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AD HOC COMMITTEE OF EXPERTS ON ROMA AND TRAVELLER ISSUES¹ (CAHROM)

**THEMATIC REPORT OF THE GROUP OF EXPERTS ON ROMA HEALTH MEDIATORS
(following the CAHROM thematic visit to Sofia, Bulgaria on 2-4 November 2015)**

Expert from BULGARIA, requesting country

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¹ The term “Roma and Travellers” is used at the Council of Europe to encompass the wide diversity of the groups covered by the work of the Council of Europe in this field: on the one hand a) Roma, Sinti/Manush, Calé, Kaale, Romanichals, Boyash/Rudari; b) Balkan Egyptians (Egyptians and Ashkali); c) Eastern groups (Dom, Lom and Abdal); and, on the other hand, groups such as Travellers, Yenish, and the populations designated under the administrative term “Gens du voyage”, as well as persons who identify themselves as Gypsies.

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I. INTRODUCTION

1.1. Context of the thematic report and visit

At its 7th meeting (Strasbourg, 14-16 May 2014) the CAHROM took note of the proposal by the Italian CAHROM member to set up a thematic group on Roma and health issues, and agreed with this proposal provided the identification of a requesting and sufficient number of partner countries. At its 8th meeting (Sarajevo, 28-31 October 2014), the CAHROM heard from the representative of the International Organisation for Migration (IOM) about recent developments on the Equi-health project and took note of the IOM suggestion to establish a thematic group on Roma health mediators.

The thematic group on Roma health mediators (hereafter RHM) was set up following a proposal made by the Bulgarian CAHROM member to host a thematic visit. Representatives from Belgium, Bosnia and Herzegovina, Montenegro, Poland, “the former Yugoslav Republic of Macedonia” and Turkey confirmed their interest to join this thematic group. An official letter from the Bulgarian authorities was received by the Secretariat inviting the group of partner countries’ experts to visit Sofia on 5 October 2015 (see Appendix 1).

The setting up of such a thematic group was also a concrete follow-up to the action undertaken by the Council of Europe together with the European Commission under their joint ROMED programme, to the Council of Europe’s Committee of Ministers Recommendation CM/Rec(2012)9 on mediation as an effective tool for promoting respect for human rights and social inclusion of Roma, as well as to several years of experience gained at training Roma community members to become Roma health mediators in many European countries.

Although there are few comprehensive and transnational researches on the health situation of Roma in Europe² there are Roma health studies available at national or local levels. Reports and data available show that Roma communities’ health status is much worse compared to other minority groups or to the majority population, for example as regards their life expectancy and the infant mortality rate. The reasons for that situation are complex, starting with bad housing conditions, poverty, lack of vaccination, and obstacles in access to public services, including health services, caused – among others - by the lack of identity documents, birth certificates, property certificates, health insurance. Initializing sexual relations and giving birth at an early age, combined with a low awareness among the Roma community on health prevention, illiteracy, unhealthy way of life and bad dietary habits, increase the risks. The discriminatory attitude and intercultural misunderstandings between medical staff and representatives or the Roma communities should be also taken into account when considering the poor health situation of Roma.

At the same time, available data point out that Roma is one of the youngest groups in Europe. Inequalities in access to health care services and persistent health problems will be transferred to the next generation, if they are not properly and timely addressed.

Although the greatest number of Roma lives in Central Eastern Europe and are sedentary, 15% to 20 % of Roma and Travellers in Europe are still nomadic or semi-nomadic which imply other specific challenges³.

² See for example “Health status of the Roma population. Data collection in the Member States of the European Union”, by MATRIX, European Commission, 2014 http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf.

³ See in that context, the All-Ireland Traveller Health Study from 2010.

As the health dimension is an inevitable part of comprehensive policies and national strategies for the inclusion of Roma (and Travellers), some actions are being undertaken for improving the Roma situation, either by national authorities, or through international funded programmes. The joint Council of Europe/European Commission programme ROMED1 which aimed at training Roma mediators, including Roma health mediators has contributed to reinforce mediators' skills and to facilitate communication and cooperation between Roma and public institutions, including health services (doctors, nurses, hospitals, etc.).

1.2. Composition of the thematic group of experts

The Bulgarian authorities appointed Ms Rosita Ivanova, Secretary of the National Council for Cooperation on Ethnic and Integration Issues Council of Ministers, and Bulgarian CAHROM member, as expert for this thematic group. CAHROM members on behalf of Bosnia and Herzegovina, Montenegro and “the former Yugoslav Republic of Macedonia”, who are all responsible within their respective ministry for the coordination and implementation of the national Roma integration strategy, took part in the thematic visit. Belgium appointed the Head of the Intercultural Mediation and Policy Support Unit in the Federal Service of Health, Food Chain Safety and Environment; Poland appointed a Main Specialist in the Institutional Cooperation Department of Wroclaw Municipality Social Development Centre; and Turkey appointed two experts, respectively from the Ministry of Health and from the Ministry of Family and Social Policy. The list of the experts participating in the thematic group can be found in Appendix 3.

1.3. Agenda of the thematic visit

The agenda included on the first day meetings with state officials, various institution and civil society representatives (about 38 participants attended the first day meeting). The agenda followed the guidelines developed by the CAHROM and allowed the possibility for partner countries to introduce their experience and exchange views with local interlocutors. The main issues addressed during the discussion were the following⁴:

- 1) Overview, goals and functioning of the system of Roma health mediators (RHM) or equivalent models;
- 2) Health-related challenges and needs of Roma communities;
- 3) Interaction with RHM and efficiency of Roma health mediators' work;
- 4) Needs and obstacles in the effectiveness of RHM;
- 5) Perspectives of the development and institutionalisation, where relevant, of the system of RHM, tailored to the countries' and Roma communities' specific situation.

A field visit to Roma settlements in Blagoevgrad was organised during the second day of the thematic visit, together with the meeting with Roma NGO.

The morning of the third day was, as usual, devoted to a debriefing session between the experts of the thematic group. The detailed programme of the thematic visit is reproduced in Appendix 2 to this report.

⁴ During and after the thematic visit, a lot of information was collected from experts addressing other aspects, such as housing, education or employment. The present thematic report reproduces information on health matters; the rest of the information can be found in the Addendum of this thematic report.

1.4. Terminology

Council of Europe's Committee of Ministers Recommendation CM/Rec(2012)9 on mediation as an effective tool for promoting respect for human rights and social inclusion of Roma pays attention to the fact that different terminology is used in member States to designate Roma mediators (see in italics below). Some mediators handle specific tasks (school, health or employment mediators, whilst others perform more general duties).

"The terminology used for persons carrying out mediation (whether as their sole task or as one task among others) varies from one country to another: mediators, facilitators, assistants, social workers, community facilitators, community mediators, pedagogical assistants, etc."

Therefore the terms Roma health mediators used in the present thematic report should be understood in a broader sense and includes equivalent positions under a different name. The participating countries of this thematic visit use the following terms:

Bulgaria uses the term "*Roma Health Mediators*". In addition, it has also "Roma labour mediators" to facilitate access of Roma to the labour market, as well as "teaching assistants" or "educational mediators" in the educational system. Most of them are of Roma ethnic origin and are often women.

Bosnia and Herzegovina and "**the former Yugoslav Republic of Macedonia**" both use the term "*Roma Health Mediators*". Most of them are of Roma ethnic origin and are often women.

In **Montenegro** – the term "Roma Health Mediators" is used in practice but formally the term for this position and with the specific scope of work is "*Associate in social inclusion for Roma and Egyptians for health*".

In **Poland**, they are called "*environmental nurses*", term used in the governmental strategy for Roma. None of them have a Roma ethnic background due to the fact that medical professions are considered by Roma in Poland as culturally forbidden⁵. They are hired through state funding resources or European Social Funds in the framework of, or independently but complementary to, projects implemented under the governmental strategy for Roma; Environmental nurses have a medical or social welfare professional background.

In **Belgium**, the term "Roma health mediators" as such does not exist. Other terms are used such as "*intercultural mediators*", "*neighbourhood stewards*", "*consultants for EU migrants*", "*Roma mediators*", "*Roma stewards*" or "*bridge figures*", depending on the location and the scope of their activities. Some are of Roma ethnic origin; some are not.

In **Turkey**, the term and position of Roma health mediator does not exist.

⁵ For more information on forbidden professions among traditional Roma communities in Poland, see the CAHROM (2016)7 Thematic report on vocational education and training for Roma.

II. SIZE, COMPOSITION, LANGUAGE, LIFESTYLE AND HEALTH CHALLENGES OF THE ROMA GROUPS

2.1 Bulgaria

Size, composition, language and religious affiliation of the Roma community

As it is most commonly admitted, the first big waves of Roma immigrants arrived in the Balkans during the 13th and 14th centuries from Asia Minor (which was, at that time, a part of the Byzantine Empire). During the 18th and especially during the 19th centuries, Roma from the Romanian principalities of Walachia and Moldova also entered the Bulgarian territory (a part of them came straight from the Romanian principalities; another part crossed first the territory of Austro-Hungary). This immigration process particularly intensified with the so called "Kalderash invasion" from the second half of the 19th century. That is the reason why the contemporary Roma who live in Bulgaria speak different dialects (often quite different from one another) of the Romani language and belong to at least three different Roma groups, each of them sub-divided into a number of sub-groups and branches.

Historically, the first group of Roma are the so-called "Yerlii," who are nowadays all sedentary. They are the descendants of those Roma who came from Asia Minor in the first waves of Roma immigration. They were forced to abandon the free nomadic life to durably settle in villages and towns. The greater part of them adopted Islam as confession. The Yerlii are divided into two big groups: the "Horahane Roma", i.e. Muslim Roma who often identify themselves as Turks and speak Turkish and the "Das(i)kane-Roma" who are Christians (Eastern Orthodox or Protestant), identifying themselves often as Bulgarians and speak Bulgarian. Horahane Roma is probably the most numerous Roma (sub-)group in Bulgaria, but it is difficult to assess since some of them prefer to self-identify as Turks. There are well preserved branches of Horahane Roma, such as Drandars, Katkaji, etc., but there are also well preserved branches of so called Walachian Roma, Burguji, etc. who clearly demonstrate their Roma identity and call themselves "parpul Roma" - "the real Roma".

The second largest Roma group in Bulgaria is the Kalderash (also known as "Kaldarashi" or "Kardarashi"). They are the descendants of big Roma groups who left Romania within the so-called "Kalderash invasion" during the second part of the 19th century. A great part of the Kalderash came from Austro-Hungary, passed through Serbia and settled in Bulgaria; that is why they are known as "Austrian gypsies", "Hungarian gypsies" or "Serbian gypsies". The Kalderash are prominently Orthodox Christians. They preserve the Romani language and self-determination, as well as a significant part of the Roma traditions, such as the Gypsy court ("meshere"). The Kalderash are divided into two main sub-groups: the "Lovari" and the "Kalajiji", as well as into more additional branches within these sub-groups: "Grebenari", "Bakarjii", "Reshetari", etc.

The third main Roma group in Bulgaria are the Rudari (also known as "Vlax gypsies"). They also came to Bulgaria from Romania during the big "Kalderash invasion". Unlike the Kalderash, they do not speak Romani, but an old Romanian language⁶ and have predominantly Romanian self-determination. The Rudari are also divided into three sub-groups: the "Mechkari" (known in other countries as "Ursari" – bear trainers), the "Kopanari" (known in other countries as "Lingurari" – carpenters and wooden bowl makers), and "Lautari" (musiciens). Another ground of self-determination of the Roma is indeed their traditional occupation: basket makers, miners, goldsmiths, horse tradesmen, etc.

⁶ Rudari are similar to the Boyash in Croatia or to the Béas in Hungary.

After the democratic changes, the Roma, along with all other citizens of Bulgaria, started facing new challenges. The problems in place at the time of the transition are complemented by new problems, some of which escalate, thus causing social tension and setbacks in the dialogue with the rest of society.

Data from the National Statistical Institute from the population and housing census of 2011 show that Roma remain the third largest ethnic group in Bulgaria. 325,343 persons, i.e. 4.9% of the Bulgarian citizens identified themselves as belonging to the Roma ethnos. Data on ethnicity are collected only on the principle of voluntary self-determination and in accordance with the Constitution of the Republic of Bulgaria, the Personal Data Protection Act and the Protection from Discrimination Act, which are synchronized with European legislation.

The census shows a persistent tendency from a part of the population to self-identify as Bulgarians, Turks, or Romanians, whilst they would be identified by the general population as Roma or “Gypsies” (derogatory term). This is possible due to the fact that the persons participating in the census have the right to define their ethnic background themselves or to refrain from indicating it.

NGO estimates consider that the total number of Roma living in Bulgaria is between 600,000 and 800,000 (closer to 9% of the total population), in line with the Council of Europe estimate of 700,000.

Health challenges faced by Roma

The risk factors create conditions and increase the morbidity rate. With the citizens belonging to the large minority communities in Bulgaria we observe the influence of the primary (mass scale and grave impoverishment, high unemployment rate, worse income and consumption structure, bad environment and housing conditions, lifestyles and genetic diseases) and the secondary risk factors (certain chronic diseases, creating conditions for complications or other diseases).

Infectious diseases are also a very acute problem in the Roma neighbourhoods in Bulgaria. The overpopulation of neighbourhoods and houses does not allow the virus carriers to be properly isolated and diseases often result into an outbreak of epidemics. A serious problem is also the lack of health insurance among the Roma population.

According to a report prepared by a coalition of NGOs, there has been no significant progress in implementing the relevant priority areas related to Roma integration into mainstream society in Bulgaria due to the lack of synergy and coherence including in the field of health care. Other major weaknesses identified are the lack of mechanisms for collecting and disseminating disaggregated data. In addition, the NRIS fails to provide for sufficient funding since 71 out of 122 activities in the Action Plan are not specifically budgeted⁷:

More than half of the Roma do not have access to health insurance. Infant mortality for Roma is twice that of the total population and the situation has not changed over the Decade. The life expectancy of Roma remains less than of the total population.⁸

⁷ See ECRI Report on Bulgaria (fifth monitoring cycle, published in 2014, p.23.

⁸ 2015 Roma Inclusion Index, p. 18. http://www.romadecade.org/cms/upload/file/9810_file1_roma-inclusion-index-2015-s.pdf.

2.2 Belgium

Size, composition, language and life style of the Roma community

Roma have been present in Belgium since the 15th century. However, Roma migrants have come in higher number since the fall of the Iron Curtain, when Belgium saw increased immigration flows from Central and Eastern Europe.

According to the National Roma Integration Strategy, there are four main groups of “Roma” in Belgium, which can be sub-divided on the basis of their migration history. The first three groups are composed mainly of Belgian citizens:

- *Sinti/Manush* (called “Manouches” as in France or Switzerland or “Sinti” as in Germany and German speaking regions). They are thought to be the descendants of the first Roma who arrived in Belgium in the early 15th century. They are also referred to as “the original migrants”. Most Sinti/Manush live (partially) in caravans and their first language is Sinti Romani; their second language is the language of the area in which they are living (Dutch, French or German). There are around 1,500 Sinti/Manush living in Belgium.
- *Roma*, i.e. the descendants of Roma who arrived in Belgium following the abolition of slavery in Romanian principalities of Moldavia and Wallachia in 1856. Their first language is Vlax Romani and their second language is French. The Roma are semi-nomadic: in summer they travel and in winter they stay on private or public caravan sites. There are around 750 Roma living in Belgium.
- *Travellers (Voyageurs)* who are indigenous Belgians, descendants of the former itinerant craftsmen. Ethnically they are not linked to the Roma but they share certain cultural characteristics associated with their (past) nomadic lifestyle (housing, mobility, trades). They currently live in caravans or houses. Their first language is Dutch (in Flanders) or French (in Wallonia) but they still use a lot of words that have been borrowed from their own language, Bargoens. There are around 7,000 Travellers living in Belgium.
- *Roma migrants*: the first Eastern European Roma came to Belgium after World War II (among others, Yugoslavian Roma looking for a job). However, the main influx of migrants was triggered by the fall of the Iron Curtain. The majority of these Roma have kept their original nationality and so the residence status of many of them remains precarious. However, an increasing number of Roma have been granted Belgian residence permits. Most of them live in houses or apartments.

The descendants of the earliest migration waves (non-migrant Roma) are still travellers or semi-nomads, while the Roma coming from Eastern Europe are generally sedentary.

The National Roma Integration Strategy (NRIS) refers to the estimates of the Council of Europe (“around 30 000 Roma living in Belgium”), which represent 0.29% of the total population. These numbers are however based on old (and out-dated) estimates. The actual numbers are undoubtedly higher. For example, in Brussels, an increase of 4,000 Roma was noted as compared to 2004 figures. There are no reliable data at hand as no estimates exist for Wallonia. The only ethnic data included in the NRIS are those of the Flemish Action Plan of Central and Eastern European migrants, including Roma, adopted in 2012.

The below table indicates estimates of Roma living in various towns/cities in Flanders and Brussels-Capital region, originally indicated in the Flemish Action Plan on Eastern and Central European migrants (source: NRIS):

	Influx of Central and Eastern European migrants in 2010	Estimated number of Roma in 2010	Estimated number of Roma in 2014
Antwerp	3,600	4,000	5,000
Ghent	1,935	4,300	6,320
Sint-Niklaas	234	800	6,320
Heusden-Zolder	148	75	
Diest	73	230-250	
Temse	58	400	
Brussels Capital Region		6,500-7,000 ⁹	8,383-11,630

However, it is not clear from the table what exactly indicates the “estimated number of Roma in 2010” column. It may refer to a number of different statistics: Roma migrants already present in Belgium in 2010. It contains the following estimates of the number of (Eastern European) Roma (migrants) living in various towns/cities in Flanders and Brussels-Capital region:

The CAHROM thematic report on halting sites from 2013 (based on a study visit to Belgium) provides estimates that are different from the numbers above. Its estimates are more recent and highlight the nationalities of Roma migrants in different towns in Flanders and Brussels-Capital Region. The data show that the nationality of Roma is different from one town to another: Bulgarians (5,840), Slovaks (1,715) and Romanians (mostly Roma) in Ghent; mostly Romanians and Bulgarians in Brussels (in 2013: up to 10,000); Romanians and Kosovars (approximately 5,000 Roma) in Antwerp, thirteen major families of Kosovars in Temse and Saint-Nicolas (about 1,000 people), etc.

Latest numbers include only migrants who registered in the respective municipality following a complicated procedure in getting residency permits. Real numbers might be much higher if they are to include also people who have not been issued residency permits.

As stated above, there are no official statistics on the number of Roma living in Wallonia and the German-speaking Region. This could be explained, as previously mentioned, by the strong adherence to colour blind, inclusive/egalitarian approach in Wallonia, as well as by the fear of stigmatization.

Health challenges faced by Roma

There is no research on Roma health at the national level in Belgium. However, such approach seems to be encouraged by the Ministry of Health, following the 2011 report recommendations to better adapt the healthcare system in Belgium to the specific needs of migrants and ethnic minorities. Experts interviewed back then pointed out that the lack of data on ethnicity and/or nationality in health surveys and hospital statistics undermines both the development of efficient programmes addressing inequalities and the monitoring of existing anti-discrimination policies.

Currently, a recommendation to carry out a feasibility study on healthcare for migrants and ethnic minorities is included in the memorandum drafted by the Directorate General Healthcare for the federal Government.

⁹ This number is based upon an extrapolation of data of 2004 to 2010 in the absence of a new estimate. For 2014, the estimated number of Roma in Brussels-Capital Region is +/- 10,000 Roma (estimates vary between 8,400 and 11,600).

The only qualitative research on Roma health in Belgium is the research led by Médecins du Monde (MdM) in 2012. This survey, however, only covered the Brussels-Capital region and all the Roma respondents were migrant Roma women and children from other EU countries – Slovakia, Bulgaria and Romania. Among others, the report results show that 65% of the respondents reported barriers in access to healthcare, while 8 % did not try to access health services at all. Financial obstacles appear as the most important and the most discouraging barrier; linguistic barriers are an additional barrier that can be successfully addressed with the help of intercultural mediators. Furthermore, administrative difficulties are closely connected to linguistic barriers aggravate the understanding of the healthcare system and related procedures.

