mechanism for HIV. The vicious cycle experienced by the Roma included persecution, less access to public services, lower educational levels and, consequently, increased crime rates. Thus the Roma population had an increased prevalence of HIV, TB, drug addiction and are more likely to be imprisoned<sup>48</sup>.

Research reports higher rates of infectious diseases such as measles and hepatitis A, as well as a higher risk of outbreaks of infectious diseases, especially amongst Roma living in segregated conditions. Available evidence on vaccination shows that, with the exception of Croatia, Hungary and the Czech Republic, overall rates of childhood vaccination uptake in Europe is lower or much lower in the Roma populations. The limited evidence existing related to rates of HIV/AIDS points to faster disease progression.<sup>49</sup>

More recent research in the area of communicable diseases has explored the health determinants that lead to higher rates of certain communicable diseases in Roma populations. These studies point to factors related to low SES and the living conditions associated with poverty, and other socioeconomic determinants such as access to health services, as possible

<sup>46</sup> Masseria et al (2010) The socio-economic determinants of the health status of Roma in comparison with non-Roma in Bulgaria, Hungary and Romania. European Journal of Public Health, Vol. 20, No. 5, 549–554. Available at <http://eurpub.oxfordjournals.org/content/20/5/549.full.pdf+html>

<sup>47</sup> Fundación Secretariado General Gitano (2009) *op cit*

<sup>48</sup> Handbook for Action in the Area of Health Services with the Roma Community. Fundación Secretariado General Gitano [2006]

<sup>49</sup> Matrix Consulting (2014). The Roma Health Report. Consumers, health and food executive agency.

explanations.<sup>50</sup> Research results strongly recommend the need for targeted preventive and care interventions to decrease the marginalisation that is found to lead to drug use and crime, and to improve the lives and survival rates of those living with infectious diseases.<sup>51 52</sup>

According to HCDCP<sup>53</sup> an increased number of hepatitis A cases have been reported among Roma since the beginning of 2013 in Greece. Reported outbreaks and clusters of cases mainly affect camps. The occurrence of new cases among Roma has continued in 2014. Another survey<sup>54</sup> suggests universal vaccination of Roma children and improving conditions at Roma camps as a cost-effective approach to address this issue.

An overview of affected groups by measles transmission in Europe in 2005–2009<sup>55</sup> identifies individuals susceptible to measles as previously uninfected and unvaccinated. The reasons for nonvaccination ranged from lack of information to poor access to health care. Roma and Sinti, Traveller and migrants among other groups have been identified as being particularly at risk. Public settings for transmission included mostly educational and health care facilities. Other research<sup>56</sup> documents the impact of mass immunisation in preventing further measles spread in the Roma community, and the surrounding population.

#### **Slide 15 Figure 4: Recent measles outbreaks among the Roma<sup>57</sup>**

#### **Slide 16 Prevalence of major chronic diseases**

Research into non-communicable diseases affecting the Roma is still quite limited. However, data suggest that the prevalence of cardiovascular disease, diabetes, asthma, hypertension and obesity is higher in the Roma populations than in the non-Roma.<sup>58,59</sup> In Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain 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<sup>60</sup>.

Some evidence reports links between these higher rates of chronic disease, and higher prevalence of risk factors (lifestyle e.g. diet, exercise, stress), poor access to and uptake of primary care and preventive health programmes among Roma.

<sup>50</sup> Casals, M. *et al* (2011). Incidence of infectious diseases and survival among Roma population: a longitudinal cohort study. *The European Journal of Public Health*, 1-6.

