



# **Implementation of the National Roma Integration Strategy and Other National Commitments in the Field of Health**

## **ROMANIA**

**A multi-stakeholder perspective report on 2005–2014 developments**

The information and views set out in this report are those of the author and do not necessarily reflect an official opinion of the EC or IOM. Neither they nor any person acting on their behalf may be therefore held responsible for any use of the information contained therein.

Reproduction is authorized provided the source is acknowledged.

This Progress Report from a multi-stakeholder perspective on the implementation of the NRIS (National Roma Integration Strategy) and other national commitments in respect to Roma Health was undertaken by the International Organization for Migration (IOM) within the framework of the project “Fostering Health Provision for Migrants, the Roma, and Other Vulnerable Groups” (Equi-Health). The EQUI -HEALTH project is co-financed under the 2012 work plan, within the second programme of Community action in the field of health (2008–2013), by direct grant awarded to IOM from the European Commission’s DG for Health and Consumers (SANTE), through the Consumers, Health Agriculture, and Food Executive Agency (CHAFEA).

The Equi-Health project is designed and managed by the International Organization for Migration (IOM) Regional Office Brussels, Migration Health Division (MHD).

The Progress Report was produced under IOM MHD, RO Brussels guidance by Adrian Pana, and benefitted from peer reviews by Adriana Galan and Mariya Samuilova. We thank DJ Krastev for his copy-editing, proofreading, and general editing assistance.

A special note of thanks is due to Maria Voica and Mircea Mocanu of IOM Bucharest for their assistance in the preparation of this report.

IOM would like to express its gratitude to all stakeholders involved in this research, their active participation, knowledge, and experience which they generously shared.

IOM is grateful to local and project implementation partners involved during the National Consultative Committee (held in April 2013), for their personal and technical support. In particular, we thank staff and representatives of the Office of the Prime Minister, the Ministry of Health, the National Public Health Institute and WHO.

**CONTENTS**

- ACRONYMS ..... 5**
- EXECUTIVE SUMMARY ..... 6**
- 1. INTRODUCTION..... 9**
- Methodology..... 10**
- Challenges and limitations ..... 10**
- 2. OVERVIEW OF THE SITUATION OF ROMA IN ROMANIA ..... 11**
- 2.1. General information about Roma in Romania ..... 11**
  - 2.1.1. Poverty ..... 14
  - 2.1.2. Housing ..... 15
  - 2.1.3. Education ..... 17
  - 2.1.4. Employment ..... 19
  - 2.1.5. Local socio-development index (LSD) ..... 21
- 2.1. Data on Roma health ..... 22**
  - 2.2.1. Mortality..... 22
  - 2.2.2. Self-assessment of health status..... 23
  - 2.2.3. Limitations in daily activities ..... 23
  - 2.2.4. Health Risk factors..... 24
  - 2.2.5. Communicable diseases..... 25
  - 2.2.6. Non-communicable diseases..... 25
  - 2.2.7. Accidents..... 26
  - 2.2.8. Maternal and reproductive health ..... 26
- 2.3. Roma access to health-care services..... 27**
  - 2.3.1. Legal framework..... 27
  - 2.3.2. Medical insurance coverage..... 27
  - 2.3.3. Access to preventive services ..... 28
  - 2.3.4. Vaccination coverage ..... 29
  - 2.3.5. Access to primary health care and ambulatory services ..... 30
  - 2.3.6. Access to emergency services..... 31
  - 2.3.7. Access to hospital services ..... 31
  - 2.3.8. Access to dental services..... 33
  - 2.3.9. Access to medicines..... 33
  - 2.3.10. Spatial accessibility..... 34

2.3.11. Financial accessibility .....	34
2.3.12. Experiences and perceptions of discrimination on the grounds of ethnicity .....	34
<b>2.4. Policy framework with a specific focus on the NRIS .....</b>	<b>36</b>
2.4.1. European Union and Council of Europe Framework .....	36
2.4.2. Other relevant recommendations regarding Roma health (UN).....	37
2.4.3. National Roma Integration Strategies .....	37
2.4.3.1. Preparatory works .....	<b>37</b>
2.4.4. NRIS Budget and the use of EU funds towards health care .....	49
<b>3. EXAMPLE OF GOOD PRACTICE – ROMA HEALTH MEDIATORS PROGRAMME .....</b>	<b>50</b>
<b>4. CONCLUSIONS.....</b>	<b>57</b>
<b>5. RECOMMENDATIONS.....</b>	<b>59</b>
<b>BIBLIOGRAPHY.....</b>	<b>60</b>
<b>ANNEX 1 - ASSESSMENT OF RHMS PROGRAMME AT THE LEVEL OF DISTRICT PUBLIC HEALTH AUTHORITIES (2013) .....</b>	<b>64</b>
<b>ANNEX 2 - INTERVIEW GUIDELINE .....</b>	<b>73</b>

## ACRONYMS

EC	European Commission
ERRC	European Roma Rights Centre
EU	European Union
EUFRA	European Union Fundamental Rights Agency
IOM	International Organization for Migration
MoH	Ministry of Health
NHIF	National House Insurance Fund
NHIH	National House Insurance House
NRIS	National Roma Integration Strategy
RHM	Roma Health Mediator
TB	Tuberculosis
UN	United Nations
WHO	World Health Organization

## EXECUTIVE SUMMARY

The purpose of this report is to provide an analysis, from a multi-stakeholder perspective, of the implementation of the National Roma Integration Strategies (NRIS) and other national commitments with respect to Roma health in Romania.

Roma integration has been on the agenda of the Government of Romania since year 2000, in the context of Romania's accession to the European Union (EU). Thus far, the government has adopted and implemented two NRIS, aiming to improve the lives of Roma living in Romania. The first Strategy of the Government of Romania towards improving the situation of Roma for the period 2001–2010 was launched in 2001. One of the most successful outcomes of this strategy was the Roma Health Mediator (RHM) Programme which improved Roma access to health-care services and decreased disparities between Roma and non-Roma in Romania.

In order to create a common framework for action towards the social inclusion of Roma, the European Commission (EC) created the European Platform for Roma Inclusion, which brings together national governments, EU bodies, international organizations, and Roma civil society, and aims to foster cooperation and exchanges of experience between various stakeholders and provide analytical support to all parties concerned by Roma inclusion issues. The EC also requested that all Member States formulate NRIS.

In this context, in 2011 the Government of Romania, in cooperation with civil society and Roma non-governmental organizations (NGOs), drafted the second Strategy for the inclusion of Romanian citizens belonging to Roma minority for the period 2012–2020 along with sector action plans and indicators approved by Government Decision 1221/2011. This second strategy has been subject to several revisions, the latest of which covers the period 2014–2020 and has not yet been officially approved by the Government of Romania.

Apart from the two NRIS mentioned above, the present report analyses other policy documents issued by the Government of Romania between 2000 and 2014 that also tackle the issue of Roma health, such as the National Plan for combating poverty and promoting social inclusion 2002–2012, the Joint Memorandum on Inclusion (2005), the National Development Plan (2007–2013) and the National Strategic Reference Framework (2007–2013).

The present report was written in the framework of the second component of the International Organization for Migration's (IOM) Equi-Health project: Fostering health provision for migrants, Roma and other vulnerable groups. The project aims to improve the access to and appropriateness of health-care services, health promotion and prevention to meet the needs of migrants, the Roma and other vulnerable ethnic minority groups, including irregular migrants residing in EU/EEA.

The Equi-Health project, designed and implemented by IOM, was launched in February 2013 and is co-funded by the EC, through the Consumers, Health, and Food Executive Agency, within the Second Programme of Community Action in the Field of Health (2008–2013) of the EC's Directorate General for Health and Food Safety (DG SANTE).

## **Methodology**

Research for this report, conducted between April and July 2014, includes a review of current literature on Roma health (legal and policy developments with respect to national programmes and action plans relative to Roma health), and stakeholder interviews with relevant governmental institutions and non-governmental organizations with responsibilities in the field of Roma health. The research also includes an assessment of the RHM Programme in Romania.

The main conclusions and recommendations are summarised below and are detailed further in the various chapters of the report.

## **Conclusions**

- Despite the high number of policy documents and two NRIS strategies, including the latest revised version of the second strategy, targeting the Roma ethnic minority, members of the group face multi-dimensional disparities in terms of education, housing, employment, quality of life and access to basic health-care services. These have a direct, negative impact on Roma life expectancy and other health indicators, such as mortality and disability;
- The majority of Roma live in severe material deprivation. Poor living conditions, such as substandard housing, the lack of infrastructure facilities (water or heating), or the proximity to facilities associated with health risks, such as landfills, impact negatively on Roma health. Overcrowding in certain Roma settlements leads to high risks of contagion and epidemics. Poverty and, more specifically, the lack of regular and sufficient income, leads to malnutrition and incidence of nutrition-related deficiencies. Poverty diseases (TB, hepatitis, certain dermatologic conditions) occur at a higher incidence rate among Roma when compared with non-Roma;
- The lower health status of Roma is also related to obstacles in accessing medical services and the lack of medical insurance coverage of those not integrated in the labour market and/or who lack social security coverage;
- Different levels of health status self-evaluation among Roma respondents were observed. The report highlights the fact that an optimistic self-evaluation of the health status is not supported by clear evidence of positive health indicators among Roma. This indicates that Roma respondents lack information regarding their health situation;
- Insufficient access to dental care services, immunisation, and medical tests for the prevention of certain forms of cancer (namely breast and cervical cancer) point to deficient information among Roma regarding preventive medical services. The same applies as regards contraceptive measures among both Roma men and women, with a high incidence of abortion as the preferred contraceptive method;
- Among the access barriers as regards medical services the report underlines the lower rate of registration with a general practitioner in the case of Roma compared with non-Roma, as well as a low trust in medical staff, lack of financial resources to cover the formal and informal costs related to medical services, and lower accessibility to medical facilities in the case of segregated, rural Roma settlements;
- The national policies and strategies targeting Roma are fragmented and incoherent. There is a lack of intersectoral approach as regards their implementation, lack of financial resources, and lack of monitoring and evaluation of their effectiveness;

- The health component of the second NRIS did not initially address the specific needs of the Roma population. Although the latest amendments to the strategy appear to address the issue in a more structured and innovative way, taking into account social determinants of health, at the time of the writing of this report, the latest revised version of the second NRIS for the period 2014–2020 was not yet officially approved by the Government of Romania;
- The RHM programme is a successful initiative with positive outcomes as regards Roma health. Nevertheless, the decentralisation process of the programme, the high turnover of decision-makers at central and local level, and the lack of funds risk to impact negatively on its sustainability and the profession of RHMs.

### **Recommendations**

- Collaborative efforts should focus on stronger cooperation between all relevant stakeholders in terms of strategically defining and implementing health policies targeting Roma. These policies should be linked to the implementation of the strategic objectives established for other sectors, such as education, housing and employment, aimed at improving the quality of life of Roma;
- Close supervision and intensive support for a mainstreamed implementation of revised NRIS along with secured sustainable funding, and concrete monitoring and evaluation indicators, in order to increase the chances of reaching better health outcomes and reducing health disparities of Romanian Roma;
- Tailored health policies focused on health education and access to primary health-care services supported by adequate information and awareness-raising campaigns on preventive measures and health risk factors should be established and implemented for Roma.



## 1. INTRODUCTION

The Roma ethnic minority accounts for around 3 per cent of the total Romanian population<sup>1</sup> and is mainly located in rural areas. Over the past 10 years, several national policies and health programmes targeting Roma have been developed by the Ministry of Health (MoH) and international organizations in the field and implemented with the help of District Public Health and local authorities, as well as Roma NGOs.<sup>2</sup> They focused directly or indirectly on the improvement of Roma access to health services. However, despite these policies and programmes, Romanian Roma continues to experience health inequalities, mainly due to institutional, financial, social, educational and cultural factors.

These health inequalities result in a 10-year disparity in terms of Roma life expectancy compared with non-Roma, and a high mortality rate among the Roma population when compared with the general population. Roma children below the age of ten die three times more often as compared with non-Roma children. In terms of vaccination coverage, for every unvaccinated non-Roma child, there are four unvaccinated Roma children.

In addition, there is a higher incidence and earlier onset of non-communicable diseases, such as cardiovascular diseases, diabetes, respiratory diseases, and others, among the Roma population mainly due to a lack of access to preventive measures, targeted health education, and medical health insurance, as well as poverty, and high unemployment and illiteracy rates.

As a result, around 30 per cent of Roma access the emergency medical services rather than the services of specialised doctors and they usually do this during the last stages of the diseases they are suffering from. Health statistics on the health status of Roma are therefore very worrying. Approximately 80 per cent of Roma women have never used mammography as a screening tool for the early detection of breast cancer and almost 90 per cent of young Roma women have never undergone a Pap test for the detection of cervical cancer.<sup>3</sup> Furthermore, 34 per cent of Roma women consulted a gynaecologist only once they got pregnant or just before delivering the baby. Finally, the incidence of tuberculosis (TB), HIV/AIDS and viral hepatitis is highly disproportionate among the Roma population compared with the rest of the population.

In line with the above, it is clear that the Roma population in Romania faces various health difficulties that need to be analysed and addressed effectively. The present report will explore and tackle the health problems the Roma population in Romania is confronted with, the underlying factors for these problems, the policy framework that aims to improve Roma access to health services, the outcomes of policies and programmes targeting Roma health, and the steps that can be taken to improve the health status of Roma and their access to health care.

---

<sup>1</sup> Central committee for 2011 census. Available from [http://194.88.149.157/e4/0a/f9/cd/Comunicat\\_DATE\\_PROVIZORII\\_RPL\\_2011.pdf?c=83e3bff32bc843a0b6d800acab5774bf](http://194.88.149.157/e4/0a/f9/cd/Comunicat_DATE_PROVIZORII_RPL_2011.pdf?c=83e3bff32bc843a0b6d800acab5774bf)

<sup>2</sup> See at: [www.anr.gov.ro/index.php/transparenta/rapoarte](http://www.anr.gov.ro/index.php/transparenta/rapoarte)

<sup>3</sup> Public Policy Institute, *The map of the access to medical services in Romania. Case study: Challenges for Roma population*. 2013, page 51. Available from [www.ipp.ro/pagini/harta-accesului-la-servicii-de-s259n.php](http://www.ipp.ro/pagini/harta-accesului-la-servicii-de-s259n.php)

## Methodology

The research methodology used for this report combined desk with field research, and included a case study. The desk research summarized and critically evaluated existing policies, strategies, reports and statistical data in the field of Roma health.

Based on the results from the desk review, a semi-structured interview questionnaire was developed in order to capture, as much as possible, the opinions and perceptions of, as well as facts from, various stakeholders as regards the social determinants of health, health interventions, health policies, and their outputs/outcomes, related to the health-care status of the Roma population. Data and information thus collected were subjected to a qualitative assessment based on factors influencing Roma's access to and utilisation of health services. Interviews and two focus group discussions involved representatives from the Romanian Parliament (Health Commission), the National Agency for Roma (NAR), the MoH, the National Health Insurance House (NHIH), the National Institute of Public Health (NIPH), health-care providers (General Practitioners, specialists, nurses), and Roma NGOs.

<b>Nr. Crt</b>	<b>Research type</b>	<b>Institutions</b>	<b>Number of persons</b>
1.	In-depth interview	Romanian Parliament, Chamber of Deputies ( <i>Health Commission</i> )	2
2.	In-depth interview	National Roma Agency	1
3.	In-depth interview	Ministry of Health	2
4.	In-depth interview	National Health Insurance House	1
5.	In-depth interview	National Institute of Public Health	2
6.	In-depth interview	Roma NGO representatives	2
7.	Focus group	General Practitioners	6
8.	Focus group	Hospital health-care providers (doctors, nurses)	10

Finally, a case study of the RHM Programme, considered one of the most successful initiatives on Roma health in Romania as well in the CEE region, was carried out by sending a detailed questionnaire (open and closed questions) to RHMs employed in each district in the country.

## Challenges and limitations

As stated above, one of the main purposes of the report was to provide an in-depth analysis of strategies, policies, studies and data on the health situation of Roma in Romania. However, due to the lack of ethnically disaggregated data regarding Roma access to health services, there are limitations in the analysis of the real impact of the health component of the NRIS and other national health policies targeting the Roma population.

In addition, throughout the present report, reference is made to unofficial results or unpublished data, to which access was provided by the MoH for the purpose of this report. These data are still undergoing analysis at the ministry level and should therefore be considered with caution.

## 2. OVERVIEW OF THE SITUATION OF ROMA IN ROMANIA

### 2.1. General information about Roma in Romania

According to the last census carried out in 2011, the official number of Roma residing in Romania is 621,573 persons, or 3.08 per cent of the total population. This number is much smaller than estimates by other sources that consider the number of Roma to be between 1.5 and 2 million persons.<sup>4</sup> There are several reasons that can explain the discrepancies between the official statistics and estimates from other sources, such as the lack of residency documents, the high internal and external mobility of Roma, and reluctance in terms of ethnic self-identification, which is linked to the fear of stigma and discrimination.<sup>5</sup> Above all, declaration of ethnicity was not compulsory for the census.

When looking at the last three censuses, a steady increase can be observed in the absolute numbers of Roma, as well as in terms of the percentage of Roma out of the total population in the country – from 1.8 per cent (1992 census) to 2.5 per cent (2002 census) to 3.08 per cent (2011 census).<sup>6</sup>

Romania is organised in 42 districts or counties and 8 regions. Each district has an administrative centre located in the biggest city, as well as smaller urban and rural localities. During the last census, in approximately 75 per cent of the total number of registered localities (N=3,186 localities), at least one person declared him or herself to be of Roma origin. In more than 50 localities including two cities, over 30 per cent of the total population self-identifies as Roma. The geographical distribution of officially declared Roma is heterogeneous throughout the country, with a high degree of concentration in some of the districts of the NUTS1 (EU Nomenclature of Territorial Units for Statistics) regions (Northwest, Centre and South) and a low degree of concentration in other regions (e.g. Northeast).<sup>7</sup>

---

<sup>4</sup> “An EU Framework for National Roma Integration Strategies up to 2020” - Brussels, 5.4.2011 COM (2011) 173 final;

*NRIS a first step in the implementation of the EU framework* - European Communities, 2012;

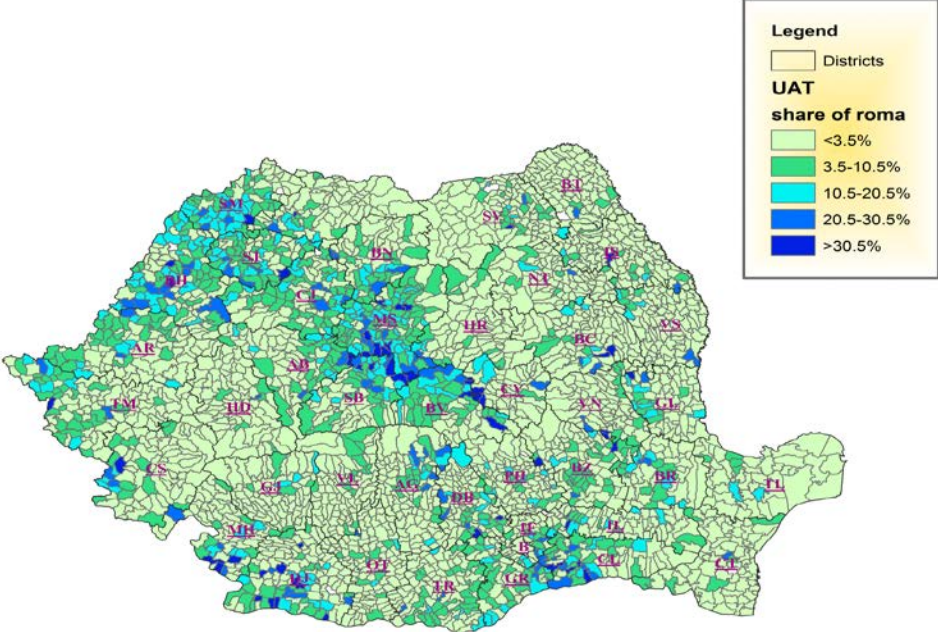
*Roma health mediation in Romania* – WHO 2013.

<sup>5</sup> Discussions with Key Opinion Leaders in the field of Roma health.

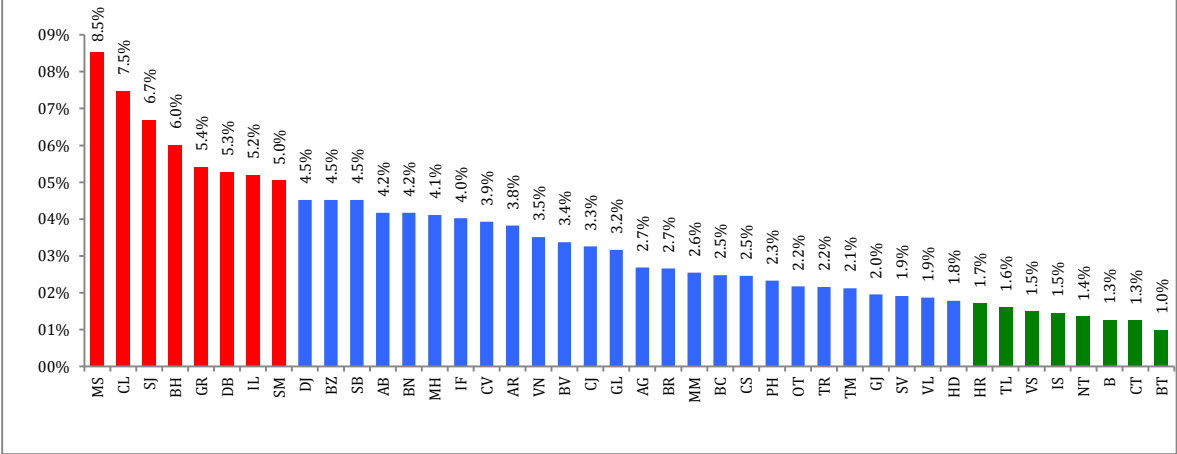
<sup>6</sup> See at: [www.recensamantromania.ro/rezultate-2/](http://www.recensamantromania.ro/rezultate-2/)

<sup>7</sup> Ibid.

