



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

BELGIUM

A multi-stakeholder perspective report on 2005–2014 developments

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ACRONYMS

AMU	Aide médicale urgente
CSO	Civil Society Organization
EC	European Commission
ECRI	European Commission Against Racism and Intolerance
EHIC	European Health Insurance Card
EP	European Parliament
EU	European Union
FPS	Federal Public Service
GP	General Practitioner
HP	Health Professional
INAMI	Institut National d'Assurance Maladie Invalidité
IOM	International Organization for Migration
MdM	Médecins du Monde
NGO	Non-Governmental Organization
NRIS	National Roma Integration Strategy
ONE	Office de la naissance et de l'enfance
OSCE	Organization for Security and Cooperation in Europe
PSWC	Public Social Welfare Centre
WHO	World Health Organization

EXECUTIVE SUMMARY

This research is part of the Equi-Health project: *Fostering health provision for migrants, the Roma, and other vulnerable groups* launched by the International Organization for Migration in February 2013. The project aims to improve the access and quality of health-care services, health promotion, and prevention in order to address health inequities in the EU.

The progress report on the “Implementation of the National Roma Integration Strategy and other national commitments in the field of health in Belgium” is one of the eight country reports assessing relevant developments from 2005 to 2013, drafted in participating European countries, and divided in two groups: EU countries with high percentage of Roma nationals and EU countries with high percentage of Roma migrants. The report goal is to assess the actions taken to date in respect to Roma health, including the implementation of the NRIS, related programmes or similar strategies in Belgium.

Data collection on ethnic minorities’ access to health care

There is no research on Roma health at a national level in Belgium. However, such study is encouraged by the Ministry of Health, following the 2011 report recommendations¹ to better adapt the health-care 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 for a feasibility study on migrants and ethnic minorities’ access to health care is included in the memorandum drafted by the Directorate General for Healthcare for the next federal Government. In addition, a research proposal was submitted in 2014 by the Ministry of Health to the KCE (Knowledge Centre on Health Care).

Findings on Roma health and reported obstacles in access to health care

The only qualitative research on Roma health in Belgium is the study led by Médecins du Monde (MdM) in 2012.² 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 per cent of the respondents experienced barriers in access to health care, while 8 per cent did not try to access health services at all. Financial obstacles appear as the most important and most discouraging barrier; linguistic barriers – specific to Roma migrants are an additional barrier that can be successfully addressed with the help of intercultural mediators. Furthermore, administrative difficulties closely connected to the linguistic barriers aggravate the understanding of the health-care system and related procedures.

Focus on prevention - mother and children health

The MdM study,³ in its part on sexual and reproductive health, reveals that only 49 per cent of the interviewed women had received postnatal consultation after their last birth. Among

¹ Recommendations of ETHEALTH group in favour of reduction of inequalities in health care for migrants and ethnic groups (2011).

² Synthèse de l’enquête sur l’accès aux soins de santé et la couverture vaccinale des populations Roms de Bruxelles (2013).

³ Ibid.

the 48 interviewed women who no longer wished to have children or who wanted to have them at a later stage, only 46 per cent were using birth control method at the time of the survey. Insofar as vaccinations, 27 per cent of mothers did not know where to get their children vaccinated, while 15 per cent of mothers thought that their children were vaccinated at school, whether they were or not. Some of these numbers can be explained by the lack of information about prevention facilities, birth control methods, pre and postnatal care, and vaccination schedule follow up. A significant need for raising awareness on all these topics was further substantiated.

Relevant practices in this field have been developed by two public health institutions: ONE (French-speaking Community) and Kind & Gezin (Dutch-speaking Community). Nurses provide advices about nutrition, hygiene, breast-feeding and/or vaccination, and raise women's birth control awareness. On the one hand, these agencies are appreciated for their mobility: they go directly to the homes of concerned people, which can be precarious settlements and/or any other settings 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 doctor's supervision is required, and the costs of laboratory and technical examinations (ultrasound, blood testing, etc.) are not covered.

Assessment of the NRIS in the field of health

While the existing health-care gap between the Roma and the general population is well acknowledged, there is no detailed evidence on the extent of this disparity, the identification of specific barriers faced by Roma in the field of health, and their respective origins. The focus of the NRIS health section does not seem to set precise, quantifiable objectives in the field of health and does not propose quantifiable objectives to reduce the gap in access to health care. It instead provides a list of existing approaches, including the intercultural mediation programme in hospitals, in the framework of the intercultural mediation programme of the Federal Public Service for Health, Food Chain Safety and Environment. If the programme is of strong relevance and improves access to health care for Roma, additional steps and measures are needed to complete the strategy.

One of the two main initiatives of the NRIS, besides the participation in the ROMED programme, is the implementation of the projects funded by the European Social Fund (ESF) on social and professional activation of Roma. These are one-year, renewable projects, addressed to Public Social Welfare Centre (PSWC) beneficiaries, who must be Roma with legal residence permits. So far, six projects have been implemented in six cities with a total of 178 participants in 2013. One out of the six projects focused on health education. In the first year, a partnership with family-planning organization led to information sessions about birth-control methods. In the second year, health education activities were extended to partnership with ONE in order to raise awareness on maternal and children's health.

Another good practice is the recruitment of “experts by experience in poverty and social inclusion” who work in various departments of the Belgian Federal Administration, including Programming Public Service – Social Inclusion. An expert by experience of Roma origin herself works at the Anti-poverty Policy Unit and links policymaking with realities from the field. Two other experts work in public hospitals and provide support to patients experiencing poverty and exclusion, including Roma.

Access to health care based on residence status

There are no specific legal provisions regarding Roma access to health care. Roma access to health services is closely related to their residence status. In theory, Belgian Roma nationals and Roma with residence permits can benefit from the same provisions as any other Belgian national. As many Belgian Roma nationals are nomadic, their access to health insurance and health facilities is challenged due to administrative reasons and precarious/temporary housing.

Roma EU citizens without residence permit are considered undocumented migrants. However, the procedure remains more complex for EU citizens than for undocumented migrants from third countries and leads to situations of lack of health coverage (See Appendix 19). Contrary to third country nationals with undocumented status, EU citizens are entitled to similar health-care provisions to undocumented migrants only after three months of stay without residence permit. This puts a significant burden either on emergency services in public hospitals or free of charge facilities, such as the Free Clinic or Médecins du Monde consultations. Social workers report incidental free of charge interventions of health professionals willing to overcome this situation. Specific rules for access to health services apply to asylum-seekers, in the case of Roma mainly coming from the Western Balkans. They receive health coverage in respective reception centres, where they live; they can also apply for “payment warrant” at the Mediation Unit of Fedasil, if they have independent accommodation possibilities and do not benefit from the health-care coverage provided in reception centres (“no show” asylum-seekers).

Relevant initiatives at regional and municipal level – support for professionals working with Roma

As a result of the general governmental and administrative decentralisation tendency in Belgium, policy responses are different from one region to another. While in Flanders a specific Action Plan on Eastern and Central European migrants was adopted in 2012, Wallonia opted for an approach aimed at all migrants in general. This affected the initiatives developed at municipal level in the Flanders and Brussels Capital Regions, where more proactive local authorities employ different types of professionals working with the Roma. These municipal employees intervene in various fields, such as education (“bridge figures”) or neighbourhood problems (“neighbourhood stewards”) and may themselves be of Roma origin. However, funding possibilities remain scattered and often project based only. In addition, these workers do not focus specifically on health issues, though health concerns often appear as a necessary part of any general support of Roma families.

Overcoming barriers by intercultural health mediation

The Belgian Federal Public Service – Public Health supports and finances an intercultural mediation programme in hospitals, not specifically designed for Roma patients. Currently, more than 50 public hospitals employ intercultural mediators, covering languages such as

Albanian, Bulgarian, Romanian, and Serbo-Croatian. In addition to intercultural mediation units in public hospitals, there is a unique service at the Foyer Regional Integration Centre (Foyer). Interviewed mediators confirm that the large majority of patients speaking these languages are of Roma origin, mainly coming from former Yugoslavia. Mediators mitigate the adverse implications of language barriers and cultural differences.

1. INTRODUCTION

Background

Roma have been present in Belgium since 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. Therefore, concrete policy developments related to the inclusion of Roma are still relatively new. The National Roma Integration Strategy (NRIS) was adopted in February 2012 and is the only policy commitment at the national level specifically addressing Roma populations. Relevant policy initiatives are also undertaken at the regional and local level, including the Flemish Action plan on Eastern and Central European migrants.

There are no official statistics on the various ethnic groups living on Belgian territory due to strict interpretation in Belgium of the EU Data Protection Directive (exemptions to the principle of prohibition of processing of personal data that contain information on racial and/or ethnic origin). The Council of Europe estimated that as of 2012 around 30,000 Roma live in Belgium. This figure includes both Roma nationals⁴ (persons who self-identify as Roma, Gypsies, Voyageurs, Manouches, Ashkali, Sinti, etc.) and Roma migrants from EU and third-countries. Other estimates reveal that the number of Roma migrants is higher than that of Roma nationals, both categories facing different challenges in access to health-care services, mainly dependent on one's residence status.⁵ The only available research on access to health care for Roma population in Belgium was conducted by the NGO Médecins du Monde. While focusing on Roma women, EU nationals living in Brussels Region, the study shows evidence of strong administrative, financial, and cultural barriers in access to health care for Roma communities.⁶

Methodology

This report aims to assess the implementation of the Belgian NRIS and other national commitments in the field of health care. The report is based on both desk research and fieldwork. The existing policy and legal framework in Belgium is analysed in the desk research section. The analysis further looks at NRIS implementation, as well as at concrete initiatives at regional and local level. It underlines good practices and outcomes which could potentially be further transposed and reproduced at local level. The analysis of recent developments and initiatives is based on interviews with relevant stakeholders from the national (7), regional and local levels (8) including field professionals working with Roma, health-care providers (9), and civil society organizations (7). A crucial input on the coordination of the strategy is provided by the Cabinet of the State Secretary for Social Integration and Combating Poverty, completed by the information from the Technical Secretariat at the Public Programming Service on Social Inclusion. Fundamental information on the implementation of the intercultural mediation programme in hospitals is gained from the Intercultural Mediation and Policy Support Unit, Federal Public Service Health, Food Chain Safety and Environment. Interviews with the municipalities (Ghent, Saint-Josse, Ixelles) and public social welfare centres provide details on implemented projects and policies at local level. Finally, analysis of

⁴ Belgian citizens of Roma origin.

⁵ National Roma Integration Strategy, p. 13.

⁶ Synthèse de l'enquête sur l'accès aux soins de santé et la couverture vaccinale des populations Roms de Bruxelles (2013).

the Roma health situation and related challenges is based on the feedback from civil society organizations and health professionals.

The case study findings identified the intercultural mediation programme in health care, as the most relevant and suitable approach for migrant health, studied in details at the “Citadelle” hospital in Liège and its intercultural mediators, as well as with the health mediation team at the NGO Foyer.

2. BACKGROUND: LIMITED INFORMATION ON THE SITUATION OF ROMA POPULATION IN BELGIUM

2.1. Lack of disaggregated data

There seems to be a consensus among international human rights bodies on the fact that States should collect equality data disaggregated by ethnic origin. In particular, UN Committee on Elimination of Racial Discrimination (CERD),⁷ the Council of Europe's European Commission Against Racism and Intolerance (ECRI), and EU institutions,⁸ have issued general recommendations for States to measure inequalities.

For instance, in its 2014 report on Belgium,⁹ ECRI called on the authorities to “consider collecting data broken down according to categories such as citizenship, ethnic origin, language, and religion, as well as to ensure that this is done in all cases with due respect for the principles of confidentiality, informed consent, and voluntary self-identification of persons as belonging to particular group. Such a system should be drawn up in close co-operation with all concerned, including civil society organizations, and should take into consideration the possible existence of multiple discriminations.”

Likewise, a report by the Organization for Security and Co-operation in Europe (OSCE) also expresses concerns on this issue: “civil society continues to insist on data collection and baseline studies as a key to ensuring effective policy design, evaluation and monitoring, and measurement of progress. As the collection of ethnically disaggregated data runs against general policy in many participating States, the data made available or cited by governments are often fragmentary and difficult to aggregate and compare.”¹⁰

Despite these recommendations, it is not possible to know the number of Roma, either nationals of Belgium, EU citizens, or third-country nationals, currently residing in Belgium. Besides, an unknown number of them does not have residence permits and is thus not included in available administrative data. Due to this lack of data, assessments of enjoyment of fundamental rights, including access to health care are impossible. Thus, the only calculations available are of non-governmental origin and are limited to specific regions and/or categories – i.e. gender or age based (see further Médecins du Monde report).

According to another ECRI report,¹¹ data collection in Belgium differs between the three regions: Brussels – Capital Region, Flanders and Wallonia. While the Flemish part is more eager to collect ethnic data, this is not done in Wallonia because of the “relatively restrictive regulations on the production of ethnic groups in Wallonia, while the Flemish community has a resolute policy on equal opportunity”.

⁷ General Recommendation IV (1973).

⁸ Council recommendation on effective Roma integration measures in the Member States (2013); European Commission, Improving the tools for the social inclusion and non-discrimination of Roma in the EU (2010).

⁹ ECRI report on Belgium, fifth monitoring cycle, adopted on 4 December 2013, recommendation n° 18.

¹⁰ Implementation of the Action Plan on Improving the Situation of Roma and Sinti within the OSCE Area, Status Report 2013.

¹¹ ECRI, “Ethnic” statistics and data protection in the Council of Europe countries, Study Report, Strasbourg 2007, p. 44.

Accordingly, the Flemish Government encouraged Flemish administrations already in its decree of 8 May 2002¹² on proportional participation in the employment market to establish an annual action plan on integration and employment of “under-represented target groups”, including nationals of third countries.

In the framework of these legislative efforts, the Privacy Protection Commission has been asked several times to issue an opinion on legislation encouraging sensitive data collection. For example, a draft decree from the Flemish Government attempted to authorize members of the staff of the Employment Authority in the Ministry of the Flemish Community to process personal data on people from “groups with potential” for the purpose of promoting proportional participation in the employment market. The Privacy Protection Commission declares in its opinion of 15 March 2004¹³ on this decree that the processing and recording of sensitive data for the purpose of awarding a privileged position to members of a given ethnic or cultural minority, and so removing or mitigating actual inequalities was lawful, and also essential to achieve this aim.

These differences in the field of data collection are largely reflected in the policymaking at federal level. The latter appears to prefer inclusive policies and the only specific political commitment as to Roma population is the NRIS. The strategy itself states that “it is currently impossible to determine exactly how many Roma are living in Belgium since the term ‘Roma’ refers not to nationality but to ethnicity. Consequently, Roma do not feature in the population register, the foreigners’ register, or the provisional register of asylum-seekers, as registration is based on country of origin, not ethnic origin. Moreover, Article 6 of the Act of 8 December 1992¹⁴ on privacy rules in processing personal data states that ‘the processing of personal data that contain information on racial or ethnic origin... is forbidden’. Consequently, there are no official federal statistics on the various ethnic groups living on Belgian territory.”¹⁵

This is a particularly narrow interpretation of Directive 95/46/EC of the European Parliament and Council on the protection of individuals with regard to the processing of personal data and on the free movement of such data (EU Data Protection Directive),¹⁶ which actually does provide for exceptions to this principle. The EU Directive states that data revealing racial or ethnic origin are sensitive data, which can be collected only when the data subject gives an explicit written consent, for reasons of substantial public interest, of health treatment, or for the defence of legal claims. Specific safeguards (Data Protection Directive, Art. 34) also foresee the possibility to collect sensitive data when the data are anonymized. The Act of 11 December 1998 (Belgian Official Journal of 3 February 2001), amending the Privacy Act of 8 December 1992, transposed the EU Data Protection Directive into the Belgian Data Protection Act.

In conclusion, if the collection of sensitive data does not contradict national legislation, it is up to national authorities whether they are eager to encourage such focus. In Belgium there

¹² Decree of 8 May 2002 on proportional participation in the employment market in the field of professional orientation and training.

¹³ Privacy Protection Commission, Opinion n° 3/2004 of 15 March 2004.

¹⁴ « Loi relative à la protection de la vie privée à l'égard des traitements de données à caractère personnel », 8 December 1992.

¹⁵ National Roma Integration Strategy, p. 9.

¹⁶ Directive 95/46/EC of the European Parliament and of the Council of 24 October 1995 on the protection of individuals with regard to the processing of personal data and on the free movement of such data.

seems to be a certain degree of incongruity between different ministries, and in any case the position of the Belgian Federal State makes it difficult to collect data on ethnic groups such as the Roma. However, Belgium uses proxies for race and ethnicity such as “migration background” and “origin”.¹⁷ These proxies are not helpful in assessing the situation of groups such as Roma migrants. They also limit the comparison between any kind of treatment, of Roma migrants and non-Roma migrants – therefore making discrimination difficult to pinpoint, especially as it concerns access to health care.