<sup>51</sup> *Ibid.*

<sup>52</sup> *Ibid.*

<sup>53</sup> Hellenic Center for Disease Control and Prevention (2014) <http://www2.keelpno.gr/blog/?p=5187&lang=en>

<sup>54</sup> Mellou K, et al. (2015) Considerations on the Current Universal Vaccination Policy against Hepatitis A in Greece after Recent Out-breaks. *PLoS ONE* 10(1): e0116939. doi:10.1371/journal.pone.0116939. Available at: <http://www.plosone.org/article/fetchObject.action?uri=info:doi/10.1371/journal.pone.0116939&representation=PDF>

<sup>55</sup> Muscat, MD (2011). Who Gets Measles in Europe?. *The Journal of Infectious Diseases* 2011;204:S353–S36 [http://jid.oxfordjournals.org/content/204/suppl\\_1/S353.full.pdf+html](http://jid.oxfordjournals.org/content/204/suppl_1/S353.full.pdf+html) (Retrieved 4<sup>th</sup> March, 2015)

<sup>56</sup> Orlikova H, Rogalska J, Kazanowska-Zielinska E, Jankowski T, Slodzinski J, Kess B, Stefanoff P. Spotlight on measles 2010: A measles outbreak in a Roma population in Pulawy, eastern Poland, June to August 2009. *Euro Surveill.* 2010;15(17):pii=19550. Available online: <http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=19550> (retrieved 4<sup>th</sup> March, 2015)

<sup>57</sup> Dinca, I. (2011) Vaccine preventable diseases and the Roma. European Centre for Disease Prevention and Control. <http://www.ecdc.europa.eu/en/press/events/Documents/1111-Dinca-Vaccine-preventable-diseases-and-the-Roma.pdf>

<sup>58</sup> Zeljko, H.M. et al (2013) Age trends in prevalence of cardiovascular risk factors in Roma minority population of Croatia. *Economics and Human Biology* 11: 326-336.

<sup>59</sup> Dobranici et al (2012).

<sup>60</sup> Fundación Secretariado General Gitano (2009) *op cit*

Gender and age play an important part, with **Roma women** experiencing a higher prevalence of some of these health problems than Roma men.

A number of studies again highlight the disproportionate **impact of the economic crisis** on Roma populations and its relevance to chronic disease risk factors.

As with other non-communicable diseases, there is a dearth of research into the **mental health** of Roma in Europe. Links have been suggested between low Socioeconomic Status (SES) of Roma and its negative impact on mental health, as well as the impact of discrimination and racism on mental health.<sup>61</sup> Some Roma suffer anxiety as a result of traumatic **war experiences** in the Balkan region, leading to mental health problems and psychosomatic complaints<sup>62</sup>. In terms of **prevention and care**, Roma populations' social representation of mental health and well-being (e.g. the importance of family and social network, are found to be of significance in the development and implementation of interventions.<sup>63,64</sup>

According to another Report<sup>65</sup>, 15% of the European Roma population in Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain has some sort of **disability or chronic illness** (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 in these countries 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.

### **Slide 17 Roma life styles**

- While data<sup>66</sup> on health lifestyles and behaviours among Roma populations are generally limited, the available evidence suggests that Roma have poorer health related lifestyles. Available data on diet and physical activity consistently suggest that healthy diet and physical activities to stay healthy are less common in Roma. Therefore Roma tend to have higher rates of illnesses associated with poor diet and stress.
- There is also a high frequency of eye and dental problems, which can be attributed to poor diet and malnutrition and access to adequate services and health promotion<sup>67</sup>. The most pervasive dental problem among the Roma population in Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain is cavities. 32.5% of the Roma population in the countries surveyed have never seen a dentist. 34% of Roma minors and 61% of the adults have cavities and 1/3 of the Roma population living in the countries studied (over age 15) has some vision or hearing difficulty (560,000 people)t. Hearing problems are most

<sup>61</sup> Skodova, Z. et al (2010) Psychosocial factors of coronary heart disease and quality of life among Roma coronary patients: a study matched by socioeconomic position. *International Journal of Public Health*; 55(5): 373-80.

<sup>62</sup> FRA (2013) FRANET Country thematic studies on the situation of Roma, Luxembourg, Publications Office Available at: <http://fra.europa.eu/en/country-data/2013/country-thematic-studies-situation-roma> )

<sup>63</sup> Monteiro, A.P. et al (2013) Promotion of mental health in Roma people: social representations of mental health and wellbeing in a Roma community. *European Psychiatry: Abstracts of the 21th European Congress of Psychiatry*.