**Figure 1: Percentage of Roma by locality (Census 2011)**



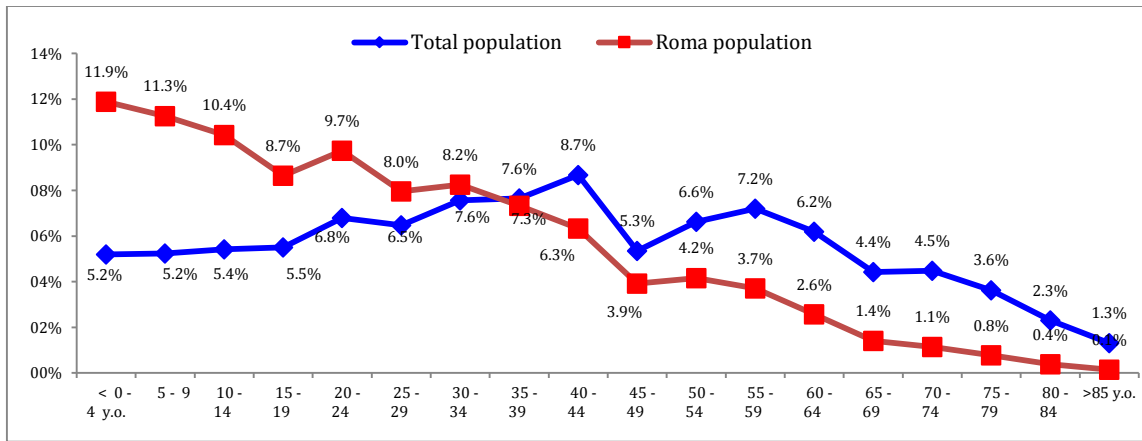
**Figure 2: Percentage of Roma by district (Census 2011)**



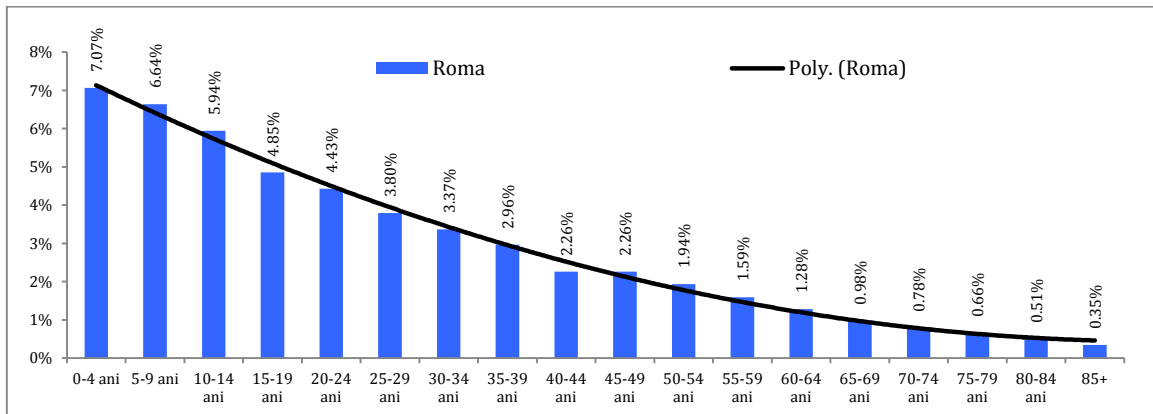
The districts with a 5 per cent or more share of Roma population out of the total are (in descending order): Mures, Calarasi, Salaj, Bihor, Giurgiu, Dambovita, Ialomita, and Satu Mare. The distribution of Roma in these districts is variable, with a more homogenous distribution across most communities and districts in the Central and North-Western regions, in contrast with a cluster-like concentration in the South. According to data released by the National Institute of Statistics (NIS), no relationship has been identified to date between the number of Roma in a district and the economic development (GDP/capita) of that district.<sup>8</sup> Distribution by residence shows that a majority of Roma (63% versus 37% non-Roma) live in rural areas, whereas a majority of the non-Roma population (54% versus 46% Roma) lives in urban areas.

<sup>8</sup> See at: [www.insse.ro/cms/ro/content/produsul-intern-brut](http://www.insse.ro/cms/ro/content/produsul-intern-brut)

**Figure 3: Age group structure by ethnicity (Census 2011)**

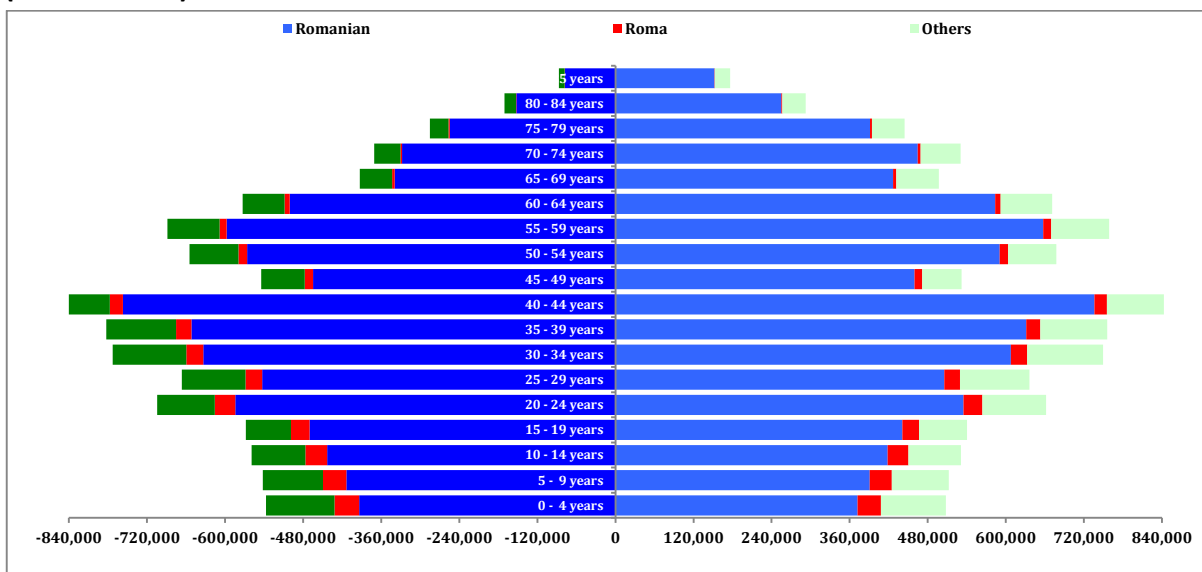


**Figure 4: Percentage of Roma out of the total population by age group (Census 2011)**



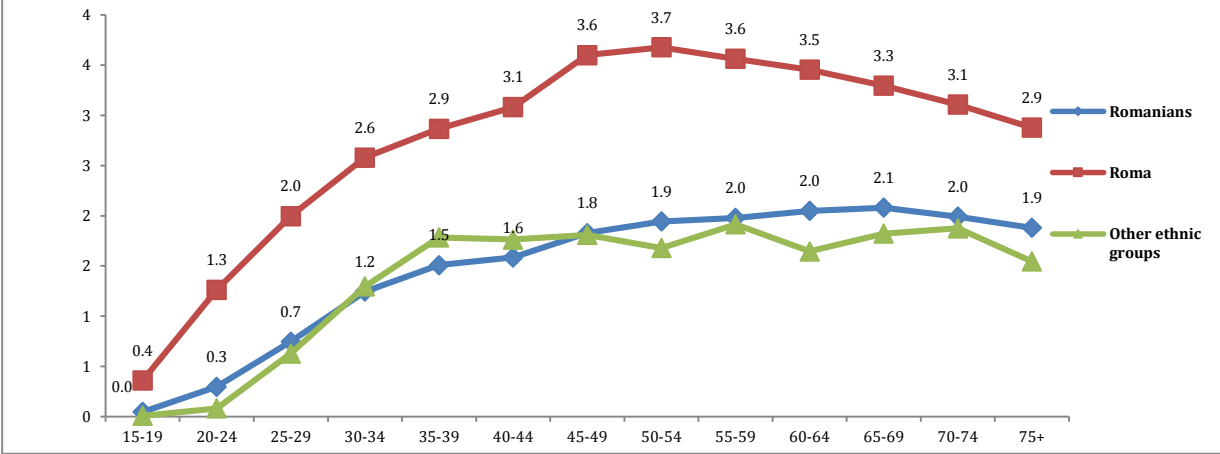
The demographic profile of the Roma population is very different as compared with the general population, with Roma presenting a high number of new-borns, followed by a steady decrease in the life expectancy and excessive premature death.

**Figure 5: Distribution of the population by age group, gender (male – female) and ethnicity (Census 2011)**



The age pyramid shows the same tendency as the previous figures, and is consistent with studies emphasising that Roma life expectancy is much shorter than the national average.

**Figure 6: Average number of children born per woman by age group and ethnicity during the entire life course (Census 2011)**



There are major differences regarding the reproductive behaviour of Roma women as compared with non-Roma women. The chances for a Roma girl from the age group 15–19 years old to deliver a baby are eight times higher than for a non-Roma girl from the same age group.

The distribution by gender shows that the percentage of Roma men is higher than that of Roma women (50.8% men versus 49.2% women), which is in contrast with the gender distribution among the non-Roma population (48.7% men versus 51.3% women).

Several scientific and policy papers published by NGOs or EU institutions<sup>9</sup> conclude that Roma are exposed to various disparities, including lack of adequate housing and safe neighbourhoods, isolated communities, lack of minimal education, high rate of unemployment and low paid jobs, extreme poverty, discrimination, and others, that have a direct impact on their health and wellbeing. Several of these disparities are examined below.

**2.1.1. Poverty**

Roma living in Romania suffer from a high level of socioeconomic exclusion and discrimination. There are severe and constantly growing poverty “bubbles” comprised almost exclusively of Roma. According to a report issued by the Romanian Research Institute for Quality of Life *“Roma communities represent a concentration of several interrelated problems: low level of job occupation, severe poverty, precarious housing, very low rate of school completion, marginal access to health care, minimal access to public utilities and transportation, and spatial isolation”*.<sup>10</sup>

A survey carried out in 2011 by UNDP shows that Romanian Roma have the lowest daily-income (USD 6 per person per day in Purchasing Power Parity (PPP) in contrast with non-Roma

<sup>9</sup> Romani CRISS, Sastipen, National Roma Agency, ERRC, EUFRA.  
<sup>10</sup> National Roma Agency Institutional Capacity Evaluation, ICCV Bucharest, 2014.

who earns around USD 13 in PPP).<sup>11</sup> Nearly 40 per cent of Romanian Roma earn below USD 2.42 PPP/day, as compared with only 6 per cent of Romanian non-Roma who earn below this amount. When looking at income distribution in Romania, disaggregated by ethnicity, figures for Roma and non-Roma in the poorest percentile of the population are significantly different (40% versus 6%), while, when comparing the percentage of Roma and non-Roma earning USD 8.78PPP/day, the figures are very similar (79% for Roma and 73% for non-Roma).

Furthermore, according to a study conducted by the World Health Organization (WHO),<sup>12</sup> in 2009 Romania had the highest child poverty rate (33%) among EU and European Economic Area (EEA) countries, based on a <60 per cent median income. Another survey carried out by the European Union Fundamental Rights Agency (EUFRA) in 2011 in 11 EU countries showed that 80 per cent of Romanian Roma lives in households at risk of poverty in contrast with only 40 per cent of Romanian non-Roma. Also, when measuring the percentage of persons living in households in which someone went to bed hungry at least once in the past month, the proportion of Roma was five times higher than that of non-Roma (62% versus 12%). Similarly, 90 per cent of Romanian Roma households are in severe material deprivation<sup>13</sup> as compared to 55 per cent of non-Roma.<sup>14</sup> Finally, according to the UNDP survey from 2011, the EU material deprivation index shows that in Romania 95 per cent of Roma live in material deprivation as opposed to 71 per cent of non-Roma living in proximity to Roma communities surveyed, and 90 per cent of Roma live in severe material deprivation as compared to 54 per cent of non-Roma living in proximity to Roma communities surveyed.<sup>15</sup>

### 2.1.2. Housing

In Romania, Roma live in different types of communities, the majority of them in rural areas, either inside localities or on their outskirts. According to research carried out by the Romanian sociologist Dumitru Sandu in 2005, out of 104 (24 urban/80 rural) Roma communities assessed for inadequate housing and limited or no access to public utilities, 87 were located at the peripheries of localities, 13 were at some distance from the main locality and 4 were located in centre of the locality.<sup>16</sup> Most of these communities were segregated settlements with insufficient physical accessibility and infrastructural deficiencies.

According to a survey carried out in 2009 by the Fundación Secretariado Gitano, 65.8 per cent of Roma declared that they live in a standard flat or house, 33.5 per cent in substandard housing and only 0.8 per cent in shantytowns. This percentage is low when compared with

---

<sup>11</sup> UNDP/WB/EC Regional Roma Survey 2011  
<http://eurasia.undp.org/content/rbec/en/home/ourwork/sustainable-development/development-planning-and-inclusive-sustainable-growth/roma-in-central-and-southeast-europe/roma-data.html>

<sup>12</sup> "Review of social determinants and the health divide in the WHO European Region: executive summary", UCL Health Equity Institute WHO Europe 2013.

<sup>13</sup> See at: [http://ec.europa.eu/eurostat/statistics-explained/index.php/Material\\_deprivation\\_statistics\\_-\\_early\\_results](http://ec.europa.eu/eurostat/statistics-explained/index.php/Material_deprivation_statistics_-_early_results).

<sup>14</sup> *The situation of Roma in 11 EU Member States*, Vienna EUFRA 2012.

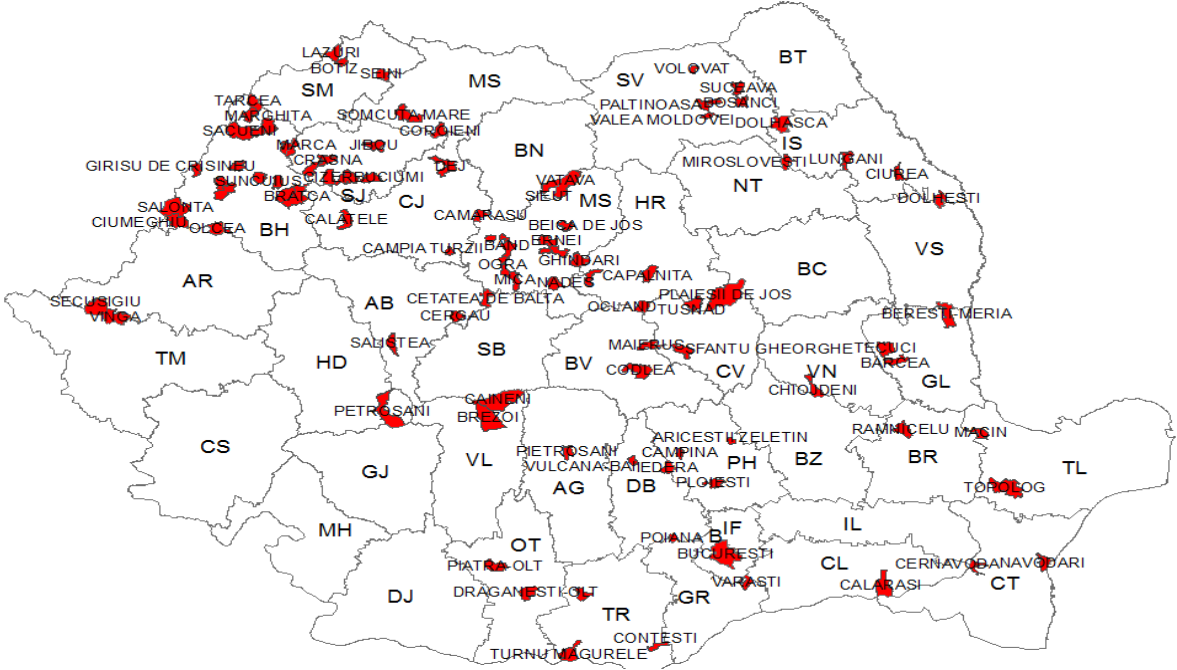
<sup>15</sup> UNDP/WB/EC Regional Roma Survey 2011.

<sup>16</sup> Dumitru Sandu "Comunitățile de Romi din România. O hartă a sărăciei comunitare prin sondajul PROROMI" Banca Mondiala 2005.



figures from other countries like Greece or Portugal where the percentage of Roma living in shantytowns is between 21.9 per cent and 30.5 per cent.<sup>17</sup>

**Figure 7: Roma communities with inadequate housing and limited and no access to public utilities<sup>18</sup>**



The houses that Roma are living in are, in general, newer than those owned by non-Roma, two thirds of them having been built after 1990, but their quality is very poor.<sup>19</sup> Self-reporting on living conditions showed that 33 per cent of Roma were consistently unsatisfied with the quality of their housing in contrast with only 7 per cent of non-Roma. Various surveys conducted by the government between 1992 and 2006 showed a significant decrease in the number of Roma households connected to city water, sewage system and gas (from 55% to 15%). This can explain the decreasing number of Roma households living in apartment buildings in cities and the increasing number of households living in improvised housing conditions either in segregated urban or rural settlements. Possible explanations for the change in type of residence include the steady increase of the price of utilities and renting, as well as the real estate bubble in 2004–2008. The segregation of the settlements limits Roma access to health care as there are no health-care services nearby and inadequate housing conditions and living in proximity to facilities associated with health risks impact negatively on the health status of Roma.

Another issue that has a direct impact on Roma access to health-care services is the absence of property titles or rental agreements leading to a lack of national identification documents, which are provided based on the legal place of residence of a person and are necessary to

<sup>17</sup> *Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK) – Madrid 2009.*  
<sup>18</sup> Dumitru Sandu “Comunitățile de Romi din România. O hartă a ărsăriei comunitare prin sondajul PROROMI” Banca Mondiala 2005.  
<sup>19</sup> “Riscuri și inechități sociale în România Comisia Prezidențială” Pentru Analiza Riscurilor Sociale și Demografice, Bucuresti 2009.

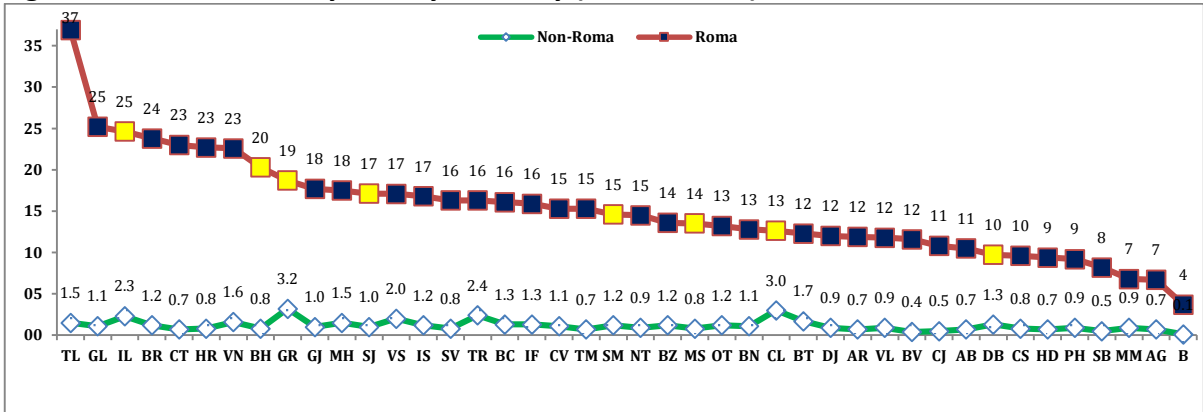


access health-care services. The same report<sup>20</sup> summarizes surveys carried out in 1998 and 2006, which show that more than one-quarter of Roma families did not have valid property titles or rental agreements for the residences they were living in. An additional problem related to housing is the average interior living space available per person – 65.3 per cent of Roma reported that they live in less than 11.9 square meters, in contrast with only 25 per cent of non-Roma that live in the same space. Also, 33.7 per cent of Roma declared that between 2 and 4 persons share a room in contrast with only 8.6 per cent of non-Roma. A direct relationship has been found between the density of people sharing a room and the educational level of these same people; the higher the crowdedness, the lower the educational attainment.<sup>21</sup>

According to the survey conducted in 2011 by EUFRA, 87 per cent of Roma were affected by housing deprivation (lack of one or more basic facilities – toilets, gas, running water, heating, electricity) in contrast with only 57 per cent of non-Roma. The figures are the highest among 11 EU countries that were included in the study, the average figures for these countries being 42 per cent for Roma and 12 per cent for non-Roma. Moreover, when taking into consideration the number of children living in the household, 93 per cent of Roma households with four or more children faced severe housing deprivation.<sup>22</sup>

2.1.3. Education

Figure 8: District illiteracy rate by ethnicity (Census 2011)

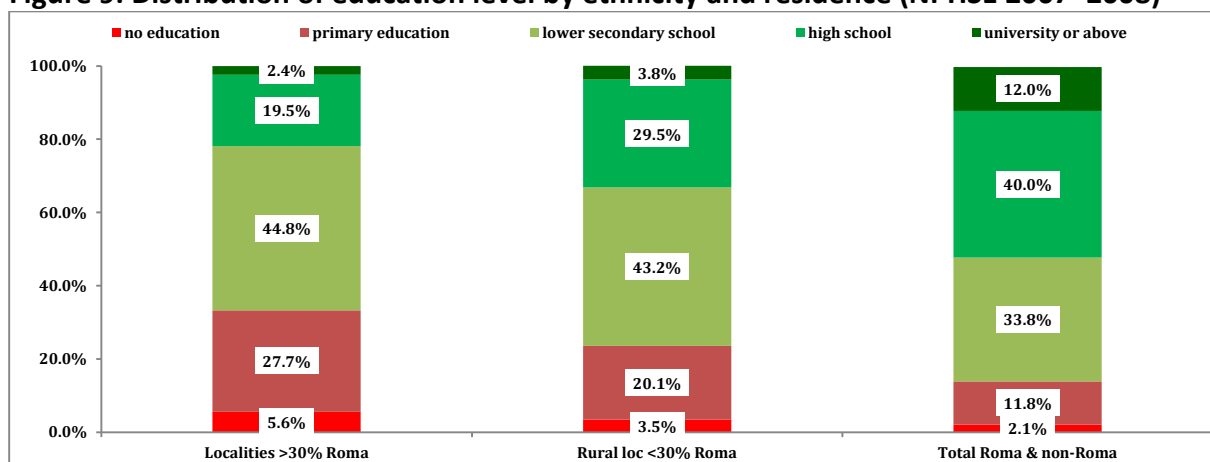


The national illiteracy rate, as well as district illiteracy rates, is more than ten times higher for Roma (15.2%) when compared with non-Roma (1.2%). The highest illiteracy rates are found in Tulcea, Galati, Ialomita, Braila, and Constanta districts (all of them positioned in the South and Southeast regions of Romania) and the lowest illiteracy rates are found in Prahova, Sibiu, Maramures, Arges and Bucharest districts. There is no direct correlation between the proportion of Roma population in the district and the illiteracy rate of Roma; instead, in all districts with more than 5 per cent Roma out of the total population, the illiteracy rate for non-Roma is above the national average probably due to the fact that these districts are also amongst the poorest in the country, and that may hinder the access to education in general.

