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Kosovo's Roma: a Challenge for Public Health

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Access to healthcare for Roma in Kosovo, as in other parts of the region, is low, but this problem is compounded by a number of factors unique to Kosovo. For a start, the Albanian-speaking Ashkalia and Egyptian groups increasingly distance themselves from Serbian-speaking Roma, in line with the general ethnic tension in the country. [1] Second, the fact of ethnic violence has engendered a fear of racial victimization among Kosovar Roma, Ashkalia and Egyptians (RAE) [2] more acute than elsewhere. Third, RAE generally live in enclaves protected by the UN, separate from the general population of Kosovo, often far from health centres.

Kosovo, a province of Serbia within the Federal Republic of Yugoslavia, [3] is currently governed by the newly inaugurated "Kosovar Provisional Institutions of Self Government", with administrative support and oversight provided by the United Nations Mission in Kosovo (UNMIK), [4] and security guaranteed by the NATO-led KFOR. [5] Although Yugoslavia is unlikely to join the European Union in the near future, governments in Kosovo, Serbia proper, and Montenegro have begun to incorporate Council of Europe guidelines into ongoing reforms. [6] Some of these reforms, which include respect for the rights of minority groups, have been instituted in current EU candidate countries as part of their accession. [7] Given the importance, for Yugoslavian integration with Europe, of improving conditions for RAE, and the fact that the promotion of human rights is central to UNMIK's mandate, better access to essential services, such as healthcare, must be high on the agenda of government and international and national organisations alike.

Many Roma in Kosovo do not travel outside of the KFOR-guarded enclaves in which they live. Further, they reside in an area essentially administered by the UN. As the UN becomes increasingly involved in government-building worldwide, UN ability to address the needs of the most vulnerable is becoming more relevant to the welfare of minorities such as the RAE, as well as to the integrity of the institutions the UN seeks to establish.

Although public health indicators for Kosovo residents are currently quite poor, figures for the RAE population, where available, point to even worse health conditions. For example, according to community reproductive health surveys conducted by Doctors Of the World (DOW), 56 percent of mothers surveyed in the RAE-inhabited Internally Displaced Persons (IDP) Camp in Plemetina gave birth at home; 12% reported losing a child in the first month after birth. For a rough comparison, the overall Kosovar "perinatal mortality rate" (including stillbirths and deaths under 7 days) stood at 2.82 percent in 2001. [8]

Reasons for the gaps in health conditions are manifold and difficult to isolate. Security concerns, both real and perceived, remain a primary barrier to improving the health status of the RAE population. Only some RAE enclaves have medical facilities, many of which provide only primary care for a few days a week at most. Travel outside of the enclave is therefore often necessary for healthcare access, but is not always safe. The Organization for Security and Cooperation in Europe (OSCE) recently reported "a gradual decrease in security incidents" affecting ethnic minorities in Kosovo, but the organization also reported "the continued existence of day-to-day intimidation and harassment, as well as the occasional […] occurrence of extremely violent ethnically-motivated attacks." [9] These incidents include murder, threatening letters, grenade attacks, attempted rape, arson, and street abductions. Violence towards RAE has been perpetrated by both Serbian and Albanian offenders. [10]

Even in cases where RAE do not fear travelling to health facilities outside their community, they are often unable to gain access due to lack of transportation. In some RAE communities, no public transportation exists and very few families own a vehicle. In others, public transport is prohibitively expensive. Many Kosovar RAE have so little income that they cannot afford the five or six Euros necessary to travel to secondary (or in some cases, even primary) healthcare in neighbouring towns.

In addition, RAE often cannot pay for the health services themselves. Although healthcare is nominally free in many East European countries, including Kosovo, healthcare providers routinely require payment for services and accept bribes to prioritise patients. In many cases, these payments are essential to receiving healthcare services. As RAE in Kosovo are generally poorer than other minority groups and the majority population, out-of-pocket payments affect this group disproportionately. [11] Moreover, in some cases, fees are reportedly higher for RAE. The OSCE and UNHCR assessment of the situation of ethnic minorities confirms that RAE living in the Prizren region have complained of being charged high fees for both services and medicines, despite having the right to receive both free of charge. [12]

Many of those RAE who overcome security, transport, and financial barriers to access healthcare report discrimination and poor treatment once they reach a facility. Poor treatment of RAE patients on the part of providers

stems in large part from the providers' perceptions of their working conditions and their work assignment. Serb providers working in the Plemetina IDP Camp health clinic, a small primary care facility in a community served by DOW, report low morale due to working at what is regarded as a degrading post. This outlook, exacerbated by the great inadequacy of the facility itself, negatively affects the quality of care provided. In other cases, providers simply refuse to work in facilities serving RAE communities. In the winter of 2001-2002, Kosovo Serb doctors refused KFOR transportation from Mitrovica to neighbouring RAE enclaves, resulting in a discontinuation of healthcare services and distribution of medicines in those areas. [13] This reluctance or refusal to work in facilities serving the RAE populations is indicative of the discrimination RAE sometimes claim to face when accessing healthcare. [14]