<sup>64</sup> Smith, D., Ruston, A. (2013) 'If you feel that nobody wants you you'll withdraw into your own': Gypsies/Travellers, networks and healthcare utilisation. *Sociology of Health and Illness*, Vol. 35; 8:1196-1210.

<sup>65</sup> Fundación Secretariado General Gitano (2009) *op cit*

<sup>66</sup> Roma Health Report. (2014). European Commission, Health and Consumers. Available at:

[http://ec.europa.eu/chafea/documents/health/roma-health-report-2014\\_en.pdf](http://ec.europa.eu/chafea/documents/health/roma-health-report-2014_en.pdf)

<sup>67</sup> European Commission, Health and Consumers (2014) *op cit*.

prevalent (427,000 people)<sup>68</sup>.

- Tobacco use follows clear socio-demographic patterns and is becoming increasingly concentrated in lower socioeconomic groups; it has a strong association with lower levels of education. Smoking prevalence generally being high, with Roma tending to smoke more cigarettes and start at a younger age than the non-Roma population. 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<sup>69</sup>. Those living in caravans in the UK are more than twice as likely to smoke as the general population<sup>70</sup>.
- Available evidence on alcohol consumption and illicit drug use amongst Roma communities reports conflicting findings. The proportion of daily alcohol, drug users, and smokers is higher among Roma teenagers in Vilnius (Lithuania) and Ventspils compared to the general population of the same age<sup>71</sup>. According to other data<sup>72</sup> 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.
- Regarding **drug abuse**, consumption by Roma youth does not differ much from that of their counterparts in the general population. Still, poverty, segregation, low access to education, employment and health services keep them at higher risk. Prevention programs should propose alternatives for youth to experience positive effects associated to contexts of drug use (e.g. of peer group interaction) in healthy activities. Often legal status (for migrant Roma), lack of medical insurance or low school attendance exclude Roma youth from general prevention or health promotion programs.<sup>73</sup>
- **Migrant Roma** from Central or Eastern Europe often suffer from poor health, which further deteriorates during their stay as a result of poor living conditions.
- Evidence<sup>74</sup> suggests that Roma generally have a poor diet, most likely a result of poverty. Roma tend to eat fewer vegetables, consume less nutritional food and eat more fatty food. Poor diet and life style are believed to be the result of unfavourable socioeconomic factors including in the limited access to recreation and sport services and facilities. It is also associated to culture: the Roma population tends to prioritise short-term over long-term health considerations, whilst the prevailing health culture (education and promotion) might not be sufficiently diversity adapted nor reaching out, and, distrust of health professionals is also common.

<sup>68</sup> Fundación Secretariado General Gitano (2009) *op cit*.

<sup>69</sup> Fundación Secretariado General Gitano (2009) *op cit*

<sup>70</sup> Zenner, D., & Allison, T. (2010). Health of caravan park residents: A pilot cross-sectional study in the East Riding of Yorkshire. *Health & Place*, 16(2), 309-314. Cited in Matrix Knowledge (2014)

<sup>71</sup> Kanapeckiene, V., Valinteliene, R., Berzanskyte, A., Kevalas, R. & Supranowicz, P. (2009). Health of Roma children in Vilnius and Ventspils. *Medicina (Kaunas)*. 45(2):153-61. Cited in Matrix Knowledge (2014).

<sup>72</sup> Fundación Secretariado General Gitano (2009) *op cit*

<sup>73</sup> SRAP Network. Understanding drug addiction in Roma and Sinti communities. Available at: <http://srap-project.eu/files/2012/06/SRAP-Action-research-final-report-Long.pdf>