The MdM study, in its part on sexual and reproductive health, reveals that only 49% of the interviewed women had received postnatal care after their last birth. Among the 48 interviewed women who no longer wished to have children or who wanted them at a later stage, only 46% were using a birth control method at the time of the survey. Insofar as vaccinations, 27% mothers did not know where to get their children vaccinated, while 15% of the mothers thought that their children were vaccinated at school, whether they were or not. Some of these numbers can be explained by a lack of information about prevention facilities, birth control methods, pre and post natal care and vaccination schedule follow up and religious factors.

2.3 Bosnia and Herzegovina

Size and composition of the Roma community

Roma are the biggest minority among the 17 national minorities officially recognized in Bosnia and Herzegovina. The last census was in 2014 but official results have not been announced. In the last census from 1991, only about 8,864 Roma declared Roma ethnicity. Information from the field reveals that there are more Roma living in Bosnia and Herzegovina. Roma are present in 64 municipalities.

The lack of data was the reason that the Ministry for Human Rights and Refugees of Bosnia and Herzegovina had registration process of Roma population and their needs in 2010. Registration of Roma needs was useful for better planning of activities and funds allocation. Special attention was paid to data protection, according to the Law on data protection.

During 2010 and 2011, data were registered and included in a unique data base. The registration process continued to be opened for each Roma returnee family or other Roma who missed the chance to be registered. Local social welfare centres have led the registration process and they were delivered technical equipment (computers) in order to establish their database. In total about 17,000 Roma were registered during that process.

Taking into consideration that not all Roma registered and that some were absent, authorities estimate the real number of Roma living in Bosnia and Herzegovina to be between 30,000 and 40,000 (close to 1% of the total population). Other sources estimate that the Roma population in Bosnia and Herzegovina could be around 76,000 persons (almost 2% of the total population)¹⁰.

¹⁰ See PowerPoint presentation of *Hilswerk International Austria*, delivered at the CAHROM thematic visit on social housing for Roma held in Skopje, “the former Yugoslav Republic of Macedonia”, in April 2012.

Health challenges faced by Roma

A number of persons in Bosnia and Herzegovina suffer discrimination in access to health insurance, bearing in mind *inter alia* that this problem particularly affects vulnerable groups such as minority returnees and Roma. As regards the health status, social and economic factors such as poverty, inadequate food and lack of access to health care facilities negatively impact Roma. Roma women's reproductive health is also reported to be problematic.¹¹

Access to health insurance of Roma is significantly less than for others, although a small decrease in the gap has been achieved over the Decade. Earlier data show that infant mortality of Roma is 4 (3 for females) times more than others, but recent data are not available to assess any change.¹²

2.4 Montenegro

Size and composition of the Roma community

According to the existing and available data from the census 2011, households and apartments in Montenegro 6,251 persons said that they belong to the Roma ethnicity or 1.01% of the total population. In addition, 2,054 persons declared belonging to the Egyptian community, or 0.33% of the total population. 5,169 persons declared speaking the Romani language. About a hundred Ashkali live in Montenegro. Most of them arrived to Montenegro in 1999.

A large number of Roma and Egyptian populations came to Montenegro during the Kosovo*¹³ conflict. The number of displaced Roma, Egyptians and Ashkali is between 4,000 and 5,000 (UNHCR estimated figure from 2005). Some of them have returned to Kosovo.

The largest number of Roma live in the territory of Podgorica (3,988), Berane (531), Niksic (483), Bijelo Polje (334), Herceg Novi (258), and most Egyptians live in Podgorica (685), Niksic (446), Tivat (335) and Berane (170).

Health challenges faced by Roma

The Roma, Ashkali and Egyptian population is relatively well integrated in Montenegrin society and their situation is encouraging. However, there remains a substantial group of Roma, Ashkali and Egyptians who are without doubt the most destitute, marginalised and vulnerable of all population groups in Montenegro. The possession of identification documents is a fundamental prerequisite for social inclusion and poverty reduction of Roma and Egyptian population. This allows the regular access to the labour market, social protection, health and education services and everything else which is necessary for regular organisation of life. In order to regulate the status of foreigners with permanent residence or temporary residence in Montenegro, the Montenegrin government, through the relevant ministries and institutions and with the help of international organisations has made visible and measurable results.

¹¹ See ECRI Report on Bosnia and Herzegovina (fourth monitoring cycle), published in 2011, p. 30.

¹² 2015 Roma Inclusion Index, p. 18. http://www.romadecade.org/cms/upload/file/9810_file1_roma-inclusion-index-2015-s.pdf.

¹³ All reference to Kosovo, whether to the territory, institutions or population, in this text shall be understood in full compliance with United Nations Security Council Resolution 1244 and without prejudice to the status of Kosovo.

Significant improvement is detectable across all indicators in health. Nevertheless, infant mortality rate remains about 6 times more for Roma than for the total population and the life expectancy for Roma remains 25 years lower than the total population¹⁴.

2.5 Poland

Size, composition and language of the Roma community

Roma in Poland are recognized as an ethnic minority. According to the 2011 National Census of Population and Housing, 16,723 Polish citizens declared Roma ethnicity: 9,622 declared the Roma nationality alone. This was more than in the previous 2002 census figure (12,731 in total). More realistic estimations based on information provided by the voivodes and other implementing partners of the “Roma Programme” carried out in 2004-2013 put the total number of Roma between 20,000 and 25,000 (0.08% of the total population).

Roma are divided into five main groups who differ in cultural, social and economic terms: Polish Roma, Bergitka (Mountain, Carpathian) Roma, Lovara, and Kalderash (Kelderari), as well as two smaller groups of Sinti and Chaladytka (Russian Roma). Lovara, Kelderari, Polish Roma and Russian Roma used to be nomads until the half of the 1960s and were forced to sedentarize by the communist regime. The Bergitka Roma, on the contrary, had a sedentary way of life since ages.

Vast majority of Roma in Poland constitute urban population: 92 % live in major cities and 8% in rural areas. In the 2002 census, 15,657 Polish citizens declared using the Romani language at home.

According to the 2011 census, Roma is a young population: people aged 0-19 consist of 32.5 % of the total Roma population (compared with 21.5 % within the majority population); people aged 60 and more consist of 7.7 % of the total Roma population (19,7 % within the majority). The Polish Roma population consisted in 2011 of 8,604 women and 8,119 men, including 10,840 persons of working age.

During the communist regime a number of Roma emigrated, mainly to Germany and Sweden but there is no reliable data on the scale of that migration. The next migration wave was connected with Poland joining the European Union in 2004. The search for a better life after the enlargement resulted in the migration of Polish Roma to Western Europe. The main destination countries were (and still are) the United Kingdom and the Republic of Ireland. Very few Roma from other European countries have recently arrived in Poland, mostly from Romania and fewer from Bulgaria.

Health challenges faced by Roma

Roma ethnic minority in Poland is the only minority at risk of social exclusion. This diagnosis is due to a number of social and cultural factors, of which the first one is the low educational level of this group, which directly affects the lack of qualifications desired in the labour market, and thus the health situation and living conditions of the Roma.

This situation is reflected in the health situation of Roma, poorer health than the general population. Available data show that the average life expectancy of Roma in Poland is shorter compared with non-Roma. Results of the surveys conducted in 2011 with community nurses who work with Roma families show that disease units among Roma

¹⁴ 2015 Roma Inclusion Index, p. 18. http://www.romadecade.org/cms/upload/file/9810_file1_roma-inclusion-index-2015-s.pdf.

community do not differ from the diseases occurring generally, only their frequency is higher. Chronic diseases and decreasing immunity are also playing a role, as well as inbreeding of this population (rare mixed marriages with persons from outside the group). Simultaneously, there is an increase in substance abuse, which is a relatively new phenomenon in this part of the community, proving the disintegration of existing cultural norms.

2.6 “The former Yugoslav Republic of Macedonia”

Size, composition, language and religious affiliation of the Roma community

According to the 2002 population census, the number of self-declared Roma is 53,879, i.e. 2.6% of the total population¹⁵. Estimates of the Roma population provided by NGOs and researchers vary from 80,000 to 260,000. The authorities' estimated figure is 100,000 to 150,000 (Egyptians excluded), i.e. 7.5% of the total population.

The country is also home to nearly 1,700 refugees, mostly Roma, who fled their homes as a result of the 1999 conflict in Kosovo*. Most of these persons are living in the municipality of Šuto Orizari in Skopje, Europe's first “Roma municipality” (i.e. led by a Roma mayor) and the only one in the world where the Romani language has been granted an official status. Roma do not concentrate in a particular region of the country, but are instead spread all over the territory. According to the 2002 population census, 27 municipalities have a share of Roma exceeding 1%; 10 of them have a share of Roma exceeding 4%.

Ethnic differences are less relevant than the way of life, costume and appearance of members of this group. Most Roma speak Romani as their first language; others speak Albanian, Macedonian or Turkish pending on the surrounding population and regions where they are located. Most of them are Muslim, some practise other religions.

Health challenges faced by Roma

One of the main challenges faced by a number of Roma in “the former Yugoslav Republic of Macedonia” is the lack of personal documents (identity cards, birth certificates, medical insurance cards and employment cards), which has the effect of restricting the exercise of their rights in many fields of life. It can lead to individuals' imprisonment in a vicious circle and exclusion, since persons without birth certificates of proof of nationality cannot obtain identity cards or other documents required for access to basic services and, through a knock-on effect, the children of persons without such documentation often find themselves in the same situation. It could be caused *inter alia* by indirect discrimination stemming from the criteria for obtaining these documents (such as payment of the fee or the requirement of having completed primary education). More research would need to be conducted to identify the problems experienced by Roma in obtaining such documents so as to remedy the situation.¹⁶ The gap in access to health insurance seems insignificant, but Roma face significantly higher infant mortality and around 10 years lower life expectancy than the total population.¹⁷

2.7 Turkey

Size, composition and life style of the Roma community

¹⁵ In addition, 3,843 declared to be Egyptians.

¹⁶ See ECRI Report on “the former Yugoslav Republic of Macedonia (fourth monitoring cycle), published in 2010, p.31.

¹⁷ 2015 Roma Inclusion Index, p. 18. http://www.romadecade.org/cms/upload/file/9810_file1_roma-inclusion-index-2015-s.pdf.

Although Turkey's population consists of a lot of ethnic majorities and minorities, there is no official record of the number of any ethnic group since the Republic of Turkey citizenship is not based on ethnicity. Turkish authorities estimate the total number of Roma in Turkey to be between 500,000 and 2.5 million¹⁸. Several NGOs, including Istanbul-based Zero Discrimination association and the European Roma and Travellers Forum (ERTF), indicate 3 to 5 million¹⁹. Researchers working in the ERRC/HYD/EDROM Research covering cities in seven regions of Turkey, mention 4.5 to 5 million²⁰. In Turkey, there are four main Roma groups: Roma, Lom, Dom and Abdal. Roma live mostly in Aegean Region, Lom live in the Black Sea Region, Dom live in Eastern and South-Eastern Anatolia, while Abdal live in Central and South-Eastern Anatolia. Most of these groups have similar living standards.

Health challenges faced by Roma

According to studies conducted by some Roma NGOs which exist since early 2000s, Roma people in Turkey lives in conditions less than ideal. Considering observations of some public institutions and assumptions of NGOs, Roma people live in poverty, work at temporary jobs, have limited access to education and live in unfit dwelling compared to general population. They also have a perception of discrimination, according to those studies. However, there is no statistical data concerning the depth and width of the social exclusion towards Roma.

For Roma people in Turkey, health services are the easiest accessible one among other public services. As observed in a field study, Roma people do not face any problems about accessing primary healthcare services. However, their health situation is worse than the general public and their health literacy level is lower. This situation is mostly associated with other determinants of health such as low educational level, poverty, unfit accommodation.

According to presentation delivered in Istanbul in 2010 by F. Villareal entitled "Challenges for Roma social inclusion in Turkey"²¹, key challenges for improving the health condition of Roma in Turkey as follows:

- ensuring free access to health care services (resolving the issue of lack of ID cards);
- outreaching Roma with health information, education, and prevention;
- ensuring medical check-ups for pregnant women and vaccination and check-ups of children;
- improving interaction and mutual trust between primary health care services and Roma;
- improving health from the perspective of its structural determinants.

There is a need for Turkish authorities to pursue their efforts to reduce de facto inequalities in health status and access to health care. More in-depth research should be conducted to assess the situations of different minority groups [including Roma, Lom, Dom and Abdal] with respect to health status and access to health care. There is also a need to ensure that obstacles that may be experienced by patients due to linguistic or cultural differences are also examined.²²

¹⁸ Estimated figure provided by the Turkish Ministry of Family and Social Policy at the 6th CAHROM meeting (Rome, Italy, 28-31 October 2013).

¹⁹ See Appendix 5 of CAHROM (2011)25 Meeting report of the 2nd CAHROM meeting, Istanbul, Turkey, 22-25 November 2011, available at <http://www.coe.int/en/web/portal/cahrom>, as well as ERTF factsheet on Turkey available at https://www.ertf.org/images/Reports/The_situation_of_Roma_in_Turkey_17062015.pdf.

²⁰ http://www.hyd.org.tr/staticfiles/files/biz_buraday%C4%B1z_turkiye'de_romanlar-1.pdf.

²¹ The study: "Challenges for Roma social inclusion in Turkey" for was a project funded by the European Commission's PROGRESS programme, implemented during 2009 and 2010 by the *Fundación Secretariado Gitano* (FSG) in cooperation with European Roma Rights Centre (ERRC) and EDROM

http://ec.europa.eu/enlargement/taix/dyn/create_speech.jsp?speechID=19913&key=47c8eae2079d2f2dc1b8ac6ba14cb250

²² See ECRI Report on Turkey (fourth monitoring cycle), published in 2011, p. 29.

III. EUROPEAN AND INTERNATIONAL STANDARDS AND REFERENCE TEXTS

Both the Council of Europe and the European Union prioritise the implementation of integrated approaches on Roma issues, including the improvement of the health situation of the Roma since this community encounters many health-related issues and suffer from limited access to the public healthcare services. A worrying factor is the life expectancy in the Roma communities around the Europe which is 10 to 25 times shorter than in other communities/minorities and the majority population.

The right to the proper healthcare is regarded as a human right. All national and local governments and their representatives have a legal obligation to respect, protect and fulfil this human right.

3.1 Standards and reference texts at the level of the Council of Europe

The Strasbourg Declaration on Roma

The Strasbourg Declaration on Roma adopted at the High Level meeting on Roma on 20 October 2010 states that member states of the Council of Europe agree on the non-exhaustive list of priorities towards improvement the situation of the Roma in Europe and the health care is one of them.

The members states should then “Ensure equal access of all Roma to the healthcare system, for instance, by using health mediators and providing training for existing facilitators” (par. 35).

More concrete tools referring to improvement of health conditions are clearly pointed out in par. 46, in which Member States: “agree to set up a European Training Programme for Roma Mediators with the aim to streamline, codify and consolidate the existing training programmes for and about Mediators for Roma, through the most effective use of existing Council of Europe resources, standards, methodology, networks and infrastructure, notably the European Youth Centres in Strasbourg and Budapest, in close cooperation with national and local authorities”.

Committee of Ministers of Council of Europe Recommendation Rec (2006)10 on better access to health care for Roma and Travellers in Europe

In 2006 the Committee of Ministers of the Council of Europe adopted Recommendation Rec (2006)10 on better access to health care for Roma and Travellers in Europe

According to Paragraph IV.1 Framework for health policies effective access of above mentioned Recommendation Governments of member states should ensure “physical access to health care including emergency care, through the provision of adequate roads, communication, ambulances and services for Roma and Traveller communities of the same standard as for the general population”.

According to Paragraph IV.2 Framework for health policies planning of this recommendation Governments of member states should “make the improvement of conditions of Roma and Travellers’ health a priority area for action and develop the necessary comprehensive health policies and strategies” and “take into account the range of good practices existing in other member states and/or regions (for example Roma and Traveller health units, Roma and Traveller health mediators, training on primary health care, guidebooks)”.

A strong impact is also put on the right to “respect of cultural traditions in the delivery of health care services in so far as they do not endanger the health of the person” (par. II. viii) and “participation of the community in the elaboration of health care policies and strategies” (par. II. ix) as well as “promote the involvement and participation of all parties concerned (policy makers, local health authorities, health professionals, researchers, representatives of Roma and Travellers and non-governmental organisations) in the planning, implementation and monitoring of health policies” (par.II, vi).

Committee of Ministers of Council of Europe Recommendation CM/Rec(2012)9 on mediation as an effective tool for promoting respect for human rights and social inclusion of Roma

The Recommendation calls Member States to develop and maintain an effective system of quality mediation with Roma communities based on the following principles:

- a. human rights: the full enjoyment of human rights of members of Roma communities without any form of discrimination is an essential principle underpinning and governing such mediation; this implies that mediation should aim at empowerment of Roma to exercise their rights and increased capacity of public institutions to guarantee these rights in practice, not at rendering or keeping Roma or public institutions dependent on mediation;
- b. systematic consultation, participatory planning and evaluation allowing the members of Roma communities to express their needs and concerns, and to be actively involved in finding the most appropriate solutions to the problems facing their local community in co-operation with representatives of the public institutions;
- c. intercultural sensitivity, non-violent communication and conflict mediation, based on good knowledge of the “cultural codes” of the community and of the relevant institutions;
- d. impartiality: the mediator should work, and be able to work, in a balanced way with both the public institution and members of Roma communities to help overcome cultural and status differences and focus on improving communication and co-operation and on stimulating both parties to take responsibilities and engage with each other; legitimate interests of both parties should be recognised (art.1).

The European Commission against Racism and Intolerance (ECRI) General Policy Recommendation no. 13 on combating anti-Gypsyism and discrimination against Roma

7. combat anti-Gypsyism in health care, and accordingly:

- a. take measures to secure equal access to all quality health care to Roma;
- b. recruit health mediators, in particular from the Roma community to provide liaison between health personnel and managers and Roma;
- c. take positive measures to ensure that no financial or administrative hindrance impedes the access of Roma to health care and medical treatment;
- d. provide training to health workers aimed at combating stereotypes, prejudice and discrimination against Roma;
- e. ensure that acts of discrimination against Roma in the health sector are prosecuted and punished;
- f. expressly prohibit any practice of forced sterilisation of Roma women;
- g. prevent and combat any segregation in hospitals and in particular in maternity wards.

Other relevant texts of the Council of Europe:

- the 1950 Council of Europe Convention for the Protection of Human Rights and Fundamental Freedoms (ETS No. 5) , in particular Article 14 (Prohibition of discrimination);
- the 1995 Framework Convention for the Protection of National Minorities (ETS No. 157);
- the 1961 European Social Charter (ETS No. 35); its additional Protocol of 1988 (ETS No. 128); its additional Protocol of 1995 providing for a system of collective complaints, and the Revised European Social Charter of 1996 (ETS No. 163);
- the Recommendation CM/Rec(2008)5 of the Committee of Ministers to member states on policies for Roma and/or Travellers in Europe;
- the Recommendation 1924 (2010) and Resolution 1740 (2010) of the Parliamentary Assembly on the Situation of Roma in Europe and relevant activities of the Council of Europe”;
- the Congress Recommendation 315 (2011) and Resolution 333 (2011) on the situation of Roma in Europe: a challenge for local and regional authorities;

- the Summit of Mayors' Declaration on Roma (Strasbourg, 22 September 2011), which calls for the setting-up of a European Alliance of Cities and Regions for Roma Inclusion;
- Commissioner for Human Rights: [Human rights of Roma and Travellers in Europe](#) (2012)²³.

3.2 Other relevant standards and reference texts at European and international levels

Roma and health issues such as the life expectancy, infant mortality, data collecting etc. have been extensively addressed and documented by European and international governmental and non-governmental organisations through conventions, recommendations, case-law, reports and projects.

