



The European Roma Rights Centre (ERRC) is an international public interest law organisation engaging in a range of activities aimed at combating anti-Romani racism and human rights abuse of Roma. The approach of the ERRC involves, in particular, strategic litigation, international advocacy, research and policy development, and training of Romani activists. The ERRC is a cooperating member of the International Helsinki Federation for Human Rights and has consultative status with the Council of Europe, as well as with the Economic and Social Council of the United Nations.

Racial discrimination against Roma in health care is manifested in exclusion from health services and access to health services of inferior quality. It magnifies previously existing inequities establishing separate and independent barriers for Roma to enjoy the right to the highest attainable standard of health. Provision of medical services often disproportionately excludes those Roma who are not covered by health insurance. Roma frequently lack one or more personal documents crucial for gaining access to health care, and in some cases may even lack the citizenship of any state. In some cases, access to health care is obstructed by the physical separation of Roma from the mainstream of social and economic life. Many Roma live in segregated communities where public services are restricted or entirely unavailable. In its most egregious forms, racial discrimination in the provision of health care manifests itself as denial of treatment of Romani patients by health care providers and/or in inappropriate or negligent treatment. Reports of segregation of Roma in medical facilities, verbal abuse and degrading treatment reveal a pattern of substandard level of health care provided to Roma. Finally, Roma have been subjected to extreme, race-based violations of fundamental human rights, through practices such as the coercive sterilisation of Romani women.



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European Roma Rights Centre

AMBULANCE NOT ON THE WAY



The Disgrace of Health Care for Roma in Europe

ERRC

Ambulance Not on the Way: The Disgrace of Health Care for Roma in Europe



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“Put your wife into a wheel-barrow and wheel her to the medical centre” – Emergency medical officials in the town of Čakovec, Croatia, to Mr Mirko Oršuš, after he called to report that his wife Verica had complications while in labour, 9 February 2001. Their child was born stillborn. Emergency health officials arrived approximately one and a half hours, and five telephone calls, after they were first called.

INTRODUCTION

A number of studies reveal a serious gap in health status between Roma and non-Roma in many European countries. Roma live shorter lives and show markedly higher instances of diseases such as tuberculosis, long thought eradicated but now making a dramatic comeback in Central and Southeastern Europe, as elsewhere. Other diseases avoidable by vaccine are also reported disproportionately among Roma in Europe. According to the World Health Organization (WHO), during 2004–2006, there have been a number of measles outbreaks, primarily in Romani communities, in countries including Germany, Greece, Italy, Portugal and Romania. The Romanian outbreak involved over 6,000 reported cases, and resulted in 14 deaths among children. Subsequent investigation indicated high levels of non-vaccination against measles and polio among segments of the Romani communities affected. According to WHO officials, “The WHO European Region was declared polio-free in 2002, and currently has measles and rubella elimination targets for 2010; however, the inability of Roma to access health services recognised as a serious impediment for all 53 countries in the Region if they are to maintain polio free status and achieve the measles and rubella targets.”¹

Disparities in health status between Roma and non-Roma are frequently explained in terms of economic inequalities such as overrepresentation of Roma in the lowest economic strata of the societies in which Roma live; overrepresentation of Roma in the categories of the uneducated or poorly-educated; and higher exposure to health-related risk factors such as poor living conditions. Stigmatising views explaining the generally poor health status of Roma as resulting from behavioural problems such as drinking, smoking, and poor diet, are also widespread. Health status is a complex phenomenon, influenced by numerous factors, and these reasons for the poor health of Roma cannot be ignored. Policies to improve Romani health would be ineffective, however, were they to fail to take into account the prevalence of racism and discrimination against Roma in health care systems in Europe.

¹ ERRC communication with Mr. John Spika, Medical Officer, Vaccine Preventable Diseases and Immunization, WHO Regional Office for Europe, 17 August 2006.





To date, government policies have not been based on a clear understanding of factors driving disparities between Roma and non-Roma. Particularly missing is an understanding of factors hindering Roma from equal access to medical care, including access to services, treatment options and outcomes. Indeed, government policies to facilitate the access by Roma to medical care are for the most part nascent, where they exist at all. Where such policies do exist, by failing to acknowledge and confront discrimination against Roma in the health care system, governments postpone the solutions to these problems to the distant future. Eliminating discrimination and ensuring equal treatment and equal opportunities for Roma to access the national health care systems are obligations that require immediate action and are not dependent on resources available to the state. Actions to eliminate discrimination and to ensure equal treatment of Roma to health care are an obligation of the authorities regardless of the economic strength of the poorer states of Central and Southeastern Europe.

Racial discrimination against Roma in health care is manifested in exclusion from health services and access to health services of inferior quality. It magnifies already existing inequities establishing separate and independent barriers for Roma to enjoy the right to the highest attainable standard of health. Provision of medical services often disproportionately excludes Roma because they are not covered by health insurance. Exclusion of Roma from citizenship and from access to a range of social services has resulted in denial of access to the public provision of medical care. Furthermore, access to health care is obstructed by the physical separation of Roma from the mainstream of social and economic life, in segregated communities where public services are restricted or entirely unavailable. In its most egregious forms, racial discrimination in the provision of health care manifests itself as denial of treatment of Romani patients by health care providers and/or in inappropriate and negligent treatment. Furthermore, reports of segregation of Roma in medical facilities, verbal abuse and degrading treatment reveal a pattern of substandard level of health care provided to Roma.

Racial discrimination outside the health care system also affects the health of Roma in a number of ways. Institutional racism – the operation of various institutions in society in a way which denies equal rights and opportunities to Roma – affects major socio-economic determinants of health such as living conditions, nutrition, work conditions, and other areas of life. The multiple effects of denial of equal opportunities in education – substandard education in racially segregated settings or lack of any education; exclusion from the labour market – denial of jobs to Romani applicants and lack of policies to remedy exclusion; and exclusion of Roma from social safety nets – through direct rejection of Roma and through policies which result in excluding Roma, are responsible for both poor health and lack of access to health care.

One area in which the impact of racial discrimination on the health of Roma is particularly visible is housing. The enforcement of measures directly aimed at or resulting in separation of Roma from mainstream society and exposure of Roma to substandard conditions, as well as failure to undertake actions to improve housing conditions of Roma, has resulted in higher

incidence of diseases and other negative health consequences. Patterns of housing discrimination against Roma have forced numerous individuals into inhuman and degrading conditions of segregated slum settlements; exposed Romani individuals to environmental hazards; and made them vulnerable to forced evictions and other violent abuse by state and non-state actors. Health disparity of Roma is thus the cumulative result of both past and current racism.

In the case of Romani women, the complexity of influences on health status and access to health care, stemming from the rejection of Roma in their societies at institutional and individual levels, is magnified by gender-related discriminatory barriers and forms of abuse. Lack of access to medical services and inferior medical services have a particular negative impact on Romani women's health, especially where reproductive and maternal health are concerned. In some countries, Romani women continue to experience extreme forms of human rights violations by health professionals, such as coercive sterilisations. Higher vulnerability of Romani women from excluded communities to trafficking, domestic violence and early marriage are other factors aggravating their health status. While efforts to promote Romani women's health and access to health care are even more fragmentary and incoherent than health policies on Roma in general, Romani women also are mostly excluded from gender equality policies, underdeveloped as they are at present, especially in Central and Eastern Europe.

For a number of years, the ERRC has collected documentation revealing the interference of racism in the provision of health care services to Romani men and women in a number of European countries. The findings from previous years have been reinforced by research during 2005 in Bulgaria, Hungary and Spain indicating persistent and widespread practices of denying Roma the quality of health services available to others and in many instances – health services altogether. This report explores major systemic causes for exclusion of Roma from access to health care as well as various degrees of provision of inferior medical services to Roma. Due to unavailability of data, the evidence of disparate treatment of Roma by health care practitioners provided in this report is assembled empirically through testimony and other documentation. In some instances, such as the segregation of Romani patients in medical facilities, there is objective evidence of inferior treatment as long as at least the physical conditions in which Romani patients have been placed for treatment were inferior.

Testimony-based evidence of discriminatory treatment by medical professionals has limitations: In the first place, the effects on the patient's health of the various forms of inferior treatment are evident only in certain well-documented instances of egregious malpractice or negligence. Difficulties in establishing the link between numerous reports of discriminatory treatment and the health of Romani patients arise from factors such as lack of medical competence of patients to define whether they were provided with an equal standard of medical treatment accorded to others in a given case. Difficulties also arise as a result of a lack of research comparing diagnostic and therapeutic treatment of Romani patients with that applied with



respect to non-Romani patients. Systematic disparate treatment can be established only on the basis of complex, specialised studies and data gathering examining and comparing treatment for various medical conditions available to Roma and non-Roma. Despite these limitations, the anecdotal evidence provided in this report clearly defines a number of patterns of disparate treatment of Roma by health care providers: (i) in quantitative terms – such complaints are formulated by significant numbers of Roma from various countries, as well as (ii) qualitatively – as a description of repeated and systematic negligent, abusive and humiliating treatment. Finally, the testimonies about discriminatory treatment provided by Roma in this report are at least in part corroborated by documented stereotyped, negative attitudes of medical providers with respect to Roma.

To date, few countries have visited seriously the need for health care reform to ensure that health care reaches Roma and other extremely marginalised groups. Those countries which have thus far done so have not yet managed to design effective policies in these areas, and indeed have in certain key areas not yet managed even to check and reverse emergencies, such as the development of epidemic diseases such as tuberculosis and hepatitis b. Effective health care policies on Roma would involve revision of laws and policies which are shown to have a disparate effect on Roma in the field of social services as well as specific targeted action to ensure equal access to such services. Furthermore, health policies are contingent on the effectiveness of policies aimed at reducing levels of exclusion of Roma from mainstream and quality education, reducing insecurity and exclusion from unemployment and improving housing standards.



DATA AND RESEARCH ON THE HEALTH STATUS OF ROMA AND THEIR ACCESS TO HEALTH CARE

Data collection is critically important in efforts to understand and eliminate disparities in health and health care between Roma and non-Roma. In the health sector, as in all other social sectors, however, most governments in Europe are resistant to collecting and/or making publicly available data disaggregated by race or ethnicity. This fact makes the analysis of the impact of racial discrimination on Roma health a very difficult undertaking. Even where political will to tackle discrimination against Roma in health care exists, lack of data undermines the effectiveness of policy efforts in this direction.

While a number of studies on the health status of Roma have been carried out, assessment of Roma access to health care is fragmentary and assessment of the quality of medical services available to Roma and utilised by Roma – non-existent. A number of factors which crucially influence access to health care and quality of treatment have not been adequately studied to date, most notably:

- physical access of Romani communities to health care facilities; health insurance coverage in law and practice;
- rates of usage – and reasons for non-usage/exclusion from primary and preventative health care services;
- access to treatment of non-communicable diseases with high health risks such as oncological and cardiovascular diseases;
- the extent of diseases giving rise to serious public health threats such as tuberculosis and hepatitis in the Romani community, and reasons for non-provision of treatments and/or vaccinations against these;
- issues related to Roma and mental health care, including but not necessarily limited to (i) exclusion from care and (ii) automatic or quasi-automatic transfer from children's homes into state care for the mentally ill;
- perception/satisfaction of Roma with the quality of health care received; attitudes of medical professionals to Romani patients;
- as well as other key issues influencing effective realisation of the right to the highest attainable standards of physical and mental health.

Many of the existing studies do not make clear to what extent certain health problems of Roma are due to factors of social exclusion, and how much could be ascribed to factors relating to being members of an ethnic minority – that is, factors such as racism by health care providers, and discriminatory barriers to accessing the health system, to name only two.

A positive step towards identifying ethnically-based disparate treatment in the provision of health services, has been a recent evaluation of the health care system carried out by the regional government of Andalusia on the basis of a survey among the users. The survey included the question: “Have you felt that you have been discriminated against in any of the services of the public health system for any of the following reasons?” The options provided included, among others, gender and ethnicity. Further, the survey provided participants with the option to indicate their ethnic background, the list including Romani ethnicity as well.²

Some studies have indicated that the prevailing part of the research on Roma and health-related issues focuses on communicable diseases. Thus, the predominating concern with respect to Roma health is the possible threats to public health. There are reasons to believe that public health concerns – and in particular tuberculosis and hepatitis b – indeed need to be taken far more seriously than they are currently by public officials in a number of countries in Europe. However, there are indications that concerns about public health issues in the Romani community derive not primarily from efforts to see the right to the highest attainable standards of physical and mental health realised by all, but rather primarily as a result of alarm over “threats Gypsies pose to the public-at-large” and in some countries over concerns at the growth of the Romani population. A survey of published literature on Roma and health in the late 1990s, for example, discovered that out of some 105 publications on health and Roma, the overwhelming number dealt with reproductive health and communicable diseases.³

In order to better assess health and human rights issues as they relate to Roma in Europe, there is a need for better data – and in particular statistical data disaggregated by ethnicity – in the following areas:

- Effective coverage by health insurance;
- Availability of physicians and health care facilities in or in close proximity to Romani neighbourhoods;
- Rates of utilisation of various types of services, and in particular rates of effective access to primary and preventative care;
- Health outcomes – death, illness complications, etc., and especially rates of negative health outcomes thought to be preventable;
- Romani access to mental health care services, including issues related to institutionalisation and placement in guardianship.

Further, the following preconditions for quality of health services also need to be the subject of better data than currently exists:

² The results of this survey have not been available as of the date this report went to press.

³ Hagioff, S., McKee, M., “The Health of Roma People: A Review of the Published Literature”. *Journal of Epidemiology and Community Health* (2000), vol. 54: 864- 869.



- Health provider attitudes, beliefs and behaviour towards the Romani minority patients, including perceptions that are likely to influence recommendations, referral patterns and receipt of appropriate care;
- Factors influencing Romani patient experiences, ethnic bias in the provision of health care and its influence on the future utilisation of health care services, including compliance with provider recommendations, delays in seeking care, and continuity in care.





METHODOLOGY AND STRUCTURE OF THIS REPORT

This report is based on ERRC research and documentation of discriminatory practices and other forms of human rights abuse against Roma in the provision of health care as well as exclusion from access to health care and factors which prevent Roma from the ability to realise the right to the highest attainable standards of physical and mental health, as guaranteed by international law, in several countries throughout Europe. Most recently, in 2005, research was conducted in Bulgaria, Hungary and Spain. The report also draws on findings from ERRC research in a number of countries in recent years – Bosnia and Herzegovina, the Czech Republic, Croatia, Greece, France, Italy, Kosovo, Macedonia, Romania, Serbia and Montenegro, Slovakia and Slovenia, as well as material from ERRC legal databases and archives. The 2005 research was conducted by means of interviewing Romani women and men from different age groups, roughly between 18-70 years of age, living in different types of locations – cities, smaller towns and villages. In Bulgaria, Hungary, and Spain, the ERRC also interviewed physicians involved in providing primary and specialised health services to Roma. Some desk research, particularly into quantitative data, where this was available, was also undertaken. The 2005 research in Bulgaria, Hungary and Spain further focused on identifying good practices ensuring equal access for Roma to health care, as well as on analysing problematic areas in policy-making on Roma and health.

This report does not address issues concerning the access of Roma to mental health care. The authors are not aware of any significant study concerning Romani usage of mental health care services. Anecdotal evidence indicates that there may be overrepresentation of Roma in certain areas of the mental health care system. However, at least in some institutions for the mildly mentally ill, the opposite trend appears true – Roma appear to be underrepresented among users, at least among institutionalised users. Since community or other forms of in-home care are relatively underdeveloped in Central and Southeastern Europe, persons not in institutions frequently do not benefit from any form of mental health care, and Roma may be overrepresented in particular in this category. In some countries, there are also reports of quasi-automatic placement in state mental health care of Romani children who have been in state child-protection, when such children reach the age of adulthood. However, these and other very large areas remain to date severely under-studied, and this report does not remedy this lacuna.

Chapter one of this report reviews States obligations under international law to respect, protect and fulfil the right to the highest attainable standard of health and to eliminate racial discrimination in the enjoyment of the right to health. Chapter two focuses on systemic factors influencing exclusion of Roma from health care such as in-built inequalities in laws and policies resulting in the exclusion of Roma from accessing social aid and medical services,





exclusion from citizenship, lack of personal documents, and physical remove from medical services. Chapter three provides evidence of discriminatory treatment of Roma by medical practitioners. This chapter includes both objectively verifiable evidence about discriminatory treatment and testimony of the most frequently reported types of discriminatory treatment experienced by Romani patients, based on the perceptions of the patients, and believed to be motivated by biased, stereotypical and prejudicial attitudes of health care providers to Roma. Chapter three also provides an overview of physicians' attitudes towards Roma documented by the ERRC and a summary of the results of a survey of physicians' attitudes towards Roma in Hungary. Chapter four looks at two major determinants of health – housing and education – and highlights the deleterious effect on the health of Roma of systematic violations of the rights to adequate housing and education. Chapter five outlines some good practices in tackling inadequate health care provision for Roma. The report concludes with ERRC recommendations to governments for effective policies to eliminate discrimination of Romani women and men in health care.





1. THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF PHYSICAL AND MENTAL HEALTH, AND THE BAN ON DISCRIMINATION IN THE PROVISION OF HEALTH CARE

Patterns of direct and indirect discrimination against Roma in access to and provision of health care contravene states obligations under international law to ensure the exercise of the right to health without discrimination on any grounds, including on the grounds of race and ethnicity.

The right to health is guaranteed by a number of international law instruments. The most comprehensive statement is provided by the International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12.1 of the Covenant, States parties recognise “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”. In its General Comment No 14, the UN Committee on the Economic, Social and Cultural Rights (CESCR) interprets the right to health, as defined in Article 12.1, as “an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.” The General Comment lists the following components of the right to health:

Availability. Functioning health care facilities, services, and programs, must be available in sufficient quantity within the country. These include safe and potable drinking water, adequate sanitation facilities, health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs.

Accessibility. Accessibility has four overlapping dimensions:

- Non-discrimination: health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact. For example, investments should not disproportionately favour expensive curative health services, which are often accessible only to a small, privileged fraction of the population, rather than primary and preventive health care benefiting a far larger part of the population.
- Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as women. Medical services, safe and potable water, and adequate sanitation facilities must also be within safe physical reach in rural areas and for persons with disabilities.
- Economic accessibility: health facilities, goods, and services must be affordable for all. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.



- Information accessibility: everyone has the right to seek, receive and impart information and ideas concerning health issues.

Acceptability. All health facilities, goods and services must be respectful of medical ethics and sensitive to gender and life-cycle requirements, as well as designed to respect confidentiality and improve the health status of those concerned.

Quality. Health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

As one of the internationally guaranteed social rights, the right to the highest attainable standards of physical and mental health is subject to progressive realisation, i.e. it is acknowledged that States may not be able to ensure instant realisation of the rights contained within the ICESCR due to the limits of available resources. The principle of non-discrimination in the exercise of the right to health is not subject to progressive realisation but has immediate effect. States have immediate obligations to guarantee that the right to health is exercised without discrimination of any kind and to take steps towards the full realisation of Article 12. Article 2.2 and Article 3 of the ICESCR proscribe any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health. The CESCR General Comment 14 provides that resource constraints cannot be a justification for not protecting vulnerable members of society from health related discrimination stressing that “many measures, such as most strategies and programmes designed to eliminate health-related discrimination, can be pursued with minimum resource implications through the adoption, modification or abrogation of legislation or the dissemination of information” (Paragraph 18). Non-discrimination further requires that equality of access to health care and health services has to be emphasised. States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services, especially with respect to the core obligations of the right to health (Paragraph 19).

In order to give effect to the right to health without discrimination, States are required to undertake the following:

- To abolish laws and policies which deny access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination and to abstain from enforcing discriminatory practices as a State policy (Paragraphs 19, 34, 50);



- To adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct (Paragraph 35);
- To adopt national health policies and detailed plan for realizing the right to health prioritizing the needs of vulnerable and disadvantaged individuals and communities (Paragraphs 20-27, 36)
- To undertake positive action in favour of individuals and communities unable, for reasons beyond their control, to realize the right to health themselves by the means at their disposal, including by providing them with the necessary health insurance and health-care facilities (Paragraphs 19, 37, 52).

The prohibition of discrimination in the exercise of the right to health is further set out in the International Convention on the Elimination of All Forms of Discrimination (ICERD), the International Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), and the Convention on the Rights of the Child (CRC). ICERD obliges States Parties to pursue, by all appropriate means and without delay, a policy of eliminating racial discrimination in all its forms.⁴ Specifically, States Parties must guarantee the right of everyone, without distinction as to race or ethnicity, to equality before the law in the enjoyment of economic, social and cultural rights. This obligation applies expressly to the right to public health, medical care, social security and social services.⁵ States parties to the CEDAW committed themselves to take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on the basis of equality of men and women, access to health care services, including those related to family planning as well as to ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.⁶ The CRC contains a general prohibition of discrimination in the exercise of the rights guaranteed by the Convention, irrespective of, among others, the child's or his or her parent's or legal guardian's race, national or ethnic origin, birth or other status,⁷ as well as an obligation of States to ensure that no child is deprived of his or her right of access to health care services.⁸

⁴ ICERD, Article 2.

⁵ ICERD, Article 5(e)(iv).

⁶ CEDAW, Article 12.

⁷ CRC, Article 2(1).

⁸ CRC, Article 24.