<sup>74</sup> European Commission. (2014). *Health and Consumers. op cit*



**Slide 18 Access to and use of health services and prevention programmes**

- Access and use of health services is of course not homogenous across the Roma populations in the EU countries, implying different impacts on Roma health and experience of health care. The level of marginalisation or integration of the Roma populations appears to be a crucial factor.
- Where data is available it provides sufficient evidence that there are numerous barriers to health care in the majority of countries. Evidence consistently suggests that barriers to access are closely linked to social exclusion factors, and specifically include the following factors:
  - a) **Language and literacy barriers** further affect the ability of migrant Roma to access health services; Roma who have recently arrived have little knowledge of how the health system works and the services available to them.
  - b) Use of health services is conditioned by **linguistic and cultural differences** as well as lack of knowledge of their entitlements concerning welfare related issues and available services.
  - c) Barriers to health care are rooted in experiences of **racism and discrimination** as well as a lack of understanding of Roma culture on the part of many health professionals.
  - d) **Mistrust** of health providers and personnel limits access to health services.
  - e) When access to social services requires residency registration, potentially represent a deterrent for both nomadic communities and sedentary Roma, due to the prevalence of **lack of documentation** in national Roma as well as, of course, for Roma migrants, including EU ones.
  - f) **Lack of a postal address**, having to **travel long distances** to visit their GP and evictions due to a lack of authorised sites.
  - g) **Lack of health insurance cards or ID documents, poor economic conditions** for countries without universal health care access. Non-insured Roma may have access only to emergency care but cannot use other health services.
- Evidence also shows that patterns of health care utilisation among Roma differs from the general population, for instance including higher levels of use of acute hospital services, perhaps as the result of lower levels of engagement with or access to primary and preventive care. Available data<sup>75</sup> shows that the most frequently consumed medicines both in the case of Roma minors and adults living in Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain 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).
- There is evidence that the economic crisis is disproportionately impacting Roma populations' access to health care.

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<sup>75</sup>Fundación Secretariado General Gitano (2009) *op cit.*



- Until 2014 Roma with EU citizenship from Romania and Bulgaria faced difficulties in being employed, therefore their situation has being particularly vulnerable.

### **Slide 19 Roma Culture and Health**

The health-disease process and care of ones body are culture-specific meaning that each group or cultural minority will have their own set ideas regarding this process<sup>76</sup>. Working with ethnic and cultural minorities entails gaining insight into the most important aspects of their culture because these will play a decisive role in the therapeutic process. Regarding Roma population there are several key cultural aspects which will influence the relationship with the health-care system in terms of the use of the services. Despite Roma diversity there is a series of commonly accepted elements that persist and form an essential part of the culture, orally transmitted mostly by Roma women.

Cultural identity is very important for Roma communities and the source of community self-esteem. Community support is a protection factor to individuals. This is especially evident in extended family support offering material resources and both physical and emotional care to face old age or disability.

Roma Cultural features affecting health and disease:

- Social organisation based on the extended family (e.g. when a member becomes ill, the entire family accompanies them in the process)
- Prevalence of the group over the individual.
- High value put on the spoken word which takes precedence over the written word.
- Respect for elders, who have an essential role within the community and are cared for at home. Older Roma have great influence on the younger members. Therefore it is essential to seek support from influential members e.g. to introduce changes in the lifestyle.
- Mourning affects social and labour activities and imposes rules regarding personal appearance and community life e.g. in terms of expressions of joy or entertainment activities.
- The deceased are very important, thus affecting reactions when informing of the death of a close relative or when ordering the removal of a corpse or calling for an autopsy.
- Worship: each church and pastor has a different influence on parishioners.
- As in most patriarchal societies women are responsible for care and treatment of illness.
- Overprotection of young women, who are prepared for an early marriage and to assume early maternity. Sex is sometimes viewed as taboo (e.g. impact in sexual education, family planning or prevention of gynaecological diseases programs)

### **Slide 20 Migrant Roma**

Roma migrants can be found in all EU countries. There are four countries with migrant Roma populations estimated to be 50,000 or above (United Kingdom, Greece, Germany, and Italy). France has an estimated population of 10,000-15,000 migrant Roma (2010). There are sizeable Roma migrants also in Belgium, the Czech Republic, Ireland and Spain although no actual estimates were identified. The largest group appears to be found in the UK, where estimates range between 50,000 and 1 million.

