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

CZECH REPUBLIC

A multi-stakeholder perspective report on 2005–2014 developments

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CONTENTS

ACRONYMS

CR	Czech Republic
Council	Government Council for Roma Community Affairs
Committee	Committee on the European Platform for Roma Inclusion and Decade 2005–2015
CZK	Czech Crown – local Czech currency
Decade	Decade of Roma Inclusion 2005–2015
EC	European Commission
ESF	European Social Fund
ESIF	European Structure and Investment Funds
FRA	Fundamental Rights Agency
MoH	Ministry of Health
MLSA	Ministry of Labour and Social Affairs
NAP	National Action Plan for implementation of the Decade of Roma Inclusion 2005–2015
RHSA	Roma Health and Social Assistant
NRIS	National Roma Integration Strategy
NMCD	National Monitoring Centre for Drugs
NGO	Non-Governmental Organization

EXECUTIVE SUMMARY

The Government of the Czech Republic did not pay much attention to Roma health issue in the National Roma Integration Strategy (NRIS) in the Czech Republic as implemented during Decade of Roma Inclusion 2005–2015 (Decade). The Ministry of Health did not consider the conceptual creation of NRIS, nor in its implementation to be an important part of Roma integration policy and a national health policy as well. Employment, housing, and social services agendas of NRIS dominated. This fact also explains that EU funds are not often used to remove barriers faced by Roma in the public health-care system and to improve Roma health. There is a widely shared belief that an improvement in this respect will also improve the health of Roma. The only project specifically dedicated to health aspects of Roma integration, and supported by EU funds was the Roma Health and Social Assistant (RHSA – pilot project which is basically the Czech form of the Roma health mediation project. regrettably it has not yet been integrated in the Czech health-care system or standard social services agenda, despite successful pilot testing and partial implementation in practice.

The available data indicate significant Roma health inequalities and disadvantages compared to the general population. Current knowledge about Roma health and health determinants can be summarized and/or characterized as follows:

- Roma life expectancy is about 10 years lower than Czech national majority; infant mortality is two times higher than the national average. Roma children are about 3 per cent of all live births but 5 per cent of all stillbirths;
- Higher than national average fertility rate with higher proportion of teenage mothers and significantly lower birth weight;
- There are striking differences in birth outcomes between Roma and non-Roma mothers: the causes are complex but largely socioeconomic; mother's education made the largest contribution to the ethnic differences;
- High prevalence of cardiovascular diseases and type 2 diabetes;
- High prevalence of back pain and mobility disorders starting at a relatively young age higher level of limitations in daily activities due to poor health;
- Higher incidence of infectious diseases, especially hepatitis A and B; and in isolated settlements, greater risk of TB, sexually transmitted diseases, and HIV/AIDS;
- Obesity and poor nutrition, high prevalence of smoking;
- Drug addiction among youth and children, esp. in socially excluded localities;
- Poor oral health, poor oral hygiene, lower number of visits to dentists;
- Lower utilization of preventive and dental services and higher utilization of primary care, esp. in older age; postponing visits to doctors at the later stage of the disease.

The causes of the above listed differences are complex but largely socioeconomic – factors such as poverty, poor housing conditions (especially in socially excluded areas), and low health literacy make the biggest negative impact.

The legal framework of the Czech health-care system is generally considered equitable and well developed. As the overwhelming majority of Roma on the territory of the Czech Republic are permanent Czech residents – Roma have guaranteed full legal entitlement to health care. Nevertheless, in everyday life Roma have to overcome many other obstacles which make their access to health-care services much more challenging when compared to the majority.

Research indicates that Roma use preventive and dental services significantly less than the population at large, although I could not confirm this for other types of medical care. However, **financial burden stemming from co-payment requirements** makes barrier especially for pharmaceuticals, which are often connected with co-payment paid out of pocket by patient. In this context, the recent decision of the Government of the Czech Republic to abolish significant part of co-payments in the health care for all patients is of great importance, and with the potentially positive impact of rendering Roma access to health care more affordable.

Discrimination and prejudices are as damaging to the quality of health-care services for Roma as they are, regrettably, common. Discrimination does not mean direct refusal to provide care. It can take different veiled and subversive forms:

- Reluctance of some primary care physicians to register Roma patients to take care continuously about them (more often at dentists and gynaecologists);
- Express use of professional jargon and low responsiveness in communication, resulting in Roma patients´ emotional distress;
- General condescension and haughtiness, lack of respect of Roma and their cultural identities, treating Roma patients as second class citizens.

To address obstacles and barriers Roma have to face, stakeholders recommended that the following measures and initiatives be incorporated into the NRIS for the next period:

- To ensure development and operation of Roma Health and Social Assistants (health mediators) in socially excluded areas;
- To improve local accessibility of health-care services for Roma inhabitants in socially excluded communities;
- To ensure registration of Roma patients at primary care providers (especially at GPs, dentists, and gynaecologists);
- To eliminate discrimination and to monitor complaints of Roma patients and related problems documented by monitoring organizations such as non-governmental organizations (NGOs); Roma discrimination has to be addressed through collection of relevant data, by raising awareness of the Roma rights and issues, and by strengthening professional training programmes in medical law and ethics for health-care personnel;
- To ensure that Roma community is better informed on health-care system organization and public health insurance;
- To identify specific health risks and to develop relevant health promotion programmes targeted especially at children and pregnant women. To build up and to incorporate Roma health topics into the graduate/postgraduate educational curricula for health professionals; to improve health professionals' sensitivity and responsiveness to Roma health needs (adequate and culturally appropriate communication, sensitivity to cultural specificities, etc.);
- To support epidemiological studies on Roma health and health determinants in order to develop an evidence-based Roma health promotion strategy.

For the successful implementation of above listed measures, **a greater involvement of the Ministry of Health** in Roma health issues is needed. Some overall health system regulations (e.g. re-definition of the role of all primary care providers, specification of the GP´s responsibilities in paediatric care, etc.) should be considered.

As another “condition sine qua non” for an effective and meaningful Roma integration strategy (and the successful fulfilment of NRIS objectives), we need a systematic, reliable, and statistically valid way to collect ethnic data. Only a comprehensive data collection strategy would allow us to objectively examine, improve, and monitor the Roma situation in all domains of social life, including health care. Monitoring of NRIS implementation has to be done according to clearly and comprehensively defined and measurable indicators. In the last decade, we have failed to achieve much progress in this respect, so now is the time for urgent and positive change. The monitoring component of the NRIS implementation will be incorporated in the NRIS 2014–2020 as one of the priority.

1. INTRODUCTION

The main goal of this study is to collect, review, and analyse available data on Roma health status and health services usage patterns, and to report on related policy developments with focus on the NRIS and action plans implemented in the Czech Republic during the last decade. The study is based on a qualitative methodology implemented in three phases: desk research, semi-structured in-depth interviews with twenty selected stakeholders/experts in the field, and a pertinent case study. The key activity was the stakeholders' survey. Relevant national, regional, and local authorities, NGO representatives, human rights and health professionals were on the list of interviewed stakeholders. Some other experts such as the expert in Roma data collection and expert in postgraduate medical education were additionally interviewed to get details and to clarify investigated topics. Except for the specific opinions and statements obtained from stakeholder's interviews, the acquired information was also verified via other literature sources. The case study is an analysis of the history, development, and current "state of the art" of the project "Roma Social Health Assistant" (RSHA). The case study provides an insight into the history and current situation in a practical implementation of the project of health mediation within the NRIS in the Czech Republic, its successes and failures.

In the conclusion section, I outline some specific recommendations and priorities for the near future. Priorities are defined not only in terms of their relevance, but also depending on affordability and feasibility in the current political and social environment.

2. BACKGROUND INFORMATION ON THE ROMA IN THE CZECH REPUBLIC

The Roma people are Europe's largest ethnic minority. The term "Roma" is widely used to include Roma, Sinti, Kale, and other related groups in Europe, including Travellers and the Eastern groups, Dom and Lom. Contrary to popular belief, the Roma are not nomadic, except to a limited extent in France, Italy, and Greece. The Roma in Central and Eastern Europe, including the Czech Republic, were forcibly sedentarized by governments under the Iron Curtain communist regimes.

In the Czech Republic, Roma populations were systematically hunted and exterminated by Nazi German mobile killing units and in camps such as the ones at Lety, Hodonín, and Auschwitz. Nineteen per cent of native Romani died, and so present day Czech Roma are mostly post-war immigrants from Slovakia or Hungary, or the descendants thereof.

The population of Roma in Europe is estimated at about ten to twelve million, in the EU – about six million, and in the Czech Republic – up to 250,000, although estimates vary significantly from one source to another.

The Roma are the most socially excluded ethnic group in the Czech Republic (CR). Roma people are the poorest, most marginalized, least educated, and most frequently unemployed (over 50% and on the rise) (Vláda CR, 2013b). Though the Czech Roma population is ethnically, culturally, and socially diverse, the majority population negatively perceives Roma as a single and more or less homogenous group. Since the early 1990s the socioeconomic situation of the Czech Roma has been steadily worsening. Low education attainment, widespread

discrimination, and their negative media image are among the most direct causes why Roma are not able to participate proportionally in the labour market. Many Roma are at risk of exclusion and social isolation, as a significant percentage of them lives in segregated enclaves with limited opportunities for outside communication or social exchanges. One stakeholder in interview stated that Czech society is divided between "Roma and non Roma."

Notwithstanding, about two thirds of Roma are to some extent integrated into society and their lives do not differ substantially from the lives of poorer Czechs. However, the number of Roma living in socially excluded[1] localities is increasing. It is estimated that currently about 80,000–100,000 Roma live in social exclusion in around 400 localities *(NRIS 2014–2020 proposal*, Vláda CR, 2014a*).* In the last few years, a shift of Roma from big cities to small villages in the countryside has been observed by governmental Agency combat to Social Exclusion and by the NGOs assisting to Roma; the reason being availability of cheap housing in somewhat rundown apartment buildings that are rented mostly to poor Roma – sometimes called "Roma hostels."

The Roma's relative isolation and the lack of opportunities for integration can be traced to childhood,[2] and can frequently be a source of the interrelated prejudices on the part both of Czechs and the Roma. Providing employment opportunities for adult Roma and abolishing the segregation of Roma children[3] are the best way to speed up the integration process. It seems that in recent years, the situation improves. For example, integration of Roma children into mainstream schools has improved as measured by the decline in the proportion of Roma children educated in so called "practical" schools (Ombudsman's survey, 2012). Nevertheless, the Roma are still considered undesirable neighbours by majority society (Centre of Public Opinion Research, 2010). The media regularly presents the Roma as a socially non-adaptable population living on the dole, while often overemphasizing and sensationalizing the Roma criminality issue.

In sum, the Roma population in the Czech Republic is trapped in a vicious circle of unemployment and poverty. High unemployment gives the impression that Roma do not want to work and prefer to rely on social benefits. That stigma is a crucial factor perpetuating and reinforcing inaccurate and negative public attitudes towards the Roma and is a clear hindrance to integration (*Report on Roma minority in the Czech Republic, 2010,* Vláda CR, 2011b). In addition, the traditional Roma culture and related lifestyles are viewed as rather distinctive and outside of the mainstream by both groups, Roma and Czechs, which may in fact contribute to the persistent segregation between them (*NRIS 2014–2020 proposal,* Vláda CR, 2014).

Internationally, the Roma situation in the Czech Republic is being eyed with concern. The Roma theme is considered central human rights issue of the Czech society (NRIS 2014–2020,

[1] As the socially excluded localities are understood locations or part of them where inhabitants suffer from severe social deprivation, they are indented, mostly unemployed and live in isolation from others. Such locations are negatively perceived by others as "bad addresses"".

[2] As well known, since 90s´ segregation of Roma children was introduced and practiced, see verdict of the ECHR Czech republic versus D.H. and others.

[3] "Segregation "in this context means that Roma children create a significant part of children being educated in so called "practical schools" which are dedicated to children with learning disabilities and less scope of knowledge is required there. Nevertheless, placing a child in this school is possible only with consent of their parents.

proposal, Vláda CR, 2014). Undoubtedly, some negative events[4] which occurred in recent years had a negative impact on the effort for a friendly coexistence between the Roma minority and majority population. And so, despite some partial successes and stated efforts conceptualized in a series of strategies and initiatives, the Czech Republic has thus far come up short in offering and implementing practical solutions to problem of Roma integration into Czech society.

[4] Such as for example anti-Roma protests in northern Bohemia or sporadic attacks on Roma.

3. ROMA POPULATION IN THE CZECH REPUBLIC IN NUMBERS

There is no precise data available on quantitative and structural characteristics of the Czech Roma population. Since the early 1990s, the number of citizens reporting Roma ethnicity in the national census has been decreasing.[5] By the last census there are only 5,200 inhabitants who have self-declared as Roma, with another 7,951 reporting Roma nationality in combination with other nationality, usually Czech or Slovak (ČSÚ, 2014). In the same national census, however, about 40,000 individuals identified the Romani language as one of their mother tongues. In fact, the real number of Roma is significantly higher – according to expert estimates, there are about 200,000–250,000 citizens of Roma origin living in the CR (Vláda ČR, 2013b). There are several Roma groups, the largest one being the so called "Slovak Roma," who originally moved to the CR after World War II and who comprise three quarters of the Roma population. The second group (about 10% of all Roma) is Roma Vlachika, and it is widely considered the most socially isolated Roma group in the country. The smallest group is Sinti – which is represented only by several families.

In terms of demographic structure, Roma constitute a progressive (i.e. expanding) type of population with a typical higher fertility rate and an early pregnancy age. Roma population can be illustrated by the progressive population pyramid model, wherein the population has high birth and death rates, as well as a low life expectancy. Children, who represent by far the highest proportion of Roma population, put a strain on the adult population to provide enough income, education, and services to this large youth group. This type of pyramid is often seen in developing countries, where poverty is experienced due to the high dependency ratio. On the other hand, people over 60 are represented significantly less among the Roma than in the general population (Kalibová, 2003; Sastipen, 2009). Despite, demographic aging is also a phenomenon at least partially affecting the Roma population. Roma reproductive behaviour more or less follows the general Czech pattern of decreasing number of children, though at a slower rate than in the general population (Sastipen, 2009). Although current valid data are not available it can be estimated that age structure of Roma population is changing especially in terms of lower representation of youngest age cohorts.