The barriers to healthcare access described above are compounded by low levels of knowledge within the RAE communities regarding the importance of consulting health providers, and of other general health issues. According to community health surveys conducted by DOW, 40 percent of Ashkalia mothers in the community of Fushe Kosove did not see a doctor during their pregnancy; all but nine percent of these said they did not think it important. Seventy-five percent of sexually active women surveyed did not use any method of contraception; 79 percent of these had no information about contraceptives.

Human Rights Watch, the European Roma Rights Center, and Voice of Roma have all criticized the failure of international and national entities to make a commitment to improving the situation of RAE, including access to healthcare. UNMIK, WHO, and the newly formed Kosovar Ministry of Health (which leads health reform in Kosovo) have all failed to improve the situation significantly. For example, for much of 2001, RAE living in the UNHCR-run Plemetina IDP camp were only able to access healthcare in the nearby Obilic health centre using transport provided by the UNHCR implementing partner, the Italian Consortium of Solidarity (ICS). The health centre available to the Ashkalia population of Medvec is supposedly staffed two days a week by a physician; in fact the doctor attends the facility only sporadically. The health centre serving the Ashkalia population of Fushe Kosove is larger and thus regularly staffed, but basic equipment, including an examination table, was unavailable prior to a DOW donation. All these gaps are contrary to standards laid out in the Kosovo Health Policy. [15]

The failure of UNMIK and the new Ministry of Health to address these issues is in part enabled by the absence of an organized RAE political voice and a concomitant incapacity to seek international assistance. The RAE population is itself increasingly fragmented as different groups attempt to align themselves with either the Serbian or Albanian population. [16] In addition, RAE often lack capacity to access the international assistance provided to their Serbian or Albanian compatriots, due to having little project management experience and low levels of English proficiency. [17]

To address these issues at both provider and client levels, Doctors of the World initiated its "Minority Health Education Project". Utilizing a two-pronged approach, RAE community members are trained as Peer Health Educators (PHE) and healthcare providers are trained in the provision of culturally appropriate care. The Project also includes advocacy training and support related to healthcare access.

The Project has had considerable success in training PHEs, but has encountered obstacles in implementing training for providers. Although the RAE population has become fractured, DOW has been able to foster unified groups within and between communities. Working from the assumption that RAE are not only the target group, but also the practitioners of solutions to poor health service access, DOW has convened meetings for PHE training at which members of different communities share experience and participate in training activities together. This has fostered the formation of a cohesive but mixed (incorporating Roma, Ashkalia, and Egyptian) group of educators who have already proceeded to educate over 1,300 members of their respective communities on nutrition, hygiene, and basic reproductive health issues. PHE enthusiasm has enabled significant project expansion to occur, such as the provision of graphic art training and the formation of community-based Health Committees, in addition to enhancing planned activities such as week-long advocacy training sessions. The Project has expanded to include a youth component, which addresses the issues included in adult training, as well as sexually transmitted infections (STIs), HIV/AIDS, and life skills. DOW has been able to link up with the OSCE-initiated RAE Community Advocates Training, and has established relationships with RAE NGOs.

PHEs have visited health facilities both inside and outside of their enclaves, and, where relevant, relayed positive experiences to fellow community members, decreasing fear of either discrimination or abuse at the hands of Albanian or Serbian providers. Although DOW has not yet conducted a mid-project impact assessment, anecdotal evidence suggests that the PHE-led trainings have improved knowledge regarding the importance of accessing

healthcare. Providers in community and neighbouring facilities report that attendance of RAE at healthcare facilities has increased, and that these individuals are more actively participating in their care, asking pertinent questions and engaging providers. Health centre records support this conclusion; in one health centre accessed by Roma and Ashkalia living in a targeted community, utilization by Roma and Ashkalia increased by a factor of ten after five months of PHE-led community sessions.

A significant continuing obstacle is the unreceptive response of healthcare providers to training addressing the specific needs of the RAE population. DOW has been able to garner health facility support in providing health education to RAE, but has not succeeded in convincing Albanian or Serbian providers of the importance and necessity of improving the quality of care provided to RAE. [18] The infrequency with which most health facilities in RAE areas are staffed presents another barrier to provider training.