European Union

- the European Union Council conclusions on an EU Framework for National Roma Integration Strategies up to 2020 in Brussels on 19 May 2011;
- the European Parliament Resolution on the EU Strategy on Roma Inclusion (March 2011);
- the European Union Fundamental Rights Agency (FRA) Report "Breaking the Barriers – Romani Women and Access to Public Health Care" (2003);
- European Commission: Report on the implementation of the EU framework for National Roma Integration Strategies (2014).

In 2014, the European Commission published the report "Health status of the Roma population - Data collection in the Member States of the European Union".²⁴ Key findings concerning the health situation are like follows:

- Roma experience substantially lower life expectancy compared to non-Roma (up to 20 fewer years - p. 37);
- higher rates of infant mortality are reported in some Roma populations (those living in poor housing, with low educational levels and migrant Roma) compared to non-Roma in countries including Bulgaria, the Czech Republic, Hungary, Italy and Slovakia (p. 37);
- some of the available studies show higher rates of infectious diseases or risk of infectious disease outbreaks amongst Roma (including measles and hepatitis A), particularly segregated Roma compared to the majority population, (p.42);
- evidence relating to rates of HIV/Aids is more mixed, though there are some reports of faster disease progression, (p.42);
- there is a lack of data on vaccination uptake in the Roma population, (p.42);
- the available evidence suggests that with some exceptions (Croatia, Hungary and the Czech Republic) the Roma population, particularly migrant Roma, have lower or much lower rates of childhood vaccination uptake (p.42);
- Roma suffer disproportionately from illnesses that are associated with the social determinants of health, (p. 49);
- while data on health lifestyles and behaviours among Roma populations are generally limited, the available evidence from a large majority of countries included in the project suggests that Roma have poorer health-related lifestyle, (p. 49);
- available data on smoking prevalence from Austria, Croatia, the Czech Republic, Slovakia, Bulgaria, Hungary, Ireland, Portugal and Romania consistently show that smoking is more common in the Roma population, (p. 49);
- available evidence on alcohol consumption and illicit drug use amongst Roma communities reports conflicting findings, (p. 49);
- very few interventions specifically target the health behaviours of Roma, though exceptions include drug rehabilitation programmes in Croatia, Finland, Ireland, Latvia and Lithuania (p. 49);

²³ See in particular chapter 6.4. "The right to the highest attainable standard of physical and mental health" which covers a) Denial of and discrimination by emergency medical services; b) Discrimination by health care providers, including segregated wards; c) Exclusion from health insurance and denial of medical services as a result of a lack of personal documents or related status issues; d) Exclusion from health care as a result of physical distance from health care facilities; e) Health outcomes; and f) Roma and health care systems: overcoming mistrust.

²⁴ http://ec.europa.eu/health/social_determinants/docs/2014_roma_health_report_en.pdf

- *small scale studies have identified a number of cultural factors which have a negative impact on the health lifestyles of Roma, (p. 49).*

The report identifies the following main barriers to access the health care system, which are closely linked to social exclusion factors:

- *language and literacy barriers;*
- *a lack of knowledge of available health care systems;*
- *discrimination by health care professionals;*
- *a lack of trust in health professionals;*
- *physical barriers — mobility and distance;*
- *a lack of identification and/or insurance;*
- *evidence also shows that patterns of health care utilisation among Roma differs from the general population, for instance including higher levels of use of acute hospital services, perhaps as the result of lower levels of engagement with or access to preventative care;*
- *there is evidence that the economic crisis is disproportionately impacting Roma populations' access to health care in the countries studied (p. 57).*

A special attention is dedicated to situation of Roma women, also in the area of health conditions and threats as the Roma women are vulnerable to multiply discrimination. The key findings in this context are:

- *available evidence suggests a range of additional barriers to improved health amongst Roma women, including expectations to fulfil traditional gender roles, limited educational and employment opportunities, physical and social isolation and poor living conditions;*
- *maternal health risks (i.e. early and late pregnancies, large families, poor access to and low uptake of antenatal care) and poor outcomes (i.e. miscarriage and still birth) are more common in Roma women;*
- *evidence suggests that Roma women are at higher risk of domestic violence and the associated mental health risks;*
- *a Spanish study suggests that the position of Roma women had improved as a result of lower birth rates, but also reported that they suffered more from obesity, depression, metabolic diseases and sexual health problems, exercised less and had lower uptake of breast and cervical cancer screening;*
- *a French study suggests Mediation Programmes appear to offer a potentially effective means to engage with Roma women about health issues (p.71).*

OSCE

- *the 2003 Action Plan on Improving the Situation of Roma and Sinti within the OSCE Area;*
- *the ODIHR Status Report on the Implementation of the Action Plan on Improving the Situation of Roma and Sinti within the OSCE Area (Warsaw, 2013).²⁵*

UNITED NATIONS

- *the Universal Declaration of Human Rights (Article 25.1)*
- *the International Covenant on Economic, Social and Cultural Rights (Article 11.1)*
- *the International Convention on the Elimination of All Forms of Discrimination Against Women*
- *the International Convention on the Elimination of All Forms of Racial Discrimination*
- *the International Convention on the Rights of the Child*
- *UNDP Report "The health situation of Roma communities" (2013).²⁶*

²⁵ <http://www.osce.org/odihr/107406?download=true>.

²⁶ <http://fr.scribd.com/doc/154052782/The-health-situation-of-Roma-communities>.

World Bank

- *“Poverty and Ethnicity: A Cross-Country Study of Roma Poverty in Central Europe” (2002).*

World Health Organisation (WHO)

- *Roma health mediation in Romania (2013).*

International Organization for Migration (IOM)**THE EQUI HEALTH PROJECT²⁷**

The objective of the EQUI-HEALTH action is to improve the access 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 the EU/EEA.

EQUI-HEALTH was launched in February 2013 by the Migration Health Division of the Regional Office for Europe of the International Organization for Migration (IOM). The 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 Directorate General for Health and Food Safety (DG SANTE), through the Consumers, Health, Agriculture and Food Executive Agency (Chafea).

The EQUI-HEALTH action is divided in 3 sub-actions:

1) MIGRANT HEALTH at SOUTHERN EU BORDERS sub-action aim is building a comprehensive multi-sectorial approach in upholding migrant and public health: situational assessments, discussions about data collection mechanisms and referral systems as well as trainings to meet the capacity building needs are taking place to increase the understanding of migrant, occupational and public health, including in open/closed centres and border facilities, and enhance the capacity of public health authorities, law enforcement services and healthcare providers.

TARGET COUNTRIES: Southern EU Member States

COUNTRIES COVERED: Bulgaria, Croatia, Greece, Italy, Malta, Spain, and Portugal (in certain activities)

2) The ROMA HEALTH sub-action focuses on promoting dialogue among key stakeholders (governmental and non-governmental groups) on Roma health issues. Eight Progress Reports on national strategies (with health focus), will allow EU MS to better monitor, share and strengthen their respective national approaches. A training package for healthcare providers will develop competencies in working with ethnic minorities, including the Roma (Roma health sub-action info sheet).

TARGET COUNTRIES: EU countries with high percentage of Roma nationals and EU MS with high percentage of Roma migrants

COUNTRIES COVERED: Belgium, Bulgaria, Croatia, Czech Republic, Italy, Romania, Slovak Republic and Spain

3) Under the MIGRANT HEALTH sub-action available information on national legal and policy frameworks will be aggregated in the form of country reviews for policy makers linking to the MIPEX (Migrant Integration Policy) index by developing a Health Strand. Thematic study on cost analysis of non-provision of healthcare to migrants and ethnic minorities in support of consensus guidelines on access to healthcare services for those in undocumented situation will foster a harmonized EU approach to access to and provision of healthcare for migrants, Roma and other vulnerable ethnic minority groups.

SITUATIONAL ASSESSMENT REPORTS ON [BULGARIA](#), [CROATIA](#), [GREECE](#), [ITALY](#), [MALTA](#), AND [SPAIN](#)

PROGRESS REPORTS ON THE IMPLEMENTATION OF NATIONAL ROMA INTEGRATION STRATEGIES IN [BELGIUM](#), [BULGARIA](#), [CROATIA](#), [CZECH REPUBLIC](#), [ROMANIA](#), [SLOVAKIA](#), AND [SPAIN](#)

²⁷ <http://equi-health.eea.iom.int/>.

European Roma Rights Centre (ERRC)

- *Collective Complaint against Bulgaria under the Revised European Social Charter Claims Violation of the State's Obligation to Protect Health;*
- *Report "Ambulance not on the way: The Disgrace of Health Care for Roma in Europe" (2006);*

Open Society Foundations (OSF)

- *Report "Roma Health Mediators: Successes and Challenges" (Budapest, 2011);*
- *Report "Roma Health Rights in Macedonia, Romania, and Serbia. A Baseline for Legal Advocacy" (2013).²⁸*

Decade of Roma Inclusion

- *Review and reorientation of the "Programme for active health protection of mothers and children" for greater health equity in "the former Yugoslav Republic of Macedonia", Roma Health - Case Study Series no. 2;*
- *"Reducing Health Inequities in Antenatal and Postnatal Care of Romani Women in the Republic of Macedonia - Policy Action Brief", National Roma Centrum (2011);*
- *Decade Watch reports on the implementation of Decade Action Plans (2011);*
- *Civil Society Monitoring Reports on the Implementation of the National Roma Integration Strategy and Decade Action Plan in Albania and in "the former Yugoslav Republic of Macedonia" respectively (2012);*
- *Roma Inclusion Index 2015²⁹.*

Fundación Secretariado Gitano (FSG)

- *Health and the Roma Community. Analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain (2009).³⁰*

²⁸ <https://www.opensocietyfoundations.org/reports/roma-health-rights-macedonia-romania-and-serbia-baseline-legal-advocacy>.

²⁹ http://www.romadecade.org/cms/upload/file/9810_file1_roma-inclusion-index-2015-s.pdf.

³⁰ http://ec.europa.eu/justice/discrimination/files/roma_health_en.pdf.

IV. HEALTH LEGISLATION, POLICY, MEASURES AND PROJECTS

4.1 Bulgaria

Roma policy framework

Bulgaria's integration policy for the Roma is based on two main strategic documents: the National Roma Integration Strategy of the Republic of Bulgaria (2012-2020) adopted by the National Assembly and Action Plan for the Implementation of the National Roma Integration Strategy of The Republic of Bulgaria (2012-2020). The state has defined six priorities: education; healthcare; housing; employment; rule of law and non-discrimination; culture and media.

The Strategy integrates the existing strategic policy documents and plans for the development of the different sectors, including the Strategy for Educational Integration of the Children from the Ethnic Minorities, the Health Strategy for Disadvantaged Persons belonging to Ethnic Minorities, and the National Programme for Improvement of the Housing of Roma in the Republic of Bulgaria, with a view to achieving better interaction and complementing the planned activities. By ensuring integrated management of the sectoral policies we shall increase the effectiveness of their implementation. The activities under the individual priorities will be carried out by mainly using an integrated territorial approach, allowing the simultaneous undertaking of measures across the territory of the country and unifying the resources under different priorities, taking account of the specific local needs, particularly the needs of the most disadvantaged people, in order to bring about visible changes in the individual settlements/neighbourhoods.

Implementation of activities under the National Action Plan is ensured with funds from the budgets of individual ministries and organisations, from the Operative Programmes, as well as from other European and international programmes and projects.

Structures responsible on Roma integration issues

Currently in Bulgaria there is a national mechanism for coordination, cooperation, partnership, exchange, and dialogue on ethnic minorities.

The National Assembly adopted the National Strategy in 2012 in accordance with the European framework for National Roma Strategies in 2011. The government is focused on improving the established mechanism for integration of Roma and the involvement of all stakeholders in it.

It was defined that the National Contact Point for the implementation of the National Strategy is the Secretariat of the National Council for Cooperation on Ethnic and Integration Issues to the Council of Ministers (NCCEII). The Secretariat is a unit in the administration of the Council of Ministers and is responsible for coordinating the implementation of the national strategy.

The Secretariat of NCCEII acts as a coordinating structure of administrative activities at the national level for the formulation, implementation, monitoring and evaluation of integration policy. A mechanism for inter-institutional coordination in the formulation, implementation, monitoring and evaluation of integration policy, incl. implementation of the National Strategy of the Republic of Bulgaria for Roma Integration 2012-2020, was created.

The National Council for Cooperation on Ethnic and Integration Issues to the Council of Ministers (NCCEII):

- has advisory and coordinating functions and assists the government in developing and implementing the state policy on ethnic and integration issues. It is not an independent legal entity;
- supports cooperation and coordination, conducts public consultation, and protects human rights, and is the main platform for dialogue between public authorities and non-governmental organisations of Bulgarian citizens, including those belonging to ethnic minorities and non-governmental organisations working in the field of interethnic relations;
- is chaired by the Deputy Prime Minister, and the members are: deputy ministers, representatives of the Bulgarian Academy of Sciences, the National Association of Municipalities in Republic of Bulgaria, and representatives of NGOs.

The Regional Council for Cooperation on Ethnic and Integration Issues:

- has advisory and coordinating functions; are not independent legal entities;
- is chaired by the governor, with members of: deputy mayors of municipalities in the region, heads of territorial units of the central executive authority in the field, representatives of NGOs, and regional administrations experts engaged on Ethnic and Integration Issues.

Municipal Councils for Cooperation on Ethnic and Integration Issues - created by a decision of the respective municipal council:

- have only advisory and coordinating functions; are not independent legal entities;
- their composition is determined by the municipal council.

Health related policy and measures for Roma

The Ministry of Health is the institution with has for commitment to improve health care for disadvantaged groups, including Roma, and to perform the Health Strategy for Disadvantaged Persons Belonging to Ethnic Minorities.

The Health Care related activities of the Ministry of Health that are implemented under the National Action Plan of the Decade of Roma Inclusion and the National Roma integration strategy of the Republic of Bulgaria 2012-2020 aim at increasing the health literacy of the target groups, preventing the possibility of spreading preventable diseases, as well as favourably influencing the development of good hygiene habits and behaviour of Roma children. To that effect, the Ministry performs preventive examinations in settlements and neighbourhoods with predominantly Roma population using 23 mobile units. It also implements *inter alia* the Programme for Prevention and Control of HIV/AIDS and the programme for Improving TB Control in Bulgaria.

Another major achievement has been the inclusion of the position of “health mediator” in the National Classification of Professions and Occupations in the Republic of Bulgaria. The purpose of the mediator programme is to overcome cultural barriers in communication between the Roma communities and the medical personnel on the spot, overcoming of existing discrimination attitudes in health service provision to the Roma people, optimising conducting of medical precautionary programmes amongst the Roma population, health education of the Roma people and active social work in the community and particularly amongst vulnerable Roma groups.

In 2011, 105 health mediators were active in 57 municipalities. In 2012, 109 health mediators were active in 59 municipalities, and in 2013 the number of those was already 130 distributed in 71 municipalities. The estimated number for 2014 is 150 health mediators, and for 2015, 170 health mediators.

Periodically, the knowledge of the medical personnel of the health issues specific for the Roma population is enhanced by improving the curricula for medical education in medical universities and colleges.

With regard to Reduction of Child Mortality:

For the period 2005-2015 the infant mortality indicator (number of deaths of children aged up to 1 year per 1 000 live births) marks a steady decline from 10.4 in 2005 to 7.6 in 2014. Despite the increased level of infant mortality in 2014, it should be noted that the achieved level of infant mortality in the past few years is the lowest in the demographic development of Bulgaria; however, it continues to be higher than in European countries.

To reduce child mortality, the following factors are important: early registration of pregnant women, monitoring during pregnancy and timely hospitalization of women in childbirth: *annually there has been performed and reported a significant number of gynaecological examinations and consultations in units (including mobile ones) operating near areas of compact Roma population.* Example: for the period 2011-2015 mobile paediatric units have performed a total of 32,763 examinations, and the result is more than 100% achievement of the set indicator.

Ordinance No. 26 was adopted in 2007 to provide obstetric care to uninsured women and to carry out examinations outside the scope of mandatory health insurance for children and pregnant women, which regulates the provision of obstetric care to women without health insurance, examinations beyond compulsory health insurance for children and pregnant women and the scope of one prophylactic examinations during pregnancy.

Implementation of programmes to reduce adolescent pregnancies and prevent congenital anomalies

During the period 2009-2013 was implemented the National Programme for Rare Diseases, which provided screening for a total of 3 diseases for all new-borns. The scope of pregnant women for congenital abnormalities has increased (in 2013, 22 942 women were examined). Despite declining birth rates, there is a trend for increase of the number of women examined in the programme.

It is important to note that after completion of the programme, this activity was continued in 2014 (a total of 15,595 examinations) and also in 2015, and the provision of reagents and consumables is guaranteed by Decree No. 26 to provide obstetric care for uninsured women and to carry out examinations outside the scope of mandatory health insurance for children and pregnant women.

According to information from the State Agency for Child Protection for the period 2005-2014, on the basis of national statistics maintained by the National Statistical Institute (NSI), the gradual increase in births marked a peak in 2009. Since 2010 NSI has registered a gradual decrease in the number of births. It is to be noted that the proportion of births to mothers under the age of 18, albeit with a slight pace, marks a lasting downward trend. If in 2005, 60 of each 1,000 births were to mothers under 18; in 2014 this number dropped to 46.4 per 1,000. However, in 2014, 3,162 children were born to underage mothers, which requires continuing and focusing on measures to address the negative phenomenon.

Improving health care for infants and pre-school children are implemented through mobile paediatric units performing annual immunizations of children with incomplete immunization status. During the period 2011-2015, mobile paediatric units performed 45,441 vaccinations of children with incomplete immunization status with a general practice mobile unit.

Improving awareness on healthy nutrition of infants and young children are carried out with regular training and campaigns to raise health awareness on healthy nutrition of infants and young children. The indicator set in the Plan is implemented in full.

As concerns regular medical examinations for each age group, during the period 2011-2015 mobile paediatric units carried out a total of 31,565 examinations, resulting in over 50% achievement of the set indicator.

An extraordinary immunization campaign against polio for all children 1 to 7 years of age with irregular immunization status was carried out, which has increased the scope of the Roma population according to the National Immunization Calendar.

Performing preventive examinations in settlements and neighbourhoods in which live uninsured Bulgarian citizens of Roma origin

Annual prophylactic examinations are conducted in settlements and neighbourhoods populated mainly by uninsured Bulgarian citizens of Roma origin, and in settlements with predominantly Roma population. Examinations are carried out by 23 mobile units obtained within the PHARE programme: five units for general check-ups, two fluorographs, two mammographs, three units for ultrasound examinations, three units for laboratory tests, four paediatric and four gynaecological units. Annual examinations and tests are carried out on uninsured persons of Roma origin in various areas of the country. For the period 2011-2015, mobile units carried out a total of 44,249 tests and examinations, resulting in over 50% achievement of the set indicator.

It is important to note that during the period 2005 to 2015 the performance of examinations in certain areas was preceded and accompanied by annually conducted awareness campaigns, lectures and training to increase health knowledge on various topics, discussions, consultations, distribution of informational materials, contraceptives and others.

Persons from the Roma community are included as a target group in the implementation of the Programme Prevention and Control of HIV/AIDS and the programme Improving TB Control in Bulgaria

The programme Prevention and Control of HIV/AIDS was launched at the beginning of 2004 and its implementation continues. The programme covers various groups, including risk behaviour groups of Roma communities. Thanks to its implementation as of 2005 until now, regular services have been provided in the field of HIV prevention in the region of the country with compact Roma population (10 municipalities – Burgas, Varna, Kyustendil, Pazardzhik, Plovdiv, Sliven, Sofia, Stara Zagora, Haskovo and Yambol). The basic result from conducting the planned interventions is keeping the incidence of HIV in the country below than 1%. From that experience can be highlighted the following positive assets for the prevention and avoidance of HIV prevalence in the community:

- a significant success of the Programme is the development of the capacity of local communities. Over the years a good practice was established, namely, interaction of the Ministry of Health with non-governmental organisations, constantly increasing the number of those working in the Roma community.
- field workers and team coordinators are of Roma origin.
- by means of the programme are built and operate eight health and social centres in the Roma community.
- an individual approach was introduced to support each risk case according to the “case management” method.
- joint activities and cooperation with the country's 19 Units for anonymous and free counselling and testing (KABKIS).

