



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

CROATIA

A multi-stakeholder perspective report on 2005–2014 developments

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This Progress Report from a multi-stakeholder perspective on the implementation of the NRIS (National Roma Integration Strategy) and other national commitments in respect to Roma Health was undertaken by IOM within the framework of the project “Fostering Health Provision for Migrants, the Roma, and Other Vulnerable Groups” (Equi-Health). The EQUI-HEALTH project is co-financed under the 2012 work plan, within the second programme of Community action in the field of health (2008–2013), by direct grant awarded to IOM from the European Commission’s DG for Health and Consumers (SANTE), through the Consumers, Health Agriculture, and Food Executive Agency (CHAFEA).

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ACRONYMS

AP	Action Plan for the Implementation of the National Roma Inclusion Strategy for the period 2013–2015
CBS	Croatian Bureau of Statistics
CES	Croatian Employment Service
CHIF	Croatian Health Insurance Fund
CNIPH	Croatian National Institute of Public Health
CSO	Civil Society Organization
DDD	Disinfection, Disinsection and Deratisation
EC	European Commission
EU	European Union
GoC	Government of the Republic of Croatia
GOHRRNM	Government of the Republic of Croatia’s Office for Human Rights and Rights of National Minorities
GP	General Practitioner
IOM	International Organization for Migration
IPA	Instrument for Pre-Accession Assistance
JIM	Joint Memorandum on Social Inclusion of the Republic of Croatia
MoH	Ministry of Health
MoSES	Ministry of Science, Education and Sports
NRIS	National Roma Inclusion Strategy for the period 2013–2020
NSDPH	National Strategy of the Development of Public Health 2012–2020
UN	United Nations
UNDP	United Nations Development Programme
WB	World Bank

EXECUTIVE SUMMARY

About the project

This country situation report is written within the framework of the International Organization for Migration's (IOM) Equi-Health project: *Fostering health provisions for migrants, the Roma, and other vulnerable groups*. The project was awarded funding in 2012 by the EC DG Health and Consumers (DG SANTE), within the second EC Public Health Programme 2008–2013. The aim of the sub-project on Roma Health is to improve the access to and quality of health care, promote health education and prevention in eight EU countries with a high percentage of Roma nationals and/or migrants. The Equi-Health project plan is to develop a network of key stakeholders, possessing knowledge of and experience in Roma health and related issues, who will delineate strategies for capacity building and cooperation between participating States. In order to better approach the subject of Roma health in Croatia, this country situation report provides an overview of the implementation of national integration strategies on Roma health.

Methodological approach

Methodological approach comprised desk research and fieldwork. Desk research consisted of literature, legal, and policy reviews. Fieldwork included designing and conducting three types of semi-structured interviews with key stakeholders.

Roma health in Croatia – empirical data

Based on the literature review, it is clear that research on Roma health is sporadic. One of the rare examples providing insights on Roma health in Croatia is the research conducted by the UNDP/WB/EC in May–July 2011 on a random sample of Roma and non-Roma households living in areas with higher population density of Roma. Analysis presented in this country situation report mostly relies on this survey. As regards some elements of personal health status and health behaviour, Roma significantly differ from non-Roma. For instance, Roma respondents experience more health problems with chronic anxiety or depression, chronic bronchitis, chronic obstructive pulmonary disease or emphysema, and asthma. With the exception of diabetes and hypertension, health problems in the over 50 age group are much more prevalent among Roma than among non-Roma. Concerning health behaviour, Roma smoke cigarettes, cigars, or pipes more frequently than non-Roma. Among respondents over 50, Roma underwent cholesterol tests and heart health check-ups less frequently than non-Roma. Findings with respect to frequency of blood sugar, blood cholesterol, and blood pressure tests were similar. Furthermore, Roma women took a cervical smear (Pap smear) test less frequently (30.2% in last 12 months) than non-Roma women (40.6% in last 12 months), while two thirds of Roma women had never done a test for early diagnostic of cervical cancer in comparison to non-Roma women (54%). Although there was a significant lack of empirical data on Roma children's health, there was some evidence pointing to a poorer health status of Roma children compared to non-Roma children (the infant mortality rate for Roma was 40.9%, whereas the average for non-Roma was 5%).