2.2. Available estimates on Roma numbers in Belgium

Available estimates from the Council of Europe suggest there are about 30,000 Roma living in Belgium,¹⁸ which represent 0.29 per cent of the total population.

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

- **Manouches:** the Belgian Sinti (as in France, Switzerland and certain areas of Germany) self-identified as Manouches. 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 Manouches live in caravans and their first language is Sinti Romani; their second language is the language of the area in which they are living. There are around 1,500 Manouches living in Belgium.
- **Roma:** descendants of Roma who arrived in Belgium following the abolition of slavery in Moldavia and Wallachia in 1856. Their first language is Vlax Romani and their second language is French. These 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.
- **“Voyageurs” (Travellers):** 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 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. It is estimated that there are around 7,000 Voyageurs living in Belgium.
- **Roma migrants:** The first Eastern European Roma came to Belgium after World War II (among others, Yugoslavian Roma looking for work). However, the main influx of migrants was triggered by the fall of the Iron Curtain.

The NRIS refers to the estimates of the Council of Europe (“around 30,000 Roma living in Belgium”), but it remains confusing whether this applies to migrant Roma or the whole Roma population in Belgium.¹⁹ According to the glossary of the Council of Europe, the term Roma “covers a wide diversity of the groups concerned,” thus the estimates do not seem to apply exclusively to Roma migrants.

¹⁷ See for instance in the field of employment, socioeconomic report from the Belgian Equality Body: “*Monitoring socio-économique*”, based on the nationality and national origin.

¹⁸ Statistics by the Council of Europe, Roma and Travellers Division, 2010.

¹⁹ Glossary on Roma and Travellers, Council of Europe, 2012.

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.

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, adopted in 2012,²⁰ is the only official Belgian source which offers Roma-specific data. These are the only data included in the NRIS for Belgium. 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, Roma migrants and nationals arriving on Belgian territory in 2010, or to the Roma population as a whole, after the immigration flows. It contains the following estimates of the number of Roma living in various towns/cities in Flanders and Brussels-Capital region:

Table 1: 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 (NRIS)

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

The CAHROM report from 2013 (based on a study visit to Belgium)²¹ provides estimates 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 (7,000 Romanian Roma) in Brussels, Romanians and Kosovars (approximately 5,000 Roma) in Antwerp, thirteen major families of Kosovars in Temse and Saint-Nicolas (about 1,000 people), etc.

²⁰ Vlaams actieplan MOE (Roma) – Migranten (2012).

²¹ CAHROM (2013) 6 Add.2.

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 haven't been issued residency permits.

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.

2.3. Research on Roma health, Belgium

As already pointed out, there has not been any targeted research on Roma health at the national level. Such an inquiry seems to be encouraged by the Ministry of Health, as it would fill data gaps on Roma health and access to health care, including on the topic of discrimination.²²

2.3.1. Report of Ethealth project (2011): recommendations on data collections

The Report of the Ethealth project,²³ commissioned by the Minister of Public Health, Laurette Onkelinx, in 2011, includes a series of recommendations to better adapt the health-care system in Belgium to the specific needs of migrants and ethnic minorities. Experts interviewed for this report pointed out that the lack of data on ethnicity and nationality in health surveys and hospital statistics undermines both the development of efficient programmes addressing inequalities and the monitoring of existing anti-discrimination policies. It seems the Federal Public Service on Public Health has been one of the few entities being in favour of collecting data on ethnicity. The report notes that "Belgium could learn from these practices such as developed in Scotland, Switzerland, or from the experience of the Flemish Community regarding employment data" (see above). In order to improve the minority and ethnic groups related data collection, the Ethealth experts issued the following recommendations:

"Submit to the Commission for Privacy Protection a request for systematic recording of health-related data on persons belonging to ethnic, cultural and/or religious minorities, based on continuous monitoring. This monitoring should also include, if possible, indicators related to social determinants of health."

"Encourage the study of health situation (physical, mental and social) and health care of migrants and ethnic minorities in Belgium."

At this stage, a recommendation to provide a feasibility study on health care for migrants and ethnic minorities is included in the memorandum from the Directorate General Healthcare for the next federal Government.²⁴ In Addition, a research proposal has been submitted in 2014 to the KCE (Knowledge Centre on Healthcare).

²² Recommendations of ETHEALTH group in favour of reduction of inequalities in healthcare for migrants and ethnic groups, 2011.

²³ Ibid.

²⁴ Information from Hans Verept, Head of the Mediation Unit, FPS Public Health, Consultative Committee meeting, 10 July 2014.

2.3.2. Report of Médecins du Monde on Roma health (2012)

2.3.2.1. Access to health care

The only qualitative research on Roma health in Belgium is the research done by Médecins du Monde in 2012.²⁵ However, this survey only covered the Brussels-Capital region and all the Roma respondents were migrant Roma from other EU countries – Slovakia, Bulgaria, and Romania, and only women and children were interviewed (52 women and 120 children). The entire study has not yet been published and the following findings are based on the summary.

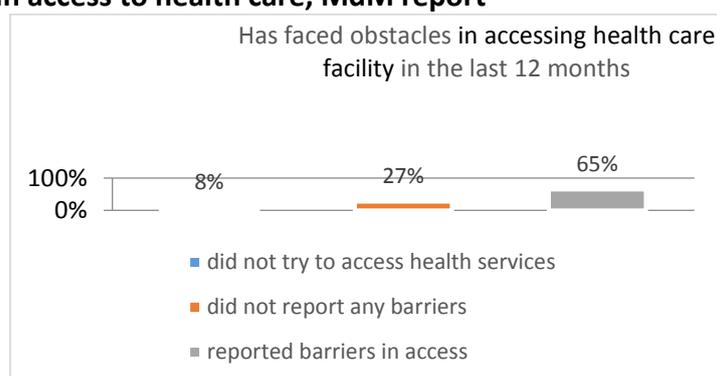
The study aimed at evaluating Roma women and children access to health care, reproductive and sexual health services, vaccination and education for children up to 14 years of age. The choice to focus on women and children's health situation was based on their increased vulnerability and related consequences on Roma communities in general.

In terms of access to health care, the report results are appalling:

Indicated barriers are of various origins as listed below:

- 46 per cent of interviewed Roma women did not have medical coverage for themselves and their children at the time of the survey;
- 65 per cent of women reported having encountered barriers in accessing health care: financial (31%), administrative (26%), linguistic (24%), or bad experience in the health-care system (5%);
- 51 per cent of respondents had given up in trying to get health care for themselves or their family over the past 12 months, due to difficulties in access to health care;
- 26 per cent of women had been refused care by a health services provider in Belgium.

Figure 1: Barriers in access to health care, MdM report



In brief, according to this limited snapshot of the situation, the Belgium health-care system appears complex and difficult to access for vulnerable groups. Financial barriers appear most important and most discouraging. Lack of financial means and precarious living conditions impact negatively on quality of Roma health, who are not aware of the possibility to access available free of charge services. Linguistic barriers faced by Roma migrants can be successfully addressed via intercultural mediators, who support the process of mutual understanding and thus discourage the abandonment of care, often a result of miscommunication and lack of understanding of the gravity of the situation. Administrative

²⁵ Médecins du Monde, "Synthèse de l'enquête sur l'accès aux soins de santé et la couverture vaccinale des populations Roms de Bruxelles" (in French only).

issues further complicate Roma understanding of how the health-care system functions and related procedures. Indeed, all such barriers are interconnected and need to be addressed in a coherent manner in order to ensure Roma access to health-care services.

2.3.2.2. Focus on sexual and reproductive health, school enrolment and vaccinations

Regarding sexual and reproductive health, the survey results are the following:

- All 52 interviewed women, with the exception of one young girl at the age of 15, had already given birth (including one 16 year old and two 17 year old women);
- On average, they have given birth to 3.86 children (min. 1 and max 12 children);
- 92 per cent of the women received prenatal care during their last pregnancy; 31 per cent of them at a late stage (later than 3 months of pregnancy);
- Only 49 per cent of the women had received postnatal consultation after their last birth;
- 3 women were pregnant at the time of the survey and one woman wanted to have children later;
- Among the other 48 interviewed women who no longer wished to have children or who wanted them at a later stage, only 46 per cent were using birth control method at the time of the survey;
- At the time of the research, the male condom (30%) was reported as the most popular method of contraception, followed by IUD (26%), and implants (13%);
- No single woman had taken contraceptive pills during the years preceding the survey, while 26 per cent of interviewees had used a female condom.

According to these numbers, there is an appalling lack of access to birth control methods and proper follow up of pregnancies. This is most probably the result of barriers in access to appropriate health-care services, whether preventive or curative. Sexual and reproductive health is often a taboo subject in Roma communities, which consequently leads to weak health literacy and a lack of knowledge about birth control methods. Besides, these methods often require strict adherence and regularity, which is why Roma women prefer more permanent birth control methods, such as IUD and implants, instead of contraceptive pills. Use of female condoms appears as a responsible choice and avoids possible refusal on the part of their partners to use male condom.

Regarding school enrolment and vaccination coverage, interviewed mothers reported the following about their children:

- Majority (86%) of children between 6 and 11 years of age, and 83 per cent of children between 12 and 14 years were attending school at the time of the survey;
- 32 per cent of children had already had measles;
- 32 per cent of children possessed a vaccination record that investigators could consult on site;
- The majority of vaccinations were provided by ONE (“Office de la naissance et de l’enfance”);
- According to the mothers interviewed, out of the 82 children who did not have vaccination records, 4 per cent had already been vaccinated against all diseases on the immunization schedule;
- Among all the 120 children, only 5.8 per cent were completely up to date in the immunization schedule;

- The vaccination coverage of children in the survey was significantly lower than for the general population in Brussels;
- For children whose vaccination schedule was incomplete or unconfirmed, 98 per cent of mothers expressed their willingness to vaccinate their children, but half of them did not know where to get their children vaccinated.

Lack of vaccination coverage despite the willingness of mothers clearly underlines limited access to prevention health-care facilities and available information about them. These high numbers can be addressed by appropriate responses at policy level targeting reported barriers to vaccination.

Reported barriers to vaccination are of the following origins:

- 27 per cent of mothers do not know where to get their children vaccinated;
- 17 per cent of mothers did not know that the immunization schedule was not up to date during the interview;
- 5 per cent of mothers think that their children are vaccinated at school;
- 7 per cent of mothers think that vaccination is not free of charge/expensive;
- 3 per cent of mothers just arrived to Belgium and 4 per cent did not indicate any reason;
- 23 per cent of mothers indicated other reasons, not specified in the study.

The majority of reported barriers stem from lack of information, either about prevention facilities, schedules or vaccination provided in schools. There is a significant need to better inform Roma on these issues, improve their health literacy and further act on the material barriers such as distance from health service provider (for example, with a campaign by mobile, outreach methods).

Relevant efforts are being made in that direction by two preventive institutions, ONE and Kind & Gezin, as described in box 1.²⁶

²⁶ Information completed by two nurses: Sophie Dierickx, Kind & Gezin Schaerbeek, 28 May 2014 Annelies Deviaene, Kind & Gezin Anderlecht, 26 June 2014.

Box 1: Missions of ONE and Kind & Gezin

Role of ONE (French-speaking) and Kind & Gezin (Dutch-speaking) public institutions working on child and maternal health

It is important to underline the strong involvement in this field of two public, free of charge, health institutions working on child and mother health: ONE (French-speaking) and Kind & Gezin (Dutch-speaking).

ONE is an independent public body under the Minister for Childhood of Wallonia-Brussels Federation (French-speaking part). Its two main missions are :

- To support children's development within their family and social environment; to advise and support pregnant women, parents and families on health and social issues in order to ensure the wellbeing of their children;
- To oversee day care centres for children outside of their home environment. ONE's role is to ensure that these structures operate correctly and provide quality care for children. It mainly operates through access to prenatal care, consultation points for children from 0 to 6 years or day care settings.

The role and mandate of Kind & Gezin is slightly different. It is an agency of the Flemish Government. Its mission is to “actively contribute to the well-being of young children and their families by providing services in the field of preventive family support, child care and adoption”. Its target group are children from their birth to their third anniversary, before they continue with maternity schools, and are followed by health professionals at school. In case of problems with the school attendance, what happens to be often the case of Roma migrant children, Kind & Gezin continue to intervene until the child is six years old.

“Since I have been followed by nurses at Kind & Gezin, my children’s vaccinations are to date and I do not have to worry about their prevention. Their schedule is clearly indicated in the vaccination book and we only have to keep an eye on different appointments. In addition, I have received relevant information about child care, breast feeding and even birth control possibilities.

Unfortunately, we have been evinced from the building that we used to occupy and currently live far away from the Kind & Gezin where we used to go. However, I try to manage to go to the same place, as I really trust the nurse who takes care of us.”

(Roma migrant from Czech Republic, Brussels)

Their nurses are present in hospitals settings right after the child’s birth, they explain their work to interested patients and are available to support mothers with their newly born children, if needed and/or requested. They support with advices about nutrition, hygiene, breast-feeding and/or vaccination, and raise the awareness of women on birth control methods. One of the most appreciated aspects of their work is their mobility. Indeed, they go directly to the homes, which can be even precarious settlements and/or any other accommodation where Roma families live. Nurses admit that sometimes it is the only way to help these families, who do not dare to come directly to the health facilities, do not have enough information about the health care system and/or cannot manage to access them

(transportation problems, distance, etc.). Otherwise, mothers often don't show up to a previously set appointment and irregularity in the medical follow up is a frequent problem.

In case of language and/or cultural barriers, nurses can rely on intercultural mediators, who are often provided from the Foyer NGO team, especially in the Brussels Region.

Nurses note that a lot of information and awareness-raising is still needed amongst Roma women, especially in the field of vaccination and birth-control. Even if a number of illustrated brochures easy to understand are distributed to them, some women tend to change their mind at the very last moment, before a vaccination or an implant insertion procedure.

However, there are three main limitations to the activities of ONE and Kind & Gezin, mostly related to their preventive and non-curative missions:

- Exclusively preventive approach – is the main limitation of their action which can also raise confusions, especially for vulnerable patients;
 - Nurses cannot provide outreach vaccinations – if the outreach approach in health care appears as very relevant especially for precarious populations, medical action of this kind should not be provided without supervision of a doctor. Therefore, these actions and their follow up are rare and complex to organize;
 - Cost for maternity follow up – pre-natal and post-natal care demand important specialized examinations (ultrasound, blood testing, etc.) and these tests require proper coverage of related costs and remain challenging in case of missing medical coverage.
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3. LEGAL REVIEW

3.1. Anti-discrimination legislation

The non-discrimination principle established in Article 11 of the Belgian Constitution reads: “rights and freedoms which are recognized for Belgians shall be secured without discrimination.” Article 23 further reads: “everyone has the right to live in conditions of human dignity. To this end, laws, decrees or any regulation guarantee, by taking into account related obligations, economic, social and cultural rights, and determine the conditions of their exercise.” These rights include among others, “the right to social security, health protection and social, medical, and legal assistance.”²⁷

The Anti-racism Federal Act and the anti-Discrimination Federal Act (10 May 2007) transposed the EU 2000 Equality directives²⁸ into Belgian law. While the former prohibits discrimination on the grounds of race, colour, descent or national or ethnic origin and nationality, the latter prohibits discrimination based on age, sexual orientation, marital status, birth, wealth, religion or belief, political belief, trade union conviction, language, current or future health situation, disability, physical characteristics, genetic and/or social origin. The anti-racism act applies to the field of social protection, including social security and health care. The anti-discrimination act has a rather broad scope that covers all areas of public life, including social security and health care.

The EU equality legislation has therefore been correctly transposed to Belgian law and encouraged development of complaint procedures. A victim of discrimination can fill out an online questionnaire on the website of the Belgian Equality Body (Centre pour l'égalité des chances). According to available sources of the Belgian Equality Body, there are no records on health based complaints lodged by Roma in Belgium to date, but this does not necessarily mean the absence of instances of discrimination. First, a victim of discrimination has to know that it is actually possible to file a complaint, and then to be acquainted with the procedure for doing so. Second, the online complaint system requires that the victim speaks French, Dutch, English, or German in order to understand and accurately complete the complaint document, not to mention the necessary prerequisites of computer literacy and access to the Internet.

Complaints can also be addressed to the Federal Mediator. Ever since the Act of 22 March 1995, there have been two federal mediators, one French- and one Dutch-speaking. However, they intervene only on administrative decisions taken at the federal level and mainly in the field of justice, which does not seem particularly relevant to discrimination in access to health care.

To sum up, even though EU equality legislation has been correctly transposed to Belgian law, available procedures remain complex and difficult to access for vulnerable groups such as Roma populations. Further efforts are needed to streamline these procedures, making them more transparent and operational.

²⁷ Belgian Constitution, coordinated version from 17 February 1994.

²⁸ Directive 2000/78/EC of 27 November 2000, establishing a general framework for equal treatment in employment and occupation; Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin.

3.2. National legislation on access to health care

Belgium has a mandatory national health insurance system managed by six non-profit health insurance funds.²⁹ The funding comes from employee social security contributions, as well as from federal government subsidies. Complementary health insurance, for example for hospitalisation, is also available, but it represents a small portion of the overall health-care system.