<sup>21</sup> Ibid.

<sup>22</sup> “Analysis of EUFRA Roma survey results by gender (EL, PT, RO, FR, IT, PL, ES, BG, HU, SK, CZ)”. Vienna, EUFRA 2012.

**Figure 9: Distribution of education level by ethnicity and residence (NPHSE 2007–2008)**



In 2007–2008, the Romanian MoH carried out the largest to date National Programme of Health Status and Risk Factors Evaluation. More than 60 per cent of the total population in the country participated in the programme. The figure above shows the education level distribution among persons screened for the risk factors as a comparison between Roma populations residing in localities with more than 30 per cent Roma, rural localities with less than 30 per cent Roma and non-Roma, and the total population (Roma and non-Roma). As can be easily seen, the education attainment rates of Roma for the upper education level are the lowest. Data from the same study showed that there is a direct correlation between the low level of education attainment and higher incidence of behavioural risks (smoking, alcohol abuse, and unhealthy diet) as well as high morbidity rates.

Another survey conducted in 2009 by the Fundación Secretariado Gitano in 7 EU countries (Bulgaria, Czech Republic, Greece, Spain, Portugal, Romania, Slovakia) showed that 37.4 per cent of Romanian Roma had never attended school, 26.9 per cent had completed primary school and 35.7 per cent had completed lower secondary school and beyond. These data are opposed to the data presented by the study above as probably a different methodology and/or sampling were used. When comparing Romanian Roma figures with the average levels of education enrolment and education attainment of non-Roma in the EU countries included in the study, the following significant differences can be observed:

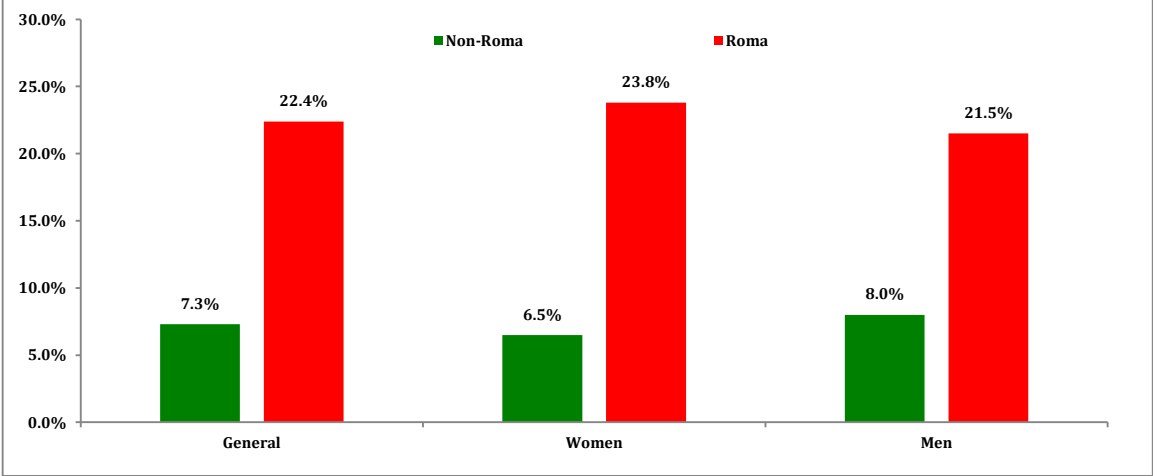
- Only 36 per cent of Romanian Roma completed secondary and higher education in contrast with 67.9 per cent of non-Roma in the 7 EU countries included in the study;
- 9.9 per cent of Romanian Roma children between the ages of 0 and 5 were enrolled in kindergarten as opposed to 45.2 per cent of non-Roma children in the same age group, in the 7 EU countries;
- 19.6 per cent of Romanian Roma between the ages of 15 and 24 were enrolled in school as compared with 59.5 per cent of non-Roma in the same age group, in the 7 EU countries;<sup>23</sup>
- As regards primary and lower secondary education, the difference in enrolment is much smaller (86.9% Romanian Roma versus 99.6% non-Roma in the 7 EU countries).

<sup>23</sup> "Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)" – Madrid 2009.

Similarly, a survey conducted by UNDP in 2011 shows prominent differences in education achievements between Roma and non-Roma living in proximity of Roma communities in Romania. The literacy rate for the age group 16–24 years old is 83 per cent for Roma men and 97 per cent for non-Roma men, and 78 per cent for Roma women as compared with 98 per cent for non-Roma women. There are big discrepancies between Roma and non-Roma in terms of gross pre-school enrolment (37% for Roma and 63% for non-Roma) and upper secondary school (high school) enrolment rates (23% for Roma and 83% for non-Roma). In general, Roma have only half the average years of education when compared with non-Roma.<sup>24</sup>

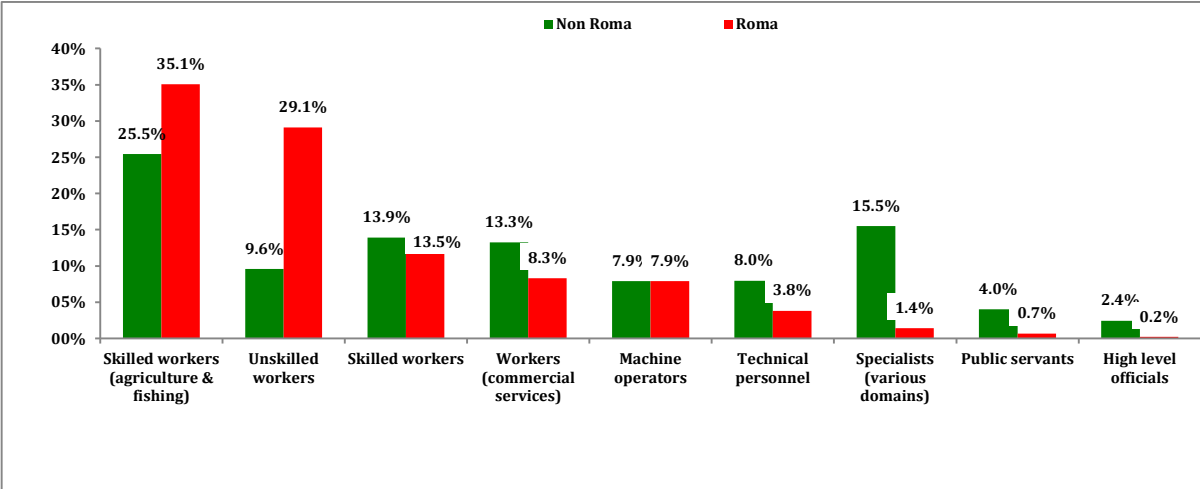
2.1.4. Employment

Figure 10: Distribution of unemployment by gender and ethnicity (UNDP/WB/EC – 2011)<sup>25</sup>



The percentage of unemployed Roma is three times higher when compared with non-Roma, with higher numbers for Roma women than for Roma men.

Figure 11: Distribution by occupation and ethnicity (Census 2011)



<sup>24</sup> “UNDP/WB/EC Regional Roma Survey 2011”.

<sup>25</sup> Ibid.

Regarding types of professions, Roma have a much larger representation in unskilled or low-skilled occupations (unskilled and skilled workers in agriculture and fishing – approx. 65%) as opposed to non-Roma (approx. 35%), and a much lower representation in higher-skilled occupations.

In 2009, more than 56 per cent of Roma in Romania were employed in the informal sector as compared with only 15 per cent of non-Roma. Furthermore, the employment rate in the formal sector for Roma was only 36.3 per cent (28% for Roma women) in contrast with 46.4 per cent for non-Roma.<sup>26</sup> Considering that the majority of workers in the informal sector work seasonally but, at the same time, work a very high number of hours per week in precarious conditions, and they do not receive social or health benefits as the employers do not pay contributions thereon, the health of Roma working in the informal sector is negatively impacted by the work they do, as well as the working conditions.<sup>27</sup>

At European level, the survey on Roma carried out by the Fundación Secretariado Gitano in 7 EU (Bulgaria, Czech Republic, Greece, Spain, Portugal, Romania, Slovakia) countries in 2009 showed that, in Romania, 48.6 per cent of Roma were employed. This percentage is similar to the employment rate for Roma in the rest of the countries included in the study. However, 42.6 per cent of Roma were reported as inactive as compared with only 34.8 per cent in the other countries. When comparing self-perceived employment and unemployment rates, 57.4 per cent of Roma in Romania considered themselves to be employed and 15.3 per cent considered themselves to be unemployed.<sup>28</sup>

At regional level, a study conducted by the World Bank in 2010 in Romania, Bulgaria, Serbia and the Czech Republic, examined employment rates among Roma and non-Roma men and women. It showed that Romania had the highest percentage of employed Roma men – 69 per cent nearly the same as non-Roma men in contrast with only 31 per cent of Roma women (24% lower than non-Roma women). All the other countries in the study presented similar employment rates for non-Roma men and only about half of the percentage of employed Roma men as compared with Romania. The study also showed that the average labour earnings for Romanian Roma, irrespective of gender, were about 39 per cent lower than the labour earnings for employed non-Roma. When asked about the reasons for their unemployment, Roma declared insufficient education and qualification (87%) as being the most important factor, followed by preference to receive social assistance (81%), lack of willpower (66%) and discrimination (35%). On the other side, Roma are also declaring that they are willing to work but often cannot find jobs, and only about 12 per cent of working Roma receive the minimum wages. The study concludes that if Roma had not been excluded from the formal labour market in Romania, government revenues would have increased between EUR 202 and EUR 675 million per year, depending on the population estimates used for calculation, but this assumption can be challenged by the fact that is quite unlikely that an

---

<sup>26</sup> “*Riscuri și inechităţi sociale în România* Comisia Prezidențială” Pentru Analiza Riscurilor Sociale și Demografice, Bucuresti (2009).

<sup>27</sup> Ibid.

<sup>28</sup> “*Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)*” – Madrid. (2009).

increase of 24 per cent in Roma women employment rates will increase the Government revenues by such a large amount.<sup>29</sup>

On the contrary, the regional Roma survey carried out in 2011 by the UNDP, the WB and the EC showed different data as regards Roma employment rates in comparison with the report released in 2009 (30% employed Roma and 44% employed non-Roma living in proximity of Roma communities surveyed) with significant differences between genders (42% Roma men, 56% non-Roma men, 19% Roma women, and 34% non-Roma women). In addition, the unemployment rate reported in 2011 was higher than the one reported in the previous survey (33% for Roma versus 18% for non-Roma), continuing the same trends for men and women. As regards the incidence of employment in the informal sector, it increased compared to the report from 2009 and reached 65 per cent for Roma in contrast with 19 per cent for non-Roma. One of the explanations for these differences could be the negative effect of the global economic crisis on the Romanian economy. When looking at occupations, the 2011 UNDP study found results similar to the afore-mentioned, with the majority of Roma are employed as unskilled workers (43% of Roma versus 16% of non-Roma), followed by skilled workers (18% of Roma versus 43% of non-Roma) and landless workers (16% of Roma versus 2% of non-Roma). When classified by trade, the highest percentage of Roma work in agriculture (33% of Roma versus 15% of non-Roma), followed by industry or mining (14% of Roma versus 23% of non-Roma), construction (13% of Roma versus 10% of non-Roma) and other commercial services (13% of Roma versus 11% non-Roma).<sup>30</sup>

Finally, another survey carried out by EUFRA in 2011 showed that the percentage of Romanian Roma children aged 7–15 working outside their home was around 13 per cent, the highest percentage in the 11 EU countries surveyed.<sup>31</sup>

#### 2.1.5. Local socio-development index (LSD)<sup>32</sup>

The local socio-development index (LSD) is a composite measure that was introduced by a well-known Romanian sociologist, Dumitru Sandu,<sup>33</sup> in order to allow for a comparison between different localities, taking into account seven indicators – life expectancy, education level, personal goods (TV, cars, etc.), utility consumption, average size of the house (square meters), and size of the locality. This index is somewhat similar to the community deprivation index used by the United Kingdom, Canada and New Zealand in order to assess the inequities in terms of accessing health services or health outcomes. When comparing Roma population distribution and the LSD index, there appears to be no correlation between low LSD index values and a higher density of Roma in a given locality, with a notable exception in the South-eastern part of Romania (Calarasi, Giurgiu, and Teleorman districts).

---

<sup>29</sup> “Roma Inclusion: An Economic Opportunity for Bulgaria, Czech Republic, Romania and Serbia” (2010).

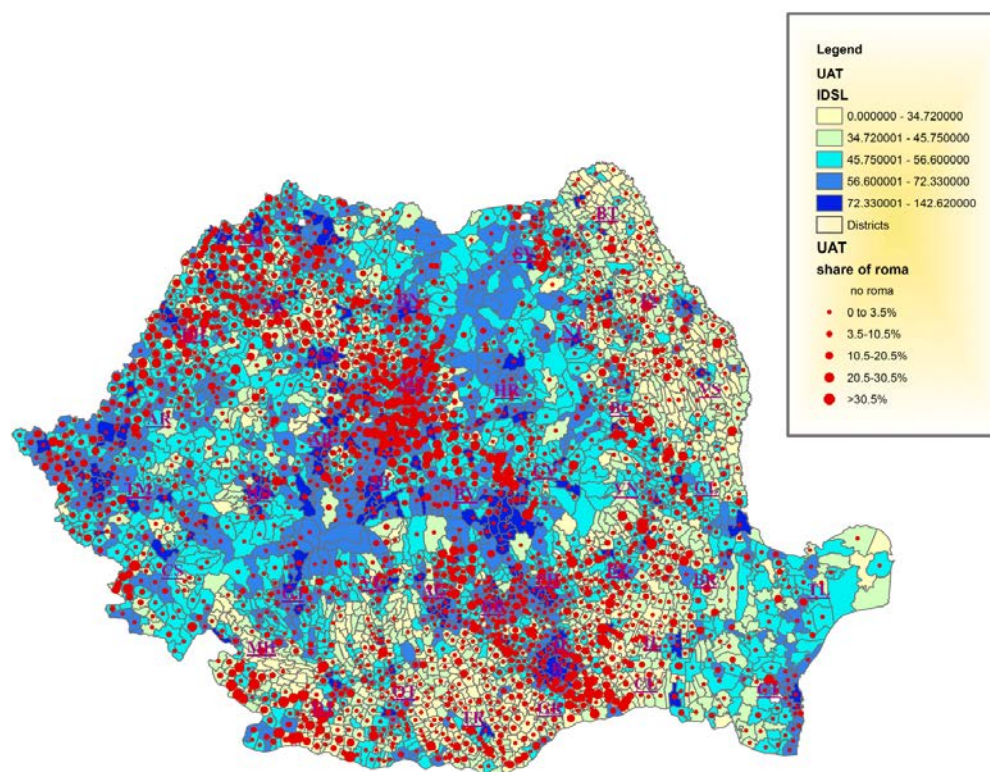
<sup>30</sup> “The UNDP/WB/EC Regional Roma Survey 2011”.

<sup>31</sup> “The situation of Roma in 11 EU Member States”, Vienna – EUFRA (2012).

<sup>32</sup> Dumitru Sandu – “Social Disparities in the Regional Development and Policies of Romania” *“International Review of Social Research”*, Volume 1, Issue 1, February 2011, 1–30.

<sup>33</sup> See at: <https://sites.google.com/site/dumitrusandu/bazededate>

**Fig.12 Distribution of Roma population and local socio-development index**



## 2.1. Data on Roma health

Several surveys assessing the socioeconomic determinants of health, the health status of Roma and Roma access to health services have been conducted over the last ten years. Data presented in four studies carried out in 2009, 2011, 2012 and 2013, although executed by different international, regional and national organizations, will be taken into consideration in this report, due to the fact that they used valid sampling methodologies, representative of the Roma population in Romania.<sup>34</sup>

### 2.2.1. Mortality

As noted in the previous chapter, the life expectancy of Roma is shorter than that of non-Roma. Different studies mention a gap between 6 and 16 years. The lowest figure was provided in the UNDP/WB/EC Regional Roma Survey (2011)<sup>35</sup> and the highest one was reported in a Gallup study (2013) carried out in Romania.<sup>36</sup> The latter study also stated that the mortality rate for the age group 0–14 years old was seven times higher for Roma than for non-Roma and that for the age group 35–64 years old the mortality rate was 39.7 per cent for Roma as compared with 26.6 per cent for non-Roma.

<sup>34</sup> “Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)” – Madrid, (2009); “The UNDP/WB/EC Regional Roma Survey 2011”; “The situation of Roma in 11 EU Member States”, Vienna EUFRA (2012); “Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate”, ERRC Budapesta (2013).

<sup>35</sup> “The UNDP/WB/EC Regional Roma Survey 2011”.

<sup>36</sup> “Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate”, ERRC Budapesta (2013).

The average period from the initial diagnosis to death, as regards severe disease (e.g. HIV/AIDS, cancer, stroke, etc.), is 3.9 years for Roma as opposed to 6.8 years for non-Roma. Another study showed that Romania had the highest mortality rate among children (Roma and non-Roma) under five years old in the EU (approximately 12%) when correlated with housing deprivation, or the lack of three or more essential items in the household (58%).<sup>37</sup> This result can be correlated with the fact that Roma have the highest percentage of deprived households when compared with non-Roma.<sup>38</sup>

### 2.2.2. Self-assessment of health status

Although most studies that examine the self-assessment of Roma health status provide figures showing that Roma tend to estimate their health status as very good (25% of Roma versus 17% of non-Roma) or good (67% of Roma versus 62% of non-Roma), when the data is classified by age group or gender, the results are different, with more Roma perceiving their health status as worse or worst.<sup>39</sup>

Thus, when compared with non-Roma women, Roma women 16 years old and over reported more frequently that their health status is bad or very bad (34% of Roma versus 27% of non-Roma) despite the fact that the Roma women interviewed were on average significantly younger than the non-Roma women. The gap increases with the age, with 67 per cent of Roma women aged 50 years and over who reported that their health status is bad and very bad as compared with 44 per cent of non-Roma women interviewed in the same age group.<sup>40</sup>

Regarding self-reporting of the health status as good or very good, there is an inverted relationship when considering the age. For example 86.4 per cent of Roma minors declare that their health status is good or very good compared with 75.4 per cent of Roma adults.

Compared with Roma populations from other EU countries, Romanian Roma are regularly reporting a better health status and, up until now, it is not clear whether this is related to poor health literacy or to specific cultural factors.

### 2.2.3. Limitations in daily activities

As shown in the previous chapter *“General information about Roma in Romania”*, the Roma population in Romania faces a number of socioeconomic constraints, which have negative effects on their health condition, and this in turn impacts their daily activities. Although the results of the UNDP/WB/EC Regional Roma survey (2011) showed that the overall self-assessment of the health status was better for Roma (67%) than for non-Roma living in proximity of Roma communities surveyed (62%), when classified by age groups, there is a strong association between increasing age and a higher proportion of Roma declaring a worse

---

<sup>37</sup> *“Review of social determinants and the health divide in the WHO European Region: executive summary”*, UCL Health Equity Institute WHO Europe 2013.

<sup>38</sup> *“Riscuri și inechități sociale în România Comisia Prezidențială”* Pentru Analiza Riscurilor Sociale și Demografice, București (2009).

<sup>39</sup> *“Criza ascunsă din sanătate. Inegalități în domeniul sănătății și date dezagregate”*, ERRC Budapesta (2013); *“Diagnostics and policy advice for supporting Roma inclusion in Romania”*, Bucharest, The World Bank Group 2013.

<sup>40</sup> *“Analysis of FRA Roma survey results by gender”*, Vienna EUFRA (2012).



health status. In this respect, the study entitled “*The situation of Roma in 11 EU Member States*”, carried out by EUFRA in 2011, shows that 44 per cent of Romanian Roma aged between 35 and 54 have health problems that limit their daily activities when compared with 24 per cent of non-Roma in the same age group. The figure for the Romanian Roma population is the second highest in the sample following the one reported for Polish Roma (53%). When classified by gender, 68 per cent of Romanian Roma women aged 50 years and over said that health problems limited their daily activities, as compared with 59 per cent of non-Roma women.<sup>41</sup>

#### 2.2.4. Health Risk factors

There are several risk factors that affect Roma health in a disproportionate manner.

##### **Food**

According to results from the NPHSE study carried out in 2007–2008, the share of Roma declaring consumption of red meat and fat is twice as high when compared with the national average. Also about 54 per cent of the Roma adult population is overweight. Salt consumption is also higher, with 60 per cent for Roma and 53 per cent for non-Roma.<sup>42</sup>

In terms of daily consumption of main food groups, a survey examining eating habits among Romanian Roma, carried out by Romani CRISS in 2009, showed the following: bread and similar products, followed by pasta and rice, dairy products and vegetables. Meat and red meat is normally consumed once per week and fish is eaten sporadically.<sup>43</sup> These data are quite contradictory with the data presented by the NPHSE study but this could be explained by the different sampling methodology used in these studies and the sample size.

##### **Smoking**

Nearly 50 per cent of Roma adults smoke every day compared with about 30 per cent of non-Roma adults, and the share of Roma women who smoke is 2.2 times higher than non-Roma women (15%).<sup>44,45</sup>

##### **Alcohol consumption, low physical activity**

The same NPHSE survey mentioned above indicated that the low level of education and lack of employment were associated with excessive alcohol consumption and low physical activity. Low levels of education are also linked to abnormal biochemical markers (*e.g. glucose, cholesterol, triglycerides, alanine transaminase*) that are predictors of several chronic diseases such as type 2 diabetes, stroke, myocardial infarction or chronic hepatitis/liver cirrhosis. According to the majority of studies, the alcohol consumption level of Roma compared with non-Roma is inconclusive. It is not evident that Roma are consuming alcohol in excess as compared to non-Roma.

---

<sup>41</sup> “*Analysis of FRA Roma survey results by gender*”, Vienna EUFRA (2012); “*The situation of Roma in 11 EU Member States*”, Vienna EUFRA (2012).

<sup>42</sup> See at: [www.ms.ro/?pag=133](http://www.ms.ro/?pag=133)

<sup>43</sup> “*Sanatatea si comunitatea roma - analiza a situatiei din Romania*”, Romani CRISS Bucuresti (2009).