Roma-specific health issues were discussed by the interlocutors interviewed for this report from the health, socioeconomic and cultural perspectives. For example, teen and frequent pregnancies do not only cause adverse consequences on the reproductive health of mothers and the health of newborns, but also influence family life and family income because child

support benefits represent an important financial source for daily life expenditures. The main health problems facing the Roma paediatric population are: malnutrition (starting at 6 months and caused by inadequate complementary feeding); parasitosis (further contributes to malnutrition); injuries and deaths related to accidents; and, respiratory diseases related to active or passive smoking, further exacerbated by low socioeconomic status (unsanitary and sub-standards living conditions, low educational status, and insecure and low family income). The health status of elderly Roma is especially alarming as this group is not included in specific health care programmes.

On the other hand, certain elements in Roma culture, such as breast-feeding and close family relationships with a strong emotional attachment between parents and children, have a positive effect on their health and should be strongly encouraged. The need to raise Roma awareness of the importance of quitting smoking, especially during pregnancy and lactation, of the quality of nutrition, hygiene and a more sanitary living environment, is largely recognised. Based on the interviews conducted for this report, it can be concluded that to raise awareness of the above-mentioned issues, a culturally sensitive approach is required, combined with visual and/or verbal health education tools, and continuous personal contact between medical practitioners and Roma populations. Data on vaccination coverage among Roma children is showing continuously improving results. Based on currently available information, the best results can be observed in Međimurje County, where the vaccination coverage among preschool-aged Roma children is at 85 per cent to 90 per cent and of school-aged Roma children around 99 per cent. During 2013, in Primorje-Gorski Kotar County (including Rijeka City), data shows that 69.3 per cent of Roma children were fully immunised, in accordance with the national childhood immunisation schedule, 20 per cent of Roma children were partially immunised, 3 per cent of Roma children were unimmunised, and the immunisation status of 7.7 per cent of Roma children was unknown. In the same year, in Bjelovar-Bilogora County, 79 per cent of Roma children were fully immunised, in accordance with the national childhood immunisation schedule, 13 per cent of children were partially immunised and 8 per cent of children were unimmunised. Disinfection, disinsection and deratisation (DDD) preventive action is part of routine activities undertaken by epidemiological services targeting Roma settlements with inadequate sanitary, hygienic and communal living conditions.

Roma health in Croatia – policy framework

During the EU accession process, over the last ten years, various Roma issues and challenges (living conditions, education, employment, poverty, etc.) have come to the attention of civil society, political actors, and public bodies. Croatia created the National Roma Programme in 2003, and as a member of the Decade of Roma Inclusion since 2005, focused the 2005–2015 Action Plan for Roma Inclusion on education, employment, health, and housing. In 2012, the Croatian government adopted a new 2013–2020 National Roma Inclusion Strategy, and in 2013 the National Action Plan (AP) for the Implementation of the National Roma Inclusion Strategy (NRIS) for the period 2013–2015 was adopted. The AP focuses on non-discrimination and desegregation of Roma in the areas of education, employment and economic inclusion, health care, social welfare, physical planning, housing and environmental protection, social and cultural life, status resolution, and minority rights. These documents bring Croatia's strategic policy framework for Roma inclusion in line with the EU Framework for National Roma Integration Strategies.

Existing practices, obstacles and challenges in NRIS and AP implementation

Institutional and organizational practices described in this report reflect inconsistencies in integrating the Roma minority at various socioeconomic levels in Croatia. Proposed methods for gathering necessary health-related data for Roma in the NRIS and sources of financing are not adequately specified. Thus, it may be assumed that a significant number of indicators in respect to Roma health will not be monitored and reported on. NRIS and AP health care funding is mostly based on the State budget, local self-government units budget funds, international donors, and EU funds. However, during the 2007–2013 pre-accession period, when the Instrument for Pre-Accession Assistance (IPA) funding was available for programmes aimed at improving Roma quality of life (total IPA amount for the period was EUR 11.468 billion), health was the least funded sector in terms of funding allocated from IPA. No funding was allocated towards improving Roma health whereas most of the resources were used for improving the education of Roma (42.50%) and housing (39.45%), followed by employment (9.9%), culture and tourism (5.37%), and legal status issues (2.69%).

The challenge in collecting health data disaggregated by ethnicity is not only a financial and software one, but also a question of how health-care officials and practitioners understand ethnicity and Roma-specific health matters. This is a complex subject, not least because health-care workers in Croatia lack pertinent education and training on the above-mentioned issues, and because there is no general consensus on what type of information to collect, how to ask questions about ethnic self-identification, and/or via what combination of proxies. Since keeping statistical data disaggregated by ethnicity is not regulated, it is neither consistently collected nor universally shared among institutions.