There are no specific legal provisions regarding Roma access to health care in Belgium, as it is largely dependent on their residence status. Roma nationals and Roma with a residence permit can benefit from the same provisions as any other Belgian national. Roma EU citizens without residence permit are considered undocumented migrants. Specific rules for access to health services apply for asylum-seekers, mainly coming from Western Balkans after the visa liberalisation travel regime.

The majority of Roma in Belgium are migrants, either EU citizens or third country nationals. Related health provisions are analysed in the following sections.

Table 2: Access to health care according to the residence status

	Residence status	Health coverage
Nationals	Belgian residents	Compulsory health insurance in Belgium; Specific provisions possible for low income patients/social aid beneficiaries
EU citizens – short-term stay – without specific requirement	Authorized to reside for less than 3 months	European health insurance card (EHIC) – if insured in the country of origin OR health insurance possible in Belgium for university students, employees or legal cohabitants of a person insured in Belgium
EU citizens – long-term stay – required to register at the municipality of residence	During the first 3 months after the demand to register – “Appendix 19” status	Same rules as above, besides EHIC (only for short-term stay) “Urgent Medical Care” (Aide Médicale Urgente - AMU) is not possible
	After the first 3 months, if the residence authorised – “Appendix 8 or “Appendix 8bis” case (residence permit)	Compulsory health insurance in Belgium; Specific provisions possible for low income patients/social aid beneficiaries
	After the first 3 months, if the residence permit refused =>	AMU, if all conditions completed, including absence of insurance in the country of origin

²⁹ Loi relative à l'assurance obligatoire soins de santé et indemnités coordonnée le 14 juillet 1994 (Act on compulsory health insurance, 14 July 1994).

	undocumented migrant	
Third country nationals	Authorised residents	Compulsory health insurance in Belgium; Specific provisions possible for low income patients/social aid beneficiaries
	Undocumented migrants	AMU, if all conditions completed (unauthorised stay, medical need, financial hardship, address in Belgium)
	Asylum-seekers	Health coverage in the reception centre if “no show”(not residing in reception centre), a “payment warrantee” can be examined on demand and delivered by the Medical Unit of Fedasil

3.2.1. Access to health care for nationals and migrants with residence permit

Nationals and “authorized” residents in Belgium must register with a health insurance fund of their choice. This means that they are insured on the basis of their present or past professional activity, status as a student and/or as a dependent beneficiary. The insured person must pay contributions to this health insurance fund, as well as fixed fees established by law for the cost of the health services (so-called “*ticket modérateur*,” which is the patient’s contribution, proportional to the patient’s income). The health insurance pays and/or reimburses the rest of the health-care costs. Patients are free to choose their medical practitioner and hospital.³⁰

Several mechanisms have been established to help people in precarious economic situations. According to a list of criteria set by Institut National d’Assurance Maladie Invalidité (INAMI),³¹ some categories of patients are entitled to a preferential rate of health-care reimbursements (Preferential Reimbursement Rate Beneficiaries or BIM (FR)/RVV (NL) status). This entitlement is extended to include the spouse, legal cohabitating partner, or life partner, and dependents. Some categories of people who do not fall into these criteria but have low income are also entitled to an increased insurance allowance (OMNIO status).³² However, this system includes only Belgian residents and social allowance beneficiaries.

People facing extreme financial hardship can also request additional health-care assistance from the PSWC. In fact, according to the Organic Law on Public Social Welfare Centres of 8 July 1976, their mission is to offer “each and every person the possibility of leading a dignified human existence.” As described further in this paper however, any demand of social assistance might have negative impact on the migrant’s residence status.

3.2.2. Access to health care for Roma nationals

According to the NRIS, Roma nationals are divided into three groups: Manouches, Travellers, and Roma. In theory, they benefit from the same entitlements to health care as any other

³⁰ Access to healthcare - Update on legislation in 10 EU countries, Médecins du Monde, April 2013.

³¹ Social assistance beneficiaries, people with handicap, etc. listed on the INAMI Website: www.inami.fgov.be

³² Access to healthcare - Update on legislation in 10 EU countries, Médecins du Monde, April 2013.

Belgian national, while their access to health insurance and health facilities is challenged, mainly by their nomadic living conditions. Specific provisions to adapt access to health care to Roma nationals are clearly needed, such as simplification of the procedures and development of outreach services. Access to health care for Roma nationals is further reported in the RIPEX (Roma Integration Policy Index)³³ questionnaire hereafter.³⁴

Table 3: RIPEX questionnaire

ITEMS FOR A “RIPEX” HEALTH STRAND Target group: members of resident Roma communities (nationals)	
A) ENTITLEMENT TO HEALTH SERVICES	
1a	<p>Entitlement to services: Do Roma enjoy the same entitlement?</p> <p>In Belgium, a majority of services and allowances depends on the residence certificate (family allowances, social aid, health insurance, etc.). In addition, the address defines which service is responsible (usually it is the service situated in the municipality of stay).</p> <p>Access to health-care services is hindered in case of Roma nationals, mainly nomadic, in two ways:</p> <ul style="list-style-type: none"> - Administrative difficulties, in terms of contact address and residence permit which is obtained: <p>Either by a proof of residence for more than six months on the same site OR by identification of an “address of reference” (may be also an NGO)</p> <ul style="list-style-type: none"> - Geographic isolation and/or temporary presence on the same site <p>They usually do not have a permanent family doctor. Distance lead to similar behaviours as migrant Roma – seeking for health facilities in case of emergency.</p>
4	<p>Special entitlements for vulnerable groups. Do these exist for:</p> <ul style="list-style-type: none"> a. Pregnant women (ante-natal care) Yes, ONE and Kind & Gezin. b. Mothers and babies (childbirth and post-natal care) ONE and Kind & Gezin – only for post-natal care. c. Children ONE and Kind & Gezin (from 0 to 6 years). d. People at increased risk of exposure to, or suffering from, infectious diseases None. e. Victims of violence or psychological trauma. None. f. Victims of human trafficking. None. g. Others (please specify)
5	<p>Difficult requirements for obtaining entitlement note: <i>Refer to the paper on insurance, item on discrimination?</i></p> <p>Requirements for obtaining entitlement to health services which may be especially problematic for Roma, for example:</p> <ul style="list-style-type: none"> a. Documentation of citizenship Preferable but nobody should be refused emergency care, regardless citizenship or health insurance. b. Declaration of legal address required Yes, needed to get health insurance, may be difficult for nomadic Roma. c. Entitlement dependent on having an employer who will pay premiums Not necessary. d. Complicated procedures demanding high levels of language proficiency and know-how Yes, nomadic population has to go through to more complicated procedures (see above). e. Obstruction due to individual discrimination. f. Others (please specify)

³³ Adapted version of the MIPEX – Migrant Integration Policy Index, specifically targeting Roma.

³⁴ Completed with the comments from Annelies Deviaene, Kind & Gezin nurse, 26 June 2014 And Gabi Bala, intercultural mediator from the Foyer, 22 May 2014.

6a	<p>Prevalence of out-of-pocket payments: formal payments (for all users, whether Roma or non-Roma). Yes, the whole amount has to be paid and is reimbursed only once the documents (proofs of payments, etc.) are sent to the insurance company. In public hospitals, patients receive an invoice and out of pocket payments are not required in general. Each health insurance company decide whether the costs are reimbursed once the invoice is paid by the patient, or whether they intervene directly to cover the invoice.</p>
6b	<p>Exemptions from out-of-pocket: formal payments (for all users, Roma or non-Roma):</p> <p>a. Complete or partial exemption (please specify) for low-income or unemployed patients Several mechanisms exist for low income patients and/or long term unemployed– they allow lower payments (or higher reimbursements), under several conditions (low income, social aid beneficiary, handicap, etc.). They are so called OMNIO status, “tiers social payant”, “intervention majorée”.</p> <p>b. Exemptions for people with illnesses that generate high out-of-pocket payments A “Maximum to pay” mechanism for people with chronic diseases and high/frequent payments.</p>
6c	<p>Prevalence of out-of-pocket payments: informal payments Include “informal payments” where these are a normal practice in the health-care system. Does not seem of relevance. <i>Note: Is this a barrier or not (chocolate or money)</i></p>
6d	<p>How equitable is the national system of health care coverage? Significant efforts are made towards a universal access to health care, including vulnerable groups, such as low income patients and undocumented migrants. Points of improvement reside mostly in the administrative complexity, lack of harmonisation of procedures and intercultural approach.</p>
B) POLICIES TO FACILITATE ACCESS	
7a	<p>Targeted information for Roma concerning entitlements and use of health services In order to reach and influence Roma effectively, three aspects need to be adapted: method of dissemination, content and (where necessary) language. Which aspects are commonly adapted? Method of dissemination – frequent isolation or distance of Roma from traditional health facilities require outreach approach. There is not specific information sessions organized directly on the sites or they are not systematic and/or depend on individual possibilities of HPs. Content – Roma nationals speak either French or Dutch, but they encounter literacy problems. There is any specific information addressed to Roma and particular situation they live in (i.e. temporary settlements or precarious accommodation). ONE and Kind & Gezin provides publications on sexual and maternal health (prevention) which are clearly illustrated, and adapted to literacy challenges.</p>
7b	<p>Groups covered by the above targeted information Women and mothers, but the dissemination method seems limited to already sensitized patients and/or distributed on place.</p>
8	<p>Information for service providers about entitlements Are service providers (individuals and the organizations they work in) explicitly trained or informed about entitlements? Few universities provide adapted trainings.</p>
9a	<p>Targeting of health education and health promotion for Roma (other than the issues covered in question 7) Examples: campaigns to reduce health risks (smoking, unhealthy eating, substance abuse, etc.) and assistance in managing health problems. None.</p>
9b	<p>Methods used in activities mentioned in 9a</p> <p>a. Printed materials (e.g. patient folders, brochures, handbooks) Very general.</p> <p>b. Materials on websites Broad information, further advice possible (Foyer, Mediation Centre in Wallonia).</p> <p>c. Courses or meetings for target group Initiated and organized by civil society organizations, but target most often Roma migrants.</p> <p>d. Community-based interventions (e.g. hotlines, mobile vans or units, media campaigns, use of social media) Rare and not systematic.</p> <p>e. Other (please specify)</p>

9c	<p>Language of targeted measures referred to in questions 9a and 9b. In how many and which languages is information commonly available? National languages – French and Dutch.</p>
10a	<p>Measures to reduce practical obstacles to access No, Roma nationals do not benefit from specific measures or adaptations.</p>
	<p>a. Roma do not have to go through additional procedures to receive care (e.g. bring residence permit to consultations) b. Geographical location of services is convenient for Roma (or mobile services are available) c. Opening hours take needs of Roma into account d. Cost of transportation e. Other measures</p>
11	<p>Provision of “cultural mediators” or “patient navigators” to facilitate access <i>Are there policies? To what extent are they implemented? – only intercultural mediators for migrants</i></p>
	<p>C) RESPONSIVE HEALTH SERVICES</p>
13a	<p>Requirement to provide qualified interpreters for patients with inadequate proficiency in the official language(s) Not relevant</p>
14	<p>Requirement for “culturally competent” or “diversity-sensitive” services Standards or guidelines require that health services take account of individual and family characteristics, experiences and situation, respect for different beliefs, religion, culture, competence in intercultural communication. <i>Recommendations of the Ehealth Project (2011), commanded by the Ministry of Health, require further adaptation of health-care services to ethnic minorities.</i></p> <p>a. Standards or guidelines exist on "culturally competent" or “diversity-sensitive” services b. Compliance with these standards or guidelines is monitored by a relevant authority</p>
15	<p>Training and education of health service staff Policies exist to support training of staff in providing services responsive to the needs of Roma. <i>Not systematic. Some trainings were organized by the Mediation Unit at FPS Public health in cooperation with the Foyer, targeting Roma migrants.</i></p> <p>a. Training is an obligatory part of basic professional education b. Training is an obligatory part of in-service professional development c. Training is provided not only for carers but also for staff in other functions</p>
16	<p>Involvement of Roma in information provision, service design and delivery</p> <p>a. Roma are involved in service delivery (e.g. through the employment of “cultural mediators”) – <i>the only two Roma health mediators work for the Foyer, but are (and work with) Roma migrants. Mediators working in public hospitals are not Roma.</i> b. Roma are involved in the development and dissemination of information <i>None.</i> c. Roma are involved in research (not only as respondents) <i>None.</i> d. Roma patients or ex-patients are involved in the evaluation, planning and running of services <i>None.</i> e. Roma in the community are involved in the design of services <i>None.</i> <i>Mention only forms of Roma involvement that are explicitly encouraged by policy measures (at any level)</i></p>
17	<p>Encouraging diversity in the health service workforce Recruitment measures (e.g. campaigns, incentives, support) to encourage participation of people with a Roma background in the health service workforce:</p>
	<p>a. Aimed at diversifying entry to professional training b. Aimed at diversifying the workforce of individual service providers</p> <p><i>None (Diversity is encouraged in general but no specific target on Roma).</i></p>
18a	<p>Development of capacity and methods Diagnostic procedures and treatment methods are adapted to take more account of variations in the sociocultural background of patients <i>None.</i></p>

18b	<p>Specific forms of the above</p> <p>None.</p> <p>Policies exist to encourage:</p> <ol style="list-style-type: none"> Development of treatments for health problems specific to certain Roma communities Adaptation of standard treatments for routine health problems in order to better serve Roma communities Use of complementary and alternative “non-Western” treatments for physical and mental health problems
	<p>D) MEASURES TO ACHIEVE CHANGE</p>
19	<p>Collection of data on Roma health</p> <p>Data on Roma status, medical records containing information on health and utilisation of health services. Alternatively, it must be possible to link databases containing information on health with databases containing the above personal information.</p> <p>None.</p>
20	<p>Support for research on Roma health</p> <p>Funding bodies have in the past five years supported a significant amount of research. Please list the topics covered:</p> <p>None.</p> <ol style="list-style-type: none"> occurrence of health problems among Roma social determinants of Roma health issues concerning service provision for Roma evaluation of methods for reducing inequalities in health or health care affecting Roma
21	<p>"Health in all policies" approach</p> <p>Attention to the health impact of all policies</p> <p>To what extent is attention paid to the impact on Roma of policies in other sectors than health? Is such attention structural or incidental?</p> <p>No specific policies on Roma nationals.</p>
22	<p>Whole organization approach</p> <p>Roma or ethnic minority health is a priority throughout service provider organizations and health agencies ("integrated" versus "categorical" approach).</p> <p>None.</p> <p><i>This does not exclude a certain amount of specialisation.</i></p>
23	<p>Leadership by government</p> <p>Note: in countries where a large amount of responsibility for health services is devolved to regional or local government, the term "government" may refer to these levels.</p>
24a	<p>Roma contribution to health policymaking at national level</p> <p>How do Roma stakeholders (e.g. NGO's and CSO's) participate in national policymaking affecting health? NGO's and CSO's have been invited to contribute to the NRIS drafting and some of the meetings of the Working Group.</p> <p><i>NB: participation at service provider level is covered by q. 16)</i></p>
24b	<p>Creation of synergies between stakeholders</p> <p>Stakeholders may include: international, national, regional and local administrations and health authorities; service providers; health insurers; Roma organizations; professional bodies; universities; accreditation agencies; NGO's; and commercial organizations.</p> <p>To what extent is the creation of such synergies anchored in policy?</p> <p>None. Synergies are mostly focussed on Roma migrants.</p>

3.2.3. Access to health care for EU citizens

In Belgium, access to health care for EU citizens (including Roma) depends on two main criteria: their length of stay and their residence status.

3.2.3.1. Short-term stay: European Health Insurance Card – EHIC

For temporary stays shorter than 3 months, the recommended option for those who have health insurance in their country of origin is the EHIC. For insured persons, the card is issued on demand for free and gives access to medically necessary, State-provided health care. This means that the EHIC does not cover planned care; it applies only to unforeseen/emergency cases. These medical cards are issued by relevant national health insurance providers, before the travel to another country in the EU.³⁵

It is important to emphasize that the EHIC card does not guarantee free services. The health care is provided under the same conditions and at the same cost as for insured people in the country of stay.³⁶ Expenses are also reimbursed according to the rules and rates in the country where the care is given. In Belgium, patients should first provide an out of pocket payment to a GP and/or specialised doctor and the reimbursement is provided in the country of origin. However, the full cost is not refunded and the patient has to provide a co-payment. For instance in 2013 a consultation with a GP cost 20.63 euro, including a co-payment of 4 euro by the patient.³⁷

In public hospitals, including emergency services, out of pocket payments are not required in general and patients receive an invoice. Afterwards, the patient has to manage to cover the invoice according to the rules of her/his insurance company in the country of origin: either paying the bill and then getting reimbursed, or forwarding the invoice directly to the insurance company for payment.

If a patient does not have an EHIC or cannot prove any other health coverage, which is often the case with Roma migrants, there is nothing in the Belgian legislation addressing this particular situation (within a three months stay).