[5] The reluctance of the Roma to declare their ethnic heritage is often stemming from insufficient awareness of legal differences between ethnicity and nationality, rejection of Romani identity due to perceived stigmas attached to it and fear of persecution (Kahanec, 2009).

4. HEALTH STATUS OF ROMA IN THE CZECH REPUBLIC

4.1. Availability of data

Official statistics do not provide any data on Roma. Czech statistical legislation, namely the Law on State Statistics Service No. 89/1995 Coll. does not enable to collect ethnic data in routine statistics. In addition, information relating to health in general is treated as "sensitive data" and its collection is further limited.[6] There is some fear that ethnic data could lead to further discrimination. However, lack of data on minorities in the Czech Republic is perceived by the many professionals[7] dealing with Roma issue as a problem to be solved. It was also discussed in the wider EU context. The European Commission against Racism and Intolerance in its monitoring reports recommended that Czech Republic consider ways to monitor the living conditions of minorities, since without relevant data it is hardly possible to assess the extent and causes of possible discrimination. Without specific data, measuring the impact of corrective actions remains limited (ECRI, 2004 and 2009). This applies in full on health and health care data.

Roma health is significantly worse compared to the majority. Life expectancy is 10 years lower and infant mortality is 2.5 times higher than national averages. Cardiovascular diseases, type 2 diabetes, mobility disorders and respiratory diseases are among the most frequent health problems. Mental disorders are on the raise. Some infectious diseases such as hepatitis are more frequent among Roma compared to major population. Pregnancy duration of Roma women is significantly shorter, premature births are more frequent. Roma children are born with lower birth weight and are more frequently hospitalized.

Reports on Roma health are based on academic research, NGO provided information, and expert opinions (mostly by doctors who treat Roma patients). Many experts agree Roma health is significantly worse than the health status of the majority (Nesvadbova, 2003; Davidova 2010; Hajduchova and Urban, 2014). However, this cannot be verified using Roma mortality and morbidity data from the routine statistics, because ethnic data are not collected.

4.2. The global health indicators: life expectancy and infant mortality

Roma life expectancy is estimated by experts to be 10–15 years lower than it is for the majority, and **infant mortality** is two times the national average. Kalibová (2003) reported ten years lower life expectancy in comparison to majority in 1980s and 1990s. Latest studies indicate an even lower life expectancy for Roma population. For example, Davidová (2010) reported life expectancy for Roma men as 57 years and for Roma women as 65 years. Comparable data for the whole of Czech population in the same year show 75 years for men and 81 years for females (UZIS ČR, 2012). Roma children are about 3 per cent of all annual live births but make up 5 per cent of stillbirths, as estimated from available statistics. These indicators are significantly worse in regions with a higher percentage of Roma residents; Infant

[6] Act on Personal Data Protection No.101/2001.

[7] This opinion was also found in stakeholders' survey.

mortality in the North and West parts of Bohemia,[8] namely districts Ústí nad Labem, Děčín, Louny, Cheb a Sokolov reached 5 per cent (ÚZIS, 2012) while national average was 2.6 per cent (ÚZIS ČR, 2013). Nevertheless, such trends are not always consistent. For example, Moravia–Silesia region – where is also higher share of Roma in population[9] – is not among the regions with the highest infant mortality, although its rate does exceed the national average (ÚZIS ČR, 2013).

In sum, lack of ethnic data causes in effect means that health statistics such as life expectancy and infant mortality can only be estimated or has a character of replication of older data. Despite, there is not any doubt among experts that Roma health in terms of basic indicators is significant worse in comparison to major population.

4.3. Roma Health research studies

Over the last decade, there have been several domestic and international research surveys on Roma health status and health-care utilization (Koupilova, 2001; Nesvadbová, 2002; Rambousková, 2003; Bobák, 2005; Nesvadbová, 2009, etc.). Their methodology was predominantly based on questionnaire surveys assessing subjectively perceived health and well-being of Roma, as well as subjective indication of health-care services consumption. Socioeconomic determinants of Roma health and lifestyle issues were also investigated. In some studies, the objective data from medical records about Roma morbidity were included in order to validate the subjective perception of health and disease prevalence (Nesvadbová, 2002). In Roma populations, there comparatively more accidents, disability claims, disability pensions, and higher frequency of infectious diseases (Maryšková, 2010). The most frequently occurring conditions in the Roma population were hypertension, rheumatism, type 2 diabetes, and depression (UNDP Europe and the CIS, *2012).* As the Roma are mostly employed in physical, low qualified and low paying jobs with a placing particular stress on the body, mobility disorders and lower back pain are the most common reasons for Roma visits at primary care physicians (Kašparová, 2008). Need for treatment of mobility disorders often masks other much serious health problems. It is not uncommon that Roma patients complaining of back pain in reality suffer from long-term untreated cardiovascular disease.

Primary care physicians observe a premature aging of some Roma patients – associated with diseases which are not obvious in certain age group (e.g. type 2 diabetes in young people) as specific for Roma (Kašparová, 2008). In biomedical research, the genetic origin of some Roma-specific disorders was explored in order to enable early disease detection, better diagnostic, and quality treatment (Seeman, Šišková, 2005).

Roma health in the CR is also systematically investigated within international comparative studies. The latest aggregated data about the health of the Roma in the Czech Republic comes from the large international study Satipen (2009). Researchers examined Roma health on the basis of subjective perception of 900 respondents, and found that two-thirds of Roma

[8] As estimated by the regional Roma coordinator – in the North and West part of Bohemia proportion of Roma residents is about 8-10 per cent.

[9] Exact data is not known since ethnicity is not followed in national statistics – see 3.1.; Information on higher Roma representation in the particular locations are based on long-term experience /observations of local governments, NGOs, etc.

evaluate their health favourably (which the authors identify as a common Roma tendency). However, according to the findings, the proportion of Roma people with significant physical limitations and chronic diseases increases with age much more than in major population which is supported by the findings that Roma middle age people (45–59) perceive themselves subjectively to be unhealthy two times more often than the general population. In Roma over 60, the perception of being unhealthy is already 2.5 times higher than that of the general population (Sastipen, 2009).

Positive subjective perception of health by Roma was also found in the set of three surveys carried out in the years 2001–2009 within the framework of South Bohemia University's research project. Nevertheless, investigators also found high prevalence of cardiovascular diseases and type 2 diabetes, and they pointed out to existing discrepancies between Roma's subjective health perception and objective health status (Hajduchová and Urban, 2014).

A 2011 large-scale Fundamental Rights Agency (FRA) survey of Roma populations in the EU interviewed 64,000 Roma and 20,000 non-Roma in 11 EU Member States (including the Czech Republic). Results provided a comparative perspective on the Czech Roma situation in cases where they use health services. The study concluded that the health situation of Roma in the Czech Republic is not the worst in the EU, but that at the same time many persistent problems still exist. Important health differences were observed between Roma living in "standard" residential areas and those living in socially excluded areas. Obesity, diabetes, heart diseases, and high blood pressure were very frequent medical problems in Roma communities. Roma children often suffer from respiratory disorders and asthma. Even if they seem to value healthiness and wellbeing, Roma people tend to neglect health prevention – from child health care (vaccines, dental care, etc.) to their own preventive doctor visits. Health is considered a family issue in Roma culture and this can lead to misunderstandings with health providers – for example, in case of hospitalization, long and frequent visits of relatives, loud voices and other noise, and Roma patients (in particular Roma mothers after giving birth) leaving the hospital prior to being released/cleared by medical staff can all lead to conflicts and arguments.

4.4. Roma children and pregnant women

Unfavourable birth outcomes of the Roma women were found in the population-based study of 8,938 non-Roma and 1,388 Roma hospitalized singleton births in two Czech districts between 1995 and 2004 (Bobak et al., 2005). During their stay in hospital, mothers completed a questionnaire on their demographic and socioeconomic characteristics and maternal smoking and alcohol consumption. Data on maternal height and weight and on infants' birth weight and gestational age were taken from hospital records. There were striking differences in birth outcomes between Roma and non-Roma mothers. Roma mothers (and infants) had much less favourable profile in most characteristics, except of body mass index and alcohol consumption. Roma infants had considerably lower birth weight, somewhat shorter gestation, and much higher rate of intrauterine growth retardation. Maternal education made the largest contribution to the ethnic differences; the role of health behaviours was relatively modest (Bobak et al, 2005). Other source of objective information on health of Roma children provides the *European Longitudinal Study of Pregnancy and Childhood* (Kukla, 2011). That prospective longitudinal study was initiated in the 80s by the World Health Organization in six

European countries such as United Kingdom, including Isle of Man, Slovakia, Russian Federation, Ukraine, and Czech Republic. The Czech part of study monitored physical, social, and psychological development of 7,600 children born in 1991–1992 in two cities in South Moravia region. Family background and family environment was included. The study also includes a subset of Roma children (N=162) who were followed from mothers' pregnancy to 18 years. Among other objectives of the study was also to compare health development of Roma and non Roma children of preschool age, i.e. from birth to seven years. Special attention was paid to childbirth and its pathologies (if any), breast feeding, to child growing stage and development and vaccination. Data were extracted from medical records of primary care physicians. Study findings indicated significant health disadvantages of Roma children:

- Pregnancy duration of Roma women was shorter;
- Roma new-borns and children have lower body height and weight;
- Roma children are less frequently breastfed and vaccinated;
- By 18 months of age, Roma children are sicker;
- From 18 months of age onwards, developmental defects in Roma children are more frequent;
- Roma children are more frequently hospitalized.

Maternal education made the largest contribution to observed ethnic differences. And maternal smoking is one of the covariates of these differences (Bobak et al., 2005). Pregnant Roma women smoke significantly more than the majority population – almost 60 per cent of pregnant Roma women smoke regularly during pregnancy compared with 20 per cent of the mothers of the majority population (Rambousková, 2009). Furthermore, Roma pregnant women have more undesirable eating habits than the general population of women. They often prefer "junk food", sweetened soft drinks, fatty and sweet foods, and consume significantly less protein, vegetables, and fruit (Rambousková, 2003 and 2009). It is alarming that Roma neonates do not have an optimal iodine saturation as confirmed by a study of new-borns in Prague (Dlouhý, 2006). Iodine deficiency may cause a number of serious issues, including childhood thyroid disorders which may lead to developmental disorders and mental retardation. The unhealthy eating habits of Roma women likely have an impact on the quality of breast milk of nursing mothers. A recent study (Marhoul, 2009) showed a higher content of trans-isomers of fatty acids in the milk fat of lactating Roma women in comparison to the major population. The poor eating habits are the likely cause for this finding (ibid.). Another recent study (Belešová, 2013)[10] confirmed Roma women's dependency on nicotine as well, and it found that midwifes do not provide educational information about pregnancy and lifestyle to Roma women.

However, the greatest health risks are related to higher prevalence of drug addiction among Roma children combined with lower age of initial drug use, especially among those living in socially excluded communities (Černý et al., 2004; NMCD, 2011).

[10] Some stakeholders pointed out the unhealthy nutrition of Roma children might be a serious problem. They indicated a regular drinking of caffeinated beverages (cola, coffee) at primary school Roma children.

4.5. Infectious diseases

Available information on Roma health and health determinants point to various causes for the Roma's generally poor state of health - poverty, low education attainment, low health literacy, and high risk taking behavior. Hence, targeted interventions addressing health risks could significantly contribute to reducing health inequalities between Roma and the majority. Interventions could involve anti-drug programs focused on children and youth, improving the nutrition of Roma children and pregnant women, and systematic childcare education for Roma women.

Reporting incidences of infectious diseases is required by law in the Czech Republic, and are the only times when the Czech Public Health Service authorities explicitly record the ethnicity of infected patients – due to epidemiological reasons. Data, however, is not publicly available. According to an anonymous source,[11] epidemics of hepatitis A in 2009 and in 2010 mostly affected the Roma population (30–40% infected patients were Roma while their representation in population is about 2–3%). The same source states that TB in Roma population occurs ten times more than in the rest of the society. The empirical study of Roma health determinants (Nesvadbová, 2003) reports that 12 per cent of respondents indicated TB in their family history, which is a much higher prevalence than in the general population. Some infectious diseases such as sexually transmitted diseases and HIV/AIDS are more prevalent in Roma communities (MoH, 2014). DROM[12] – one of the Roma assisting NGO – through an investigation done by their RHSAs found that there are recurrent infections such as viral hepatitis, impetigo, fungi infectious, and parasites in socially excluded communities (DROM, 2014).

4.6. Roma health determinants

As to major health determinants, research results reveal several common factors leading to higher morbidity and inferior health status of Roma populations. Chief among them are the poor living conditions and risky health related behaviour due to Roma's social and economic status (Nesvadbová, 2009; Janečková a kol., 2003; Bobák, 2005; Sastipen, 2008). Causes of Roma's ill health and general health deterioration are complex. Different overlapping influences play interrelated roles – low social status, low economic and culture capital, unhealthy nutrition habits, and lack of exercise resulting in higher obesity levels among Roma population. Low housing standards are closely related to poor personal hygiene and consequently to a higher risk of infection diseases. Furthermore, low health literacy reflected in that Roma are generally interested in health issues only when they find themselves suffering from advanced stages of disease, is considered a significant barrier to Roma health improvement even by the Roma themselves (Dušková, 2011). According to primary care physicians, a low compliance with recommended treatment creates another frequent Roma health risk; for example, prescribed medications are often not taken as indicated or not at all; mandatory vaccination schedules have to be constantly supervised and managed by the community social workers in order to ensure adequate Roma participation.

[11] Wishing to remain anonymous.

[12] DROM is the romany word denoting "path".

Drug addiction and alcohol consumption: Recent studies show an overall higher rate of drug abuse in Roma communities compared to the majority (Nepustil et al., 2012). Drug addiction is prevalent in socially excluded Roma communities throughout the Czech Republic. In 2005, Winkler and Šimíková described the range and severity of drug addiction in most affected locations. The interim report of the National Monitoring Centre for Drugs (NMCD) indicates that the situation is getting worse. About three quarters of all Roma communities are affected by drug addiction, and young people of adolescent age and in early adulthood living in socially excluded localities are at the greatest risks (NDMC, 2012; Nepustil, 2012). According to NMCD findings, it is one of the biggest risk groups due to the fact they are living in an environment where drugs are common daily reality. Alarming is the fact that majority of users of inhalants (toluene) are young Roma who start using this drug at the age of about ten (Vacek, Štastný, Miovský, 2010). Researchers found that the Roma community in the Czech Republic lacks information about the devastating effects of drugs and the associated health risks, e.g., HIV or hepatitis (Nepustil et al., 2012). Higher prevalence of smoking compared to the majority is also confirmed – about 60 per cent of Roma adults smoke; children are often "second hand smokers", and they themselves start to smoke cigarette already at a very early age (MoH, 2014).