Thanks to the efforts undertaken in the implementation of the National Programme for Prevention and Control of Tuberculosis in the Republic of Bulgaria for the period 2012-2015 and of programmes for tuberculosis financed by the Global Fund, in Bulgaria in recent years there is a trend of reduction of morbidity – from 39.1 per 100,000 in 2006 to 23.8 per 100,000 in 2013.

Important positive assets of these measures include:

- Building a team of non-governmental organisations, working with medical institutions on tuberculosis. Over 100 field workers and coordinators of Roma origin who work on preliminary schedules with patronage nurses in Roma neighbourhoods;
- Introduced individual approach to reach vulnerable people through surveys of the risk of tuberculosis for the early detection of cases of tuberculosis;
- Organizing local campaigns of important dates in the prevention of tuberculosis;
- Motivating any risk person and escort to a hospital to receive medical examination – a sample of the Mantoux test, microbiological examination, radiographic examination;
- Assistance of medical personnel in covering contact persons of patients with tuberculosis in the Roma neighbourhoods;
- Supporting and motivating TB patients to complete the course of treatment by providing food vouchers.

Health mediators

The most successful practice throughout the years is the Health Mediator. Over the years, the profession has evolved from a pilot non-governmental activity to a government policy – in 2007 health mediators were appointed in municipalities with funds allocated from the state budget, and from 57 mediators in 2007, their number reached 170 in 2015.

The Health mediator profession was included in the National Classification of Occupations in the Republic of Bulgaria and the number of mediators in the country is continuously on the rise and is enjoying recognition in society. They participate in the Council of Europe/European Commission ROMED training programme. Health mediators assist the population in neighbourhoods with compact Roma population and medical professionals who serve this population. They contribute to: assisting and facilitating the access of all disadvantaged citizens to health and social services; improvement of the quality of health and social services in Bulgaria; raising the health culture of disadvantaged ethnic minorities; increasing the efficiency of general practitioner doctors and healthcare services on the spot.

On April 2007, the National Network of Health Mediators was established and built good partnership relationships with municipal and regional experts on ethnic and integration issues, local authorities, and they are recognized and accepted by the local health institutions – the Regional Health Care, Centres (RHC), Regional Inspectorates for Public Health Protection and Control (RIs for PHPC, etc.).

Encountered problems and difficulties in the realization of the objectives were mainly related to:

- lack of health mediators working in the Roma community;
- poor attitudes among the Roma community for integration to common preventive activities for better health;
- unsatisfactory range of preventive examinations among the Roma community as a result of:
 - irregular health insurance;
 - no choice of family doctor;
 - low literacy and lack of health education.

A significant problem remains regarding further follow-up and possible treatment of persons without health insurance covered in the programme who have a health problem found in the prophylactic examination, as well as the implementation of mandatory immunization of children with no evidence of conducted immunizations, immunization scheme for the respective age is incomplete, have no GP and/or no permanent address registration, according to the Immunization Calendar of the Republic of Bulgaria.

4.2 Belgium

Roma policy framework

At the federal level, significant efforts in the field of Roma integration can be observed since 2010, especially in the framework of the Belgian Presidency of the European Union. Federal authorities have been actively involved in organisation of the Roma Summit in Cordoba (trio-presidency: Spain – Belgium – Hungary), and the Belgian Presidency organized the Roma Platform in December 2010.

The National Roma Integration Strategy (NRIS) was adopted in February 2012 and is the only policy commitment at the federal level specifically addressing Roma populations. It aims at combatting discrimination in employment, education, housing and access to healthcare, in line with the priorities of the EU Roma Integration Strategy. Relevant policy initiatives are also undertaken at the regional and local levels. In Flanders, Roma are among the target groups at whom the integration policy is aimed. The integration policy is aimed at all persons of foreign extraction. This policy provides a concrete set of instruments intended to advance the integration of such persons, which includes the Roma. In particular, this relates to actions such as civic integration and language courses, grants for towns and cities to develop local integration policies, the funding of an agency which specifically works towards interculturalisation and, in doing so, also runs specific activities geared to Roma and travellers and the funding of a participative organisation. In addition to the above, the integration policy also comes with a horizontal component, with the focus on an inclusive approach, meaning that it is the responsibility of the various Government ministers to put in place actions within their respective policy areas that are aimed at furthering the accomplishment of the objectives of the integration policy, i.e. improving the degree of social participation and accessibility, along with active and shared citizenship. The same vision is also adopted in respect of the Roma. To lend impetus to this policy in respect of Roma, in 2012 a Flemish Action Plan on Eastern and Central European migrants was devised, which also served as

the Flemish contribution to the National Roma Strategy. The horizontal component of the integration policy is coordinated and monitored by the Integration Policy Committee set up under the Horizontal Integration Policy Plan.³¹

Due to the high number of migrants to Flanders from Eastern and Central Europe since the 1990s, Flemish authorities adopted specific action plans and began implementing projects to adequately address the new demographic situation. The Flemish Action Plan on Central and Eastern European migrants, including Roma, was adopted in 2012 (and is the only official Belgian source which offers Roma-specific data – see chapter 2.2).

Consideration is given to coordinate actions at federated level and to gather reliable data, both of which are essential if policies are to be implemented effectively.

Number of Roma NGOs encouraged the Belgian authorities to work more closely with Roma, Sinti and Traveller organisations, be regularly in dialogue with them and involve them in the implementation, as well as in the monitoring of the implementation of the Strategy³¹:

Representativeness, consultation bodies and coordination

A few years ago a National Roma Council was created by the then Minister for Internal Affairs. Due to internal tensions and disagreements, this council has been unable to represent the Roma vis-à-vis the authorities. To address these challenges, the Belgian EU Roma Contact Point (coordinated by the Federal Public Service for Social Integration) has submitted a project proposal for the creation of a National Roma Platform to the European Commission (DG Justice)³². Through this platform, the competent authorities wish to reinforce cooperation with the target group and ensure an active dialogue. Since the regional authorities are competent in Belgium for most integration issues (e.g. housing and education), the proposal was developed in close collaboration with them. Organisations of local authorities, the Inter-federal Centre for Equal Opportunities and NGOs specialized in supporting Roma will be highly involved in the functioning of this platform. It will also address health-issues.

Since 2011, the State Secretary for Social Integration and Combating Poverty at the federal level is responsible for the coordination of the Belgian National Roma Integration Strategy (NRIS). Further coordination and implementation of the strategy depends on a Working Group of representatives of the different regions in Belgium and the Federation of Municipalities.

Health related policy and measures for Roma

The Intercultural Mediation and Support Unit of the Federal Public Service Health, Food Chain Safety and Environment (administration of the Minister of Health), is responsible for the coordination of the Intercultural Mediation Programme in public hospitals. It was invited to present the programme at the last meeting of the Working Group in 2014.

Besides the *Intercultural Mediation Programme*, there are two other actions listed in the NRIS in the field of health: networking between healthcare providers in the Flemish Region and psychological and psychiatric help for recognized refugees and asylum seekers supported by the German-Speaking Community. None of them targets

³¹ See ECRI Report on Belgium (fifth monitoring cycle), published in 2014.

³² Belgium expects an answer from the European Commission in February or March 2016.

specifically Roma communities or addresses particular challenges in their access to health services. Furthermore, there are no figures or specific evidence about the presence of Roma communities in the German speaking part. Furthermore, there is no specific funding allocated to these actions via the strategy. Some activities have been developed before the entry into force of the strategy. Thus, they appear as “good practices” rather than specific objectives of the strategy. At this stage, no additional action, objectives or developments in the field of health has been added to the NRIS.

Flanders’ policy in health care is to strive for universal access to care, which means that policy development is wide and for all citizens, considering that some groups are vulnerable and need different approaches.

An example can be found in the implementation of the new mental health policy for children and young people. In March 2015 an Inter-ministerial conference on Health (Federal and Regions) endorsed the Guide for this new policy. One of the goals is to get a community based mental health care for children and younger people by the creation of flexible and demand driven care such as mobile and assertive treatment of very vulnerable groups or hard-to-reach young people.

The first phase focus of the Guide is the creation and coordination of networks with organizations and professionals in the field and in the communities. The second focus will be the organisation of crisis-care. All this is part of the Programme for long-term care and aims for an appropriate mental health care at micro-level.

Another example are the recently created (April 2015) Mobile Vaccine Teams. The teams move to hard-to-reach communities in order to explain the benefit of vaccinations. So far it seems rather successfully, the response rate is higher and easier to get than expected. In two years an evaluation will follow. The teams started with the Jewish Community in Flanders and have in the meantime already visited several caravan parks of Roma people.

Also in prenatal and early childhood a series of measurements are taken towards the most vulnerable groups, like individual family support.

Since the adoption of the NRIS, the FPS Social integration publishes every year a call for proposals on “social and professional activation of Roma” projects, addressed to PSWCs. These pilot projects are co-financed by the ESF and developed under Axe 1 of the Federal Operational Programme 2007-2013 “Regional competitiveness and employment”. They are one-year, renewable projects, addressed to PSWC beneficiaries, who must be:

- Roma community members
- EU or non EU citizens with a residence permit
- Beneficiary of social assistance from PSWC

According to these conditions, it seems that project beneficiaries are already in a rather stable situation if they have obtained residence permit and have consequently had access to social assistance, may it be on a temporary basis. Additional, specialized workers are hired in the frame of these projects. It is also recommended to hire an intercultural mediator who acts as a bridge between beneficiaries, PSWCs and other institutions. These intercultural mediators have the following characteristics:

- Not necessarily of Roma origin
- With a good knowledge of Roma populations and their culture
- Having a proven mediation experience.

As they can benefit from the Council of Europe ROMED trainings or other relevant measures, the Foyer NGO organized specific trainings for the mediators working within these projects in Belgium, following the demand of the FPS Social integration. So far, 6 projects have been implemented in 6 cities with a total of 178 participants in 2013. A seventh project was due to start in Leuven in June 2014.

List of projects developed in PSWCs:

- PSWC Antwerp: "A" op stap met Roma – Amalia;
- PSWC Ghent: "Natuurlijk";
- PSWC Heusden-Zolder: "Sociale activering van Roma";
- PSWC Mortsel: "Over de Brug";
- PSWC Sint-Joost: "Une guidance vers une activation sociale et professionnelle";
- PSWC Temse: "Roma 't werkt".

It should be underlined that the participating cities listed above (5 in Flanders and 1 in Brussels Region) have previous experience in working with Roma and recognize their needs and specific approach to improve their situation. It is reflected not only through their participation in these project but also by the existence of a large civil society network (Integratie Netwerk and Opre Roma in Ghent, Rom en Rom in Saint Josse, etc.). Even if these projects are not specifically health-oriented, some of them have direct consequences on Roma health, by improving the living conditions of Roma.

Belgium participates in the ROMED programme since 2012 with the objective to improve the quality and efficiency of its Roma intercultural mediators, acting in various fields including health, being of Roma ethnic origin or not.

The FPS Social Integration acts as the general coordinator of the programme and co-organizes related trainings. There have been already 4 cycles of training since 2012, two of them in Dutch organized by two trainers from the Foyer and one trainer from the Integration service of the city of Diest, and two in French organized by the "Centre de mediation de Gens du Voyage et des Roms en Wallonie".

The participants are intercultural mediators working in public administration, mostly in municipalities, or CSOs. According to ROMED website³³, there are 48 mediators in Belgium: 31 in Brussels, 17 in Flanders and none in Wallonia. In Flanders, they work in Leuven, Ghent, Temse, Antwerpen, Heusden – Zolder and Diest. One health mediator from the Health Mediation Unit of the Foyer participated in the training.

In order to ensure a proper follow up of the NRIS, the State Secretary asked her administration, the FPS for Social Integration, to act as the Technical Secretariat of the strategy. One of its main roles is the coordination of the ROMED programme and projects financed by the ESF.

The *Roma Helpdesk* has also been established as a contact point for towns, municipalities and PSWCs, who are usually the first to come in contact with Roma communities. It is namely relevant for the PSWC workers, and allows them to raise specific questions and problems while working on the pilot-projects (see ESF funded projects above). Workers in PSWCs can ask the Helpdesk questions about Roma situations, as well as about relevant methods and difficulties they encounter. So far, questions about health-related issues have not been reported. The Helpdesk

³³ romed.coe-romact.org

provides information, ensures that good practices are shared among partners and keeps contact with other stakeholders, in an effort to provide useful service to all. It aims also to help workers to improve services and support to Roma communities. According to the Helpdesk officer³⁴, it is not very known on the field and its role should be further valorised and communicated more largely. Furthermore, social workers working with Roma communities do already have a well-established network of professionals and prefer to share their concerns at closer and more operational level than to the desk established within the federal administration. To reinforce FPS Social Integration's work in the field of Roma inclusion, an expert by experience of Roma origin works with the team. In general, "experts by experience" are employees of the federal administration who give expertise and advice based on their experience.

Their main tasks are as follows³⁵:

- contributing to improving the reception and the information addressed to public, especially those who struggle with poverty,
- supporting the users in dealing with administrative procedures,
- taking stock of the needs and requirements of people in poverty,
- improving the general quality of, and access to, services by preparing proposals for enhancing communications, procedures, and measures,
- contributing to the development of synergies among services,
- signaling structural problems, lacunae in the legislation, unnoticed and untreated needs of people in poverty to policy makers.

In this way, their experience is valorized and they receive also targeted training in order to foster and improve their expertise. They intervene in different fields, including health related issues. Currently, two experts by experience work in public hospitals (in Brussels and in Ghent). They are in particular involved in the social services of these hospitals. Their daily tasks consist in guiding patients, living in precarious living conditions including Roma families, to appropriate services (i.e. public social welfare centres).

Most of the patients in Brussels who rely on the guidance of the experts by experience are undocumented migrants or are going through a regularization procedure. A lot of the patients in Ghent are homeless who, after their hospitalization, have nowhere to go to recover. The added value of the guidance given by the hands-on-experts is multiple:

- orientation of patients to relevant services,
- advice on administrative procedures including health coverage,
- encouragement towards autonomy in access to healthcare facilities.

Currently, there are 27 experts by experience, divided into different 15 different departments³⁶. Roma expert by experience has been employed within this Unit after the adoption of the NRIS, but it is not a specific initiative listed in the strategy. She is invited to give her feedback at meetings, comment the documentation on Roma related issues. The role of this expert is to maintain the link between practical level/reality and political level/policy. Therefore, her input is strongly pragmatic and taken into account.

³⁴ Interview 23 May 2014

³⁵ Information from the Technical Secretariat of the Working Group, 8 May 2014

³⁶ [PPS - SI experts by experience](#)

In order to respond to specific challenges raised by migration flows, there was the specific project on “*neighbourhood stewards*”, which is a term that Flemish authorities use instead of mediators. Through this project, the Flemish Government aims to foster “proportional and responsible” citizenship through participation and empowerment of Roma communities and Roma access to services, as well as to strengthen social cohesion through an inclusive and coordinated policy, based on the subsidiarity principle. The project started on the 1st of September 2012 and focusses on the cities of Ghent, Antwerp, Sint-Niklaas and Brussels Capital Region.

The Social Cohesion Plan of the Walloon government also includes Roma migrants and pays particular attention to addressing the issue of “cohabitation and reweaving of intergenerational and intercultural links”. It aims at integration of migrants, via “local integration plans” and “regional centres for integration”. A Decree on the integration of foreigners and “persons of foreign origin” provides the establishment of regional integration measures in municipalities with high percentage of migrants, without specifically targeting Roma migrants, most often explained by Walloon authorities by fear of stigmatization³⁷.

At the regional level, the “Directory for Integration of Foreigners” mandated the NGO “*Mediation Centre for Travellers and Roma*”, to ensure mediation services between “some migrant groups” and municipalities.

General missions of the Mediation Centre are:

- improve living condition of Travellers and Roma
- ensure harmonious cohabitation between populations
- support of local and regional policies adapted to realities of Travellers and Roma families.

To realize these objectives, the Mediation Centre intervenes in mediation with different stakeholders: Roma and Voyageurs, public authorities and civil society. Its employees provides also information about their fundamental rights, administrative procedures including access to healthcare and organizes seminars for social workers with Roma in Wallonia.

Since 6 years, there have been about 300 Roma, mainly of Slovak origin, without a stable accommodation in Brussels. Following forced evictions, this group has moved from one place to another, including parks, railway stations or unoccupied buildings. This is the first time in the “migration history” of Belgium that migration flows composed of entire families are characterized by homelessness and severe, precarious living conditions. Large families with women, children and new-born live in inhumane conditions, putting in danger their health and future.

Besides temporary interventions by different municipalities in Brussels region, civil society organisations have mobilized forces to accommodate the community’s needs. A conference was held in October 2013, which gathered political authorities from local and regional level directly concerned by the presence of Roma families living in precarious conditions on their territory. Political authorities from municipal and regional level expressed their support and concern by signing a manifesto towards sustainable solutions in different fields, which are similar to those included in the NRIS (access to employment, education, healthcare and housing). The manifesto has been drafted in cooperation of Bruxelles Laïque, Regional Integration Centre Le Foyer, CIRE, FÉBUL, the League of Human Rights, Médecins du Monde, UNICEF and Rom en Rom, with the support of the General delegate for children’s rights, Belgian network for fight against poverty and Amnesty International³⁸.

³⁷ « La situation des personnes dites Roms migrants in Belgium », 2013, Ciré

³⁸ [Manifesto](#), Médecins du Monde Web page

The Manifesto aimed at:

- stabilizing the situation of migrating Roma families: stop any evictions from places where they found temporarily shelter or expulsion from Belgium. Families must live in the same place for a period of at least 2 years. This is the minimum time that allows families to find stable solutions,
- development of adapted, social follow-up, namely in accessing their rights. The situation of extreme vulnerability requires urgent measures, including humanitarian support, and consecutively specific social support to allow proper, long-term integration, and solutions in the field of employment, housing, education and health,
- inclusion in the common law: develop specific measures answering the needs of these families in terms of humanitarian relief and social follow-up.

In order to achieve this, there should be two types of solutions regarding basic humanitarian needs, and mid-term integration.

Solutions regarding basic humanitarian needs: emergency measures in respect of basic needs should cover emergency housing, food, health and access to water. These urgent measures must be supported by local authorities but should not lead to long term humanitarian assistance.

Solutions for mid-term integration: Besides specific responses in the field of housing, there is demand, within the framework of social follow up, to ensure access to healthcare, and continuity of care by providing medical cards, (via the “urgent medical card” coverage or via compulsory insurance based on residence status).

In order to meet these aims, the signatories asked the government to establish an emergency “Task Force on vulnerable families” chaired by the Region of Brussels, and coordinate the support for families and development of sustainable solutions. For this purpose, a regional governmental note has been adopted in December 2013, which refers to the principles of the Manifesto. Its implementation is in progress, however hindered at the moment by the regional and federal elections³⁹.

The above-mentioned NGO's mentioned, signatories of the Manifesto, meet on a regular basis to discuss emergencies, collect and follow information about the situation of Roma families in Brussels, and look for appropriate solutions. Due to the high number of emergencies and termination of temporary solutions in May and June 2014 (just after the regional and federal elections), the Task force, gathering regional ministries⁴⁰, municipalities, PSWCs and NGOs met in the beginning of May, to make sure that the initiated work will continue, without suffering from possible political change. Unfortunately, the representatives could not propose or finance concrete solutions at this stage, but promised to forward an urging demand to the next government by insisting on the following principles: adequate responses, universality of rights, access to accommodation, healthcare, education and work.

If the above-mentioned initiatives tend to set the general framework for action by recognizing the specific needs of Roma, the main actions, including in the health sector, are undertaken at the local level.