Within the Council of Europe framework, Protocol No. 12 to the European Convention on Human Rights and Fundamental Freedoms (ECHR), which entered into force in April 2005, strengthens the guarantees with regard to equality and non-discrimination in the European Convention on Human Rights and Fundamental Freedoms (ECHR) by providing an independent prohibition of discrimination on a non-exhaustive list of grounds. The Revised European Social Charter providing protection of the right to social and medical assistance also prohibits discrimination of any kind in the exercise of the rights guaranteed by the Charter.⁹

Finally, at EU level, the Race Equality Directive includes an express prohibition of direct and indirect discrimination in a broad range of fields including social security and healthcare, and access to and supply of goods and services which are available to the public.¹⁰ The Directive defines direct discrimination to occur where one person is treated less favourably than another is, has been or would be treated in a comparable situation on grounds of racial or ethnic origin. Indirect discrimination occurs where an apparently neutral provision, criterion or practice would put persons of a racial or ethnic origin at a particular disadvantage compared with other persons, unless that provision, criterion or practice is objectively justified by a legitimate aim and the means of achieving that aim are appropriate and necessary.¹¹

⁹ European Social Charter (Revised), Article 13 and Article E.

¹⁰ Council Directive 2000/43/CE “implementing the principle of equal treatment between persons irrespective of their racial or ethnic origin”, Article 3(e).

¹¹ Council Directive 2000/43/CE, Article 2(a) and 2(b).





2. SYSTEMIC EXCLUSION OF ROMA FROM ACCESS TO HEALTH CARE

Throughout Europe, large numbers of Roma, regardless of legal status in the respective country, find themselves unable to take advantage of the health care services available to the rest of the population. One major reason for this situation is the adverse effect on Romani communities of laws and policies regulating access to social services in general. In some countries eligibility for social benefits for the poor is a precondition of accessing state-provided health insurance. Where Roma are not among those receiving social benefits – sometimes as a result of arbitrary and racially discriminatory action of authorities – they are not entitled to state-provided medical insurance for the socially vulnerable groups either. Social benefits and health insurance are also unavailable to Roma who do not have personal documents, including identity documents, despite their holding of the citizenship of the respective state.

For a significant number of Roma living in the states which have emerged after the dissolution of the Yugoslav Federation and the Soviet Union, unsettled legal status is a barrier to the enjoyment of social and economic rights, including access to health care provision which is available only to those who can pay for the services. For more than a decade, after the formation of the new states, numerous Roma who have factual ties with the respective countries, still find it impossible to obtain citizenship or any kind of permanent legal status in the respective country.

Finally, access to medical services is made impossible in many instances of remote segregated Romani settlements where medical facilities do not exist and transportation to facilities outside the settlement is either unavailable or unaffordable to many people.

2.1. Exclusion from Health Insurance

Health care reforms in a number of countries in Central and Eastern Europe have rendered large numbers of Romani citizens of their states excluded from health insurance schemes and from access to health care respectively. Compulsory health insurance contributions are not affordable for many Roma, who are not employed and do not have regular or any kind of income. Provisions for health insurance for the poor in a number of countries also exclude disproportionately Roma, who are not registered as people in need of social aid or have lost the right to social aid. Lack of documents, including birth certificates, identity cards, and documents certifying eligibility for non-contributory health insurance precludes many Roma from accessing health services.

The lack of possibility to access health care in a timely manner sometimes had fatal consequences for Roma in Bosnia and Herzegovina. Mr Esad Ibralić from the Lipovica village



in the Tuzla Canton testified to the ERRC/HCHRRS how he had lost his son in the long struggle with the bureaucratic health care system. When Mr Ibralić returned to his native Lipovica in 2000, after refuge in Switzerland, he registered at the local unemployment office but was told that he and his family members did not have the right to state-supported health care. This was also the time when Mr Ibralić's 18-year-old son Asmir started complaining about having headaches very often. With the assistance of friends, Mr Ibralić managed to have Asmir checked by a doctor and it was established that he had a brain tumour. In late 2002, Asmir had to undergo surgery, where – again with the assistance of friends – his father had to cover only the basic expenses. After the surgery, Mr Ibralić applied with the Kalesija Social Work Centre, asking for health care for Asmir, so that he could receive adequate post-surgery assistance. The officials in charge told Mr Ibralić that he would need to wait for a reply for 2-3 months, but as he pleaded with them, they promised that they would inform him over telephone as soon as the decision was made. As he received no reply for more than a month, Mr Ibralić paid another visit to the Kalesija Social Work Centre where the officials told him that his case was under review by the cantonal social work authorities in Tuzla. In Tuzla, however, Mr Ibralić was told that they had never received any information on his case. In the meanwhile, Asmir's health was rapidly deteriorating, as he did not have access to adequate medicine and treatment, since his family could not afford these. From mid-February 2003, Asmir was unable to walk. At that time, still without any information on his application, Mr Ibralić carried his son to the Kalesija Social Work Centre to urge them to decide on the application status, and was told that he should apply with a medical commission in Tuzla. Mr Ibralić took his son to Tuzla immediately, and the commission found out that Asmir Ibralić should receive social assistance and have state-provided health coverage. Several days later, Mr Ibralić received a health-care booklet, which is proof that a person is insured and can seek free assistance at state institutions. However, in the first checks afterwards, the doctors could only establish that the tumour spread to other parts of the body as well. Asmir Ibralić died on March 12, 2003.¹²

In addition to barriers created by exclusion of certain groups from health insurance, Roma in socially vulnerable situations find it difficult to pay various users' taxes and the costs for medication. For example, Bulgarian Health Insurance Act requires payment of a user fee for each visit to the General Practitioner, for dental care, and for each day spent in hospital.¹³ Furthermore, medication is unaffordable and a number of types of medicines are not covered by health insurance.

¹² For this and other forms of abuse of Roma in the health care system, see ERRC Country Report "The Non-Constituents: Rights Deprivation of Roma in Post-Genocide Bosnia and Herzegovina", at: <http://www.errc.org/db/00/06/m00000006.pdf>.

¹³ User fees were first implemented with the introduction of health insurance financing of services, and amount to 1% of the minimum monthly wage per visit in outpatient centres and 2% of the minimum wage per day of hospitalisation. These co-payments vary according to the minimum wage in the country (In 2005 the minimum wage was set at 150 leva per month (Euro 77))

In Bulgaria, although existing legislation provides for state-sponsored health insurance for socially vulnerable individuals, health insurance coverage is not universal as it excludes unemployed persons with no right to social assistance.¹⁴ This category of persons, who presumably cannot make their own contribution to the health insurance fund, are not insured from the state budget either. Health care contributions are to be paid by everyone, except by certain categories of individuals specified in the Health Insurance Act, including pensioners and children, who are ensured from the state budget. An amendment to the Health Insurance Act from 2002 provided that socially vulnerable individuals who are entitled to social aid shall be ensured by the state budget. This amendment, however, did not benefit many Roma, especially Romani persons who were long-term unemployed. These persons were frequently not registered or dropped out of the registers of unemployed individuals, and therefore did not receive social aid. Large numbers of Roma cannot pay compulsory health insurance contributions due to unemployment and lack of a regular or of any income.

Although lack of health insurance is not only a problem affecting Roma, Roma are disproportionately represented among the Bulgaria's unemployed and poor population. As such, exclusion from health insurance disproportionately impacts the Romani population.¹⁵ For poor people, lack of health insurance means in practice exclusion from access to health services, because individuals without health insurance are supposed to pay for all health services, except for emergency health care. A survey conducted by the sociological agency Fact Marketing in 2004 indicated that 46% of Roma surveyed were without health insurance.¹⁶ ERRC research in 2005 revealed that, not including pensioners and children who are insured from the state budget, more than half of the Romani persons surveyed were without health insurance. According to information provided to the ERRC by Romani organisations in different towns throughout Bulgaria, the percentage of uninsured Roma ranges between 40-90%. In addition, many Roma who were entitled to social aid and respectively to health insurance from the state budget failed to submit applications requesting health insurance and were also excluded from

¹⁴ The adoption of the Bulgarian Health Care Act in 1998 established a system of compulsory health insurance through the collection of health care contributions for ambulatory care, effective from July 1, 2000, and for hospital care, effective from July 1, 2001. Health care contributions for children, disabled persons, pensioners, socially vulnerable persons entitled to social aid, and some other categories of persons, are paid by the state budget. See Bulgarian Health Care Act, last amended 2006, available in Bulgarian at: <http://www.paragraf22.com/pravo/zakoni/zakoni-d/z20940.htm>.

¹⁵ Ministry of Health Report on the State of Health of the Nation in the 21st Century provides the following information: "Bulgarians constitute 40% of the poor people in the country, which means that the other ethnic groups constitute the remaining 60% of the poor population. Particularly high levels of poverty is found among Roma, who constitute almost half of the poor population (46.5%), while the Turks are 12.8%. In comparison to Bulgarians, a person of Romani background is ten times more likely to be poor." See Ministry of Health, August 2004. (Unofficial translation from Bulgarian by the ERRC.)

¹⁶ Data provided in the Government Health Strategy for Persons in Disadvantaged Situation from the Ethnic Minorities, adopted by the Bulgarian Council of Ministers on September 8, 2005, available in Bulgarian at: http://www.mh.government.bg/doc/zdravna_strategia_prieta.doc.

the health insurance. As a result, Roma accumulated significant debts to the health insurance fund because in the course of 2-3 years, they were listed as individuals obliged to pay health care contributions. These individuals have to pay their debts before they can restore their health insurance rights. Furthermore, many Roma who were eligible for health insurance provided by the state were excluded due to a complex of factors, including discriminatory practices by social workers. According to information provided by Romani activists in Pazardjik, for example, authorities from the regional branches of the Ministry of Labour and Social Policy in that city would reject applications for social aid from Roma in which the individual declared zero income. Reportedly, in many cases, Roma are forced to declare a non-existent income in order to have their application for social aid accepted. In this way, the amount of social aid they receive is reduced and they are obliged to pay their own health insurance contribution.¹⁷

While health insurance alone cannot ensure that patients will obtain all needed services, it can help protect individuals and families from the costs of illness and routine health maintenance. Lack of health insurance coverage and a usual source of care have both been associated with lower utilisation of preventive and disease management health services. A number of Roma interviewed by the ERRC in the course of research in 2005 declared that they had not used any medical services for one year or more due to lack of health insurance and lack of means to pay for such services: “Two years ago I was in hospital because I had problems with my thyroids. Since then I have not been to a doctor because I owe 800 leva [approximately Euro 400] for my health insurance. My GP¹⁸ struck me off the list of his patients and if I went to a specialist, I would have to pay.”¹⁹ Other uninsured Roma stated that they could pay for occasional checks by doctors but hospital care was unaffordable: “I have a breast cyst and often experience pain in my breast. I pay for consultations with a doctor almost every month. The GP in the neighbourhood also agreed to examine me although I do not have health insurance. However, I could not afford to go for surgery as recommended, because I am unemployed and a single mother and would have to pay out of my own pocket.”²⁰

A government decree of January 2006 is apparently aimed at mitigating the effects of exclusion of vulnerable groups from health insurance by setting up a fund for diagnostic and therapeutic treatment of citizens without health insurance.²¹ It is difficult to assess the impact

¹⁷ ERRC interview with Plamen Assenov and Minko Minkov, Napredak Foundation, Pazardjik, December 2, 2005.

¹⁸ In most health care systems in Europe, the General Practitioner – or “GP” – is a primary health provider offering a wide range of services to patients. Patients can register with a GP if they have health insurance or as private patients in which case they are supposed to pay for the GP’s services. It is a GP’s assessment whether the patient requires specialist care in which case the GP refers them to the respective health professional. GPs thus act as “gatekeepers” to the wider health system, such as hospitals and specialist clinics.

¹⁹ ERRC interview with 46-year-old A.C., Novi Pazar, Bulgaria.

²⁰ ERRC interview with 32-year-old D.K. from Plovdiv, Bulgaria.

²¹ The decree does not specify whether the fund will provide one-time support or eligible persons will be entitled to support whenever they need medical treatment.

of the decree because, as of the date this report was published, this reform was too new for changes brought about by the decree to have been fully realised. However, the criteria for granting funds for the medical treatment of persons without health insurance raise some concerns. For example, one of the criteria, formulated as “no income”, raises questions whether citizens will be required to prove lack of any income or whether they can still be eligible for this social aid if their income is below the guaranteed minimum income for the country but not exactly zero. During research in Bulgaria, the ERRC met Roma who did not have health insurance, and were not able to pay for medical treatment. However, they did have some “income” earned by collecting waste paper, scrap metal, etc.

Problems with exclusion of Roma from health insurance are also prevalent in Romania. After the first year of implementing the reformed health-insurance system, research revealed that 75% of those persons interviewed from the population at large were registered with a family doctor, in contrast to only 34% of the Romani population.²² A later survey of 1,511 adults revealed that 84% were registered with a family doctor; for unemployed persons this percentage was 79%.²³

Similar to the Bulgarian case, eligibility for non-contributory health insurance in Romania is conditional on access to social assistance. Reports indicate that the eligibility criteria for social assistance can be affected by arbitrary and discriminatory decisions by authorities, leading consequently to exclusion from health insurance. During ERRC research in 2002, the ERRC received reports that the lower the representation of Roma in local councils, the greater the limitations placed on social aid payments. For example, according to the minutes of Hearing 35 on July 31, 2002, the Maerus Commune Council in Braşov County decided that “People who have horses and not land use the horses to steal.” Because of this, according to the decision, horse-owners who receive social aid were assumed to earn 2,000,000 Romanian lei (approximately 57 Euro). As this amount is higher than the maximum payment allowable under the Minimum Income Law, no one with a horse would receive social aid. Reportedly, there were no Romani council members in the Maerus commune. A similar decision in the Budila Commune in Braşov County with four Romani council members, had a different effect. The Budila Commune Council passed a decision that horse-owners are assumed to earn only 150,000 Romanian lei (approximately 4 Euro) and the government supplements people’s income beyond this amount.²⁴

Another legal provision which has a disparate effect on Roma concerns the definition of the “family” in some Romanian laws. According to the law on the guaranteed minimum

²² Sorin Cace, Cristian Vladulescu. *The Health Status of Roma Population and Their Access to Health Care Services*. Bucharest, 2004, p. 62.

²³ *Ibid.*, pp.38-40.

²⁴ See Tara Bedard. “Romanian Roma: Two Years After the Adoption of the Government Strategy, No Visible Change”. In *Roma Rights* 1-2, 2003, at: <http://www.errc.org/cikk.php?cikk=1417>.

income, couples living in customary-law marriages are eligible for social support,²⁵ but an ordinance on social medical insurance stipulates that only the “wife of” or the “husband of” an insured person have the right to non-contributory health insurance.”²⁶ This opens the way for administrative discretion regarding interpretations of eligibility for social support and thus access to health insurance. This provision, which discriminates against persons on the basis of marital status, has a disparate impact on the Roma because a large number of Romani couples – as opposed to Romanians – live in common-law marriages.

In Macedonia, many Roma are not eligible at all for state-provided medical insurance, because (i) they lack Macedonian citizenship; (ii) because they do not qualify for state medical insurance because they are listed neither as employed nor as officially unemployed, a precondition for inclusion in the state-provided medical insurance protection system; (iii) because they have not managed to keep their medical insurance booklets updated through regular procurement of relevant stamps; or (iv) for other arbitrary reasons. A 2000 report published by UNICEF found that of 3,122 interviewed Romani families in Macedonia, 574 (18.39%) did not have health insurance while 2,421 (77.55%) were covered. Of those families with coverage, 127 (4.07%) families had only partial health coverage (only some of the family members, predominantly children and elderly).²⁷ According to a 2005 UNDP study, of 1,836 Romani and 1,399 non-Romani respondents, 204 (11.1%) Romani women and 198 (10.7%) men were denied medical service due to lack of proper documents, compared to 63 (4.5%) female and 61 (4.4%) male non-Roma living in close proximity to Roma. During interviews with 237 Romani women in Macedonia in 2005, the ERRC and partners documented 22 Romani women who did not have any form of state health insurance. Seven of these women did not have citizenship; the basic requirement for all state benefits. Twenty-six-year-old M.K. from Stip told researchers working on the partners’ documentation project, “I do not have health insurance and I have to pay for all medication. I go to a doctor only when my children are very sick. I don’t have money and save just for them [...]”

In Hungary and Spain, lack of health insurance coverage does not appear to be a problem for the prevailing part of Roma. ERRC research in Spain, however, revealed that exclusion of Roma from health insurance in previous years have had a long-lasting impact on the health status of Roma. Access to health insurance in Spain reportedly dramatically improved since 1986 when amendments to the General Health Care Act went into force giving effect to universal health insurance coverage. Before that, full health care coverage was available only to individuals who made health insurance contributions as employees or self-employed.

²⁵ Law no. 416 of 18 July 2001 concerning the minimum guaranteed income, Article 2(3).

²⁶ Emergency Ordinance no. 150 of 31 October 2002 concerning the organisation and the functioning of the system of social medical insurance, Article 6(1)(b).

²⁷ Lakinska, Divna. *Vulnerability of Romani children in the Municipality of Suto Orizari*. UNICEF and World Bank. Skopje, 2000.

Roma were massively excluded from access to health care and received health care by charity organisations and, in some cases, by private doctors. Representatives of various institutions and health care practitioners interviewed by the ERRC in Spain in 2005 noted that the disparities in health status between Roma and non-Roma at present are also a consequence of the exclusion of Roma from health care in previous years.

2.2. Lack of Citizenship and Personal Documents

Holding the citizenship of a state is often a prerequisite for access to the full range of social and economic rights guaranteed by the state. ERRC field research has revealed that a large number of Roma in countries arising out of the dissolution of federations, such as the former Yugoslavia, the former Soviet Union and Czechoslovakia, despite genuine and effective links to the respective country, are without the citizenship of the respective country and in many cases are stateless.²⁸ There are various causes influencing the unsettled legal status of Roma, such as displacement during the wars of Yugoslav succession, no registration at birth, lack of financial resources to replace necessary missing documents or to pay the application fee, illiteracy, lack of information about application and granting procedures, or often simply rejection decisions by local officers. However, one key underlying cause of the statelessness is systemic exclusionary practice in the area of allocating citizenship to persons who do not belong to the ethnicity of the majority population of the respective state, particularly where state succession has drawn the margins of the polity in an ethnically exclusionary manner, such as in Croatia, the Czech Republic and Slovenia.²⁹

In Croatia, ERRC research indicates that a disproportionate number of Roma do not have access to a full range of fundamental rights due to the lack of clear legal status, i.e. citizenship or legal residence. Many Roma factually residing in Croatia were initially excluded from the body of citizens of the Croatian state and treated as foreigners. Provisions for naturalisation in

²⁸ For example, according to the 2002 census in Macedonia, out of a total of 17,652 individuals without citizenship status, 734 were Roma. Bearing in mind the number of citizenship status seekers provided by NGOs specialised in dealing with this issue, the official numbers are likely underestimated. NGOs working on this issue under the auspices of UNHCR in Macedonia report that in the last 5 years they administered more than 1,000 applications for citizenship by Roma. According to the same reports, about 500 of such persons were Romani women. For more details on this issue, see European Roma Rights Centre./Roma Centre of Skopje/Roma Women's Initiative, Shadow Report on the Situation of Romani Women in the Republic of Macedonia, October-November 2005, pp.10-11, available at: <http://www.errc.org/db/01/97/m00000197.pdf>.

²⁹ The International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) provides at Article 5 that "[i]n compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights: [...] (d) Other civil rights, in particular: [...] (iii) The right to nationality.

the Croatian Law on Citizenship have allowed for arbitrary and discriminatory treatment of Roma who applied, resulting in numerous cases of rejection of Romani applicants for Croatian citizenship. Lack of citizenship, which in turn means an inability to obtain health insurance, in effect excludes Roma from medical care.³⁰ Without citizenship, it is only possible to obtain state-provided health insurance for three months and in the case of an emergency (there is still a small payment required).

Similarly, in Slovenia, numerous Roma do not have access to health services due to lack of citizenship. Many Roma classified as “non-autochthonous” by Slovenian authorities³¹ are not able to become Slovene citizens, notwithstanding real factual ties to Slovenia, in many cases dating prior to Slovenia’s independence in 1991, and despite November 2002 legal amendments to the Slovene Act on Citizenship attempting to some extent to ameliorate conditions precluding such persons from having access to Slovene citizenship.³² ERRC field research indicated that at least two-thirds of the “non-autochthonous” Roma do not have Slovene citizenship. ERRC research in 2005 revealed that Roma who do not have citizenship are also unable to access social services, including health services.

Czech lawmakers took advantage of the break-up of Czechoslovakia to pass an exclusionary law on citizenship in the new Czech Republic, designed to force as many Roma as possible to leave the new state and to go to Slovakia, as well as to preclude many tens of thousands of Roma with real and effective ties to the Czech Republic from having access to Czech citizenship. Czech authorities also physically expelled a number of Roma to Slovakia. For the most part, however, those Roma denied Czech citizenship through the Act on Citizenship which entered into force on 1 January 1993 remained in the Czech Republic. Czech lawmakers eliminated many of the worst aspects of the 1993 law through amendments to the Act in 1999, by allowing access to Czech citizenship to persons with the previous Czechoslovak citizenship, who had been continuously on Czech territory from 1 January 1993 to the present. However, the law as it currently exists still exercises exclusionary force in areas relevant to health. For example, a number of Roma with real and effective ties to the Czech Republic have been

³⁰ ERRC interview with Ms Brigita Bajrić of the Association “Roma for Roma Croatia”, November 15, 2004, Budapest.

³¹ Authorities distinguish in law and practice between so-called “autochthonous” Roma (those whose families have lived continuously in Slovenia for generations) and so-called “non-autochthonous” Roma (those who are perceived to have primary links to other former Yugoslav republics, other foreign countries, or are otherwise viewed as not having a full claim on belonging in Slovenia).