<sup>44</sup> “*Diagnostics and policy advice for supporting Roma inclusion in Romania*”, Bucharest, The World Bank Group 2014.

<sup>45</sup> “*Smoking prevalence study in Romania (Totem Communication, Institutul de Pneumoftiziologie Marius Nasta, Bucuresti)*”.



### 2.2.5. Communicable diseases

Tuberculosis (TB) is one of the major public health problems affecting disproportionately people living in poverty. Romania has the highest number of TB cases in the EU<sup>46</sup> and a significant number of Multi-drug-resistant (MDR) TB cases resulting from lack of specific treatment and improper treatment. According to operational research carried out in 2011 in two districts with a high prevalence of TB cases, one in every five Roma has TB.<sup>47</sup>

Several surveys have indicated that there were significant discrepancies between Roma and non-Roma respondents regarding TB knowledge and the rate of TB treatment completion due to various socioeconomic and cultural factors.<sup>48</sup> Another study conducted by the European Roma Rights Centre (ERRC) in 2013, at the national level, indicated that the TB prevalence was 1 per cent for Roma and only 0.2 per cent for non-Roma<sup>49</sup> but these results should be considered with caution due to the fact that the methodology used in the study was not clearly explained.

Regarding HIV/AIDS, 10.5/10,000 persons from localities with a high number of Roma are admitted in hospitals with this diagnostic as compared with only 6.3/10,000 persons from localities with a predominantly non-Roma population (2013).<sup>50</sup> The situation is similar for acute viral hepatitis type A, where the number of hospital admissions is almost four times higher for localities with a predominantly Roma population as opposed to localities with a predominantly non-Roma population.

### 2.2.6. Non-communicable diseases

The survey conducted by the Fundación Secretariado Gitano, in seven EU (Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain) countries in 2009 showed that Romanian Roma had a lower incidence of chronic diseases when compared with Roma from the other EU countries included in the study. The most frequent, diagnosed health problems reported by Roma adults were high blood pressure (17.5%), followed by heart disease (13.7%), migraines and headache (11.9%), high cholesterol (11%), and musculoskeletal problems (10.6%). This is different when compared with the results of the NPHSE study, which showed that the average number of persons with high blood pressure was above 40 per cent for localities with a predominantly Roma population as opposed to 32 per cent for localities with a predominantly non-Roma population. The difference can be explained by the fact that in the first study results were provided through the respondent's self-assessment of his/her disease history as opposed to the second study where the results were provided objectively by a medical practitioner following a medical examination. As regards Roma children, the most frequent diseases reported were respiratory ailments, such as asthma and bronchitis (5.5%), followed by hernias (3.4%) and allergies (2%).<sup>51</sup>

---

<sup>46</sup> See at: <http://data.euro.who.int/hfad/>

<sup>47</sup> *Operational research (conducted under the Round 6 TB Grant) "TB prevalence in Roma communities in Bihor and Arad counties"* (2011).

<sup>48</sup> *"Confronting a Hidden Disease: TB in Roma Communities"* Marta Schaaf - 2007 by the Open Society Institute.

<sup>49</sup> *"Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate"*, ERRC Budapesta (2013).

<sup>50</sup> *"National hospital admission database 2013"*.

<sup>51</sup> See at: [www.ms.ro/?pag=133](http://www.ms.ro/?pag=133)

The study conducted by ECCR in 2013 indicated that there was a higher incidence of self-declared respiratory diseases among Roma (50%), such as pneumonia, chronic obstructive coronary disease, TB, when compared with non-Roma (33%), and this trend increased with age (27% of Roma and 16% of non-Roma aged 65 and over as compared to only 16% Roma and 11% non-Roma aged 35–64).<sup>52</sup> In 2013, 391/10,000 persons residing in localities with a high density of Roma were admitted to hospitals with respiratory problems as compared with only 275/10,000 persons residing in localities with a predominantly non-Roma population. Moreover, self-declared ischemic coronary disease (21.5% of Roma versus 12.3% of non-Roma) and diabetes (23% of Roma versus 15.4% non-Roma) appears to be more prevalent among the Roma population, with prevalence increasing with age (2.7% of Roma 35–44 years old with ischemic coronary disease as compared with 12.6% Of Roma over 65 years old). The biggest difference recorded between Roma and non-Roma in terms of cardiovascular diseases was that for the age group 35 to 44 years old, with Roma reporting an almost three times higher disease prevalence compared with non-Roma, 2.7 per cent and 0.3 per cent respectively.<sup>53</sup>

Overall, Romanian Roma are disproportionately affected by multi-morbidity, or the co-existence of two or more chronic conditions, as well as by the development of chronic diseases at a younger age, when compared with non-Roma, and this requires tailored health policies focused on health education and access to primary health care services.

#### 2.2.7. Accidents

According to the study conducted by the Fundaci3n Secretariado Gitano, in seven EU countries (Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia and Spain) in 2009, the accident rate for Romanian Roma was lower (6.5 % for minors and 7.4% for adults) than the average of all of the countries combined<sup>54</sup> (10.6% for minors and 10.6% for adults). The majority of accidents occur at home (57.1%), followed by work or school (17.5%). Men are more prone to accidents than women. Furthermore, men are more exposed to cuts, fractures and contusions, while women are more exposed to burns. The age category most affected by accidents is 45 years and above.<sup>55</sup> Possible explanations for this injuries' distribution could be related to the inadequate living conditions in which Roma reside, the high risk jobs accepted by Roma men, and the fact that women work mainly around the house and are thus exposed to domestic accidents.

#### 2.2.8. Maternal and reproductive health

Romanian Roma tend to marry early and to have children at a very young age. According to the UNDP/WB/EC Regional Roma survey (2011), 28 per cent of Roma get married between the ages of 15 and 19 as opposed to only 2 per cent of non-Roma in the same age group, living in proximity of Roma communities. The same tendency is true for the age group 20 to 24, with

---

<sup>52</sup> "Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate", ERRC Budapesta (2013).

<sup>53</sup> Ibid.

<sup>54</sup> "Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)" – Madrid (2009).

<sup>55</sup> "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS – Bucuresti. (2009).

63 per cent of Roma in this group getting married as compared with only 17 per cent of non-Roma.

The proportion of girls between the ages of 14 and 16 that give birth for the first time is three times higher for Roma than for non-Roma, according to a study conducted by the World Bank group in 2014. Also, Roma women in the lowest income categories are more likely to become pregnant at an early age due to socioeconomic, educational and cultural factors.<sup>56</sup>

The study carried out by the Fundaci3n Secretariado Gitano in 2009, examining the situation of Romanian Roma in 7 EU countries (Bulgaria, Czech Republic, Greece, Spain, Portugal, Romania, Slovakia), showed that 12.2 per cent of Roma female respondents had never consulted a gynaecologist, and 34.1 per cent had consulted a gynaecologist uniquely for reasons related to pregnancy and delivery. Almost 50 per cent of the Roma women who had visited a gynaecologist declared that they had done so once during their pregnancy, and the remaining 50 per cent were divided equally between visiting a gynaecologist once per month and once every two months, during their pregnancies. This is quite common especially for Romanians living in rural areas, with family doctors performing check-ups during normal pregnancies and only women with high-risk pregnancies receiving more frequent check-ups by gynaecologists. The main reasons cited by Roma women for visiting a gynaecologist were: gynaecological problem (34%), followed by other reasons (24.9%), routine exam (19.6%) and family planning (17.5%).<sup>57</sup>

## 2.3. Roma access to health-care services

### 2.3.1. Legal framework

The legal foundation, on which the provision of health-care services in Romania is based, is the Law 95/2006 on "Health-care reform". This law has been modified more than 100 times since its proclamation in 2006. It governs mechanisms for financing and provision of health-care services, as well as the eligibility of Romanian citizens in terms of accessing these services.

### 2.3.2. Medical insurance coverage

Eligibility for and access to health-care services is regulated through the social health insurance system that requires regular financial contributions to the National Health Insurance Fund (NHIF) from the entire population. The value of the contribution depends on the employment status of an individual and the type of professional activity, but in general it amounts to 5.5 per cent of the monthly salary. Certain categories of citizens, such as children, students up to 26 years of age, persons receiving social benefits (pregnant women, persons living with disabilities, etc.), are eligible for insurance coverage and are exempt from the payment of social health contributions if they can prove that they have no other income. There are additional categories of persons covered by insurance and who are exempt from payment of the contribution, such as detainees and unemployed persons but for these categories different government institutions (Ministry of Justice or Ministry of Labour) have to pay their

---

<sup>56</sup> "Diagnostics and policy advice for supporting Roma inclusion in Romania", Bucharest, The World Bank Group 2014.

<sup>57</sup> "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS – Bucuresti (2009).

premiums. Related to the latter, there are major problems in the provision of the compulsory contributions by the governmental institutions almost every year.

Unless a person is employed, in which case the contribution is deducted directly from their salary, the process of paying the social health insurance contributions is cumbersome, as is providing proof of insured status, and no mechanisms are anticipated in the near future to simplify these processes.<sup>58</sup> One of the rules included in the Law on Health-care Reform that has a negative impact on citizens' enrolment in the social health insurance system, is the requirement for the uninsured to prove that they were insured for the last five years or to pay up to five years' worth of backdated contributions. Between 2007 and 2010 the requirement was lowered to 6 months and, during that period, the number of enrollees increased; however, after 2010 the 5 year provision was reinstated. It is possible that the number of insured Roma increased during the period 2007–2010, taking into consideration the lowered amount of insurance enrolment payment; however, there is not data to support or refute this due to the fact that data records on enrolment in the insurance system are not ethnically disaggregated.

At present, even if the collection of the social health insurance contribution is the responsibility of the district branches of the fiscal administrative authority, the total number of insured persons is around 88 per cent out of the total number of citizens.<sup>59</sup> According to different studies analysing the health situation of Roma, the percentage of insured Roma is only around 45 per cent,<sup>60</sup> with a predominance of elderly Roma (pensioners). The least represented group among insured Roma is that of young adults (18–25 years old). Several factors contribute to the low insurance coverage of Roma, such as:

- Absence of identity documents;
- Absence of property title, residence status or rental agreement;
- Lack of adequate information on how to be enrolled in the social health insurance system due to the fact that this specific information is not available for them and when available is provided only in Romanian language;
- Long periods of unemployment, and a high level of informal employment;
- Extreme poverty (living on less than 2 USD/day).

Furthermore, when comparing the results of the NPHSE study and hospitalisation records for persons residing in localities with the highest percentage of Roma, there is a difference between the declared medical insurance statuses of Roma (73.3%) and non-Roma (86.6%) evaluated in NPHSE and hospital admission records for insured Roma (94.3%) and non-Roma (95.9%).<sup>61</sup> The difference between these figures can be explained by the fact that hospital admission for non-urgent problems is strictly dependent on the insurance status, implying that Roma are unable to access adequate hospital care compared with non-Roma.

### 2.3.3. Access to preventive services

The main public health interventions (vaccination, maternal and child health-care services, etc.), as well as treatment for major public health problems (HIV/AIDS, TB, cancer, diabetes,

---

<sup>58</sup> See at: [www.cdep.ro/pls/legis/legis\\_pck.htm\\_act\\_text?id=72105](http://www.cdep.ro/pls/legis/legis_pck.htm_act_text?id=72105)

<sup>59</sup> NHIH data (2013). Available from [www.cnas.ro](http://www.cnas.ro)

<sup>60</sup> "The situation of Roma in 11 EU Member States", Vienna EUFRA (2012).

<sup>61</sup> Hospital admission database. See at: [www.ms.ro/?pag=133](http://www.ms.ro/?pag=133)

organ transplants, etc.), are financed by both the MoH and the NHIF. All persons are eligible to receive these services irrespective of their insurance status.

Preventive measures, although considered cost-effective, are insufficiently funded and delivered irregularly.<sup>62</sup> Child vaccination and maternal and child health-care services are the most regular and evenly distributed preventive services available throughout the country. Other preventive services, such as specific vaccinations for adults (e.g. influenza), screenings for cancer and services providing support to quit smoking are not available throughout the country and are not provided in an organised and systematic manner.

Secondary and tertiary prevention services such as treatment for high blood pressure or rehabilitation services are almost exclusively provided through the basic health insurance package, which is available only to insured persons, making them inaccessible for a majority of the Roma population. Moreover, there is a lack of adequate information on preventive services and education campaigns on these services targeting Roma and non-Roma as well. In fact, there are no health campaigns or public health interventions targeting Roma specifically, with the exception of communities with Roma health mediators (RHMs) that are normally better informed than the rest of the Roma population on preventive services and the avoidance of health risk factors.

#### 2.3.4. Vaccination coverage

Romania used to enjoy a high rate of child vaccination coverage. However, notably since 1989, vaccination rates have been in a constant decline.<sup>63</sup> The factors that have contributed to this decrease include: difficulties in the sustainable provision by the MoH of the vaccines included in the national immunisation programme; insufficient funding for the vaccination programme; frequent organizational changes in delivery and funding for vaccination services; insufficient information on and a lack of sustained vaccination campaigns, especially concerning new vaccines; the negative attitude of the population as regards vaccination mainly due to the fact that parents are forming an opinion towards vaccination after accessing biased information presented on the internet in a non-professional manner about the negative effects of vaccines; and, the fear of accepting the informed consent procedure, something that wasn't required up to now.

The Roma population faces additional factors that contribute to the low rate of vaccination coverage of Roma children, such as lack of targeted information on and knowledge related to the importance of vaccination, low access to primary health-care services, and high mobility inside and outside of the country.<sup>64</sup>

The study carried out by the Fundaci3n Secretariado Gitano in 2009, showed that, out of the 7 EU countries, Romania had the largest proportion of Roma minors that had not completed the entire child vaccination schedule (45.7%), a proportion that was almost double the average of these seven countries. Roma girls were less frequently vaccinated than Roma boys, and children from isolated Roma communities, with bad self-reported health status were also

---

<sup>62</sup> See at: [www.ms.ro/?pag=133](http://www.ms.ro/?pag=133)

<sup>63</sup> See at: <http://data.euro.who.int/hfad/>

<sup>64</sup> See at: [www.recensamantromania.ro/rezultate-2/](http://www.recensamantromania.ro/rezultate-2/)

less frequently vaccinated. The main reason stated by parents for not completing the vaccination schedule or missing it all together was that “the parents forgot to vaccinate their children”, followed by lack of information on the service and insufficient financial resources.<sup>65</sup> Similarly, the study carried out in 2013 by the ERRC showed that the number of unvaccinated Roma children (6.4%) was four times higher than non-Roma children (1.7%), and the number of unvaccinated Roma girls (6.6%) was eleven times higher as compared with non-Roma girls (0.6%).<sup>66</sup>

### 2.3.5. Access to primary health care and ambulatory services

The family doctor holds a principal role in the Romanian health-care services provision framework, and is supposed to be the one that guides the patient through all the health-care pathways required for diagnostics and treatment of most health problems. However, twelve out of forty localities with the highest percentage of Roma analysed in 2012 did not have a family doctor serving the locality.<sup>67</sup> Some reports issued by Roma NGOs, such as Romani CRISS, stated that even in localities where a family doctor is present, in some cases, the Roma population is discriminated against and they do not receive the same attention as the non-Roma population.<sup>68</sup>

Most of the outpatient specialised health-care services are obsolete, lacking adequate diagnostics facilities and personnel, and are, for the most part, located in the capital city of a given district, even though some may exist in other cities as well. Considering that the majority of Roma live in rural areas and that the poverty rate is higher among Roma, medical check-ups conducted by a specialist physician are only possible through appointment and referral from the family doctor, and certain specialised services might only be available as costly private services, it is highly likely that Roma face obstacles in accessing these services. In this respect, an unpublished study conducted by the World Bank Group in 2013 stated that “*while the vast majority of Roma feel that they have access to doctors when needed, only 28 per cent of Roma households report medical check-ups on every occasion they are required as opposed to almost 70 per cent of their non-Roma neighbours*”.<sup>69</sup>

According to the CRISS study carried out in 2009 in seven EU countries (BG, CZ, EL, ES, PT, SK, and ROM), 7.8 per cent of Roma children and 27.1 per cent of Roma adults had visited a physician more than one year ago and about 3 per cent of Roma children or adults had never visited a physician at all. Compared with Roma in the other six EU countries participating in the study, Romanian Roma appears to go for medical check-ups less often. However, in terms of the scope of the check-up, the only difference compared with Roma in the other EU countries concerns the certification of sick leave (0.2% for Romanian Roma versus 1.4% Roma average in the countries studied). Furthermore, 7.3 per cent of Romanian Roma had

---

<sup>65</sup> “*Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)*” – Madrid (2009); “*Sanatatea si comunitatea roma - analiza a situatiei din Romania, Romani*”, CRISS Bucuresti (2009).

<sup>66</sup> “*Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate*”, ERRC Budapesta (2013).

<sup>67</sup> Centrul National pentru Statistica si Informatica in Sanatate Publica. See at: [www.insp.gov.ro](http://www.insp.gov.ro)

<sup>68</sup> Romani CRISS annual reports (2007–2011).

<sup>69</sup> “*Diagnostics and policy advice for supporting Roma inclusion in Romania*”, Bucharest, The World Bank Group 2014.



unaddressed medical needs as compared with a 7.5 per cent average in the seven countries studied.<sup>70</sup>

Furthermore, the study conducted in 2013 by the World Bank Group, showed that the number of Roma with unaddressed medical needs reached 11 per cent and was more than double as compared with non-Roma (5%). The main reason for this appeared to be the cost of the medical check-up (72% of Roma versus 56% of non-Roma), followed by transportation costs (48% of Roma versus 31% of non-Roma).<sup>71</sup>

### 2.3.6. Access to emergency services

Emergency services are the most accessible health-care services in Romania, although their distribution is not uniform throughout the country. 18.8 per cent of Roma adults and 13.7 per cent of Roma children had used emergency services in the last twelve months, according to the 2009 CRISS study, with a preponderance of women and persons above 45 years of age. Nevertheless, Romanian Roma reported less frequent use of emergency services (16.7%) in the last 12 months as compared with the Roma average in the 7 EU countries studied (24.1%).<sup>72</sup> As regards Roma in rural areas, an analysis of inpatient hospitalisation records shows a higher probability of being admitted to the hospital through emergency services or due to an emergency for Roma (63%) as compared with non-Roma (50%).<sup>73</sup>

### 2.3.7. Access to hospital services

The 2009 study showed that one in six Roma in Romania were hospitalised at least once during the last year, more frequently women and persons 45 years of age and over. This number is somewhat similar to the average rate of hospitalisation of Roma throughout the seven EU countries included in the CRISS study, with the exception of the age group of 45 and over (37.4% for Romanian Roma and 27.3% average for Roma from the seven EU countries). Further information is not available in order to explain this difference. Romanian Roma reported that the main reason for hospital admission was medical treatment (47.9%), followed by diagnostic procedures (23.7%), and deliveries (15.2%).<sup>74</sup>

Based on 2013 data from the national hospital database, 64 per cent of hospitalised persons living in localities with a high percentage of Roma were adults as compared with 83 per cent of hospitalised persons from localities with majority non-Roma. In addition, the average age for admission to a hospital in 2013 was 51 years for persons from localities with a high number of Roma as compared with 55 years for persons from localities with majority non-Roma. In 2013, the top six hospital discharge diagnoses by category for persons from localities with a high number of Roma were: viral pneumonia, acute bronchiolitis, chronic obstructive

---

<sup>70</sup> "Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)" – Madrid (2009); "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS Bucuresti (2009).

<sup>71</sup> "Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate", ERRC Budapesta (2013).

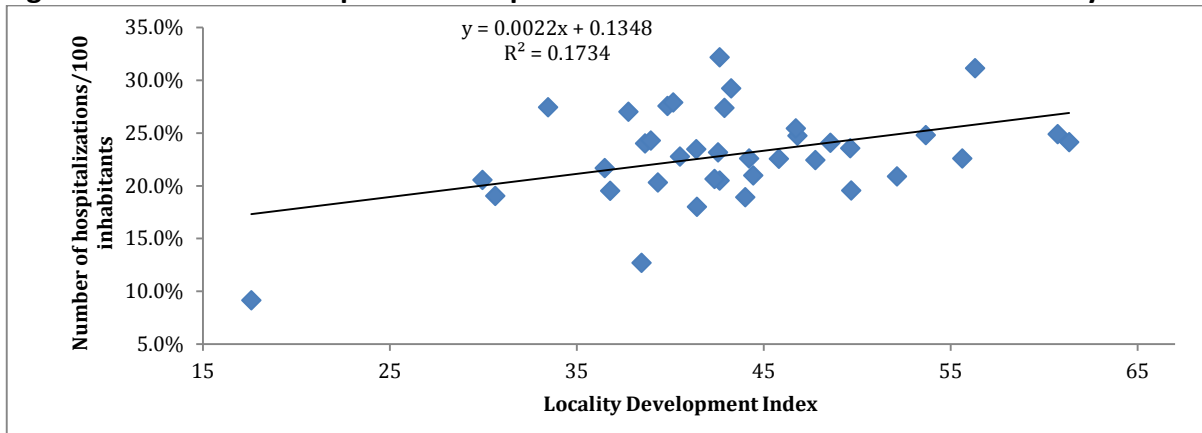
<sup>72</sup> "Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)" – Madrid (2009); "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS Bucuresti (2009).

<sup>73</sup> Hospital database 2013.