Semi-structured interviews conducted with medical professionals working with Roma provide an overview of the currently unsatisfactory health status of Roma. Furthermore, interview respondents did not focus solely on their assessment of Roma health, but also provided a critical review of the health-care system, as a whole. Health-care workers underlined the need for clear directives from the Ministry of Health (MoH) regarding collection of ethnically disaggregated health data and improvement of health-care software infrastructure. Roma civil society organizations (CSOs) expressed their willingness to participate in the collection of ethnically disaggregated health data, if adequately trained and supported to do so.

Roma health mediation programme

The MoH perceives health mediators as a valuable link between the Croatian health system and the Roma population, and is therefore committed to launching the Roma health mediator programme and developing it gradually through 2020. Initially, a pilot project will be launched in one or a few Roma settlements and an evaluation will be conducted to analyse the effectiveness of the approach. Subsequently, the project will be expanded to all counties where Roma settlements are located. A general requirement for health mediators is that they reside in a Roma settlement, and that they have a good knowledge of the local culture and people. Education qualifications for health mediators have not been decided on yet, but it is very likely that secondary education will be required. Temporary employment through the Croatian Employment Service (CES) public works programme is the only current means available for financing the work of health mediators. Although the Roma health mediators' pilot project has not been launched yet, there is at least one example of good practice involving a Roma health mediator employed temporarily through the CES public works

programme at the paediatric ward of the County Hospital in Čakovec. Although the work conducted by the mediator in question benefited Roma children, parents and health professionals, and was in line with the latest recommendations about humanising the hospitalisation of children, it has not been possible to secure funding for the full-time employment of this mediator, despite of the director of the ward's attempt to extend the mediator's contract. Important lessons on mediation can be drawn from experiences with education mediators for Roma pupils in the Croatian education system. Some of these experiences can be applied to the health mediator programme. Certain Roma CSOs are critical towards the Roma health mediator project and call for the introduction of a sustainable, meaningful and useful programme that would involve building the capacity of young Roma through education and training in various health professions.

1. INTRODUCTION

This report is a part of the International Organization for Migration Equi-Health project: *Fostering health provisions for migrants, the Roma, and other vulnerable groups*. The project was awarded by the EC DG Health and Consumers, within the Public Health Programme 2012. The aim of the sub-action on Roma Health is to improve the access to and quality of health care, promote health education and prevention in eight EU countries with a high percentage of Roma nationals and/or migrants. The project plans to develop a network of key stakeholders, possessing knowledge of and experience in Roma health and related issues, who will delineate strategies for capacity building and cooperation between participating States. In order to support participating countries in better approaching the subject of Roma health, one of the project activities is to provide country situation reports on the implementation of national integration strategies on Roma health. Country reports are structured to include baseline information regarding actions taken to date with respect to Roma health. They include reporting on the implementation of various national legislative commitments concerning Roma health, as well as examples of good and unsuccessful practices.

Methodology and sampling

Desk research: Desk research consisted of literature, legal and policy reviews. Literature review involved analysis of data from published peer-reviewed literature, reports, databases and relevant internet sites on Roma populations pertaining to demographics, health status and access to health-care services, quality of health care, with a special focus on basic, emergency and specialized health-care services, and women's and children's health. Legal review involved analysis of Croatian legislation with regard to the level of fulfilment of the right to health for Roma in the country, including access to health-care services and protection from discrimination. Policy research involved analysis of data published in peer-reviewed literature, reports, databases and relevant internet sites to identify barriers as regards access to health-care services (e.g. geographic, economic, social, etc.) experienced by Roma and how these barriers are addressed by national policies and strategies.

Field research: For the purpose of this project, three types of semi-structured interviews were developed and conducted between May and September 2014 (explained below). The protocols used in the interviews focused on topics related to the implementation of the Roma integration strategies, as well as national action plans and commitments at diverse levels in different national and local governmental institutions. However, Roma health in Croatian everyday context was the main subject discussed during interviews.