³⁹ May 2014

⁴⁰ Representatives of Minister – President of the Brussels Region and Minister for housing of the Brussels Region

There are several municipalities which are very proactive in replying to unexpected situations and providing inspiring problem solving approaches. Even without benefiting from specific framework, they look for appropriate solutions and raise the awareness further, at the regional and/or federal level (bottom-up approach). Their willingness to develop specific policy or action for Roma populations is mainly characterized by their work with relevant professionals and different types of mediators, as indicated in the table below.

According to detailed information from 2013⁴¹, there are currently 26 Roma mediators in Brussels and Flemish municipalities. Their functions are slightly different, according to their funding and their field of work:

- “neighbourhood stewards” are supported by the Flemish Government,
- “consultants for EU migrants” have been developed before the adoption of the Flemish Action Plan (which brought “neighbourhood stewards) as an independent, municipality initiative in Ghent,
- “Roma mediators” or “Roma stewards” of Roma origin,
- “Bridge figures” – school mediators supported by EU funds, initiated in cooperation between education and integration services.

While dealing with particular Roma migration related situations, healthcare appears as one of the fundamental issues in transversal problem solving, closely related to accommodation and nutrition problems met on the field.

4.3 Bosnia and Herzegovina

Roma policy framework

The Ministry for Human Rights and Refugees of Bosnia and Herzegovina leads and coordinates all activities related to the integration of Roma. The Human Rights Department of the Ministry is responsible for providing professional, administrative and operational support and for monitoring, promoting and protecting the rights of Roma. At the initiative of the Ministry for Human Rights and Refugees of Bosnia and Herzegovina, the Council of Ministers of Bosnia and Herzegovina adopted the following Roma policy documents:

- In 2005, the Strategy of Bosnia and Herzegovina for Roma;
- In 2005, the Action Plan on Roma Education;
- On 3 July 2008, the Action Plan of Bosnia and Herzegovina on Roma Issues in the Fields of Roma Employment, Housing and Health Care;
- In July 2010, the Revised Action Plan on Roma Educational Needs of Bosnia and Herzegovina.

The basis for the adoption of all these Roma-related documents is the Law on the Protection of Minorities in Bosnia and Herzegovina adopted in 2003.

Funding of the Roma policy

⁴¹ *Context, drijfveren en opportuniteiten van Middenen Oost-Europese immigratie - Een exploratief onderzoek met focus op Roma* - Heleen Touquet & Johan Wets 2013, p. 53
Context, motivations and opportunities of the Central and Eastern European immigration – Explorative research with the focus on Roma populations

Every year since 2009, the Ministry of Human Rights and Refugees of Bosnia and Herzegovina and the Council of Ministers of Bosnia and Herzegovina have allocated funds at the state level amounting to 1.5 million Euros in order to fund the implementation of the Roma Action Plan. These funds are increased through a system of co-funding by other ministries and implementing partners, particularly in the field of Roma housing, which has been the main priority. The funds are also increased with donations from international organisations that co-fund activities. Most municipalities allocate funds at the local level to improve the living conditions of Roma and invest their funds in infrastructure projects.

The Ministry of Human Rights and Refugees of Bosnia and Herzegovina regularly applies for IPA funds from the European Commission. The European Commission approved the 5 million Euros IPA project and the implementation of the first stage amounting to 2.5 million Euros began in the second half of 2013. Most of these funds, i.e. 80%, are devoted to Roma housing and the improvement of living conditions. Funds planning will continue regularly on a yearly basis. All funds are used solely to improve the inclusion of Roma in society, by providing better living conditions. These funds are also used to award small grants for employment and for improving health care and education.

Representativeness and consultation bodies

The Roma Board, an advisory body of the Council of Ministers, is responsible for systematic monitoring of the implementation of the Action Plan, the adoption of new action plans and proposing measures for improving the situation of Roma, as well as for initiating the provision of budgetary resources for Roma and the like. A Roma Thematic Group (RTG), consisting of all relevant institutions, international organisations and Roma umbrella NGOs, deals with and shares information about Roma activities to provide a better planning and avoid overlapping of activities.

At the moment, there are about 107 Roma associations officially registered, but only 10% of them are active. A network of Roma women is very active in Bosnia and Herzegovina and actively participates in programmes to improve the situation of Roma women

The Ministry of Human Rights and Refugees has involved many Roma in fieldwork at local level, particularly in the selection of beneficiaries of housing. In this way, massive participation of Roma representatives in the decision-making process was ensured. Every year, the Ministry for Human Rights and Refugees organises several referral meetings with Roma representatives and local authorities in order to better coordinate activities. Representatives of Roma and Roma NGOs take therefore an active part in the process

Monitoring is done on the ground in different directions by several actors. Independent monitoring is performed by Roma representatives and independent experts, experts in particular areas coming from local and national institutions and others.

Health related policy and measures for Roma

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he legislation in Bosnia and Herzegovina allows Roma population the right to health care, because the Health Care Act guarantees every citizen the right to health care, while Health Insurance Act guarantees the right to mandatory health insurance based on some ground. Health care is covered by Entity Laws on health care in the whole Bosnia and Herzegovina, for all the citizens.

In order for members of the Roma national minority to be able to exercise these statutory rights, it is necessary to first meet certain requirements, i.e. to register new-born children and other persons of national minority who are not registered in birth records, in compliance with law, to raise awareness of regular registration with Social Welfare Centres and other relevant institutions, to raise awareness about preventive programmes, etc.

Roma usually do not register themselves and are therefore not included in regular health care system. According to the Registration of Roma and their needs, held in 2010, approximately 30% of the Roma national minority have been faced with lack of health insurance, because of missed procedures for registration. That was the reason that the Council of Ministers of Bosnia and Herzegovina adopted the Revised Action Plan for Roma Health Care, in order to include Roma in the system.

The implementation of the Revised Action Plan for Roma Health Care (initially until the end of 2013) was continued in 2014 and 2015. The Revised Action Plan contains priorities in line with the needs expressed by the representatives of Roma and all other relevant participants in the review process.

Access to, and coverage with, health care, as well as training and health prevention, are the priorities of the new Revised Action Plan for Roma Health Care. Its implementation will enable equality, improve the overall health situation of the Roma through access to health care, enable obtaining important baseline data on specific diseases and achieve a higher level of awareness of health care and the right to health care.

The Ministry of Human Rights and Refugees of Bosnia and Herzegovina has been also allocating certain financial resources as an incentive to competent medical institutions to carry out certain actions to improve access to and provide better health care for Roma minority in Bosnia and Herzegovina. The main activities are related to ensuring access to health care and programmes, as well as to health prevention and education.

A particularly significant progress was made in the inclusion of many Roma families into the mainstream health care system in Bosnia and Herzegovina, raising awareness about the importance of health care of the Roma minority, prevention of addictions, immunization of Roma children, oral health, reproductive health and maternity care, in training of Roma civil society in local communities in health care.

A lot of implementing partners and international organisations in Bosnia and Herzegovina are implementing projects, among them the ROMED joint programme of the Council of Europe and the European Commission. 50 persons (including 17 Roma women) have undergone training under this programme to become mediators.

The Action Plan for Roma Health developed as a part of the Roma Decade of Roma Inclusion includes positive action measures to ensure that Roma are able to enjoy fully the right of access to health care, as well as awareness-raising and preventive health measures such as immunisation programmes⁴²

In 2014 and 2015, the Ministry of Human Rights and Refugees of Bosnia and Herzegovina continued allocating certain financial resources as an incentive to competent medical institutions to carry out certain actions to improve access to and provide better health care for Roma minority in Bosnia and Herzegovina. Roma health mediators have been helping on the local level.

⁴² See ECRI Report on Bosnia and Herzegovina (fourth monitoring cycle), published in 2011, p.36.

The earmarked funds for Roma health care in Bosnia and Herzegovina in 2014 were spent by relevant institutions on the basis of signed Memoranda of Understanding for the implementation of the Action Plan for Roma Health Care of BiH signed between the Ministry of Human Rights and Refugees of Bosnia and Herzegovina and the Public Health Institute of the Federation of Bosnia and Herzegovina, the Public Health Institute of the Republika Srpska and Brcko District Government, the Department of Health and Other Services of the Brcko District of Bosnia and Herzegovina.

The funds were spent for:

- ensuring Access to Health Care and Programme;
- prevention and Education;
- improving Health Care of the Roma Minority.

A particularly significant progress was made in the inclusion of many Roma families into the mainstream health care system in Bosnia and Herzegovina, raising awareness about the importance of health care of the Roma minority, prevention of addictions, immunization of Roma children, oral health, reproductive health and maternity care, in training of Roma civil society in local communities in health care.

Role of all *Roma health mediators* is very important for the Roma communities, including also ROMED mediators. In order to avoid overlapping and to share information with all institutions working on the issue, the Ministry for Human Rights and Refugees of Bosnia and Herzegovina has established Roma Thematic Group, consisted of all international organisations, local institutions and Roma roof associations. They meet once in two months in order to share information and agree about future steps. In this way, the Ministry for Human Rights and Refugees of Bosnia and Herzegovina is coordinating all activities regarding Roma, including Roma health mediators and make plans for further steps. Regardless of the fact that the Roma health mediators are funded by projects, the Ministry is having regular negotiations with local authorities in order to find permanent solutions for their employment.

Mediators engaged by international organisation

Taking into consideration that Bosnia and Herzegovina is in the recovering phase and in the transition period, there is a lack of financial means to permanently employ Roma mediators. International organisation in Bosnia and Herzegovina are aware of the fact and the state Ministry for Human Rights and Refugees of Bosnia and Herzegovina has established very good cooperation with Roma mediators and ensure regular financial support. Many international organisations provide funds for Roma mediators, such as:

- *World Vision* in Bosnia and Herzegovina, together with Roma association "Romalen" in Kakanj, through ROMED programme, has provided funds for 22 Roma mediators in BiH. 9 mediators are Roma women and 13 mediators are men. The mediators have been engaged in all activities planned in the Action Plans for Roma Issues, mainly focused on health issues. Many Roma children and adults have been included in the health system in Bosnia and Herzegovina. The mediators are helping Roma to get health cards, they identify health problems in Roma communities and coordinate regular check-up with health centres. In 2015, Roma mediators identified increased number of gynaecological problems with Roma women in the municipality Kakanj and organized check-up and discovered cancer problems at the beginning phase. In this way, prevention of the disease was achieved.

- World Vision covered costs for 50 Roma women. The Roma mediators have established very good cooperation with Social Welfare Centres, Health institutions and education institutions in each municipality. The cooperation with health mediators has been lasting for the last 10 years, funded by World Vision and Global Fund. It is related also to HIV and tuberculosis prevention. 100 municipalities are included in the programme. Roma health mediators and medical nurses have been trained several times and, thanks to them, 145 new patients of tuberculosis have been discovered. The Roma health mediators will continue with their work.
- *UNHCR mission in Bosnia and Herzegovina*, in 2013 and 2014, conducted extensive field visits in 256 Roma communities throughout Bosnia and Herzegovina in order to identify and collect data for persons of statelessness, number of Roma families and persons, information related to Roma rights regarding health care, education, employment, social protection, housing, etc. During additional field visits in 2015, the number of known 256 Roma communities has been increased to 277, by the mid-2015. 11 Roma mediators were hired to assist Roma population and be a link with local institutions, in order to help Roma to exercise their rights. UNHCR, jointly with its legal aid partner "Vaša prava" (Your rights) in Bosnia and Herzegovina, continues to conduct extensive field visits to all Roma communities to identify all Roma problems.
- *Roma women network*, supported by CARE International, is very active and engaged many Roma health mediators, in order to assist Roma to exercise their rights on health care. They arrange regular check up of Roma children and women, in order to prevent and provide health assistance with serious illnesses.
- *Kali Sara - Roma Information Centre* has engaged 135 Roma mediators since 2007, and 50% of them were Roma women. They are link between Roma local communities and local institutions. They have been dealing with various issues, including prevention of TBC diseases, vaccinations, registration, organisation of check-up, etc. All of them have been paid by projects.

4.4 Montenegro

Roma policy framework

Montenegro was part of the "Decade of Roma Inclusion 2005-2015" initiative. The Government of Montenegro in January 2005 adopted its Action Plan for the Implementation of the Decade, with a tendency that with the projects in the fields of education, employment, housing and health care break the vicious circle of poverty and social exclusion of Roma from Montenegro life.

Given the limited effects of the Action Plan on four priority areas, the Government of Montenegro in 2007 adopted the Strategy for Improving the Position of Roma, Ashkali and Egyptian Population in Montenegro 2008-2012. The strategy was represented by a set of concrete measures and activities in the four-year period, the legal, political, economic, social, town-municipal, educational, health, cultural, informational and any other necessary fields.

The strategy has been defined bearers of activities, deadlines and financial costs, as well as a way of monitoring the implementation of projects and one-year obligation to inform the Government of Montenegro. Taken measures and activities aimed at improving the situation of Roma and Egyptians resulted in very significant and visible, but not quite sufficient changes.

The New Strategy for Improving the Position of Roma, Ashkali and Egyptian Population in Montenegro covers the period from 2012 to 2016, and it is realized through a one-year Action plans, which specify the priority measures and activities to be performed in that year.

The responsible institutions for the implementation of the activities in the Strategy and the Action plans are:

- the Ministry for Human and Minority Rights,
- the Ministry of Internal Affairs,
- the Ministry of Education,
- the Ministry of Culture,
- the Ministry of Labour and Social Welfare,
- the Ministry of Health,
- the Ministry of Sustainable Development and Tourism,
- Employment Agency of Montenegro,
- Directorate for the Refugees
- Centres for social work, and others.

In the implementation of the activities can participate:

- local self-government,
- NGOs
- other legal entities and persons.

Funding of the policy

Financial resources for the four-year implementation of the Strategy were in total € 1.7 million, and they were distributed through the public tenders. Although certain results have been achieved in the implementation of the Action Plan of the Decade of Roma Inclusion in Montenegro and the Strategy for Improving the Position of Roma, Ashkali and Egyptian Population in Montenegro 2008-2012, the expected progress in improving the overall situation of the Roma and Egyptian communities as collectives was not at expected stage.

The Commission, which has approved funds for the implementation of projects for each year has also fixed the priorities. Priority areas of funding in the 2008 were education and the database, in the 2009 education and housing, in the 2010 education and personal documents, and in the 2011 also education and personal documents.

Representativeness, consultation bodies and participation in political and public life

The main objective of the strategy, improving the position of Roma and Egyptian population and its inclusion in society cannot be achieved without adequate participation of Roma and Egyptians in public and political life, that without political representation of the Roma community as a specific cultural and political entities and collectives. This is an important and necessary part of the overall cultural and social emancipation of the Roma and Egyptian population, but also a very important factor and concrete struggle against discrimination, for equal and non-discriminatory treatment of Roma and Egyptian communities as citizens and as a collective.

In accordance with the Law on Minority Rights and Freedoms, minority people and other minority communities and their members, in order to preserve its national identity and advancing their freedoms and rights, may establish the Council of that minority people or other minority communities. The Council represents minority people and other minority national communities to submit proposals for the improvement and development of the rights of minorities and other minority ethnic groups and their members can participate in the planning and establishment of educational institutions, etc. In Montenegro, there is a Roma Council

The Ministry for Human and Minority Rights, in cooperation with the NGO sector in 2014 and 2015 continuously organized seminars, round tables and public lectures where topics of gender equality were discussed, including international and national legal framework in the area violence against women, forced marriages in RE communities, the importance of education and employment of RE population and their inclusion in decision-making bodies. Participants were RE women and men, representatives of local self-governments, NGO sector, state institutions and international organisations.

Roma in Montenegro are not politically organized, that is not yet registered Roma political party.

Health related policy and measures for Roma

The right to health protection has been prescribed in the Law on Health Protection and the Law on Health Insurance of Montenegro. In the health system no data is collected based on ethnical, national or any other belonging of health protection users.

The Law on Health Insurance stipulates that socially vulnerable categories, women during pregnancy and in a year after delivery, older than 65 and those suffering from contagious diseases do not participate in treatment costs, meaning that they have free health protection. The Directive on the manner of exercising health protection of foreigners ensures that also refugee Roma and Egyptian population women receive health protection, like all the other citizens of Montenegro.

With the aim of preventing contagious diseases of RE children who do not have their elected paediatrician, and who do not go to school but live in collective settlements, vaccination is organized in those communities. The Institute for Public Health organized a number of campaigns which resulted in high percentage of coverage (for certain diseases up to 98%).

Activities were conducted both in terms of monitoring health situation of Roma and Egyptian population, but also in terms of education-informative workshops and public calls through the media for examinations and vaccinations. Brochures were printed for women, youth and children.

Other measures include:

- *The development and introduction of the position Associate in social inclusion for Roma and Egyptians for health*
- *The Roma Health Mediation IPA Assistance programme for integration and return of RAE and other I/DPs residing in the Konik area Phase I 2013/2014: the Ministry of Health of the Government of Montenegro and*

NGO HELP (Hilfe zur Selbsthilfe) and REF signed memorandum of cooperation on implementation of health activities within IPA Assistance programme for integration and return of RAE and other I/DPs residing in the Konik area phase I 2013/2014.

- *Study visit April 2013:* In cooperation and with financial support of OSCE, HELP at the end of April organized a 2 day study tour for the Montenegrin Ministry of Health officials to the Ministry of Health in Serbia in order to familiarize them with the system of Roma Health Mediators in Serbia. On that occasion Serbian representatives presented to the study group the programme of Roma health mediators in Serbia. This programme includes the employment of 75 Roma health mediators - RHM in 59 towns in Serbia. During this study tour the following was agreed:
 1. The Ministries of Health agreed that the Ministry of Health from Serbia will provide trainers for the first RHM training including methodology in Montenegro.
 2. The Ministry of Health of Montenegro confirmed that they are interested to take over this programme with support of NGOs.
 3. The Ministry of Health of Montenegro informed that they plan to develop a professional profile of RHM and educational module in near future (next year).
 4. The Ministry of Health of Montenegro informed that they plan to open a health centre in Konik area.

- *Training for Roma Health Mediators July 2013:* as agreed during the study tour a Roma health mediators' seminar was held in Montenegro from 30 June - 4 July 2013. The participants were four candidates for Roma health mediators, social workers from HELP, field nurses and doctors from health centres in Podgorica and representatives of the Montenegrin Ministry of Health. In the workshop the methodology implemented in Serbia (legal framework, position of mediators in health system in Serbia, planned and monitored field work, reporting, evaluation, cooperation with the Ministry of Education, Ministry of Interior, Centres for Social Work and other social institutions) was presented, but also case studies of different situations which can occur during the field work and there were provided advice on how to prevent some of these situations. The instructors stressed the importance of continuation of the training for mediators after the first 4 days cycle, mentoring and monitoring of the field nurse in order to gain needed knowledge and develop skills to perform the task of a health mediator. Representative of Montenegrin Minister of Health presented the legal framework in Montenegro and possible legal solutions for the employment of Roma health mediators in health centres. The Ministries agreed on continuation of cooperation and possible extension of the cooperation through cross border activities where health centres from western Serbia will share experience of Roma health mediators in northern municipalities in Montenegro Berane, Bijelo Polje with participation of both ministries and HELP.

- *Field visit of Ministry of Health of Montenegro and Ministry of Health of Serbia July 2013*
 After completion of the seminar the representatives of the Serbian Ministry of Health and of the Montenegrin Ministry of Health jointly visited the Konik camp in Podgorica where Roma population lives, and met representatives of the Roma Council of Konik. They discussed obstacles of using health services for inhabitants of the Camp as well as possibilities for more efficient procedure for their treatment in Serbian hospitals in case of serious illness.

- *Publishing handbook and recruiting health mentor July 2013:* the initial training of Roma health mediators has been conducted in July 2013. In order to continue education and prepare RHM to work in the field HELP hired a consultant to prepare a manual for RHM. The manual was prepared and it was accepted by the Ministry of Health and is now being used by the RHM. Since September 2013 the RHM mediators are supported in their field work by a professional mentor. It is expected that after completion of the project RHM could completely independently carry out their activities.
- *Pilot employment of 2 Roma health mediators:* RHM have to have following qualifications: completed high school III grade, knowledge of minority language Romani/Albanian. Under the same condition preferences will be given to persons who are: female, belong to minority community.