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<sup>76</sup> Based on Handbook for Action in the Area of Health Services with the Roma Community. Fundación Secretariado General Gitano (2006) Available at:  
<http://www.msssi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/handbookHealthServices.pdf>

Most migrant Roma within the EU are EU citizens from East/South East EU countries. EU Roma face the same restrictions to health care assistance as for other EU citizens. There are also Roma from former Yugoslavia and Turkey who face additional legal barriers. Regarding access to health it's important to distinguish among these two categories.

Migrant Roma may face discrimination as a result of their migrant status, their Roma status and/or both. As migrants, Roma risk receiving inferior health care compared to host communities as a result of administrative and language barriers. According to the International Organization for Migration<sup>77</sup> they face different health practices, lack of empathy and lack of cultural sensitivity of health professional. For irregular migrants, the situation is worst as in most EU countries these migrants can only access emergency health services with few countries offering primary or specialised care.

According to literature<sup>78</sup>, in all EU countries the availability of data regarding migrant Roma is even scarcer than in the case of national Roma minorities.

### Health of Roma Women

- Roma women play a key role within their community as educators, caregivers of children and the elderly, and the transmitters of the norms and values of Roma Culture.
- Roma women were reported to suffer more health problems in comparison to Roma men and non-Roma women. The data identified problems associated with poor uptake of gynaecological prevention services and health problems caused by work overload.
- Maternal health risks (i.e. early and late pregnancies, large families), and poor outcomes (i.e. miscarriage and still birth) are more common in Roma women.
- In Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain 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<sup>79</sup>.
- Evidence suggests that Roma women are at higher risk of domestic violence and associated mental health risks.
- Available evidence<sup>80</sup> suggests a range of barriers to improved health amongst Roma women, including expectations to fulfil traditional gender roles, limited educational and employment opportunities, physical and social isolation, and poor living conditions.
- The impact of education, demographic changes, information technology and urban life are contributing to intensify an ambivalent cultural transformation, reflected particularly in younger Roma, but also in women.
- The position of Roma women has improved in some countries as a result of lower birth rates, but also reported that they suffered more from obesity, depression, metabolic diseases, and sexual health problems, exercised less and had lower uptake of breast and cervical cancer screening.
- Mediation Programmes<sup>81</sup> appear to offer a potentially effective means to engage with Roma women about health issues.
- There is a significant evidence gap in the research around the health of migrant and undocumented Roma women. High ratio of medically uncontrolled pregnancies among

<sup>77</sup> Equi-Health project to address Roma, migrant health issues in Europe. Available at <http://www.iom.int/cms/en/sites/iom/home/news-and-views/press-briefing-notes/pbn-2013/pbn-listing/equi-health-project-to-address-r.html>

<sup>78</sup> Mock-Muñoz de Luna C, *op cit*.

<sup>79</sup> Fundación Secretariado General Gitano. (2009) *op cit*.

<sup>80</sup> FRA for the European Parliament. (2013). Analysis of FRA Roma survey results by gender. Available at: <http://fra.europa.eu/en/publication/2013/analysis-fra-roma-survey-results-gender>

<sup>81</sup> See Module 4 for information on Roma Health Mediation Programmes.

Roma women that have recently arrived is documented. Also complications such as miscarriages, in-utero foetal deaths and many other preventable complications.

### **Slide 21 Community-Based interventions with Roma population**

The *Bordernet project*<sup>82</sup> experience on training community leaders for prevention interventions selected models based on their innovative approaches for ethnic minorities in order to decrease the health risks and sexual risky behaviour at individual and community level. Some spotlights of the models` analysis are the following:

- Higher level of involvement of the communities is necessary in order to **mobilize** their **inner resources** and to trigger the process of change. Crucial for community development, including community self organization, is to strengthen these resources and enable the community to develop strategies to cope with the identified problem.
- Another central aspect is that every model/intervention is constructed in such a way that it is adequate to the community needs in order to be effective. It does not matter which community or group is addressed and which model is applied, but it is always important to **understand** thoroughly and correctly **the community norms before** starting the intervention. Whatever is offered, a training program or a community–based research programme, the **needs of the community have to be identified and met**.
- To find the appropriate stage of participation<sup>83</sup> that corresponds with the living conditions of the community and other social context factors as well as the participating persons is crucial. The aspect of participation is fulfilled through the members of the community who not only get trained, but are **involved in the planning and implementation** of the intervention and have therefore a role as **co-agents**. These members are not merely interested and motivated community members, but rather “experts” of their community and the life circumstances. They function as peer educators, leaders, mediators and peer researchers.
- From the perspective of community-based participatory prevention, the models have to address structural **health inequalities** by coordination and community mobilisation.
- One of most important aspects for implementing a model in any community is to **gain the trust**. Within Roma community, as well as with many migrant communities, obstacles include stigma and taboos related to diseases, e.g. the HIV taboo is the fear of many people to get tested and their bad experiences with health services. Often **internal barriers** like the socio-economic situation of the families in the community hinder the implementation as they really don't have the time to take care of their health and have other priorities.
- **Limited resources** of the community and/or a less developed community (e.g. high level of illiteracy, poor communication channels) are obstacles for implementation of any intervention.

<sup>82</sup> Antonova R, Lex S, Vassileva S, Salman R, Kalikov J, Blumberg S, Gangarova T, von Unger H, Dreezens-Fuhrke J. (2012). From Culturally Sensitive to Community-Based A Practical Manual on Effective Models of Participatory Community-Based HIV/STI Prevention in Migrants/Ethnic Minorities. Health and Social Development Foundation. Available at: [http://www.bordernet.eu/cms/media/uploads//31/32/Manual\\_WP8.pdf](http://www.bordernet.eu/cms/media/uploads//31/32/Manual_WP8.pdf)

<sup>83</sup> Wright M. T., Block M., Unger, H. (2012). The nine stage participatory model. Partizipation in der Zusammenarbeit zwischen Zielgruppe, Projekt und Geldgeber/in. In: Wright, Michael T. (ed.), Partizipative Qualitätsentwicklung in der Gesundheitsförderung und Prävention, Bern, 2010. Cited in Antonova R *et al.*

- It is crucial for the **long-term planning** to be aware that all the models are more or less time-consuming and time-intensive. **Funds** are a further important factor and therefore the available budget should be checked properly before starting the project.
- The question of effective application of the experience gained after the training should be central, as **sustainability of the results** achieved is often a common weakness of short-term projects. Sustainability of the participation of **peer educators, community leaders and mediators** has to be assured.
- Any intervention can be more effective and sustainable if it is part of a **broader concept of health promotion** that pays attention to legal, social and cultural factors.

## 2. Activity

### **Slide 22 Activity: Strategies for Improving Access to Health Care for Ethnic Minority Population Groups in Situation of Social Vulnerability**

The activity consists of three parts:

#### **1. Presentation of the methodology**

Method: Nominal group technique.

Moderation: 1-2 facilitators / group.

Materials: Cards, markers, flip chart, adhesive (spray), self-adhesive dots.

#### **2. Identification and prioritization of strategies for improving access to health care for ethnic minority population groups in situation of social vulnerability, in small groups (8-10 people)**

Technique:

- The participants are invited to write down the 3 most relevant strategies they identify for improving access to health care for migrant and ethnic minority population groups in situation of social vulnerability in their region / country (*one idea / card*).
- The facilitators collect the cards, reading and arranging the named aspects by topics on a flip chart.
- The participants are asked to prioritize the most important strategies (*3 dots / person*).
- The participants choose a rapporteur, in charge of summarizing the most relevant aspects in the plenary.

**Slide 23** Thank you and questions.

**Slide 24-26** References.

## 3. Recommended Reading

- Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015a. Available at: [http://www.mem-tp.org/pluginfile.php/619/mod\\_resource/content/1/MEM-TP\\_Synthesis\\_Report.pdf](http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf)

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