The first semi-structured interview protocol was developed for the national ministerial level. The State has the primary responsibility for the overall implementation, coordination and monitoring of the National Roma Inclusion Strategy for the period 2013–2020 (NRIS), and the Action Plan for the Implementation of the NRIS for the period 2013–2015 (AP). Accordingly, the interview focused on the challenges with regard to the implementation of the NRIS and the AP. Within this topic, discussions centred on: 1) description of the adaptation and activities of the NRIS/AP; 2) monitoring of the process of implementation; and, 3) recommendations for the improvement of the diverse strategies, plans and activities. Seven interviews were conducted with representatives from the Parliament, the Government of the Republic of Croatia's Office for Human Rights and Rights of National Minorities (GOHRRNM), the MoH,

the Ministry of Science, Education and Sports (MoSES), the Croatian National Institute of Public Health (CNIPH), and the CES.

The second semi-structured interview protocol was developed for municipalities, public institutions and CSOs responsible for implementing the NRIS and AP at local level. Interviews with these stakeholders focused on concrete and targeted actions with regard to Roma health, including processes to develop relevant policies and action plans, and projects on Roma health in the local community. Key issues discussed were Roma education, sustainability of the health projects, employment, health mediation, discriminatory practices in the health sector, and others. Eight interviews were conducted with representatives from municipalities, schools and CSOs in Međimurje County and the City of Zagreb.

The third semi-structured interview protocol was designed to cover issues regarding the Roma health situation, and everyday practices of and challenges faced by health professionals working with Roma populations. It was constructed in a manner to allow for the examination of how health professionals perceive the general health-care context and health situation of Roma, including their practical approaches in addressing Roma health. Specific issues discussed in the interview included positive experiences with regard to working with Roma populations, and the principal medical needs and challenges faced by Roma, as identified by the medical practitioners. Interviews were conducted with four health professionals: a neonatologist, a paediatrician, a nurse and a gynaecologist. The gynaecologist did not allow the interview to be recorded for the purpose of this report.

In all, the field research consisted of nineteen interviews, eighteen of which were taped, transcribed and content-analysed. Key quotations from the interviews can be found in the Annex, and are organized according to key terms and questions.

2. CONTEXT OVERVIEW

2.1. Roma in Croatia – socioeconomic profile

Demographic characteristics

Official demographic data from the Government of the Republic of Croatia suggests a continuous increase in the percentage of Roma residing in the country, compared to the overall population, as clearly demonstrated through censuses conducted between 1971 and 2011 (Table 1). According to the last census, conducted in 2011, 16,975 people identify themselves as members of the Roma community in Croatia, or 0.40 per cent of the total population (Croatian Bureau of Statistics – CBS, 2013). These figures should, however, be regarded with certain reservations. It is estimated that the number of Roma in Croatia is much higher. For instance, according to the National Programme for Roma from 2003 and the NRIS 2013–2020, based on the assessment of the Council of Europe, it is estimated that in Croatia there are between 30,000 and 40,000 Roma, or between 0.68 per cent and 0.90 per cent, respectively, of the overall population (Government of Croatia – GoC, 2003). Some demographic experts even suggest the number could be as high as 60,000 (Pokos, 2005) or even higher (Bogdan, 1994). These divergences can be explained by a low ethnic self-identification of Roma during censuses, linked directly to fear of discrimination (so called ethno-mimicry whereby members of an ethnic group identify with other ethnic groups), as well as to the fact that the Roma minority is not a culturally homogenous group.

Table 1: Number of Roma in Croatia, based on censuses from 1971 to 2011

Census year	1971	1981	1991	2001	2011
No. of Roma	1,257	3,858	6,695	9,463	16,975
%	0.03	0.08	0.14	0.21	0.40

Source: CBS, 2013.

Since there is a lack of more comprehensive research regarding the demographic characteristics of Roma in Croatia, we can only rely on the official data from the censuses.

According to the last census from 2011, the median age of Roma people in Croatia was 29, compared to a national median age of 41.7. Roma, in comparison with all other ethnic groups, have the lowest median age. Furthermore, out of all the ethnic groups in Croatia, Roma have had the highest population growth for the period 1991–2011, primarily due to a high fertility rate. This is conditioned by the fact that the Roma population group aged 0–19 accounts for more than half of the total Roma population (Table 2.). According to the 2001 census, per 100 young Roma there were 5.5 Roma older than 60 years. In other words, the ageing index for Roma in 2001 was 5.5, while for the rest of the population it was 90.7 (Pokos, 2005). According to the 2011 census, the ageing index is 6.5 for Roma (based on the authors' calculation).