The duties of a Roma Health Mediator include:

- facilitates communication between the Roma community and health workers;
 - helps Roma in obtaining basic documents and get social and health care;
 - points to the importance of vaccination;
 - points to the importance of general and personal hygiene and proper nutrition;
 - points to the harmful effects of smoking, alcohol and abuse of psycho-active substances;
 - contributes to implement measures for the prevention and control of infectious diseases;
 - includes the Roma community in the celebration of important dates in the healthcare calendar;
 - together with health care professionals indicates the importance of periodic inspection / control;
 - participate in campaigns for disease prevention and health promotion.
- *Health mentors 2014/2015:* Given that RHM had no field experience and passed only initial RHM training, HELP NGO introduced RHM mentor to support continuous learning of RHM and assistance in field work until the end of the project when they will be able to work independently. In order to launch field activities HELP hired health mentors with following qualifications:
 - medical high school finished (Level IV qualification);
 - over 15 years field experience as visiting nurse;
 - excellent communication skills;
 - the responsibility and capacity for teamwork;
 - experience and ability to work with vulnerable population groups;
 - computer skills (Microsoft Office programmes).

The health mentors worked in a team with RHM and together with them ensures access to all health services as well as implementation of the RHM activities. Assists health mediators in first months of their work to: facilitate communication between the Roma community and health workers; help Roma in obtaining basic documents and get social and health care; point to the importance of vaccination; point to the importance of general and personal hygiene and proper nutrition; points to the harmful effects of smoking, alcohol and abuse of psycho-active substances; participate in the implementation of measures for the prevention and control of infectious diseases.

- *Consultative meeting for standardization April 2014:* HELP organized consultative meeting with Ministry of Health, Centre for Vocational training and Employment Agency in order to prepare for standardization process of the position Associate in social inclusion for Roma and Egyptians for health.

- *Roma Health Mediation IPA Assistance programme for integration and return of RAE and other I/DPs residing in the Konik area phase II 2014/2015:* The Ministry of Health of the Government of Montenegro and HELP NGO (Hilfe zur Selbsthilfe) signed a Memorandum of cooperation on implementation of health activities within IPA Assistance programme for integration and return of RAE and other I/DPs residing in the Konik area Phase II 2014/2016.
- *Standardisation process October 2014/January 2016:* The working group for standardization has been established during October 2014. The Working group developed: Initiative for standardization of the position of Associate in social inclusion for Roma and Egyptian for health, programme, and standard of qualification and catalogue of exams. The Initiative for standardization of the position of Associate in social inclusion for Roma and Egyptian for health was adopted. Standard of qualification has been approved by Sector Commission for Health and Social Welfare and submitted to Commission for Qualification for final approval and adoption. After that this position will be officially part of the state health system. During the period, from October 2014 to October 2015 RHM/Associate in social inclusion for Roma and Egyptians for health implemented:
- *Family health education:* Family health education includes in house family education visits on prevention and personal hygiene for 248 persons for 96 man 152 women; in house family education visits on maintaining hygienic conditions at living space for 214 persons 77man and 137 women. They visited 21 pregnant women and women who recently gave a birth and 18 new health books provided.
- *Workshops*
 - 6 workshops on early and arranged marriages, general health in cooperation with Montenegrin Women`s Lobby and doctor from Emergency service for 108 participants (53 girls and 55 women);
 - 8 workshops on: hypertension, health lifestyle/smoking ,first aid , contraception, hygiene, pregnancy, domestic violence, hygiene and health habits in school for 120 participants (12 man and 108 women).
- *Support to choose selected doctor*
 - 144 (56men and 58 women) adults supported and sent to health centres to choose selected doctor;
 - 2 children supported and sent to health centres to choose selected paediatrician;
 - 2 children supported in cooperation with Red Cross to visit ophthalmologist.
- *Support to choose selected dentist*
 - 60 children supported to choose a dentist among selected dentists.
- *Cooperation with institutions and organisations*
 - 19 children visited and supported for health check at request of REF and kindergarten staff;
 - In cooperation with Podgorica health centres RHM supported health check and vaccination for 53 children enrolled in first grade of primary school;
 - coordination meetings with health fund and health centres regarding collection of health cards and distributing them to beneficiaries;
 - meetings with UNHCR on coordination joint activities;

- meetings and consultations with Health Centre and Centre for mental health in support to addict persons to start weaning process;
- 2 coordination meetings with health fund regarding support of beneficiaries to select dentist;
- 3 meetings with health centres regarding health check and vaccination for children who enrolled in first grade of primary school, regular communication/meetings with Red Cross and REF regarding individual cases.

4.5 Poland

Roma policy framework

Poland has gained experience on professional activation during three successive governmental programmes aimed at the integration of the Roma community in Poland:

- The Pilot government programme for the Roma community in the Malopolska Province (2001-2003);
- The Programme for the Roma community in Poland in the period 2004-2013;
- The Programme for the integration of the Roma community in Poland in the years 2014-2020;

All these programmes have a comprehensive character with several intervention areas, including education, housing and social situation, health, labour market, anti-discrimination and security, culture, promotion of Roma culture and civic education of Roma (education with cultural, historical and civic component).

Representativeness and consultation bodies

There are approximately 120 Roma non-governmental organisations registered in Poland, declaring themselves as Roma minority organisations, 50 of them are active in the implementation of the national programme for the integration of Roma.

Two representatives of the Roma community are present in the Joint Commission between the Government and National and Ethnic Minorities, established by the Act of 6 January 2005 on National and Ethnic Minorities and Regional Languages.

Making use of the institutional opportunity to establish a permanent panel of this Commission, a Roma Team, consisting of 20 representatives of Roma origin, was established in 2008. It acts as a forum of exchange of information on matters relating to the Roma ethnic minority, and serves an advisory body whose aim should be to develop proposals for actions aiming at improving the situation of Roma in Poland.

Health related policy and measures for Roma

The systematic actions for the benefit of the Romani people in Poland are conducted since 2001. It was also then that have been hired the first so-called assistants of Roma education (Roma school mediators). The idea of employment of educational mediators turned out to be a great success. These are persons with the trust of the Romani people, often acting as an example and exceeding their activity beyond school and the purely educational issues. Unfortunately, there was no similar success in the project of employment of the so-called "environmental

assistants" (Roma health mediators) – this proposal did not encounter a significant response, both among the local governments as well as the Romani NGOs, as the projects implementers.

- *The environmental nurses⁴³ working among the Roma community*

In Poland owing to the sensitivity of data concerning the ethnic origin there are no statistics regarding the health sphere. For this reason, the only available source of information on the health condition of the Roma people in Poland is the knowledge of people working with this community, in this case the so-called environmental nurses. Every year within the scope of several projects, a dozen of the so-called environmental nurses have been hired, the role of which is close to the role a health mediator. In the environment of Polish Roma the issues related to the performance of professions related to health care, are an "unclean" area, especially for the representatives of traditional groups, therefore, the contact with nurses, whether belonging to the community or not, bears the risk of "contamination" (magerdo/marime/prasto). Solely mentioning this nuance indicates how difficult and demanding is the work of environmental nurses and how difficult it is to find people from the Roma community involving in this kind of projects.

In Poland works only one nurse of Romany origin (with a diploma of the Medical University) and conducts actions in the local Roma community. Even in the community, from which she originates (Carpathian Roma, are less bound by the taboo approach to the external world) her work has not been accepted.

The catalogue of the actions undertaken by the environmental nurses:

- the use of diagnostic and treatment methods;
- measurements of blood sugar level, measurement of the respiratory rate (RR), heart rate, analytical tests;
- assistance in the implementing of medicinal services or their partial performance (injections, beauty treatments, filling prescriptions);
- making purchases of auxiliary equipment: inhalation tubes, inhalers, glasses, etc.;
- informing what illnesses are cured by a given specialist;
- fixing terms at specialists and often participation in these visits;
- preparation of mothers concerning the care over the new-borns;
- promotion of women cancer prevention - teaching the breast self-examination, popularization of performing cytology, etc.;
- primary secondary prevention among the children of kindergarten age - detection among children of development defects, especially the defects of eyesight, hearing, speech, posture, deficit in the mental and physical development;
- informing in the cases of specific diseases, side effects of diseases, dosing of drugs, etc.;
- equipment of the wards with hygiene measures and the basic medical measures;
- cooperation with a primary care doctor, midwife, Vaccination Centre and social services;
- running rehabilitation exercises.

⁴³ In the period 2004 -13 under the governmental Programme for the benefit of the Roma community in Poland together 5,500 of projects have been completed, of which ca. 4% related to the health. This means a relatively small interest in this field, both at the level of local authorities and non-governmental organizations, including Roma NGO, submitting the applications for a financial support of activities.

The work of environmental nurses also applies to a non-medical support when filling in documents, reading and explaining the medical recommendations, prescriptions, but also official letters etc.

The subject of health as emphasized by the Romani is not a priority for them. People working in this community often say: "Roma do not like to be treated. They go to the doctor no sooner than when the health situation is serious". They often have bad memories from the visits to the health institutions, and the topics related to the physicality are shameful and often appear in the context of health care, and thus it appears that the organisation of the so-called "white days" giving the possibility of a special, additional arrival of Romani people to clinics for prophylactic tests - is not entirely an effective form of support because the required collective participation in this project generates discomfort.

From the survey of environmental nurses working with Romani families conducted in 2012 by the Ministry of Administration and Digitalization, it seems that the diseases occurring in these communities do not differ from those occurring throughout the population, only their frequency is greater. The most often found diseases among the Romani community in Poland are:

- respiratory diseases – asthma, inflammatory diseases of upper and lower airways,
- cardiovascular diseases – hypertension, ischemia,
- metabolic diseases – diabetes with different complications like kidney failure, eyesight defects skin lesions,
- urinary system diseases and genital system diseases (bacterial infections),
- mental defects and disabilities,
- diseases of the nervous system : eyesight defects, defects of hearing and of speech,
- epilepsy, psychophysical hyperactivity,
- alimentary system diseases: diarrhoea, vomiting, reflux, ulcers.

Table: The tests conducted on the population of 100 Romani people living in a compact manner in the town in the southern part of Poland

Age	Most often diagnosed diseases
0-15 years	respiratory diseases, thyroid diseases, heart diseases, eyesight defects, diseases of the nervous system, blood diseases, orthopaedic diseases,
16-30 years	diabetes, eyesight defects, heart diseases, mental and neurologic illnesses, defects of hearing, musculoskeletal disorders,
31-45 years	kidney diseases, vertebral syndromes, pancreatobiliary diseases, mental disorders, cardiovascular diseases, musculoskeletal disorders, diseases of the digestive system, eyesight defects,
46-60 years	diabetes, cardiovascular diseases and heart diseases, kidney diseases, respiratory diseases, digestive system diseases, liver diseases, vertebral syndromes, blood diseases,
61 years and more	diabetes, cardiovascular diseases, kidney diseases, liver diseases respiratory diseases, vertebral syndromes, heart diseases.

Social and biological determinants affecting the health situation of the Romani community in Poland:

- financial situation of the Romani families - in its vast majority, this community lives in poverty, and the main source of income remains the support provided under the social services system;
- housing conditions - definitely better in cities than in clusters covering the rural areas;
- availability of the health care system – diverse in the rural and municipal areas;

- large number of children – the surveys have shown, that the half of families having four and more children lives in poverty, providing in this number are also included the Romani families with many children;
- education – low level of education in the vast majority, of this group affects both the low awareness of living a healthy lifestyle, proper nutrition, consequences of addictions etc. and smaller possibilities of an effective navigating in the health care system;
- sex – death rate among men is significantly greater than among women.

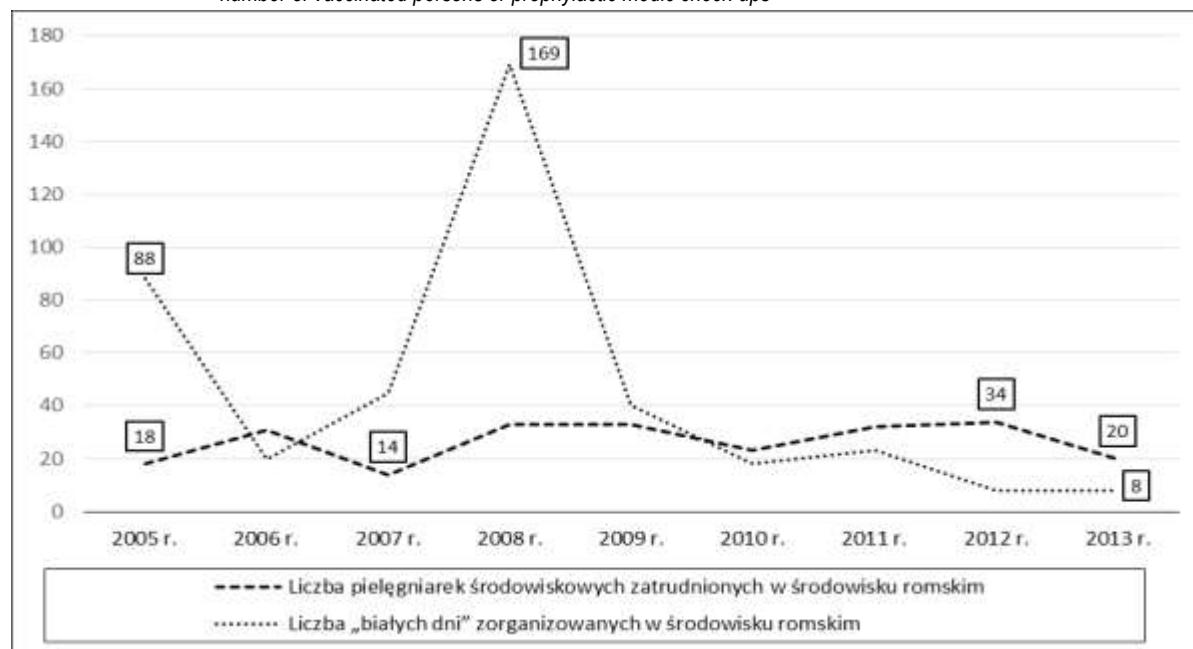
Health problems are also intensified by cultural issues:

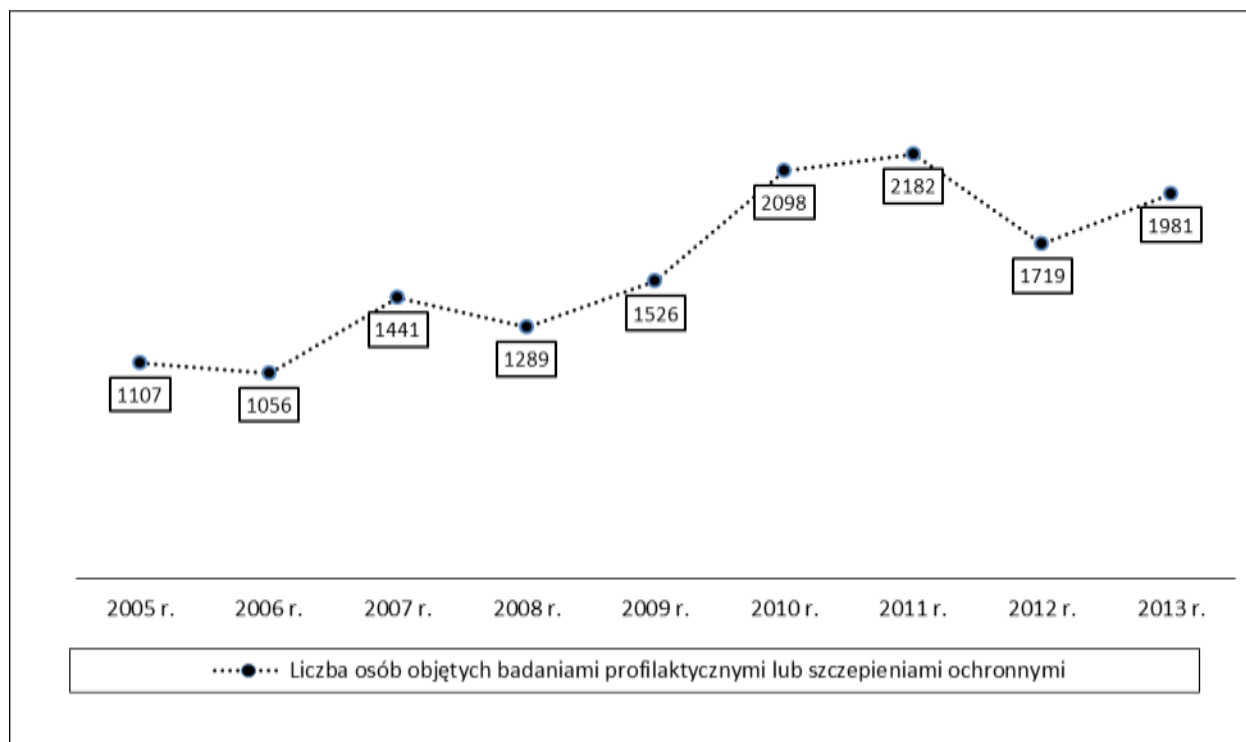
- overpopulation in flats, promoting the development of infections, and also associated with the many generations and large number of children in the Romani families,
- low level of health awareness and difficulties with education of health-conscious habits, also often a lack of skills in the interpretation of the purposefulness of the medical recommendations,
- bad nutritional habits, also unhealthy diet and low physical activity,
- no regularity in treatment, control, taking medications,
- no monitoring of the pregnancy,
- early parenthood and social immaturity causes a non-fulfilment of the assumed obligations,
- lack of vaccination of children and, as a result, - falling ill with contagious diseases,
- inbred relations causing inborn defects,
- lack of trust to the health care system;
- addictions: smoking cigarettes, alcohol abuse and the occurring phenomenon of drug addiction.

Programme in figures – the summary of the field "Health" implemented under the Programme for the benefit of the Romani community in Poland for the years 2004-2013

Graphs legend:

- = number of "environmental nurses" working in Roma communities
 = number of "white days" – organised in Roma communities
 = number of vaccinated persons or prophylactic medic check-ups





Evaluation of activities

The evaluation of activities undertaken under the Programme for the benefit of the Roma community in Poland in the years 2004-2013, conducted in 2011, indicated several weaknesses of the undertaken pro-health activities. Among others the term "white days", commonly used by the projects implementers turned out to be unclear for the Romani people, which reduced their participation in them. At the same time the participation in these projects did not influence the growth in pro-health and prophylactic behaviours. Due to a small number of environmental nurses, working only in a dozen of communities, their work did not translate in an increase in trust towards the external world whether the growth of pro-health behaviours.

However, the evaluators note a visible effect of the actions of nurses manifested in: vaccinations, number of children equipped with glasses, diabetics who received glucose meters etc. The evaluators drew attention that a number of problems are not disclosed by the Romani community to the outside. Such a problem is, among others, alcohol addiction, drugs addiction and gambling among men. During the evaluation women mentioned this problem as a cause of the behaviour related with violence. This situation is identified by the Roma minority as a problem, but such that should be solved on their own inside the community. However, women indicated that the community does not indeed solve the problem, and only balances its negative effects. To sum up, there is a lack of a long-term support for men addicted to alcohol or committing aggression.

Another issue is the reference to these cultural standards that contribute to the consolidation of the social isolation situation. Such phenomena include, among others, conclusion of marriages at an early age and early maternity. Their effect is, among others, the abandonment of education, which contributes to a low education among the Romani people - particularly this phenomenon has negative consequences for the education of girls, including for their health.

Some respondents participating in the evaluation research of the Romani Programme believed that health-promoting projects are not necessary to them, and the funds directed for this purpose should be spend on more necessary matters to them (e.g. repair of apartments).

To the question what health problems Romani people see in their community appeared answers concerning: premature maternity (52% of answers), alcoholism (30%), generally bad health condition (30%), drugs (15%). There is not any reference to threats of AIDS -0%.