3.2.3.2. Long-term stay

Beyond three months (the foreseen period without obligation to fulfil specific requirements according to the EU free movement principle), it is required for any person to respect the residency rules in Belgium. This means that EU citizens need to apply for residence permit in the municipality where they live.³⁸ The requirements to be met for the EU residence permit are extremely difficult to fulfil, particularly for most disadvantaged families. Access to health care is closely related to the different stages of this procedure.

³⁵ Webpage DG Employment, Social Affairs and Inclusion, section on the European Health Insurance Card.

³⁶ Guidelines by INAMI to health professionals. See at: www.riziv.fgov.be/care/fr/infos/europeancard

³⁷ Rates specified on the INAMI Website. See at: www.inami.be/care/fr/doctors

³⁸ Article 40–47 of the Act of 15 December 1980; Articles 43–57 of the Royal Decree of 8 October 1981; Article 69bis of the Royal Decree of 8 October 1981.

3.2.3.2.1. EU citizens who apply for residence permit

Right after the request, the applicant receives a document called “Appendix 19”, which is an attestation that the demand is registered and informs the list of requested documents and/or proofs, that the applicant must present for the next stages of the procedure, mainly related to the proof of “sufficient financial resources” (work contract, work applications, independent-worker proofs, etc.). Until January 2014, labour market access and respective work opportunities for Romanian and Bulgarian citizens had been limited³⁹ (work permit required), and made the acquisition of Appendix 19 very difficult. Currently, Bulgarian and Romanian Roma benefit from the same regulation as the other new EU MS citizens i.e. Slovak and/or Hungarian citizens.

This situation (people without access to urgent medical care while awaiting their residence permit) occurs quite often in Belgium and raises a number of problems, despite the existing recommendations for change.

“My children have always suffered from more or less severe health problems, mostly due to our precarious living conditions, nutrition difficulties and lack of access to prevention services. They need proper and frequent follow up of their health situation. Two of them also need significant surgeries, for their eyes and some physical malformations.

Thanks to the precious help of different volunteers, my children have received necessary health checks, examinations and have been prepared for recommended operations. As we are not registered at the municipality, we have received medical coverage thanks to the AMU, which benefit to people without residence certificate in Belgium. We couldn't register at the municipality because we did not have all the necessary documents, every document has to be certified by the authorities in the country of origin and translated by a lawyer-linguist.

Once we have got all the required documents, we registered at the municipality and received an “Appendix 19”. From that moment on, we have lost our health-care coverage... and I would even say, our courage. Not only your situation does not change by registering at the municipality, but also you lose your health coverage. We were so close to improving my children's health situation, I find these rules absurd and difficult to overcome.

Finally, we did not receive a residence permit because we could not prove sufficient financial resources. However, we could ask again for the “urgent medical care” again and restart the whole procedure. Hopefully, this time my children will receive the entire necessary treatment, their health is the most important value for me. Despite these difficulties I am convinced that once our health expenses can be covered, my children will receive a high quality health care.”

(Roma migrant from Slovakia, Brussels)

A specific body working in the field of migrant health in Ghent, *SOGA – Stedelijk Overleg Gezondheid Asielzoekers* (Community consultation group on health of asylum-seekers), decided to also focus on other migrants and ethnic groups, and in particular EU migrants (with the idea of targeting the Roma community), because of the specific barriers they are often

³⁹ End of transitory measures (restrictions to access the labour market) applied by some EU Member States including Belgium.

faced with in accessing health services. The group – composed of public institutions, health professionals, and NGOs – issued in June 2013 a political statement on the specific situation of families and children without access to health services, during the period of time covered by Appendix 19 (request of residence permit, conditioned by the proof of work contract or sufficient financial means for three months). The group members drafted the political note because of the high number of Roma families with Appendix 19, and without any health coverage. The note is focused on the **“Right to health care for minor migrants – health coverage based on school attendance.”**

According to the statement, the inability to pay for health care presents a serious problem for a number of families, with a number of negative repercussions observed in schools: children were frequently absent due to illnesses but without a doctor’s note. The situation is even worse than that of asylum-seekers and their children; asylum-seekers can apply for medical help from their reception centres, and non – accompanied minors (or their tutors) can apply for urgent medical care at PSWC of their “residence”. However, children of EU migrants with a precarious residence status cannot benefit from any of this, as migrant minors with European citizenship are not included in the category of non-accompanied minors, even if they are separate from their parents.⁴⁰ In fact, this barrier leads not only to problems with school attendance but also to higher outstanding health-care invoices for health professionals, who are willing to treat uninsured children. This also implies additional costs for medicines and/or further consultations, resulting in an expensive and inefficient situation by creating repeated expenditures without reimbursement or by providing treatment which goes unreimbursed. Further, this kind of approach does not bring a comprehensive answer to the problem and complicates it even further. Only a systematic response in access to health-care facilities can improve their cost-effectiveness and have positive impact on the health situation of patients.

Since 2008, there is a possibility for non-accompanied minors to get free health coverage after at least three consecutive months of school attendance, or if they consult ONE or Kind & Gezin. Both conditions are accepted and applied regardless of the minor’s residence status. The mutual dependency between school attendance and health care has been interlinked to encourage school attendance.

On the basis of these provisions for non-accompanied minors, the SOGA group calls for an “extension” of this rule to all migrant minors, in the way that their right to health would not be determined by the residence situation of their parents, but would depend on actual school attendance. This approach will resolve the situation of number of Roma families with Appendix 19 status, but also cover all migrant minors in need of health care. These proposals are based on respect for fundamental children’s rights, including their right to health care, and are supported by a number of health professionals and organizations besides the City of Ghent.⁴¹

⁴⁰ Programme Act from 24 December 2002 on tutorship of non-accompanied minors does apply only to EEE nationals.

⁴¹ “Oriëntatiepunt Gezondheidszorg Oost-Vlaanderen”, “Ondersteuningspunt Medische Zorg Antwerpen”, “Kruispunt Migratie-Integratie” and Medimmigrant; Livre vert sur l’accès aux soins en Belgique, 2014 (Green book on access to healthcare in Belgium, 2014).

There have been several relevant court decisions which attempted to find a solution to the health-care coverage dilemma during the Appendix 19 period. Eventual application of these decisions has been claimed at federal level in order to respect these decisions, but regrettably has not been accepted by the Secretary of State in charge of social integration and fight against poverty.

In addition, according to a 28 March 2012 circular titled “on the right of residence and social assistance for EU citizens and their family members,” which came into force on 27 February 2012 (Organic Law from 19 January 2012), the conditions of entitlement to social assistance have changed. **Any titular of Appendix 19 cannot receive social assistance during the first three months of residence in Belgium.**⁴² This period starts from the date of issue of Appendix 19 and can be extended to four months by Appendix 20. In theory, EU citizens are eligible for social assistance only after the expiry of the three months period and only if they get their residence permits. In practice, delivery of the residence permit is almost impossible for Roma who are EU citizens, if they are without work or else sufficient financial resources. In most cases, they are not entitled to social assistance even after the three months period.

It is also important to mention some recent rules which have made the availability of social assistance even more restricted. If a European citizen authorized to reside in Belgium faces financial hardship and applies to the PSWC for social assistance, he/she would risk losing his/her residence permit. This is a consequence of the recent programme-law of 28 June 2013, accompanied by a Circular from Public Programming Service on Social Integration,⁴³ which has had an important impact on the migration and social inclusion policies in Belgium, officially due to budgetary restrictions. In this matter, the circular refers to data-sharing between PPS-SI and the Immigration Office. The Immigration Office is supposed to investigate if a person “satisfies the residence rules and if he/she did not become a burden to the social assistance system.” In addition, a person whose residency has been regularized by work contract and who happens to seek social assistance (due to less than full time employment, loss of employment, etc.) is at risk of losing their residence status. Indeed, these provisions might have a disproportionate effect on Roma population.

EU citizens who register as job seekers are excluded from the right to social assistance during the entire period of unemployment and/or job search, which puts them in a vulnerable situation without any resources. This applies to significant number of Roma who do not work. Without the possibility of proving sufficient financial resources from lawful employment, they usually get “a refusal of residence permit” from the Immigration Office.

3.2.3.2.2. EU citizens who are refused residence permit

Appendix 19 is considered a temporary residence permit with limited validity of three months, which can be extended for one additional month – via “Appendix 20”, which is in fact a refusal of residence permit, if the requested documents are not provided in due time (within a month).

⁴² A Ministerial Circular from May 2014 and a Constitutional Court decision from July 2014 should correct this situation and be applied by relevant services in future. (This research is only on the 2005–2013 period).

⁴³ Service public de programmation – Intégration sociale; a service of the federal government, crucial in social field and fight against poverty.

The refusal of residence permit in fact classes EU citizens as undocumented migrants and thus makes applicable to them the same provisions in access to health care. However, their obligations and specific procedures to obtain health coverage (AMU) appear more complicated than those for undocumented migrants – third country nationals, as explained hereafter.

During this period, the applicant is not entitled to AMU, which is specific medical assistance put in place for undocumented migrants in Belgium.

A patient without health insurance can apply for AMU only once the Appendix 19 is expired – after three months – and if the residence permit is refused. Thus, from that moment on, such people fall under the category of undocumented migrants.

European citizens residing in Belgium without financial resources and without health coverage will be entitled to AMU only if they do not have medical insurance in the country of origin anymore, which implies a very complex and long procedure of tracking and transnational cooperation. In the Information document on supporting medical documentation within the framework of the law of 02/04/1965 and the Modified Decree of 30/01/1995 of October 2012, the PPS-SI stipulates: “In very exceptional cases, EU citizens in need retain entitlement to reimbursement of medical costs:

- In the case of proven residence of over three months by an EU citizen with Appendix 19 who does not have job seeker status. Before they are entitled to reimbursement of medical expenses, their membership in health insurance fund in their country of origin and in Belgium must be checked (via CAAMI).”
- In the case of proof of uninterrupted presence during a period of over three months in Belgian territory of an EU citizen without a residence permit. This means that PSWC file must contain evidence of this. There can be no discontinuity that could raise a doubt concerning actual presence on Belgian territory. Possible evidence: lease, proof of schooling of children, documents from official authorities, invoices in the applicant’s name, travel tickets, etc. It goes without saying that more evidence there is, the more solid the case.

This implies:

- Either the relevant PSWC or the hospital contacts CAAMI to verify the non-existence of health insurance in the country of origin, through the national contact offices. This can take several months, depending on the country. At the moment, there is a contact office in every EU Member State, which was not the case back in 2010, when Bulgaria and Romania were not yet included on the list.
- Or, the patient provides the proof by his/her own means – by contacting the former health insurance company and asking for a declaration.

If the applicant is registered with a health insurance fund in the country of origin, the PSWC can refuse any assistance for a period of one year and will advise the patient to exercise the rights in the country of origin. This means that recently arrived Roma migrants have to go through a complicated procedure to prove the inexistent health insurance in their country of origin.

After one year period of uninterrupted unauthorized stay, the patient is considered as no longer insured in the country of origin – a written proof is no longer necessary. However, it

still remains rather challenging to prove the uninterrupted stay, especially for migrants in precarious situation (proof or bills implies stable accommodation and financial resources). This one-year rule is not based on any legislation, but is set in several working documents, such as the Information document of the PPS-SI. However, PSWC has to refer to concrete records, such as contracts, school attending, medical consultations, etc.

3.2.3.2.3. EU citizens authorized to register with a health insurance fund

If a migrant does not have any health insurance in his/her country of origin and stays in Belgium for a longer period, it is possible in some cases to register with a Belgian health insurance fund. These cases apply to the following:⁴⁴

- professionally active persons (employee, independent worker, etc.);
- dependents of another person;
- trustees on the list of the Register of Foreigners;
- non-accompanied minors (under certain conditions);
- students.

It is clear from this list that in most cases Roma migrants living in precarious situations would not qualify.

3.2.4. Access to health care for third country nationals

This section applies specifically to Roma migrants from Western Balkan countries, i.e. former Yugoslavia, who has a visa-free regime of travelling within the EU. To ensure compliance with residency regulations, they need to apply for residence permits at the Belgian diplomatic mission in their country of origin, unless there are exceptional circumstances, in which case they can submit an application in Belgium to the mayor of the municipality in which they plan to reside. This requirement is challenging for Roma migrants, both in terms of admissibility of the application (exceptional circumstances needed) and in terms of required proofs (integration, work, knowledge of the language, school-age children, etc.).⁴⁵

If they do not secure residency permits in Belgium, they are considered undocumented migrants.

3.2.4.1. Undocumented migrants – AMU procedure⁴⁶

Belgium is one of the few EU Member States to offer – under specific conditions – destitute EU migrant’s health-care coverage in the system for undocumented migrants. Migrants residing in Belgium without residence permits can access health care through the AMU system put in place by Organic law from 8 July 1976, completed by a Royal decree from 12 December 1996 related to “urgent medical care.”

⁴⁴ NGO Medimmigrant. See at: www.medimmigrant.be, section on health insurance rules.

⁴⁵ NRIS Belgium.

⁴⁶ Livre vert sur l'accès aux soins en Belgique, 2014 (Green book on access to health care in Belgium, 2014).

Obtaining AMU is subject to four conditions: unauthorized stay, medical need, financial hardship, and territoriality.

In practice, the medical need must be established and proven by a medical certificate; lack of financial resources is established through a mandatory verification that usually takes the form of a visit to the applicant's home or habitual residence. As to unauthorized stay, the PSWC can get the necessary information on residence from the municipality or the Foreigner Office. Territoriality refers to their presence and actual address in Belgium (not to be confused with authorised residency). This information is crucial in defining which PSWC will be competent to deal with the demand, normally it is the PSWC situated in the municipality where the person lives.

The title of this health-care arrangement (AMU) is itself confusing, as it states "urgent", when in fact it covers not only emergencies. Despite the fact that it is clearly set in the Royal Decree from 1996 that AMU refers to procedures which might include either treatments or prevention, and not only urgent situations, it is clear neither to health professionals, nor to patients the services it encompasses. Therefore, many people fear to visit a doctor, when they consider their health problem is not "urgent" enough. On the other hand, health professionals themselves often do not know if the consultation will be considered "urgent" and respectively reimbursed.

If all the necessary conditions are fulfilled (a stay longer than three months without a residence permit and medical need attestation submitted by a doctor), the request can be addressed to the PSWC of residence/stay. However, before undergoing the procedure, people need to become aware of it and to know exactly how it works.

The procedure requires a visit to PSWC, taking a ticket to be able to get an appointment, and coming back again to present the health-care service request. This part might itself take several days or weeks, depending on the demand at the moment, which in some municipalities is extremely high. During the appointment with a social assistant, a number of required documents are verified and the assistant has 30 days to finalize the social inquiry and verify if the patient faces financial hardship. The assistant verifies this through a home visit, which implies that a stable, non-temporary accommodation is required. If the applicant moves from one municipality to another, the whole procedure begins anew. The length of the procedure is one of its weakest points, despite the maximum legal duration; it can in some cases be longer than the initially set 30 days. With the rising number of demands it is also observed that PSWC is gradually tightening the conditions to be fulfilled and necessary documents provided. This is noted by hospitals, medical centres, NGOs, and patients themselves. For example, a recently instituted requirement is to prove the three months period of stay without residence permit by the patient (travel tickets, bills, school attending, etc.), while previously, the PSWC had to prove the opposite was the case in order to issue a refusal. This can be interpreted as an important change of the burden of proof, which makes the procedure even more difficult.

As PSWC are responsible for receiving the demands of AMU and to deal with its implementation in case the request is accepted, there are a lot of differences, depending on the municipality where a person lives, which create geographical inequalities.

One of the main differences concerns the way how, upon which modalities, a patient benefits from urgent medical care. While some of the PSWC deliver “medical cards” which are valid for a predefined period of time, some of them require a visit to the PSWC before each medical visit. In practice this means that a patient has to first make an appointment with a doctor, come to the PSWC to get a “certificate of health-care coverage” (which guarantees the doctor would get reimbursed), and then receives the medical appointment. If a patient needs medications, it is necessary again to get back to the PSWC to verify if they are on the list of reimbursed drugs, he/she gets another certificate for the pharmacy, and only then it is possible to get the medicines. These steps are not only difficult to understand and remember, and even more discouraging during an illness, but also almost impossible in case of real emergency. At the end of the day, it is a long list of appointments and travels. Once the demand for urgent medical care is accepted, it is valuable only for a limited period of time, which in general varies from 2 to 6 months. Afterwards, the whole procedure has to be re-launched from the beginning.

“While I was helping a pregnant woman in getting necessary check-ups, I realized how difficult it was not only to get to relevant services, but also to receive the “urgent medical care” that she was entitled to.

We took an appointment at a public hospital and went through an inquiry at the social service of the hospital, to fill in the necessary files. During the interview we were informed that the examination was not going to be covered, as the patient did not ask for the “urgent medical care” before the appointment, the only solution was to pay the visit without any possibility of reimbursement.