Table 2: Age distribution of Roma in Croatia – 2011 Census

Age	No. of Roma
0 – 4	2,706
5 – 9	2,455
10 – 14	2,419
15 – 19	1,825
20 – 24	1,397
25 – 29	1,239
30 – 34	1,113
35 – 39	967
40 – 44	778
45 – 49	700
50 – 54	517
55 – 59	366
60 – 64	243
65 – 69	116
70 – 74	77
75 – 79	37
80 – 84	12
85 and over	8

Source: CBS, 2013.

Table 3 shows the spatial distribution of Roma in Croatia, compared between the 2001 and 2011 censuses. Although differences between counties can be observed, it is obvious that in each of the listed counties there is Roma presence. The highest numbers of Roma reside in Međimurje County. In a majority of counties, there was a 50 per cent increase of Roma residents during the time span of ten years.

Table 3: Number of Roma by counties

County	2001		2011	
	No.	%	No.	%
Zagreb	231	0.07	258	0.08
Krapina-Zagorje	4	0.00	3	0.00
Sisak-Moslavina	708	0.38	1,463	0.85
Karlovac	7	0.00	26	0.02
Varaždin	448	0.24	711	0.40
Koprivnica-Križevci	125	0.10	925	0.80
Bjelovar-Bilogora	140	0.11	391	0.33
Primorje-Gorski Kotar	589	0.19	1,072	0.36
Lika-Senj	10	0.02	21	0.04
Virovitica-Podravina	4	0.00	14	0.02
Požega-Slavonia	7	0.01	13	0.02
Slavonski Brod-Posavina	586	0.33	1,178	0.74
Zadar	4	0.00	12	0.01
Osijek-Baranja	977	0.30	1,874	0.61

Šibenik-Knin	8	0.01	22	0.02
Vukovar-Sirmium	167	0.08	253	0.14
Split-Dalmatia	11	0.00	8	0.00
Istria	600	0.29	858	0.41
Dubrovnik-Neretva	4	0.00	11	0.01
Međimurje	2,887	2.44	5,107	4.49
City of Zagreb	1,946	0.25	2,755	0.35

Source: CBS, 2013.

Education

Research conducted by the United Nations Development Programme (UNDP), World Bank (WB) and European Commission (EC) in 2011 provides additional information on Croatia's Roma population. The research was carried out in twelve countries,¹ included Roma and non-Roma populations, with the goal of gaining an in-depth understanding of the significant differences with regard to access to education for the two target groups. The study showed that there was a significant disparity as regards literacy. In Croatia, around 84 per cent of Roma older than 16 years of age participating in the research reported being literate, while the non-Roma group reported a literacy rate of 99 per cent. There was also a difference concerning school enrolment. For Roma children between 7 and 15 years of age the level of school enrolment was 87 per cent, while for the non-Roma group it was 93 per cent. The difference was much higher for individuals between 16 and 19 years of age – the level of school enrolment for Roma was 31 per cent, while for the non-Roma group it was 77 per cent (Ivanov et al., 2012). In 2008, the Open Society Institute (OSI) estimated that 22.1 per cent of Roma school-aged children (7–15 years of age) in Croatia were enrolled in schools (Institut za otvoreno društvo, 2008). As regards secondary education, the OSI estimated the enrolment rate of Roma as 5.2 per cent in 2008. It should be noted that the education level of the Roma population is quite low, and the average number of years spent in the education system is considerably lower for Roma children compared to the non-Roma children – for Roma children it is on average 5.5 years, while for the non-Roma children it is 9.2 years (Institut za otvoreno društvo, 2008). Furthermore, based on the NRIS, Roma children are underrepresented in preschool education. At primary school level, high absenteeism rates can be observed,² as well as a low rate of completion of primary education. Roma pupils often repeat grades several times during their primary education and, for the most part, leave school after completing the fifth or sixth grade of primary school (usually when they reach the age of 15, but without completing their primary education) (GoC, 2012).

Employment

According to the study carried out by the UNDP/WB/EC in 2011, the unemployment rate for Roma in Croatia was 59 per cent, while for non-Roma it was 20 per cent. In comparison with other countries of Central and Eastern Europe (CEE), including the Czech Republic, Slovakia, Hungary, Bulgaria, Romania, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Republic of Moldova, Serbia, Albania and Montenegro, Croatia presented, together with Slovakia, the highest unemployment level for Roma in the CEE (O'Higgins, 2012).