The collected information indicates that Romani people have quite well diagnosed the diseases, they are aware of them. In significantly greater degree than diagnostics, the problem is the need to buy expensive drugs or rehabilitation equipment. This has resulted in a "re-profiling" of the support towards more specific purchases: rehabilitation equipment, glasses for children with eyesight defects, glucose monitors, breathing apparatus etc.

This direction of support is better evaluated; however, it does not alter in any way the attitudes towards the disease prevention.

In the case of using the assistance of an environmental nurse, the opinions of the Romani people about this aid are ambivalent. Among 78 people who commented on this - 49% are satisfied, and 42% dissatisfied. This ambivalence, towards this form of assistance may result from several issues that can be illustrated as follows:

- Reluctance to disclose domestic details/fear against an outsider: "They will interfere in what is in my house", "One looked into my pots to see what I was cooking";
- Declared self-reliance in this area: "I deal with the matters in the clinic myself", "I am for the time being healthy and do not need care".
- The sense that this is a loss of money: "It's a waste of money for this, they can be spend on repairs, Gypsies on their own take care for of the sick and old, there is no need for an outsider who shall pry into their home" .
- Reluctance to invade their competences: "Because I take care of my child properly",
- Wrong experience associated with the visit of a nurse: "She looked strangely at us".

The Contractor of projects partially confirms a lack of interest in the participation in the health development projects. In one of the cities after two years (dental project) the actions have been discontinued, because there were no volunteers, or they did not come for the arranged visits".

However, those who performed the health-promoting projects indicated a popularization of vaccinations among children, the overcoming of the fear of injections, improvement of dental care etc. It is beyond doubt that since we will not in the predictable future live to see Roma health development mediators, working environmental nurses should in a particular manner know the special cultural character of the Roma people in order to help them in a better way, to motivate to undertake prophylactic activities. As a result, the evaluators recommend the support of this function and the focusing of activities on the prevention, works in small groups (e.g. homogenous in terms of sex, age, etc.) for the purpose of obtaining a freedom of formulation by the Roma people of their needs or problems.

The programme of integration of the Roma community in Poland for the years 2014-2020

The new strategy to a greater extent focuses on the promoting of health and the prevention of diseases among women, preventive health care over children and young people in the community teaching and education, especially by encouraging to an individual responsibility for their own health, early multi-specialist and complex care over the child, as well as the prevention connected with addictions among the teenagers and adults. In the new financial perspective there may be trainings in first aid, trainings concerning the life in the family, the planning of a family, the course of pregnancy, care for a new-born, healthy nutrition and healthy lifestyle, as well as activities aiming at taking care of the families with small children.

Novum in relation to the previous strategies is an obligation of complexity under the actions constructed by the local authorities in partnership with the Roma organisations – the so-called local strategies of situation improvement of the Roma people, containing at least three from four designated domains: education, health, housing, work. Such a solution, being the condition of receiving subsidies, to a greater extent will involve the local government, is significant for improving this situation for long-term activities.

Educational campaigns: "Healthy teeth - healthy start"

The "Healthy teeth healthy start" project is the idea of the only nurse of Roma origin⁴⁴. As part of meetings with children both prophylactic actions were conducted as well as the familiarizing of kids with a dentist and dental treatments were performed. Under the workshops children learnt what bacteria are and what diseases they cause, they learned various techniques of cleaning teeth and what importance for the health has oral cavity hygiene. The workshop participants received brushes, toothpaste and control notebooks to take home, with the order of brushing the teeth 3 times a day – during the next week. Parents were obliged to judge the competition and reward their children. The next stage was a prophylactic visit in the dentist's office. Children got to know the equipment and had an opportunity to talk and ask questions to a doctor. After the conducted diagnostics children with dental problems underwent dental treatments.

Drug trainings under the training for Roma School assistants

The element of training organized for the assistants of the Roma education⁴⁵ were drug workshops. The city guards and police officers, with few years of experience concerning the drug prevention, conducted a practical training concerning the type of intoxicants, the observed effects of usage and the most common methods of hiding by children and teenagers of using and having intoxicants.

Diagnosed barriers:

- lack of Roma health mediators (defined as Roma from the local communities operating in the sphere of health improvement situation);
- a lack of interest in the selection of medical fields of study by the students of Roma origin;
- the occurring inadequate level of knowledge of the Polish language, particularly among elderly people, may be the cause of difficulty in understanding the medical recommendations and proper dosing of drugs;
- detachment, lack of trust to environmental nurses and, on the other hand, cultural restrictions associated with the access to medical professions for their-Romani people;

⁴⁴ Project implemented by the Roma Association *Harangos*.

⁴⁵ The project conducted by the Roma Association of Assistants of the Roma Education in Poland.

- reluctance/shame to disclose serious problems (addictions);
- lack of awareness related to the influence of lifestyle, nutrition on the development of civilization diseases (diabetes, obesity).

Health threats observed in the Roma community:

- addictions (alcoholism, drug addiction);
- relations concluded within the family (as emphasized by the assistants of the Roma education and what is a sign of a slow breaking of some taboo)⁴⁶;
- wrong diet and unhealthy, sitting lifestyle, obesity;
- lack of prevention;
- inability to use the available possibilities of the health care system;
- early age of sexual initiation;
- reluctance to "embarrassing" tests (mammography, cytology, gynaecologic examinations);
- difficult access of people from the outside resulting in the lack of trust to new nurses, which ends in the refusal of cooperation or rejection of the project of introduction of a new nurse.

4.6 “The former Yugoslav Republic of Macedonia”

Roma policy framework

The Preamble of the Constitution explicitly recognizes Roma as an ethnic community. The same applies for the Ohrid Framework Agreement signed in 2001. The National Strategy for Roma Inclusion (NRIS) is a policy document that was first adopted in 2005 and then reviewed in 2014 for a decade. A National Action Plan for Education was developed as part of this strategy.

Representativeness and consultation bodies

Approximately 1,600 Roma are employed in the public and national sectors. Three Roma women are working in high position in ministries.

Roma NGOs are very active and contribute to the implementation and monitoring of numerous projects. Roma, especially women, are also active as Roma school assistants and as Roma school and health mediators.

Health related policy and measures for Roma

With a view to address the problem of lack of ID documents by a number of Roma, a programme was launched in 2008 with the participation of international organisations, non-governmental organisations and the authorities, aimed at identifying cases of *de facto* statelessness, lack of official proof of nationality and lack of documentation within the Roma population, which has already allowed over 2,000 people to obtain the documents they were lacking.⁴⁷

⁴⁶ In Poland the number of Romani people is relatively small as compared to other states of the region (16 732 according to the national common census from 2011). Romani people belong to 5 various groups, reluctantly concluding marriage with each other and doing this at a relatively early age.

⁴⁷ See ECRI Report on “the former Yugoslav Republic of Macedonia (fourth monitoring cycle), published in 2010.

As a collateral effect of the possibility now offered to Roma women without health insurance of giving birth in hospital free of charge, there should be an increase in the number of births registered and this should help to settle at least in part the question of insurance of birth certificates.⁴⁸

Roma health mediators

The authorities have used the Romanian and Bulgarian experience of Roma health mediators (RHM) and now 32 RHM work in “the former Yugoslav Republic of Macedonia”. They are trained according to the Ministry of Health curricula, employed on temporary basis by the Ministry of Health and other health agencies with salary approx. 300 Euros per month (200 netto). Requirements are: minimum secondary education, although some of them has academic grade. Roma health mediators are working in hospitals and have contacts with medical personal and can share with them information and issues. RHM are visible in the Roma community and they are directly working on the field with the Roma population. They are included in the ROMED programme to learn to be good mediators between institutions on local level and local community. In many activities in Strategy for Roma and National Action Plans for Roma they are mentioned like persons who are in charge to help Roma and they are include in many activities.

Roma Information Centres exist in “the former Yugoslav Republic of Macedonia”. Counsellors from these centres and health mediators closely cooperate in helping Roma achieving their rights.

4.7 Turkey

Roma policy framework

A National Strategy Document for Social Inclusion of Roma People 2015-2020 has been prepared by the Ministry of Family and Social Policy in co-operation with other public institutions, such as the Ministry of Labour and Social Security, the Ministry of Education, the Ministry of Interior and the Ministry of Health, as well as with Roma NGOs. The process of drafting this Strategy Document started in 2013. The Strategy Document was finalized and should be soon published.

The Ministry of Family and Social Policy has taken a leading role in ensuring this co-ordination since it has been established in 2011. A number of activities on social inclusion of Roma are also directly carried out by the Social Inclusion Department of the Ministry of Family and Social Policies. The Department is also the national contact point of Turkey on Roma in the context of EU accession negotiations.

Representativeness and consultation bodies

There are approximately 320 registered Roma NGOs in Turkey. However, most of them do not have the capacity to advocate for their rights. Since 2009 and the dialogue with Roma initiated and embraced by the Prime Minister and Secretary of State at the time, the Ministry of Labour and Social Security, the Ministry of National Education, the Ministry of Health have worked in co-operation with Roma NGOs to find permanent solutions for the problems of Roma.

⁴⁸ See ECRI Report on “the former Yugoslav Republic of Macedonia (fourth monitoring cycle), published in 2010, p.31.

Health related policy and measures for Roma

Challenges Roma people face has been recognized by the Government for the first time in 2009, and a dialogue with Roma has been initiated and embraced by the Prime Minister and Secretary of State at the time. Since then, the Ministry of Labour and Social Security, the Ministry of National Education, the Ministry of Health and Roma NGOs have worked in cooperation to find permanent solutions for problems of Roma. Also, the Ministry of Family and Social Policy has taken a leading role since it has been established in 2011.

A “Promoting Social Inclusion in Densely Roma Populated Areas Project”, funded by the IPA Mechanism of the EU, started on 5 November 2015 and will last until 9 November 2017. The Project will address objectives of the National Strategy Document for Social Inclusion of Roma People 2016-2021.

Turkish Government has published the Social Insurance and General Health Law on 1st of January, 2012. According to the Law, individuals with a monthly income lower than one third of the minimum wage can access public healthcare services free of charge. Other Roma people can also benefit from General Health Insurance System. Furthermore, 2015 Turkey Progress Report published by the European Commission noted that Roma people's access to health services is improved. Medical services are largely accessible for Roma families. Besides the Report emphasizes that problem of Roma people are associated with social determinants of health such as accommodation, employment and education rather than health services.

The Action Plan of 64th Government was released on 10th of December, 2015. According to this Action Plan, it is aimed that new practices will be implemented to solve Roma citizens' problems by evaluating previous practices (Act. No: 7). With this Action Plan, the Government highlighted its dedication to solve problems of Roma people by taking measures on education, accommodation and employment.

The National Strategy Document for Social Inclusion of Roma People 2016-2020 has been prepared by the Ministry of Family and Social Policy in cooperation with other public institutions such as the Ministry of Labour and Social Security, the Ministry of Education, the Ministry of Interior and the Ministry of Health, and with Roma NGOs. The Strategy Document preparation process which has started in 2013 will be finalized soon and the Strategy will be published. In addition, “Promoting Social Inclusion in Densely Roma Populated Areas Project” which is funded by the IPA Mechanism of EU has been initiated on 9th of November, 2015. The Project addresses objectives of the National Strategy Document for Social Inclusion of Roma People 2016-2020.

Lastly, a comprehensive Anti-Discrimination and Equality Law has been drafted and submitted to the Prime Ministry. It is expected that this law will be adopted soon and prevent discrimination against Roma in all services.

V.OVERVIEW OF THE JOINT COUNCIL OF EUROPE/EUROPEAN COMMISSION ROMED PROGRAMME

The Joint programme between the Council of Europe and the European Commission was initiated in 2011 based on the following **observations**:

For countries that did not have introduced the system of Roma mediators:

- unequal and unfair distribution of community resources disfavours Roma;
- lack of consultation mechanisms or exclusion of Roma when they do exist;
- paternalistic attitudes, dependency, mutual mistrust and blaming between Roma and public authorities.

For countries, where the system of mediators was in place;

- lack of human rights standards-based approach;
- mediators' lack of independence (either community activists or "Trojan horses" of the authorities);
- lack of networking between mediators.

The ultimate goals of the ROMED programme are therefore to move:

- from a vicious circle of blame and discouragement to a virtuous circle of trust building and cooperation;
- from dependency and paternalism to empowerment, recognition, and community participation, as well as respect for human rights and active citizenship.

The ROMED programme has developed into two programming phases with a different focus, pending the needs:

- ROMED1 (since 2011 and co-funded by DG EAC): focus on the training of Roma mediators;
- ROMED2 (since the end of 2013 and co-funded with DG EMPL): focus on democratic governance and community participation through mediation.

The specific objectives of ROMED1 are the following:

- training mediators as agents of change;
- improving dialogue and building confidence between Roma and public authorities;
- increasing responsibility of public institutions towards Roma;
- advocating for a recognised status of mediators and the improvement of the situation of mediators;
- creating a community of learning practices and changes at the European level;
- working towards the transferability and sustainability of quality mediation.

The specific objectives of ROMED2 are the following:

- improving community participation and access to local governance through mediation;
- activating, engaging and entr Roma capacity at local level.

The ROMED1 programme in figures⁴⁹:

More than 1,400 ROMED mediators trained since 2011; Out of them:

1,227 certified ROMED mediators; 46% are men and 54% are women; 87% are Roma; 13% are non-Roma.

Over 500 municipalities covered in 23 member States of the Council of Europe:

⁴⁹ Based on the figures provided at the 1st evaluation Reference Group meeting held in Brussels on 15-16 March 2016.

- Romania: 332; Bulgaria 151; “the former Yugoslav Republic of Macedonia” 118; Greece 101; France 55; Bosnia and Herzegovina 46; Belgium; 42; United Kingdom 40; Ukraine 34; Italy 32; Albania 30; Portugal 30; Serbia 30; Czech Republic 28; Slovak Republic 28; Hungary 25; Republic of Moldova 21; Switzerland 19; Germany 18; Spain 18; Turkey 12; Russian Federation 9 and Lithuania 8. The ROMED1 programme is under an inception phase in Ireland.

Out of the 1,223 ROMED certified mediators, 533 are school mediators (43%); 17% are health mediators; 7% are employment mediators; 10% are community mediators and 23% are classified under others (the two last categories also perform school mediation duties).

In addition, several hundreds of Roma mediators were trained through partnership programmes with the EEA and Norway Grants.

Results, outcomes and outputs of the ROMED1 programme include:

- a training curriculum for mediation was developed
- The ROMED training curriculum and standards were adopted and use to train mediators outside the ROMED programme in Romania, Bulgaria, Ukraine, Belgium, Sweden, etc.
- Having followed the ROMED training programme is a plus in the recruitment of mediators, like in Greece;
- A European code of ethics for mediators was developed to guide the work of mediators. It includes a set of principles and norms and is regarded as a key tool for protecting mediators against abuse and for enhancing the quality of the services provided;
- The Committee of Ministers of Council of Europe adopted Recommendation CM/Rec(2012)9 on mediation as an effective tool for promoting respect for human rights and social inclusion of Roma;
- Roma mediation was included in most National Roma integration strategies;
- Roma mediation was institutionalised in the Republic of Moldova and in “the former Yugoslav Republic of Macedonia”.

On 12 May 2016, a 127-page ROMED1 Trainers’ Handbook was released⁵⁰. This Handbook is based on five years of implementation of the Council of Europe and European Commission (DG EAC) joint programme “ROMED1 – Intercultural mediation for Roma communities”. It comprises 26 modules and 24 handouts used in two training sessions of 3 to 4 days and a 6 months’ practice period in between the two sessions.

For any additional information about the ROMED programme, in particular ROMED2 and concrete examples of the implementation of ROMED2 in Bulgaria, consult the ROMED PowerPoint in Appendix 4 of this report.

⁵⁰ <http://coe-romed.org/articles/romed1-trainers-handbook-published>.

VI. CONCLUSIONS, LESSONS LEARNED, GOOD PRACTICES IDENTIFIED AND POSSIBLE FOLLOW-UP

6.1 General conclusions and lessons learnt

The Roma population across the Europe is in visibly worse health conditions, compared to other minorities or the majority population. Their life expectancy is 10 to 25 times lower than the rest of the population. Some of the reasons include their poor economic situation, their low level of education, and their exclusion from the labour market thus depriving their economic situation. The results are poor living conditions, bad nutrition habits, worse nutrition, no physical activity, lack of proper health care, etc.

The need for Roma health mediator system varies from country to country but it is considered by the group of experts as a useful tool for improving the health conditions of Roma, especially in countries with a relatively high number of Roma living in poor housing conditions, in isolated areas or in socially deprived communities. A lower life expectancy, a higher child mortality rate and death rate among men, the growing level of addiction to drugs among youngsters, often followed by HIV infection (AIDS and death among Roma progress faster than in non-Roma communities), etc.: all these factors sufficiently justify the introduction, development and financing of Roma health mediators. They are very helpful in the field and the local authorities have started to respect their support.

In recent years, the policy of mediation has become an inherent part of many state policies towards minorities, vulnerable groups or migrants. Roma communities profit from this approach, nonetheless not in the sustainable way. The introduction of mediation has often been in different countries an initiative of Roma NGO rather than a proposal from national or local authorities to meet the needs of Roma communities or to improve the state policy of Roma minority integration. It was the case of Bulgaria where the Roma health mediators were initially an initiative of Roma non-governmental organisations. Similarly, in Poland the introduction of Roma assistants (mediators) in schools was a Roma activists' proposition. In Bosnia and Herzegovina and in "the former Yugoslav Republic of Macedonia" the Roma health mediators were strengthened thanks to the Council of Europe/European Commission joint programme ROMED. Some ROMED training activities were also conducted in Belgium and Turkey. It is worth mentioning that all experts of the thematic group whose country is part of ROMED highlighted their deep appreciation of this programme and underlined that after a while, local authorities have started to respect their work and granted their support.

Grass-roots experiences of Roma health mediators mentioned during the thematic visit were all positive and showed that health mediation brings significant results and outcomes, although the system and its implementation differs from country to country, depending on the country's situation and legislation, as well as the size and the specific needs of the Roma and Traveller communities.

During the discussion, it was also highlighted that the work of Roma health mediators work is especially important in the context of regional (including cross-border) cooperation due to a several factors:

- the appearance of "exotic" diseases (because of war situation);
- the increasing interaction with refugees and migrants from different environments;
- the urgent need for cooperation in case of epidemics (like measles in Bulgaria in 2009 or the 1,500 cases of tuberculosis discovered in Bosnia and Herzegovina thanks to the work of Roma health mediators).

Some of the shared conclusions of the experts of the thematic group are reproduced below:

- a) Roma health mediators (RHM) are a good model of effective cooperation between authorities, vulnerable groups and civil society;
- b) The work of RHM should be used by national and regional and local authorities to promote a change of the common widespread negative stereotypes on Roma;

- c) RHM's activities can and should become one major element for ensuring the transition from an "only demanding community" (passively expecting public funding support) to "equal citizens", in line with the approach used by the Council of Europe and European Commission ROMED2 Joint Programme;
- d) RHM's work is strongly appreciated by the medical personnel;
- e) There is a need for institutionalization of the position of RHM in terms of law and applicative framework, and according to local needs (on governmental or self-governmental level);
- f) There is a need for working out a system of monitoring the quality of the work of RHM;
- g) To ensure sustainability and effectiveness of the work of RHM, their salary must be decent and stable (it can be achieved by their institutionalization); the "project-to-project" situation limited in time should be avoided;
- h) Several serious, culture-rooted obstacles were observed on the side of the Roma community such as:
 - o all the "medical" professions are forbidden as culturally "unclean" (Roma community in Poland);
 - o early marriages and early birth-giving have a consequence for health conditions of Roma women;
 - o lack of health-domestic practices during pre- and postnatal period and lack of pregnancy monitoring practice;
 - o prejudices concerning vaccinations;
 - o mistrust towards health providers.

One of the proposed solutions suggested during the thematic visit to change the above mentioned cultural obstacles was to work with Roma women, especially with mothers-in-law which can be useful in very traditional communities or/and to launch public awareness-raising campaigns. In case of countries with medical profession perceived as "forbidden" by the Roma communities (e.g. Poland), the role of RHM could be played by nurses from the majority society following training to work in a different cultural environment, although the effectiveness of this system might encounter some limitations due to the still general mistrust.