Unlike the above mentioned behavioural risk factors (diet, smoking, drug addiction), it seems that high alcohol consumption is not widespread among the Roma, as confirmed by some stakeholders. In addition, interviewed emergency medical staff stated they rarely see alcohol intoxicated Roma in the course of their work, while in the general population alcoholism is a growing problem, particularly among young people. Unfortunately, there are not available epidemiological studies on Roma alcohol consumption to verify this. However, Koptiková states that in Roma culture – pregnant Roma women are not prohibited from drinking alcohol during pregnancy; "pregnant woman can eat and drink whatever she likes", because the most important condition for a successful pregnancy is to feel well (Koptíková, 2012). Yet another study found that Roma females very often smoke during their pregnancy but usually do not drink alcohol (Belešová, 2013).

In summary, poor Roma health is related to:

- Poverty, high unemployment rates, low levels of education, poor living conditions, psychosocial stress resulting from long standing social exclusion, and direct and indirect discrimination;
- Low health literacy, low motivation to care about health;
- Unhealthy lifestyles: heavy cigarette smoking, drug addiction, risky sexual behaviour, including becoming sexually active at a young age, unhealthy and unbalanced nutrition, and high prevalence of obesity;
- Low compliance with prescribed medical treatments, abandonment of therapy after remission of acute symptoms.

4.7. Health care utilization

Roma use preventive services and dental care significantly less than the majority. This isn't the case with other types of medical care, especially primary care. Recent data show higher health services utilization by Roma, especially in older age brackets. However, co-payment requirements make prescription medications unaffordable. Thus lower utilization of certain kind of health-care services may influence Roma health status negatively. But overall, it appears that insufficient use of the public medical care system might not impair the health of Roma as much as postponed and overdue doctor visits.

In earlier studies on Roma health-care utilization (Janečková, 2002; Nesvadbová, 2003), no difference in primary care utilization between Roma and non Roma patients was found, unlike the same metric in specialized health-care utilization. Roma visited specialized health-care services significantly less than other Czech citizens. The most recent representative study (Sastipen, 2009) shows that Roma health-care utilization is relatively high and higher than that of the non-Roma population. In this research, based on self-reported data, Roma consume health-care services more than non Roma. About 40 per cent of the respondents were identified as "permanent patients" visiting doctors at least once a month. Authors indicate that comparable data for the Czech population at large is about 28 per cent (ÚZIS, 2009). One third (34%) of the Roma were classified as "opportunity patients" visiting health-care providers at least once a year, and about 25 per cent of respondents were termed "sporadic patients" who use health care less than once a year (Sastipen, 2009);[13] 96 per cent of Roma older 60 years belonged to the "permanent patients" (Sastipen, 2009). Although fully comparable data for the general population from other sources is not available, SHARE[14] data indicate eight (8) contacts with physicians per one person in the year 2010, which is lower than in the same Roma age group. Roma utilization of dental care is significantly lower – 34 per cent of respondents visited the dentist at least once per year, versus 69 per cent of the majority. About 7 per cent of Roma had never visited the dentist (Sastipen, 2009) in comparison to less than 1 per cent of the majority (UZIS, 2009). Acute need of dental care is the most frequent cause of a Roma visit to the dentist's office (Sastipen, 2009). However, some experts point out the growing price of dental care as another significant reason for infrequent oral health-care utilization *(two stakeholders)*. Lower utilization of all preventive services which are covered by public health insurance and thus free of charge is repeatedly reported as typical for Roma population (Nesvadbová, 2003; Janečková, 2002; Sastipen, 2009; Vláda CR, 2013b; Drom, 2013); this also includes preventive programmes for children. Neglecting regular preventive medical examinations and mandatory vaccination programmes are frequent causes of child protection authorities (Vláda CR, 2009b). Roma also tend to neglect preventive dental care: only 33 per cent of Roma respondents went to see a dentist for preventive check-ups, compared to 79 per cent in the case of non-Roma (UNDP Europe and the CIS, 2012). Although Roma public health insurance coverage is comparable to the majority (95% for Roma, 98% for non Roma), co-payment requirements create de facto financial barriers to health-care services use by Roma. Most frequently, this affects the affordability of various prescription drugs. A total of 44 per cent of Roma reported that in the

[13] In this research the kind of services was not followed.

[14] SHARE – Survey of Health, Retirement and Ageing in Europe, data are relevant for the Czech population over 50.

previous year they had at least on one occasion been unable to afford a prescribed drug, while for non-Roma it was only of 11 per cent (UNDP Europe and the CIS, 2012). In a reaction to this finding, the Czech Ministry of Health pointed out that under the rules – at least one drug from each indication group must be available for patients without any co-payment, i.e. fully covered by public health insurance (Vláda CR, 2013b). However, it might be that not all doctors are well informed of this possibility and others prefer to prescribe another drug because of professional reasons (preferred drugs are more effective, having less side effects etc.) and thus they do not prescribe to Roma drugs which are available without co-payment. This rather complicated issue should be addressed in the NRIS for the next period.

5. NRIS DEVELOPMENT: STRATEGIC DOCUMENTS, INSTITUTIONAL STRUCTURE, HEALTH COMPONENTS

5.1. EU context

CR is one of the EU Member States with improved national coordination of integration policy; progress was also made in increasing Roma policy cooperation and developing dialogue between Roma representatives and Czech civil society. However, civic engagement in Roma integration strategy is not sufficient on a national level. Further, even if the level of public awareness on Roma discrimination is constantly improving, anti-discrimination initiatives as a whole are not sufficiently developed, especially when it comes to health care. Competent and adequate monitoring systems to measure the progress and impact of the NRIS have not yet been adopted.

Since 2008 EC has been holding regular bilateral dialogues with Member States on Roma integration. However, an important milestone in the policy of Roma integration in the EU was the 2011 adoption of the *EU framework for the National Roma Integration Strategies up to 2020 (EU framework)*. It calls on Member States to pay greater and more systematic attention to integration of the Roma population. The EU framework follows existing international initiatives, particularly related to the *Decade of Roma Inclusion 2005–2015* (Decade) and calls for coordination of national strategies in EU Member States. The overarching objective is that by 2020 Europe will see visible positive change in four integration areas: education, employment, health care, and housing. EC requires the National Roma Integration Policy to be linked to the national strategic objectives. In all Member States, relevant programmes are being formed and their implementation financed from State budgets and supplemental EU resources. Monitoring is to be focused on the differences in the socioeconomic situation of Roma in comparison to the majority. The European Union Agency for Fundamental Rights (FRA) provides methodological support in this respect (Kahanec, 2009), while the overall strategy has to be implemented in close cooperation with Roma community leaders, regional, and local authorities.

In 2013 – two years after the EU framework submission – The European Commission called on Member States to deliver on their commitments to ensure equality and to do more to improve the economic and social integration of Europe's 10 to 12 million Roma. The call followed the Commission's progress report which showed that Member States need to do better in implementing their national Roma integration strategies submitted under the EU framework. The *EC Progress Report on NRIS and Council Recommendation on Roma Inclusion* presented in June 2013 was the first ever legal instrument on Roma inclusion measures. It found that while many Member States have set up mechanisms to better coordinate their Roma integration policy and activities, there is room for improvement in involving civil society organizations and "putting in place sound monitoring and evaluation methods to measure results" (EC, 2013). The report also found that a majority of Member States have not allocated sufficient resources from their national budgets to implement the stipulated Roma integration strategies. In addition, it said that public authorities need to do more still to fight discrimination, to promote and describe the social and economic benefits of Roma integration. The report is accompanied by a *Recommendation* addressed to EU countries, which proposes on the one hand specific

measures, including positive actions for change, and on the other hand, horizontal policy measures, including local actions to improve the situation of Roma people (EC, 2013a,b). Member States were given two years to put concrete measures into practice. The ongoing negotiations between EC and Member States on the use of EU funds are to ensure an appropriate allocation of funds to concrete actions. For the 2014–2020 funding period, the Commission has proposed a specific investment priority to be devoted to the integration of Roma, and a requirement that an appropriate Roma inclusion strategy is in place anywhere EU funds are spent for this purpose. It has also proposed to allocate a significant share of the cohesion policy budget to investment into people through the European Social Fund (ESF), and to use at least 20 per cent of ESF resources for social inclusion programmes in each Member State. EC proposed "country specific recommendations" for five Member States – Bulgaria, Hungary, Romania, Slovakia, and the Czech Republic, indicating funding priorities for the period 2014–2020 (EC, 2013b).

Assessment of the CR's efforts in the fulfilment of NRIS objectives points to important aspects of the integration process. On the one hand, the CR is one of the 16 Member States with markedly improved national coordination of integration policy, and cooperation between central and regional authorities in strategy implementation. On the other hand, EC identified some weaknesses which need to be addressed in the forthcoming funding period. Here is overview of evaluation of the Czech NRIS implementation which was done by the EC – pros and cons by specific areas of:

1. **Getting local and regional authorities involved:** CR is among Member States introduced structured dialogue on Roma integration issues between central government and local and regional authorities. Promotion of experience exchanges and cooperation among local authorities was also set up.

2. **Working closely with civil society:** Dialogue with civil society and Roma representatives on a local level is encouraging. However, on a national level, commitment of civic society in integration strategy is still not sufficient.

3. **Allocating proportional financial resources:** CR has adopted a territorial development approach and methodology to allocating finance resources, and is among the Member States which distribute funds to local governments to support local integration projects.

4. **Monitoring transformation and enabling policy adjustment:** A mapping of the situation of Roma integration as well as identification of areas with extremely poor Roma communities was implemented; nevertheless, a monitoring system to measure the results and impacts of the NRIS has not yet been developed.

5. **Measures to fight discrimination:** Although awareness of discrimination issues in public administration is generally on the upswing, preventive anti-discrimination measures on a local level are not sufficiently developed, if at all – resulting in cases of lingering unjust or prejudicial treatment of Roma.

The Government of the Czech Republic will respond to the above mentioned critical assessment in the new NRIS 2014–2020; NRIS 2014–2020 should be completed by the end 2014. An integral part of the NRIS is its link to the EU framework and other EU coordinated policies, as well as international initiatives, in particular the Council of Europe in relation to the Decade of Roma Inclusion and related UN recommendations.

5.2. The NRIS in the Czech Republic during Decade. Institutional structure, development, and implementation

The CR acceded to the *Decade of Roma Inclusion 2005–2015* in 2005 *(Government resolution No 136/2005*). In the same year the Council of Europe drew up the basic framework document *National Action plan for the Decade of Roma Inclusion 2005–2015 (NAP)*. Thus, the Government of the Czech Republic is also internationally committed to fulfilment of the programme that aims to eliminate discrimination and close the gap between Roma and the majority. NAP implementation in the Czech Republic is framed by government resolutions, whose fulfilment is regularly monitored and reported by the relevant governmental bodies dealing with Roma issues (Vláda CR, 2004, 2008, 2009b 2011b, 2012b, 2013a,b). In accordance with the EU framework, the following areas are addressed: education, housing, employment, and health. Over the last 10 years, various activities have been developed to respond to Roma situation at national as well as at community levels. The goals and fulfilment of the NAP are outlined in two corresponding strategic documents issued during the Decade of Roma Inclusion period, and which are considered part of ***the*** official ***NRIS in the Czech Republic.*** They are the ***"Concept of Roma integration in the years 2005–2009"*** (Vláda CR, 2004) and the ***"Concept of Roma integration 2010–2013"*** (Vláda CR, 2009a). Another strategic paper, ***"Action strategy combat to social exclusion in the years 2011–2015,"*** represents a complementary strategy which is not explicitly targeted at Roma, but still very relevant to Roma issue (Vláda ČR, 2011a).[15] A review of this strategy is also included in this report.

Since 2002, in the public administration reform context, the term "integration of national minorities has become an integral part of Czech legislation. At present, the key resort in the implementation of the national Roma integration policy is the Ministry of Human Rights, which is the coordinating body on all Roma linked policies. This year (2014), the Minister of Human Rights was also appointed Head of the Legislation Board of the Government of the Czech Republic. This overlap of human rights agenda and the legislative agenda offers a unique and valuable opportunity to include integration principles into all legal norms proposed by the Government. Other ministries engaged in Roma issues are the Ministry of Labour and Social Affairs (MLSA), the Ministry of Regional Development, the Ministry of Education, the Ministry of Interior, the Ministry of Justice, and the Ministry of Industry and Trade. The health agenda in the above mentioned strategic documents on Roma integration is associated with the social services agenda and both agendas are conceptualized as the common and mutually related area of the Roma integration policy. It is assumed that both Ministry of Health (MoH) and MLSA will cooperate closely in meeting the mutually linked strategic goals.

[15] The issue of social exclusion does not concern in the Czech Republic only Roma and this strategy (compared with NRIs) has a broader scope.