¹ Bulgaria, Czech Republic, Hungary, Romania, Slovakia, Albania, Bosnia and Herzegovina, Croatia, the Former Yugoslav Republic of Macedonia, Montenegro, Republic of Moldova and Serbia.

² Estimates show that by the eighth grade of primary school approximately 70 per cent of Roma pupils are lost to the primary school system (GoC, 2012).

At the end of 2011, the CES reported 4,500 unemployed Roma, representing 1.5 per cent of all unemployed persons in Croatia. Unemployment is gender biased, as evidenced by a significantly higher rate among women compared with men. This is very much evident among Roma in Croatia (a 2009 study showed that 33% of Roma women were never employed, while the percentage for Roma men was only 17%) (Baranović, 2009). Research has also shown that 40 per cent of Roma respondents work in the informal labour market, in comparison with 6 per cent of non-Roma (European Union Agency for Fundamental Rights – UNDP, 2012). The main obstacles for Roma participation in the formal labour market include their low level of education and low level in terms of additional qualifications, employer prejudices, and the negative self-perception of Roma that no matter what they do they will not find a job (GoC, 2012).

Poverty and living conditions

When examining the socioeconomic profile of Roma, it is imperative to look at the dimensions relative to poverty and living conditions. Although during the last thirty years there have been improvements concerning the poverty and living conditions of Roma in Croatia (Šućur, 2005), their situation remains inferior to that of non-Roma. In 2014, 9 per cent of Roma in the country were registered as living in extreme poverty (below the poverty line of USD 4.30 per day)³ compared with 5.47 per cent of non-Roma. In terms of relative poverty (income below 60% of median national income), 92.31 per cent of Roma were considered poor, whereas only 41.96 per cent of non-Roma were regarded as poor (Bagić et al., 2014). Discrepancies can be also observed as regards average employment income per month. The average employment income per month for Roma in 2014 was 3,517.15 HRK, while for non-Roma it was 5,646.92 HRK (Bagić et al., 2014; Šućur, 2005). Regarding living conditions, research has shown that substandard housing and living conditions are more often present among Roma than among non-Roma (Miletić, 2005). Approximately one fourth of Roma families reside in slums and dilapidated housing units (OSCE, 2013). Furthermore, 35 per cent of Roma households do not have access to potable water compared with 4.32 per cent of non-Roma households, and 53.91 per cent of Roma households do not have access to improved sanitation facilities compared with 6.3 per cent non-Roma.

Based on the facts and figures above, it is possible to conclude that the socioeconomic position of Roma in Croatia significantly differs in comparison with non-Roma. In various aspects of everyday life and in their general social position Roma experience many more problems and challenges.

The inferior socioeconomic status of Roma in Croatia compared with non-Roma is very much relevant in the context of examining the health status of Roma populations, including challenges in terms of access to and provision of health-care services to Roma.

³ This figure is established by the World Bank, as the level above which people cease to be economically vulnerable.

2.2. Roma health in Croatia – empirical data

Research conducted by the UNDP/WB/EC in May–July 2011 gives a rare glimpse on Roma health in Croatia. It was conducted using a random sample of Roma and non-Roma households living in areas with a higher population density (or concentration) of Roma in the EU Member States of Bulgaria, Czech Republic, Hungary, Romania, and Slovakia, and the non-EU Member States of Albania, Bosnia and Herzegovina, Croatia, the former Yugoslav Republic of Macedonia, Montenegro, Republic of Moldova, and Serbia. In each of the countries, approximately 750 Roma households and 350 non-Roma households living in proximity were included in the sample (Mihailov, 2012). Most of the data concerning Roma health in Croatia that will be presented here originates from this study, and was re-analysed by the authors of this report.

It is important to emphasize that individual health can be both subjective and objective. From an objective perspective, a person can be affected by a particular health problem that causes certain physical pathologies but how he/she feels about that and how he/she behaves are subjective dimensions that are equally important for both science researchers and health practitioners. Some researchers even believe that health is a basic subjective category, and that the only valid measure of health is when people assess their own health status (Blaxter, 1990; Pierret, 1995). Consequently, the perception of health varies not only among individuals but also among different social groups.