³² A considerable number of those Roma in Slovenia without Slovene citizenship – persons who in many instances are in fact stateless – were victims of the 1992 “erasure”, during which Slovene authorities deleted the records of a large number of persons from other republics of the former Yugoslavia (including a large number of Roma), evidently in an effort to re-arrange Slovenia’s demography, as well as in an effort to preclude them from being counted among the initial group of citizens of the new Slovenian state. Persons “erased” by Slovene authorities have for the most part not received due remedy for their summary exclusion from the Slovene polity.



unable to claim Czech citizenship in practice, because at some point during the period 1993-1999 they left the Czech Republic. A particularly frequent scenario was women who had left the Czech Republic to give birth in Slovakia, because their place of residence was still listed in Slovakia, and because they therefore could gain access to natal care and related health care services there; these have been frequently refused Czech citizenship even after the amendments of 1999. Such persons are still today stateless or, more commonly, Slovak citizens, although in fact they should have access to Czech citizenship under the relevant international law standards. Also, Czech lawmakers have never undertaken policies to ameliorate the effect of creating a massive category of “foreigners” – with limited rights to social services – out of groups of persons with deep stakes in Czech society, where the grounds of the exclusion had solely racist underpinnings. To the present day, local authorities frequently design policies with the goal of excluding Roma, based on the fact that many Czech Roma are “Slovaks”, for example by precluding access to social housing where one partner of a family is not a Czech citizen.

In a number of countries, although Roma may have the citizenship of the state, they lack the documents to prove it. A survey in Serbia and Montenegro undertaken in late 2001, for example, established that over 39% of Roma in Serbia, including both local Roma and those displaced from Kosovo, were not in possession of the basic Serbian identification document (*lična karta*). In addition, more than half of all Roma in Serbia had no document proving their citizenship and were not in possession of a birth certificate, and close to one third did not possess a document certifying eligibility for state-provided medical care (health card).³³ Roma without identification documents cannot access essential government services such as health care. Lack of identity documents of the parents often precludes the issuing of birth certificates for the children. Once a person lacks one basic document, such as a birth certificate, she may find herself in a position where it is impossible to procure any other personal documents or to realise fundamental rights.

Reports from Serbia and Montenegro indicate that some doctors refuse to treat patients without documents. For example, on January 8, 2005, Ms Jagodina Ferizović took her daughter Ms Anica Ferizović, who was at that time three or four months pregnant, to the Merkator hospital in Novi Beograd because she was experiencing a fever, pain in her stomach and could not walk. The attending nurse refused to admit the daughter because she did not have the proper documentation and allegedly proceeded to verbally abuse both Jagodina and Anica Ferizović. Jagodina Ferizović was only able to obtain care after walking from room to room requesting the assistance of doctors.³⁴

Particularly severe is the situation of Kosovo Roma refugees in Serbia and Montenegro who are more likely to find themselves without proper documents. Instances of refusal of

³³ Cameron, Lindsey. “The Right to an Identity.” In *Roma Rights 3/2003*, at: <http://www.errc.org/cikk.php?cikk=1066#3>.

³⁴ See “Roma Discriminated against in Access to Health Care in Serbia and Montenegro”. In *Roma Rights 2/2005*, “Snapshots from around Europe”, at: <http://www.errc.org/cikk.php?cikk=2336>.





medical assistance have been reported. On October 18, 2004, Ms Seljveti Ramadani, a Romani refugee from Kosovo, testified to the ERRC, working in partnership with the Belgrade-based Minority Rights Centre (MRC) in Belgrade, that employees of a hospital in Novi Beograd refused to treat her 3-month-old daughter on September 2, 2004. According to Ms Ramadani, on the day in question, she brought her daughter, who was experiencing an earache, to the hospital in Block 45 and presented her refugee card to the nurse at the reception. The nurse reportedly asked to see the child's card, to which Ms Ramadani responded that the child did not have one. Ms Ramadani stated that the nurse then insisted that she pay 250 Serbian dinars (approximately 3 Euro) before a doctor would see her daughter. Ms Ramadani paid the fee.

In Romania too, lack of personal documents – identity papers and papers to prove the status of insured, is a cause for the exclusion of Roma from health insurance and respectively from access to medical services. Without an identity card individuals cannot access social assistance and consequently health insurance. According to a survey of the Romania Center for Health Policies and Services, approximately 10% of Roma in Romania do not have identity documents and 2.4% do not have birth certificates.³⁵

Access to health care for undocumented Roma is also a problem in Spain, although by law, health care shall be provided to undocumented foreigners who have registered their residency with the municipality. In the case of undocumented Roma who live in camps, registration with municipalities is often facilitated by Romani associations. Individuals who are outside the camps, however, experience problems related to lack of passports and registration of children. According to Gustavo Rioja of the CCEM association of Madrid, working in a temporary accommodation for Romani immigrants from Central and Eastern Europe, “Embassies create obstacles issuing documents. They do not issue passports and offer only documents for people to return to Romania, for example.”³⁶ Without personal documents one cannot register their residence and respectively cannot register for the public health system.

Similarly, in France, immigrant Roma who have the right to use the system of the State Medical Aid (AME) often encounter difficulties in accessing it in practice, due especially to problems with providing proof of a legally registered address for this purpose. Moreover, recent changes in AME coverage expose numerous Romani migrants to exclusion from the state-provided medical aid. Until the end of 2003, persons with limited financial resources living on French territory without a residence permit were able to access the State Medical Aid providing them with free medical care. However, as a result of changes to this system enacted in December 2003, individuals may now only benefit from AME after three months of uninterrupted presence on French territory. These changes have excluded from AME many

³⁵ Sorin Cace, Cristian Vladulescu. *The Health Status of Roma Population and Their Access to Health Care Services*. Bucharest, 2004, p. 62.

³⁶ ERRC interview with Gustavo Garcia Rioja, April 19, 2005, Madrid, Spain.



Romani migrants who come to France for three-month periods as tourists, as they are legally entitled, before exiting the country and then re-entering it.

2.3. Physical Remove from Quality Health Care

In a number of areas, exclusion from access to health care proceeds from the fact that many Roma live in geographically isolated areas, such as in settlements on the margins of urban areas or extremely isolated rural areas. Some settlements may be many miles or tens of miles from the nearest general practitioner or emergency health unit, and hours or days from more specialised medical assistance which may be only available in a regional centre or the capital, if available at all in a given country.

Problems of segregation and geographical isolation of Roma appear to actually be getting worse throughout Central and Eastern Europe, as Communist-era development policies – not entirely successful in the first place – were eviscerated during the 1990s. A recent Hungarian policy document – the 2003 “Joint Inclusion Memorandum” prepared with the European Commission – for example notes the following:

In 1971,³⁷ nearly two-thirds of the Roma households (65.1%) lived in segregated areas called ‘colonies’ under unfavourable housing conditions. [...] Started in the 1960s and continued until 1988, the colony elimination programme had a very important role in improving the settlement and housing conditions of Roma people compared to their former situation. The 1993-94 survey pointed out that 13.9% of the Roma population (about 70,000 people) lived in segregated settlements or colony-type neighbourhoods with insufficient utility supply, and low infrastructure, or in urban colonies in poor conditions. Another study carried out in 2000³⁸ found that approximately 20% of the Roma population (100,000 people) lived in segregated settlements. The difference between 1993-94 and 2000 can be explained by the increasing segregation and marginalisation of the poorest stratum of the population.³⁹

A survey conducted by the Hungarian Delphoi Consulting in 2003 revealed inequalities in access to health care affecting smaller settlements.⁴⁰ Excluding Budapest, 5.9% of the country’s

³⁷ Sociological Institute of the Hungarian Academy of Sciences, 1971 survey.

³⁸ Study commissioned by the Ministry of Agriculture and Rural Development, 2000.

³⁹ See *Joint Memorandum on Social Inclusion of Hungary*, December 18, 2003, Brussels, p. 13, available at: http://europa.eu.int/comm/employment_social/soc-prot/soc-incl/hu_jim_en.pdf.

⁴⁰ Delphoi Consulting. *Differences in Access to Primary Healthcare – Structures, Equal Opportunity and Prejudice. The Results of an Empirical Study*. 2004, available in English at: <http://www.errc.org/db/00/CC/m000000CC.doc>.

population lived in a settlement without a local GP. This number was 6.1% in the case of pensioners or about 128,000 pensioners lived in settlements without direct access to a GP. In the case of Roma, figures indicated that, excluding Budapest, 18.6% of the country's total Roma population or over 100,000 individuals lived in settlements without a local GP. This situation results from the fact that Roma tend to live in small settlements, and their numbers are high in very small villages that are dying out or are secluded and are becoming predominantly Roma. These settlements have no basic institutions and the non-Romani inhabitants have moved out while poorer Roma have moved in.

Structural inequalities between the Hungarian counties have a disproportionate impact on Roma because the most economically depressed areas tend to be also populated by compact Romani communities.⁴¹ In Baranya and Somogy counties nearly 40% of Roma live in villages without a local GP, in Borsod and Heves this ratio is 20%, in Nógrád the ratio is 26.4%, and in Zala it is 33.1%. By contrast, in Bács-Kiskun County, for example, only 1.6% of Roma live under such conditions.

Furthermore, the social and material conditions of Roma living in settlements where there is no local GP are significantly worse than average. The social disadvantages thus compound the problems arising from a lack of direct access to a local GP. Population in these settlements suffers simultaneously from poverty, a high incidence of health problems, and the lack of direct and immediate access to the services of a local GP.

According to information provided to the ERRC by Mr Kalo Karoly, member of the Gypsy Minority Self-government in Szendrölád, Borsod-Abaúj-Zemplén County, as of October 2005, approximately 15 Romani settlements in the area around Miskolc, the capital city of the county, were served by not more than 4-5 GPs. For example, in the village of Csenyété, ERRC researchers were told that until 2005 there was no GP. In that year, a medical centre was finished in the village and there is now a GP who comes twice a week for one hour.⁴² Some of the people interviewed by the ERRC complained that the GP sometimes would not stay for a whole hour but "just for 15 minutes".⁴³ Csenyété is a village of 450 people, 90% of whom are reportedly Romani. Most of the families are poor and live on social aid. In the village of Szendrölád, with 1,800 inhabitants 80% of whom are Romani, there is one GP. The GP consults patients for three hours a day in the afternoons, every day except weekends. The village does not have an emergency service. The nearest one is located about five kilometres away in the town of Edelény.⁴⁴ Physical access

⁴¹ For example, according to the 2001 Hungarian national census, around one-third of the Romani population lives in the Borsod-Abaúj-Zemplén county, which is among the poorest areas in Hungary. See Népszámlálás 2001, Központi statisztikai hivatal, 2002, pp. 26-28.

⁴² ERRC interview with a Romani leader, October 2005, Baktakék, Hungary.

⁴³ ERRC interview with a Romani leader, October 2005, Baktakék, Hungary.

⁴⁴ ERRC interview with 30-year-old P.E., October 2005, Szendrölád, Hungary.

to health services is also very problematic for the inhabitants of the Bánszállás settlement, located about five kilometres from the town of Ózd, in the Borsod-Abaúj-Zemplén County. The settlement which is home to about 450 people, mostly Roma and socially vulnerable individuals from the Hungarian majority, has no medical centre. The closest one is located in the town of Ózd, about five kilometres away.

Restructuring of health care facilities in Bulgaria, has resulted in creating disproportionate obstacles for Roma to access medical services. The Stolipinovo neighbourhood of Plovdiv is the biggest compact ethnic minority neighbourhood with about 40,000 inhabitants.⁴⁵ Until 2000 the neighbourhood had a polyclinic with specialists in various fields as well as a child care ward. The polyclinic was then transformed into a branch of one of the Plovdiv hospitals and most of the specialists moved to other health care facilities in the city. The child care ward was closed too. This change rendered access to specialized medical services for the prevailing part of the neighbourhood's population practically unavailable because travelling 15-20 kilometres to the hospitals in the city is unaffordable for the people in the neighbourhood.

In Spain, physical isolation also prevents Roma from accessing health services, especially specialised health care available in the hospitals which are usually located far from Romani neighbourhoods. In the town of Gaudix, in Andalucia, which has around 18,500 inhabitants, around 500 Roma live in one separate neighbourhood. According to a nurse at the local health centre Consultorio las Culvas, "Roma have no real connection to the main part of the town because of lack of public transportation."⁴⁶ A 2005 study conducted among 1,200 Romani families from 9 marginal neighbourhoods on the periphery of Madrid, indicated that physical separation and lack of public transportation impede access to health services. Travel time from each neighbourhood to the nearest neighbourhood health centre, to the nearest specialised health centre and to the nearest hospital was found to be considerably longer than for the rest of the population. In some instances to reach a health care facility takes over an hour.⁴⁷ For example, according to Ms Pilis Teresa, a social worker at the La Quinta Romani neighbourhood of Madrid,⁴⁸ "the local health centre is 7 kilometres away and there is no public transportation. Gypsies in the community must walk to the health centre, crossing 2 train tracks on their way, or drive."⁴⁹

⁴⁵ Some of the inhabitants of the neighbourhood identify themselves as ethnic Turks. According to the majority population in Plovdiv and Romani organizations, these people belong to the Romani ethnic group.

⁴⁶ ERRC interview with Ms Antonia Perez, April 15, 2005, Guadix, Spain.

⁴⁷ ERRC interview with Mercedec Ruiz, researcher from the EDIS consulting company, April 18, 2005, Madrid. See also EDIS. "Acceso a los servicios sanitarios de la población en los asentamientos marginales en la Comunidad de Madrid. Ed. Conserjería de Sanidad y Consumo, CAM. Madrid, 2005.

⁴⁸ The La Quinta is a ghetto home to about 300 people. According to social workers, the local government will disperse the families in other parts of the city in 2006.

⁴⁹ ERRC interview with Teresa Pilis, April 18, 2005, Madrid, Spain.



2.4. Lack of Information about Access to Health Care

Lack of information about the availability of health care is a serious barrier to access health care for numerous immigrant Roma in Spain, especially the ones who live outside the authorised camps. According to the Gustavo Rioja of the ACCEM association of Madrid, “Foreign Roma do not know how to use the system because they are isolated and fear rejection by doctors.”⁵⁰ Several immigrant Roma from Romania in Spain testified to the ERRC that they have not used medical aid for more than one year because they were not aware they were entitled to it. Ms Lenuta Alexe, a Romani woman from Romania, told the ERRC: “When I first came I did not know I had a right to free health. It was only one and a half year before I knew. I friend told us to go to the camp and get papers. I did not go for treatment during this time. I would just go and get medicine on my own.”⁵¹ Poor sanitary conditions in unauthorized camps may lead to fast spread of infectious diseases. For example, in 2005, the ACCEM association detected tuberculosis in one of the unauthorised camps in Madrid. At the same time the public health system is not doing outreach to communities living in irregular camps.

2.5. Exclusion of Romani Women from Access to Health Care

Like Romani men, Romani women are affected by the same exclusionary forces operating within the health care systems and in most other social institutions – lack of equal opportunities in employment and education, exclusion from access to social services and health insurance in particular, physical remove from health facilities. The ethnicity/race-induced inequality is reinforced by gender-specific structures both in the broader society and within some Romani communities that further limit Romani women’s opportunities to enjoy the highest attainable standards of health. In many instances, lack of equal opportunities to access health care where Romani women are concerned is aggravated by the disadvantaged position of Romani women in comparison to Romani men in social fields such as education and employment. The fact that Romani women are generally less educated than Romani men increases the risks of them being excluded from health care. Furthermore, since Romani women, especially single mothers, tend to be economically worse-off than Romani men, the various costs implicated in using health services affect Romani women disproportionately.

As a result of fewer opportunities to access the labour market and lower educational levels, Romani women are more likely to be excluded from health insurance. For example, research in Macedonia in the course of 2005 indicates that Romani women may benefit less from provisions in Macedonian Health Insurance act allowing working members of families to insure non-working members. A number of Romani women interviewed testified that they

⁵⁰ ERRC interview with Gustavo Garcia Rioja, April 19, 2005, Madrid, Spain.

⁵¹ ERRC interview with Lenuta Alexe, April 19, 2005, Madrid, Spain.



had received health insurance through their husband, but had separated from their spouse and lost this entitlement. At the time of the interview they had no health insurance because they were not eligible for registration with the State Employment Bureau via which state-sponsored medical insurance is administered. In order to register, a person must have completed at minimum a primary education. This provision is applied in practice, although “the educational criteria” is not present in Macedonian legislation concerning employment or health care.

Exclusion from the health care system has a disproportionate impact on Romani women’s health, especially where reproductive and maternal health is concerned. Romani women who do not have health insurance cannot avail themselves of pre-and postnatal medical services. For example, Neviana Miroslavova, a 23-year-old Romani woman from the north-eastern Bulgarian town of Shumen, was four months pregnant and had pregnancy complications. In September 2004, she had stayed in hospital for several days and needed regular medical control. In October 2004, she went to her GP, Dr. Hristova, to ask for an appointment to a gynaecologist. Dr Hristova reportedly refused to examine her, or to do anything for her, because she had not paid her health insurance for the previous four months. Neviana Miroslavova used to work as a street cleaner for one year in the government public works scheme “From social benefits to employment”. After her contract was terminated, she registered herself as unemployed and was presumably entitled to state-provided health insurance.⁵² However, she was in practice unable to avail herself of this good.

In Slovenia, some Romani women testified to the ERRC that they did not have access to pre-natal care due to lack of citizenship. Ramiza Krasniqi, born in 1984 in Kosovo, has been living for 15 years in Slovenia. She was married to a Slovene citizen and applied for Slovene citizenship in 2001. When the ERRC interviewed her in May 2005 she had reportedly still not obtained Slovene citizenship. Ramiza Krasniqi told the ERRC that she was 7 months pregnant and could not attend pre-natal care because she did not have health insurance and was unable to pay for the medical services.⁵³

⁵² ERRC interview with Neviana Miroslavova, November 4, 2004, Shumen, Bulgaria.

⁵³ ERRC interview with Ramiza Krasniqi, May 10, 2005, Maribor, Slovenia.





3. DIRECT RACIAL DISCRIMINATION AGAINST ROMA IN THE PROVISION OF HEALTH CARE AND OTHER EXTREME FORMS OF HUMAN RIGHTS ABUSE OCCURRING IN THE HEALTH CARE SYSTEM

Racial discrimination against Roma in the provision of health care occurs at many levels within the health care system and ranges from overt denial of medical services to more complex forms of discrimination resulting in the provision of inferior medical services to Romani patients. This part of the ERRC report details examples of discrimination in the provision of health care which are not related to the broader systemic inequalities causing exclusion of Roma from access to medical services but have occurred at individual patient-provider level and were perceived by Roma as motivated by biased, stereotypical and prejudicial attitudes of health care providers to Roma. The testimonies collected by the ERRC from different countries point to a consistent pattern of discriminatory treatment of Roma by medical professionals. For example, during 2005, research conducted by the ERRC and partner organisations in Macedonia⁵⁴ revealed that of 237 Romani women interviewed in the course of the research, 113 reported having experienced discrimination in access to health care or other forms of abuse by health care workers. Of these, 65 described mistreatment and insults from doctors, while 48 described such treatment by other medical personnel, including nurses and cleaners. Racial discrimination in access to health care and other failures of the medical system to provide basic care with dignity were documented extensively in Kumanovo, Bitola, Stip and Prilep, where Roma comprise the largest ethnic minority. According to a survey among 717 Romani women in Romania, in 2005, 23% of Romani women believe they have suffered discrimination on gender grounds in access to health care, while 70.7% considered that Roma suffered discrimination based on race/ethnicity at the hands of health care professionals. Acts of discrimination, in the respondents' opinion, include substandard treatment resulting from a lack of interest in Romani patients on the part of health care providers, the prescription of the least expensive available medication – often ineffective – and the denial of free medication.⁵⁵

A representative survey in Hungary found that 25% of the interviewed Roma reported having faced discriminatory treatment in hospitals and other health care institutions, and 44.5% reported discriminatory treatment by general practitioners.⁵⁶

⁵⁴ The research was conducted in cooperation with the Roma Centre of Skopje and the Romani Women's Initiative of the Open Society Institute's Network Women Program, together with eleven Romani women researchers from Macedonia, in a research project aiming to document issues facing Romani women in the health care system in Macedonia.

⁵⁵ See Open Society Institute. *Broadening the Agenda. The Status of Romani Women in Romania*. Open Society Institute, 2006, pp. 57-58.

⁵⁶ See Delphoi Consulting. *Cigányok Magyarországon – szociális-gazdasági helyzet, egészségi állapot, szociális, és egészségügyi szolgáltatásokhoz való hozzáférés*. Budapest, 2004, p. 62, available at: <http://www.delphoi.hu/download-pdf/roma-szoc-eu.pdf>.





The ERRC has documented a complex of experiences in doctor-patient interaction recounted by Romani patients or their relatives and defined by them as discriminatory treatment based on their ethnicity. These include egregious forms of negligent and/or inappropriate medical treatment leading to the death of the patient or to deleterious effects on the patient's health; inadequate attention to Romani patients, including avoidance of physical contact during medical examination and absence of professional physicians during certain procedures requiring the presence of a professional doctor; prescription of inappropriate medicine; verbal abuse and degrading treatment. In addition to these, this section provides evidence of recurring incidents of denial of medical services and inferior treatment of Romani patients which are objectively verifiable such as denial of emergency aid, refusal of doctors to provide medical services to Roma and segregation of Roma in hospital facilities. This testimony in itself offers compelling evidence to conclude that Roma experience inferior treatment by medical professionals. However, the information based only on patient's testimony is bound to be limited, uncovering just a small part of the whole picture of treatment of Roma in the system of health care provision. In order to document in detail what health care services are available to Romani patients, research should collect data on the rates of utilisation of different types of services among Roma and non-Roma; rates of negative health outcomes thought to be preventable, and types of utilisation of medical services such as hospitalisation. Such data is at present missing, due in large part to a lack of political will to gather it and make it public.