At the national level, coordination of all integration activities in the Czech Republic is responsibility of the *Government Council for Roma Community Affairs* (*Council*) and its executive bodies – the *Office of the Government Council for Roma Community Affairs* and the *Secretariat of the Government Council for National Minorities.* Both are organizational units of the Ministry of Human Rights. For consultative purposes, the Council established an expert team representing the institutions involved in the implementation of policies for Roma integration (i.e. ministries, academia, civil sector, Roma civic associations, and some Roma). Members meet regularly within the *Committee on the European Platform for Roma Inclusion and Decade 2005–2015* (Committee), which is one of the organs of the Council. The Committee is headed by the National Coordinator of the Decade of Roma Inclusion. At the community level, there is a network of the Roma advisors in key positions in local institutional structures of Roma integration; Roma advisors work in all major Roma communities and assist local authorities in implementation of integration policy. At the regional level, there is a network of 15 Roma regional coordinators established by law as an integral part of regional public administration, and working in each CR region, including In the City of Prague. Regional Roma coordinators participate in setting NRIS's objectives and are the go to experts for coordination and supervision of implementation of Decade of Roma Inclusion strategy and NRIS in all CR regions (Uherek, 2012). They have direct links to the national coordination bodies, as well as to local Roma communities through the local Roma advisors. Local Roma advisors are the agents of the local governments in the integration of Roma communities, the de facto mediators between the Roma minority and the majority, and represent a direct way of increasing Roma participation in public administration. They are the "bridge" between Roma communities and local governments (Vláda CR, 2014b). Before the public administration reform of 2000, Roma advisors were based in all district/municipal offices, mostly in the Department of Social Prevention. As a result of the reform – district offices were abolished in 2002, and the key responsibilities of Roma advisors were shifted to regional Roma coordinators, and the direct consequence was that municipalities no longer had the obligation to appoint a Roma advisor. Nevertheless, in the municipalities with Roma community representation, local Roma advisors are usually established even if their agenda is often associated with other activities. In 2012, there were 162 such Roma advisors working in and with municipalities (Vláda CR, 2014).

5.3. NRIS health aspects in the context of Roma integration strategic goals

NRIS objectives aim to achieve full Roma integration and participation in all facets of socioeconomic life in the Czech Republic (Vlada CR, 2009a). The goals of the NRIS are correlated with the three key aspects of integration: human rights, Roma culture and identity, and adequate socioeconomic development. In terms of human rights it means to enable Roma to exercise full control over their individual rights under the Czech Constitution. The socioeconomic aspect of integration reflects the efforts of the Government to achieve Roma participation in all spheres of Czech society at levels comparable to the majority (Vlada CR, 2004, 2009a). To protect Roma against discrimination and to encourage Roma identity through support for Roma culture and language are defined as the key umbrella objectives. In more practical terms, the principal mandate of the NRIS is to create a framework for action that will help to reverse various negative trends in education, employment, housing, and health, and will accelerate the positive changes leading to elimination of unjustified and unacceptable inequalities between Roma and the majority population. As mentioned previously, the *Strategy to Combat Social Exclusion 2011–2015* is not targeted only at Roma.[16] However, according to available data, about three quarters of the population in socially excluded localities are Roma. So, key areas of the inclusion strategy – housing, education, employment, social services, and health – overlap with the NRIS, the "local" dimension of the strategy being much emphasized. Focused and consistent regional development is arguably the most direct and effective way to eliminate social exclusion in deprived localities (Vláda CR, 2009a,b). Since 2008, specific activities to that end at the local level are coordinated by the *Agency for Social Inclusion*, currently operating in 27 municipalities (Vláda CR, 2014b).[17]

Unfortunately, Roma health issues are not prioritized in any of the above mentioned strategic documents. Priority areas of integration are employment, housing, education, and Roma empowerment. Health and health care are generally associated with social services, with clearly overlapping integration strategy priorities. Hence, from a strategic point of view, Roma health

Health objectives of the NRIS:

- *To improve health literacy of the Roma especially in terms of information on rules of health system and related rights and obligations;*
- *To develop relevant health promotion and preventive programs tackling the risky health related behaviour of Roma (smoking cessation, drug addiction, nutrition);*
- *To ensure equal access to health care to Roma; to eliminate discrimination and prejudices practiced in health care;*
- *To develop and ensure full operation of Roma Health and Social Assistants in the excluded areas;*
- *To support epidemiological studies on Roma health and health determinants;*
- *To ensure systematic education and training of all health professionals in Roma health related topics in order to provide Roma culture sensitive health care.*

[16] Due to the increase of poverty and social inequalities, there are also other groups at risk of social exclusion in the Czech Republic thus a rather more general approach in this strategy is preferred.

[17] The Agency is a Department of the Ministry for Human Rights and affiliated to the Office of the Government.

inequalities and problems with Roma access to health care are issues which have not been adequately addressed. It goes without saying that improvements in Roma employment prospects, education opportunities, and living conditions will also improve their health status. As was expressed by the several stakeholders, there is not so urgent need to deal with health care issue because legal entitlement to health care is sufficiently guaranteed by the Czech health system, which is equitable, in principle.[18] Discrimination against Roma in health-care area has not dimension of discrimination such as in education, employment and/or housing.[19] The NRIS's monitoring reports (Vláda CR, 2008, 2009a, b, 2011b, 2012a) repeatedly identified one and the same or similar problems to solve, the measures proposed therein were not always fully implemented, and some were seemingly altogether ignored.

In summary, relevant health and health-care tasks and objectives covered in the NRIS strategic documents and related health objectives during the Decade of Roma Inclusion are as follows:

- To improve Roma health literacy, especially in terms of information on public health system rules, insurance, and related rights and obligations;
- To develop relevant health promotion and preventive programmes tackling risky health related behaviour prevalent among Roma (smoking, drug addiction, poor nutrition);
- To ensure equal access to health-care services for Roma; to eliminate discrimination and prejudices in the health-care system;
- To ensure sufficient number full operation of Roma Health and Social Assistants to work in socially excluded areas, to provide practical support in resolving Roma everyday health-care problems; to ensure availability of all needed social services to Roma;
- To support epidemiological studies on Roma health and health determinants;
- To ensure systematic education and training for all health professionals in Roma related health topics in order to provide Roma culturally sensitive health care and to reduce communication barriers.

In the last three years, steps have been taken in the right direction with respect to NRIS defined strategic health and health-care goals. In the *Decade Monitoring Report 2011* (Vláda CR, 2012a), the health objectives were better addressed and more emphasized than it used to be before. For example, need for training of health workers on specific culturally and socially determined factors influencing the health status of minorities in both graduate and postgraduate educational programmes were formulated. Another newly stated objective was to promote longitudinal epidemiologic surveys on Roma health, including health consumption patterns and identification of obstacles and barriers to health-care access. However, the larger Roma population based epidemiological studies have not yet been implemented, so regrettably valid and reliable data on Roma health is still lacking. Roma specific topics are not systematically included in the mandatory training programmes of physicians and other health professionals, especially in postgraduate training courses. There was consensus among stakeholders that the standardization of curriculum of the "Health

[18] See Public Health Insurance Act No 48/1997 as amended.

[19] However, Roma living in socially excluded localities undoubtedly face difficulties in access to health services which should be addressed in Roma integration policy.

legislation, ethics, and communication in health care" specialty training course[20] for physicians would provide ample opportunity for shedding light on Roma specific health-care issues.

One of the most discussed NRIS health measures – it can be found in all relevant reviewed strategic documents[21] for the entire programme period – is the **Roma Health and Social Assistants (RHSA**) initiative, prioritized since 2005 under the shared responsibilities of MLSA and MoH. This is a mediation programme between the Roma and health-care professionals in socially excluded Roma localities (refer to details in case study). For example, the *Decade Monitoring Report 2008* recommended that MLSA conduct an independent annual analysis of the effectiveness of RHSAs in order to manage the programme (Vláda CR: *Information on implementation of the Decade of Roma Inclusion in 2008)*, yet none such has apparently been conducted so far.[22] The *Decade Monitoring Report 2012* (Vláda CR, 2013a) noted that the RHSA's project was not being satisfactory implemented and that the number of RHSA workers was decreasing every year, due to uncertain funding and vaguely defined competencies; Yet no specific measures were proposed to address these shortcomings.

5.4. EU funds used in Roma integration policy

Social integration of Roma is financially supported by two main sources, i.e. the European Social and Integration funds (ESIF) and the State budget of the Czech Republic. The responsible body for the administration of the ESIF is the MLSA. The ESIF also provides funding for most of the NRIS's implementation, while government support plays a supplementary role. Most activities and programmes covered by ESIF are being developed and managed within the framework of *the Operational Programme Human Resources and Employments* (OPHRE). Other relevant operational programmes, such as "*Education for Competition" and* "*Integrated Regional Operational Program"* are also used for Roma relevant projects. In order to improve effectiveness, efficiency, and coordination of the Roma targeted projects supported by ESF, a Working Group for the Roma Minority (WGRM) was established in 2005. The WGRM is the leading advisory body of the Monitoring Committee, responsible for ensuring efficient use of EU funds in all matters dealing with Roma minority, and its 20 members meet twice a year. Their focus is on:

- Support of social integration and social service;[23]
- Support of social integration of inhabitants of Roma localities.

In this context, it is also relevant to mention the establishment of the ESF supported/funded Agency for Social Inclusion in 2008. Although the agency is not dedicated exclusively to Roma, it concerns primarily the Roma, who comprise the majority population in socially excluded localities. A Roma specific health programme supported by the ESF was the pilot project of the RHSAs in 2005–2007, although Roma health does not appear to be a priority in the context of EU funding the same way that social housing is.

[20] This course is manadatory part of specialty training programmes for all physicans.

[21] Concept of Roma integration in the years 2005–2009" (Vláda CR, 2004) and "Concept of Roma integration 2010–2013" (Vláda CR, 2009); "Action strategy combat to social exclusion in the years 2011–2015 (Vláda ČR, 2011).

[22] Except of the annual reports of the DROM (NGO involved in the RHSA project) evaluating their activities in this area.

[23] Not exclusively targeted to Roma.

Only one Roma specific health programme was funded through the ESIF OPHRE – **Pilot Project of the Roma Health and Social Assistant** in 2005–2007. According to a WGRM member who spoke on condition of anonymity, *"health promotion and availability of health service is in the context of Operational Program Human Resources and Employment a marginal topic; preferred area is social housing*" (2014).[24] The MoH said that no institutions of any kind submitted health related project proposals in response to the ministry's call for grants. However, MoH stated that Roma health issues are adequately addressed within the frame of standard preventive programmes, since these are tailored to the specific needs of vulnerable groups, e.g. drug addiction preventive programmes; another example is the MoH project aimed at increasing participation in standard health screening programmes[25] currently managed by the General Public Health Insurance Company (2014). The project is based on a special personal invitation distributed by mail to those people who do not participate in health screening programmes for a long time to remind them to visit their GPs.[26] MoH argues that Roma will be included as they often belong just to this group.

5.5. Integration progress during the Decade of Roma Inclusion

On one hand, the Decade of Roma Inclusion's contribution can be seen in the facilitation and acceleration of the development of measures and tools for creating inclusive policies. The CR is now on the whole more aware on Roma issues and the government has begun to earmark more funds for Roma inclusion projects. On the other hand, the gap between Roma and non Roma in everyday life is increasing and discrimination against Roma continues. High level of Roma unemployment, poor health, and worsening housing conditions, and persisting segregation in education are evidence for that. Some experts believe that the strategic and conceptual documents on Roma integration are handled well in principle, but that their practical implementation is rather faltering, despite appropriate institutional framework in both the government and non-government sectors. Among the reasons might be underestimation of Roma specific issues by previous Governments of the Czech Republic which were too focused on economic policy and did not attend to the ever increasing social inequalities, as some stakeholders pointed out in their interviews.

To measure objectively the progress of Roma integration, hard data is needed. In the Czech Republic such data is either incomplete or non-existent, and its validity and reliability are often questionable. When available, such information comes from various uncoordinated surveys or more or less random academic research. Another problem is the slow implementation of proposed measures to improve Roma situation and a lot of related bureaucracy. The implementation of Roma integration measures also depends on the overall political climate and the degree of involvement of various key politicians, which has been lacking in recent years. In general, the shortcoming of the NRIS and other related documents (*Decade Monitoring Reports* issued in 2008, 2011, 2012)[27] is the absence of a

[24] Member of the WGRM who was invited for a stakeholder interview but declined.
[25] The screenings are the following: breast cancer, colorectal carcinoma and cervix carcinoma.
[26] The screenings are fully covered by public health insurance and thus free of charge.
[27] Vláda ČR (2009). Zpráva o naplňování Dekády romské inkluze v letech 2005–2015 v roce 2008 Vláda CR 2012: Informace o naplňování Dekády romské inkluze 2005–2015 v roce 2011; Vláda CR 2013: Zpráva o naplňování Dekády romské inkluze 2005–2015 za roky 2006–2012.

clear monitoring mechanism and lack of relevant quantitative and qualitative indicators. Since these are either completely missing or poorly defined, a comprehensive evaluation of the Decade of Roma Inclusion is therefore difficult, if not impossible. Notwithstanding, there are some examples of good practices in Roma integration at the local level – in the village of Obrnice with 50 per cent Roma population, for example. There, observable and substantial progress in Roma integration was achieved due to the creation of job opportunities for Roma, willingness to invest relevant resources to Roma integration projects, and active cooperation of local authorities with the Roma community and its leaders. Most of the activities targeted to Roma are supported by EU funds, although none of them are directly related to health care.

5.6. National Roma Integration Strategy 2014–2020 and its health aspects

It appears that the current Government of the Czech Republic is committed to achieving visible progress in the implementation of Roma integration policies. Human rights agenda and redressing social exclusion are among the current government's top strategic goals, according to the statement of the Prime Minister Sobotka which he expressed in response to the letter he obtained from the Council of Europe, namely from the Commissioner for Human Rights Nils Muižniekse (Sobotka, 2014).[28] In the context of the "pro-European course" of the Government of the Czech Republic, its strategic approach in Roma integration policies has to more consistently parallel the EU framework, including management and monitoring mechanisms (*NRIS 2014-2020 proposal;* Vláda CR, 2014a). This is also one of the reasons why the finalization of the *Strategy for Roma Integration 2014-2020 has been postponed* to the end of 2014 since it was needed to re-elaborate some its parts and outline effective measures to be fulfilled. The new strategy has to emphasize the development of methodology and effective monitoring of the progress, in Roma integration which was previously rather formal and vague. In addition, the government seeks to connect the NRIS 2014–2020 with EU platforms – especially the EU Council Recommendation on effective measures relating to Roma integration in the Member States. Recommendations of the Council of Europe, the Organization for Security and Co-operation in Europe (OSCE), and UN bodies are also to be taken into account.[29] The 2014–2020 NRIS was open for review, comments, and consultations by all relevant stakeholders and the public until May 2014, and its preliminary version was available online (Vláda CR, 2014).

[28] N. Muižniekse expressed in a letter to concerns about anti Roma sentiment in the Czech Republic and ask for the official statement of the Government of the Czech Republic.

[29] In 2013, the special working group for the NRIS 2014–2020 was established and a meeting was organized.