Afterwards, we introduced the demand at the PSWC at her municipality of residence. Unfortunately, she had to move to another place, situated in another municipality and had to re-launch the procedure from the beginning. In the end, she delivered her baby before getting the health coverage, due to the length and complexity of the procedures.”

(Volunteer at Médecins du Monde, Brussels)

Besides these modalities and complexities of the procedure, language barriers also play a crucial role. Therefore, it is practically impossible to go through the whole process without the help of an assistant, mediator, and/or a volunteer.

3.2.4.2. Asylum-seekers

Unlike other EU Member States, EU citizens can apply for asylum or subsidiary protection in Belgium. Asylum applications submitted by EU citizens are subject to the fast-track procedure (for which the law stipulates that the Commissariat-General for Refugees and Stateless Persons must reach a decision within five days).

However, evidence submitted by Roma is often insufficient to allow their asylum applications to be admissible. While many Roma suffer from systematic persecution and discrimination in their countries of origin, they generally do not trust public institutions and have difficulties in reporting cases of violence and discrimination they have faced.

Asylum applications from the Western Balkans (Serbia, Bosnia and Herzegovina, UNSC resolution 1244 – administrated Kosovo, the former Yugoslav Republic of Macedonia, and Montenegro) currently have a priority to have their claim processed within two months, due to the large number of unjustified asylum applications from these countries following the end of the visa regime to enter Belgium on 19 December 2009.

There has been also a temporary facilitation of admission criteria for asylum-seekers in 2009 (in accordance with the order of 19 July 2009⁴⁷ on regularisation of stay for more than three months for humanitarian reasons) which allowed a number of Roma to obtain residence permits.

In 2010, 74 Serbs, 83 Kosovars and 13 Macedonians were granted refugee status in Belgium. On 1 November 2011, the figures were respectively 49, 128, and 3. It is difficult to determine precisely how many applicants were Roma, but estimates show that quite a few of these asylum-seekers are of Roma ethnic origin. The refugee status is generally granted to members of specific ethnic or social group (particularly the Roma) who are still being discriminated against or persecuted in their country of origin.

According to Directive 2005/85/EC on asylum procedures, Belgian authorities draw up a list of safe countries of origin (including countries with high percentage of Roma population). Asylum-seekers from these countries will be subject to fast-track procedure (their application will be processed within 15 days), the burden of proof will be increased and the decision can be appealed only by submitting a request for annulment to the State Council.

According to the Act on Reception of 12 January 2007 on the entitlement to medical care, all asylum-seekers are entitled to medical care listed in the INAMI nomenclature (with the exception of some specific medical treatments). Asylum-seekers are also entitled to additional types of health care not listed in the INAMI nomenclature (in line with the Appendix of the Royal Decree of 9 April 2007).

If asylum-seekers live in a reception centre, their medical expenses are normally covered by the Belgian Agency for the Reception of Asylum-Seekers (Fedasil) or one of its reception partners. If they live elsewhere, they must obtain a 'payment warranty' to receive care and treatment without having to pay. The administrative procedure is rather complicated and most health-care providers are not familiar with it.

3.2.4.3. Recommendations to improve the access to health care for migrants, including Roma

Despite efforts to improve the efficiency of the Belgian health system, it remains one of the most complex systems in Europe.⁴⁸ Beyond the inequalities between nationals and migrants, there are also inequalities in access between different migrant groups. This fact relates mainly to the characteristics of the procedure to receive AMU.

⁴⁷ « Instruction du 19 juillet 2009 concernant la régularisation de séjour de certains étrangers ».

⁴⁸ Observatoire européen de l'accès aux soins, Médecins du Monde, septembre 2009: L'accès aux soins des personnes sans autorisation de séjour dans 11 pays d'Europe et avril 2013: L'accès aux soins en Europe en temps de crise et de montée de la xénophobie.

“I find that there are two main challenges when it comes to access to health care of Roma living in settlements. First, their living conditions, hygiene and nutrition problems, which are specific to their field realities. Second, the lack of stability in their accommodation, they are often forced to move from one place to another and we lose the track of them.

This situation is really challenging for health professionals in providing appropriate health follow-up. For this reason, we are convinced that mobile projects and outreach health-care services are the most effective methods in improving Roma’s health.”

(Nurse at Kind & Gezin)

Because of the specific living conditions of precarious Roma migrants, combined with these complex procedures, health professionals, and especially Médecins du Monde, recommend:⁴⁹

- **Simplify and harmonize procedures** for obtaining health coverage, such as AMU;
- For EU citizens, guarantee access to medical care **during the investigation of coverage** in their country of origin;
- **Adapt in dealing with disadvantaged groups** in multidisciplinary, primary health centres, and in reception and orientation services; social and psychological services; with the possibility to call **for intercultural mediation and translation, or specific training;**
- Develop **mobile and proactive approach** for actors of preventive health (immunization, pregnancy care, family planning, health education, HIV testing, etc.) in places where vulnerable populations live or are used to meet;
- Role of Municipalities – PSWC – Regions: **develop mobile and proactive approach in cooperation with other stakeholders** towards precarious places (squats, stations, streets, settlements) to address social rights: housing, health, education and legal advice.

⁴⁹ Médecins du Monde, “Synthèse de l’enquête sur l’accès aux soins de santé et la couverture vaccinale des populations Roms de Bruxelles”.

4. REVIEW OF POLICY FRAMEWORK

4.1. National policies on inclusion of Roma

4.1.1. National Roma Integration Strategy – scope and assessment

At the federal level, significant efforts in the field of Roma integration have been put forth since 2010, especially in the context of the Belgian Presidency of the European Union. In this framework, a report on combating child poverty has been drafted: “Who cares? Roadmap for a Recommendation to fight child poverty” and presented on 2 and 3 September 2010.

Federal authorities have been actively involved in the organization of the Roma Summit in Cordoba (trio-presidency Spain – Belgium – Hungary), and the Belgian Presidency organized the Roma Platform meeting in December 2010.⁵⁰ However, The National Roma Integration Strategy is the only political commitment on the inclusion of Roma at federal level in Belgium.

4.1.1.1. General coherence of the strategy

According to WHO criteria,⁵¹ while the Belgium NRIS seems coherent with different EU Communications and Conclusions,⁵² it remains weak in terms of concrete objectives, allocated funds or monitoring and evaluation mechanisms.

The NRIS makes reference to the 10 Common Basic Principles on Roma Inclusion in its introduction and takes clearly into account several of them. Strong attention is paid for instance to involvement of regional and local authorities, civil society organizations and Roma communities during the process of preparation of the strategy. In addition, it promotes the development of intercultural services and encourages accessible, quality and sustainable health-care services, based on existing services (following mainstream and avoiding parallel systems).

According to different assessment tools, such as WHO criteria and EC assessment, a number of crucial developments are missing, such as non-discrimination policies, inclusive targeting, awareness of the gender dimension, transfer of evidence-based policies, and/or use of community instruments.

4.1.1.2. Focus on the health situation of Roma and related challenges

The NRIS describes the health situation in Belgium concisely: “There is a significant gap between the health of Roma and the health of the Belgian population as a whole. This gap is primarily caused by the precarious conditions in which Roma live, as well as by their limited access to health care”.

⁵⁰ PPS-IS, The Fourth meeting of the Roma platform.

⁵¹ Potential Criteria for the Review of the health component of the National Roma Integration Strategies, WHO Regional Office for Europe. (2012).

⁵² EC Communication “National Roma Integration Strategies: A First Step in the Implementation of the EU Framework” (May 2012); EC, Steps forward in implementing national Roma integration strategies (2013). EC, Proposal for a Council recommendation on effective Roma integration measures in Member States (2013).

The policy document recognizes that there is no “reliable data in this country on the health of the Roma or on the problems that they experience with the health-care system” but there is “plenty of evidence to suggest that they face many problems in terms of their health and health care.”⁵³

If the existing gap between Roma and general population is well acknowledged, there is no further detailed evidence on the extent of this gap or on the identification of specific barriers, health problems and their respective origin, being socioeconomic and/or cultural. There are no provisions on filling the data gap, either. The focus of the NRIS health section does not seem to set precise, quantifiable objectives in the field of health, and does not propose quantifiable objectives to reduce the gap in access to health care. However, the strategy provides a list of existing approaches, including the intercultural mediation programme in hospitals, in the framework of the intercultural mediation programme of the Federal Public Service for Health, Food Chain Safety and Environment. If the programme is of strong relevance and improves access to health care for Roma, additional steps and approaches are needed to complete the strategy.

OSCE refers to this already developed practise in its report on Implementation of the action plan on improving the situation of Roma and Sinti in the OSCE area: “The mediators are currently employed in a number of hospitals and are of Albanian, Bosnian, Romanian, and Serbian origin. The mediators primarily serve immigrant communities residing in Belgium. The government has found that, for vulnerable groups like the Roma, these social services in hospitals are particularly important in order to guarantee accessibility, continuity, and quality of care.”

To support this approach, the Federal Public Service on Intercultural Mediation and Policy Support Unit organized in 2013 two training sessions for professionals – especially intercultural mediation coordinators – working with Roma patients in various hospitals. This initiative will be subject to further analysis in the report.

The way NRIS was developed, it presents an overview of existing best practices in the country rather than an actual action plan.

4.1.1.3. Assessment of the NRIS by European institutions – European Commission and Council of the EU

Existing EU evaluations and reports, i.e. the EC Communication “National Roma Integration Strategies: A First Step in the Implementation of the EU Framework,” May 2012, EC “Steps forward in implementing national Roma integration strategies,” 2013, EC, Proposal for a Council recommendation on effective Roma integration measures in Member States, 2013, and others take into account the official reports by the Belgian authorities on the results that have been achieved so far under the NRIS implementation framework.

According to assessments by the European Commission, Belgium has an efficient approach in involving local and regional authorities; a structured dialogue has been set in cooperation with

⁵³ NRIS, p. 35.

them, as well as promotion of exchange of experiences among local authorities. This can be interpreted as the strength of its decentralization history, reflected in concrete initiatives on the field, especially at the local level. In the field of governance, there is also a strong involvement of civil society organizations and a structured dialogue at national level, as well as involvement of Roma communities at the local level. The weakest points, according to the European Commission, are the allocation of EU funds, existing monitoring mechanisms, and anti-discrimination measures.

In terms of health, Belgium did not report any concrete measures for the first assessment (EC Communication “National Roma Integration Strategies: A First Step in the Implementation of the EU Framework”) in terms of plans to reduce the health gap or specific measures to improve the access for children and women to health. In this sense, the Commission called on Belgium to “further work to clarify the goals, indicate how progress will be evaluated and develop an action plan with detailed measures.”⁵⁴

4.1.1.4. Contribution to the National Reform Programme

The Belgian NRIS contributes to its stated objective to help lift 380,000 people out of poverty by 2020, as stated in the National Reform Programme adopted in 2011. The Programme does not refer to Roma population explicitly; it follows an inclusive approach and targets “population at high risk of exclusion or poverty.” The Programme further sets several integration measures addressed specifically to “first comers”, without further precisions on the migrants’ origin. In the field of health, the government has established guidelines “to ensure a rigorous and sustainable funding of health care, while ensuring a high level of quality and accessibility.” The Programme proposes for example the following initiatives:⁵⁵

In Flanders, within the framework of health promotion and health-care equality, a decree will encourage partnerships for practical implementation of first line care. A specific component will also be dedicated to district health centres and partnerships that specifically target people suffering from poverty.

In Wallonia, there is nothing specific on health care for migrants, but a rather broad initiative for newcomers, aiming at their integration and information about their rights. These rights might include access to health care, though not explicitly developed. For instance, a decree will establish a “host course for first comers.” This course will target foreigners living in Belgium less than three years with a permit to stay longer than three months, with the exception of citizens from EU Member States, European Economic Area, and Switzerland. It will be implemented in eight regional integration centres or home offices and will include advice on migrants’ rights, assistance with administrative procedures including access to health care, language courses, etc.

⁵⁴ National Roma Integration Strategies: A First Step in the Implementation of the EU Framework, EC, 2012.

⁵⁵ National Reform Programme, 25 April 2013.

4.1.2. Coordination of the NRIS and consultation with Roma communities

A Working Group on Roma was established on 21 March 2011, during the Inter-Ministerial Conference on Social Integration. It is composed of political representatives from the Federal Government, Regions, and the Federation of Municipalities. This working group was tasked with drafting an integrated action plan for improving the support for Roma communities in Belgium, coordinating initiatives of various policymaking levels and monitoring related developments.⁵⁶

In this context, the Working Group (WG) was commissioned to prepare the National Roma Integration Strategy. During the drafting phase, the WG consulted a number of organizations representing Roma communities in Belgium, such as “Foyer”, “Minderheden Forum”, and “Le centre de médiation des Roms et des Gens du Voyage”. While the participation of these organizations during the drafting process was appreciated, the same organizations reported a very weak opportunity to participate in the implementation of the strategy.⁵⁷ In addition, they regret the strongly inclusive orientation of the strategy and the risk of missing specific actions targeting Roma. They consider that there have not been any innovative actions and projects regarding Roma, instead of already existing practices.⁵⁸

The Working Group meetings gather mostly high – level political authorities such as ministerial cabinets and do not include representatives of Roma communities or relevant organizations in every meeting. The structure of the meetings is based on their agenda, and may or may not include NGOs.⁵⁹ As such, it brings on a risk of limited involvement of NGOs and Roma communities in the implementation of the strategy, as initially foreseen in the NRIS document.

Beginning in 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. The current government was formed in December 2011 and the Cabinet of the State Secretary, Maggie de Block, began work on the strategy then. Further coordination and implementation of the strategy will depend on the creation of a new Working Group reflecting the outcomes of the last federal elections of 25 May 2014. As it is a group composed of political representatives, it also reflects the priorities and the political agenda of the government in power.

Since 2012, the Working Group (composed of Federal Cabinets, Regions and Federation of Municipalities) has been meeting at least twice per year to discuss some of the most pertinent issues related to Roma in Belgium, mainly focusing on the monitoring of the NRIS strategy required by the European Commission. Different cabinets responsible for the fields of action of the strategy drafted consequently and independently of each other required feedback, including the Cabinet of the Minister of Health.⁶⁰ However, if each Ministry keeps its responsibility and field of focus, it may imply a strongly sectorial policymaking, without taking into account relevant interconnections and “health in all policies” approach.

⁵⁶ NRIS.

⁵⁷ Interview with Foyer, 14 April 2014.

⁵⁸ Interview with Minderheden Forum, 12 June 2014.

⁵⁹ Interview with the Technical Secretariat of the working group, 23 April 2014.

⁶⁰ Feedback from the Cabinet of the State Secretary for Social Integration and Combating Poverty, 18 May 2014.

The Mediation Unit of the Federal Public Service on Public Health (administration of the Minister of Health), responsible for the coordination of the Intercultural Mediation Programme in public hospitals – was invited to present the programme at the last meeting of the Working Group, in 2014. Nevertheless, they admit not having been specifically aware of the NRIS's existence before that time, or involved in the drafting and the implementation of the strategy.⁶¹

Besides the Intercultural Mediation Programme, there are two other actions listed in the NRIS in the field of health: networking between health-care providers in the Flemish Region and psychological and psychiatric help for recognized refugees and asylum-seekers supported by the German-speaking Community. Neither of them specifically targets Roma communities or addresses particular challenges in their access to health services. There are no figures or specific evidence about the presence of Roma communities in the German-speaking part as well. Furthermore, there is no specific funding allocated to these actions via the strategy; some activities have been already 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. Even if the Working Group admits that a revision might be useful, no concrete step has been undertaken in this direction.⁶² More concrete actions and adapted mechanisms can be developed only once the new government is in place and further actions will depend on the priorities set by the new Minister of Health.

4.1.3. Concrete actions developed in the frame of the NRIS

4.1.3.1. “Social and professional activation of Roma”, projects co-financed by the European Social Fund (ESF)

Since the adoption of the NRIS, the PPS 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, awarded to PSWC beneficiaries, who must be:

- Roma community members;
- EU or non EU citizens with residence permits;
- PSWC social assistance beneficiaries.

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 by PSWCs within the framework of these projects. It is also recommended in the programme documents to hire an intercultural mediator who can act as a bridge between the beneficiaries, PSWCs and other institutions. These intercultural mediators:

⁶¹ Interview with the Mediation Unit, FPS Public Health, 28 April 2014.

⁶² Feedback from the Cabinet of the State Secretary for Social Integration and Combating Poverty, 18 May 2014.

- Are not necessarily of Roma origin;
- have a good working knowledge of Roma populations and their culture;
- have 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 PPS 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 June 2014 in Leuven.

Table 3: 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 emphasized that the participating cities listed above (five in Flanders and one in the 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 projects but also by the existence of a large civil society network (De Acht in Antwerp, 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 and beneficial consequences on Roma health, vastly improving Roma living conditions.

Box 2: Description of the ESF implemented projects

PSWC Saint-Josse

“Guidance towards social and professional activation”

This is the only pilot project implemented in the Brussels Region since July 2012. The aim of the project is threefold: to provide literacy classes, to offer health education information sessions and to promote socio-professional inclusion (CV drafting, work searching, etc.). The follow-up individual meetings are held on a monthly basis, (compared to every six months for other PSWC beneficiaries). The beneficiaries are about 40 Roma from Romania.