3.1. Extreme Human Rights Abuse of Romani Patients by Medical Professionals

In some instances Romani patients have been victims of negligent medical care and treatment which resulted in the death of the patient or in irreparable damage to her health. Since medical malpractice affects also non-Romani patients and given the lack of any studies examining the frequency of preventable medical errors among Roma and non-Roma, to infer discriminatory treatment from the facts of a single case or even several cases, would be impossible. Cases of extreme human rights abuse of Romani patients by medical professionals however have occurred together with numerous reports alleging inferior medical care and refusal of medical services to Romani patients, sometimes accompanied by explicit humiliating remarks referring to the patient's ethnicity made by health care providers. ERRC therefore has reasons to believe that Roma have been victims of inferior treatment precisely because of their ethnicity.

In at least one case documented by the ERRC, racially offensive language used by a doctor indicates that the treatment of the patient may have been influenced by racial prejudice. According to information provided to the ERRC by the Sofia-based Bulgarian Helsinki Committee, on May 1, 2004, 22-year old Mr Mihail Tsvetanov, a Romani man from the northeastern Bulgarian town of Iperih, died in his home. The previous day Mr Tsvetanov was released from hospital and, according to the information provided by the medical personnel to his parents, he was in good condition.



Mr Tsvetanov was admitted to the hospital with stomach pains on April 16, 2004. He was held for several days, without a diagnosis. In the morning of April 21, Mr Tsvetanov complained of an acute stomach ache to his father, who was visiting. Despite repeated requests by the father that a doctor see his son, only at 6:30 PM did a doctor examine Mr Tsvetanov. Dr Minkov established that Mr Tsvetanov had a perforated ulcer and required an emergency operation. After the operation, Mr Tsvetanov was released on April 30. Ms Todorova stated that Dr Krastev informed her that her son was in good condition.

At around 3:00 AM on May 1, Mr Tsvetanov's condition deteriorated. His parents called an ambulance, which arrived only one hour later and a second phone call though the family live less than one kilometre from the emergency aid service. When it arrived, the medical team established the death of Mihail Tsvetanov.

On May 3, Mr Todorov met Dr Krastev at the hospital to ask for his son's medical file. Mr Todorov demanded that Dr Krastev explain why, after he stated Mr Tsvetanov was in good health, his son had died. Dr Krastev then allegedly stated, "It is not a big thing – one Gypsy less." In the following days, Mr Todorov went to the hospital several times to obtain the medical file but each time was denied access by Dr Krastev who claimed that the father did not need the document.

In Hetes, Hungary, a 39-year-old Romani woman told the ERRRC that her tenth child died at the age of 11 months of meningitis. The child had a choking cough and was hospitalised for bronchitis. The baby was released a couple of days later despite that she had a high fever. The parents took her to the emergency room in the village. At the emergency room, they reportedly had to wait for the doctor who was out visiting patients. When the doctor was back, they had to wait several hours for the ambulance to take the baby to hospital. The baby died several hours after she had been taken to hospital.⁵⁷

3.2. Extreme Human Rights Abuse Affecting Romani Women in Particular

Romani women are particularly vulnerable to abuse by medical practitioners at the time of pregnancy and childbirth. Practices of extreme abuse, as illustrated by several cases in this section, include death after child-birth, serious damage on the woman's health, as well as forceful termination of the woman's reproductive capacity through coercive sterilisation.

On October 30, 2004, Mr Plamen Tsankov testified to the ERRRC that his sister-in-law, Ms Rusanka Mateva, a Romani woman from the southern Bulgarian city of Pazardjik, died on October 17, 2004, in the Pazardjik Regional Hospital, after giving birth. The death was apparently due to

⁵⁷ ERRRC interview, March 2005, Hetes, Hungary.

loss of blood. At the beginning of October, Ms Mateva's health insurance coverage was reportedly terminated as a result of unpaid dues. Mr Tsankov reported that Ms Mateva was admitted to the emergency ward of the hospital to deliver her baby and, following the delivery, doctors left her without any medical supervision for several hours. Mr Tsankov also informed the ERRC of his belief that Ms Mateva's ethnicity also factored into her inadequate medical treatment.

On February 24, 25 and 26, 2004, doctors of the Gynaecological-Obstetrical Department of the Constanța County Clinical Hospital failed to provide Ms M.I., a 22-year-old Romani woman, with adequate treatment, resulting in severe harms to her person. Doctors and other medical staff repeatedly ignored her requests for assistance when she appeared to be suffering an infection after giving birth by caesarean section. According to ERRC research, conducted in co-operation with the Bucharest-based Romani organisation Romani CRISS on March 7, 2004, medical staff disregarded her reports of abdominal pain, headaches and nausea. On February 27, 2004, two junior doctors and one doctor removed Ms M.I.'s uterus without her consent then failed to inform her of the details and consequences of the operation.⁵⁸

In Kumanovo, Macedonia, 30-year-old Ms F.A. told the ERRC and partner organisations that four years previously she had had a very hard pregnancy. One night she had strong pains and went to the hospital where she was admitted. That night, the pain was severe but no one came to help her. She asked the nurse to give her some medicine to ease her pains but the nurse reportedly said that the woman complained too much. That night F.A. miscarried.⁵⁹

3.2.1. Coercive Sterilisation

ERRC field research in Slovakia and the Czech Republic in the period 2002-2004 revealed that practices of coercive sterilisation of Romani women in these countries – policy under Communism – have continued in the post-Communist period⁶⁰ and that Romani women are at risk of being subjected to sterilisation absent fully informed consent. Instances of coercive sterilisation of Romani women have also occurred in recent years in other countries, such as Hungary.

⁵⁸ Details about the incident are available in *Roma Rights 1/2004, What Is Roma Rights*, "Snapshots from Around Europe", <http://www.errc.org/cikk.php?cikk=1877>.

⁵⁹ ERRC/RCS/RWNP interview with F.A. June 16, 2005, Kumanovo, Macedonia.

⁶⁰ From the 1970s until 1990, the Czechoslovak government sterilised Romani women programmatically, as part of policies aimed at reducing the "high, unhealthy" birth rate of Romani women. This policy was decried by the Czechoslovak dissident initiative Charter 77, and documented extensively in the late 1980s by dissidents Zbynek Andrs and Ruben Pellar. Helsinki Watch (now Human Rights Watch) addressed the issue in a comprehensive report published in 1992 on the situation of Roma in Czechoslovakia, concluding that the practice had ended in mid-1990. Criminal complaints filed with Czech and Slovak prosecutors on behalf of sterilised Romani women in each republic were dismissed in 1992 and 1993. No Romani woman sterilised by Czechoslovak authorities has ever received justice or even public recognition of the injustices to which they were systematically subjected under Communism.

With respect to matters in Hungary, on 14 August 2006, the UN Committee on the Elimination of Discrimination against Women (CEDAW) condemned Hungary for violating the Convention on the Elimination of All Forms of Discrimination against Women in connection with the sterilisation of a Romani woman without her consent in January 2001.

On 2 January 2001, a Romani woman (Ms S.) was sterilised by doctors at the Fehergyarmat hospital. While on the operating table she was asked to sign forms giving her consent to this and other operations, without a full explanation about the intervention, its nature, possible risks, or what the consequences of being sterilised would be. She was not told about other forms of birth control either. It was only after the operation that she learnt that she could not become pregnant again.

On 15 October 2001, Ms S. and her attorney filed a civil claim for damages against the hospital. They requested finding the hospital in violation of the plaintiff's civil rights and that it had acted negligently in its professional duty of care with regard to the sterilisation of Ms S in the absence of her full and informed consent. The claim was turned down on 22 November 2002.

On appeal, the Szabolcs-Szatmar-Bereg County Court held that the hospital doctors had indeed acted negligently in failing to provide Ms S. with the relevant information about the sterilisation and stressed that "the information given to the plaintiff concerning her sterilisation was not detailed ... [and that she] ... was not informed of the exact method of the operation, of the risks of its performance, and of the possible alternative procedures and methods". Nevertheless, the same Court concluded that sterilisations as such are fully reversible operations and that as Ms S. had provided no proof that she had suffered a lasting detriment, therefore she was not entitled to compensation.

Since Hungarian courts failed to provide adequate remedy for Ms S. on 12 February 2004, the European Roma Rights Center (ERRC) and the Legal Defence Bureau for National and Ethnic Minorities (NEKI) jointly filed a complaint against Hungary with CEDAW relating to the illegal sterilization. The complaint asserted that Hungary, as a State Party to the Convention on the Elimination of All Forms of Discrimination against Women, is in violation of a number of provisions of the Convention, as a result of (1) failures to provide adequate information on contraceptive measures and family planning, (2) the lack of informed consent on the part of Ms S. as a violation of her right to appropriate health care services, and (3) interference with Ms S.'s ability to have children in the future.

In its decision, the Committee stated that it was convinced by the ERRC/NEKI arguments that sterilization is intended to be irreversible, that the success rate of surgery to reverse sterilization is low and depends on many factors, and that reversal surgery is risky. With respect to the claim that Hungary violated the Convention by failing to provide information and advice on family planning the Committee stated that the applicant "has a right protected

by article 10(h) of the Convention to specific information on sterilization and alternative procedures for family planning in order to guard against such an intervention being carried out without her having made a fully informed choice.”

In connection with the sterilization surgery without an informed consent the Committee reiterated that according under article 12 of the Convention, States parties shall “ensure to women appropriate services in connection with pregnancy, confinement, and the post-natal period”. According to its General Recommendation 24, “Acceptable [health care] services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her needs and perspectives. States parties should not permit forms of coercion, such as non-consensual sterilisation.”

The Committee also recalled its general recommendation 19 in which it states that “Compulsory sterilization...adversely affects women’s physical and mental health, and infringes the right of women to decide on the number and spacing of their children.” The Committee found that the sterilization surgery was performed on Ms S. without her full and informed consent and must be considered to have permanently deprived her of her natural reproductive capacity, therefore her right to decide freely and responsibly on the number and spacing of her children was also violated.

In conclusion, the Committee holds that appropriate compensation should be paid to Ms S. commensurate with the gravity of the violation of her rights. The Hungarian government should also ensure that the relevant provisions of the Convention and the pertinent paragraphs of the Committee’s general recommendations in relation to women’s reproductive health and rights are known and adhered to by all relevant personnel in public and private health centres, including hospitals and clinics.

The decision further states that the government should review domestic legislation on the principle of informed consent in cases of sterilization and ensure its conformity with international human rights and medical standards. Repeal provisions allowing physicians “to deliver the sterilization without the information procedure generally specified when it seems to be appropriate in given circumstances”. Public and private health centres which perform sterilization procedures, including hospitals and clinics, should be monitored so as to ensure that fully informed consent is being given by the patient before any sterilization procedure is carried out, with appropriate sanctions in place in the event of a breach.

The coercive sterilisation of Romani women has been undertaken on a more extreme and systematic level in the Czech Republic and Slovakia, as well as in the predecessor state to those countries, the former Czechoslovakia. In the Czech Republic and Slovakia, cases documented include:

- Cases in which consent has reportedly not been provided at all, in either oral or written form, prior to the operation;

- Cases in which consent was secured during delivery or shortly before delivery, during advanced stages of labour, i.e. in circumstances in which the mother is in great pain and/or under intense stress;
- Cases in which consent appears to have been provided (i) on a mistaken understanding of terminology used, (ii) after the provision of apparently manipulative information, and/or (iii) absent explanations of consequences and/or possible side effects of sterilisation, or adequate information on alternative methods of contraception;
- Cases in which officials put pressure on Romani women to undergo sterilisation, including through the use of financial incentives or threats to withhold social benefits.

In a number of the cases, explicit racial motive appeared to have played a role during doctor-patient consultations.

In December 2005, Czech Public Defender of Rights (“Ombudsman”) published the “Final Statement of the Public Defender of Rights in the Matter of Sterilisations Performed in Contravention of the Law and Proposed Remedial Measures”. The report is the result of more than a year of research by the Ombudsman and his staff, on the basis of complaints brought by women coercively sterilised by Czech doctors.⁶¹ The overwhelming majority of the victims are Romani. During the course of his research, the Ombudsman filed a number of criminal complaints in connection with cases brought to his attention. The report concludes that “The Ombudsman is convinced that in the Czech Republic, the problem of sexual sterilization – carried out either with unacceptable motivation or illegally – exists, and that Czech society stands before the task of coming to grips with this reality.” In the section entitled “Sterilization and the Romani Community” the Ombudsman reaches that the conclusion of racial targeting of Romani women. Measures undertaken by the Czech Ministry of Health are seen as to date grossly inadequate.⁶²

Despite the elapse of over eight months since publication of the Ombudsman’s report, the Czech government has not yet acted at all on the Ombudsman’s recommendations, and there are few indications that it intends to.

In addition, the Ombudsman filed tens of criminal complaints against doctors in connection with harms identified in the course of his investigation. A number of these have now been dismissed by Czech prosecutors or police.

⁶¹ The Ombudsman’s investigations followed discussions between the Ombudsman and the European Roma Rights Centre, the League of Human Rights (Prague/Brno), Life Together (Ostrava) and the Group of Women Harmed by Sterilisation (Ostrava).

⁶² The original Czech language version of the report is available at: <http://www.ochrance.cz/documents/doc1135861291.pdf> and the English language version is available at: <http://www.ochrance.cz/en/dokumenty/dokument.php?doc=400>.

Concerning the matter of the coercive sterilisation of Romani women in Slovakia, following publication of a report by the Center for Reproductive Rights and the Advisory Centre for Citizenship and Human and Civil Rights,⁶³ and supported by documentation undertaken by the ERRC,⁶⁴ significant international attention was focussed on this issue beginning in early 2003. In 2003, the Council of Europe's Commissioner for Human Rights Mr Alvaro Gil-Robles stated, following visits to Slovakia: "[...] on the basis of the information contained in the reports referred to above, and that obtained during the visit, it can reasonably be assumed that sterilizations have taken place, particularly in eastern Slovakia, without informed consent. The information available to the Commissioner does not suggest that an active or organized Government policy of improper sterilizations has existed (at least since the end of the communist regime). However, the Slovak Government has, in the view of the Commissioner, an objective responsibility in the matter for failing to put in place adequate legislation and for failing to exercise appropriate supervision of sterilisation practices although allegations of improper sterilizations have been made throughout the 1990's and early 2000."⁶⁵

The Commissioner further concluded that "The issue of sterilizations does not appear to concern exclusively one ethnic group of the Slovak population, nor does the question of their improper performance. It is likely that vulnerable individuals from various ethnic origins have, at some stage, been exposed to the risk of sterilization without proper consent. However, for a number of factors, which are developed throughout this report, the Commissioner is convinced that the Roma population of eastern Slovakia has been at particular risk."⁶⁶

Slovak authorities have expended extensive efforts to deny the problem, to thwart justice, and to harass and threaten the advocates of victims, as well as the victims themselves. To name only a few actions undertaken by Slovak authorities in response to these issues:

- Authorities including the Slovak Human Rights Commissioner and the Slovak ambassador to the Organization for Security and Co-operation in Europe threatened "the authors of the Body and Soul report" that they would be prosecuted. If the issues raised in the report were true, they would be prosecuted for failing to report a crime; if the issues in the report were false, they would be prosecuted for spreading false alarm. Both are crimes in Slovakia;

⁶³ Center for Reproductive Rights and the Advisory Centre for Citizenship and Human and Civil Rights, "Body and Soul: Forced Sterilization and Other Assaults on Roma Reproductive Freedom in Slovakia", on the Internet at: http://www.crlp.org/pub_vid_bodyandsoul.html.

⁶⁴ See for example "Joint Statement of the European Roma Rights Center (ERRC), the International Helsinki Federation for Human Rights (IHF) and the Slovak Helsinki Committee (SHC) on the Issue of Coercive Sterilizations of Romani Women, on the Occasion of the OSCE Supplementary Human Dimension Meeting on Roma and Sinti", on the Internet at: <http://www.errc.org/cikk.php?cikk=312&archiv=1>.

⁶⁵ "Recommendation of the Commissioner for Human Rights Concerning Certain Aspects of Law and Practice Relating to Sterilization of Women in the Slovak Republic", paras. 51 and 52, at: http://www.coe.int/T/E/Commissioner_H.R/Communication_Unit/CommDH%282003%2912_E.doc.

⁶⁶ *Ibid.*, Para. 35.

- The Slovak Ministry of Health directed hospitals not to release the records of the persons concerned to the legal representatives of the victims;
- Slovak prosecutors – despite extensive advice not to do so – opened investigations for the crime of genocide, a crime so serious that evidentiary standards could not be met, and they then predictably concluded that this crime had not been committed, ending their investigation into the matter. The same authority has repeatedly released misleading information to the media, deliberately perpetuating a state of delusion about the matter currently prevailing among the Slovak public.
- Slovak police investigating the issue urged complainants to testify, but reportedly warned a number of them that their partners might be prosecuted for statutory rape, since it was evident that they had become pregnant while minors; under this pressure, a number of victims withdrew testimony.

A number of legal complaints are pending with respect to these issues in the Czech Republic and Slovakia. Since no authority in any country in Central and Eastern Europe has yet provided the kind of just satisfaction the governments of Norway and Sweden have managed on coercive sterilisation issues, these efforts will continue. There are also reasons for believing that the time is right for a pan-European or even global initiative to examine the issue and to provide guidance on ways forward.

3.3. Overt Forms of Discrimination

In numerous instances documented by the ERRC differential negative treatment is not only perceived by the patients but also objectively verifiable. Such are the cases of failure of emergency aid services to respond to requests for assistance coming from Romani neighbourhoods; outright refusal of medical professionals to provide medical services to Roma; the segregation of Roma in hospitals; the extortion of money from patients and others.

3.3.1. Denial of Emergency Aid to Roma

For a number of years, the ERRC has been regularly receiving reports that emergency services fail to respond or respond in an inefficient manner to calls for assistance received from Roma. The systematic failure of emergency services to respond to Roma as well as the fact that in most of the cases personnel at the emergency aid can immediately recognise that the call comes from a Romani neighbourhood by the address of the patient, indicate the discriminatory nature of this denial of access to medical care.

Denial of emergency aid to Roma has had fatal consequences for some patients. In one case, on February 9, 2001, in the Romani settlement of Trnovce, near Čakovec, north-

western Croatia, the baby of a Romani couple, Mirko and Verica Oršuš, was stillborn after the local emergency medical team refused their calls for help. The Zagreb daily newspaper *Vjesnik* reported on February 11, 2001, that a neighbour had called the emergency medical technicians in the neighbouring town of Čakovec when 20-year-old Ms Oršuš went into labour, but was reportedly told that the team would not come, and that Ms Oršuš should be driven to the local medical centre, after which the person on the other end of the line hung up. Mr Oršuš called the same medical centre, and after he told them he did not have a car, according to *Vjesnik*, the staff mockingly told him to “put his wife into a wheel-barrow and wheel her to the medical centre”. Another neighbour called the medical centre in Varaždin, another nearby town, and was reportedly told that they were not obliged to cover the settlement at Trnovec, after which the neighbour called the local police and requested that they call an emergency team. By the time an ambulance finally arrived, Ms Oršuš had given birth on the floor of their house and the child was dead. The Zagreb daily newspaper *Večernji list* reported on February 13 that the ensuing internal investigation at the Čakovec medical centre established that they received the first call for help from the Oršuš family at 6:43 on the morning of February 9, and that the ambulance was finally sent out at 8:13 AM, after altogether five calls to the Čakovec medical centre for assistance.⁶⁷

A number of cases of abuse of the patient’s right to get emergency aid for free were also reported. According to information provided to the ERRC by the Plovdiv-based Roma Foundation:

In 2005, sixty-two-year-old Mr B.C. from the Stolipinovo Romani neighbourhood of Plovdiv had an acute headache, speech disturbances, was vomiting and had lost coordination. His son called the emergency aid service, and when he told them that the ambulance should go to Stolipinovo neighbourhood, the doctor on duty demanded to talk to the patient. B.C.’s son explained that his father’s condition was critical and he cannot talk. Then the doctor on duty said that there were no cars and that the patient should wait. After several calls to the emergency aid service, it was not clear whether a car would be sent. At that point the son requested a neighbour – an ethnic Bulgarian – to call the emergency service. The doctor on duty then demanded that the Bulgarian woman should guarantee the security of the emergency aid team. Finally, an emergency aid team arrived but before checking the patient, the doctor demanded to be paid 20 leva (approximately Euro10). The doctor established high blood pressure and a brain insult and called for a car to send the patient to the intensive care ward of the second city hospital. A complaint about the incident filed with the regional department of the National Health Insurance Fund was left without response.⁶⁸

⁶⁷ Legal action in the case was pending before Croatian domestic courts as of the date this report went to press.

⁶⁸ ERRC interview with Asen Karagoyzov, Roma Foundation –Plovdiv, June 2005, Plovdiv and telephone interview February 2006, Budapest.