- i) Criteria to become RHM should encompass several from the below mentioned requirements (for objective reasons):
 - o minimum secondary education;
 - o finishing the training course for RHM with certification of any medical institutions;
 - o preferably Roma ethnic origin and Romani language skills;
 - o acceptance by the local Roma community;
 - o computer literacy,
 - o mobility of the person who wants to be RHM (to attend compulsory trainings, ad hoc meetings, etc.);
- j) Close cooperation among all stakeholders and daily basis connections between the national and the local level should be established so as to intensify the results of the actions taken by the authorities towards the Roma and to produce the expected synergy effect of these efforts (for example cooperation among Roma health mediators, Roma school assistants, Roma labour mediators, etc.);
- k) The use of IT technologies is strongly recommended (e-learning, video conferences, on-line communication platform, etc.) in order to improve the professional skills and overall cooperation (see practice in Belgium);
- l) To ensure its efficiency, the support given to Roma should be a reasonable "system" instead of a philosophy; it should list several projects financed by the state and meet at the same time both the needs of Roma and the demand of the state;
- m) Apart from working in Roma settlements, it is equally important that RHM provide assistance in hospitals;

- n) There is a need to promote the RHM system and increase the visibility of RHM within the wider public, especially in countries where several violent attacks for medical personnel was reported;
- o) It is important to develop a sustainable system of recruiting candidates (on reasonable criteria) and developing the professional skills of RHM, especially in medical area;
- p) It would be useful to create or reinforced RHM in countries where the problem of the lack of IDs persists and where the lack of health insurance is present (due to Roma working in the grey economy), which are serious barriers in access to health care;
- q) Special attention should be put on working with Roma women and children, as the most vulnerable groups, in health-related areas.

6.2 Country specific conclusions and lessons learnt

6.2.1 Bulgaria

There is a well-developed system of mediation in the areas of health and labour market but there are no Roma school mediators. The introduction of Roma health mediators came from a proposal from the Roma civil society, namely the foundation “Health Problems of Minorities” in 2001. This proposition met with authorities’ interest and was subsequently developed as a governmental policy. The profession of Roma health mediator has been included in the National Classification of Occupations, introduced in the policy framework and supported financially by the state.

Roma health mediators need to meet several requirements to reach this position, including at minimum completing secondary education and possessing Romani language skills, computer skills and the support from the local Roma community. Thanks to strong cooperation with local communities, their work is built on mutual trust and understanding. There is a system put in place for 200 hours of training necessary to become a Roma health mediator. This training is organised by a medical faculty, and includes topics such as health and social legislation, basic health information, the health care system, patient’s rights etc. In 2015, 170 Roma health mediators were working in 90 municipalities. In 2016 funds have been allocated for a total of 195 Roma health mediators.

6.2.2 Belgium

The concept of “Roma health mediator” does not exist. However, within the context of the “Intercultural Mediation in the Health Care Programme” (run by the Federal Public Services for Health, Safety of the Food Chain and the Environment), over 20 of the 100 mediators employed work with Roma patients coming from Albania, Bulgaria, ex-Yugoslavia (including Kosovo*), Italy, Romania and Turkey. Intercultural mediators are called upon to resolve linguistic and socio-cultural barriers, and are expected to be patient’s advocates when confronted with discrimination or racism.

None of the intercultural mediators involved in the programme is of Roma ethnic origin. This is one of the reasons why, within the context of the ROMED-programme, special training sessions were organised for them. This was done in close collaboration with the Federal Public Service for Social Integration, the Foyer (an integration centre with an intercultural mediation service specifically developed to work with Roma) and the Diversity Department of the city of Diest. Supplementary training sessions will be organised in 2016.

Intercultural mediation in the field of health care started in Belgium in the early 1990s. Intercultural mediators have either completed a 1,200 hour training programme on intercultural mediation or hold a degree in a relevant field (e.g. nursing, social work, psychology) which by law makes them eligible for funding as an intercultural mediator on the hospital budget. All intercultural mediators have also received interpreter training.

In order to address the situation of the Roma present in Brussels-Capital Region, a Roma Intercultural Mediation Service was founded by the NGO “Foyer”. Although these mediators are mainly involved in the sector of education, integration and employment, their importance for the local Roma-community should not be under-estimated. Recently, a group of professional Roma-mediators has been created. They have improved school-attendance of Roma-children and collected and published a wealth of information on the situation of Roma in Belgium.⁵¹

The relationship between the level of education and the health status is well-established through collected information. It is to be expected that this programme will also impact – be it indirectly – the health status of the Roma.

As far as the “Intercultural Mediation in the Health Care Programme” is concerned, intercultural mediators are available on site at over 50 hospitals. In addition, they intervene in 65 hospitals, in 16 primary care centres (in two centres working with undocumented persons and in ten centres working for asylum seekers using video-conference technology). In addition it is possible for the Roma-patients, through collaboration with the Foyer, to call on a Roma-intercultural mediator who is specialized in health issues. Research has made clear that “remote intercultural mediation” (using video-conferencing technology) is a valid alternative to on site interventions although the latter remain the preferred option under most circumstances.

Other relevant practices in this field have been developed by two public health institutions: ONE (French speaking) and Kind & Gezin (Dutch speaking). Nurses provide advices about nutrition, hygiene, breast-feeding and/or vaccination, and raise the awareness of women on birth control methods. On the one hand, these agencies are appreciated for their mobility: they go directly to the homes, which can even be precarious settlements and/or any other accommodation where Roma families live. On the other hand, there are several limitations in the mandate of ONE and Kind & Gezin, mostly related to their preventive and non-curative missions: nurses cannot provide outreach vaccinations - a supervision of a doctor is required, and costs for laboratory and technical examinations (ultrasound, blood testing, etc.) are not covered in general.

6.2.3 Bosnia and Herzegovina

There are 22 mediators engaged and paid by World Vision (9 Roma women; 13 Roma men). Their goal is to include Roma community members into the health care system, to coordinate regular checkouts, etc. Although the RMH met with lack of trust and cooperation at the very beginning of that process, for the last past years good cooperation between RHM and other Roma related social or educational institutions, has been developed. Roma mediators were trained in the framework of the ROMED programme. Their work is now highly appreciated by medical staff.

Thanks to the work of RHM 1,500 cases of tuberculosis were discovered. International organisations, like World Vision or the UNHCR, deliver assistance in the context of post-war refugees, assisting them in gaining ID documents, conducting legal aid centres for health insurances, gaining social rights, etc. They also enabled Roma NGOs to hire 145 Roma health mediators. Mediators in Bosnia and Herzegovina are mainly engaged by international organisations and through some projects implemented by Roma NGOs. Bosnia and Herzegovina is allocating financial means for Roma issues and there are some plans to use a certain amount for ROMED mediators in the future.

6.2.4 Montenegro

Part of the 6,251 persons declared belonging to the Roma community and 2,054 declared belonging to the Egyptian community in Montenegro are refugees from Kosovo*, with all problem typical either for refugees or for indigenous Roma, like housing, lack of documents etc. Anyway they profits from citizens’ law like any other citizens in Montenegro. Similarly like in Bosnia and Herzegovina Montenegro profits from international support, including the system of Roma Health Mediators with cooperation with national stakeholders. Two Roma health mediators work as

⁵¹ See http://www.foyer.be/?page=sommaire&modal=article&id_article=11537&ztr=65&lang=en&nouv.

full employees. Demands for this position are already prescribed by the Ministry of Health, the process of training is going to be continued in order to hire more Roma health mediators paid by the state. Roma women and children are the main target of Roma health mediators.

6.2.5 Poland

There is a well-functioning system of Roma school mediators since 2001, reaching now approximately 100 persons of Roma ethnic origin working at public schools. Unfortunately, although a system of Roma health mediators was initially planned in parallel to school mediators, Roma health mediators did not function at all among the Roma communities, due to the fact that all “medical” activities are perceived - according to cultural patterns - as forbidden for members of the Roma community. So the only solution was to hire health mediators from outside the Roma community. Obviously the level of mutual trust is therefore more restricted; nevertheless health mediators deliver several medical facilities to the community.

6.2.6 “The former Yugoslav Republic of Macedonia”

The authorities have used the Romanian and Bulgarian experience to introduce the system of Roma health mediators. 32 Roma health mediators are currently working. They are trained according to the curricula of the Ministry of Health and are employed on a temporary basis by the Ministry of Health and other health agencies with a salary of approximately 300 Euro per month (200 Euros net salary). Educational requirements to be Roma health mediators are minimum secondary education, although some of them have an academic grade.

Roma health mediators are working in hospitals and have contacts with medical personnel and can share with them information and discuss individual cases. They are visible in the Roma community and they are directly working in the field with the Roma population. They are included in the ROMED programme so as to be trained to be good mediators between local institutions and the local community. Roma health mediators also closely work with Roma Information Centres in helping Roma achieve their rights. Roma mediators are mentioned as persons who are in charge of helping Roma in many activities of National Strategy for Roma and National Action Plans for Roma.

6.2.7 Turkey

Generally-speaking, the problems of Roma are similar to those encountered in other countries: poverty, unemployment, limited access to public services, although research made in Istanbul by the Ministry of Health in 2012 indicated that in the case of Istanbul the situation of Roma is better as regards access to health services. Since the sample was limited to approximately 200 persons, there is a need for conducting a larger survey.

Within the scope of the Rodimata Project, quantitative and qualitative field research studies have been conducted in five provinces. As a result, policy options were offered in the field of health such as increasing health literacy, introducing and deploying Roma health mediators, raising awareness about health-care services and improving social determinants of health.

In 2012-2013 the Public-NGO Dialogue Group Project was set up. It consisted of five NGOs and seven public institutions and served as a platform for exchanging views and sharing experiences. One of its outcomes was the establishment of family mobile health centres and preparations for their work programme. The needed service for nomadic workers in the field of agriculture was prepared, as well as fresh water delivery and field type bath service with the cooperation of district governorships.

Improving the health status of Roma people and increasing their access to health care, including protective and preventive health care in disadvantaged areas, are parts of the health-related goals of the National strategy for Social Inclusion of Roma 2015-2020. Within a new IPA-funded umbrella project (under IPA) developing and delivering training to NGO representatives and opinion leaders to act as facilitators in increasing health literacy is planned.

6.3 Good practices identified

In Bulgaria, all mediators are chosen through a **competitive selection process**, which is announced for 30 days on the website of the municipality, in the local press, and in neighbourhoods where vulnerable representatives of the local Roma community live. Candidates submit a resumé, a cover letter and a certificate of secondary education. The Selection Committee is composed of representatives of the municipality, Roma health mediators, local health professionals, representatives of local social services, representative of vulnerable communities, and representatives of the National Network of Health Mediators.

Access to training is only available for candidates chosen by this regularly held competition. The well-developed and approved procedure for selecting mediators ensures the transparency of the selection process, and a broad consensus on who is the best candidate for the position is discussed between all members, thereby enhancing cooperation of the invested groups.

The selected individuals for the position "health mediator" complete a training programme of 240 academic hours. This programme is approved by the Ministry of Health and implemented in authorized medical colleges. The intensive training programme includes a wide variety of topics for instruction of the health mediators. The main objective of this training programme is to elevate the competences of trainees in matters of health problems, health systems and rights, and health and social legislation. Included in the training programmes are practical examples, role-playing, case studies and several communicative exercises. All trainings are paid by municipal budgets or projects.

One of the main problems initially was that training sessions could only be carried out occasionally for large groups of mediators, meaning it was less frequent. However, from 2012 onwards, training of mediators has been conducted annually. This is required for two reasons: first, due to the annual increase in the numbers of mediators on a delegated budget; and second, because of turnover at the position (some trained mediators are leaving). In 2015, the practical part of the training programme included exchange visits with experienced mediators for the first time, allowing new trainees to work together in the field with established health mediators to carry out meetings with institutions in the settlement, to identify and learn from individual, real-life cases, and to work to improve reporting activities.

The **training curriculum for Roma health mediators** was prepared by the academic medical faculty. Training at medical universities include 240 hours distributed between the following modules:

- health and social legislation;
- system of health services;
- patient's rights;
- health and health problems;
- basic health information;
- health and intercultural differences;
- case work;
- working with at-risk groups;
- communication and advocacy;
- professional role of the health mediator;
- leadership and teamwork;
- project preparation and management.
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The health and labour mediators also participate in the Council of Europe/European Commission ROMED training programmes and receive certificates from doing so. Training passes through a cycle from learning into practice to implement the instruments and approaches learned during the training. Building up on ROMED, the joint Council of Europe/European Commission programme ROMACT strengthens authorities' efforts to address the challenges of the integration of vulnerable groups, including Roma, and helps bringing mediators' skills into their work.

Mediators also have various other opportunities to enhance their skills in the form of training organised in the framework of various projects. In recent years, dozens of mediators went through training in family planning, anti-discrimination, domestic violence, and vaccine prophylactics. They use their training to contribute to assist and facilitate access of all disadvantaged citizens to health and social services; improve the quality of health and social services in Bulgaria; raise the health culture of disadvantaged ethnic minorities; and increase the efficiency of general practitioner doctors and healthcare services on the spot.

Health mediators have an **official job description** adopted by the state. The **main tasks** include:

- to collaborate with General practitioners for obtaining high immunization coverage (search for non-immunized children, inform parents about vaccine-preventable diseases, etc.);
- to search for and identify people with disabilities and chronic illnesses, young mothers with many children, and pregnant women who do not have health insurance;
- to assist illiterate people when submitting documents to health and social institutions;
- to assist in the organisation of prophylactic check-ups with mobile techniques;
- to organise meetings for improving the health culture and increasing awareness within the community, schools and kindergartens (in cooperation with local and regional health specialists and institutions);
- to provide information and assistance to women who are interested in using IUDs (HMs receive IUDs free of charge from the Bulgarian Association for Family Planning);
- to report cases of discrimination.

As regards **requirements**, health mediators:

- must have graduated secondary education or beyond;
- must belong to the local vulnerable community;
- must speak the language of the community (Romani, Turkish, etc.);
- must be communicative and well-accepted by the community;
- must have computer literacy (Internet, Word, etc.);
- must be free to travel for the required 14-day initial training, for annual meetings of health mediators, and be willing to participate in additional training sessions and meetings as needed.

At the end of 2015 work began on creating a unified standard for the work of mediators, including the framing of a common reporting form. This issue is still under discussion.

On April 2007, the **“National Network of Health Mediators”** was established. Founders of the National Network of Health Mediators are health mediators, specialist doctors, general practitioners and nurses that serve disadvantaged groups, experts on integration policies, experts and specialists in the field of public health and others. Over the years, the network has built a good partnership relationship with municipal and regional experts on ethnic and integration issues and local authorities. They are recognized by local health institutions such as: the Regional Health Care Centres (RHC), Regional Inspectorates for Public Health Protection and Control (RIs for PHPC), etc. The National Network of Health Mediators is a member of the National council for integration on ethnic and integration issues.

Continued efforts of the members of the network and the successful work of the mediators on the ground have led to the transformation of the network into the largest NGO in Bulgaria. The National Network of Health Mediators continues to expand every year, and now unites more than 190 members; of which, 170 are mediators trained and certified by the Medical Universities and the Ministry of Health. Each year the network organises a national meeting of all of the involved mediators. Additionally, meetings and training of mediators are performed regularly throughout the year at the local and regional level, mainly through projects. The national meeting of health mediators serves as a platform for mediators and related parties to share experiences, challenges and best practices. Through this discussion, the capabilities and usefulness of health mediators in the communities can be expanded. Simultaneously, meetings of the network create a support network for health mediators to enhance their sense of community and to help them cope with the demands of the Roma health mediation profession.

Experts took note of the *use of IT technologies*, like videoconferences, especially in situations of manpower shortage, **in Belgium** or the establishment of “*the family mobile health centres*” who deliver the health service to people in rural areas, especially to the season’s agriculture workers **in Turkey**. They also found interesting the *Educational campaign for Roma children: “Healthy teeth - healthy start”* implemented **in Poland**. This campaign was conducted as follows:

- as part of meetings with children both prophylactic actions were conducted as well as the familiarizing of kids with a dentist and dental treatments were performed;
- under the workshops children learnt what are bacteria and what diseases they cause, they learned various techniques of cleaning teeth and what importance for the health has oral cavity hygiene;
- the workshop participants received brushes, toothpaste and control notebooks to take home, with the order of brushing the teeth 3 times a day – during the next week;
- parents were obliged to judge the competition and reward their children;
- the next stage was a prophylactic visit in the dentist’s office. Children got to know the equipment and had an opportunity to talk and ask questions to a doctor;
- after the conducted diagnostics children with dental problems underwent dental treatments.

In “**the former Yugoslav Republic of Macedonia**”, some identified good local practices included:

- *Work with patients without ID in Tetovo municipality*, health mediators together with Roma information centres and Roma NGOs work with Roma without identification documents (IDs). In one Roma settlement they find a 15 year boy sick from cancer and without ID. Therefore he could not go to the hospital. Roma health mediators together with Roma NGOs and Roma workers from Roma Information Centres intervened in the Tetovo Hospital and informed the Ministry of Labour and Social Policy which made an intervention in Skopje State Hospital which accepted this patient and treated him two weeks in hospital free of charge.
- *Roma health mediators’ assistance during the hospital intervention*: In Skopje, municipality of Shuto Orizari, Roma health mediators help in many cases with the vaccination of children, gynaecological intervention and other medical interventions in Skopje’s hospitals. They always accompany Roma who need help in hospital.

6.4 Possible follow up

1. Institutionalization

The need for **institutionalization** at the national level was underlined by each country using the system of RHM. This need encompasses:

- the legal framework (RHM position should be a part of the official country jobs’ list with adequate description of the position, rules, criteria, etc.);
- standardization of requirement for RHM: minimum education level, Romani language skills, computer literacy, acceptance by the local Roma community, etc.,
- appropriate salary enabling decent life;
- safety of work contract (the institutionalization should help avoiding the situation of temporary contracts paid from different limited in time projects’ resources) and assure the access to worker’s rights;
- a stable and on-going professional training system with strong medical background, certified with “exams”;
- establish a mechanism of monitoring, supervision and assessment of the work of RHM since there is a threat of burn-out due to hard work conditions (RHM work in constant pressure due to high expectations from the side of the Roma community);
- the establishment of a the platform of cooperation on local level with relevant stakeholders (like local authorities, health centres, schools, Roma school mediators or Roma labour mediators, social offices – all institutions on the local level working for/with Roma community),
- depending on country specificity the responsibility for RHM work should be taken by local authorities or national relevant entities.

Several existing examples, like Roma School Mediator system regulation can be used as an example.

2. Promotion

Promoting the RHM job as a tool of changing the stereotypical image of Roma and raising their position – the prestige of that job outside the community and inside - promote RHM as a role model. The advantages of healthcare and RHM work should be also promoted among the Roma communities. In general, the advantages of RHM should be promoted among all health-care providers.

3. Exchange possibilities

The Council of Europe is proposed to create a kind of on-line exchange platform for RHM for all the countries, taking into account the medical confidentiality. Regardless, any form of exchange of views and experiences and good practices was strongly underlined.

4. Data collection

It was underlined that there is a justified need to build any data collection system in the areas of health mediation, health situation and health care, which can play a key role in preventing the epidemics. It can also serve to working on “Roma health map” - to diagnose the situation in each country, identify the main threats and challenges and prepare the outcome data in order to be able to monitor the progress.

APPENDICES

Appendix 1: Official invitation received from Bulgarian authorities on 5 October 2015



Letter thematic visit
health mediators 2-4

Appendix 2: Agenda of the CAHROM thematic visit to Sofia, Bulgaria, on 2-4 November 2015



FINAL AGENDA OF
THE THEMATIC VISIT

Appendix 3: List of experts participating in the CAHROM thematic group



List of experts of the
CAHROM thematic gr

Appendix 4: Presentations of ROMED1 and ROMED 2 Council of Europe/European Commission joint programmes



THE ROMED
PROGRAMME.pptx