Since the beginning, the project includes a component on health education. The activities related to health have been implemented in partnership with two organizations. In the first year, a partnership with a family-planning organization led to information sessions about birth-control methods. In the second year, the health education activities were extended with a partnership with the ONE in order to raise awareness on maternal and children’s health. The project manager reports that the health situation of the family members often plays a role in their participation in the project (i.e. pregnancies, care for ill children or other family members, etc.). Awareness-raising and information sessions are addressed both to men and women, but it is observed that some women feel more confident and at ease without their partners⁶³. Unfortunately, attendance rate in these sessions has been low and beneficiaries may not always realise their added-value⁶⁴. The information sessions organized by ONE were addressed to couples where less than 50 per cent of beneficiaries participated, while family planning sessions were addressed to women and men separately, with a significantly higher participation of women (almost 100% present). In both cases the invitations have been reminded several times to participants and organizers have not identified the reason behind the low attendance to these sessions. However, they have suggested bad timing (family religious rituals taking place at the same time as the sessions) as one possible cause.

While other projects do not focus specifically on health related issues, project managers report interdependencies between project activities and state of health or related issues.

PSWC Ghent

“Natuurlijk”

The Public Social Welfare Centre of Ghent began implementing a Roma related project in 2008. The project aims to address Roma so-called “distance” from the labour market, due to lack of language proficiency (Dutch), education or professional skills, and work experience. Therefore, a strong emphasis is placed on language classes, as a crucial mean towards integration and regular labour market opportunities. Trainers choose an informal learning environment, better suited to Roma learners, and insist on the main goal of the project – the job search. Specific focus is given to vocabulary which they need for job

⁶³ This is also reported by a Roma self-organization in Ghent, Opre Roma, which implemented the same type of activities – awareness on women’s health related issues.

⁶⁴ Interview with the project coordinator, 14 April 2014.

interviews, work or everyday life. This approach stimulates their interest in Dutch, by aiming something concrete such as professional integration. They also learn how to establish contacts with Belgians as relevant for integration into the Belgium society. Indirectly, they can also more easily access different services and discuss with professionals, including health facilities.

PSWC Heusden – Zolder

“Sociale activering van Roma” – social activation of Roma

The project aims to provide specialized support to a number of Roma living in the municipality, following the footsteps of a previous research project studying the situation of Roma in Heusden-Zolder.

Individualized pathways are determined for each participant in collaboration with the project team. Their role is to provide guidance and help to participants by guiding them to relevant instances for specific issues. In this context, there are a lot of activities to explain requirements of administrations and how these requirements need to be fulfilled. New ways of communicating and establishing bridges between the Roma and the majority population are experimented, for example in cooperation with NGOs and the “Roma-team” (intercultural mediator and project manager) has become a significant support structure for other workers within the PSWC and for external organizations.

PSWC Temse

”Roma ‘t werkt” – Roma, it works

This project is unique because it gathers three PSWCs working as a cluster: Temse, Sint-Niklaas, Beveren, and ODICE (NGO). The purpose of the project is sustainable employment, and it is designed for 13 Roma families from the UNSC resolution 1244 – administrated Kosovo, Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Bosnia and Herzegovina, and Serbia. The project provides guidance to beneficiaries when searching for job, but as the beneficiary families face a lot of additional problems, the project manager – – working together with a Roma mediator – is required to intervene in additional matters: Dutch language, housing, education, financial situation, and administrative issues (residence and social aid). Sometimes, the project team also helps Roma with health matters, even if it is not a specific goal of the project. The coordinators are in contact with actors such as doctors and Kind & Gezin, and guide the project’s beneficiaries to relevant services if necessary.

PSWC Mortsel

“Over de Brug” – Over the bridge

This project tackles the problems encountered by Roma communities on a halting site in Mortsel. The site is situated on the outskirts of the city nested between an airport, a busy road, train tracks and fields. Mobility is therefore a crucial challenge for both the project’s beneficiaries and the team leading the project. The project is supported by a local

organization that promotes cultural diversity. This approach aims to provide a better understanding of the role and added value of “Roma experts” in PSWCs and to establish an integrated action plan, rather than sectorial approaches. Residents on this site live in precarious conditions and far from health facilities. Here again, mobility and outreach provisions would be of particular relevance in terms of access to health services.

PSWC Antwerp

”A’ op stap met Roma – Amalia” – “A” on the way with Roma – Amalia

The project activities are mainly aimed at Roma women. It aims on their social and professional activation by responding to their everyday needs. Roma living in Antwerp are mainly from the former Yugoslavia and have been in Belgium for some years. Participants have attended schools in Belgium, which makes the communication easier, notwithstanding the main challenge remains their low level of education. Project activities are frequently challenged by absences due to health problems, and coordinators may be asked by beneficiaries to find solutions.

4.1.3.2. Participation in the joint programme of Council of Europe and European Commission – ROMED

Belgium has participated in the ROMED programme since 2012, with the stated objective to improve the qualifications and efficiency of its Roma intercultural mediators working in various fields, including health, whether they are of Roma ethnic origin or not.

The PPS Social Integration acts as the general coordinator of the programme and co-organizes related trainings. There have already been four cycles of training since 2012, two of them in Dutch organized by two trainers from the NGO 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 website,⁶⁵ 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 intercultural mediator from the Mediation Unit of the NGO Foyer participated in the training.

According to the interviews with the two trainers at Foyer,⁶⁶ mediators’ reactions are as follows:

- Participants are enthusiastic about the added value of the exchange of experiences between mediators. It appears very relevant to them to work in teams, which is often not the case in Belgium. Some services employ only one mediator who might feel a bit isolated in his/her work. The exchange of experiences between mediators is crucial.
- Participants report that it is very useful to organize the team work with both Roma and non-Roma mediators.

⁶⁵ See at: <http://romed.coe-romact.org>

⁶⁶ Interview 14 April 2014.

- Mediators who participate in the training are employed in different towns in Flanders and Brussels Region. These cities do not always follow the same approaches; therefore a discussion on different approaches was described as an added value of the training.
- Participants appreciated the training modules of neutrality/being impartial, the importance of reflection on personal behaviour, how to deal with discrimination and racism, mediation as a process, not a one off intervention. The training also increased mediators' self-confidence in performing their daily tasks.

4.1.3.3. Establishment of the Technical Secretariat and Roma Helpdesk

In order to ensure a proper follow up of the NRIS, the State Secretary asked her administration, the Public Planning Service (PPS) 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 contact the helpdesk with questions about Roma specific situations, as well as about relevant methods and difficulties they encounter. So far, questions about health-related issues have not been reported. The helpdesk 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 also aims to help workers improve services and support for Roma communities. According to the helpdesk officer,⁶⁷ because the helpdesk does not appear to be well known in the field, it needs additional popularization and valorisation among social workers who can directly benefit from it. It appears that some social workers working with Roma communities already have a well-established network of contacts and mentors, and so prefer to share their concerns closer at hand, on a more operational level rather than with a federally established helpdesk.

To reinforce PPS 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 provide expertise and advice based on their relevant and direct experience.

Their main tasks are as follows:⁶⁸

- 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;

⁶⁷ Interview 23 May 2014.

⁶⁸ Information from the Technical Secretariat of the Working Group, 8 May 2014.

- Contributing to the development of synergies among services;
- Signaling structural problems, lacunae in the legislation, unnoticed and untreated needs of people in poverty to policymakers.

In this way, their experience is valorised and they also receive targeted training in order to foster and improve their level of 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 of guiding patients from 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 those who 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 health-care facilities.

Currently, there are 27 experts by experience, divided into 15 different departments.⁶⁹ An expert by experience of Roma origin 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 on the documentation of Roma related issues. The role of this expert is to maintain the connection between practical level/reality and political level/policy. Therefore, her input is generally pragmatic and taken into account.

Unfortunately, all these concrete developments of the strategy mostly benefit Roma who are already social aid beneficiaries, and not to the most precarious and vulnerable group – Roma migrants without residence permits.

4.2. Regional policies on Roma inclusion

4.2.1. Flanders – Flemish action plan on Migrants from Central and Eastern Europe (Roma)

In order to respond to specific challenges raised by migrant flows, the Flemish Action Plan applies the EU "explicit but not exclusive" approach and intends to call for "neighbourhood stewards," which is a term that Flemish authorities use instead for mediators. 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.

⁶⁹ Webpage of the PPS-IS. See at: www.mi-is.be, section on "experts de vécu".

Key actions of the Action Plan include:

- Establishment of Working Group "Migrants from Central and Eastern Europe" in the framework of "Agentschap voor Binnenlands Bestuur" (Agency for domestic governance) to strengthen the coordination of the Action Plan and assessment of relevant initiatives in Flanders;
- Participation of Roma in the NGO "Minorities Forum" (Minderheden Forum);
- Additional resources for schools with Roma students;
- Assistance measures to help Roma migrants in their integration process;
- Enhanced integration by involving "neighbourhood stewards";⁷⁰
- Study on specific motives of intra-European migration, including Roma.

There are no specific objectives in the field of health, but as a regional action plan it gives a good basis for coordination and further action in different fields. The document is based on realities on the field, thanks to the contribution of different municipalities in its drafting (e.g. Integration Service Ghent). It provides an overview of the situation in Flanders and municipalities with high concentration of Roma population and aims at better coordination of different initiatives. In addition, some of its developments have served as a basis for the NRIS.

The Plan not only sets a framework, but also proposes a concrete response to challenges faced by municipalities with Roma populations by establishing "neighbourhood stewards" to act as mediators in neighbourhoods where Roma live. This proposal has been actively followed and implemented with allocated budget, which makes it one of the most tangible accomplishments of the action plan.

4.2.2. Wallonia – Social Cohesion Plan of the Walloon Government

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, due to, as stated by Walloon authorities, fear of stigmatization.⁷¹

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.

⁷⁰ Kind of "integration mediators", acting at the local level in some municipalities; each municipality decides about their specific field of work or specialization.

⁷¹ «La situation des personnes dites Roms migrants in Belgium », 2013, Ciré.

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

4.2.3. Brussels Region – Governmental note establishing a Regional Task Force on vulnerable, especially Roma families

In the last four years, there have been about 300 Roma, mainly of Slovak origin, without stable accommodations in Brussels. Following forced evictions, they have 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-borns live in inhumane conditions, putting in danger their health and lives.

Besides temporary interventions by different municipalities in the Brussels region (see *Local policies at the municipal level*), civil society organizations have mobilised 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, health care and housing). The manifesto was drafted in cooperation with Bruxelles Laïque, Regional Integration Centre Le Foyer, Ciré, 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 International.⁷²

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.

According to the manifesto, two types of solutions regarding basic humanitarian needs and mid-term integration were needed:

⁷² Médecins du Monde Webpage. See at: www.medecinsdumonde.be

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 health care, 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 goals, 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 elections.⁷³

The above-mentioned NGOs, 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 to 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 ministries,⁷⁴ 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, health care, education, and work.

4.3. Local policies at the municipal level

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.

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

According to detailed information from 2013,⁷⁵ there are currently 26 Roma mediators in Brussels and Flemish municipalities. Their functions are slightly different, according to their

⁷³ May 2014.

⁷⁴ Representatives of Minister – President of the Brussels Region and Minister for housing of the Brussels Region.

⁷⁵ Context, drijfveren en opportuniteiten van Middenen Oost-Europese immigratie - Een exploratief onderzoek met focus op Roma - Heleen Touquet and Johan Wets 2013, p. 53 Context, motivations and opportunities of the Central and Eastern European immigration – Explorative research with the focus on Roma populations.

funding and their field of work:

- “neighbourhood stewards” are supported by the Flemish Government, as the most concrete initiative of the Flemish Action Plan, described below;
- “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.

Table 4: List of professionals working with Roma in Flanders and Brussels – Capital Region⁷⁶

Municipality	Organization/Service	Number and type of mediation
Antwerp	Minorities Centre “De Acht”	4 neighbourhood stewards
	PSWC (ESF-project Roma)	1 intercultural mediator
Brussels Region	Foyer – Regional integration centre	4 Roma-stewards 3 Roma-mediators 1 intercultural health mediator 1 project coordinator
	PSWC Saint-Josse-ten-Node	
	Integration service	6 neighbourhood stewards 2 consultants for EU migrants
Ghent	Education Department	4 bridge – figures for EU migrants
	PSWC (ESF-project Roma)	1 intercultural mediator
	VDAB – Employment office	1 bridge - figure for EU migrants
	PSWC (ESF-project Roma)	1 intercultural mediator
Heusden-Zolder	PSWC (ESF-project Roma)	1 intercultural mediator
Leuven	Integration service	1 worker with travellers 1 project manager for education of travellers
	PSWC (ESF-project Roma)	1 bridge figure for travellers
Mortsel	PSWC (ESF-project Roma)	1 bridge figure for travellers
Sint-Niklaas	Police/Welfare	2 neighbourhood stewards
Temse	Integration service	1 education officer 1 intercultural mediator for education
	OCMW (ESF-project Roma)	1 intercultural mediator

While dealing with particular Roma migration related situations, health care appears as one of the fundamental issues in transversal problem solving, closely related to accommodation and nutrition problems met on the field. Some relevant examples of municipalities in Flanders and in Brussels Region are developed hereafter.

4.3.1. Initiatives in the City of Ghent – Flanders

Being confronted with migrants from new EU Member States early in the enlargement process, the municipality of Ghent has developed a specific approach which allows it to work with

⁷⁶ Idem.

rather than against Roma families. The majority of Roma people are from Bulgaria, but field workers report that Slovak Roma live in the most precarious conditions, moving from squat to squat, without mid-term or permanent place to live.

The municipality aims at proactive solutions solving and its initiatives are often seen as a model in working with Roma in Belgium. For instance, their expertise remains of interest to other municipalities who are willing to tackle similar challenges. The project “Instapwonen” for two Roma families (integration via accommodation, similar to “housing first” kind of projects) implemented by the Integration Service of the city of Ghent inspired a similar project being prepared in the municipality of Ixelles (Brussels-Capital Region) and has caught the attention of other municipalities.

“I wish that there could be more projects such as “Instapwonen”. It is a global approach helping to stabilize the families, provide them with a close follow-up, support them to progress in different fields and improve their situation in general. A stable accommodation and appropriate social work are essential.”

(Coordinator, City of Ghent)

4.3.1.1. Action at the municipal level

The first steps in working with Roma migrants were taken back to 2008, when the municipality administration was informed of strong concentration of migrants from new EU Member States in several Ghent neighbourhoods. In 2010, the city administration came out with a policy statement on how to address the new situation at different administrative levels: strengthening the coordination (establishment of permanent consultation committees – acting in different fields); actions in the field of housing by combating illegal squats; activities in the field of residence situation and access to work; information campaigns addressed to other inhabitants of these neighbourhoods to explain the background of Roma populations and their culture. Various consultation committees have been active since 2010 and continue the work in respect to housing, work, education and health. The *Stedelijk Overleg Gezondheid Asielzoekers* (Community consultation group on health of asylum-seekers) is in charge of health issues and proposes political action, such as the note on Appendix 19 described above.

Even before the adoption of the Flemish action plan, which was inspired by the briefings coming from local levels, the municipality of Ghent had developed the model of so-called “consultants for European migrants”, who facilitated the communication between Roma and non-Roma inhabitants, and helped in solving neighbourhood conflicts.

Afterwards, with the support of the Flemish Government, the Integration service of Ghent employed in 2012 six “neighbourhood stewards,” one of Slovak origin, who intervene in different fields, including access to health. They will be funded until 2016 and their work has been highly appreciated. The stewards are in permanent contact with Roma families; one of the most challenging parts of their work is to monitor forced evictions from squats or temporary housing solutions and help evictees find temporary shelter.⁷⁷

⁷⁷ Interview with Marieke Lamaire, coordinator, Integration Service of Ghent, 14 May 2014.

The stewards participate in research project supported by the University of Ghent in the field of health of minorities, including Roma, on specific health problems and access to health care. While the University provides support in methodology and drafting of the research, the stewards contribute to questionnaires and interviews with Roma and encourage their feedback on different issues: health problems, barriers in access to health, use of health services, etc.⁷⁸ The outcome from interviews should be finalised by the end of 2014. In addition, they participate also in the “SOGA” group.⁷⁹

The health division of the municipality (Gezondheid Dienst) also intervenes in epidemics of scabies. There is a specific “scabies procedure”, which allows patients to benefit from coverage of all related health costs and necessary care. As individual treatments are not effective in getting rid of such epidemic, spread among families living together, a large and coordinated approach at municipal level has been developed.

4.3.1.2. Other health partners

The health situations that stewards are dealing with are different from one case to another and mostly related to Roma without health coverage. In most cases, if urgent medical care cannot be provided, they search different solutions. For example, they cooperate with “**Wijkgezondheid Centra**”, neighbourhood medical centres easily accessible for vulnerable patients, providing only primary health care, not completely free of charge and with health professionals not trained to deal with Roma patients.