ERRC research revealed that the practice of not sending ambulances to Romani neighbourhoods is systematic in some parts of Bulgaria. For example, all nine Roma interviewed in the town of Novi Pazar, northeast Bulgaria, during ERRC research in 2005, declared that the ambulances do not go to their neighbourhood. A Romani woman testified to the ERRC: “I have had several instances when I called the emergency aid for myself and my child. They refused to come to our neighbourhood and made me go to them. In some cases when they hear the address, they simply hand up.”⁶⁹ Another Romani woman, who suffers from high blood pressure and the Hashimoto syndrome (hypo-active thyroid), told the ERRC: “A month and a half ago my condition deteriorated and I called the emergency aid. It was very difficult to make them come. We had to call several times before they sent an ambulance. They were frightened when they saw my condition; they gave me a shot and told me to go to a cardiologist.”⁷⁰

In an earlier case in Novi Pazar, Ms Brigita Hristova testified to the ERRC that at around 11:00 PM on March 29, 2004, Mr Mitko Asenov, a Romani man from the Romani neighbourhood in Novi Pazar, called an ambulance when his 3-year-old daughter Emiliya Mitkova fell seriously ill, but the ambulance did not arrive. After some time, Mr Asenov brought Emiliya, who was experiencing a high fever and stomach pains, to the hospital in a car he borrowed from a neighbour’s guest. According to Ms Hristova, doctors at the hospital told Mr Asenov and his wife Zyulbie Asenova, that they might have lost Emiliya had they arrived later.⁷¹

Residents of the Stolipinovo neighbourhood of Plovdiv, Bulgaria, reported to the ERRC that in some instances emergency aid doctors demand that the patients show proof of insurance or pay in cash in order to receive emergency aid. A woman told the ERRC: “The emergency aid does not send ambulances in time. They ask whether we are insured, who is our GP, and whether we can pay for the services if we are not insured.”⁷²

In Hungary, ERRC research also revealed problems with emergency aid services in some parts of the country. A 37-year-old woman from the Bánszállás settlement, near the town of Ózd, in Borsod-Abaúj-Zemplén county, told the ERRC that her mother died in 2004 reportedly because the ambulance took a long time to arrive to her house.⁷³ Another family in the same district also complained that once when their 8-year-old daughter was ill they had to call the emergency three times before they arrived.⁷⁴ A representative survey of

⁶⁹ ERRC interview with 41-year-old B.S., May 26, 2005, Novi Pazar, Bulgaria.

⁷⁰ ERRC interview with 38-year-old R.M., May 26, Novi Pazar, Bulgaria.

⁷¹ ERRC interview with Ms Brigita Assenova, April 4, 2004, Novi Pazar, Bulgaria.

⁷² ERRC interview with 32-year-old D.K., June 28, 2005, Plovdiv, Bulgaria.

⁷³ ERRC interview, March 2005, Bánszállás, Hungary.

⁷⁴ ERRC interviews, March 2005, Bánszállás, Hungary.



Delphoi Consulting in 2004 found that 20.7% of adult Roma reported denial of ambulance coming on calls during weekends and nights. The denial of visitations by an ambulance during night duty affects children and adults at the same ratio. Forty percent of the Roma who live in segregated settlements with a large number of people together, experienced the denial of an ambulance visit.⁷⁵

Denial of emergency aid services to Roma is also confirmed by medical professionals themselves. Some of them justify failure of emergency services to respond to call from Roma by claiming that Roma abuse the emergency aid system – they try to avoid paying their health insurance and rely on the emergency aid which is free; they resort to emergency aid because it is more comfortable and they don't have to wait for their appointment with doctors. A paediatrician from Arlo, north-eastern Hungary, for example, commented:

When they call the emergency, they are often very arrogant. I don't even feel like talking to them. They call the ambulance for no reason. Somebody is coughing and they cannot go to the doctor because there are another five kids at home. It is easier for them to call the doctor.⁷⁶

Some doctors with whom the ERRC spoke admitted that they know that their colleagues from the emergency services do not always respond to calls from Roma, assuming that the calls are not about an urgent case. A GP from Bánszállás, north-eastern Hungary commented:

Fifty percent of my district was occupied by Gypsies. They came because of the iron, family and acquaintances from all over the country. There has been lots of black economy and I had to suffer the consequences. Their presence here also meant extra workload for the emergency services. There are lots of false calls. Yes, I know that some of my colleagues do not respond when they believe that they had received a false call.⁷⁷

A GP serving the Romani neighbourhood in Novi Pazar, where Roma consistently reported failure of emergency services to arrive to their neighbourhood, commented that “Roma do not use the regular medical services. They do not come for examinations and prophylactic check-ups. They prefer to use the emergency service because it is free of charge. That is why the emergency service does not send ambulances to the Romani neighbourhood.”⁷⁸

⁷⁵ See Delphoi Consulting. *Cigányok Magyarországon - szociális-gazdasági helyzet, egészségi állapot, szociális, és egészségügyi szolgáltatásokhoz való hozzáférés*. Budapest, 2004, p. 62.

⁷⁶ ERRC interview, March 2005, Arlo, Hungary.

⁷⁷ ERRC interview, March 2005, Bánszállás, Hungary.

⁷⁸ ERRC interview with Dr S.K., May 27, 2006, Novi Pazar, Bulgaria.



3.3.2. Refusal to Treat Romani Patients

According to the testimony of Sabka Sabeva, 24, from Shumen, Bulgaria, to the ERRC, on August 17, 2005, she was pregnant and had pains in the belly and started bleeding.⁷⁹ She got pregnant after two-year treatment of her ovaries. She reportedly called the emergency aid and was told that she needed a referral from the GP. Ms Sabeva went to her GP, Dr Panayotova, who was not in her office although it was during her working hours. On the following day, Sabka went to the GP again and requested to be given a referral to see a specialist. Sabka explained to her that she was bleeding and she wanted to check the state of her pregnancy. The GP then reportedly said that she could not refer her to a gynaecologist because she kept the referral documents only for emergencies. Sabka insisted that her case was urgent but the doctor refused. On August 19, Sabka borrowed money from her sister and went to see a gynaecologist. The gynaecologist sent her to hospital, where she was examined and it was established that the foetus was no longer alive. Sabka then underwent a surgical abortion. On August 23, she was released from hospital. She filed a written complaint to the regional department of the National Health Insurance Fund about the incident with the GP. She received a letter stating that her complaint had been reviewed and the GP had been sanctioned for violation of the Health Care Act. She received no further information, nor any form of compensation.

According to the testimony of H.A., 58-year-old woman from the village of Izgrev, in northeastern Bulgaria, the former GP in the village refused to give her referral to cardiologist. She suffers from cardiovascular and thyroid problems. She is insured through the social welfare office. The GP, however, refused to refer her, and reportedly told her son who went to request for the document: "Let your mother die, I don't care!"⁸⁰ As of the date of the ERRC visit, the village of Izgrev was without a GP for about two months. The former GP was expelled following a petition sent by many villagers to the mayor, complaining about rude and negligent treatment by the GP.

In February 2002, Ms Stefka Dimitrova had a spontaneous abortion and needed emergency medical assistance. The doctors at the St Sofia hospital in Sofia, Bulgaria, refused to provide her with the necessary treatment unless she paid them 5 leva (approximately 2.5 Euro). At the same time, according to the testimony of Ms Dimitrova, an ethnic Bulgarian woman was accepted for consultation without any conditions. Ms Dimitrova returned home to take money with her and went back to the hospital with two relatives. By the time she reached the hospital, her condition had deteriorated. She was profusely bleeding and her clothes were stained with blood. She explained to the doctors that she had undergone spontaneous miscarriage. At this point doctors refused her medical treatment again requiring her to pay a larger amount of

⁷⁹ ERRC interview with Sabka Sabeva, August 25, 2005, Shumen, Bulgaria.

⁸⁰ ERRC interview with H.A. May 31, 2005, Izgrev, Bulgaria. The village has around 500 inhabitants, most of whom are ethnic Turks and Roma.

money – 20 leva (approximately 10 Euro). Since Ms Dimitrova had only 5 leva with her, she had to return home. On the evening of the same day, her condition became critical – she had high fever and was suffering from severe pain. Ms Dimitrova sought assistance from a non-governmental organization in Sofia and was taken to the Medical Academy in Sofia, where she was accepted for treatment. A woman at the non-governmental organization reportedly told Ms Dimitrova that the medical practitioners in St. Sofia maternity hospital demanded as a matter of practice that Romani women who reported spontaneous abortions pay the amount of 20 leva. The motivation for this practice was reportedly that Romani women intentionally provoke spontaneous abortions to avoid paying the regular tax of 20 leva which is due in cases of surgical abortions.⁸¹

In the Hungarian town Tiszavasvári, in the Szabolcs-Szatmár-Bereg county, two Romani women testified to the ERRC that the local paediatrician refused to examine their children. A 37-year-old woman told the ERRC that their 8-year-old child had a high fever and they brought her to the paediatrician on duty. The doctor reportedly sent them away by saying, “I am not going to check your child now,” and using an extremely rude phrase with them. Another woman from the same town told the ERRC that the same paediatrician refused to check her 3-year-old daughter in the summer of 2004. The paediatrician went to the house of the Romani family, but when he saw the girl, he reportedly stated that she was too dirty and he would not examine her. He also threatened the family that he would report them to the social workers and make sure that the child was taken into state care.⁸²

ERRC research in Romania revealed that family doctors strike Roma off their lists of patients even in cases when Roma had health care coverage.⁸³ According to their testimony to the ERRC, in September 2003, a Romani family filed a complaint against Dr Elena Nitulescu of Cumpâna village with the Constanța Public Health Department because she refused to see and vaccinate their two children, reportedly on the grounds that they were “dirty” and “noisy”. The family receives social welfare benefits, including state-sponsored medical insurance. Dr Nitulescu reportedly took the family off her patients list and informed the Constanța Health Insurance Agency. According to ERRC research, the case was transferred from the

⁸¹ On April 20, 2006 the Sofia District Court rejected the civil claim against St. Sofia hospital filed by Ms Dimitrova by a local attorney with support from the ERRC. The Court held that there was no evidence supporting the claim that the refusal of free medical assistance to Ms Dimitrova was based on her ethnic origin. Further, the Court ruled that there was no illegal act with respect to the claimant because it was not established that she needed emergency medical assistance. The decision of the Sofia District Court was appealed before the Sofia City Court on May 8, 2006.

⁸² ERRC interviews, May 2005, Tiszavasvári, Hungary.

⁸³ Family doctors (General Practitioners) provide primary medical assistance in Romania. Patients are free to register with any family doctor and can switch doctors at any time. Family doctors are paid depending on the number of patients. See Emergency Ordinance no. 150 of 31 October 2002 concerning the organisation and the functioning of the system of social medical insurance.

Public Health Department to the Social Welfare Office. Ms Lacramioara Georgescu, a social worker, informed the ERRC that she visited Cumpâna to accompany the Romani family to Dr Nitulescu's office for a consultation. According to Ms Georgescu, Dr Elena Nitulescu's medical assistant verbally abused the family, saying that they were noisy and did not wait their turn and said, "Not only do you come dirty and have a big mouth, but you also threaten the doctor." The medical assistant then told them that they could not see Dr Nitulescu because they were not on her list of patients. Ms Georgescu informed the ERRC that when she asked Dr Nitulescu why she refused to treat the family, she stated, "I am fed up with them because they are noisy and because they abuse me. They stink and are dirty! That is why I took them off the list." Dr Nitulescu told Ms Georgescu that she refused to vaccinate the children because the mother had not signed a form. After Ms Georgescu again requested that she vaccinate the children, Dr Nitulescu vaccinated one of the children, in a very aggressive manner, apparently without first sterilising the needle.

On February 8, 2004, the Cumpâna Town Hall wrote a letter to the Constanța Public Health Department, listing sixteen people who were not registered with a family doctor because the patients' lists of the doctors were full. On February 19, 2004, an employee of the Cumpâna Town Hall who requested anonymity stated that thirteen of the people on the list were Romani. The Town Hall employee further stated that the reason for non-registration was the ethnicity of the patients. However, those persons listed in the letter of the Cumpâna Town Hall had not been registered on the patients' lists of any family doctor, according to the Town Hall employee.⁸⁴

3.3.3. Extortion of Money from Romani Patients

The practice of giving money to doctors for provision for which the doctor is not entitled to a direct payment is widespread in several countries and does not affect only Romani patients. In Central and Eastern European countries, this practice dates back to Communist times and remains more or less unchanged to date. The usual explanation for such payments provided by the patients is that they serve as guarantee for quality treatment and good attitude on the part of the health providers. Indeed, some Roma in Hungary and Bulgaria testified to the ERRC that they voluntarily offered money to doctors in the hope to be treated with due care. In a number of cases, however, provision of medical services to Roma was made conditional on the ability of the patient to give a bribe to the doctor. Doctors demanded payment from Romani patients even in cases when patients made clear that they cannot pay or cannot pay the amount specified by the health provider.

During field research in Hungary in 2005 a number of Roma testified that they were coerced by doctors into making out-of-pocket payments in order to receive services. In what

⁸⁴ See *Roma Rights 1/2004, What Is Roma Rights*, "Snapshots from Around Europe", at: <http://www.errc.org/cikk.php?cikk=1879>.



seems to be a disturbing trend doctors frequently demand money from Roma to deliver children. In the northeastern Hungarian Romani communities of Arlo and Bánzállás, seven interviewees stated that a certain obstetrician, Doctor K., made them pay for delivering their child. He reportedly told his patients: “If you pay, you will have a baby, if you don’t pay – you will not have the baby.” A 21-year-old Romani woman testified to the ERRC that Doctor K. told the woman that the delivery of her child would cost twenty thousand Hungarian forints (approximately Euro 80). The woman’s husband paid Doctor K. five thousand forints and pleaded with the doctor to allow him to pay less as he was unemployed and did not have the money. Doctor K. reportedly told him: “Isn’t your first baby worth ten thousand forints to you? If you want to have a healthy baby you’d better pay.” The husband was able to pay Doctor K. five thousand more forints after which Doctor K. agreed to assist with the birth.

3.3.4. Segregation in Hospital Facilities

Segregation of Romani patients in hospital facilities is a common practice in several countries. For example, in state hospitals in several towns throughout Slovakia like Kosice, Spisska Nova Ves, Stara L’ubovna, Trebisov, Kezmarok, Rimavska Sobota, and Luncenec, Romani patients are often placed in Roma-only rooms, sometimes use separate shower and toilet facilities and are barred from common spaces with the rest of the patients.⁸⁵

In addition to intentional separation of Romani patients from non-Romani patients, some hospital facilities, especially ones located in close proximity to Romani neighbourhoods are likely to become ghettoised mainly for economic reasons. In both cases, however, segregated facilities are inferior in material and sanitary conditions and services. For example, the child care ward located not far from the Romani neighbourhood Iztok, in Pazardjik, Bulgaria, had 100% Romani patients at the time of ERRC visit in November 2005. In this hospital, mothers are allowed to stay with their children without paying. A second child ward is operating in Pazardjik, where mothers are supposed to pay for their stay. Apparently, due to financial restrictions, this alternative is unaffordable for Romani parents who use the services of the ward near the Romani neighbourhood. According to Romani activists, the conditions in the latter facility are much worse. Romani women accompanying their sick children are reportedly made to clean the ward.⁸⁶

Racially segregatory practices especially affect Romani women in maternity wards. In a number of countries Romani women are placed in separate rooms – “Gypsy rooms” as they are known to patients and hospital staff. The “Gypsy rooms” are reported to be in worse sanitary conditions and the Romani women attended to less by medical professionals. ERRC research

⁸⁵ ERRC field research, November and December 2002.

⁸⁶ ERRC interviews, November 2005, Pazardjik, Bulgaria.

in Hungary in 2003 documented forty-four cases in which Romani women were reportedly placed in separate hospital rooms from non-Romani women. In Miskolc, Borsod-Abaúj-Zemplén County, in the Vasgyári hospital, according to the testimony of one Romani woman, despite the fact that there was a free bed in a room with five other non-Romani women, the Romani woman was placed in an empty room all by herself. She stated that this was humiliating and that she felt offended. Another Romani woman from the same hospital said that the separate “Gypsy room” was not cleaned during her stay in the hospital and that the Romani women in the room had to clean it themselves. The women stated that the phenomenon of separate rooms had not existed during Communism, when all women were treated equally. In 2005, 39-year-old Ms B.C. also told the ERRC that in the Miskolc maternity hospital, rooms 8 and 9 were only for Romani women. She herself was placed in such a room. The rooms are reportedly called by the doctors “the Chinese quarter”.⁸⁷ During an interview with the ERRC in October 2005, a doctor on duty in the Miskolc maternity hospital stated that there are separate rooms for Romani women in the hospital. He argued that this is not discriminatory treatment but was done for hygienic reasons, “because all Romani women are smokers.” He claimed that Romani women who do not smoke would be placed in a mixed room.⁸⁸

In Ózd, in Borsod-Abaúj-Zemplén county, a Romani woman stated that she was put in a separate room within the maternity ward of the local hospital. When the nurses distributed sweets and pastries to the patients, they did not bring any to the Romani women in the “Gypsy room”. The nurses reportedly ate the pastries themselves.

Ms Szilvia S., 26, a Romani woman from Nagyecséd, Szabolcs-Szatmár-Bereg county, reported that room No. 8 in the Mátészalka hospital was a “Gypsy room”. M., a young Romani woman from the same town, told the ERRC that, on both occasions when she went to the hospital to give birth, she was put in room No. 8. When she asked the nurse if she could change rooms, she was told that there were no other beds available. The nurse also said that women in room No. 8 were not allowed to bring stereos or television sets into the room, whereas this was allowed for non-Roma in other rooms. A 37-year-old woman from Tiszavasvári in the same county, told the ERRC that the maternity ward in the hospital in the town of Nyíregyháza had two divisions: Class A and Class B. Class A was for women who were able to choose a doctor and pay, and Class B was for Romani and poor women.⁸⁹ A 20-year-old man from the same town told the ERRC that in February 2004, when his wife gave birth to their youngest child, she was first placed in Class A and then moved to Class B, according to him for no other reason but her Romani background.⁹⁰

⁸⁷ ERRC interview with B.C., October 2005, Rakaca, Hungary.

⁸⁸ ERRC interview, October 2005, Miskolc, Hungary.

⁸⁹ ERRC interview, May 2005, Tiszavasvári, Hungary.

⁹⁰ ERRC interview, May 2005, Tiszavasvári, Hungary.

Segregation is reported to be a persistent practice in several places throughout Bulgaria. For example, in Pazardjik, local Romani activists reported that the maternity hospital keeps three out of thirteen rooms for Romani women. This practice has allegedly existed for the past twenty years. In Sofia, four Romani women who filed a complaint against the maternity hospital St. Sofia for racial discrimination, described the situation in the following way:

In the period 2001-2002, we were admitted in St. Sofia hospital. All of us were placed in room 15 on the 5th floor and in a room at the 2nd floor, which are known to the patients and to the medical personnel as “the Gypsy rooms”. All women in these rooms were Romani and other Romani women who were admitted in the hospital during this period were placed in these rooms. We learned that the placement of Romani women in separate rooms is a routine practice in this hospital. We also learned that pregnant Romani women who stay in the hospital with some problems during their pregnancy are also placed in separate rooms.

The sanitary conditions in the so called “Gypsy rooms” were worse than in the other rooms where ethnic Bulgarian women were placed because they were rarely cleaned. Visitors were not admitted in these rooms while in the rooms where the ethnic Bulgarian women stayed, visitors were freely admitted. We learned from other Romani women that in the winter months “the Gypsy rooms” did not have heating. In October 2001, Gergana Hrsitova requested to put her own electric heater in her room because the central heating was not on. She was not allowed to do that although there were electric heaters in the other rooms. The medical personnel was rude with us – they yelled at us and sometimes slapped us.⁹¹

3.3.5. Absence of Medical Professionals during Delivery by Romani Women

ERRC research in Hungary has documented more than a dozen cases in which nurses and/or training nurses were involved during delivery instead of practising doctors although the law requires the presence of medical doctors during delivery. According to the testimonies of Romani women, medical students are more often used to assist Romani women than non-Romani women.

⁹¹ Civil claim by Roza Anguelova, Irina Ilieva, Draga Kirilova and Gergana Hristova filed against First Specialised Obstetrics-Gynecological Hospital St. Sofia in Sofia, before the Sofia District Court on November 15, 2002. Document on file with the ERRC.

The claim was filed with support by the ERRC. The applicants relied on the prohibition of discrimination on racial grounds in the International Convention on the Elimination of All Forms of Racial Discrimination, in the International Covenant on Economic, Social and Cultural Rights, on the European Social Charter as well as on the Bulgarian Constitution and the Bulgarian Health Insurance Act. The case is pending before the Sofia District Court as of the date this report went to press. An appeal against the decision of the Sofia District Court to reject partially the civil claim in the part requesting the Court to issue an injunction barring separation of Romani women in the hospital in the future, is pending before the Bulgarian Supreme Court of Cassation as of the date this report went to press.

In Sajószentpéter, Borsod-Abaúj-Zemplén County, Hungary, the ERRC interviewed one woman who said there was no doctor present during her delivery, only a midwife. In Kazincbarcika in the same county, a 28-year-old Romani woman with two children told the ERRC she believed that health care was a matter of race; doctors and nurses did not pay much attention to her. She stated that she practically had to give birth on her own. The midwife only came around to give her an intravenous drip and some painkiller injections. The midwife reportedly showed up twice in nine hours.