6. ACCESS TO HEALTH CARE

6.1. Legal entitlement

The overwhelming majority of Roma are Czech citizens and legally entitled to participate in the public health insurance. If they are unemployed, handicapped, seniors, persons living under the poverty, they are treated as "State insures" and freed from payment of insurance fee. Thanks to well-developed legal framework of public health insurance – the Roma in the Czech Republic do not face to significant barriers in legal entitlement to health care. It does not mean that in everyday life they do not deal with obstacles of a different nature which make their access to health services much more difficult compared to majority.

Czech Republic citizens of Roma origin are entitled to public health insurance and to medical treatment subject to the same provisions as all other nationals. The CR health care legal framework is determined by *the Convention on Human Rights and Biomedicine,*[30] which was adopted in 2001. Health care is understood as a basic human right and is therefore guaranteed by the *Constitution.*[31] Furthermore, the *Charter of Fundamental Rights and Basic Freedoms, Article 31 of the Charter*[32] states the right to free provision of health care for all residents under the conditions set forth in the *Public Health Insurance Act*[33] (defining entitlement to publicly funded health care). Participation in public health insurance is obligatory for all permanent CR residents, including most (but not all) third country migrants, i.e. migrants coming from outside EU. Public health insurance is based on the solidarity principle and designed as an employment based health insurance. The premium is a fixed percentage (13.5%) of the gross employee's salary shared between the employer (9%) and the employee (4.5%). All insured has the same rights and obligations, and the government pays the insurance premiums of the following groups: children up to 18, students up to 26, pensioners, unemployed, parents on maternity leave, prisoners, and people living under the poverty line. Relevant law[34] specifies health professionals' obligations and patients' rights which have to be followed when health-care services are provided, as well as other related rules (issued by MoH) regulating various aspects of health-care provision.[35]

The Anti-Discrimination Act[36] postulates equal treatment for all persons regardless of ethnic background or social status, and provides legal remedies against discrimination. As guaranteed by the Constitution, the Act defines (§1, paragraph 1) the prohibition of direct and indirect discrimination in access to health care. Examples of direct discrimination include dismissing someone, deciding not to employ them, refusing them training, denying them a service otherwise guaranteed (such as health care, for example) because of racial or ethnic origin, nationality, etc. (§2 paragraph 3 of the Antidiscrimination Act). Indirect discrimination occurs when practices, policies, or procedures have the effect of disadvantaging people who share certain protected characteristics (as listed above, for

[30] Convention on Human Rights and Biomedicine, Act No 96 /2001.
[31] Right to health care was include into the Czechoslovak legal system in the 1966.
[32] The Charter was included into the Constitution in 1991.
[33] Public Health Insurance Act No. 48/1997.
[34] Health Services Law No 373/ 2011.
[35] List of the regulations is not relevant to this Report.
[36] Act No 198/2009 on equal treatment and legal protection against discrimination/ Anti-discrimination Act.

instance), without overtly being discriminatory. This is frequently the case with the Roma when it comes to equal protection under Czech law.

Constitution rights are logically related to all Roma, residing permanently on Czech territory as well as to all other permanent residents in the CR regardless they are Czech citizens or not. This is extremely important for the so-called "Slovak Roma" who makes up a substantial part of the Roma population in the Czech Republic.[37] Those Roma who are officially permanent residents of Slovakia have a guaranteed legal entitlement to health care through the *European Health Insurance Card*. To access all needed care beyond emergency services, they need to be registered as long term residents in the Czech Republic. In that case they are provided with health-care services on the same terms as Czech citizens. "Uninsured Roma" are not among the patients who are frequently treated in emergency care units,[38] as the lack of insurance is an issue more frequently affecting third country nationals *(stakeholders from emergency service)*. Other Roma groups, especially Roma travellers, are not typically present in the CR, except in sporadic cases when they cross over in small groups and for a short time from Romania, Bulgaria, or Hungary. In general, Czech health-care providers do not report uninsured Roma as a problem to be solved. Even if uninsured Roma come and such situation occurs, doctors have the unquestionable duty to provide health care as needed, regardless of the patient's insurance status and place of residence – if patient state of health requires a medical treatment.

6.2. Co-payments in the Czech health-care system

The co-payment requirement is an issue of concern in terms of real-world access to health care for vulnerable social groups such as the Roma. In the CR, co-payments are a thorny political subject. In the Decade of Roma Inclusion, a significant increase of co-payments was introduced into the health care, especially in the period 2007–2012 under the government of the right wing political coalition.

Schedule of co-payment as it was implemented up to 2013[39] was rather complicated. In short, there were two categories of out of pocket payments: **user´s fees** and **supplementary payment.**

User´s fees:
30 CZK (EUR 1.1) per each outpatient visit; 30 CZK per each prescribed pharmaceutical receipt; 90 CZK for emergency care including first aid dental service ; hospital fee (100 CZK) per each hospital day without any limit as to number of days spent in hospital.

Supplementary payments:

[37] Adjective "Slovak" means that their ancestors came to the Czech Republic after WW2 mostly from eastern Slovakia, during the so-called "management of Gypsy question" when the Government of the Czech Republic relocated Roma from settlements in eastern Slovakia to the less populated western Bohemia, where they were promised better living conditions (Buday, 2013). Thus, many Roma in the Czech Republic have close family relations with Roma living in Slovakia, which affects their mutual migration.

[38] According to professionals working in emergency care.

[39] After the social democrats won election in 2013, the government began to reduce continuously co-payment as they promised that to their voters.

a) *Pharmaceuticals:* the most of prescribed drugs in out-patient care is only partially covered by public health insurance, while the rest has to be paid by the patient.
b) *Dental care*: the very basic routine care is covered by public health insurance; In practice, major dental procedures (white dentures, dental bridges, crowns, advanced orthodontic care etc.) is usually fully covered by the patients
c) *Health tools/aids, devices* (hearing apparatus, sticks, chair on wheels, etc.) – patients have usually to pay minimally about 30 per cent of full price.

The social democrats – political opponents of the right-wing coalition – have been against charging of user´s fees. In frame of political struggle with coalition in power they used the strong arguments pointing to the constitutional right to free health care. Finally they achieved that hospitalization fee was cancelled by the verdict of the Constitutional Court (Constitutional Court, 2013).[40] Then in 2013, the newly elected Government of the Czech Republic[41] definitively cancelled all user fees (except of that for emergency services) as of 2015. This political decision significantly reduced the financial burden connected to health services which negatively affected Roma and other vulnerable groups in the last seven years. So, the current extent of co-payments is less burdensome for Roma patients than it was the case until recently. However, supplementary payments for drugs, medical devices, and dental care still represent considerable financial burdens for poor people such is the most of Roma.

6.3. Roma access to health care

Despite their legal entitlement to health care, Roma generally face serious barriers in access to health-care services – such as co-payment financial burden, lack of valid health insurance and other official documentation, geographic isolation from quality care providers, lack of information, various language and communication obstacles, direct and indirect discrimination, degrading treatment and human rights violations in the provision of care.

Further, areas with higher percentage of Roma inhabitants usually suffer from an insufficient network of primary care physicians – for example, Northern and Western Bohemia, as well as North Moravia (Šidlo, 2011). As confirmed both by NGOs (Drom, 2013 and 2014) and research (FRA Report, 2013), Roma access to health-care services also suffers from some medical providers' reluctance **in particular General Practitioners (GPs) for children,[42] GPs for adult patients, Gynaecologists, and Dentists) to accept Roma patients to care about them systematically and continuously ("to register" in Czech terminology).** The Czech health-care system is rather liberal – patients are not required to be registered by primary health care providers. Free choice of health-care provider (GP) is generally considered an important principle, and it is incorporated into the health-care system administration and organizational structure as a whole. As all health services – primary care is based on free choice of physicians. Patients (parents – in case of children) can choose freely registering GPs regardless place of residence or any other condition; but GP which was chosen by the patient have to have capacity to care about him/her. It means, that if number of patients in GPs´s register exceeds

[40] By the verdict of the Constitutional Court, hospital user´s fees as applied in hospitals were "socially insensitive".
[41] Coalition lead by the Social Democrats.
[42] In the CR primary care for adult and for children are separeted; GPs for chidren are specialized to care about children in out patient settings.

defined limit, GPs can reject to register other new patients, simply because of his/her register is already full.[43] And it happens that in regions with lower density of GPs it might be a problem to find GP who is willing to register new patients. Such a situation is particularly disadvantageous for Roma due to widespread prejudices and image of rather "difficult" patients. On the other hand, GPs are generally financially motivated to have an sufficient number of registered patients due to their per capita remuneration and also for that, registration rate of the Czech population at GP´s is almost 100 per cent.[44]

In the last years lack of GP´s especially in socially deprived regions – typically with higher proportion of Roma – occurs. The causes are more complex, but aging of the GP´s and in the same time less interested young physicians to work in primary care are among the most important. So, it happens that in the areas where they live much Roma may be few doctors, and those who work there are not very willing to register Roma because they have enough patients in register and due to above mentioned reasons associated with prejudices. Logically, not to be registered at GPs makes a trouble mainly to Roma patients suffering from chronic disease. Unregistered patients face various practical obstacles related to ensuring coordination and continuity of care, in addition to administrative difficulties such as getting sick notes for work or approval for disability pension, among others. It is also a great disadvantage in the health care for children especially, since the system of regular medical check-ups and long-term monitoring of child development is based on the GPs who are the "registering physician" for particular child.[45] NGOs and social paediatricians, as well as the regional child protection offices[46] report a lower registration rate amongst Roma child population. A field survey carried out by DROM in 2006[47] indicated that only 56 per cent of Roma children were registered; only 65 per cent Roma women were registered at gynaecologists, and 67 per cent of Roma were registered at dentists (DROM, 2014). There are various causes. Some are related to physicians unwilling to take Roma patients due to prejudices, discriminative attitudes, and negative expectations; others – to the Roma's own low motivation to care enough about their health, or to the lack of adequate health-care information available in Roma communities. External obstacles such as a shortage of GPs working in or close to socially excluded localities. By law, regional public health insurance offices are responsible to ensure geographic accessibility and to address any related issues, including any difficulties Roma patients might be experiencing with health-care registration. The real problem here is that there are no statistics or evidence about Roma complains in that regard. Since Roma are not identified as persons of Roma origin in any operations in State administration, no statistics mapping the situation as a whole are currently available.[48] Partial information comes in only from NGOs, such as the Roma Health and Social Assistants programme, working in a few Roma localities (Vláda CR, 2013b). As yet, there has been no explicit government policy to map and address this issue globally. Undoubtedly, this lapse is one of the glaring shortcomings of the Czech health-care system as a whole and of the national Roma integration strategy in particular.

[43] Average number of registered patients per GP is about 1,700 patients.

[44] Only homeless are usually unregistered.

[45] This long-term monitoring is highly appreciated and considered a systematic long-term measure contributing to low infant mortality, low under five mortality and good health of the Czech children.

[46] In Czech so called OSPOD – Organ sociálně právní ochrany dětí.

[47] DROM is well known NGO´s working for Roma.

[48] This information was obtained through personal communication with a representative of the Regional Public Health Insurance Office.

6.4. Quality of health-care provided to Roma; Discriminatory practices in health care

For twenty years, no forms of denial of health care for Roma citizens by the Czech health professionals were officially reported by Roma patients (Nesvadbová, 2002; Ombudsman, 2014). In 2011, the Public Defender of Rights dealt with a complaint concerning discrimination on the basis of Roma ethnicity because a dentist had refused to register a Roma patient**,** and consequently to provide the needed dental care. The complaint substantiated and discrimination was judged to have occurred (Ombudsman, 2012). The complaint was subsequently resolved by the Office of the Ombudsman and appropriate consequences were drawn from the case for the physician, including sanctions. Even though this has thus far been the only officially documented case of health-care discrimination, it is certainly not the only one. Available sources (e.g. FRA report on multiple discrimination) provide evidence of prejudices and discriminatory attitudes among health professionals. Unfortunately, Roma often do not file formal discrimination complaints. If they exceptionally do so, Roma ethnicity is not necessarily reported (o*fficer of the public health insurance company.*

Prejudices and discriminative practices among health professionals were reported in some studies carried out within the framework of the nursing programme of regional universities. The research found that health professionals do not usually communicate in a “Roma friendly” manner (Klimova, 2011). She focused her investigation on the identification of knowledge of health professionals on the principles of multicultural nursing as well as how it is applied in care for Roma patients. She investigated the quality of communication between health professionals and Roma patients. She performed a questionnaire based survey with 70 nurses and 30 doctors working in health facilities (both in hospital and in the outpatient settings) located in Kroměříž and surrounding area, South Moravia region. The research showed that nearly half of the respondents admitted they were influenced by the fact that patient is of Roma origin. Health professionals indicated that they feel less comfortable treating Roma patients, and in addition, more than half of respondents observed the same attitudes with their colleagues. The author further found that health professionals perceive Roma patients as too noisy and lacking respect for the hospital operational rules. Despite the reported troubles with Roma patients, the majority of respondents (66%) rejected the presence of a Roma coordinator in their hospitals to facilitate communication with Roma patients. Unfortunately, study does not provide any explanations of such attitude towards Roma coordinator (Klimová, 2011). Another author describes the specifics of hospital care for child Roma patients in the pre-school (5–7) years, based on qualitative research among nurses (Vejsada, 2013). He investigated whether nursing care for child Roma children differs from that provided to other children, and looked into methods of communication between medical staff and families of hospitalized Roma children. Not surprisingly, he discovered that nurses in general do not possess the knowledge and skills to provide culture specific nursing care. They admitted to prejudices in their attitudes towards Roma children. Some nurses saw this as a personal failure and confessed they would like to handle their feelings better (Vejsada, 2013). The main limitation of the above reviewed studies is that they investigate Roma health care from the health professionals’ perspective only. Roma experience and attitudes were rarely examined and recorded. However, it is encouraging that educational brochures and leaflets describing Roma patients’ cultural specifics and providing example of good practice were

produced within the framework of two reviewed studies to support the culturally specific health care provided to Roma patients in hospitals (Koptíková, 2012; Benešová, 2013).