There is also a number of charitable, free of charge health partners, for example a charity organization called “De Tinten”⁸⁰ in the Ghent city centre specializes in working with Roma migrants. They offer advice on available social services and procedures, provide access to a solidary grocery shop (offering a pre-defined amount of food to families, based on various criteria, in order to initiate resources-management), and free health consultations with a GP and a nurse.

“We have received never before such a warm and professional welcome as at “de Tinten”. Consultations with a nurse and a GP takes place every Friday and we feel at ease and encouraged to consult every time we encounter health problems. They take time to discuss with us and we manage easily to communicate, their willingness to help us is very precious and different from other health facilities.”

(Roma beneficiary, Ghent)

If necessary, health professionals refer patients to specialized health care, but it remains challenging to find cost-free partners.⁸¹ De Tinten has a partnership agreement with a nearby pharmacy – if patients have previously approved prescription form, they can obtain their medicines and the bill is paid by De Tinten. They are mainly financed by donations and charity

⁷⁸ Interview with Barbara Cottenie, neighbourhood steward, Integration Service of Ghent, 14 April 2014.

⁷⁹ Author of the note on the Appendix 19.

⁸⁰ See at: www.detinten.be

⁸¹ Interview with a GP volunteering for De Tinten, 11 April 2014.

thrift shop sales.

4.3.2. Initiatives by municipalities in Brussels Region

4.3.2.1. Municipality of Ixelles

The municipality of Ixelles has always dealt with significant migration flows of different origins, often leading to overcrowding due to lack of proper accommodation means. This is the case with a number of Roma families, mostly from Slovakia and the Czech Republic, living in different places in the municipality (ULB, AB3, Natation, Concorde, etc.).⁸² Their precarious living conditions, lacking of basic humanitarian needs, initiated a coordinated response at the municipal level from September 2011 to April 2012. This specific response was mostly based on the recognition of the particular situation of Roma with complicated migration history, and often being victims of discrimination in their countries of origin. This raised a new question within the municipality about reception of European migrants suffering from such difficult conditions.

During the aforementioned period, a “crisis unit” coordinated the response of the municipality and its partners: Prevention Service, “Street Educators”, Local Education Unit, Social Mediation, Social Services, PSWC, etc., all addressing different needs such as social, administrative and psychological follow-up, education, hygiene, nutrition, clothing, and housing. Frequent meetings and discussions were organized, in order to avoid duplication of the respective intervention sphere, and that is what helped them to be efficient in effectuating appropriate situational responses.

The precarious living conditions caused health related problems and hygiene challenges, which have been addressed by a number of health professionals. Medical consultations have been organized in cooperation with volunteer medical doctors, who ensured emergency responses as well as referral to specialized services. They helped patients to find relevant services, for example at the Free Clinic, hospital emergency rooms, medical centres, or PSWC. As the majority of Roma were without residence permits (and incidentally, without a permanent place to stay), they were entitled to get AMU. The PSWC of Ixelles facilitated these procedures (which may frequently be very complex) as previously described, and this support was vastly appreciated by different field workers and coordinators. It needs to be pointed out that this is the only help and support undocumented migrants stand to receive.

“Coordination of medical interventions and facilitation of access to AMU were essential in dealing with this crisis. It is very important to have all relevant stakeholders on board, access to health care would have been more complicated without contribution of the municipality and the PSWC.”

(Prevention service, Municipality of Ixelles)

The interventions of the crisis unit helped to stabilize a number of families, however needs

⁸² «Parcours d'exils à Ixelles : Expérience d'une commune confrontée à la crise de l'accueil », Septembre 2012. Exil patterns in Ixelles: Experience of a municipality confronted to a reception crisis.

appear frequently, at new places or after the end of temporary negotiated accommodation solutions. Thanks to this “crisis unit”, different service providers gained relevant experience in working with Roma families and are further interested in participating in new projects. They also seek advice from Roma mediators from Foyer or share their experience with other municipalities dealing with Roma migrants (Ghent, Saint-Josse, etc.), thus building a network of professionals working with Roma. Currently, a project is being submitted to the municipality level to follow two Roma families for at least two years, by providing a complete social support, including access to health care.

4.3.2.2. Municipality of Saint-Josse-ten-Noode

In a similar context, the municipality of Saint-Josse has been confronted with an influx of Roma migrants, including some (mostly of Slovak origin), who are living in unstable conditions. The most precarious Roma families until recently (October 2013) lived in an ancient convent, but ended up being evicted due to severe security problems.

As a limited response for four Roma families (a number of them are still looking for a temporary shelter), the municipality has provided them with apartments for temporary stay and put in place social follow-up. Social assistants intervene in different fields, from housing, administrative follow-up, and job seeking to health care.

As all municipalities’ beneficiaries have applied for residence permit, they have received an Appendix 19 and thus cannot be covered by the “urgent medical care”, as explained above. This situation is again an obstacle in accessing health-care services and thus social assistants look for other solutions. The assistants admit that in the majority of the cases, they are in the habit of sending patients to Médecins du Monde or other, free of charge health-care providers.⁸³

Médecins du Monde provides free consultations during permanencies in Brussels, Antwerpen, and la Louvière. Vulnerable patients without access to health care can access consultations with a general practitioner, and if needed be referred to specialists in public hospitals who have agreed to work pro bono. Mdm does not collect data on Roma patients, but their annual reports reveals increasing numbers of patients from other European countries. Between 2011 and 2012, the number of EU patients in Brussels almost doubled (from 100 to almost 200), and during the winter disposal it increased from 400 to more than 600.⁸⁴

This is just another example of finding a solution when no formal mechanisms are in place, which places an additional burden on the health-care system and on doctors working on a voluntary basis. Besides the missing coverage of these health costs, patients without health insurance seem to seek for medical help only in time of emergency. Once they leave the health facility, it remains challenging to follow their health condition properly on a regular basis. As a consequence, civil society and medical organizations call for more systematic inclusion of vulnerable patients in the public health-care system, which would not only improve their health, but also lead to more effective and equitable health-care system.

⁸³ Interview with three social assistants from the Prevention service of Saint-Josse, 18 April 2014.

⁸⁴ Médecins du Monde – Annual report 2012.

5. INTERCULTURAL MEDIATION PROGRAMMES IN HEALTH CARE

Hospitals and other health facilities receive a growing number of patients who cannot speak any of the three national languages in Belgium (French, Flemish, and German), or whose cultural views differ significantly from those of health-care providers. These barriers impact negatively on access and quality of health care; they may affect the rights of the patient as well as their treatment.

Intercultural mediation in health has been developed to address such difficulties and adapt to new intercultural realities.

5.1. Origin and scope of the programme

5.1.1. Intercultural mediation programme in hospitals

The accessibility and quality of care for migrants and ethnic groups (MEGs) suffer strongly from language barriers, sociocultural barriers, and possible ethnic tensions, racism and discrimination.⁸⁵ In order to offer MEGs equal access and quality of health care, it is necessary to minimize these obstacles, as the intercultural competences of health-care institutions are often too limited to address these challenges alone. This can lead not only to negative effects in care itself, but also to ethnic disparities in health care.

The Government of Belgium has made a choice to deploy intercultural mediators and not interpreters: mediators can not only overcome the language barrier but also deal with other barriers such as unequal quality and access to health care.

In 1991, the first intercultural mediation programme was launched for a five-year period, financed by various Flemish and Brussels Ministries, and coordinated by the Flemish Centre for Integration of Migrants (Vlaams Centrum voor de Integratie Migranten) and Foyer. The programme received the support of the Federal Public Service (FPS) - Public Health, and responded to the increase in the number of Arabic-, Turkish- and Italian-speaking patients. In 1999, thanks to the success of these projects, a specific programme and related funding were established at the FPS Public Health, which progressively grew in importance. Nowadays, more than 50 public hospitals benefit from this programme. There are around 20 languages covered and 100 intercultural mediators working all over the country.

In this framework, there are various languages which can be of benefit to Roma⁸⁶ migrants:

⁸⁵ *“Guide pour la médiation interculturelle dans les soins de santé”*, provided by the Mediation Unit, FPS Public Health.

⁸⁶ Information available from the Website of the FPS Public Health www.intercult.be, updates from 2014.

Table 5: List of relevant languages by region and by hospital

Region	Hospital or health institution	Relevant languages of mediation
Brussels Region	Clinique Saint Jean	Albanian
	CHU Saint Pierre	Albanian
	CHU Brugmann	Romanian Bulgarian
Wallonia	CHU Charleroi	Romanian
	CHR Liège	Albanian
		Bosnian
		Macedonian
	CHR Namur	Serbo-Croatian Albanian Serbo-Croatian
Flanders	Ziekenhuisnetwerk Antwerp	Serbo-Croatian
	AZ St Lucas and Volkskliniek Ghent	Bulgarian
	UZ Ghent	Bulgarian

In addition to the presence of intercultural mediators in these hospitals, the mediation units also gather in a network and operate via videoconferences. This option allows for a wider linguistic coverage all over the country, even if a direct, on-site intervention seems to be a preferred option.

Every year in December, FPS Public Health invites general and psychiatric hospitals to apply for funding for intercultural mediation (to cover the posts of intercultural mediator and/or coordinator of intercultural mediation). The application form must be sent to the FPS by the 31 January of each year. The Intercultural Mediation and Policy Support Unit then reviews the applications and is further responsible for the assessment and management of the intercultural mediation initiatives.

5.1.2. Intercultural mediation unit at the Foyer Regional Integration Centre

In addition to intercultural mediation units in public hospitals, there is a unique service at the Foyer Regional Integration Centre (Foyer). Foyer is an NGO based in Brussels which also acts as a *Roma and Travellers Support Centre*. As part of its mission, it offers a personalized support for Roma and traveller-related issues, in an effort to reinforce the empowerment and integration of those concerned through education and training. The training and information missions are on one hand designed for social service providers, public institutions, schools, and local authorities (information, advice, mediation, training, development of networks) and on the other hand, for Roma and Travellers (mediation, information, orientation, awareness raising, support).

Since 2007, a team of Roma and non-Roma mediators has been deployed to strengthen the relationship between Roma families and schools, and to improve communication and cooperation in the field of education. This team aims to improve the level of education among

Roma (school visits, registration with a school and continuing in education, regular attendance, mediation, encouraging parental involvement, family support, etc.).

Besides the focus on education, Foyer has also developed a health mediation unit, thanks to the support of the Federal Public Service Public Health described above.

At present, the team of mediators at Foyer covers, among other languages: Albanian, Bulgarian, Romanian, Romani, and Serbo-Croatian. The mediators confirm that the vast majority of patients speaking these languages are of Roma origin, mainly coming from former Yugoslavian Republics. They describe their added-value as reducing the consequences of Roma migrants' lack of linguistic skills and addressing health professionals' fear of misunderstandings due to cultural differences.

The health mediation service operates in the following ways:

- Mainly on demand: an appointment is fixed in advance, during opening hours; it can also be directly scheduled after a consultation in the hospital for a follow-up visit;
- In case of emergencies;
- Via videoconferences;
- In partnership with Kind & Gezin and ONE, during previously set consultation hours.

Besides consultations, mediators also organize information sessions on demand for health professionals to explain the cultural specificities of Roma, especially in the field of sexual and reproductive health (birth control, post-natal behaviours, breast feeding, nutrition habits, etc.).

5.1.3. Intercultural Mediation Unit at the “Citadelle” Hospital in Liège

The public hospital “Citadelle” appears to be one of the most proactive health institutions – committed to diversity in its different forms and engaged in a number of related initiatives.

➤ “Citadelle au Pluriel” initiative

The hospital Citadelle wants to reflect the diversity of society among its patients, visitors, and staff. It conveys values of solidarity and respect. In 2009, hospital president Marie-Claire Lambert, signed the Charter on Diversity in Enterprises in Wallonia. By this act, the hospital communicated its commitment to equal rights, respect of diversity and non-discrimination of patients, visitors, members of staff or partners.

It is in this context that the project “Citadelle au Pluriel” was created. Its philosophy is to consider the diversity of patients, visitors and personnel (regardless of their culture, origin, convictions, sexual orientation, age or disability), as a strength and an added value. This project is also based on the respect of democracy and human rights and is inspired by two former projects: “Hospital without racism” and “Humanization of the hospital”.

It was initiated directly by employees of the hospital concentrated mainly in the Human Resources Department. They propose different focuses and in particular to:

- Organize awareness-raising campaigns on diversity, its different forms and its benefits;
- Emphasize the respect for diversity within the hospital;
- Value and encourage experience-sharing between senior and new employees;
- Modify selection procedures in respect of diversity, etc.

In 2009, following the first campaign of Citadelle au Pluriel: "If we respected our differences?" the hospital was awarded a prize in a competition on Diversity and Human Resources in Wallonia.

➤ **“DiverSanté” project**

This project on Diversity and Health (combination of “diversity” and “santé” in French), developed from 2013 to 2014, is specifically focused on Roma migrants and Travellers. Its aim is to explain the cultural background, origins, and specificities of the Roma culture. The project began as a response to misunderstandings, tensions, and apprehensions stemming from Roma visits to the hospital, due to lack of cross-cultural understanding and information rather than actual problems.

In the course of the project, a series of activities have been designed to raise awareness and provide information about the Roma culture through:

- Projection of documentaries during lunch breaks;
- Exhibitions;
- Festival for children;
- Preparation of a documentary by health mediators working with Roma;
- Closing conference.

In order to get a precise expertise in this field, the hospital cooperated with the “Centre de médiation des Gens du Voyage” (Mediation Centre for Roma and Travelers) based in Namur. The Centre helps with the preparation of activities and the dissemination of information to a wide audience, covering both children and adults.

5.2. Definition of intercultural mediation⁸⁷

Intercultural mediation in health care is a relatively recent phenomenon. Therefore it is not surprising that there is a lack of consensus within the scientific community and among stakeholders on the definition of this concept. However, there is broad agreement that the fundamental mission of intercultural mediators is to improve the accessibility and the quality of care as much as possible.

Intercultural mediation can be defined as a set of activities that are designed to mitigate the negative consequences of language barriers, sociocultural differences and tensions between users and providers in health care settings. The ultimate goal is to create a quality care package and improve the accessibility and quality of care (outcomes, patient satisfaction, patient rights, patient safety, etc.) or equivalent for all patients – nationals, Europeans, or migrants from third countries.

⁸⁷ The following section is based on the “*Guide pour la médiation interculturelle dans les soins de santé*”, provided by the Mediation Unit, FPS Public Health.

Besides the objective of overcoming the language and cultural barriers, an important dimension of intercultural mediation is to facilitate the therapeutic relationships between patients and care providers.

The intercultural mediator is a member of the hospital staff and a member of the team within the institution responsible for treatment and care. This implies that there are a number of ethical dimensions to their work, including professional secret, transparency and impartiality.

5.3. Fundamental principles and missions of intercultural mediation in Belgium

A successful intercultural mediation leads to a situation where the negative effects of the barriers described previously have disappeared and no longer impact on the quality of care. This should enable the care providers to give the same care to nationals and foreign patients.

In principle, the intercultural mediator should not intervene more than necessary in the relationship between the care provider and the patient, in order to maximise the patient's autonomy.

The main tasks of an intercultural mediator include:

- Interpretation;
- “Culture brokerage” or cultural decoding;
- Listening and support;
- Conflict mediation;
- “Advocacy” or defending the rights and interests of the patient;
- “Outreach” provision;
- Information.

The following description of the different dimensions of intercultural mediation is informed by the experiences, testimonies and observations of:

- **2 intercultural mediators based in Liège (Citadelle Hospital), from Serbia and Croatia;**⁸⁸
- **1 intercultural mediator of Roma origin from Romania, working for the NGO Foyer.**⁸⁹

5.3.1. Interpretation

Interpretation means **substitution of a message** from the source language to a message in the target language. This type of interpreting requires accurate and complete translation of messages of different interlocutors to a conversation.

While the intercultural mediator accomplishes his/her task, the responsibilities of the different stakeholders in the care process remain very clear: the intercultural mediator is responsible for the interpretation and the care provider is responsible for the proper conduct of all other aspects of care.

⁸⁸ Study visit at the Mediation Unit, 26 May 2014.

⁸⁹ Interview at the Intercultural Mediation Unit, 22 May 2014.

Obviously, there is also a responsibility for the patient to communicate their questions and concerns clearly in the conversation, to provide correct information and to follow the prescribed treatment for the success of the medical intervention.

Mediators often recognise that in most cases, they adapt the message to make it understandable and may not always translate everything to avoid making the message too complex. Thus, their mission goes beyond a simple word for word interpretation.

“Our mission is far more than a simple interpretation. The more experienced we are, the more we know how to adapt our intervention, so it can be the most useful and efficient.”

In this sense, interpretation may also be seen as a larger mission and includes **facilitation and clarification of misunderstandings**.