Similarly, Ms Rosa Anguelova from Sofia, Bulgaria told the ERRC that when she delivered her child in October 2001, there were not medical doctors in the delivery room but only medical students – “young people in their twenties”. After the delivery, Rosa Anguelova had an infection caused by a piece of sanitary tissue left in her body by the person who assisted the delivery.⁹²

3.3.6. Verbal Abuse and Degrading Treatment of Romani Patients

A number of Roma reported being verbally attacked or otherwise abused by doctors on the basis of their ethnicity. Fifteen-year-old Ms M.T. of Štip, Macedonia, for example, told the ERRC that medical personnel kept insulting her while she was giving birth, saying: “You Gypsies have too many children and your breath smells from hunger.”⁹³

Doctors often blame Romani patients for being dirty. Twenty-seven-year-old Ms I.A. from Kumanovo, Macedonia, testified that she was the only Romani woman in her hospital room. The medical personnel did not change her sheets while they did change the sheets of the other patients in the room. When I.A. complained, she was told that she did not have clean sheets at home and she sleeps on the floor and therefore she should not ask for more than she deserves.⁹⁴ In Sendrolad, Hungary, a 46-year-old Romani woman told the ERRC that a nurse in the hospital in Miskolc, who saw her waiting for the doctor, made a comment: “I had enough of these dirty Gypsies!” In another incident, on January 19, 2005, Ms Olganica Jasarević, who was in her ninth month of pregnancy and experiencing heavy bleeding, was reportedly verbally abused by the attending nurse in the gynaecology department of a clinic in Nis, Serbia. When Ms Jasarević arrived at the clinic she was admitted; however, when hospital staff would not assist Ms. Jasarević, she was forced to lay down to stop the bleeding as much as she could. When a nurse came into Ms. Jasarević room and saw the bed covered with blood, she

⁹² Civil claim by Roza Anguelova, Irina Ilieva, Draga Kirilova and Gergana Hristova filed against First Specialised Obstetrics-Gynecological Hospital St. Sofia in Sofia, before the Sofia District Court on November 15, 2002.

⁹³ ERRC/RCS/RWNP interview with M.T., June 4, 2005, Štip, Macedonia.

⁹⁴ ERRC/RCS/RWNP interview with I.A., July 7, 2005, Kumanovo, Macedonia.



stated: “you dirty Gypsy, look what you have done.” The doctor who attended to Ms Jasarević reportedly apologised on behalf of the nurse and stated it would not happen again.⁹⁵

Several people interviewed by the ERRC testified that they have experienced situations in which they were waiting for a consultation and non-Romani patients who arrived later were admitted before them. A 50-year-old Romani woman in Fényeslitke, Hungary, told the ERRC that the nurse in the local medical centre always calls non-Romani patients before Romani patients, even though Roma may have arrived first.⁹⁶ Similarly, in Novi Pazar, Bulgaria, two interviewees stated that it happened to them several times that they were waiting for their turns at the local polyclinic and doctors admitted non-Roma who had come later before them.

3.3.7. Attitudes towards Romani Visitors to Hospital Facilities

Testimony by doctors and Romani patients alike reveal that the presence of Romani visitors in health care facilities often creates conflicts between them and the hospital personnel. Some doctors with whom the ERRC spoke blamed Roma for disturbing the work of the medical staff because they at times come in big numbers, are loud and sometimes drunk. Many Roma, on the other hand, testified that they felt uncomfortable in health care settings due to “inflexibility of the health care system”. In their opinion, health care professionals react negatively to family visits in hospitals, ignoring the fact that support from family members can have a positive impact on the patient’s condition. According to the head of the Andalusian regional government’s department of services for Roma, Jose Manuel Leal, “hospital regulations are very rigid and it is only through tacit agreements and negotiations that these issues can be solved.”⁹⁷ The negative reaction of medical staff to Romani visitors in hospitals is believed to impact the treatment of patients. According to Carmen Santiago Reyes, “Doctors may shorten the length of treatment to get rid of patients and family.”⁹⁸

While it is reasonable to assume that in some instances, the presence of too many visitors in a health care facility may disturb its functioning, some of the Romani individuals with whom the ERRC spoke testified about cases in which hospital personnel simply wanted to keep Roma away from the facility. Such behaviour on the part of medical staff is apparently linked to prejudice. There appears to be a direct connection between this form of discriminatory treatment on the one hand, and the widespread complaints by the doctors that Roma who come to their cabinets are filthy, steal, and create problems on the other. According to an

⁹⁵ See *Roma Rights 2/2005*, News Roundup: Snapshots from Around Europe, at: <http://www.errc.org/cikk.php?cikk=2336>.

⁹⁶ ERRC interview, May 2005, Fényeslitke, Hungary.

⁹⁷ ERRC interview with Jose Manuel Leal, April 16, 2005, Granada, Spain.

⁹⁸ ERRC interview with Carmen Santiago Reyes, Romani lawyer, April 17, 2005, Granada, Spain.



anthropologist in Spain, “there is a general belief that Gypsies are violent and complicated and doctors want to get rid of them.”⁹⁹ For example, several women in Sofia testified that in the maternity hospital St. Sofia, visitors were not admitted to the segregated rooms where the Romani women were placed. In Madrid, Mr Manuel Fernandez told the ERRC that he and his wife were visiting a friend in the hospital. Apart from a non-Romani couple, there was no one in the ward. Security guards approached Mr Fernandez and his wife and told them that there should be only one visitor at a time. The security guards did not ask the non-Romani couple the same. Mr Fernandez wanted to discuss the matter with the guard and then another guard approached them and started yelling that Mr Fernandez did not respect the rules.¹⁰⁰ A 37-year-old woman from Hetes, in the Borsod-Abaúj-Zemplén county of Hungary, told the ERRC that when her son was two years old, he fell and cut his leg on a piece of glass. He was taken to the Miskolc hospital where he was operated and had to remain in hospital. Although she was still breastfeeding her child, she was not allowed to stay in hospital with him. A doctor reportedly told her that it was time she stopped breastfeeding her child.¹⁰¹

Instances of violent treatment of Roma in hospitals were also reported. According to the Hungarian national daily newspaper *Népszabadság* of November 5, 2002, on November 1, 2002, a group of police officers beat a group of forty Roma at a hospital in Gyöngyös in Heves County. The daily reported that the Roma began to loudly mourn their grandmother, whom they had gathered to visit at the hospital and who had died there. Hospital security called the police. According to the daily, when the officers arrived at the hospital, they began to beat the Romani mourners, including women and children. On November 5, 2002, the Budapest-based Roma Press Centre (RSK) reported that the officers beat the Roma with truncheons. One of the Romani men was apparently beaten while handcuffed to a door at the hospital and his wife was thrown to the ground by her hair when she attempted to help him. Two Roma were reportedly hospitalised for treatment of severe injuries following the attack and several others sustained light injuries.¹⁰²

3.3.8. Neglect of Romani Patients Due to Language Barriers

Although the barriers of Romani immigrants to health care in Spain are not yet properly studied, one concern expressed by organisations helping Romani immigrants was that due to

⁹⁹ ERRC interview with Mr Juan Gamella, April 14, 2005, Granada, Spain.

¹⁰⁰ ERRC interview with Manuel Fernandez, April 22, 2005, La Mina neighbourhood, Barcelona, Spain.

¹⁰¹ ERRC interview, March 2005, Hetes. The head nurse of the paediatric ward in the hospital in the town of Ózd, to which the Hetes settlement belongs, told the ERRC that mothers who breastfeed their children are allowed to stay with them in the hospital. Those who have stopped breastfeeding should pay HUF 500 per day (approx. Euro 2) in order to stay with their children in the hospital.

¹⁰² For details of the case, see *Roma Rights 1-2/2003, Anti-Discrimination Law*, “Snapshots from Around Europe”, at: <http://www.errc.org/cikk.php?cikk=1433>.

language problems immigrants from Romania cannot access health care. According to Gustavo Rioja, from the non-governmental organisation ACCEM, helping Romani immigrants in a temporary accommodation area in Madrid, the public health system has not met its obligation to provide interpreters for patients who do not speak the Spanish language. Their organisation received a lot of complaints from doctors that they could not communicate with their patients. In one instance they reportedly mediated between a Romani immigrant and a doctor who refused to treat the patient because there was no interpreter.¹⁰³

3.4. Perceived Discrimination in the Quality of Medical Services Provided to Roma

Roma who have had encounters with medical professionals often have the perception that they have been treated with less care and respect as compared to non-Roma. Most commonly the lack of quality services has been described in terms of lack of attention on the part of the doctors to Romani patients. About one-third of the 92 Roma interviewed by the ERRC in Bulgaria stated that they believed that doctors did not pay sufficient attention to them. Their perception was that doctors are less patient with Roma, “they are always in a hurry to send us off” and “are irritated when we ask questions”. In a number of countries, Roma recounted that their visits to doctors would usually last a few minutes, during which the doctor only prescribed some medicine but did not actually examine the patient or listen to their complaints or explain in any satisfactory manner details about the condition of the patient. A number of Roma believed that doctors discriminated against them because doctors did not respect the time of arrival of patients and would let non-Roma in their cabinets first. Roma who spent time in hospitals reported that in some instances doctors refused to attend to their needs. Satisfaction with treatment was linked by some Romani interviewees to payment for medical services. A number of instances of verbal abuse of Roma, including racial slurs, were reported. Although some of the interviewed Roma found it difficult to identify obvious examples of discrimination, they believed that less favourable treatment of Roma is a fact. As a 46-year-old Romani man in Arlo, north-east Hungary, stated: “You just feel it. You feel by the way they approach you. It is difficult to express in words.”¹⁰⁴ A number of people said that they cannot describe doctors’ attitudes towards them as “rude” but rather as “lack of desire to give their time and efforts to us”.

In a number of instances, Romani patients complained that doctors failed to examine them or performed only cursory examinations. The perception of the Romani patients has been that doctors avoid physical contact with them. A 54-year-old Romani woman from the village of Csenyété, in Borsod-Abaúj-Zemplén County, Hungary, told the ERRC that the

¹⁰³ ERRC interview with Gustavo Rioja, April 19, 2005, Madrid, Spain.

¹⁰⁴ ERRC interview, March 2005, Arlo, Hungary.

GP in their village never checks patients, just writes prescriptions.¹⁰⁵ A 70-year-old Romani woman from the same village told the ERRC that she had problems with blood circulation. She was given a diuretic by the doctor who was in place of the village GP. The woman insisted that the doctor take her blood pressure. He refused to do so, and reportedly pushed her out of his room, yelling “Get out!” She thought that “the doctor hated the Gypsies.”¹⁰⁶ In Tiszavasvári, a 29-year-old Romani woman told the ERRC that the paediatrician did not want to check her 4-year-old child despite the fact that the child had high temperature. The doctor only ordered the nurse to bring an injection. The woman believed that the doctor was racist and said that she asked assistance from the medical centre to change him.¹⁰⁷ In the village of Ivanski, north-eastern Bulgaria, three out of seven Roma interviewed by the ERRC testified that the local GP – one for the whole village – does not pay enough attention to them or their children.¹⁰⁸ Mr N.K., a twenty-four-year-old Romani man, stated that “Our GP is afraid to touch Roma.” Ms M.M., a twenty-four-year-old Romani woman, said that when she brings her child to the GP, “she is always in a hurry, doesn’t bother to explain much, writes a prescription and that’s it.”

Roma also testified to the ERRC that doctors ignored their requests for assistance and acted inappropriately given the condition of the patient. According to the testimony of a Romani woman in Bulgaria, “When I went to hospital visiting relatives, I noticed that nurses are rude to sick Roma and do not want to pay attention to them. They behave as if Roma patients are not supposed to disturb them.”¹⁰⁹ A 23-year-old woman from Arlo, North-East Hungary testified to the ERRC that she had abdominal pregnancy. Once she felt severe pain and had to call the GP. He gave her an anaesthetic, but said that there was no need to call for the ambulance to take her to hospital. Since her pain did not diminish, on the following day the woman took the bus and went to hospital in the nearby town of Ózd. She was immediately taken to the surgery room and operated on. Doctors reportedly told her that had she arrived later, they could not have saved her life.¹¹⁰ Ms M.A., a thirty-year-old Romani woman from Bulgaria, told the ERRC that her husband had synositis and the local GP prescribed him some eye drops. They went to a doctor in the nearby town of Shumen, where they paid for a consultation with a doctor who told them that the eye drops prescribed by the GP were not appropriate at all. “The problem was”, said M.A., “that we borrowed money to buy the eye drops and then to go to for a consultation in Shumen.”¹¹¹

¹⁰⁵ ERRC interview, October 2005, Csenyété, Hungary.

¹⁰⁶ ERRC interview, October 2005, Csenyété, Hungary.

¹⁰⁷ ERRC interview with a 29-year-old woman, May 2005, Tiszavasvári, Hungary.

¹⁰⁸ The population of the village is 1,559 people, around 300 of which are Romani.

¹⁰⁹ ERRC interview with 22-year-old Fani Semova, June 22, 2005, Varna, Bulgaria.

¹¹⁰ ERRC interview, March 2005, Arlo, Hungary.

¹¹¹ ERRC interviews, June 6, 2005, Ivanski, Bulgaria.



Roma who had been hospitalised reported being ignored by doctors and nurses. Fifty-four-year-old Romani woman Kotai Djuzune from Csenyété told the ERRC that when she went to the hospital in the nearby town of Szikszó, where she spent some time in February 2005 because she had high blood pressure, she was ignored by the doctors. When she was hospitalised, her blood pressure was measured. After that she was left in the room without any attention – she was not given any medicine or food. On the following morning no one went to check her blood pressure. A doctor reportedly came to check a fellow patient in the same room but did not check Ms Djuzune.¹¹² In Ivanski, north-eastern Bulgaria, 26-year-old Romani man D.D. was hospitalised in April 2005 in the hospital in Shumen with bronchial pneumonia. He felt ill and asked a nurse about the doctor. The nurse reportedly told him that the doctor was not available and he should go back to his bed. Mr D.D. however was certain that he had heard the doctor's voice and she was in her office.¹¹³ Thirty-nine-year-old Romani woman N.A. was hospitalised in Shumen north-east Bulgaria. Six years earlier she was diagnosed with depressive neurosis and was treated for this condition. In the hospital, Ms N.A. felt nauseous and went to the nurse on duty. The nurse who was reportedly looking at some papers, did not pay her attention. Ms N.A. requested that her blood pressure be taken. The nurse, however, sent her off, saying “Nothing is wrong with you, go to your bed”.¹¹⁴

3.5. Racial Prejudice and Stereotyping of Roma by Health Care Providers

Racist prejudice towards Roma in Europe is intense and persistent. Surveys in various European countries have indicated that majorities' image of Roma consists of a number of negative stereotypes. Despite the fact that the impact of racism in the treatment of Romani patients is vigorously resisted, bias and negative stereotypes among medical professionals with respect to Roma are documented. ERRC interviews with a number of health care professionals in Bulgaria, Hungary and Spain as well as testimony of Roma in a number of other countries revealed that many medical professionals freely express negative prejudices and stereotypes of Roma. Medical professionals with whom the ERRC spoke shared the general negative stereotypes of Roma prevalent among non-Roma and also expressed stereotypical notions related to the state of health of their Romani patients. ERRC researchers repeatedly heard racist, humiliating remarks about excessive birth rates among Roma, abuse of the social welfare system by Roma, unwillingness of Roma to find decent work, irresponsibility about their lives and the lives of their children. A number of medical professionals told the ERRC that they believed that Roma have many children not because they want big families, but because they want to take advantage of the social welfare system:

¹¹² ERRC interview with Ms Kotai Djuzune, October 2005, Csenyété, Hungary.

¹¹³ ERRC interview with D.D., June 8, 2005, Ivanski, Bulgaria.

¹¹⁴ ERRC interview with N.A., May 5, 2005, Struino, Bulgaria.



They start having babies at the age of 12. It is worthless to instruct them. They all know about contraceptives but they have babies on purpose. They know that they will have family allowance if they have children.¹¹⁵

Linked to this is the notion that Roma do not want to work: “There are parents who do not even want to work. They can live comfortably on social welfare. They get too many benefits.”¹¹⁶ In Pécs, Hungary, a general practitioner told the ERRC that: “Gypsies make their living on irregular work, robbery and the usage of the elders’ pensions. Only 10% of them have a decent job. They expect a lot but do very little.”¹¹⁷ In Spain, a paediatrician from Cordoba admitted that most of the doctors working with her in one hospital were racist: they make comments that “Gypsies have babies like rabbits”, “they don’t behave like humans”, “they leave babies on sidewalks while begging”, etc.¹¹⁸ Ms Bergona Merino of the Spanish National Ministry of Health, testified to the ERRC, that: “Most people are racist towards Gypsies. Racism and discrimination do infect relations between health practitioners and Gypsies.”¹¹⁹ The possible impact of prejudice on quality health care was also commented by a representative of the Catalunya Health Department, who stated that, “People are prejudiced against Gypsies and this could pose a barrier to quality health care.”¹²⁰

In relation to health status, negative attitudes among health care providers have to do with stereotypical notions about Roma patients’ lifestyle, ability to comply with treatment, and ability to understand medical instructions. A number of medical professionals interviewed by the ERRC appeared to be convinced about the inferior intellect of Roma. One nurse told the ERRC that “Roma are intellectually low and they don’t like to study.” In her view, “Roma are dull-witted. There is no point to explain to them anything because they will not understand anyway, and it is intellectually exhausting to deal with Romani patients.”¹²¹ Although most of the medical professionals recognised the poorer health status of Roma in comparison to the rest of the population, explanation of this situation tended to blame Roma themselves for their lack of good health. Most common was the view that alcohol consumption and smoking are major reasons for the disparities of health status among Roma. According to one GP, disability among Roma is also caused primarily by drinking and smoking and in fewer instances by

¹¹⁵ ERRC interview with D.L., March 2005, Bánszállas, Hungary.

¹¹⁶ ERRC interview with D.L., March 2005, Arlo, Hungary.

¹¹⁷ ERRC interview with P.N., April 7, 2005, Pécs, Hungary.

¹¹⁸ ERRC interview with Marie Jose, doctor at the Queen Sophia hospital, April 17, 2005, Cordoba, Spain.

¹¹⁹ ERRC interview with Bergona Merino, April 13, 2005, Madrid, Spain.

¹²⁰ ERRC interview with Estanislav Alonso at the Catalunya Public Health Department, April 21, 2005, Barcelona, Spain.

¹²¹ ERRC interview with a nurse, March 2005, paediatric ward, Bánszállas, Hungary.



occupational conditions.¹²² Others stated that they believe Roma are irresponsible in matters involving their own health or that of their families.¹²³

A common view is that Romani patients are undisciplined with regard to medical treatment; they purportedly call doctors and ambulances on a whim and not when they really need it, and they visit the doctor when seeking some benefit. Such prejudiced attitudes may lead to inefficient treatment of patients. For example, a 32-year-old Romani man from Arlo, Borsod-Abaúj-Zemplén County, Hungary, testified to the ERRC that he is a bricklayer and as a result of the heavy physical work he suffered an intervertebral disc protrusion. He went to consult with a doctor who was acting as a substitute for his GP. The doctor expressed doubts that the man had any serious problems because the doctor thought he was too young. The doctor then made remarks that the man wanted to be examined only to be placed on sick leave and make money. The doctor reportedly did not even let the man explain his problem. Three months later, when the regular GP was back, the man was sent to hospital for treatment of his spine.¹²⁴

Interviews conducted by the Spanish consulting group EDIS with doctors and nurses serving several Romani communities located in the peripheries of Madrid established two main reactions among doctors: One group displayed prejudices and complained that Roma do not follow instructions and that they should wash before they go to the doctor. The other group expressed paternalistic attitudes, and treated Roma like individuals who would not understand and to whom one did not need explain personal health issues.¹²⁵

Not all medical practitioners interviewed by the ERRC were negative about their Romani patients. Several testified that they did not treat Roma and non-Roma differently, although they said they could distinguish Roma from non-Roma. In Bulgaria, a few doctors admitted that the reforms of the health care system have had an adverse impact on Roma access to health; that housing conditions of Roma are very poor; and/or that unhealthy conditions of work are also a cause for disease. Some general practitioners expressed views contrary to the most widespread complaint that Roma come dirty, stating that “when a Gypsy patient comes, he shaves and puts on his best shirt.”¹²⁶

A representative survey commissioned by the Hungarian government and conducted by Delphoi Consulting among health professionals and medical students sought to establish causal effects of anti-Romani prejudice and the quality of health care received by Roma. The survey,

¹²² ERRC interview, March 2005, Bánszállas, Hungary.

¹²³ ERRC interview with a general practitioner, June 22, 2005, Varna, Bulgaria.

¹²⁴ ERRC interview, March 2005, Arlo, Hungary.

¹²⁵ ERRC interview with Mercedes Ruiz, April 18, 2005, Madrid, Spain. See also EDIS. “Acceso a los servicios sanitarios de la población en los asentamientos marginales en la Comunidad de Madrid. Ed. Conserjería de Sanidad y Consumo, CAM. Madrid, 2005.

¹²⁶ ERRC interview with a general practitioner, March 2005, Hangony, Hungary.



conducted among 1,800 medical practitioners and medical students, found that an average of 30.3% of the interviewed were “prone to anti-Romani sentiment”; 14.1% expressed strong anti-Romani sentiment; 28.3% were non-discriminatory; 21% were not anti-Roma and 6.3% rejected any anti-Romani sentiment.¹²⁷ The survey revealed a correlation between the physicians’ attitudes towards Roma and the medical services provided to Romani patients. The authors concluded that physicians who expressed anti-Romani prejudice tended to be unaware of the higher incidences of diseases among Roma, while by contrast, physicians who did not express anti-Romani prejudice had higher awareness of the trends in the incidence of morbidity among Roma. For example, within the category of physicians who reject anti-Romani sentiment, the number of general practitioners who were relatively aware of the prevalence of diseases in the Roma community was twice the average. Their representation among the physicians who do not discriminate against Roma was also above average.¹²⁸

¹²⁷ “Differences in Access to Primary Healthcare – Structures, Equal Opportunity and Prejudice – The Results of an Empirical Study” is a survey, conducted in September-October 2003, commissioned by the Hungarian Ministry of Health, Social and Family Affairs. Following protest by the professional association of medical practitioners against the findings of the survey, the results were not officially published by the Ministry. The full version of the survey was translated in English by the ERRC and is available at: <http://www.errc.org/db/00/CC/m000000CC.doc>.