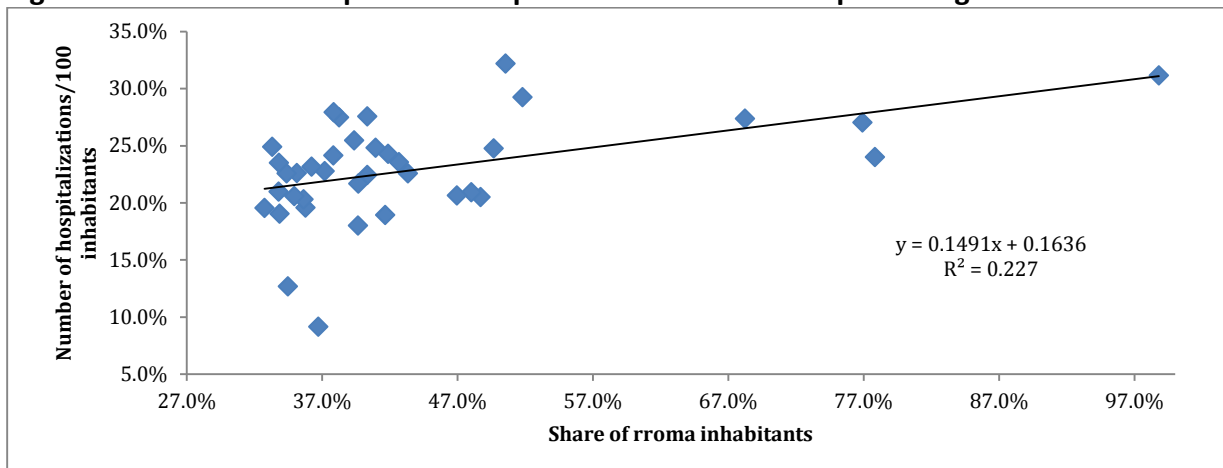
<sup>74</sup> "Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)" – Madrid (2009); "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS Bucuresti (2009).

pulmonary disease (COPD), normal and premature deliveries, threatened abortion, and infectious diarrhoea.<sup>75</sup>

**Figure 13: Number of hospitalisations per 100 inhabitants and LSD index of locality**



**Figure 14: Number of hospitalisations per 100 inhabitants and percentage of Roma**



Moreover, data from the 2013 hospital database indicated that there is a correlation between the number of hospitalisations from localities with more than 30 per cent Roma and the level of socio-development index of the locality. Figure 14 shows that a higher number of Roma inhabitants in the locality, is linked to a higher number of hospitalisations.

In conclusion, the number of hospital admissions is proportional to the level of the LSD index in such a way that people from localities with a higher LSD index can afford to travel further and be admitted to the hospital. Also there is a correlation between the percentage of Roma inhabitants and the number of hospital admissions per year, the latter being higher in localities with a higher percentage of Roma.

<sup>75</sup> Hospital database 2013.



### 2.3.8. Access to dental services

Dental care in Romania is mostly offered through private dental practices. Only a few dental offices have a contract with the NHIF and they provide mainly preventive dental services for children, as well as certain dental emergencies. Health insurance funds allocated to this sector are insignificant when compared with the rest of the medical domains, and the geographical locations of dental offices offering subsidised public services are unevenly distributed throughout the country. Thus, access to dental services is almost entirely dependent on financial affordability and, in this respect, is inaccessible for the poorest Roma.

According to the 2009 CRISS study, almost half of Roma respondents declared that they had never visited a dentist (44.3%), with a higher proportion of children (59.5%) compared with adults (33.7%). In addition, 62.1 per cent of Roma adults declared the presence of cavities, but only 26.3 per cent of those declared being able to afford treatment. Access to dental services is correlated with the geographical situation of the locality (integrated versus isolated) and self-assessment of the health status of the respondents, (*35.5% Roma from isolated and bad health status versus 78.5% Roma from integrated and good health status*). The number of Roma living in Romanian who has never been to the dentist is much higher (44.3%) than the Roma average for all seven EU countries (32.5%).<sup>76</sup>

### 2.3.9. Access to medicines

More than 25 per cent of the NHIF is spent on medicines. However, access to newer and more cost-effective drugs, especially for certain major public health problems such as cancer, chronic viral hepatitis, COPD, and psychiatric disorders, is limited. Most of the drugs are prescribed and reimbursed in various percentages through the basic health package, limiting access to medicines to insured persons and those with financial means. Romanian people's perception regarding the price of over-the-counter medicines is that, despite the high prices, consumption is also high.

According to the study carried out by Romani CRISS in 2009, 62.8 per cent of Roma respondents consumed at least one medicine during the last two weeks. The consumption of medicines increased with age and was more prevalent among women (75%) than men (48.7%). Also, nearly half of the medicines consumed were without prescription (self-medication) and the proportion of women that self-medicate is higher than that of men.<sup>77</sup>

Most medicines consumed by Roma children were intended for treatment of common colds (37%) and fever (33%), as well as vitamins (17.9%) and antibiotics (15.2%). A health professional prescribed slightly over 50 per cent of medicines consumed by Roma children, and the rest were self-administered. As regards Roma adults, most medicines consumed were intended for treatment of common colds (39.9%), fever (31.2%), and high blood pressure (21.9%), as well as antibiotics (19.3%), contraceptives (18.9%), cardiovascular drugs (17.7%), and non-steroidal anti-inflammatory drugs (NSAID) (16.5%). An important amount of drugs consumed by Roma adults was self-administered. This consumption behaviour raises

---

<sup>76</sup> "Health and the Roma Community, analysis of the situation in Europe (BG, CZ, EL, ESP, PT, RO, SK)" – Madrid (2009); "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS Bucuresti.

<sup>77</sup> "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS Bucuresti.

questions about the access to adequate diagnostic and treatment services for Roma, as well as their access to financial resources and prioritisation of these funds for buying medicines.<sup>78</sup> On the other hand, the study carried out by the ERRC in 2013 showed that Roma asked more often (22%) than non-Roma (18%) the physician or pharmacist to prescribe or provide cheaper medicines, delay the medicine procurement (25% for Roma and 15% for non-Roma), chose not to buy drugs (21% for Roma and 12% for non-Roma), and bought less medicines than prescribed (23% for Roma and 14% for non-Roma).<sup>79</sup> All of this is probably linked to a lack of money or an attempt to save money.

### 2.3.10. Spatial accessibility

The average distance to the nearest general practitioner (GP), primary health-care post or pharmacy is around 3 kilometres for more than 80 per cent of Roma households in Romania, which is far below the 5–10 km considered to be the maximum distance in terms of spatial access for vulnerable Roma communities living in rural or isolated areas. Nevertheless, only one quarter of Roma households live in proximity of an outpatient clinic or hospital.<sup>80</sup>

### 2.3.11. Financial accessibility

The most frequently reported obstacle related to access to different health-care services is the lack of financial means: 84 per cent of Roma declare they cannot afford to pay as compared with only 62 per cent of non-Roma living in proximity of Roma communities surveyed (UNDP/WB/EC Regional Roma Survey, 2011).<sup>81</sup> The figure for Roma decreased to 72 per cent in 2013, according to the ERRC study. Even so, it remains high, as well as for non-Roma (56%).<sup>82</sup> Bribery/informal payments, medicine (including vaccines) costs, laboratory test costs and co-payment of medical diagnostic services needed for diagnosis, as well as payment of medical services for uninsured Roma are considered to be the main financial barriers in terms of access to timely health-care services for the Roma population.

### 2.3.12. Experiences and perceptions of discrimination on the grounds of ethnicity

Discrimination on the grounds of ethnicity can take different forms as regards access to health-care services. Firstly, there is the unequal availability of services throughout the country, especially in rural areas and isolated communities, and Roma live predominantly in these types of communities.

Another type of discrimination with regard to accessing health-care services is related to the cost of and lack of information on these services. Roma are affected by severe poverty, lower education attainment and less job opportunities, making them more vulnerable towards discrimination practices. Roma are subject to multiple discriminatory attitudes when accessing health-care services, particularly as regards health insurance entitlements, enrolment in family doctors' patient lists, and hospital admissions, especially for obstetric and

---

<sup>78</sup> "Health and the Roma Community, analysis of the situation in Europe", Madrid (2009); "Sanatatea si comunitatea roma - analiza a situatiei din Romania", Romani CRISS Bucuresti.

<sup>79</sup> "Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate", ERRC Budapesta (2013).

<sup>80</sup> UNDP/World Bank/EC Regional Roma Survey 2011.

<sup>81</sup> "Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate", ERRC Budapesta (2013).

<sup>82</sup> Ibid.

paediatric care. Certain groups of Roma, such as women and children, as well as persons living with HIV/AIDS, are even more vulnerable to discrimination practices than others.<sup>83</sup>

Several surveys and qualitative studies conducted over the last ten years have assessed discriminatory practices towards Roma related to their access to health-care services. An EU-MIDIS survey carried out in 2009 in seven EU countries (RO, BG, HU, CZ, SK, PL, GR), showed that 11 per cent of Romanian Roma respondents had experienced some type of discrimination when accessing health-care services in the last twelve months, and 20 per cent said the same for the last five years.<sup>84</sup> This was the second most frequent reason for Roma to experience discrimination following that related to seeking employment. The UNDP/WB/EC Regional Roma survey from 2011 showed that, when accessing health-care services in the last 12 months, Roma experienced discrimination seven times more often than their non-Roma peers living in proximity of Roma communities surveyed.<sup>85</sup>

In Romania, there is a well-established governmental institution whose aim is to fight against all kinds of discriminatory practices (*National Council against Discrimination*), and a number of NGOs actively work to identify discriminatory practices against Roma. According to NGO reports, over the last 10 years, there were isolated cases of discrimination against Roma, such as refusal of family doctors to enrol Roma patients on their lists despite their insurance, refusal to offer certain health-care services (vaccinations, home visits), and segregated spaces (rooms) for Roma women and children in maternity and hospital wards.<sup>86</sup>

Another type of extreme form of discrimination regards forced evictions related to public health issues (living near waste disposing facilities), where Roma were moved from a slum neighbourhood to inadequate housing, without access to any utilities, near a polluted industrial site and without public transportation access to the city, all of which worsened their health status.<sup>87</sup>

Almost half of Roma respondents interviewed for the EU–MIDIS survey in 2009 considered that discrimination based on ethnicity is widespread, even though 81 per cent of the persons surveyed did not report discriminatory experiences to an organization and 89 per cent of the persons surveyed were not aware of any institution that can offer support in this regard.<sup>88</sup> Valuable tools for fighting against and reducing discriminatory practices related to access to health-care services for Roma are interventions by RHMs, as well as cultural sensitivity trainings offered to health-care personnel.<sup>89</sup>

---

<sup>83</sup> “*Romania Roma Decade Progress Report*”, National Roma Agency 2012; “*Riscuri și inechități sociale în România* Comisia Prezidențială”, Pentru Analiza Riscurilor Sociale și Demografice, Bucuresti (2009).

<sup>84</sup> “*The Roma; EU-MIDIS European Union Minorities and Discrimination Survey (BG, CZ, EL, HU, PL, RO, SK)*” - OSCE Budapest (2009).

<sup>85</sup> UNDP/World Bank/EC regional Roma survey 2011.

<sup>86</sup> “*Romania Roma Decade Progress Report*” National Roma Agency 2012; National Roma Agency and Romani CRISS annual reports (2005–2011).

<sup>87</sup> “*Forced Out: The Problem of Roma Evictions in Europe*”, Dzeno Association Prague (2010).

<sup>88</sup> “*The Roma; EU-MIDIS European Union Minorities and Discrimination Survey*” - OSCE Budapest (2009).

<sup>89</sup> “*Roma Health Mediators: Successes and Challenges*” - Open Society Institute (2011); “*Evaluarea impactului programului de mediere sanitară*”, Bucuresti Sastipen, INSP (2011).

## 2.4. Policy framework with a specific focus on the NRIS

### 2.4.1. European Union and Council of Europe Framework

Roma integration has been on the European agenda for a long time, evolving alongside the EU enlargement process and moving from addressing different sectors (education, employment, health and housing) to more integrated approaches, and by mainstreaming Roma issues into broader social policies.

Roma health, together with the other three sectors mentioned above, has been addressed through various EU policies and programmes.<sup>90</sup> Prior to 2010, the EU health strategies and community action programmes on health, while not mentioning Roma issues explicitly, focused on minorities' health, social determinants of health and health inequities through their objectives and allocation of funds. Efforts as regards Roma health were constantly reinforced through the EU framework of legislative, financial and policy coordination tools together with EU Member States' strategies and action plans on Roma health issues. Nevertheless, several reports showed that much remained to be done in order to decrease the gap between the health of Roma and non-Roma and innovative approaches had to be sought in order to achieve this goal.

Thus, in 2009, the European Platform for Roma decided to address these challenges through exchanges of good practices and experiences, with the aim of stimulating cooperation and increasing the coherence and effectiveness of the parallel policy processes at regional, national, European and international level.<sup>91</sup> In 2010, the new EU 2020 Strategy "*A strategy for smart, sustainable and inclusive growth (2010–2020)*" was released with the overall objective of smart, sustainable and inclusive growth for the entire European population. One of its flagship initiatives, "The European Platform against poverty", tackles the issue of Roma integration, and, consequently, the disparities and gaps between the health of Roma and non-Roma. In order to achieve more tangible results, an EU framework for National Roma Integration Strategies (NRIS) was developed in 2011 by the European Commission (EC), setting clear goals for each of the four domains – education, employment, health, and housing and essential services, goals that would have to be reflected in the Revised NRIS Action Plans of each Member State.<sup>92</sup>

In 2012, the EC undertook an assessment, based on the goals of the EU framework for NRIS, looking at how the four key areas and the structural requirements, as well as funding, are addressed by each EU Member State.<sup>93</sup> In 2013, the Council of Ministers issued a recommendation for Member States on effective Roma integration measures, stressing the importance of optimal access to health care, especially to health education, preventive services, reproductive health, immunisation, and maternal and child services, for disadvantaged and marginalised groups.<sup>94</sup>

---

<sup>90</sup> See at: [www.anr.gov.ro/index.php/transparenta/rapoarte](http://www.anr.gov.ro/index.php/transparenta/rapoarte)

<sup>91</sup> "*The social and economic integration of the Roma in Europe*" - Brussels, 7.4.2010 COM(2010)133 final.

<sup>92</sup> "*An EU Framework for National Roma Integration Strategies up to 2020*" - Brussels, 5.4.2011 COM(2011) 173 final.

<sup>93</sup> "*National Roma Integration Strategies: a first step in the implementation of the EU Framework*" - Brussels, 21.5.2012 COM(2012) 226 final.

<sup>94</sup> COUNCIL RECOMMENDATION of 9 December 2013 on effective Roma integration measures in the Member

On the other hand, in 2010, the Council of Europe issued “The Strasbourg Declaration on Roma”, underlining the importance for European States to “ensure equal access for all Roma to the health-care system by using health mediators and providing training for existing facilitators”.<sup>95</sup>

#### 2.4.2. Other relevant recommendations regarding Roma health (UN)

Several United Nations (UN) agencies and international organizations play an important role in supporting Roma integration issues, including improving Roma health initiatives through the implementation of tailored programmes in cooperation with government bodies, public authorities and NGOs. For instance, some of the Millennium Development Goals, such as infant mortality, maternal health, and HIV/AIDS, established in 2000 and agreed to by all UN Member States and various international organizations, address Roma health inequities specifically. Furthermore, valued support towards addressing Roma issues has been provided to the Government of Romania over the past twenty years by IOM and various UN programmes and agencies (WHO, UNDP, UNICEF, UNFPA, UNAIDS). Some UN agencies have also supported actions developed as part of the Roma Decade inclusion initiative, as well as the South Eastern Europe Health Network, relevant for countries in the region.<sup>96</sup>

#### 2.4.3. National Roma Integration Strategies

##### 2.4.3.1. Preparatory works

After a long period of neglect and silence during communism, in Romania, Roma issues finally became visible and part of the public debate after 1990. The first several years were characterized by exploratory policies and programmes trying to capture the magnitude of the issue, followed by more structured actions implemented by public institutions, as well as the non-governmental sector, including the preparatory work for drafting the first NRIS. Starting with the year 2000, alongside actions taken by the Government of Romania towards EU integration (e.g. Accession Partnership), various policies related to Roma integration in Romania were drafted, approved, and partially implemented. These policies are briefly outlined hereafter:

##### 2000

- “Government Programme 2001–2004” – the health policy chapter, although extensive in terms of addressing disadvantaged groups, maternal and child care, and pensioners through improved access to primary health-care services, did not mention Roma health issues at all. The chapter on policies directed at minorities mentioned specifically health education for Roma;

##### 2001

- First “Romanian Government Strategy towards improving the situation of Roma for the period 2001–2010 (NRIS)”, along with a medium term action plan (2001–2004) and a long term general action plan (2006–2008), were approved

---

States – (2013/C 378/01).

<sup>95</sup> “The Strasbourg Declaration on Roma”, Council of Europe 2010.

<sup>96</sup> See at: <http://seehnsec.blogspot.ro>

by Government Decision 430/2001 and updated by Government Decision 522/2006;

## 2002

- A “*National Plan for combating poverty and promoting social inclusion 2002–2012*”, along with a revised action plan (2006–2008), were approved by Government Decision 829/2002 and updated by Government Decision 1827/2005. Out of the total number of strategic objectives, two targeted specific health issues (improvement of access to health-care services, and improvement of child and youth health) related to universal access to the minimum health benefit package, reproductive health, maternal and child health services, rural health services, decreasing morbidity and avoidable deaths, and infant mortality.
  - Although Roma were identified as a social group lacking access to health-care services, none of the 13 objectives on health in the National Plan mentioned Roma health. This was in contradiction with two out of the eight strategic objectives of the *Government of Romania strategy for the improvement of the situation of Roma* that underlined the importance of ensuring access to reproductive health-care services, maternal and child care services, and universal access of Roma to the minimum health benefit package, irrespective of their health insurance status.
  - The lack of clear coordination mechanisms for all of the actions mentioned above coupled with the involvement of multiple institutions (National Office for Roma, Ministry of Labour and Social Security, and Ministry of Health and Family), and a high dependence on the Ministry of Finance and political will for funding, could be the reasons for the slow progress on Roma health issues in Romania during this period. Particularly, between 2006 and 2008, only programmes coordinated by the MoH and financed from the State budget, including reproductive health, maternal and child health services, and RHMs, had clearly allocated funds in the national health budget plan. None of the other health policies, such as universal access to minimal health benefit package or rural health, had explicitly allocated funds.

## 2004

- “*Government Programme 2005–2008*” – the health policy chapter promoted improvement of preventive services and primary health care in general, but there was no other specific provision on Roma health. The chapter on policies directed at minorities referred to the increase of the cost-effectiveness of Roma access to health-care services along with access to educational and social services for this group;

## 2005

- “*Joint Memorandum on Inclusion*” – took into account the situation of vulnerable groups, including Roma, and their access to different types of services. Roma health disparities were acknowledged and some of their determinants were recognised, and priority for implementation was given to the development of joint social and medical services for Roma, especially for access to primary health-care services, reproductive health, and maternal and child health-care services.

- *“National Development Plan 2007–2013”* – programmatic document that provided a thorough situation analysis of Roma as regards different sectors, and presented the priorities for development and financing through EU structural funds. The health chapter, while it described the disparities between rural and urban areas in terms of access to health-care services, did not mention anything about Roma health. Most of the EU structural funds allocated to the health sector were directed to the rehabilitation of outpatient and district hospitals, to managing medical waste, and electronic health tools.<sup>97</sup> Some of the funds were focused on training of health professionals (mostly hospital nurses, midwives, community nurses, and RHMs);

#### **2007**

- *“National Strategic Reference Framework 2007–2013”* – another programmatic document that accompanied the previous one and provided substantiation of each field of intervention to be financed through EU structural funds. Although the poor health status of Roma was mentioned explicitly in the document, further action plans for funding were not mentioned;

#### **2008**

- *“Government Programme 2009–2012”* – the health policy chapter mentioned only one specific measure related to Roma health (*“quality improvement of sociomedical services provided at community level through RHMs and community nurses”*). The chapter on policies directed at minorities mentioned the increase of the cost-effectiveness of Roma access to health-care services along with access to other services for this group (*unchanged from the previous government programme*);

#### **2011**

- Second *“Strategy of the Government of Romania for the inclusion of Romanian citizens belonging to the Roma minority for the period 2012–2020 (NRIS)”*, along with sector action plans and indicators, approved by Government Decision 1221/2011;

#### **2012**

- *“Government Programme 2013–2016”* – the health policy chapter does not mention anything specific about Roma health. The chapter on policies directed at minorities refers to the increase of the cost-effectiveness of Roma access to health services along with access to other services for this group (*identical with the previous programmes*);

#### **2013, 2014**

- Updated versions of the *“Strategy of the Government of Romania for inclusion of Romanian citizens belonging to Roma minority for the period 2012–2020 (NRIS)”*.

---

<sup>97</sup> See at: [www.inforegio.ro/ro/axa-3.html](http://www.inforegio.ro/ro/axa-3.html); [www.fonduri-ue.ro/posdru/index.php/implementeaza/lista-beneficiari](http://www.fonduri-ue.ro/posdru/index.php/implementeaza/lista-beneficiari); [www.fonduri-ue.ro/poscce/](http://www.fonduri-ue.ro/poscce/); [www.posmediu.ro](http://www.posmediu.ro)

## 2.4.3.2. Evaluation of National Roma Integration Strategies in Romania

### 2.4.3.2.1. Evaluation of the health component of the first NRIS 2001–2010<sup>98</sup>

Based on interviews and discussions with the main stakeholders involved in its drafting and implementation, the following positive and negative aspects as regards the first NRIS should be highlighted:

Positive aspects:

- Government commitment at the highest level;
- Clearly stated objectives, principles and domains of intervention;
- Establishment of dedicated institutions at all levels across the government (horizontal and vertical);
- Comprehensive document addressing various social, economic, cultural and civil and political rights;
- A wide array of health-related objectives aimed at improvement of Roma health along with clear actions, deadlines, and stakeholders responsible.

Negative aspects:

- High turnover of decision-makers (stakeholders), which had a negative impact on the implementation of the strategy;
- Poor accountability and a high turnover of decision makers at the National Roma Agency coupled with the powerlessness of this institution in terms of its relationships with line ministries, including the MoH, contributed to the low achievement of results;
- Frequent changes of the institution responsible for the leadership and implementation of the strategy;
- Preferred partnership and collaboration with only one Roma NGO impeded the successful implementation of the strategy;
- Roma health objectives not formulated in a wider context of social determinants of health;
- Lack of development of subsequent documents to monitor the progress of the implementation of the health component after 2002;
- Lack of indicators to monitor the progress (2001–2005), no dedicated budget and financial resources (2001–2005) for the health component of the strategy.

The main achievements and shortcomings related to the implementation of the health component for the period 2001–2005 are as follows:

- **Health objective 1:** *To improve Roma access to preventive and curative health-care services, through the institutionalisation of the RHM system, and the setting-up and implementation of tailored programmes for prophylaxis and treatment. **Partially achieved.*** The establishment of the RHM system is probably the most successful policy aimed at addressing Roma health disparities in Romania thus far. Nevertheless, the institutional capacity of this system needed to be further strengthened in order to fully benefit from the results. Regarding the second part of the action, a few initiatives were

---

<sup>98</sup> “HG 430\_25.04.2001 privind aprobarea Strategiei Guvernului României de îmbunătățire a situației romilor”, București, MOF (2006).



implemented as public health programmes targeting Roma, such as reproductive health, immunisation, and maternal and child health services. Tailored preventive services tackling the most prevalent chronic diseases amongst Roma were omitted completely.