This refers to facilitation of the contact between the care provider and the patient. It is clear that in many cases, care providers do not have the necessary cultural skills to provide health care to those patients in the most efficient and effective manner. In addition, many patients do not have the necessary skills, for example due to lack of knowledge with regard to the medical terminology and the health system (health literacy), to properly participate in the health-care process, regardless of language barriers.

Clarification of misunderstandings implies that the intercultural mediator will report to stakeholders when there are mix-ups and/or confusion, attempting then to clarify by steering the interview in the right direction. It should be noted here that the term “misunderstanding” does not refer to a conflict but to a situation in which the interlocutors do not understand each other.

5.3.2. Culture brokerage – cultural decoding

Beyond their help with interpretation, intercultural mediators have a “culture brokerage” role, which can be equated to “managing cultural differences”. This means that when the intercultural mediator feels that cultural differences make communication, and therefore the health-care process, more difficult, she/he will explain it to the care provider.

Cultural decoding means explaining the hospital and doctor culture to the patient and vice versa – explaining the cultural background of the patient to the doctor. Such an explanation can be particularly necessary when accurate and complete interpretation does not lead to a mutual understanding. In this regard, it is important for the intercultural mediator to raise the awareness of the care provider on cultural factors that have significant impact on the therapeutic relationship ahead of the intervention: for example, the difficulty for a patient to talk about some themes directly or matters that can be taboo in the presence of a person of the opposite sex.

Finally, intercultural mediators may, in the course of cultural decoding, interpret the meanings and feelings that certain expressions or acts may raise for some patients. This can apply to either verbal or non-verbal behaviour. Interpretation of these elements must obviously be

made with the greatest of caution. Furthermore, the mediator and the care provider should be aware that any behaviour or emotional experience of the patient is only partly determined by the culture. It should not be forgotten that the intercultural mediator does not necessarily belong to the same culture and may not have a detailed knowledge of the principles and practices prevailing within all cultural communities.

If a mediator is of Roma origin, this shared ethnicity does not automatically mean that he or she is necessarily familiar with all the beliefs, values, and mores within her/his own ethnic group. In addition, there are a lot of differences among the Roma themselves.

Personal and family factors, as well as intra-cultural variations may imply that the intercultural mediator does not have a thorough knowledge of this culture. This means that in some cases the mediator may not be able to identify and explain the cultural barriers. Besides, providing cultural information has to be done carefully to avoid presenting a stereotypical image of the patient. Interviewed mediators admit that health-care providers tend to look for explanation on cultural grounds of all behaviours, while sometimes a difficulty in understanding can be due to reasons which are shared among all patients (fear of illness, pain, etc.).

Intercultural mediators currently employed in public hospitals are not of Roma origin and they do not consider it as a barrier or a difficulty for their work. However, they are willing to exchange with Roma mediators in other countries, share their experience and get more qualified in their work. Accordingly, they also have opportunities to attend various training courses (for example developed by Foyer).

Examples of cultural decoding:

➤ **Nutritional habits**

If a Roma is hospitalised, he/she will likely receive a substantial amount of food from family members. As Roma patients are often hospitalised for diabetes, their treatment requires strict nutritional restrictions which are not always respected or understood by the family members. If health-care providers are not aware of this, it may unwittingly be seen as a sign of disrespect.

➤ **Family visits**

Pentecostal Roma migrants have a tradition of praying frequently with their family. These habits result in frequent visits with numerous groups coming to the hospital, which may be disturbing for health professionals. By being aware of these practices, medical staff can be better prepared and more tolerant.

➤ **Habits in caring for newborns**

Post-natal care is rich in differences and specific habits which may be misunderstood. For example, nutritional habits differ; whereas in Belgium it is not recommended to feed newborns yoghurt with sugar or to breast feed for too long, just the opposite is true in Roma customs.

➤ **Lack of professionalism in health care in countries of origin**

Roma patients often have had negative experiences in their countries of origin; they might have been confronted with corrupt health service providers for example. They might therefore want to reward a doctor with cash, not realizing that Belgian health

professionals have adequate salaries and provide quality service without the need for additional “encouragements”.

5.3.3. Support care providers and patients to assume their respective roles

The third facilitation task is to support or assist patients and care providers in assuming their role in the most effective manner possible, in order to obtain optimal results. In this respect, it is closely related to the management of cultural differences.

Medical jargon, even when carefully translated, can prove difficult to understand by patients unfamiliar with medical terminology. The patient may have a low level of education or find the interpretation unclear because there is no equivalent term in their language. In this case, the intercultural mediator must develop strategies that will increase the chances of mutual understanding. She/he may ask the care provider to simplify his discourse, which leads to what is essentially a kind of a brokerage between the doctor’s and the patient's cultures.

“Support for patients is largely subject to the doctor’s willingness to clarify a medical matter to us. As we are not care providers, we need to understand what is being said in order to interpret it correctly. Some doctors are less cooperative than others in providing exhaustive explanations, even though they would have been required to do so were the patients able to communicate directly.”

For example, a patient may not know how to make an appointment with a doctor or a physical therapist, or what they are expected to take with them to the hospital. Intercultural mediators can help in setting up appointments or provide patients with the necessary information to do so.

“At the intercultural mediation unit, we are often in charge of making appointments, patients are used to calling us and we schedule the appointment with the doctor afterwards. It is much easier for everybody this way.”

The extent to which these tasks can be performed by the intercultural mediator is highly dependent on her/his communication skills and empathy. On the other hand, the health-care provider’s aptitude to cooperate is also critical. Facilitating communication is often more difficult than direct interpretation; it puts more weight on the shoulders of the intercultural mediator.

In addition, intercultural mediators provide practical support to the patients and their family outside the direct interaction with health-care providers. For example, they might support the patient through the various stages to access health care, provide the patient with an explanation of the documents, help to fill some documents, explain the inner-workings of the hospital or direct the patient to any relevant service.

Intercultural mediators may, in consultation with the nursing staff, have individual contact with the patient, but this approach remains rare.

“As the procedures are too complex, we direct patients toward relevant institutions and cooperate closely with the social services of the hospital. For this reason, we often intervene during a social inquiry at the hospital, especially if a patient does not have health insurance and is required to go through the procedure independently.”

Intercultural mediators performing this task pursue the following objectives:

- Identify challenges in taking care of individual patients;
- Provide practical assistance in completing documents: this task can be performed without the care provider only if these documents are easy to complete by patients speaking one of the national languages, without any help from a care provider;
- On request from a care provider, try to convince a patient in a culturally relevant/adequate manner about the need of a treatment, if a previous interview failed;
- Establish a relationship of trust that ensures collaboration with the care provider goes well;
- Inform the patient about the health-care process or any medical issues that they do not understand and have no knowledge, due to language barrier, their low level of education or cultural background.

5.3.4. Conflict mediation

Conflict mediation refers especially to contradictory values, as ignorance of respective codes and cultural values can lead to misunderstandings. The mission of the intercultural mediator is to then verify whether the conflict is based on language barriers or cultural misunderstandings. If this is the case, the mediator can try to resolve the issue by addressing its origin.

Mobilization of intercultural mediation helps to develop solutions to situations of misunderstanding, and is based on the principle of listening and looking for the origin of a misunderstanding and the meanings of different attitudes and behaviours.

“In our work, I would rather talk about “conflict prevention”, than “conflict mediation”. It is clear that we have to stay as neutral as possible, but thorough preparation ahead of an appointment can ensure that it goes more smoothly. For example, we know which care providers are more cooperative and more open-minded when it comes to foreign patients. If we have the possibility of impacting on this choice, or even to make the appointment ourselves, we will naturally opt for a doctor who is willing to work with mediators and actively engage with migrant patients.”

“In order to prevent conflicts, we do not interpret everything, in a strict sense. Sometimes it is neither useful nor necessary to translate inappropriate remarks to patients, for example about their lack of motivation to learn languages, or about their unhealthy habits such as smoking.”

5.3.5. Advocacy or defence of rights and interests of the patient

The mediator should seek to defend the rights and interests of patients if she/he finds that they are victims of racism or discriminatory behaviours.

In general, this means that a third person – in this case the intercultural mediator – defends the cause of the patient by setting aside their own impartiality. In this sense, the intermediary receives a mandate to take the initiative by asking questions or taking actions when either the quality of care or the patient's dignity is at stake. Patient advocacy can take place peacefully, without unnecessary conflict; but it can also happen in a context where hostility or open conflicts arise.

Putting aside impartiality to deal with patient advocacy has been controversial for a long time in the world of medical interpreting. It is often argued that the mediator is not necessarily in the best position to identify the interests of a patient, though this is a fundamental prerequisite for defence or advocacy.

If intercultural mediators notice that care providers have made a mistake when formulating their message or have missed some essential elements or information, they can highlight this in the name of the patient's interest.

If a patient's dignity is compromised by disrespectful treatment from a care provider (aggressive behaviour, discrimination, racism), intercultural mediators will, to the appropriate extent, talk to the care provider inviting them to alter their behaviour accordingly.

If intercultural mediators have witnessed racism or discriminatory behaviour or other forms of harassment in health care, they have the right and even the duty to inform the manager responsible for taking appropriate measures.

“As we try to anticipate and prevent conflicts, situations which require advocacy or defense of rights are very rare. However, it already happened to me that a doctor said “Here comes the patients’ advocate!” This is not our objective, there should be a balance between all the parties and doctors shouldn’t feel confronted by us.”

5.3.6. Information

Mediators trained in this task keep patients informed during information sessions which are prepared and provided in collaboration with care providers. This also offers the opportunity for a migrant/foreign patient to share with a qualified professional any concerns they may have.

5.4. Challenges related to the work of intercultural mediators in Belgium

Based on previous developments, intercultural mediation appears to be one of the most effective means of dismantling health-care access barriers, while at the same time improving the quality of health-care services. However, this view is not unanimously shared among care

providers, and intercultural mediators can thus find themselves confronted with unexpected obstacles in their work.

5.4.1. Lack of cooperation

Even if mediators have proven to be instrumental in facilitating communication and optimizing the health-care process, they still face some resistance from health-care providers. This has been the case since the early stages of the programme.

First, doctors feel that appointments which take place in the presence of mediators require additional logistical efforts and are therefore more time-consuming. In addition to the added complexity of setting up appointments for three parties, the intervention itself takes longer due to the need for interpretation.

Second, some care providers do not feel comfortable if a “third party” is present while they do their work, and they may see it as a kind of intrusion which does not make them feel at ease.

Finally, some health-care providers may feel that patients assisted by cultural mediators are given a disproportionate amount of attention, and that they are being overindulged in vain.

All of these attitudes may challenge the future development of mediation activities and make the mediator’s mission more difficult.

5.4.2. Lack of recognition

The recruitment process of mediators in public hospitals is set by the Article 80 – 2 of the Royal Decree of 25 April 2002. The candidates must have completed a university degree in the field of medicine, para-medicine, anthropology, translation, or interpretation. In addition, they have to have undergone training in the field of intercultural mediation or be able to prove a relevant experience of at least two years in this field. Candidates with a secondary school diploma can also apply by providing a training certificate and/or experience in the field of intercultural mediation which has to be recognized as being equivalent to a university degree.⁹⁰ In some cases, i.e. if a candidate with relevant language skills does not fulfil required educational background, a specific request can be made by the hospital to FPS Public Health, Intercultural Mediation Unit to waive the diploma requirement. The final stage of their recruitment process takes place at the same unit which assess the would-be mediator’s interpretation skills.

Despite these substantial requirements, as mediators do not have specific medical qualification, they can be undervalued by other health professionals. Their profession is still not known enough and do not exist on a large scale which often leads to a lack of recognition for their work. Furthermore, some hospitals only have one intercultural mediator and this can result in a feeling of isolation for the mediator.

⁹⁰ There are currently no common trainings for intercultural mediators besides some scattered courses mostly by CSOs, the two courses of this kind previously provided in Genk and Hasselt in Flanders have been abolished.

6. CONCLUSIONS

The health-care system in Belgium has continuously been adapting to the changing socioeconomic realities and needs, in search of appropriate solutions to the issues faced by vulnerable groups, such as low-income patients or undocumented migrants. Health services also have had to adapt to the increasing diversity of the patients' cultural backgrounds and the frequent communication challenges this creates. In spite of these significant efforts, concrete policy developments related to the inclusion of Roma remain at an early stage.

Framework objectives

Concrete framework for further action

The National Roma Integration Strategy, adopted in February 2012, is the only policy commitment at the national level that specifically addresses Roma. The strategy requires a number of adaptations in order to provide a detailed plan for further action in health care and other fields, with precise quantifiable objectives and monitoring mechanisms. To this end, the European Commission recommended that Belgium should **“further work to clarify the goals, indicate how progress will be evaluated and develop an action plan with detailed measures.”** If these recommendations are seriously taken into account, they could add significant value to the NRIS and also support the coordination of relevant actions that were implemented in the field before the adoption of the strategy. In addition, involvement of representatives from a wide array of stakeholders, including municipalities, civil society organizations, and professional experts has to be ensured during the entire process, from decision-making to implementation and monitoring of the strategy.

Data collection on Roma health

Due to a strict interpretation of the EU Data Protection Directive, there are no official statistics on the various ethnic groups living on Belgian territory. Consequently, there is no research available on Roma health at the national level. However, such data collection seems to be encouraged by the Ministry of Health in the final ETHEALTH project report in 2011. The report includes recommendations to adapt the health-care system in Belgium to the specific needs of migrants and ethnic minorities. 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. Accordingly, it appears necessary to **encourage further data collection on Roma health, fundamental for relevant policymaking and monitoring, by respecting data protection rules which make sensitive data collection possible.**

Operational objectives

Towards accessible health-care services

Roma access to health services is closely related to their residence status. Roma nationals and Roma with residence permits can benefit from the same provisions as any other Belgian national, although their access to health insurance and health facilities is often challenged, mainly by their nomadic living conditions (proof of residency, distance from facilities, etc.).

Roma EU citizens without residence permits are considered to be undocumented migrants and as such benefit from the same provisions. However, the procedure remains more complex

for EU citizens than for undocumented migrants from third countries, which in turn leads to uninsured cases and scenarios frequently pointed out by HPs and social workers (i.e. Appendix 19). This results in different health-care treatment for European and third countries migrants, as EU citizens are entitled to similar health-care provisions only after three months of stay without a residence permit.

Patients without health insurance place a significant burden both on emergency services in public hospitals and on free of charge facilities, such as Free Clinic or Médecins du Monde consultations. In conclusion, it is necessary to **minimize situations without health-care coverage, which would lead to a more equitable and cost-effective health-care system**. For example, HPs call for an “extension” of the provisions available for non-accompanied minors to all migrant minors, in the way that their right to health care would not be determined by the residence status of their parents, but would depend on actual school attendance. This approach would not only solve the situation of a number of Appendix 19 Roma families, but would also cover all migrant minors in need of health care.

In addition, while the EU equality legislation has been correctly transposed to Belgian law, available procedures for victims of discrimination remain complex and difficult to access for vulnerable groups such as Roma populations. Further efforts need to be made to make them more operational and to make the complaint filing process more accessible.

Support to policy developments on Roma health

As part of the NRIS, the **intercultural mediation programme appears to be the most relevant and effective approach for Roma communities, in facilitating access to health care and improving communication**. Identified as a crucial good practice, the programme deserves to be **further developed and rolled out in other health institutions, besides hospitals and the unique civil society service of this kind at Foyer**.

Independently from the NRIS “experts by experience in poverty and social inclusion” work in various departments of the federal administration and connect policymaking with realities from the field. An **expert by experience of Roma origin** works with the team involved in the NRIS implementation, and two other experts work in public hospitals and provide support to patients experiencing poverty and exclusion. Further valorisation of their contribution can ensure future policies to remain adapted to the on-field realities.

While policy commitments at the regional and local level do not focus specifically on Roma health care, the improvement of their health conditions or access to health care is often included in broader initiatives. Several municipalities in Flanders and the Brussels Capital Region hire a variety of professionals to work with Roma (“bridge figures”, “neighbourhood stewards”, etc.). The municipalities need to **develop a more systematic way of supporting and funding those professionals**, since at present this practice remains scattered and often solely project dependent.

Develop and adapt relevant initiatives in the field of health

The missions and objectives of two public health institutions, ONE and Kind & Gezin, do not focus specifically on Roma, but contribute to the main strategy objectives, in particular by raising awareness and prevention, improving access to prenatal/postnatal care, providing advice on sexual and reproductive health, and ensuring access to vaccination. Nevertheless, they are not able to provide outreach vaccinations, and so their involvement is limited to preventive and non-curative missions.

The nurses of ONE and Kind & Gezin, as well as other HPs confirm that a mobile approach – implemented directly on sites where vulnerable Roma populations live or congregate – is often the most effective way of directly reaching Roma communities. Accordingly, it is imperative to **adopt a mobile and proactive approach in different health services, be they preventive or curative**. Cooperation between stakeholders such as HPs, social services, and municipalities also needs to be encouraged in this field.

Finally, it is fundamental to **develop adapted training opportunities for HPs dealing with vulnerable groups and specifically with Roma, and to encourage the further implementation of intercultural mediation efforts to improve overall communication**.

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