Roma discrimination was one of the topical issues of the international FRA project *"Inequalities and multiple discrimination in access to and quality of health care,"* implemented in five EU Member States, including the Czech Republic. Czech respondents were recruited predominantly from Roma communities as representatives of the most vulnerable and discriminated against ethnic group in the country. Researchers found that a combination of several factors increases the probability of discriminatory behaviour especially towards Roma women. They established a link between Roma ethnicity, discrimination, and age. With growing age an increasing number of discriminatory behaviour towards Roma women was observed. Some respondents in the FRA study reported hospitals segregating Roma patients in wards, for example by that Roma are deliberately placed on one hospital room, if it is possible to arrange.[49] And further, according to this study Czech health professionals tend to reject the existence of discrimination as well as they do not admit failure in their communication with Roma, while attributing communication problems to the patient's characters and personal adjustment. If they admit the existence of such prejudicial behaviour, they consider that as "individual failure" and not a system issue (FRA Report on multiple discrimination in the Czech Republic, 2013). This conclusion differs from with findings of two above mentioned Czech studies (Klimova, 2011; Vejsada, 2013) in which health professionals confess prejudice towards Roma. Possible explanation of such different results might be of the methodological nature.[50]

[49] In any case it is not an official hospital policy.

[50] In FRA research face to face interview was used to get information from medical staff, while anonymous questionnaire was used in Klimova´s above mentioned domestic study. Also Vejsada in his small qualitative study could use format of less formal interviews and respondents might be more open, I guess.

7. STAKEHOLDERS' INTERVIEWS

7.1. Methodology

There were twenty stakeholders included in the survey; five additional experts were invited to provide complementary information where needed such as namely experts in postgraduate medical education, in collection of ethnic data, and Roma use of emergency services. One nurse and one physician were additionally interviewed to provide more details on provision of health services to Roma in areas with high proportion of Roma.

The stakeholders' were selected according to the following criteria: knowledge of relevant policy and/or practice in respect to Roma health related issues, and the individual's ability to initiate change because of professional responsibility and/or personal commitment. Experts aware of decision-making rules and social patterns in the area of Roma health were included among the stakeholders. Interviews were carried out both to get inside "first hand" information, as well as to supplement the information obtained by other methods (desk analysis). When conducting the interviews, it was important to get respondents' personal opinion and to get information, especially if such were not yet available in Czech sources. We put an emphasis on the selection of "right" experts, i.e. those who are in a position to provide in-depth information and they are able to cover the widest possible range of issues examined as well as to provide different perspectives on the issue under consideration (Flick, 2009).

The survey script was based on the knowledge gained through desk research (see Appendix 1), after it was reviewed and revised by the IOM and few external researchers. The script consisted of several groups of topics and related questions that helped to keep the interview focus, and at the same time adapt to the particular situation and/or respondent so that no important topic was omitted. A particular emphasis in the preparation of the interview script was put on the logical sequence of questions and the coherence of the whole, in order to keep the attention of the respondent. The interview script and the stakeholder list were consulted with IOM and discussed also with some national experts.

We chose twenty stakeholders from the central and regional government administration (Ministry of Health, Ministry of Labour and Social Services, Ministry of Human Rights Council of the Government of the Czech Republic for Roma Minority, Agency Combating Social Exclusion, General Public Health Insurance Company), local authorities (mayor of locality with high proportion of Roma citizens), health professionals (physicians, nurses, emergency services, public health professionals, researchers, postgraduate medical education authority, academics), NGOs and human rights institutions (Public Defender Office, Czech Helsinki Committee). The four stakeholders out of the twenty were of Roma origin. The interview focused on:

- The state of health, health determinants, health services consumption patterns of Roma, barriers, obstacles in access to health care, discrimination practices;
- The mapping of the health policy implementation in respect to specific determinants of Roma health and cultural differences;
- The identification of the strengths and weaknesses of the national health policy over the last decade.

The interviews took place face to face (13), by phone (5), and two stakeholders submitted their statements in writing by email – after receiving the interview´s questions in the same format in which were asked to all other stakeholders. The methods of communication were adapted to the preferences of invited stakeholders. All interviews were recorded, transcribed verbatim, and analysed using thematic analysis approach in order to identify "umbrella topics". Descriptive coding and interpretative coding preceded their identification (Braun and Clarke, 2006; Flick, 2009).

Table 1: Interviewed experts

Experts	Institution	Comments	Interview mode
Lawyer	Ombudsman office		By phone
Managerial position	Government Council for Roma Community Affairs and the Secretariat of the Government Council for National Minorities		Face to face
1 physician 1 manager	Emergency Medical Service in Prague		By phone
Paramedic	Regional Emergency Medical Service		By phone
Member Roma origin	Committee of the Government Council for Roma Affairs		Face to face interview
Student of Roma origin	Charles University, 6th year of Medical Faculty in Pilsen		Face to face interview
Managerial position	Agency for Social Inclusion		Face to face interview
Roma coordinator	City Hall Prague		Face to face interview
Lecturer teaching communication issues	Postgraduate medical education		By phone interview
Managerial position	The City of Prague 14 Department of Health and Social Affairs	Manager of the project The role of cities in the integration of socially excluded Roma localities.	Face to face interview
Head	Institute of Postgraduate Medical Education		Face to face
Physician	University Hospital Motol in Prague		Face to face
Official	Ministry of Health. Department of health programmes		Face to face

Researcher	National Institute of Health Department of Health Promotion	She is involved in the preparation of the Strategy of health promotion for the Roma population	By phone
Drahomíra Miklošová	Mayor of Obrnice	She received the annual prize of the Council of Europe in the fight against social exclusion for her social policy in the village where lives 40 percent of Roma.	By phone
Physician	Society for Social Paediatrics Czech Medical Association of Jan Evangelista Purkyně	Chairman	Face to face
Three officers responsible for Roma issue	Ministry of Labour and Social Affairs	Department of social inclusion and Department of EU funds	(2) face to face (1)writing
Head	Czech Helsinki Committee	Head	Face to face
Physician	Public Health Insurance Company	Head of local office	By phone
Coordinator of RHSA program	NGO DROM		By phone

As mentioned above, five additional experts provided detailed information where it was needed – namely, postgraduate medical education, Roma specific collection of ethnic data, and Roma use of emergency services. One nurse and one physician were additionally interviewed because they were employed in health facilities in areas with high proportion of Roma inhabitants.

7.2. Findings

The findings presented in this part of the report represent a summary of the information obtained from all sources, i.e. desk research and stakeholder interviews. Much weight was given to views, opinions, and suggestions of stakeholders. Their arguments were used not only as source of information, but also to interpret data and knowledge from other sources by evaluating their objectivity and reliability. We summarize the themes most relevant for the analysis of the health component of the NRIS either as to past processes or its future development. Finally, we present key topics to be solved and to be incorporated into the NRIS 2014–2020, as well as recommended measures.

7.2.1. Stakeholders' views on the NRIS health component as defined and implemented during the Decade of Roma Inclusion

- **No entirely clear conviction that inclusive strategy should be exclusively aimed only at Roma:** As is often argued by some politicians and by many others,[51] the worsening socioeconomic situation concerns not only the Roma. Due to economic crisis in the last few years, many Czech people lost jobs and never return to work; it concerns especially those with lower education. So, poverty with all its consequences incl. social exclusion threatens also people of major society. Also these people need to support and help them re-integrate fully into society. Therefore, the government's principal plan of action in this sphere – the *"Strategy for combating social inclusion 2011–2015*" – is not dedicated to Roma exclusively, although socially excluded localities are still mainly populated by Roma. According to some stakeholders' opinions, the economic crisis, which severely affected the Czech Republic in 2008–2013, pushed Roma issues out of the public spotlight, with ranging from curtailed funding for Roma projects to diminished public support and devaluation of Roma integration activities.
- **Health aspects on of the NRIS agenda in general**: Despite the publicly stated political will to address the issue of Roma integration, findings from stakeholders survey shows that between 2006–2013, the Government of the Czech Republic was not much committed in the topic of Roma health; especially visible was the lack of political commitment in respect to the health-care integration and related issues. Social and human rights agenda dominated. As the overall socioeconomic situation of Roma has been worsening since 1990s, some stakeholders believe this is in turn reflected in the increase of Roma health disorders. During the Decade of Roma Inclusion, key health objectives were not updated and the main tasks were repeatedly put on the agenda; however, the number of objectives has grown over the years, which is attributed to the worsening of Roma health in socially excluded localities**.** Two stakeholders of Roma origin believe that greater participation of Roma is needed in the creation of integration policies to avoid the "nothing about us – without us" approach**.** With exception of those working at central government level, most stakeholders are not well informed about the NRIS process, i.e. how it was set up and how the comment procedure/revision process was conducted, analysed, how comments were assessed and taken into account so far, and who eventually most influenced the final version.
- **MoH's role and its cooperation with MLSA:** Since health aspects of NRIS are not prioritized, MoH is not generally considered an important integration agent, which results in its half-hearted approach to Roma integration agenda. The NRIS health aspects are outlined and treated together with social services as a commonly shared agenda. Logically, a large degree of cooperation between both ministries is needed to fulfil objectives which are in their shared competence. However, stakeholders indicated that wasn't always the case, as boundaries between health and social agenda are often unclear,[52] and some issues remain unsolved due to lack of consensus on who is responsible for what. Some stakeholders mentioned separation of the agendas in order to help solve some long term difficulties caused by not always

[51] Opinion, that not only Roma are at risks of social exclusion in the CR are shared by a considerable part of Czech public; opinions like that often appears in online discussion on Roma issue; I can confirmed it since I followed such online discussions in the last few months (H.H.).

[52] It is just a case of RHSAs and their job – see details in Case study 8.3.

clear responsibilities. Some stakeholders expressed their belief that there is an urgent need of greater commitment of the part of MoH on Roma issues.

- **Roma Health Social Assistant:**[53] Since 2005, the RHSA mediation programme has been considered as the most promising measure in addressing Roma health needs. However, during the Decade of Roma Inclusion, full operation of this programme was not achieved (see details in case study). To move this initiative forward remains an urgent task for the near future, and it has to be one of the main objectives of the health component of NRIS 2014–2020.
- **NRIS 2014–2020**: Some stakeholders perceived as positive that current Government of the Czech Republic has begun paying more attention to the NRIS, and there are on-going negotiations to finalize the new strategy. The essential issues to be resolved are the quantification of the financial demands of each measure and the designation of funding sources to cover planned activities/tasks. EU funds (ESF) will once more be the principal source of funding; however, the question of sustainability has to be taken into account to prevent the replication of failure from the past as happened in case of health mediation programme.

7.2.2. Lack of valid data

According to the interviewed experts, ethnic data collection should be addressed, as the current lack of valid data is a major barrier to effective monitoring of the integration progress. Available data concerning Roma health is fragmented, often duplicated, and not always representative, leading to findings and conclusions of questionable reliability and validity. The health research agenda targeted at provision of health services to the Roma concerns mostly hospital care, typically from the perspective of the health-care providers. Studies dealing with outpatient care and addressing the well-known barriers in registration at primary care were not on the research agenda over the last decade, while State authorities must often rely on data from international sources only.

Stakeholders' view is that available data and information are not sufficient and that a structured collection of ethnic data is needed. However, there is no consensus about the type of data that ought to be collected. Monitoring of ethnicity in routine statistics is considered a very sensitive issue. According to experts in the field of medical statistics, the reporting of ethnic origin (e.g. in birth statistics) is not permitted by Czech law. However, it could be possible to collect some health data on a voluntary basis, though this would necessarily have to be accompanied by a written "informed consent" signed by the patient concerned. *Office for Personal Data Protection* – the leading authority in this respect – does not support this idea. In addition, medical staff is generally unwilling to add other new informed consent procedures to the already extensive paperwork. More importantly, even Roma stakeholders could not agree on the question of data collection. Some stakeholders supported ethnic data collection within routine statistics (to some extent), while others did not. There is fear of data abuse and even more discrimination. Some stakeholders prefer data gathering by systematic research and through Roma targeted epidemiological studies.[54]

[53] The Czech name of the position is "Zdravotne socialni pomocnik".

[54] The lack of data on minorities in the Czech Republic is perceived as a problem also in the EU context. *The European Commission against Racism and Intolerance* in its monitoring reports recommended to the Czech Republic to consider ways to monitor the living conditions of minorities, since without relevant data, it is hard

7.2.3. Trends in Roma health

Roma health is regrettably not moving in the right direction. Deterioration of Roma health is observed especially in socially excluded localities, as confirmed by the majority of stakeholders. One of them said that "it is hardly possible to meet any Roma in good health." Chronic and long term untreated illnesses result in physical disability, which is frequently observed in Roma population. Circulatory system and obesity related diseases (type 2 diabetes, for example), as well as mobility disorders affect adult Roma frequently. The main threats to child health are the increase of premature births, allergies, and respiratory diseases. High morbidity in childhood is a specific risk impacting overall immunity and influencing health later on in life. According to stakeholders' observations, oncological diseases and hemato-oncological diseases, in particular, are on the rise. Some stakeholders of Roma origin pointed to a negative trend in Roma mental health, especially the higher incidence of depression and neurotic disorders. Poor mental health is attributed to the deteriorated socioeconomic status of Roma in general, and to the increase in negative attitudes towards Roma in the Czech society.[55]

Health related risks more prevalent in the Roma population as compared to the majority were identified as follows:

- Unhealthy eating habits: overconsumption of fats and sweets, not eating enough fruits and vegetables, the emergence of a "fast food culture" among higher-earning Roma, vitamin deficiencies, inadequate iodine intake, and unbalanced maternal nutrition during pregnancy;
- High prevalence of smoking: early age exposure and addiction to smoking, Roma women smoking during pregnancy;
- A high prevalence of drug addiction in young Roma, especially in socially excluded localities**;** a growing number of drug users among pregnant Roma women;
- Poor housing standards in socially excluded localities.[56]

7.2.4. Health Promotion - Roma specific or broadly aimed at vulnerable groups?

There was no consensus among stakeholders on this question. Some stakeholders do not support to focus the strategy purely and solely on the Roma. They argue this would risk reinforcing stigmatization and labelling Roma as "victims", which could further aggravate the public's perception of Roma. In addition, the national health programmes are obviously targeted at vulnerable groups and as such, Roma would be covered. On the other hand, Roma stakeholders and those working in Roma communities (NGOs workers) would like to see more special programmes. They argue that standard programmes are not tailored to Roma needs and are thus ineffective.

to assess the extent and causes of possible discrimination and the effectiveness of anti-discriminatory actions (ECRI, 2000 and 2009).