Responses were measured according to three scales: stereotyping scale, affection distance scale, and discrimination scale. The authors of the survey provided the following explanations for each of the categories measuring attitudes towards Roma:

Not anti-Romani: This group includes respondents who, to an above-average extent, reject both anti-Roma stereotyping and assertions that reflect emotional distancing, as well as statements that express an attitude discriminative against Roma;

Prone to anti-Romani sentiment: Compared to the average, those in this category accept both anti-Roma stereotyping, discrimination and emotional distancing. The reason why they are labelled “Prone to anti-Roma sentiment” rather than “Anti-Roma” is that their deviation from the extreme values on the various scales was average.

Strongly anti-Romani: Individuals in this group display high values on all three scales, which means that they expressed strong agreement with the statements indicating anti-Roma stereotyping, emotional distancing and the discrimination against the Roma.

Non-discriminatory: This group is somewhat contradictory in attitude. First, on two of the three scales, they display values close to zero, i.e. negative stereotyping and emotional distance are not particularly characteristic of them, and second, they reject discriminatory attitudes towards Roma. In contrast to those in the “Rejects anti-Roma sentiment” group, however, their values on the first two scales are close to average (that is, they stereotype to an average degree), and therefore cannot be assigned to the “Not anti-Roma” group. It follows from this that this group’s only notable attitude with respect to Roma is the rejection of outright discrimination.

Rejects anti-Romani sentiment: This is the last and the smallest group, accounting for just 6.3% of respondents, and whose members display a high negative value on all attitude scales, i.e. they strongly reject all three attitude components of anti-Roma sentiment.

¹²⁸ The Delphoi survey found that a total of 86.1% of the general practitioners are not or are not satisfactorily aware of the Roma’s enhanced exposure to diseases in the case of two or more disease factors. According to the authors, this fact implies that they are unlikely to think that Roma need a larger number of preventive and screening programmes or other medical interventions, which could reduce the incidence of these diseases among them.

Further, the survey revealed that the physicians who are relatively aware of a high prevalence of diseases among the Roma are also able to communicate better with them. Also the number of conflicts such practitioners have with Roma is below average.

According to the Delphoi study, the attitudes of physicians towards Roma also affect the frequency of referral of Romani patients to specialised care. Compared to the average, those general practitioners who reject anti-Romani sentiment refer their Roma patients to a higher level of care immediately twice as frequently. Furthermore, compared to the average, they provide primary care for their Romani patients on the GP premises and then refer them to a higher level of care 1.5 times more frequently. The authors conclude that, “As physicians who reject anti-Roma sentiment are more aware of the proportion of serious diseases in the Roma population, it is safe to assume that the condemnation of anti-Roma prejudice as such, combined with this awareness, may explain referrals to higher levels of care.”

With regard to reports on unjustified calls from Romani patients, a total of 47.6% of all the physicians who reject anti-Romani sentiment stated that they never or rarely had any unjustified calls, while 40% reported that they regularly or always had such calls. At the same time, physicians who reject anti-Romani sentiment reported the lowest proportion of frequent unjustified calls. At the other extreme, three-quarters of the physicians whose strong bias against Roma manifests itself on a daily basis claimed that they often or always had unjustified calls from Romani patients.

In addition, the survey revealed that some general practitioners provide therapy for socially marginalised patients at a lower institutional level, for which the underlying reason is the social deprivation of these patients. The fact that these patients’ potential to reduce risk factors is deemed low is also a contributing factor. Around 21.6% of general practitioners were found to strongly differentiate between the individual groups of patients. They provided primary care for most of the socially deprived patients on the GP premises, without referring them to a higher institutional level of care. Rarely, if ever, are the socially deprived referred to a higher institutional level of care and/or offered specialist treatment.



4. SYSTEMIC FRUSTRATION OF THE RIGHT TO ADEQUATE HOUSING AND THE RIGHT TO EDUCATION WHERE ROMA ARE CONCERNED AND THE IMPLICATIONS OF THIS FOR EFFECTIVE REALISATION OF THE RIGHT TO HEALTH

Systemic human rights violations in other areas have a direct impact on the ability of Roma in Europe to realise the right to the highest available standards of physical and mental health. Particularly evident are the effects of extremely substandard housing, and other housing rights violations, and problems arising as a result of racial segregation in schooling.

4.1. Denial of Adequate Housing to Roma by Policy and Practice

Inadequate housing of Roma – often the result of direct discrimination in housing policies and failure of governments to undertake measures to ensure access to adequate housing – is a crucial factor contributing to both poor health and exclusion of Roma from access to health care.¹²⁹ Numerous Roma throughout Europe live in dire housing conditions, are forced into segregated and extremely substandard housing or in hazardous environmental conditions, and are completely removed from mainstream social and economic life. Local authorities in some countries act deliberately to prevent improvement of housing conditions of Roma. For example, in Slovakia, in recent years there have been repeated efforts by local authorities to derail projects aimed at improving the situation of Roma. These efforts were frequently successful. In the village of Svinia, despite an international project of close to a decade long, involving, among others, the Canadian International Development Agency (CIDA) and the US-based NGO Habitat for Humanity, the village remains racially segregated as a result of obstruction by the local council and (very many) members of the non-Romani community. On April 1, 2003, the local council adopted Resolution 34/2003 “approving

¹²⁹ Article 11 of the International Covenant on Economic, Social and Cultural Rights (“ICESCR”) states: “The States Parties ... recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions....”

In its General Comment 4 on the right to adequate housing, the United Nations Committee on Economic, Social and Cultural rights stated: “ In the Committee’s view, the right to housing should not be interpreted in a narrow or restrictive sense which equates it with, for example, the shelter provided by merely having a roof over one’s head or views shelter exclusively as a commodity. Rather it should be seen as the right to live somewhere in security, peace and dignity [...] irrespective of income or access to economic resources. Secondly, the reference in article 11 (1) must be read as referring not just to housing but to adequate housing.” See United Nations Committee on Economic, Social and Cultural Rights, General Comment 4, Paragraph 7, Sixth Session, 1991.



the termination of activities currently being carried out in the village by the organizations Habitat for Humanity and CIDA”.¹³⁰

In other instances, local councils of villages or towns have consented to development projects for Roma only if they are in isolated or excluded areas. For example, in September 2003, the mayors of the villages of Letanovce, Hrabusice, Arnutovce, Spisske Tomasovce and Spisske Stvrtok agreed to a development project proposed by the government with European Union funding, only if it were located in the isolated community of Strelniky. Other localities to have planned and/or implemented racially segregated housing projects in recent years include Nitra and Presov.

4.1.1. Segregation and Substandard Housing Conditions

In many countries, Romani communities live in a state of physical separation from the mainstream social and economic life. While in some countries the appearance of separate all-Romani neighbourhoods is rooted in history and has not necessarily arisen as a result of government policies, in other countries racial segregation is effectively enforced by recent government actions. In both cases, however, segregated housing exposes many Roma to substandard or extremely substandard conditions; families live in makeshift shacks with little or no infrastructure, no public services such as running water, hot water, central heating and sufficient and adequate sewage and garbage removal systems.

By policy, Italian authorities racially segregate Roma. Underpinning the Italian government’s approach to Roma and public housing is the conviction that Roma are “nomads”. In the late 1980s and early 1990s, ten out of the twenty regions in Italy adopted laws aimed at the “protection of nomadic cultures” through the construction of segregated camps. This project rendered official the perception that all Roma and Sinti are “nomads” and can only survive in camps, isolated from Italian society. As a result of this policy, many Roma live physically separated from the rest of society in camps which are usually overcrowded, running water and electricity are not sufficient to meet the needs of the camp inhabitants; sewage removal and solid waste removal is extremely inadequate. In some areas, Roma are excluded and ignored, living in filthy and squalid conditions, without basic infrastructure. These Roma “squat” in abandoned buildings or set up camps along roads, rivers or in open spaces. They can be evicted at any moment, and frequently are. Their settlements are often called “illegal” or “unauthorised”.

¹³⁰ ERRRC research on housing rights of Roma in Slovakia in cooperation with the Bratislava-based Milan Šimečka Foundation, 2003-2004. For details, see Mušíňka, Alexander. “Report on the Field Research into the Housing Situation of Roma in the Village of Svinia, Slovakia”. In *Roma Rights 4/2003, Political Rights*, at: <http://www.errc.org/cikk.php?cikk=1322>. See also Zuzana Veselská, “Roma Housing Rights in Slovakia”. In *Roma Rights 1/2004, What Is Roma Rights*, at: <http://www.errc.org/cikk.php?cikk=1853>.

In his report on Italy, the Council of Europe Commissioner on Human Rights, pointed out the inadequate living conditions of Roma all over the country. He noted that doctors from the mobile medical centre that visits the Campo Nomadi Casilino 900 reported that “extremely harsh living conditions, added to poverty and integration problems, have serious effects on the health of Roma” evidenced in “chronic diseases, ... (and) skin and respiratory conditions.” The doctors further reported that medical monitoring and treatment is complicated by the fact that Roma have little or no access to medical care outside of visits by the mobile medical centre. The Commissioner further noted that the specific situation of Roma at the Romani camp Casilino 900 was exemplary of Roma living throughout Italy: “In theory, they have the same rights as other people, but direct access to medical treatment is impeded by various factors, including lack of papers and ignorance of the system. Poverty also prevents them from consulting doctors when they need to, and access to treatment too often takes the form of last-minute hospital intervention.”¹³¹

4.1.2. Environmental Racism

Poor and marginalised Romani communities are often disproportionately exposed to environmental hazards and denied access to environmental benefits such as clean air, land, and water.

In some parts of Europe, Romani communities live in extremely hazardous environmental conditions, on toxic lands. One such settlement – Patoracka, outside Rudnany, eastern Slovakia – is located on the grounds of a former mercury mine. In North Mitrovicë/a, Kosovo, around 700 Romani individuals, including many children, have been living between 1999 and to date in camps for internally displaced, despite known and documented extreme health hazards arising from toxic lead contamination of the land on which the camps were built.¹³²

In France, the only parts, outside of the very few designated stopping areas, where itinerant Gypsies are able to stop for short periods are places others would not live in, such as near the garbage dump or sewage treatment plant; in an industrial zone, especially near high risk and polluting factories; in the woods; or right beside (or at the edge of) busy freeways. Additionally, the spots are often beneath high tension wires and beside the train tracks.¹³³

¹³¹ See Office of the Commissioner for Human Rights. Report by Mr. Alvaro Gil-Robles, Commissioner for Human Rights, on his visit to Italy 10-17 June, 2005 for the attention of the Committee of Ministers and the Parliamentary Assembly. Strasbourg, 14 December, 2005, paras. 211, 214, available at: http://www.coe.int/t/e/commissioner_h.r/communication_unit/CommDH%282005%299_E.doc.

¹³² For more information on the situation of Roma in the camps in North Mitrovicë/a, see Dobrushki, Andi and Jeta Bejtullahu. “Alarming Facts about Roma Camps in North Mitrovicë/a: Lead Poisoning of Romani Children”. In *Roma Rights 3-4/2005, Justice for Kosovo*.

¹³³ A detailed account of the conditions in which many Gypsies and Travellers in France are forced into as a result of failure of municipalities to provide halting sites and repressive laws criminalising halting outside legally defined halting areas is contained in the ERRC country report on France, “Always Somewhere Else: Anti-Gypsyism in France”, available at: <http://www.errc.org/db/01/A5/m000001A5.pdf>.



In Greece, as a result of systematic forced evictions and enforcement of discriminatory legislation promoting segregation and ghettoisation, many Romani communities throughout the country live in appalling material and environmental circumstances. In one of the most notorious instances documented by the ERRC/GHM in 2003, around 200 Romani communities in the municipalities of Ano Liosia and Aspropyrgos, near Athens, after being subjected to a series of forced evictions between 1997-2001, ended up settling around the garbage dump shared by the two municipalities. The two municipalities declined a proposal by the central authorities to allocate land for the development of a self-organised Romani settlement with the explanation that the land would be used for building facilities for the 2004 Olympic Games in Athens.¹³⁴ In another instance, in 1996, in Argostoli, the capital of the island of Cephalonia, authorities relocated about ten Romani families in an area adjacent to a slaughter house. The measure was said to be temporary because according to Greek law slaughterhouses could operate only under the condition that they are located at a distance of five hundred metres from the last house. However, eight years later, during an ERRC visit to the place, the Roma continued to live in that area.

In April 2005, in its ruling on the matter *European Roma Rights Centre v. Greece*, the European Committee on Social Rights found that the Greek state is in breach of the obligation under the European Social Charter to promote the rights of families to adequate housing. The Committee held: “The Committee finds that Greece has failed to take sufficient measures to improve the living conditions of the Roma and that the measures taken have not yet achieved what is required by the Charter, notably by reason of the insufficient means for constraining local authorities or sanctioning them. It finds on the evidence submitted that a significant number of Roma are living in conditions that fail to meet the minimum standards and therefore that the situation is in breach of the obligation to promote the right of families to adequate housing laid down in Article 16.”¹³⁵

4.1.3. Forced Evictions

Forced evictions are considered to be *prima facie* violation of international law,¹³⁶ yet authorities in a number of countries are increasingly practicing evictions of Romani communities. Often, authorities fail to provide alternative accommodation to evicted Romani families thus exposing them to homelessness and extremely substandard conditions.

¹³⁴ For further details on these and other cases of inhuman and degrading treatment of Roma in Greece, see European Roma Rights Centre/Greek Helsinki Monitor report “Cleaning Operations: Excluding Roma in Greece”, April 2003, available at: <http://www.errc.org/db/00/09/m00000009.pdf>.

¹³⁵ The full text of the decision is available at: http://www.coe.int/T/E/Human_Rights/Esc/4_Collective_complaints/List_of_collective_complaints/1RC15_merits.pdf.

¹³⁶ Evaluating in its General Comment 7 the relationship between the right to adequate housing and the issue of forced evictions, the UN Committee on Economic, Social and Cultural Rights (CESCR) held that “forced evictions are *prima facie* incompatible with the requirements of the Covenant.”¹³⁷ General Comment 7 defines, at Paragraph 3, forced evictions as “the permanent or temporary removal against



A number of Gypsy and Traveller families in France told the ERRC that repeated forced evictions force them into living without even basic amenities such as water and electricity, while the stress of having no place to halt their caravans has a serious impact on their health. French laws, policies and practices related to travelling, stopping and urban planning and regulation force Gypsies and Travellers into degrading conditions of life and expose them to constant forced evictions. Despite existing legislation, very few sites are actually “designated” for Gypsies and Travellers to stop. To make the situation worse, large portions of the territory have become legally or factually off-limits for Gypsies to halt or reside, with risks of severe criminal sanctions if they do so. In a number of large cities in France, including Paris, Bordeaux, Lyon, Toulouse, and Marseille, ERRC discovered hundreds of families who “travel” around the outskirts of the city and nearby towns in search of a place to stop. On the whole, municipalities have not applied legal provisions requiring them to create halting areas. Official estimates from March 2005 put the number of existing places at around 20% of the required number. Despite their own non-compliance with their obligations to develop an area for Gypsies and Travellers to stop, municipal authorities nonetheless forcibly evict Gypsies and Travellers who halt in their municipalities, sometimes violently. The State representatives are also generally willing to lend their support to these efforts, by authorizing the police to carry out the evictions. The police sometimes also undertake to keep out Gypsies and Travellers through engaging in “preventive actions” such as blocking the path of caravans, or by escorting them to the limit of the municipality and effectively expelling them to the next town.¹³⁷

Forced evictions are widely and frequently reported in Hungary, apparently arising due to a number of factors, including changes to the legal regime which have significantly eroded the rights of tenants. Roma are particularly affected by forced evictions for a number of reasons, including raw racial discrimination. Roma in Hungary have been subjected to forced evictions with increasing frequency in recent years.¹³⁸ According to one study monitoring the

their will of individuals, families and/or communities from the homes and/or land which they occupy, without the provision of, and access to, appropriate forms of legal or other protection.” The use of the term “occupy” infers that all persons, regardless of the legality of their tenure, can be subject to forcible evictions, and as such, should be afforded adequate protection of law. Finally, at Paragraph 16 of General Comment 7, the Committee stated: “Evictions should not result in individuals being rendered homeless or vulnerable to the violation of other human rights. Where those affected are unable to provide for themselves, the State party must take all appropriate measures, to the maximum of its available resources, to ensure that adequate alternative housing, resettlement or access to productive land, as the case may be, is available.” See “General Comment No. 7 (1997), The Right to Adequate Housing (Art 11(1) of the Covenant): Forced Evictions”, adopted by the UN Committee on Economic, Social and Cultural Rights on 20 May 1997, contained in U.N. document E/1998/22, annex IV.

¹³⁷ For more information, see ERRC country report “Always Somewhere Else: Anti-Gypsyism in France”, pp. 83-124.

¹³⁸ For a non-exhaustive list of forced eviction cases documented by the ERRC with support from the Norwegian Foreign Ministry and the British Embassy in Budapest, see “Comments of the European Roma Rights Center (ERRC) and the Centre on Housing Rights and Evictions (COHRE) on the occasion of the Article 16 Review of Greece, Hungary and Turkey under the European Social Charter supervision cycle XVII-1”, December 1, 2003, available on the ERRC Internet website: <http://errc.org/publications/indices/housing.shtml>.



Hungarian media during the period January 1, 2003 through November 1, 2003, in 55% of eviction or threatened eviction cases reported, the victims were identified as Romani, although Roma account for probably around 6 percent of the total population of Hungary.¹³⁹ Further, local authorities often fail to provide alternative accommodation to forcibly evicted Roma, effectively rendering many homeless. Forced evictions often lead to the removal of children from their families into state care system given that the family is in crisis situation and cannot take proper care of the child.

A dramatic expansion of efforts at racial segregation in the field of housing is evident in the Czech Republic, a problem of which the Czech government is aware but has no adequate reaction.¹⁴⁰ In one recent example, in June 2005, the municipality of Bohumin refused to renew the rental contracts of some 250 low-income individuals, most of them Roma, who lived in a municipal building in the centre of Bohumin. Under intense pressure and harassment by municipal officials, most of the families have left the building, despite having been provided with no reasonable alternative housing. Many of the families have been forced to move to the homes of their relatives themselves living in crowded single-room flats. Several families have been coerced to move into so-called “holobyty” – bare flats – with no running water, no sanitary facilities and no electricity. The municipality has also seriously proposed to the other remaining families that they submit to the possibility of being separated as families, with women and children going to live in places different from men. Under pressure, a number of the families have in fact moved into substandard and/or racially segregated housing.

4.2. Denial of Equal Education Opportunities to Roma

Research has indicated that poor education correlates to poor health. Disproportionately high levels of illiteracy and poor education among Romani communities throughout Europe affect the health of Roma in a number of ways: Uneducated individuals are less likely to avoid exposure to health risks, including exposure to employment-related risks prevalent in low-skilled

¹³⁹ Data from the European Parliament’s Country Profile on Hungary. Available on the Internet at: http://www.europarl.eu.int/enlargement_new/applicants/pdf/hungary_profile_en.pdf.

¹⁴⁰ The Czech government informed the UN Committee on the Elimination of Racial Discrimination in 2002 that, “Although the Czech Republic has been systematically striving to prevent all forms of racial segregation, some municipalities have adopted, within their separate competencies, certain measures whose consequences show some symptoms of segregation.” Despite this fact, as of 2002, “No changes occurred in the housing legislation concerning protection against discrimination. Housing laws still lack non-discrimination provisions, even the declaratory ones. Prohibition of discrimination is not stipulated even in the laws and regulations applying to the allocation, renting, privatization or sale of municipal apartments.” This situation remains true today, and no government programme exists to reverse racial segregation in the field of housing. See Committee on the Elimination of Racial Discrimination, Reports Submitted by State Parties under Article 9 of the Convention, Fifth Periodic Report by State Parties due 2002, Czech Republic, paragraphs 38 and 99, at: <http://www.hri.ca/fortherecord2003/documentation/tbodies/cerd-c-419-add1.htm>.

occupations; they have little capacity to participate in decisions related to their health care; they are more exposed to poverty; and they face more barriers in accessing health care services.

The current educational status of Roma characterised by higher illiteracy rates; early drop-out of school; and lower school achievement is crucially influenced by past and current systemic discrimination of Roma in the education systems. In many European countries, especially those with sizeable Romani communities, the prevailing part of the Roma have found themselves excluded from mainstream education by means of various forms of racially segregated education.

The ERRC has documented the existence of a variety of practices in a number of European countries, the effect of which has been to confine Romani children to separate and substandard educational facilities.¹⁴¹ Such practices include: the placement of Roma in special schools for children with developmental disabilities, the separation of Roma in Roma-only classes within the mainstream schools, and the maintaining of Roma-only schools located in segregated Romani settlements or formed as a result of the withdrawal of non-Roma from Roma-majority schools. In a number of cases, Romani children are excluded entirely from the education system. Depending on the specific historical, demographic, and social factors, one or more patterns of segregated education of Roma prevail in a given country. Whether the result of systemic inequalities or of individual discriminatory acts of officials in the school system, segregation of Roma in education has been the underlying cause for denial of equal education opportunities of Roma and for the huge disparities in educational achievement of Roma.

¹⁴¹ Patterns of segregated education of Roma in central and Eastern Europe are described in the ERRC report “Stigmata” Segregated Schooling of Roma in Central and Eastern Europe”, available at: http://www.errc.org/Thematic_index.php.