- **Health objective 2:** *To train RHMs, nurses and physicians from Roma communities. Achieved.* In order to increase the number of RHMs several training sessions were organized in collaboration with specialised NGOs, with technical support and funding from international organizations.
- **Health objective 3:** *To identify solutions for Roma enrolment in the social health insurance system and family doctors' patient lists, and for provision of reimbursement for drugs. Partially achieved.* The main solution found was to provide support and facilitation to Roma through RHMs. Although progress was made, communities without RHMs, and persons lacking identification documents, a steady residence or employment, and proper health education ran the highest risk of being uninsured and, consequently, lacked adequate access to family doctors and medicines.
- **Health objective 4:** *To draft and implement health education programmes and family planning for Roma women, focusing on maternal and child health. Partially achieved.* Some activities targeting Roma women and children were developed and implemented irregularly throughout the country by District Public Health authorities contingent to the decision-makers' priorities and funding.
- **Health objective 5:** *To carry out immunisation campaigns in Roma communities through mixed teams, including local Roma representatives. Partially achieved.* Although several immunisation campaigns were carried out, the vaccination coverage rate for Roma children continued to be lower than the rate for non-Roma children.
- **Health objective 6:** *To carry out screening campaigns for TB, HIV/AIDS, dermatological problems, STDs, etc. Partially achieved.* Several communicable diseases campaigns were carried out jointly with specialised NGOs and support and funding from international organizations; nevertheless, Roma continued to be disproportionately affected by these diseases.
- **Health objective 7:** *To perform epidemiological studies on the health status of Roma. Partially achieved.* During the implementation period, Romanian public health authorities conducted only one epidemiological study on the health status of Roma, through a "Twinning Light" project with the Dutch Ministry of Health, mainly due to difficulties in collecting ethnically disaggregated data, as well as due to lack of funds. On the other hand, a number of local NGOs and international organizations carried out studies on the health status of Roma, some of them using debatable methodologies for sampling and presentation of the results. According to the National Programme for the assessment of the health status more than 60 per cent of the entire population of Romania, regardless their insurance status, was evaluated for several health risks between 2007 and 2008, but the results have not been published yet. Some of the intermediate results comparing health behaviours of persons residing in communities with more than 30 per cent Roma with persons living in communities without Roma are presented in the first chapters of the present report.
- **Health objective 8:** *To increase the number of health professionals of Roma origin by allocating special places for Roma students in public medical universities. Achieved* Approximately 50 Roma medical students were enrolled in public medical universities

every year.

The main achievements and shortcomings related to the implementation of the health component for the period 2006–2010 are as follows:

- **Health objective 1:** *Expand the health sector human resources pool necessary to improve the access of Roma to public health services. **Achieved.*** During this period, the number of RHMs, as well as their access to continuous training, increased steadily throughout the country.<sup>99</sup>
- **Health objective 2:** *Increase the capacity and cost-effectiveness of health-care services provided by the public sector, in order to ensure the provision of equal health services to and treatment of persons belonging to the Roma minority. **Partially achieved.*** In the absence of valid baselines and final data it is hard to provide an adequate assessment regarding the accomplishment of this health objective. Also, during the period from 2006 to 2008, Romanian public health officials did not carry out an assessment on cost-effectiveness or prioritisation of public health services for Roma or the general population.
- **Health objective 3:** *Ensure universal access to the minimum health benefit package, including for Roma. **Partially achieved.*** On the one hand, the way the minimum health benefit package was structured was not suitable to tackle the main health problems of Roma as it did not cover the main chronic diseases. On the other hand, persistent problems related to identification and residence documentation, lack of stable employment, extreme poverty, and absence of proper health education, alongside the Roma cultural environment, had a negative impact on the equitable access of Roma to health-care services, including those that are part of the minimum health package.

#### 2.4.3.2.2. Evaluation of the health component of the second NRIS 2012–2020<sup>100</sup>

Based on interviews and discussions with the main stakeholders involved in its drafting and implementation, the following positive and negative aspects as regards the second NRIS should be highlighted:

Positive aspects:

- Government commitment at the highest level;
- Clearly stated objectives, principles and domains of intervention;
- Engagement of dedicated institutions at all levels across the government, NGOs, and the Roma population for improving the level of socioeconomic inclusion of Roma;
- Establishment of a dedicated internal body inside the MoH to monitor and evaluate the progress of the implementation of the NRIS;
- Identification of key challenges and targets as regards increasing access to public health services for Roma, the number of RHMs, health education campaigns on TB prevention and vaccination coverage (in accordance with the interim EC evaluation of the second NRIS).<sup>101</sup>

---

<sup>99</sup> “Roma Health Mediators: Successes and Challenges” - the Open Society Institute (2011).

<sup>100</sup> “HG 1221\_04.01.2012 pentru aprobarea Strategiei Guvernului Romaniei de incluziune a cetatenilor romani apartinand minoritatii romilor pentru perioada 2012–2020”, Bucuresti, MOF (2012).

<sup>101</sup> “NRIS a first step in the implementation of the EU framework” - European Communities, (2012).

Negative aspects:

- High turnover of decision-makers (stakeholders), which has a negative impact on the implementation of the strategy;
- Poor accountability and a high turnover of decision makers at the National Roma Agency coupled with the powerlessness of this institution in terms of its relationships with line ministries, including the MoH, contributed to the low achievement of results;
- Health specific objective, which is too narrow and unrealistic, and does not take into account the EU 2020 strategy and subsequent documents;
- Restrictive direction of actions in the health component (focusing only on increasing vaccination coverage and hygiene in Roma communities without taking into consideration Roma health indicators for major chronic diseases);
- Roma health objectives not formulated in a wider context of social determinants of health;
- No links between the health component and the other components of the strategy;
- Lack of comprehensive approach for the health objective and its subsequent actions;
- Very few input and process indicators to monitor implementation progress;
- No specific budget for health activities;
- Insufficient in size and scope – calendar, targets, indicators, concrete measures to increase health insurance coverage are missing (according to the EC evaluation).<sup>102</sup>

The main achievements and shortcomings to date related to the implementation of the health component of the NRIS 2012–2020<sup>103</sup> are as follows:

**Specific objective:** *Implement health promotion measures, which can contribute to increasing the access of citizens belonging to the Roma minority to public health services and to an increase in life expectancy.* The specific objective of the NRIS as regards health is very limited in scope and is poorly structured, attempting to link health promotion activities, increased access for Roma to public health services and increased life expectancy.

The following two actions were established in order to fulfil the objective above:

1. *Campaigns to vaccinate unvaccinated children in communities inhabited by Romanian citizens belonging to the Roma minority.* **Partially achieved.** Several targeted immunisation campaigns were organized throughout the country aiming to cover Roma children, but organizational issues related to vaccine procurement and distribution, as well as Roma particularities towards vaccination, have hindered the process in such a way that the latest survey<sup>104</sup> showed major gaps between the immunisation coverage rate of Roma children compared with non-Roma children.

2. *Health education campaigns in the field of TB prevention in communities inhabited by Romanian citizens belonging to the Roma minority.* **Partially achieved.** These types of campaigns have been carried out for several years; the major problem in 2012 and 2013 was the constant decrease of funds allocated to these activities.

---

<sup>102</sup> "NRIS a first step in the implementation of the EU framework" - European Communities (2012).

<sup>103</sup> (Assessment is performed for period 2012–2014).

<sup>104</sup> "Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate", ERRC Budapesta (2013).

The following activities supplement these two priorities:

- *To raise the awareness of and inform members of Roma communities on certain health issues: preventive campaigns carried out at local level intended specifically for women and children. Partially achieved. The action was partially achieved through RHMs or specialised NGOs. Specific process indicator mentioned (number of campaigns/year);*
- *To improve the access of the Roma population to preventive and therapeutic public medical care, by institutionalising the RHMs system, and creating and implementing specific prevention and treatment programmes. Partially achieved. This activity was rolled over from the previous NRIS without refinement and needs to be adjusted to the present situation as regards the RHMs system and the problems faced in terms of the transition of ownership of the system from national to local authorities, the reduction of funding, and the lack of adequate monitoring and evaluation systems;*
- *To support, in accordance with existing laws, young Roma who attained higher education in the medical sector, in order to employ them in the labour market, especially in communities made up of mainly Roma populations. Not achieved. Currently, employment, especially in the public hospital sector, is restricted because of tight financial rules applied due to previous arrears. On the other hand, there are an increasing number of rural and isolated communities that do not have family doctors, mainly due to the temporary or permanent migration of medical personnel to other EU Member States, especially young graduates;*
- *To identify solutions for including members of the Roma minority in the health insurance system, registering them with a family doctor, offering them access to subsidized medicines, etc. Partially achieved. This activity was rolled over from the previous NRIS, without taking into account the underlying factors contributing to the high number of uninsured Roma;*
- *To draft and implement health education and family planning programmes for Roma women, focusing on maternal and child health. Partially achieved. This activity was rolled over from the previous NRIS, without taking into account the constant reduction of funds allocated to these programmes;*
- *Organize vaccination campaigns in Roma communities carried out by mixed teams made up of local medical staff and personnel from the Department of Public Health (Communicable Diseases Epidemiology Unit) and representatives of the Roma communities. Partially achieved. See first priority above;*
- *Organize and implement information, education and communication (IEC) campaigns on preventing TB, HIV/AIDS, sexually transmitted diseases, hepatitis and other communicable diseases, adapted to the specific features and cultural aspects of the Roma minority, followed by studies on the health status of the Roma population, in accordance with the campaigns carried out by the Ministry of Health and NGOs. Partially achieved. Due to the constant decrease of funds allocated to IEC activities, along with funding phase-out from international organizations for this purpose, this activity was difficult to implement properly (2,700 activities implemented in 2013);*
- *Analyse the situation of RHMs employed by local authorities in accordance with the strategy of decentralising public health services, to get a clear image as to the status of the health mediator and allow for the programme to be redefined in the new context of decentralising public health services; upgrade the occupational standard of health*

mediators; develop a programme for permanent monitoring and periodic assessment of the implementation of health mediation. Partially achieved. An impact study was carried out in 2011,<sup>105</sup> providing answers to some of the issues listed above. In 2013, the MoH carried out an extensive assessment on the status of RHMs in every district, pointing out the shortcomings, as well as the need to improve this activity;

- *Continue to train and employ health mediators from Roma communities whose role is to facilitate the dialogue between Roma and medical institutions and staff, and to assist in the registration of Roma on family doctors' patient lists. Partially achieved. Some NGOs offered training for RHMs despite the fact that the number of employed health mediators decreased constantly over the last few years.*
- *Assess the degree of access of Roma to public health services, both in urban and rural settings. Not achieved;*
- *Facilitate the development and implementation of action plans on Roma health by local and district authorities, in partnership with local/national Roma NGOs and with the technical support from the Ministry of Health and the National Roma Agency, starting from the principle of an integrated approach as regards the issue of Roma health. Not achieved;*
- *Include, at the level of the interministerial working group coordinated by the Deputy Prime Minister, a mechanism for providing advice and technical support to local and county authorities as regards the implementation of the action plans on Roma health. Not achieved;*
- *Implement information campaigns targeting Roma women and girls on the risks associated with early marriage, on prevention of and fighting against domestic violence, and on human trafficking. Partially achieved. This activity is part of the RHM's "job description" and is supposed to be implemented in communities with RHMs in place;*
- *Set up a unit within the Ministry of Health, called "Technical support for coordinating, monitoring and assessing health mediators". Partially achieved. This type of unit is already in place at the National Institute of Public Health, but not yet enforced by a legal act.*

#### 2.4.3.2.3. Evaluation of the revised draft NRIS 2014–2020

The second NRIS was revised mainly in order to better reflect the priorities in terms of Roma issues, as highlighted in the EU Strategy 2020, and to ensure alignment with the new financial mechanisms for accessing EU structure funds 2014–2020. The EC in its assessment of the Government of Romania's implementation of the National Reform Programme and the Stability and Convergence Programme, stated that Romania has made limited progress in fulfilling Country Specific Recommendation 4 "Ensure concrete delivery of the National Roma Integration Strategy".<sup>106</sup>

The revised draft of the second NRIS 2014–2020 ensures continuity as to some of the health actions foreseen in the original version of the second NRIS 2012–2020, taking into account internal challenges (new census, results of other studies), the new EU targets agreed on in the

---

<sup>105</sup> "Evaluarea impactului programului de mediere sanitară", Bucuresti Sastipen, INSP (2011).

<sup>106</sup> "Assessment of the 2014 national reform programme and convergence programme for ROMANIA" – Brussels, 2.6.2014 SWD (2014) 424 final.

EU 2020 strategy and the requirements for accessing EU structural funds.

According to the National Reform Programme, a programmatic document containing targets and deadlines agreed with the EC in order to access EU structural funds, the drafting of the revised NRIS should have started in January 2013 and ended in December 2013. However, the revision process started during the first trimester of 2013 and went past the deadline mentioned in the programme. Considering that the last draft of the revised strategy is dated June 2014 and that up until September 2014 the document was not finalised and submitted for public debate on the National Roma Agency's website, the approval of the revised NRIS is unlikely before the end of 2014. On a positive note, with almost a one-year delay, at the end of November 2014, the Government of Romania endorsed the National Health Strategy 2014–2020, allowing for the sector strategies to be finished and endorsed by the government as well. It is worth mentioning that the actions and proposed measures to improve the health status of Roma, as highlighted in the revised NRIS, are included in the Romanian National Health Strategy 2014–2020.

The revision process of the second NRIS was based on extensive consultations with all relevant stakeholders including civil society, academia, local and central government representatives, and international organizations. Even if the importance of the ten Roma inclusion principles listed below is alluded to in the revised NRIS, a detailed substantiation of them in the introduction of the document is missing.<sup>107</sup>

- *Constructive, pragmatic and non-discriminatory policies;*
- *Explicit but not exclusive targeting;*
- *Intercultural approach;*
- *Aiming for the mainstream;*
- *Awareness of the gender dimension;*
- *Transfer of evidence-based policies;*
- *Use of European Union instruments;*
- *Involvement of regional and local authorities;*
- *Involvement of civil society;*
- *Active participation of the Roma.*

A strong point of the health component of the revised NRIS is that, for the first time, the in-depth situation analysis of Roma health takes into account the need for a comprehensive approach, linking social determinants of health with health outcomes. Also, the analysis points out the main factors that prevent optimal achievements regarding better Roma health outcomes, such as the fragmented regulatory framework, the lack of local specialised personnel with strong knowledge regarding planning, organizing and monitoring public services, including health services, and the absence of adequate funding.

Moreover, the situation analysis highlights that, taking into consideration models that have proven their effectiveness, it is necessary that the ministries responsible for the implementation of the NRIS establish functional institutional mechanisms for applying a multisector, integrated model as regards providing basic services to the community, including health services. According to the revised NRIS “Integrated services provided to Roma at local level must be coordinated, monitored and evaluated by using specific methodologies, bringing

---

<sup>107</sup> “The 10 Common Basic Principles on Roma Inclusion”, European Communities (2012).

together all of the service providers and ensuring the participation of other local and community actors (e.g. NGOs, church, police, and local authorities)”. The concept of integrated service provision is based on interventions already implemented and independently evaluated as successful and cost-effective.<sup>108</sup>

An additional strength of the health component of the revised NRIS is that it is clearly structured, with the following details provided for each specific objective and activity:

- Institution(s) responsible for implementation;
- Timeframe;
- Indicators (definitions, and percentages and numbers to measure progress);
- Monitoring and evaluation plans;
- Budget estimates (only a lump sum is indicated – 45,000 RON per year for the first two years of implementation);
- Sources of funding (explicit, taking into account national funding, as well as EU, World Bank and international organizations’ funds);
- Expected results (intermediate for 2016 and final for 2020).

The specific objectives for health, stated in the draft revised version of the NRIS, are as follows:

1. *Improve access for Roma to high quality basic, integrated, preventive and curative health services;*
2. *Reduce risks and prevent disease-associated morbidity and mortality patterns prevalent among the Roma population;*
3. *Increase the capacity of local authorities to identify health needs, and to develop, implement, monitor and evaluate health programmes and interventions targeting Roma communities;*
4. *Prevent discrimination against Roma as regards access to health services.*

The expected results identified by the MoH in order to achieve the specific objectives above are:

1. *Develop a network of community centres, to be incorporated within the structure of local authorities, that will provide basic integrated services at community level (community nurses, RHMs, social workers, and education mediators);*
2. *Develop the capacity of local health service providers through a revision of the regulatory framework, and increase the access of RHMs and community nurses to tailored training programmes;*
3. *Increase the capacity of local authorities to develop and implement public health programmes tailored to the needs of vulnerable populations, including Roma, and to develop and implement, at county and regional level, local health plans adapted to each community (providing regulatory, training, and technical assistance).*

Below is an assessment of the revised draft of the NRIS 2014–2020 document, according to the 10 Common Basic Principles on Roma Inclusion:<sup>109</sup>

1. *Constructive, pragmatic and non-discriminatory policies – Mostly achieved. The situation analysis of Roma health in the draft of the revised strategy takes into account*

---

<sup>108</sup> “Prima prioritate - nici un copil invizibil”, proiect UNICEF 2011–2014.

<sup>109</sup> “The 10 Common Basic Principles on Roma Inclusion”, European Communities (2012).

the most current situation of Roma, the latest studies on Roma health developed with a sound methodology and various health indicators, as well as indicators related to the social determinants of health. Data from additional sources (latest census, World Bank analysis, etc.) added value to the revision process. The consultation process was properly designed and executed, engaging a wide array of stakeholders;

2. *Explicit but not exclusive targeting* – Partially achieved. One of the differences between this strategy and the previous one is that the Roma health issues to be addressed by the strategy, as well as the specific objectives and lines of actions, are explicit and embedded into the context of disadvantaged groups/communities. Some of the activities could be refined further in order to take into account this approach (e.g. preventive actions against communicable and non-communicable diseases);
3. *Intercultural approach* – Not achieved. None of the specific health objectives and lines of actions explicitly mention or promote intercultural learning, although it is supposed that the proposed integrated community model will provide an active field for cultural exchange. Objectives and actions should be revised taking into account this dimension;
4. *Aiming for the mainstream* – Achieved. The innovative approach of integrated community services along with the development of local health plans and the active involvement of Roma communities fulfil this principle;
5. *Awareness of the gender dimension* – Partially achieved. The target group definition and some of the specific health objectives and lines of actions take into account the gender dimension. The objectives and actions should be refined further in order to take into account the multiple discriminations faced by Roma women, which impact their health status, as well as to encourage the involvement of Roma women in consultative and monitoring committees;
6. *Transfer of evidence-based policies* – Achieved. Through the health component of the NRIS, concrete evidence-based policies, as well as examples of best practices, are highlighted and included into the proposed lines of action;
7. *Use of European Union instruments* – Partially achieved. The health component of the strategy takes into account the EU legislation and political instruments that support Roma inclusion and, to some extent, the specific documents that influence public health activities and the delivery of health services. The use of EU financial instruments, although not explicitly mentioned in detail (by type of financial programme), is considered essential for the adequate financing of most specific health objectives and the subsequent lines of action. Explicit reference to experts' feedback, peer reviews and cooperation with other governments will be necessary in order to fulfil this principle;
8. *Involvement of regional and local authorities* – Achieved. The entire health component of the strategy is built on the active involvement of different layers of government, especially at the local level, promoting an integrated approach and increasing the sense of ownership at this level;
9. *Involvement of civil society* – Partially achieved. The revised strategy was based on extensive consultations with civil society representatives and on the active involvement of specialised NGOs. However, the monitoring and evaluation sections need to be more specific as regards the roles and responsibilities of civil society in fulfilling monitoring and evaluation tasks;
10. *Active participation of the Roma* – Partially achieved. Roma NGOs, as well as Roma governmental structures at every level, were involved in the consultation process and



provided feedback regarding the revised version of the NRIS. These stakeholders need to be involved in the implementation of the strategy and should be engaged in the monitoring and evaluation process.

#### 2.4.4. NRIS Budget and the use of EU funds towards health care

While the latest draft of the revised version (June 2014) mentions the yearly lump sum for some of the sector components, including health (45,000 RON or approx. EUR 10,000 per year for the first two years of implementation), as well as the funding sources, there are no official budget figures for the implementation of the NRIS.

According to the National Reform Programme, 1.9 million RON (approximately EUR 432,000) were allocated by the government to the National Roma Agency in 2013 to finance programmes and projects in the four areas (health, education, employment and housing) covered by the NRIS. Nevertheless, considering the lack of explicit budget allocation and the limited accountability in the use of funds as the two main shortcomings of the previous NRIS in terms of funding, explicit engagements regarding proper allocation of funds should be outlined in the revised NRIS.

### 3. EXAMPLE OF GOOD PRACTICE – ROMA HEALTH MEDIATORS PROGRAMME

#### 3.1. Background

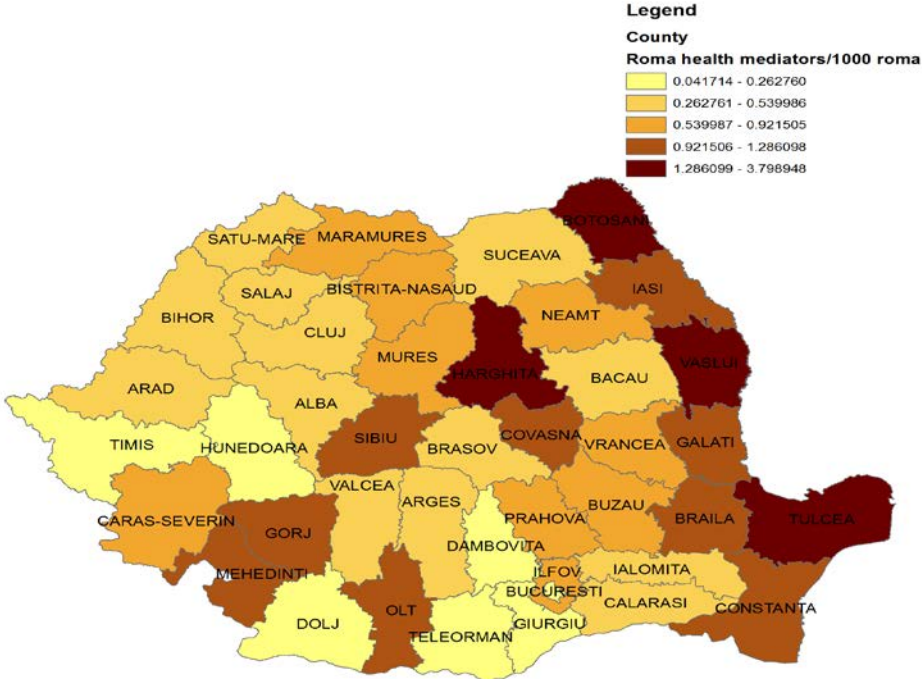
The Roma Health Mediators (RHMs) programme was institutionalised in Romania in 2002, in the context of the first NRIS (*National Strategy for Improving the Situation of Roma*), building upon a successful initiative of Romani CRISS, a Roma-dedicated NGO. The MoH took ownership of this activity, which was included in the maternal and child health programme, and issued a ministerial ordinance regarding the job description of this new profession.