[55] Further research would be needed to verify these observations.

[56] Interviewed from Emergency care service indicated a noticeable difference between those living in so called "Roma hostels" in isolation from majority and those living in standard flats.

In response to the identified Roma health risks factors, MoH funded the project "*Proposal for Health Promotion and Diseases Prevention Strategy for Roma population,*" submitted by the *National Institute of Public Health* in 2013 to address higher prevalence of cardiovascular diseases, diabetes, and obesity in the Roma population. The strategy has been outlined and submitted to MoH, Department of Health Programmes. Whether the strategy will be adopted or not is currently not known (MoH 2014, personal communication). Adoption of strategy and, if so, how this strategy is implemented in practice, will be decided after a completion of an amendment procedure which is being currently managed by MoH. There is a chance that the proposed in the project strategy is accepted and implemented as the first Roma specific national health promotion programme in the history of the Czech Republic.

Stakeholders of Roma origin stressed that extremely unhealthy housing conditions (fungi, limited access to hot water, etc.) are typical for the crowded "Roma hostels", and in fact pose serious public health dangers which need to be addressed without delay by the authorities. To put more pressure on both the private owners and the Roma residents to care better about their housing environment was recommended by several stakeholders. More commitment and greater involvement of public health authorities[57] in this respect is needed. Stakeholders believe that it could help.

7.2.5. Obstacles and Barriers in Access to Health care

In the opinion of stakeholders, access to health-care services is significantly worse for those Roma living in socially excluded communities. Some of the barriers reflect the overall situation in the Czech health care, while others are specific to the Roma situation; therefore some of the barriers that Roma encounter are similar to those that the majority deals with. The Roma, just like other socioeconomically disadvantaged Czechs, are faced with inadequate health-care provider networks, limited public transport to and from medical facilities, and added financial burdens due to co-payment requirements. The Roma remain one of the most vulnerable, if not **the most at-risk,** groups in Czech society.

- **Limited health service networks and public transport availability:** Areas with higher proportion of Roma inhabitants lack adequate coverage by primary care providers. The same holds true for public transport – it is very limited, if not completely non-existent. Poor Roma do not usually have cars, and cannot afford to travel to medical facilities by other means.
- **Negative impact of co-payment requirements:** Roma were significantly more negatively affected by the introduction of so called "user fees," which were not applied in a "socially sensitive way."[58] That was frequently mentioned as a significant financial barrier, and stakeholders pointed out the negative impact of user fees not only in socially excluded localities. Hospital care has also become prohibitively expensive, as all patients now (regardless of their social status, and including pensioners, children, and the handicapped) were required to pay for hospitalization, even if they are

[57] Regional Public Health Authorities/"Krajské hygienické stanice" (in Czech) are located in all regions and they are very effective in case of infections. They should check the hygienic conditions in "Roma hostels" in order to prevent infection diseases, fungi etc. (Public Health Protection Act No. 258/2005).

[58] According to the statement of the Constitutional Court – users' fees system was implemented in socially insensitive way which did not reflect social situation of patients (Ustavní soud CR, 2013).

hospitalized several times a year. Many Roma refused to be hospitalized simply because they could not afford to pay the hospitalization fee of 100 CZK (EUR 3.60) per day. Although those living under the poverty line were exempted from hospital fees, there is an additional administrative procedure required, and that in itself is a significant barrier for the Roma. Due to various reasons (lack of information, missing documents, emotional barriers, etc.), Roma patients are not well adapted or prepared for dealing with hospital red tape, and as a result frequently miss out on needed medical care. Therefore **permanent elimination of hospital fees at the beginning of 2014 was in fact highly appreciated by most stakeholders.**

7.2.6. Access to emergency medical service

Available information suggests that in terms of access and use of emergency care, Roma people are probably not disadvantaged. Two interviewed physicians and one paramedic working in emergency (rescue) ambulance did not identify difficulties in providing services in Roma households, even in socially excluded localities. They pointed out that standardized professional guidelines which they are required to follow disallow any form of unequal treatment. As to claims of potential overuse of emergency services by Roma – two respondents from the rescue ambulance services rejected that notion. They were not aware of any difference between Roma and the majority population in that respect. However, one interviewed stakeholder expressed a different view. He claimed that some Roma used ambulance even when they do not want to wait in the waiting rooms of GPs. However, it is not possible to generalize information which is based on the subjective opinion of few individuals. We can only presume that Roma overconsumption of emergency services is not common and it might be sometimes overestimated by those with prejudices against the Roma. Such practice is neither acceptable, nor tolerated and there are no reasons for fear or insecurity. Any difficulties regarding the validity of Roma health insurance in emergency situation were not reported although this was mentioned as relatively common situation in case of migrants.

7.2.7. Discrimination and disrespect

Physicians and other health-care personnel who were interviewed as stakeholders expressed the opinion that prejudices and stereotypes against Roma in the health-care system are real and present. Although the Czech health-care system is in theory equitable and fair, in practice Roma discrimination occurs regularly, and largely manifests as a systematic attitude of neglect and indifference towards Roma patients which is rooted partially in prejudice and racism, but also brought on by the poor social status of most Roma. Most stakeholders attributed the discriminative behaviour of health-care providers not to Roma ethnicity per se, but predominantly to poverty and low socioeconomic status. Some said that poor Czechs face also discrimination compared to rich and successful individuals.

Health-care discrimination against the Roma comes in various forms. Doctors often communicate with them or speak of them as “second class citizens”, even if no instances of Roma patients being denied hospital admission were reported. Roma in general do not feel comfortable in health-care environments and thus they try to avoid them altogether if possible (*stakeholder of Roma origin*). They are often afraid of the medical procedures, not

least because doctors and nurses rarely take the time and effort to provide adequate and culturally sensitive explanations – even worse, they sometimes make disparaging comments about Roma patients' personal hygiene or other deficiencies. This is likely one of the reasons for the lower rates of participation of pregnant Roma women in prenatal care programmes, and for Roma women leaving the hospital early and without being cleared to do so following childbirth.[59]

Interviewed stakeholders estimated that more than 50 per cent of Czech health-care professionals engage in discrimination and prejudices against the Roma. Unfortunately, many of them are themselves not aware of that fact. Such seems to be the norm in the health-care facilities located close to deprived and socially excluded localities, according to physician who had gone to work there from Prague hospitals. He said such discriminatory treatment was clearly not tolerated in "standard" Czech hospital environments, especially in large university and city hospitals with appropriate organizational culture ensuring equal treatment. There was a consensus among stakeholders that health-care discrimination against the Roma was predominantly a perverse form of superiority and lack of empathy rather than an outright refusal to treat Roma patients. Other stakeholders pointed out that not only Roma but also chronically ill and poor Czechs suffer from lack of respect and ill treatment by some health-care professionals. But stakeholders also emphasized that of many health-care professionals are committed to providing high quality health care to all patients regardless of status or background. The ratio of these opposite categories is unknown objectively.

Irrespective of personal opinions, discrimination affects the daily life of all Roma citizens. In sum, three main areas of discrimination against the Roma: Some doctors' reluctance to register Roma patients (especially dentists and gynaecologists); a general attitude of superiority and condescension, and lack of respect and empathy for Roma cultural sensitivities and differences; excessive and deliberate use of medical jargon, resulting in emotional distress and confusion in Roma patients.

7.2.8. Roma topics in medical education and in postgraduate training of health professionals

Stakeholders working in education identified two specific areas for improvement:

- **Low awareness among Czech health-care professionals of the Czech anti-discrimination law:**[60] Stakeholders from the education sector expressed the idea that health professionals are not aware of their own discriminatory practices simply because they are not informed about the nature of discrimination as defined by law. They are not provided with any information on the anti-discriminatory law in the course of their graduate studies or postgraduate training It is highly recommended to address discrimination issues as part of the overall legal topics education curriculum in medical and nursing schools in order to increase the awareness that equal treatment and no form of discriminatory practices are an essential attribute of professionalism. The topic of discrimination is currently not even included in medical ethics, medical psychology, and communication training for medical professionals. This needs to

[59] Independent research is needed to get more detailed information to explain it.

[60] Act No. 198/2009 Call, on equal treatment and legal means of protection against discrimination (Anti–discrimination law).

change, and as stakeholders point out, it would benefit not only the Roma but all other disadvantaged or vulnerable groups.[61] Stakeholders agreed that to begin an earnest discussion about discrimination in the medical community would go a long way in rectifying the existing "pro-discriminatory" culture. However, other stakeholders declared that unless Czech society as a whole modifies their attitude towards minorities, nothing would change for the better in health care.

- **Roma cultural differences and related health topics are not adequately covered in the education of medical staff**. While at a general level, this topic is included in curricula at both graduate and postgraduate level, it depends very much on the individual instructor how much, if at all, Roma issues are dealt with. Curricula lacks more detailed determination which topics should be taught and to what extent. The situation is better in nursing schools, where the curriculum has a mandatory multicultural module (introduced by MoH in 2008), covering the Roma among other groups.[62]

[61] For example, in the last period, Ombudsman´s Office recorded a number of complaints filed by handicapped.
[62] Bulletin of the Ministry of Health of the Czech Republic, 2008, part 6, page 12.

8. RECOMMENDED MEASURES

In response to identified barriers, obstacles, and discrimination practices towards the Roma, some stakeholders characterized the current Czech health system as too liberal and much less coordinated than needed. They urged more regulatory measures to reduce difficulties not only for Roma but for other vulnerable groups (e.g. homeless, migrants) as well. Recommended measures related to all discussed topics are summarized into five categories:

1. Access to health care

- MoH, as the main health-care regulatory agency, needs to be more proactive with respect to Roma health issues, in addressing and eliminating all well-known obstacles and barriers Roma face in the Czech health-care system;
- MoH and MLSA need to step up collaboration of over relevant Roma issues, with MoH taking the lead;
- The role of primary care providers (GPs, gynaecologists, dentists) needs to be redefined in a community context and with regard to adequate and accessible care for disadvantaged groups, including the Roma; [63] GPs' responsibilities in terms of care for Roma children needs to be clarified and clearly communicated;
- Preventive medical exams in primary schools need to be reintroduced, as in the past.[64]

2. Elimination of discriminatory practices could be implemented through

- Collecting data about the Roma in all relevant areas of integration, and using it for implementation of an evidence based integration policy in health care;
- Raising awareness of the Roma of their constitutional rights; providing legal support to Roma patients regarding complaints about discrimination and unequal treatment;
- Strengthening Roma themes and addressing discrimination issues in professional training of health personnel as a standard part of teaching programmes (see above);
- Monitoring the reluctance of GPs to register Roma patients and taking appropriate remedial measures, both disciplinary and educative.

3. Increasing the Roma's awareness of their own health and of the Czech health-care system

- Incorporate this topic in school curriculum for all children in primary and secondary schools (not just Roma students); in areas with higher proportion of Roma population, adapt these programmes to the local Roma specifics;
- Develop special health programme for pregnant Roma women in order to reduce risky behaviours (smoking, unhealthy nutrition);[65]
- Consider specific forms of awareness raising activities and campaigns for a more Roma targeted approach; cooperate with various Roma artists is one viable option;
- Support sport activities for Roma children and adolescents.

[63] The experts having health-care background much emphasized that.

[64] This programme was cancelled in the 90s in frame of the general liberalization of health policy and shift of responsibilities for prevention exclusively to parents.

[65] Although there is no entirely clear consensus regarding the need for development of specific health programme for Roma since some stakeholders questioned such programmes being ineffective and counterproductive for Roma, pregnant women were highly recommended to be prioritized in any future such.

4. Roma topics to be incorporated into professional training of health personnel

- Prejudices and discriminatory practices should be addressed in the context of medical ethics/medical law lectures at both graduate and postgraduate level;
- Medical curricula should be standardized in terms of content and scope of the topics and number of teaching hours. Relevant teaching materials should be developed and undergo professional review to ensure integrity and accuracy;
- Courses tailored to region and Roma specific situations to be organized in areas with higher percentage of Roma residents; this could be accomplished under the aegis of regional authorities and/or organizations (regional offices of the Czech Medical Chamber, professional societies, etc.); securing the support of the Czech Medical Chamber and other professional organizations is absolutely paramount.

5. Empower and support the Roma Health and Social Assistant programme (refer to case study)

9. CASE STUDY - ROMA HEALTH AND SOCIAL ASSISTANTS IN SOCIALLY EXCLUDED AREAS IN THE CZECH REPUBLIC

At the beginning, the RHSA's initial assumption was that in socially excluded localities there was also an increased risk of inaccessibility to health care due to:

- Lack of information about health and health determinants;
- Lack of trust in government agencies, including public health institutions;
- Inability to effectively communicate with physicians;
- Unhealthy life style and poor living conditions;
- Inadequate health-care services coverage and availability.

The case study relies on secondary data and data from experts' interviews to provide an overview of the Roma Health and Social Assistant (RHSA) project in socially excluded localities in the Czech Republic. Activity of RHSAs is regarded as one of the few effective mechanisms which can make a difference by directly combating the social and health-care exclusion of people in segregated communities. To understand RHSA's current state of affairs, it is necessary to look at the programme's inception and its subsequent development.

9.1. Genesis of the RHAS project in the NRIS context (1999–2003)

The history of RHSA project can be traced back to the late 90s, when a large study on the health status of the Roma population was carried out within the framework of the MoH research agenda. The study highlighted some Roma lifestyle specifics and provided some insights into Roma health attitudes, health status, and health-care consumption patterns (*Nesvadbová, 2003*). In the 2002, based on the activities of the Government Council for Roma Community Affairs (GCRCA), a *Roma health assistant* position was created at the municipality of Ostrava (Vláda ČR, 2005; Vláda ČR, 2006; Agentura pro sociální začleňování, 2014c). Lydia Poláčková,[66] a member of the Government Council for Roma community and a long-time Roma coordinator in the Moravia-Silesia region (and a nurse by profession) gets much of the credit for the initial implementation of the idea and the project. She considered the health and health-care aspects of Roma integration crucial but underserved in the context of the Czech integration policy (*stakeholder's interview*). The introduction of the position of "Roma health assistant" in Ostrava proved very useful. For example, cooperation between Roma and GPs was improved (Vláda ČR, 2005).