5. POSITIVE PRACTICES

The existence of health disparities between Roma and non-Roma has been recognised by some governments, especially in countries with substantial Romani populations. A variety of preliminary actions have been undertaken across Europe to improve access to health and the health status of Roma. Most recently, the Decade of Roma Inclusion – launched in 2005 with the aim of closing the gap between Roma and non-Roma in different social fields, places a particular focus on health and access to health care. This part of the ERRC report does not aim at a comprehensive analysis of government action so far but rather outlines some good practices to overcome barriers for Roma in access to health care. A number of examples are provided from Spain where health programmes targeting Roma have been in operation for more than a decade, offering opportunities for assessment of certain approaches in Roma health programming and implementation. Although in the course of research in Spain, it was indicated to the ERRC that many of these practices are very localised and there is a need to systematise them throughout the country, a variety of actors in Spain, including Roma organisations, medical practitioners and health care service managers, linked improvement of accessibility and quality of health services provided to Roma in Spain to the implementation of the practices and approaches described below:

Health Mediators: A policy measure for improving access to health of Roma that has attracted the attention of several governments is the position of the health mediator – an individual who provides liaison between Romani individuals/families/communities and mainstream public health services. In Spain and Romania – the countries where mediator programmes have been applied most systematically, the effect of the programmes is reportedly positive. Mediator programmes, however, function most effectively where governments undertake to include them into the public health system. Health mediators in Bulgaria, for example, are currently not part of the public health system and can fulfil their functions only if hired by non-governmental organisations. The functioning of the health mediators is thus contingent on the ability of NGOs to secure funding from, mainly foreign donors. The government has engaged in a meaningless series of trainings of several dozens of individuals, mostly Roma, who following the training were unable to practice. Conversely, the Romani health mediator project in Navarra, Spain, has reportedly been successful because it was formally within the public health system – in fact, it was initiated by a member of the public health system. Mediators are assigned to local neighbourhood health clinics and function as assistant health workers.¹⁴²

Spanish experience with health mediators also indicated that where these have not been included in the public health system, they have not been very efficient. According to some

¹⁴² ERRC interview with Mr Ricardo Hernández de Gaz Kalo, representative of the Federation of Roma Associations in Navarra, April 12, 2005, Navarra, Spain.



opinions, health mediators are more useful for the physicians but not so much for the Romani patients. Doctors can always call mediators when there is an issue with Romani patients, but the same is not true for Romani patients.¹⁴³ Health mediators with whom the ERRC spoke in Spain perceived their role as working to reduce prejudices and mistrust between Roma and physicians as well as acting as resource to health professionals. They found however, that this function is often not possible to perform, frequently due to a lack of support from the hospital administration. Another problem is related to the fact that health mediators do not have a permanent place in the medical institutions; they are on call and usually deal with situations in which doctors are afraid they would not be able to take things under control such as situations in which Romani families visit hospitals.

Romani participation: A range of policy-makers, social workers and Romani activists in Spain have made clear that Romani participation has been a key to the success of programmes implemented in Spain, not only to ensure that the specific needs of each community are met, but to ensure that the knowledge and skills gained remain in the community and grow. For instance, all programming in Granada's Cartuja health clinic is conducted on the basis of the results of research done by Romani women in the community, under the supervision of a local social worker. Programming in the community, including family planning, vaccination, screening for genital cancer, were designed on the basis of the needs identified during the research.¹⁴⁴

Integrated programming: Another important aspect of improving the health situation of Roma noted during the research in Spain was measures to ensure that health programmes were not carried out independently of actions in other areas, such as housing improvement, increasing employment and education levels, to name only three.¹⁴⁵ This was noted as particularly important in the field of health, given the dependence of health on external factors. For instance, in Granada's Cartuja health clinic, health programmes are a part of integral programmes in other areas, including housing and employment. A range of health programmes had been initiated in the area, but also housing, employment and other educational programmes. It was believed that the improvements in the health situation of the Gypsy community in the past 20 years were because of health programming as well as improvements in other areas such as housing.

Integrated programming is especially important when one considers the reported opinion of doctors that they can treat Romani individuals but if the external factors that negatively impact their health situation (i.e. inadequate housing) are not improved, the health situation of the persons will

¹⁴³ ERRC interviews with representatives of the Federation of Roma Associations of Catalunya, April 21, 2005.

¹⁴⁴ ERRC interview with Ms Fermina Puertas, social worker at the Cartuja Health Clinic in Granada, April 14, 2005, Granada, Spain.

¹⁴⁵ See interviews with Ms Fermina Puertas, April 14, 2005, Granada; Ms Patricia Buzunartea and Ms Elena Buceta, April 18, 2005, Madrid, Spain.



likely not change significantly.¹⁴⁶ As was indicated by the survey conducted by Delphoi Consulting in Hungary, doctors may be discouraged to provide patients with high quality services by the fact that the patient's exposure to unhealthy environment reduces the efficiency of the medical treatment and increases the likelihood of recurrence of the health problem.¹⁴⁷

Health and social professionals working together: Actions to improve the overall health situation of Gypsies in Spain have been, by most accounts, most successful with health and social workers co-operating. Preventative health measures and health promotion fall within the mandate of the public health system, which social workers are not a part of, but individual social workers have taken it upon themselves to include health promotion in their community programming. Doctors have health-specific expertise, but social workers are present in the communities, know the needs of communities and know the people in the communities. Social workers are able to bridge the divide between health professionals and Roma.¹⁴⁸

Health professionals visiting Romani communities: The most successful health programmes in Spain reportedly included doctors and other medical professionals physically going to Gypsy communities and neighbourhoods. The reasons for the visits were various and included conducting vaccination campaigns and conducting educational programmes. The health programmes which brought doctors to Gypsy communities were reported to be positive not because they provided a special service for communities with special needs, but because they provided the opportunity for medical professionals to improve their knowledge and understanding of Gypsy culture, community and living conditions which impact the health situation of Gypsies. Reportedly, this also facilitated confidence building amongst Gypsies towards medical practitioners and enabled Gypsies to perceive doctors or medical professionals as caring/wanting to help.¹⁴⁹

Such programmes however cannot substitute mainstreaming health care for Gypsy communities. Mainstreaming was believed to be key to equal access to health care for Gypsy.¹⁵⁰

¹⁴⁶ See interviews with Dr Marina Gallo and Dr Marie Jose, April 17, 2005, Cordoba, Spain.

¹⁴⁷ See Delphoi Consulting. "Differences in Access to Primary Healthcare – Structures, Equal Opportunity and Prejudice – The Results of an Empirical Study".

¹⁴⁸ ERRC interviews with Ms Nicole Perreten, Public Health Department of the Autonomous Region of Madrid, Spain, and with Ms Marisa Martinet, Department for Collectives and the Disadvantaged, April 13, 2005, Madrid, Spain.

¹⁴⁹ Interviews with Ms Mercedes Ruiz, April 18, 2005, Madrid, Spain; Ms Nicole Perreten and Ms Marisa Martinet, April 13, 2005, Madrid, Spain.

¹⁵⁰ Interviews with Ms Antonia Perez, April 15, 2005, Gaudix, Spain; Ms Patricia Bezunartea and Ms Elena Buceta, April 18, 2005, Madrid, Spain; Dr Ignacio Revuelta, April 19, 2005, Madrid; and Dr Miteresa Martinez Ruiz, April 20, 2005, Madrid, Spain.





CONCLUSIONS

When taken as a whole, the foregoing reveals a state of affairs of deep concern, namely the systemic exclusion of Roma from key aspects of health care. In some areas, it appears that Roma may only have access to health care in the context of emergency care, and/or in the immediate circumstances of childbirth. Throughout research in 2005, ERRC heard repeated testimony by both physicians and Roma that emergency aid services are the primary means of health care used by Roma. Numerous Roma throughout Europe are excluded from preventive, primary and specialised health services, and numerous Romani women have no access to pre- and postnatal health care.

The exclusion of Europe's largest minority from vast areas of the health care system should in principle constitute among Europe's most significant social inclusion policy concerns. To date, however, the interface between Roma and the health care systems of Europe has received limited policy attention, in particular by comparison with several other key areas. When Roma and health matters are discussed, the focus is frequently on issues avoiding core matters of exclusion and systemic racial discrimination by providers. Disproportionate attention is paid to the health situation of Roma, or to diseases "typical" of Roma, while matters concerning the acts of the provider are avoided.

Similar to policy approaches in other fields, Roma health policies tend to be designed and implemented outside the mainstream health policy framework of governments. The effect of implementing separate health policies on Roma while not integrating solutions to Roma health problems in mainstream policies is to diminish the impact of Roma-specific health policies and in some cases to render such policies effectively meaningless. While governments have developed and in many cases begun implementing actions to ensure better access for Roma to health services, mainstream health policies in some instances tend to work in the opposite direction – creating obstacles for Roma to access health care services. One example is the case of exclusion of Roma from access to health insurance in countries such as Bulgaria and Romania. Mainstream health policies in these countries have operated in such a way as to exclude large numbers of Romani individuals from health insurance coverage and as a result, denying access of Roma to primary and specialised health care. Thus, various programmes targeting Roma such as health mediators, health promotion campaigns, etc. are bound to have a limited impact on equalising opportunities for Roma to access health services because an inbuilt barrier for Roma to access such services – lack of health insurance coverage – has remained unaddressed. Romani activists in Bulgaria whom the ERRC interviewed noted that, in the absence of health insurance coverage, measures to improve access of Roma to health are without any real effect. A representative of Neve Droma Foundation in Shumen, for example, told the ERRC:





The municipality pays for a medical room close to one of the Romani neighbourhoods in the town. It is true that this is more convenient than going to a doctor in the centre of the town, but the problem is that people without health insurance cannot use the services of the General Practitioner who is based in the neighbourhood. No one pays the doctor to serve uninsured people and most of the Roma here do not have health insurance.¹⁵¹

Another aspect of the problem of lack of mainstream actions to confront barriers for Roma to quality health care was reported in Spain. The Spanish health care system is decentralised and the Ministry of Health and Consumer Affairs establishes norms that define the minimum standards and requirements for health care provision, while the autonomous communities decide how to organise or provide health services and implement the national legislation. The lack of specific guidelines targeting Roma in the central government framework on health care causes a fragmentary approach to Roma health issues because each autonomous government decides what policies and whether any policies on Roma at all to be implemented. A number of individuals interviewed by the ERRC noted that protocols issued by the autonomous regional governments for the primary health system are applicable to culturally homogenous populations, but they do not necessarily address the specific problems facing the Romani communities. An example of how regional policies differ is the free vaccination programme available in Navarro over the past ten years as compared to Gaudix where such a programme had just started in 2005.¹⁵² The need to avoid homogenising responses to the needs of different people and communities was noted as of importance.¹⁵³

There is little effort to create conditions to reduce inequalities in access to medical services for Roma on a long-term basis. Roma-specific actions launched at various levels of government in a number of countries are fragmentary, one-off events, often responding to emergency situations rather than aimed at systematic and comprehensive health promotion. Actions are primarily launched as part of a donor scheme and discontinued at the end of projects. The reason for this situation is often that Roma-specific actions are not funded from the central government budgets. Furthermore, the implementation of such actions does not involve establishing relevant structures in the health care management units at central and local levels, nor is it accompanied by changes in the normative basis to guarantee continuity. In Spain, Roma policies are criticised for relying on projects that are funded on a yearly basis. This is viewed as an obstacle for developing long-term strategies.

Policy documents dealing with Roma and health issues usually identify Roma as a group at risk, emphasising social assistance means rather than measures for the protection of

¹⁵¹ ERRC interview with Nikolay Yankov, June 2005, Shumen, Bulgaria.

¹⁵² ERRC interview with Antonia Perez, April 15, 2005, Gaudix, Spain.

¹⁵³ ERRC interview with Ms Fermina Puertas, social worker at the Cartuja Health Clinic in Granada, April 14, 2005, Granada, Spain.

fundamental rights. Discrimination against Roma in health care, especially the multiple forms of inferior medical services provided to Romani patients by health providers, is consistently avoided in government policy documents dealing with the issue of Roma health. Consequently, such documents do not contain any policy measures aimed at monitoring, documenting, analysing and challenging discrimination or mitigating its effects on Roma health. A review of the National Action Plans for the Decade of Roma Inclusion, for example, shows that of all eleven governments participating in the Decade initiative, only the government of Hungary identified “the fight against direct and indirect discrimination” as a target in its action plan.¹⁵⁴ No specific measures were listed however towards the fulfilment of this goal.

A related observation is that government actions in the area of Romani health are designed to target almost exclusively the Romani communities but not health providers. Along with the lack of studies to examine the attitudes and perceptions of health providers, the difficulties and the possibilities of improving quality of health, government policies do not envision sensitisation of health providers and other actions to challenge prejudices and stereotypes. In Spain, for example, there are some initiatives aimed at medical providers which are operated by non-governmental organisations but as commented by a representative of the Department of Public Health of Madrid’s Autonomous Region, “there are no systematic programmes targeting medical professionals.” The problem of the NGO-run programmes for raising cultural awareness among medical professionals is that such programmes reach a limited pool of medical professionals, often ones who already have sensitivity to issues of cultural diversity. Conversely, cultural orientation programmes for medical professionals may sometimes reinforce stereotypes. For example, some interviewees in Spain mentioned that training of medical professionals as to how to deal with immigrants is oriented towards pathological and social issues such as abuse of kids but have nothing to do with cultural diversity issues.¹⁵⁵ At the same time, experience in Spain has proven the importance of educating medical professionals. Such has been the effect of a vaccination programme in Madrid which involved visits by doctors from several clinics who treat Gypsy patients to the Gypsy communities. This experience was seen as hugely improving doctors’ knowledge and understanding of the Gypsy culture as well as helping to build confidence between the Gypsy and the medical professionals.¹⁵⁶

The recommendations following below aim to provide guidelines according to which policy-makers may begin to correct the major lacunae prevailing in these areas.

¹⁵⁴ See Decade Action Plan of the Republic of Hungary, available at: <http://www.romadecade.org/en/index.php?search=&action=20&id=0&jump=0>.

¹⁵⁵ ERRC interview with Dr. Miteresa Ruiz, a doctor participating in a health programme run by the Romani Association Barro, April 20, 2005, Madrid, Spain.

¹⁵⁶ ERRC interviews with Nicole Perreten and Marisa Martinet of the Autonomous region of Madrid’s Public Health Department, April 13, 2005, Madrid, Spain.





RECOMMENDATIONS

The recommendations which follow are based on the foregoing ERRC research findings. They aim to provide a general framework for governments and policy-makers in their work to ensure the access of Roma to health care. Specific policy measures to be undertaken may vary from country-to-country and indeed from locality-to-locality, based on local conditions.

Immediate Actions to Redress Human Rights Abuse by Medical Professionals and Address Health Emergency Situations: Government interventions are needed to remedy and terminate the influence of factors that have a direct detrimental effect on the health of Roma. In particular, Governments should, without delay, undertake the following actions:

1. Investigate reports of medical malpractice and other forms of human rights abuse in the health care system, and ensure that victims have access to adequate redress. Ensure that individuals or their relatives who want to sue medical facilities and/or individual medical practitioners have access to legal aid.
2. Carry out screening of Romani communities for tuberculosis and hepatitis B and ensure that all affected individuals are treated. Launch health prevention and promotion programmes in relation to these highly contagious and fully avoidable public health threats.
3. Immediately proceed with action to provide a safe and healthy environment for Romani communities living in extremely substandard conditions and relocate to areas providing adequate housing alternatives, on a voluntary basis and after consultation with those affected, families living under such conditions to other areas.

Measures to Equalise Opportunities for Roma to Access Health Care Should be Integrated in Mainstream Health and Social Policies: With a view to maximising the effect of policies aimed equal opportunities for Roma in the health care systems, Governments should undertake the following actions:

1. Specific actions to ensure equal opportunities for Roma to access health care services should be part of mainstream health policies. Government health policies should recognise and reflect the inequalities facing Roma in health status and in access to health care services and take into account the socio-economic and cultural context which influences the opportunities and actions of individuals belonging to Romani communities. Health services should be organised and delivered with due regard to Romani beneficiaries' understanding of health and diseases issues as well as to the information available to them about disease prevention and health promotion.
2. Review health policies and assess the impact of existing mechanisms on Roma and vulnerable populations in similar positions. In particular, in the context of review of mechanisms for financing the health care systems, governments should make sure that



- the various provisions for health insurances, user fees, etc., do not have a disparate impact on Romani communities; officials should further consider exemption of Roma and other vulnerable groups from such payments, where there is clear evidence of extreme duress.
3. Targeted actions to involve Roma as employees in the health sector. In order to accomplish the goal of incorporating Romani communities priorities in the mainstream health system, Roma should be included in policy, management and decision-making positions.
 4. Staff development and training programmes in the health care system should include components related to Roma-specific needs in health status, health services management, and assessment of the impact of health policies.
 5. Ensure that data collection in health status and access to health services is disaggregated by ethnicity and available to the public.
 6. Ensure preferential distribution of costs and benefits of investment in health care provision in areas with high numbers of Romani populations.

Systematic Approach to Roma Health Problems: In order to ensure systematic and comprehensive approach to Roma health issues, Governments should undertake the following:

1. Design long-term policies for tackling health inequalities between Roma and non-Roma and define concrete measures and targets to be achieved.
2. Allocate sufficient financial resources in the national budgets to ensure adequate health prevention, promotion and care programmes targeting Romani communities.
3. Carry out regular assessment of the impact of public health policies on Roma, based on publicly available data disaggregated by ethnicity and gender. Ensure continuity for practices proven to have had a positive impact.
4. Ensure that health policy programmes are developed with an intersectoral perspective for effective targeting of Romani communities in order to reduce health inequalities. Health policy programmes should identify ways in which health authorities can support other governmental bodies that are responsible for sectors affecting health and access to health services such as social assistance, housing and sanitation; and food security policies.

Eliminating Discrimination in the Provision of Health Services: Governments should create the necessary legal, administrative and policy frameworks to combat discrimination in the provision of health services. In particular:

1. Adopt comprehensive anti-discrimination law in conformity with the EU law. In a number of countries where research indicates pervasive discriminatory practices against Roma such as Croatia, the Czech Republic, Macedonia, Poland, and Serbia, comprehensive anti-discrimination laws have not yet been adopted. In countries where such laws have been adopted, they may not be in conformity with EU and related international law. Such laws should be adopted without delay in line with EU and related international law. In addition

to incorporating all elements of the EU and international law *acquis*, such laws should address the effects of multiple forms of discrimination experienced by women from minority groups; particular attention should be placed on providing mechanisms to ensure real and effective remedy in cases of discrimination against Romani women, including effective and dissuasive sanctions for perpetrators and adequate damages for victims.

2. Establish special mechanisms such as patients' rights Ombudspersons or other bodies specialised in monitoring and assessment of health care services to deal with discrimination in the health care system, and adequately empower these bodies with staff, budget and sufficient independence to undertake work effectively.
3. Undertake periodic analyses on the basis of health data disaggregated by ethnicity and gender of the factors influencing access of Roma to health services, including racial discrimination.
4. Conduct on a regular basis anti-discrimination training of public and private health care providers as well as include anti-discrimination training subjects in the curricula of medical universities and colleges.

Measures to Address Multiple Discrimination Affecting Romani Women: Health policies on Romani women should take into account the range of factors influencing higher exposure of Romani women to health risk factors as well as disproportionate exclusion from access to health care. In particular, Governments should undertake the following:

1. Carry out investigation into reports of preventable medical errors which have caused death to Romani women and damage to their health.
2. Examine how ethnicity and socioeconomic status affect Romani women's health;
3. Carry out research on ethnic differences among Romani and non-Romani women in disease prevalence and treatment outcomes;
4. Ensure that existing laws and policies for gender equality include provisions for preventing and addressing the multiple barriers female members of minority groups face in exercising their fundamental human rights;
5. Exempt vulnerable population groups, including Romani women in vulnerable positions, from user fees and other out-of-pocket payment for medical services and from medication costs;
6. Provide on a regular basis outreach services to reach Romani women and girls who might otherwise have little access to medical services;
7. Implement patient-oriented educational health programmes for Romani women not limited to reproductive and maternal health; support culturally appropriate interventions to reduce morbidity and mortality from breast cancer and cancer of the uterus; implement educational programmes aimed at prevention of tuberculosis and hepatitis B.
8. Ensure the availability of continuing medical education emphasising social and cultural influences on the health of Romani women.

9. Create programs focused on increasing the number of women and under-represented minority health care providers.
10. Develop, support and evaluate interventions for preventing violence, including domestic violence. Governments should provide protection to domestic violence victims in terms of intervention, investigation and assistance, taking into account the specific challenges and situation of Romani women. Measures should be taken to ensure that Romani women are not bypassed by the application of any such measures but are allowed, encouraged, and supported to use them as a way to ensure protection of their rights.

With regard to remedying victims of coercive sterilisations as well as preventing occurrence of similar extreme violations of patient's rights, Governments should undertake the following:

1. Establish an independent commission of inquiry investigating the allegations and complaints of coercive sterilisations. Thoroughly investigate reported cases of coercive sterilisations, and make available – and widely publicised – procedures for women who believe they may have been abusively sterilised to report the issue. These procedures should ensure privacy rights, as well as rights related to effective remedy. Provide justice to all victims of coercive sterilisations, including those coercively sterilised under Communism. Conduct ex officio investigations to ascertain the full extent of coercive sterilisations in the post-Communist period.
2. Review the domestic legal order to ensure that it is in harmony with international standards in the field of reproductive rights and provides all necessary guarantees that the right of the patient to full and informed consent to procedures undertaken by medical practitioners is respected in all cases.
3. Promote a culture of seeking full and informed consent for all relevant medical procedures by providing extensive training to medical professionals and other relevant stakeholders, as well as by conducting information campaigns in relevant media.
4. Undertake regular monitoring to ensure that all medical practitioners seek to attain the highest possible standards of consent when undertaking sterilisations and other invasive procedures.

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