In parallel, the Ministry of Labour included the RHM profession in the Classification of Occupations in Romania. At the beginning, the activity was carried out by 80 RHMs, employed by the MoH through local hospitals, in communities with a preponderance of Roma. RHMs were women from Roma communities, with a good command of the Romani language and awareness of the cultural context. The selection process was not fully transparent and the persons employed were chosen based on various but not explicit criteria. The number of trained and employed RHMs increased steadily every year up until 2007, to reach 475 RHMs employed in the public health system.

In 2007, the government approved the occupational standards for RHMs. Romani CRISS established regional centres for the purpose of training and monitoring the activities undertaken by the RHMs, adding more value to this profession. The Law 95/2006 on “Health-care reform”, the backbone of the health-care system in Romania, incorporated a dedicated chapter on community health services, including the overall guiding principles for organizing, providing and financing these services. The new government at the end of 2004, even though it had a different approach towards organizing and providing health services, took over and expanded the community health services, rendering the RHM system one of the leading and most well-known such programme in the region. The programme has been used as a best practice example by other countries in the area.

At the end of 2008, the Government of Romania decided to pursue a decentralisation process in the health sector by transferring the ownership of community health services and the management of a majority of local hospitals to local public authorities. In the case of community health services, the measure was only partially implemented, with the RHMs’ and community health nurses’ employment contracts transferred to the local public authorities, but their salaries continued to be paid from the State budget, through MoH transfers to the local public authorities. The incomplete decentralisation of community health services happened during the economic crisis, placing a high strain on the national health budget, and, consequently, funds allocated to this activity were reduced. In addition to this, poor preparation for the changing roles of the local public authorities and the ownership transfer of these services to the local public authorities resulted in a decline in the employment rate of RHMs. From almost 700 RHMs employed in 2008, the number went down to around 380 RHMs in 2010 and has remained at this figure since.

**Figure 14: Number of RHM per 1000 Roma inhabitants (2013)**



As of 2013, considering the shortcomings of the partially implemented decentralisation of community health services, the MoH, in collaboration with the National Roma Agency (NRA), decided to restructure this system, in order to ensure the provision of adequate and high quality community health services to vulnerable groups, including Roma, by integrating the provision of health services at the community level with other types of services (social, educational), actions highlighted in the National Health Strategy 2014–2020, as well as in the revised NRIS 2014–2020.

**3.2. Impact evaluation**

Since the launching of the RHM programme in 2002, several assessments have been carried out by different stakeholders to evaluate its impact. Two of these evaluations will be referenced in the present report – the first was conducted in 2006,<sup>110</sup> at the moment of the steady expansion of the programme, and the second was conducted in 2011,<sup>111</sup> at the worse point of the economic crisis.

**2006 Impact evaluation of RHM programme**

This evaluation sought to assess the implementation and impact of the RHM programme, in order to allow for better planning of future integrated socio-medical interventions targeting Roma communities. The evaluation was carried out by the Romanian Centre for Health Services and Policies and financed through a grant from USAID and John Snow Inc. The methodology used in the study was based on in-depth interviews, as well as questionnaires,

<sup>110</sup> “Cercetare-evaluare a programului mediatorilor sanitari în comunitățile de romi în România”, CPSS Bucuresti (2006).

<sup>111</sup> “Evaluarea impactului programului de mediere sanitară”, Bucuresti Sastipen, INSP (2011).

with the participation of a variety of stakeholders: RHMs, district public health authorities, Roma district offices, local public authorities, and family doctors. The outcomes of the evaluation were as follows:

- Regarding the RHM job description, most RHMs and family doctors considered that the most important activities are awareness, mobilisation for vaccination and mapping of Roma geographical locations, followed by reproductive and maternal and child health activities, and counselling on TB prevention and treatment;
- Almost half of the RHMs declared that they were serving more than the maximum number of Roma persons per RHM, stated in the ministerial ordinance (*500–750 Roma/RHM*), resulting in the RHMs either working more hours or providing less services to a greater number of people;
- Most of the RHMs declared that besides the activities listed on their “official” job description, they had to fulfil a number of extra social assistance and administrative functions, such as facilitation of obtaining of identity documents, enrolment of children in primary school, etc.;
- Regarding the training curricula, the courses offered up to 2006 provided only basic notions of communication and legislation, without any provision of basic medical knowledge. RHMs mentioned problems regarding the quality of the training process, lack of applied public health and medical knowledge, lack of continuous education and no incentives as regards performance. The main stakeholders were perceived as not having a direct interest in providing specialised training to and active supervision of RHMs, relying instead on dedicated training sessions offered by international NGOs with a specific interest in these subject areas;
- Concerning equipment required to perform their job, the majority of the RHMs were unsatisfied because of the lack of an office, basic equipment and stationery, as well as communication tools;
- Regarding social positioning, all RHMs demanded a stable and recognised socio-professional position in society, as opposed to the 12-month employment contracts, pending on the availability of MoH funds, and the low financial level of salaries;
- The coordination mechanism for RHMs, executed by the district public authorities, was weak and unsatisfactory, limited to summing-up monthly reports and sending them to the MoH. Although requested and welcomed by the RHMs, field visits together with district public health representative would be unusual;
- Most of the family doctors were satisfied with the RHMs’ activities in their functional area and collaboration was described as synergic; unfortunately, some family doctors treated RHMs as their subordinates, instead of as partners in solving problems, and this attitude added an extra burden on the RHMs;
- In general, collaboration with local public authorities and Roma communities was perceived as being good or very good for the majority of the stakeholders, subject to different personal attributes; on the other hand, Roma communities did not have an adequate understanding of the role of the RHMs, and this impeded the achievement of the expected results of the programme;
- The most important achievements of the RHM programme were the notable increase in addressability and access of Roma to health services, mainly primary health care, as well as the decrease of unwanted pregnancies coupled with the increased use of contraception. Other successes were related to the increased number of Roma on family doctors’ patient lists, as well as increased vaccination rates.

### ***2011 Impact evaluation of RHM programme***

In contrast to the evaluation carried out in 2006, the assessment conducted in 2011 had as a principal objective to measure the real impact of the RHMs' activities on improving the access of Roma to health services. Secondly, the study aimed to assess how the decentralisation process was implemented regarding the provision of community health services and the relationships between different institutional actors at local level.

Results from the evaluation showed that the decentralisation process affected almost every dimension of the work of RHMs and, therefore, the decision to include this issue added value to the study. The methodology was based on a comparative survey of a statistically significant sample of Roma communities with RHMs and one without RHMs. As regards the communities with RHMs, the majority of them had been employed as RHMs for nearly five years.

The study presented a variety of information on how stakeholders agreed on the localities where RHMs would be employed, the criteria used for employment, and the number of Roma communities under the responsibility of one RHM. Following the start of the decentralisation process in 2009, local public authorities had to make their own decisions about maintaining or employing new RHMs depending on perceived need and this decreased the number of RHMs employed since 2009. All of the RHMs interviewed declared that they had renewed their annual contract at least once and half of them had renewed it around four times, showing the uncertainty regarding job security for RHMs. Temporary contracts made it difficult for RHMs to obtain health insurance and to apply for bank loans. In a few cases, after the decentralisation, RHMs were able to sign permanent duration contracts.

#### **Relationships with stakeholders and other actors/peers**

Different stakeholders interviewed during the survey had different perceptions of the roles and responsibilities of RHMs, which is understandable taking into consideration their various working relationships with RHMs. These different perceptions were mostly due to the unclear understanding and expectations of each actor's role in the provision of community health services. RHMs interacted most frequently (daily and weekly) with family doctors and their nurses, and local public authority management teams, followed by interactions with district public authority representatives (monthly and quarterly). On the other hand, in some communities with a high involvement by different institutional actors (RHMs, social workers, educational mediators, etc.), as well as the presence of several NGOs working locally, an integrated strategy on community services provision was missing, hindering the achievement of expected results and wasting funds. Also, following the beginning of the decentralisation process in 2009, there was a rupture in the link between district public authorities and local public authority.

#### **Monitoring and evaluation of activities implemented by RHMs**

Unclear standards and procedures for monitoring and evaluation activities, coupled with unclear supervision applied by the district public authorities and local public authorities, allowed a variety of situations in the field like using different standards to assess the RHMs activities or having distinctive expectations regarding their performance.

### **Main activities implemented by RHMs**

Most of the RHMs were overburdened, taking into consideration the amount of administrative areas they were covering and the number of persons they were providing services to. Vaccination awareness and facilitation, and reproductive health and maternal and child health services remained the most frequent types of services provided, unchanged from 2006. Although the family doctors were responsible for planning the work of RHMs, deadlines and work plans were not elaborated, increasing the uncertainty and stress faced by RHMs. All of the RHMs declared that even though they had a job description, they had to carry out numerous activities falling outside of the scope of their jobs, some of them completely unrelated to the provision of community (health and social) services.

### **Outcomes of the activities implemented by RHMs**

Regarding the access to health services, 85 per cent of Roma from communities with RHMs were insured as compared to only 75 per cent of Roma from communities without a RHM presence. Roma enrolment in family doctors' patient lists, as well as Roma participation in preventive activities, was higher in communities with a RHM presence, irrespective of age and gender, with the caveat that these results were collected for the first time within the evaluation study performed in 2011. There are no comparison figures available before and after the employment of RHM in these communities. Regarding reproductive health services, the study could not find significant improvements between the two types of communities studied, showing that current modalities of providing reproductive health services should be analysed and improved based on the results and exchanges of best practices.

Concerning maternal and child health services, results from the study showed that Roma women from communities with RHMs are more assiduous in terms of pregnancy follow-up and are better informed regarding child nutrition. Other attitudes and practices as regards child health and access to paediatric services are similar in both types of communities.

### **Quality of interaction and satisfaction with RHMs' services**

99 per cent of rural Roma populations residing in communities with RHMs declared that they knew and understood the activities of RHMs as compared with only 77 per cent of Roma in urban communities with RHM presence. The frequency of RHM visits was higher in rural areas as compared with urban areas, but this most likely had to do with the size of the areas that had to be covered.

### **Training needs of RHMs**

Compared with the 2006 study, RHMs communicated training needs for additional or related activities (communication, psychology, social work, and IT), in addition to the basic medical knowledge courses that are part of their training curriculum. This showed that the RHM workforce wants to further develop their skills and set-up a continuous training programme tailored to their evolving needs.

### **Salary and resources allocated to RHMs**

Very low salaries and job uncertainty due to temporary contracts were two of the main reasons cited by RHMs for leaving the system when other opportunities arose. The majority of RHMs were unsatisfied or very unsatisfied with their salaries. According to an assessment

of the RHM programme carried out by Open Society Foundation in 2011,<sup>112</sup> Romania offered the lowest salaries (approx. EUR 133, which is below the guaranteed minimum wage) and least support for RHMs' expenses in the region (compared with Bulgaria, the Former Yugoslav Republic of Macedonia, Serbia, Slovakia, and Ukraine).

Regarding the availability of equipment for adequate work performance, the situation in 2011 was similar to that in 2006 (lack of communication tools, stationery, etc.), or even worse as regards medical items that were not provided following decentralisation due to a break down in the link with the public health authority and the unavailability of funds or incapacity of local public authorities to understand the importance of this service and to prioritise funds in consequence.

### 3.3. Summary of findings as regards the RHM programme

#### *Positive aspects of the programme*

The RHM initiative in Romania is the longest running programme of this type in the Central and Eastern Europe (CEE) region. It is considered to be one of the most successful actions aimed at improving Roma health and decreasing disparities between Roma and non-Roma in Romania. Different local and national stakeholders, as well as international organizations working on Roma health issues, share the same positive perception as regards this programme.

Both impact evaluations of the programme showed statistically significant and positive results in terms of an increased access to health-care services, including maternal and child health services, increased enrolment in the health insurance system and family doctor's patient lists, and a greater number of information campaigns on vaccination and greater vaccination coverage in Roma communities with RHM presence in contrast with Roma communities without RHM presence.

#### *Areas that need improvement*

Even though the RHM profession is well established and regulated, further work is necessary to update and adapt the training curriculum to the ever-evolving needs of RHMs, as well as to establish performance criteria for the provision of services by RHMs. Other areas that need further development include building up the institutional capacity of local public authorities in terms of monitoring and evaluation and setting up transparent audit criteria to evaluate services provided by RHMs.

From an administrative standpoint, more can be done to ensure greater job security for RHMs by switching from temporary employment contracts to permanent ones, increasing salaries according to seniority and performance, and ensuring a more transparent recruitment process.

Last but not least, due to the fact that the decentralisation process resulted in various adverse outcomes regarding the optimal provision of community health services, including RHM

---

<sup>112</sup> "Roma Health Mediators: Successes and Challenges", the Open Society Institute (2011).

services, it is extremely important to reconsider and clarify the roles of each stakeholder involved in the provision of funds, as well as in the provision of the services themselves.

#### ***Integrated approach as regards the provision of community services***

The draft revised NRIS proposes a new, integrated approach in terms of the provision of community services based on best practices. More efforts should be invested in offering adequate support to local public administrations to help them understand and execute their new, essential roles as regards addressing the social determinants of health and, therefore, the health status of their communities. One positive example in this regard that will be implemented soon is a project coordinated by the National Institute for Public Health and funded through the Norwegian funds (European Economic Area grants). The project aims to train and employ 45 RHMs and 45 community nurses (as community teams) in 45 communities with a high predominance of Roma. The training of RHMs, as well as of local public administration representatives, takes into account the actions outlined in the draft revised NRIS regarding the development and use of an integrated approach regarding the provision of community services at local level.



## 4. CONCLUSIONS

Despite the implementation of several initiatives aimed at greater Roma integration and improvement of Roma health, more sustainable efforts are necessary over the next few years in order to diminish the gap between Roma and non-Roma health outcome indicators. When compared with their non-Roma peers, Roma continue to be affected disproportionately by extreme poverty, low education attainment, high unemployment and low paid temporary jobs, poor and over-crowded housing, and discriminatory practices. All of these determinants have a negative impact on their life expectancy, as well as other major health outcome indicators (disability, mortality and avoidable mortality).

Even though health was nominated as one of the main pillars to be addressed in all important policy and strategic documents regarding Roma integration, successive governments since the year 2000 were not very explicit in providing and implementing a strategic vision towards improving Roma health. Problems related to narrow and fragmented health policies and measures, as well as lack of sustainable financing and poor monitoring and evaluation processes, hindered the implementation of strategic objectives regarding the improvement of Roma health. Furthermore, the inability to fully implement the strategic objectives for Roma health, and to integrate them horizontally in sector policies of different governmental institutions and vertically at different administrative levels, as well as fragmented linkages with other stakeholders (e.g. NGOs), weakened the expected results of different health policies aimed at improving Roma health.

Roma health issues have, for the most part, been perceived and addressed in a simplistic manner, as independent issues separate from educational and social issues that also affect Roma health outcomes. Thus, the results measured in decreased disability as well as increased life expectancy have been modest or inexistent knowing that the social determinants of health influence greatly these outcomes.

The RHMs programme, started out strong and was deemed a success by various stakeholders working on Roma health issues in and outside Romania, following which it went through a period marked by inertia, and in some districts remained at that stage (due to the lack of a monitoring and evaluation system or lack of continuous professional development of the RHMs), and in other districts deteriorated (due to a negative impact from other poorly implemented policies, e.g. improper decentralisation of health care).

Last but not least, poor accountability and a high turnover of decision makers at the National Roma Agency coupled with the powerlessness of this institution in terms of its relationships with line ministries, including the MoH, contributed to the low achievement of results after more than ten years of NRIS implementation.

The EC requested a revision of the second NRIS, including the health component of the strategy. This was an opportunity for the MoH, the National Roma Agency and other relevant stakeholders to get involved in a structural reflection process, revising the strategic objectives aimed at improving Roma health. Although the adoption of the revised NRIS is not finalised, the latest draft is well structured, proposes an innovative approach to tackle major Roma health issues and takes into account both the social determinants of health for this vulnerable

group and coordinated actions among all stakeholders at all levels of the government as well as civil society based on best practices and tied to tangible medium and long-term results.

Close supervision of the implementation process of the strategy by a dedicated body and continuous support from the highest echelons of the central government, as well as allocated long-term funding, will increase the possibility to attain better health outcomes between now and 2020, and to reduce the health disparities for Romanian Roma.

## 5. RECOMMENDATIONS

- Concerted efforts should focus on stronger cooperation (through the establishment of a permanent inter-institutional working group) between all relevant stakeholders (governmental institutions, central and local administrations, NGOs, and international organizations) in terms of strategically defining and implementing health policies targeting Roma. These policies should be closely linked to the implementation of the strategic objectives and specific intervention areas established for other sectors, such as education, housing and employment, aimed at improving the quality of life of Roma;
- The revised NRIS for the period 2014–2020 should benefit from close supervision and intensive support for a mainstreamed implementation along with secured sustainable funding, and concrete monitoring and evaluation indicators, in order to increase the chances of reaching better health outcomes and reducing health disparities of Romanian Roma;
- The clarification of mandates and fields of responsibilities for the implementation of the 2014–2020 NRIS as well as the impact indicators should be included in the revised NRIS;
- Tailored health policies focused on health education and access to primary health-care services supported by adequate information and awareness-raising campaigns on preventive measures and health risk factors should be established and implemented for Roma;
- Specific training to raise the level of acceptance of different attitudes, culture and Roma-specific behaviours should become part of the medical schools curricula.

## BIBLIOGRAPHY

Agenția Națională Pentru Romi

2012 Rapoarte. Available from [www.anr.gov.ro/index.php/transparenta/rapoarte](http://www.anr.gov.ro/index.php/transparenta/rapoarte)

Bucuresti Sastipen, INSP

2011 *Evaluarea impactului programului de mediere sanitară*, Bucuresti.

Casa Națională de Asigurări de Sănătate

2013 NHIH data. Available from [www.cnas.ro/](http://www.cnas.ro/)

Central Committee for 2011 Census

2011 Recensământului Populației și Locuințelor. Available from [http://194.88.149.157/e4/0a/f9/cd/Comunicat\\_DATE\\_PROVIZORII\\_RPL\\_2011.pdf?c=83e3bff32bc843a0b6d800acab5774bf](http://194.88.149.157/e4/0a/f9/cd/Comunicat_DATE_PROVIZORII_RPL_2011.pdf?c=83e3bff32bc843a0b6d800acab5774bf)

Centrul National Pentru Statistica si Informatica in Sanatate Publica

Available from [www.insp.gov.ro/](http://www.insp.gov.ro/)

Centrul Pentru Politici și Servicii de Sănătate

2006 Cercetare-evaluare a programului mediatorilor sanitari în comunitățile de romi în România.

Comisia Prezidențială Pentru Analiza Riscurilor Sociale și Demografice

2009 *Riscuri și inechități sociale în România*. Bucuresti.

Council of Europe

2010 The Strasbourg Declaration on Roma.

2013 Recommendation of 9 December 2013 on effective Roma integration measures in the Member States, 2013/C 378/01.

Dzeno Association Prague

2010 *Forced Out: The Problem of Roma Evictions in Europe*.

European Commission Communication

2010 The social and economic integration of the Roma in Europe, 7.4.2010 COM (2010)133 final.

2011 An EU Framework for National Roma Integration Strategies up to 2020, 5.4.2011 COM (2011) 173 final.

2012 National Roma Integration Strategies: a first step in the implementation of the EU framework, 21.5.2012 COM (2012) 226 final.

European Commission (EC)

2012 The 10 Common Basic Principles on Roma Inclusion.

2014 Assessment of the 2014 national reform programme and convergence programme for Romania, 2.6.2014 SWD (2014) 424 final.

European Roma Rights Centre

2013 *Criza ascunsa din sanatate. Inegalitati in domeniul sanatatii si date dezagregate.* Budapest.

European Union Agency for Fundamental Rights

2012 The situation of Roma in 11 EU Member States: survey results at a glance.

Eurostat

2015 Material deprivation statistics - early results. Available from [http://ec.europa.eu/eurostat/statistics-explained/index.php/Material\\_deprivation\\_statistics\\_-\\_early\\_results](http://ec.europa.eu/eurostat/statistics-explained/index.php/Material_deprivation_statistics_-_early_results)

Efxini Poli et al.

2009 *Health and the Roma Community, analysis of the situation in Europe: Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain.* Madrid.

Gheorghe, N. et al.

2011 *TB prevalence in Roma communities in Bihor and Arad counties.* Operational research (conducted under the Round 6 TB Grant).

Institutul de Cercetare a Calității Vieții (ICCV) Bucharest

2014 National Roma Agency Institutional Capacity Evaluation.

Institutul Național de Statistică

Rezultate. Available from [www.recensamantromania.ro/rezultate-2/](http://www.recensamantromania.ro/rezultate-2/)  
Produsul Intern Brut. Available from [www.insse.ro/cms/ro/content/produsul-intern-brut](http://www.insse.ro/cms/ro/content/produsul-intern-brut)

Lege Privind Reforma în Domeniul Sănătății

2006 Textul actului publicat în M.Of. nr. 372/28 apr. 2006. Available from [www.cdep.ro/pls/legis/legis\\_pck.htm\\_act\\_text?id=72105](http://www.cdep.ro/pls/legis/legis_pck.htm_act_text?id=72105)

Ministerul Fondurilor Europene

2014 Programul Operațional Sectorial “Creșterea Competitivității Economice” Program cofinanțat din Fondul European de Dezvoltare Regională. Available from [www.fonduri-ue.ro/poscce/](http://www.fonduri-ue.ro/poscce/)

2015 Listă beneficiari. Available from [www.fonduri-ue.ro/posdru/index.php/implementeaza/lista-beneficiari](http://www.fonduri-ue.ro/posdru/index.php/implementeaza/lista-beneficiari)

Ministerul Sănătății

2007 Programe naționale de sănătate. Available from [www.ms.ro/?pag=133](http://www.ms.ro/?pag=133)

Monitorul Oficial

2006 Privind aprobarea Strategiei Guvernului României de îmbunătățire a situației romilor.

2012 Pentru aprobarea Strategiei Guvernului României de incluziune a cetățenilor români aparținând minorității romilor pentru perioada 2012–2020.