DOW has thus reoriented project activities to focus more on the client side, while DOW staff and PHEs continue to lobby UN and the Ministry of Health to give greater attention to the low health status and access barriers faced by the RAE population. For example, DOW PHEs successfully lobbied Lipjan municipal authorities and the health centre Director to improve attendance of health professionals at the Medvec clinic. The doctor now reliably attends two days per week. DOW continues to work with providers by involving them in discussions regarding the outstanding health needs of RAE communities, and by donating basic hygiene and examination equipment to these facilities. PHEs now work alongside doctors in the clinics and conduct health educations sessions in waiting room areas, encouraging the doctors and nurses to participate in sessions. This involvement should increase morale, and thus the support of healthcare providers for the project and their willingness to treat RAE patients.

It is discouraging that the RAE in Kosovo face such a low level of international and national commitment to improving their health access and status. Given that Kosovo is the only province in the region that is effectively governed by the United Nations, an organization founded to "reaffirm faith in fundamental human rights," and that the newly formed Kosovar government is effectively undergoing a trial period in terms of its treatment of resident minorities, it is imperative that UNMIK, WHO, and the respective Kosovar ministries lead the development of a multi-sectoral approach to address the barriers to healthcare access outlined above, and that these initiatives incorporate RAE populations in identifying ways to improve their own health.

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Footnotes

[1] Sani Rifati, President of the advocacy organization "Voice of Roma" and a native of Kosovo, explains that "while both the Ashkalia and the Egyptians have for some time had a separate minority identity from the rest of the Romani population in Kosovo, until the past few years, they still acknowledged to themselves and others that they were Roma." Cited in: Bloom, C. et al. *The Current Plight of Kosovo Roma*, Voice of Roma, 2002.

[2] For the sake of inclusiveness this paper uses the term RAE to cover "Roma, Ashkalia and Egyptians", although we are cognizant of the fact that not all members of all groups would accept the appellation.

[3] On 14 March 2002, it was agreed that Yugoslavia is to be renamed "Serbia and Montenegro". At time of publication this change has not yet occurred. See here: http://www.mfa.gov.yu/Facts/agreement_e.html .

[4] Since 1999, UNMIK has performed the whole spectrum of essential administrative functions and services in Kosovo, covering such areas as health and education, banking and finance, post and telecommunications, and law and order. See here: http://www.unmikonline.org .

[5] The Kosovo Force (KFOR) is a NATO-led international force responsible for establishing and maintaining security in Kosovo, and providing assistance to UNMIK. For more see here: http://www.nato.int/kfor .

[6] Including the European Convention for the Protection of Human Rights and Fundamental Freedoms, the Framework Convention for the Protection of National Minorities, and the European Social Charter. Yugoslavia is a "Special Guest to the Parliamentary Assembly" of the Council of Europe.

[7] Goldston, J. A., "Roma Rights, Roma Wrongs", *Foreign Affairs*, March/April 2002, pp.146-162.

[8] World Health Organization and UNICEF. *Report of Maternity Wards Year 2001*. These two figures are not directly comparable, as perinatal mortality does not include deaths occurring between 7 and 30 days and relates to numbers of infants, rather than mothers. The gap is nevertheless instructive.

[9] OSCE /UNHCR, *Ninth Assessment of the Situation of Ethnic Minorities in Kosovo*, Pristina, Kosovo: OSCE /UNHCR, 2002.

[10] European Roma Rights Center, "Snapshots from Around Europe" in *Roma Rights*. Online here: http://www.errc.org .

[11] Makhalev, V. et al, *Qualitative Poverty Assessment Kosovo: Review of Secondary Materials*, Pristina, Kosovo: Inter-Agency Sub-Group on Poverty, 2000.
[12] OSCE /UNHCR, *Ninth Assessment of the Situation of Ethnic Minorities in Kosovo*, Pristina, Kosovo: OSCE /UNHCR, 2002.
[13] *Ibid*.
[14] One DOW peer health educator reports being told that a particular medicine was not available at a certain health centre, although boxes were clearly displayed on a nearby shelf.
[15] World Health Organization, *Interim Health Policy Guidelines for Kosovo*, Pristina, August 2000. Online here: http://www.who.int/disasters/repo/5635.doc .
[16] For example, the community leader in Fushe Kosove presented DOW with a document explaining that the Ashkalia population of that community was not related to the Roma, but was in fact descended from Persian ethnic groups.
[17] Ringold, D, *Roma and the Transition in Central and Eastern Europe: Trends and Challenges*, Washington D.C.: World Bank, 2000.
[18] In one case, UNMIK supervisors mandated that a health centre Albanian staff member attend PHE training, but she attended only a few sessions.