9.1.1. Early development of RHSA (2004–2005)

RHSA's initial institutionalization began in 2004, when the Government of the Czech Republic instructed[67] the MoH to submit a proposal for the establishment of a Roma health assistant position**.** The initial intention was not to establish a new health professional job classification, but a non-professionals (predominantly of Roma origin) working as a mediator/advisor in matters related to health care and disease prevention. In 2005, MoH developed an RHSA methodical guideline[68] and provided a job description. Consequently, a Government

[66] She participated in stakeholders' interview.
[67] Resolution of the Government of the Czech Republic No. 607 in 2004.
[68] Methodical Guideline for Health and Social Assistants in excluded localities, Ministry of Health, 2006.

Resolution[69] supported the RHSA project to introduce a new type of public health service for the Roma. The aim was to create a network of RHSAs who would work in socially excluded localities, mainly inhabited by members of the Roma community. The Methodical Guideline issued by the MoH also included prerequisites for applicants for the RHSA position. They were: completed primary education as a minimum (completed secondary education was considered an advantage); completed training course on health prevention and legal minimum provided by the Institute of Postgraduate Medical Education, as well as personal integrity (clean criminal record and no addictions).

9.1.2. Pilot phase (2006–2007)

The legitimacy and need for the RHSA position was tested in a two year pilot project called "SASTIPEN Czech Republic – Roma Health Social Assistants in excluded localities" (2006–2007). The Project was managed by the NGO DROM – Roma Centre located in Brno city, and was implemented in seven regions (South Bohemia, Hradec Kralove, Pardubice, South Moravia, Olomouc, Zlín, and Moravia-Silesia Region). From the beginning programme was supposed that the programme may have a secondary positive effect on the employment of Roma, since some eligible Roma applicants might obtain job as a health assistant and improve their skills through additional training. Though it was not explicitly stated, it was assumed that the RHSA positions would be filled by primarily by Roma applicants, mainly for two reasons: a) Roma would assist other Roma would generally be trusted by the community; b) project would contribute to raise the employment of Roma.

The MoH saw as a more flexible to implement the project by a NGO than by national/local administrative structures. The MoH argued that it provides, inter alia, the disbursement of funds from the ESF, namely through the Operational Programme Development of Human Resources (under the authority of MLSA), enabling financing of the RHSA project framed as social work. Thus, the pilot phase (2006–2007) was funded under two ESF calls, titled "Professional training of social workers" and "Integration of specific target groups" respectively.[70] A minor part of the RHSA project was financed through the State budget.

During the pilot period, RHSAs worked in 15 locations with 209 clients and their families, completing 494 cases and 620 interventions. A typical profile of a client was a 33 year old woman living in a socially excluded Roma community. The work of the RHSAs proved to be very effective, especially in respect to the increased interest of parents in the health and health care of their children, also in improving the Roma cooperation with general practitioners in doing regular preventive check-ups and vaccinations.

Training programme: The pilot project also included a training programme for the RHSAs which was developed and implemented by DROM in collaboration with two universities (Masaryk University, Medical School and University in Ostrava, Health Social Care School). In total, 19 participants passed successfully the training programme in 2007. Later, in 2008, the training programme was accredited by the Ministry of Labour and Social Services as the

[69] Resolution of the Government of the Czech Republic No. 219 in 2005.

[70] As a further source of funding, "Joint Regional Operational Programme" guaranteed by the Ministry of Regional Development was proposed.

Training Programme for Roma Health and Social Assistants within the framework of continuing lifelong learning for social service workers.

Curriculum: The training programme consisted of several modules, comprising a total of 348 hours. Detailed study materials were developed and published by DROM in 2008.[71] RHSAs were trained not only in the field of basic medical knowledge, but also in methods and techniques of social work. The programme was focused on public health topics such as child care and care for pregnant women, basics of hygiene and epidemiology, health promotion and disease prevention, relevant social medicine topics, etc. Some related cross-sectional topics, e.g. social work methods, communication skills, and computer skills were also included. Overview of the Czech health-care legislation and social security system accounted for a large part of the programme. Besides theoretical study, practical work in field covered a proportional part of the training. Final examination included a written paper concerning one of the studied topics, and an oral exam. The oral part was based on discussion of the interventions provided to individual clients within the framework of the casework.

9.1.3. Development in 2008–2014, evolution of interventions

Since the pilot project's conclusion in 2007, RHSA activities have been financed exclusively through the State budget for social services.[72] Because of the government's restrictive budgetary policy between 2008 and 2013, there was very limited room for further development of this service. Due to the European economic crisis, social problems were on the raise, but funding was not available. The number of RHSAs trained and employed in the pilot phase year by year declined to eight (8). Interviewed stakeholders indicated that over the years, the focus of RSHA activity has also evolved in the context of deterioration of the socioeconomic situation of the Roma, namely loss and/or deterioration of housing, increase in debt and unemployment. Opportunities for health promotion dwindled, although the work of RHSAs intensified. For example, in 2010, a total of 6,890 interventions took place with 519 clients, of which 70 per cent were women. The RHSAs worked on 950 long-term tasks in total. Long-term tasks were successfully completed in 73 per cent of cases, i.e. the target set together by the client and the RHSA was achieved. Tasks were related to Roma registration at doctors' offices, health insurance issues, diagnostics/treatment of long-term untreated illnesses, improving sanitary conditions, vaccination, reduction of substance abuse, etc. In addition to their long-term tasks, RHSAs also provided one-off interventions to another 960 clients (DROM annual reports).

Quality assessment: Client surveys in the form of questionnaires were done to assess the quality of the RSHA service in 2010 and 2013. The survey included a total of 100 to 200 randomly selected clients and representatives of collaborating institutions (medical staff, municipal offices, the Labour Office, and non-profit organizations). In both years about 75 per cent of users saw at least some positive change, for example, increase in registration with physicians and increased number of regular visits to physicians; more than half of the clients declared that the cooperation within the RHSAs provided them with new information they can use in everyday life, such as newly acquired skills related mainly to communication with authorities and physicians. Most clients showed an interest in using the service again in the

[71] See "Study material for field workers providing health and social assistance", DROM, Brno 2007.
[72] Act on Social Service No. 106 /2006.

future. Half of the clients believed that in case of termination of the RSHA service in the area, they would have no one to turn to for assistance with their health related problems. Almost all users were satisfied with the way services were provided and about one third of users would appreciate an even more intensive cooperation. All users praise the interpersonal and communication skills of the RHSAs. Representatives of the RHSA collaborating institutions also reflected on the service positively, and health professionals specifically emphasized its educational aspects.

9.1.4. RHSA programme – current State of Art

In spite of the official support in the NRIS,[73,74] as well as all stakeholders' consensus on the urgent need of a RHSA position including the positive experience from practice (as mentioned above), the programme has not been anchored in either the Czech health services system and the standard social services system. Czech legislation doesn't provide an adequate legal framework for implementation of the RHSA programme in terms of employment status and professional competencies. Although RHSA interventions are being currently covered by the social services budget,[75] they do not belong to the standard social services package, and thus their financing is not continuous and excessively dependent on the availability of project funding. Guidelines and job requirements developed in 2005 should be also revised. By law, non-professionals cannot provide social services as it was originally suggested by MoH. A Bachelor's degree or a Diploma in social work is needed at a minimum. So, there are currently only eight (8) RHSAs working in three regions, while between 30 and 150 are in fact needed (stakeholder interviews). It is not surprising that stakeholders working in Roma communities estimate a much greater number of RHSAs is needed compared to other stakeholders (politicians, health-care managers, government administrators).

9.2. Overview of the main RHSA interventions

- **Prevention, preventive examinations, vaccination:** intervention takes the form of mediation of a Roma contact with a doctor or presenting the information. RHSAs informed clients about the prevention of number of health problems, such as obesity, infectious diseases, and sexually transmitted diseases. They supported patients during preventive visits at paediatricians, gynaecologists, and dentists. A large portion of RHSAs' workload consisted of collaboration with physicians to ensure compliance with mandatory vaccinations of children. They often accompanied Roma people to the doctor or subsequently checked whether the patients had visited the doctor.
- **Pregnancy and baby care:** RHSAs asked pregnant women whether they go for regular checks and when needed, they actively collaborated with physicians to monitor these mothers. Another part of the interventions concerned topics such as early child development, harmful effects of smoking during pregnancy, and information on hospitalization.
- **Registration and re-registration for doctors:** Clients of RHSAs relatively often asked for help in this respect, mainly concerning registration at GPs and gynaecologists.

[73] See NRIS 2010–2013: "Support and Enlargement of RHSA programme".
[74] See the working version of the Roma Integration Strategy to 2020.
[75] Some stakeholders considered it temporary "emergency" solution.

Sometimes the reason was change of residence, and at other times loss of contact with a registered doctor due to long periods of time between visits.

- **Processing of disability pension and mobility support:** RHSAs assisted in reviewing pensions payments for accuracy (i.e. change from partial to full disability pension) and identification of potential claims. RSHAs assisted Roma clients with the necessary paperwork. They also helped with the administrative procedure for obtaining of various types of assistive devices – from crutches to hearing aids.
- **Psychological problems:** A significant part of interventions consisted of assistance with psychological problems of children. RHSAs managed to order to the medical specialists (psychiatrist, neurologist) or by clinical psychologists. Other cases concerned adult clients suffering from depression for various (i.e. loss of dwelling, poor health, substance abuse). In these cases, RHSAs provided emotional support in addition to contacting the appropriate medical specialists.
- **Obesity:** RHSAs intervened in cases of obesity amongst children and adults. In some cases they mediated anti-obesity treatments.

9.3. Summary

In spite of the official support in the NRIS, as well as all stakeholders' consensus on the urgent need of a RHSA position including the positive experience from practice (as mentioned above), the programme has not been anchored in either the Czech health services system and the standard social services system. The main reasons are as follows:

- Following the initial RHSA stage (2005–2006), no long-term or sustainable sources were directed to this programme; the project relied on the ESF financing, and when this ended no additional resources were allocated, so no further development was possible.
- Neither of the two responsible agencies – MoH and MLSA – appeared committed to the implementation and management of this valuable programme. They expected greater involvement of partner institutions, but in the meantime they were unable to agree on long-term financing, on the professional status of the RHAS mediators, or on the programme's management structure.

However, despite these fundamental flaws and management failures, the RHSA project not only survived the pilot phase, but demonstrated that it can be scaled and implemented successfully in multiple locations, offering a real opportunity for change and progress. Undoubtedly this was due in no small part to the personal involvement, commitment, and professionalism of individual RHSAs who stayed with the programme.

10. CONCLUSION

NRIS health aspects in the Czech Republic were not sufficiently addressed during the Decade of Roma Inclusion. Agendas concerning employment, housing, and education dominated the health related agenda. That was the reason why EU funds were sparsely allocated to Roma integration projects related to health care. Only one project – Roma Health Social Assistance (RHSA) – was dedicated to the health aspects of Roma integration. Despite successful pilot phases and consensus of the most stakeholders about the urgent need for such a programme, the RHSA project has not become the permanent part of the Czech health-care system, or the standard social services agenda.

The available data indicate a significant Roma health inequalities and disadvantages compared to the majority. Regrettably, an accurate data on Roma health in the Czech Republic is currently not available since ethnicity is not monitored in routine statistics. According to data from international and domestic academic research, reports of NGOs, and expert estimations, Roma health is significantly worse compared to majority. The average Roma life expectancy is about 10 years lower and Roma infant mortality is two times that of the general population. Roma suffer from high prevalence of chronic conditions such as cardiovascular diseases, the type 2 diabetes, mobility disorders, and back pain. Limitations in daily activities due to poor health are common reason for disability at a relatively young age. The causes are complex, but include socioeconomic factors such as poverty and low health literacy among others. Among related health risks which are more prevalent in the Roma population compared to the majority are poor housing standards, unhealthy eating habits and inadequate nutrition, smoking from young age and drug addiction. Thanks to the fact that the vast majority of Roma are Czech residents with mandatory participation in the public health insurance system, they do not generally face significant barriers in their legal entitlement to health care. But in everyday life they have to deal with many obstacles of a different nature which make their access to health services more difficult when compared to majority. In this context, the relevant issue is discrimination against the Roma – regrettably still seen as the norm rather than the exception not only in employment, housing, and education – but also in the health care. Stakeholders' observations confirmed what research findings had already pointed out – the widespread discriminatory practices towards the Roma in the Czech health-care system. Discrimination does not take the overt and direct form of a health-care service refusal. It is most often manifested in doctors' reluctance to register Roma patients, in the medical personnel deliberate use of medical jargon, in health-care staff's insensitivity to ethno-cultural issues, and doctors' downright haughtiness – all of which cause Roma patients confusion and undue emotional distress. In summary, this means that Roma are not denied health care, but the problem is rather in the poor interpersonal quality of the health care delivery to Roma, which can be due to widespread prejudices against Roma.

As to health-care services consumption, Roma utilizes significantly less dental and preventive services, including those for children, though it may not be true for other medical services. The co-payments also create substantial financial barriers for some Roma. It is most evident for prescription pharmaceuticals. In this context, the government's decision to abolish permanently all users fees (except for emergency services) starting in 2015 is a positive development. In order to address other identified obstacles and barriers, stakeholders recommended adopting measures which are summarized into five categories. The

improvement of access to health care by removal existing barriers and obstacles; the elimination of discriminatory practices; increasing the Roma's awareness of their own health and the Czech health-care system offering; incorporation of Roma topics into professional training of health personnel; and ensuring availability of Roma health mediators. In each category specific measures are proposed which could lead to more effective Roma national integration policy in the Czech Republic when incorporated into the NRIS in the near future. The often mentioned precondition for a successful implementation of the health aspects of the NRIS is a greater involvement of the Ministry of Health. Regulations to overcome identified difficulties and barriers are urgently needed, for example to redefine the role of all primary care providers, as well as more precisely identify GPs' responsibilities in terms of care for Roma children. The discrimination has to be addressed through a better collection of relevant data, strengthening Roma awareness of their own rights, and including Roma specific themes in the professional training of health-care personnel. A steady effort needs to be directed at improving Roma health literacy, in particular that of children and pregnant women, through targeted health promotion programmes. The availability of health mediation personnel especially for Roma living in excluded localities is considered very urgent task for the upcoming period.

To monitor the effectiveness of the integration process is essential to have valid data, which is impossible without collection of certain ethnic data.

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