- National Roma Agency  
2012 Romania Roma Decade Progress Report.
- Open Society Institute  
2011 Roma Health Mediators: Successes and Challenges.
- Organization for Security and Co-operation in Europe (OSCE)  
2009 *The Roma*. EU-MIDIS: European Union Minorities and Discrimination Survey (BG, CZ, EL, HU, PL, RO, SK).
- Public Policy Institute  
2013 The map of the access to medical services in Romania, p. 51. Case study: Challenges for Roma population. Available from [www.ipp.ro/pagini/harta-accesului-la-servicii-de-s259n.php](http://www.ipp.ro/pagini/harta-accesului-la-servicii-de-s259n.php)
- Regio – Programul Operational Regional  
Ghidurile solicitantului pentru Axa prioritara 3 Imbunătățirea infrastructurii sociale. Available from [www.inforegio.ro/ro/axa-3.html](http://www.inforegio.ro/ro/axa-3.html)
- Romani CRISS – Centrul Romilor pentru Intervenție Socială și Studii  
2009 *Sanatarea si comunitatea roma - analiza a situatiei din Romania*. Bucuresti.  
2011 Annual Reports 2007–2011.
- Sandu, D.  
2005 Comunitățile de Romi din România. O hartă a sărăciei comunitare prin sondajul PROROMI. *Banca Mondiala*.  
2011 Social Disparities in the Regional Development and Policies of Romania. *International Review of Social Research*, 1(1): 1–30.
- Schaaf, M.  
2007 *Confronting a Hidden Disease: TB in Roma Communities*. Open Society Institute.
- Totem Communication, Institutul de Pneumoftiziologie Marius Nasta  
n.d. *Smoking prevalence study in Romania*, Bucharest.
- UN Development Programme/World Bank/European Commission  
2011 Regional Roma Survey.
- United Nations Children's Fund (UNICEF)  
2014 Prima prioritate - nici un copil invizibil, proiect 2011–2014.
- World Bank (WB)  
2010 *Roma Inclusion: An Economic Opportunity for Bulgaria, Czech Republic, Romania and Serbia*. Policy Note.  
2014 *Diagnostics and policy advice for supporting Roma inclusion in Romania*. Bucharest.

World Health Organization (WHO)

2013 Roma health mediation in Romania.

2013 Review of social determinants and the health divide in the WHO European Region: executive summary.

2014 European Health for All Database (HFA-DB). Available from: <http://data.euro.who.int/hfad/>

## ANNEX 1 - ASSESSMENT OF RHMS PROGRAMME AT THE LEVEL OF DISTRICT PUBLIC HEALTH AUTHORITIES (2013)

	District	Main activities implemented by RHMs	Improvement suggestions for RHMs activity	Outcomes of decentralisation of community health services
1.	Alba	IEC activities Active monitoring of discrimination cases	RHMs new employment contracts	Lack of interest of local public authorities in RHM employment and further training
2.	Arad	Facilitation of communication between Roma communities and medical practitioners	RHMs new employment contracts	Multiple subordination issues together with unclear roles for each stakeholders in relationship with RHMs
3.	Argeş	IEC campaigns for Roma families, kindergarten and schools	Provision of RHMs diploma by accredited training bodies RHMs employed back by the DPHAs	Only 4 RHM employed in the district from the moment the decentralization process has started
4.	Bacău	- IEC campaign regarding breastfeeding, children nutrition, counselling regarding preventing teenage pregnancies, including family planning - Support for vaccination campaigns	Periodic working meeting in Roma communities Further training and competence development Closer relationship with DPHAs coordinator	- Job insecurity (temporary working contracts) - Low level of salaries
5.	Bihor	- Need and risk assessment of most vulnerable Roma groups as well as informing DPHAs	- Continuous training development courses for RHM - Provision of an office by the LPA and stationery Better collaboration with family doctors	- Job insecurity (temporary working contracts) - Low level of salaries - Tasks that are overpassing training or are not appropriate for their job description - Multiple subordination issues together with unclear roles for each stakeholders in relationship with RHMs



				- Positions available (empty) but not open for new employments
6.	Bistrița-Năsăud	- Identification, monitoring and assessment of Roma women with pregnancies at risk, and provision of mother and child health services	- Provision of integrated team approach of community services	- One RHM less after decentralization
7.	Botoșani	- Counselling regarding issuing identity documents, social health insurance and enrolment on family doctors lists, domestic violence as well as social issues - Need and risk assessment of most vulnerable Roma groups	- Continuous training development courses for RHM - Provision of an office by the LPA and stationery	- None
8.	Brăila	- Counselling regarding issuing identity documents, social health insurance and enrolment on family doctors lists, domestic violence as well as social issues - Need and risk assessment of most vulnerable Roma groups	- RHMs employed back by the DPHAs	Out of 11 RHMs employed before decentralization only 9 positions were funded after
9.	Brașov	- Facilitation of communication between Roma community and LPA - Facilitation of communication	- Simplifying the procedures for employment of RHMs	Positions available (empty) but not open for new employments; Lack of interest of local public authorities in RHM employment and further training

		between Roma and health personnel		
10.	București	Need/risk assessment of Roma with multiple socio-medical needs	- Vacancies but not open for new employments - Evaluation of possibility to change RHM's working contracts from temporary to permanent	Vacancies but not open for new employments (according to the new legislation regarding restrictive employment for public services starting with 2010 – <i>1 new employee for 7 positions closed</i> )
11.	Buzău	- IEC activities	- Improvement of community health services legislation	- Unsuccessful takeover by the LPAs
12.	Călărași	- Potential risk for RHM's to lose public health and medical services from their activities	- Better role definition of DPHAs regarding provision of community health services	No change
13.	Caraș-Severin	- Signalling child abandonment to social workers	- Changing RHMS working contracts from temporary to permanent	- To increase the RHM's employed according to legal provisions
14.	Cluj	- Identification and assessment of chronic diseases case from vulnerable groups	- RHM's employed back by the DPHAs	- Multiple subordination issues together with unclear roles for each stakeholders in relationship with RHM's;
15.	Constanța	- Active monitoring of health problems emerging in Roma communities and communicating to family doctor	- Provision of necessary funds for first aid kit as well as for transport and stationery - Better cooperation with LPAs	- Lack of interest of local public authorities in RHM employment and further training
16.	Covasna	No provision of medical services	Clearer roles and expectation for all stakeholders involved in provision of community health services	- Job quitting due to relocation abroad or due to finding better jobs

17.	Dâmbovița	<ul style="list-style-type: none"> <li>- Identification and surveillance of Roma pregnant women and children</li> <li>- Facilitation of enrolment on social health insurance scheme</li> </ul>	Provision of integrated community services	Lack of sustainable job
18.	Dolj	<ul style="list-style-type: none"> <li>- Identification of Roma children and their needs in Roma communities;</li> <li>- Counselling regarding mother and child health issues;</li> </ul>	Difficulties in providing salaries for the RHMs employed already	RHMs employed back by the District Public Health Authorities through a National Health Programme
19.	Galați	<ul style="list-style-type: none"> <li>- Counselling regarding issuing identity documents, social health insurance and enrolment on family doctors lists, domestic violence as well as social issues;</li> <li>- Identification of domestic violence cases, disabled persons, old age and other vulnerable categories;</li> </ul>	- RHMs employed back by the DPHAs	- Positions available (empty) but not open for new employments
20.	Giurgiu	<ul style="list-style-type: none"> <li>- Counselling regarding personal and living spaces hygiene</li> </ul>	- RHMs employed back by the DPHAs	- Lack of interest of local public authorities in RHM employment and further training
21.	Gorj	<ul style="list-style-type: none"> <li>- Counselling regarding issuing identity documents, social health insurance and enrolment on family doctors</li> </ul>	- RHMs employed back by the DPHAs	Out of 10 RHMs employed before decentralization only 8 positions were funded after

		lists, domestic violence as well as social issues; - Identification of domestic violence cases, disabled persons, old age and other vulnerable categories;		
22.	Harghita	- IEC activities for family planning, mother and child health	- MoH provision of necessary funds for first aid kit as well as for transport and stationery - Development of new job description for RHMs	Lack of interest of local public authorities in RHM employment and further training
23.	Hunedoara	- Home care provision	- Provision of integrated community services	- Job quitting due to finding better employment
24.	Ialomița	- Health education activities in schools together with a Roma NGO	- Provision of activities according to job description	- Overburden with extra activities that are not in RHMs job descriptions - Decreasing salaries by shifting RHMs from DPHAs to LPAs
25.	Iași	- Identification of vulnerable persons	- Enforcement of DPHAs roles regarding provision of community health services - Standard of practice for provision of community health services	- Untimely payment of salaries - No grading and performance schemes for RHMs profession
26.	Ilfov	- Risk assessment of Roma families at high risk	- Integrated team of community services	- Lack of specialised personnel at LPA level
27.	Maramureș	- Facilitation of Roma women access to family planning services	- Provision of continuous development credits through National Order of Nurses - Provision of stationery and computers	- Positions available (empty) but not open for new employments - Lack of funds for RHMs employment

28.	Mehedinți	- Facilitation of provision of first-aid	- Provision of first-aid kits RHM's employed back by the DPHAs	- Low level of salaries
29.	Mureș	- IEC activities regarding breastfeeding, children nutrition - Integrated team work with community nurse and social worker for better assessment of Roma problems in the community	- Setting up an electronic system for reporting - Provision of basic epidemiologic training - Standard operation procedures regarding integrated provision of community services	- Low level of salaries - Job quitting due to relocation abroad or due to finding better jobs
30.	Neamț	Need and risk assessment of most vulnerable Roma groups	- Old persons monitoring and provision of home care activities	
31.	Olt	- Communication and awareness activities to family practitioner regarding new cases of communicable diseases in the community	- Increased number of RHM's	- Job insecurity (temporary working contracts); - No grading and performance schemes for RHM's profession - Low level of salaries; - Tasks that are overpassing training or are not appropriate for their job description;
32.	Prahova	- Provision of different medical services mainly preventive, rehabilitation and home care	Establishing and financing a new budget line for transport and stationery	- Job quitting due to relocation abroad or due to finding better jobs
33.	Sălaj	- Increasing mutual trust between Roma communities and LPAs	- Continuous training regarding field activities	- 1 RHM newly employed

		- Active search and identification of Roma not enrolled on family doctors lists		
34.	Satu-Mare	- Mobilizing Roma community members for participating in public health activities - IEC activities regarding healthy lifestyle	- Continuous training regarding field activities - Development of collaboration protocols with LPAs for better and synergic involvement in social / health matters	- Job quitting due to relocation abroad or due to finding better jobs
35.	Sibiu	- Counselling regarding issuing identity documents, social health insurance and enrolment on family doctors lists, domestic violence as well as social issues - Need and risk assessment of most vulnerable Roma groups	- Revised National Health Strategy based on Strategy developed in 2004 - District Council involvement regarding LPAs better understanding of RHMs role and support of funding	- Job insecurity (temporary working contracts) - Low level of salaries - Tasks that are overpassing training or are not appropriate for their job description - Multiple subordination issues together with unclear roles for each stakeholders in relationship with RHMs - Job quitting due to relocation abroad or due to finding better jobs - Positions available (empty) but not open for new employments
36.	Suceava	- Identification, monitoring and assessment of Roma women with pregnancies at risk - Facilitation of communication between Roma communities and different State institutions	Provision of necessary funds for first aid kit as well as for transport and stationery	- Job insecurity (temporary working contracts)
37.	Teleorman	- Facilitation of communication		- Low level of salaries

		<p>between Roma communities and health personnel</p> <ul style="list-style-type: none"> <li>- Health and social risk assessment of Roma with multiple vulnerabilities</li> </ul>		<ul style="list-style-type: none"> <li>- Improper involvement of mayors in RHMs activities</li> </ul>
38.	Timiș	<ul style="list-style-type: none"> <li>- Assessment and facilitation of provision of identity documents especially for most vulnerable groups</li> </ul>	<ul style="list-style-type: none"> <li>- Advocacy and persuasion of LPAs regarding importance of RHMs employment</li> </ul>	<ul style="list-style-type: none"> <li>- Closing RHMs contracts due to the lack of funds</li> <li>- Low level of salaries</li> </ul>
39.	Tulcea	<ul style="list-style-type: none"> <li>- Facilitation of communication between Roma communities and health personnel</li> <li>- Health and social risk assessment of Roma families</li> </ul>	<ul style="list-style-type: none"> <li>- Clearer job description and tasks</li> </ul>	<ul style="list-style-type: none"> <li>- Tasks that are overpassing training or are not appropriate for their job description</li> </ul>
40.	Vâlcea	<ul style="list-style-type: none"> <li>- Facilitate enrolment in social health insurance system</li> <li>- Needs assessment of Roma communities</li> </ul>	<ul style="list-style-type: none"> <li>- RHMs employed back by the DPHAs</li> </ul>	<ul style="list-style-type: none"> <li>- Job insecurity (temporary working contracts)</li> <li>- Low level of salaries</li> <li>- Tasks that are overpassing training or are not appropriate for their job description</li> </ul>
41.	Vaslui	<ul style="list-style-type: none"> <li>- Activities performed according to job description plus other tasks if requested by the LPAs</li> </ul>	<ul style="list-style-type: none"> <li>- Changing the working contract from temporary to permanent</li> </ul>	<ul style="list-style-type: none"> <li>- Job insecurity (temporary working contracts)</li> <li>- Low level of salaries</li> <li>- Tasks that are overpassing training or are not appropriate for their job description</li> </ul>
42.	Vrancea	<ul style="list-style-type: none"> <li>- Needs assessment in Roma communities</li> <li>- Problems identification and</li> </ul>	<ul style="list-style-type: none"> <li>- Development of community health services</li> </ul>	<ul style="list-style-type: none"> <li>- Job insecurity (temporary working contracts)</li> <li>- Low level of salaries</li> </ul>

		reporting to LPA, DPHA and family doctor		
--	--	--	--	--

**Legend:**

- DPHA - District Public Health Authority*
- IEC - Information, Education, Counselling*
- LPA - Local Public Authority*
- RHM - Roma Health Mediator*



## ANNEX 2 - INTERVIEW GUIDELINE

### Title

Evaluation of the implementation of the Romanian NRIS in the health sector (2005–2013)

### Objective

Qualitative assessment of social determinants of health, health interventions, health policies, and outputs / outcomes, related to health-care status of Roma population;

Qualitative assessment of factors influencing Roma access to and utilisation of health services.

### Participants

- Romanian Parliament's representatives (Health Commissions); *2 persons*
- National Agency for Roma; *1 person*
- Ministry of Health; *2 persons*
- National Health Insurance House; *1 person*
- National Institute of Public Health; *2 persons*
- Health-care providers: *medical doctors (GPs and specialists), nurses (2 focus groups)*
- Roma NGOs representatives; *2 persons*

### 1. Introduction-warm up

#### Allocated time: 5–10 min

- 1.1. General discussion about the health chapter included in the Romanian NRIS correlated the political, economic and social environment;
- 1.2. General discussion about the involvement related to tackling social determinants of health for Roma;
- 1.3. In your opinion, what is the major issue(s) identified related to social determinants of health for Roma? Please describe in more detail the problem identified and the reasons of the situation described.
- 1.4. General discussion about the involvement related to Roma health policy / health interventions.
- 1.5. In your opinion, what is the major issue(s) identified related to the Roma health policy / health interventions? Please describe in more detail the problem identified and the reasons of the situation described.

### 2. General discussion about the social determinants of health for Roma

#### Allocated time: 20 min

- 2.1. In your opinion what is/are the most relevant social determinants of health impacting Roma health status?
- 2.2. In your opinion what is/are the least relevant social determinants of health impacting Roma health status?
- 2.3. In your opinion what are the tools in place for prioritizing health needs for Roma population? To what extent, are they used?
- 2.4. Are any of the social determinants of health identified included in a specific health policy / health intervention? Please provide more details about the measures. Are they related to:
  - Concrete actions to reduce the health gap

- Access to quality health care especially for vulnerable groups inside Roma minority
  - General measures relying on existing structures to reduce the health gap
  - Additional measures
- 2.5. Please describe if there is any coordination between the health-care sector and other sectors – particularly education, housing, employment, and anti-discrimination.
- Since health is determined by factors outside the health system, effective health policies should be integrated with all relevant policy sectors, in particular the social, education and environment policies.*
- 2.6. Please mention outcomes (if there are any) of the interventions described before.

### **3. General discussion about the health policy / health interventions in Romania**

**Allocated time: 20 min**

- 3.1. In your opinion what is the most relevant health policy / health intervention related to the improvement of Roma health status and quality of life?
- 3.2. In your opinion what is the least relevant health policy / health intervention related to the improvement of Roma health status and quality of life?
- 3.3. In your opinion what are the tools in place for prioritizing health policies / health interventions for Roma population? To what extent, are they used?
- 3.4. Are any specific health-care measures included in the intervention previous described? Please provide more details about the measures. Are they related to:
- Concrete actions to reduce the health gap
  - Access to quality health care especially for vulnerable groups inside Roma minority
  - General measures relying on existing structures to reduce the health gap
  - Additional measures
- 3.5. Please mention outcomes (if there are any) of the interventions described before.

### **4. Specific discussion of policies / interventions related to Roma health care**

**Allocated time: 20 min**

- 4.1. Roma reproductive health policies / interventions (*early marriage and childbearing, contraception, national health programmes, etc.*):
- In your opinion what is the most relevant health policy / health intervention related to the improvement of Roma reproductive health?
  - In your opinion what is the least relevant health policy / health intervention related to the improvement of Roma reproductive health?
  - Concrete actions to reduce the health gap
  - Management / budget / quality issues
- 4.2. Roma mother and child health policies/interventions (*pregnancies, infant mortality, maternal mortality, national health programmes, etc.*):
- In your opinion what is the most relevant health policy / health intervention related to the improvement of Roma mother and child health?

- In your opinion what is the least relevant health policy / health intervention related to the improvement of Roma mother and child health?
  - Concrete actions to reduce the health gaps
  - Management / budget / quality issues
- 4.3. Roma health promotion and diseases preventions policies / interventions (*health literacy campaigns, immunisation, specific risk factors, etc.*):
- In your opinion what is the most relevant health policy / health intervention related to the improvement of Roma health promotion and diseases preventions health?
  - In your opinion what is the least relevant health policy / health intervention related to the improvement of Roma health promotion and diseases preventions health?
  - Concrete actions to reduce the health gap
  - Management / budget / quality issues
- 4.4. Improvement of Roma life expectancy through successful infectious diseases policies / interventions (HIV/SIDA, TB, hepatitis, etc.):
- In your opinion what is the most relevant health policy / health intervention related to the improvement of infectious diseases for Roma people?
  - In your opinion what is the least relevant health policy / health intervention related to the improvement of infectious diseases for Roma people?
  - Concrete actions to reduce the health gap
  - Management / budget / quality issues
- 4.5. Improvement of Roma life expectancy through effective chronic diseases policies / interventions (*cardiovascular diseases, cancer, diabetes, respiratory diseases, etc.*):
- In your opinion what is the most relevant health policy / health intervention related to the improvement of Roma chronic diseases?
  - In your opinion what is the least relevant health policy / health intervention related to the improvement of Roma chronic diseases?
  - Concrete actions to reduce the health gap
  - Management / budget / quality issues
- 4.6. Reduction / removal of cost barriers for accessing comprehensive health services for Roma (*health insurance, co-payments, proper nutrition, etc.*):
- In your opinion what is the most relevant health policy / health intervention related to the reduction / removal of cost barriers for accessing comprehensive health services for Roma?
  - In your opinion what is the least relevant health policy / health intervention related to the reduction / removal of cost barriers for accessing comprehensive health services for Roma?
  - Concrete actions to reduce the health gap
  - Management / budget / quality issues

## **5. Specific assessment of policies / interventions related to Roma health care**

**Allocated time: 20 min**

### ***Roma entitlement to access health services***

- 5.1. Please mentioned if there are any special rights for vulnerable groups (included Roma citizens)?
- 5.2. How equitable do you consider the national system of health-care coverage?
- 5.3. In respect to obtain entitlements to health services, what is your opinion about the legal requirements in place?

### ***Roma information to access health services***

- 5.4. How you describe the level of information about accessing different types of the health-care services? Please comment this versus the general public awareness about the basic, emergency and specialised health care services.
- 5.5. To what extent is the method of dissemination adapted in order to reach and influence the Roma population effectively?
- 5.6. To what extent is the content of the information adapted in order to reach and influence the Roma population effectively?
  - What are the methods used in these activities:
    - Printed materials (e.g. patient folders, brochures, handbooks)
    - Materials on websites
    - Courses or meetings for target group
    - Community-based interventions
- 5.7. Involvement of Roma in information provision, service design and delivery-please comment this aspect.

### ***Roma discrimination in accessing health-care services***

- 5.8. How you describe the extent of discrimination practices against Roma in accessing different types of the health-care services?
- 5.9. To what extent are the methods used to combat discriminatory practices against Roma adapted in order to be enforced and influence the health professionals effectively?
- 5.10. To what extent is the content of the information used to combat discriminatory practices against Roma adapted in order to reach and influence the health professionals effectively?

## ***6. Cross-sectorial sustainable policies towards improving Roma health***

- 6.1. How many of policies towards improving Roma health are designed / implemented in a cross-sectorial manner? Please describe.
- 6.2. To what extent it is feasible to set-up cross-sectorial policies in order to improve Roma's health status?
- 6.3. What are the strong points? What are the shortcomings?
- 6.4. What are the opportunities? What threatens needs to be addressed?

## ***7. Roma health mediators' initiative***

- 7.1 Roma health mediators policy – please describe the positive outcomes / adverse outcomes / shortcomings
- 7.2. What gaps do you identify?  
Please detail for each category:
  - Programme objectives

- Programme coverage
- Programme structure (*municipality local engagement and programme management, etc.*)
- Programme restructuring (*decentralization, etc.*)
- Training and continuous education development
- Programme Budgeting
- Programme Monitoring and Evaluation

**8. *Other comments / suggestions / feedback***