Self-perceived health

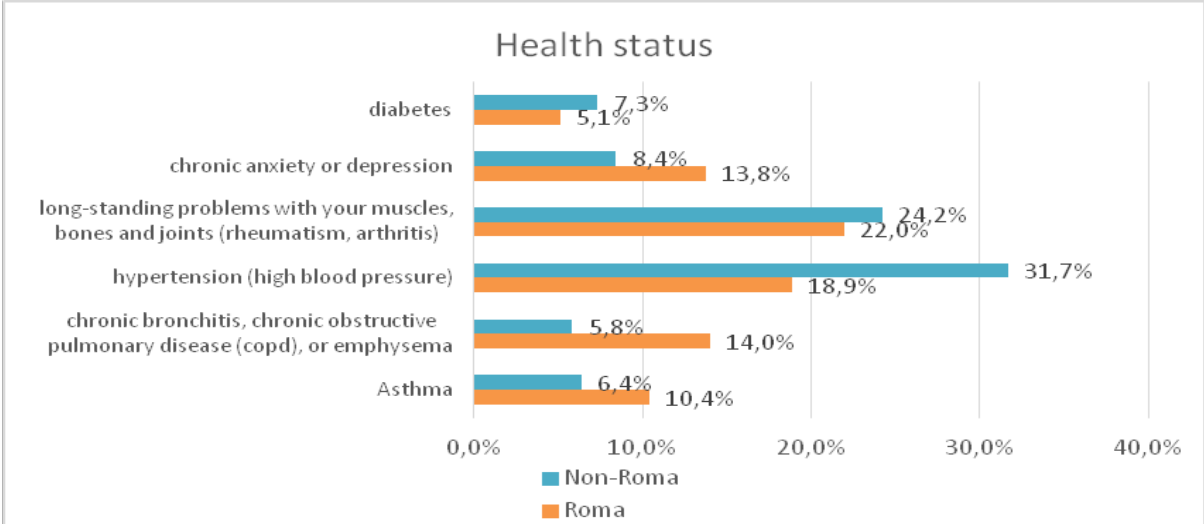
In line with the above, when examining Roma health it is important to understand how Roma assess their personal health. According to the UNDP/WB/EC survey, approximately 12 per cent of Roma assesses their health as poor and very poor, compared with 10 per cent of non-Roma. In contrast, a much higher percentage of Roma assesses their health as good and very good (77.85%), compared with non-Roma (71.25%). The difference in terms of self-perceived health has been discussed in several reports on the topic, and is predominantly linked to a younger demographic structure of Roma populations (higher proportion of younger population) (Bagić et al., 2014). In the UNDP/WB/EC study, respondents were asked whether health problems in any way limited their everyday activities, such as working, shopping or keeping in contact with other people, over the course of the last 6 months. A majority of Roma and non-Roma respondents reported they were not restricted in their everyday activities due to health problems (85% and 83%, respectively).

In the context of the above-mentioned survey, respondents were asked about their health status,⁴ including whether they have any of the following chronic health conditions: diabetes,

⁴ The concept of health status indicates the state of health of an individual, a group or even an entire population, and is measured at a given point in time, according to certain standards or indicators (Kirch 2008:649). Certain standards or selected indicators point to the assessment of the level of an individual's good or bad health condition, primary mental or physical functioning and the general quality of life. There are two possible ways of measuring an individual's health status. The first involves medical exploration for the presence or absence of disease(s) that affect(s) the individual's state or quality of life. The second has to do with the individual's self-assessment of his/her health status, in other words the individual's perception of his/her health. One should be cautious considering that a person can have a very specific health problem that causes certain physical pathology, but how he/she feels about it and how he/she behaves is a matter of subjectivity, a dimension that is equally important for both science researchers and health practitioners.

chronic anxiety or depression, long-standing problems with muscles, bones and/or joints (rheumatism, arthritis), hypertension (high blood pressure), chronic bronchitis, chronic obstructive pulmonary disease (COPD), or emphysema, and asthma. As can be seen in Figure 1, the health status of Roma and non-Roma differs as regards all of the listed health problems. Health issues related to chronic anxiety or depression, chronic bronchitis, chronic obstructive pulmonary disease or emphysema, and asthma, are more prevalent among Roma compared with non-Roma.

Figure 1: Health status of Roma and non-Roma (UNDP/WB/EC, 2011)



Health problems related to diabetes, long-standing problems with muscles, bones and joints, and hypertension are more prevalent among non-Roma populations. When we examine the age group of respondents 50 years and above, the differences between Roma and non-Roma become quite pronounced⁵ (Figure 2). With the exception of diabetes and hypertension, all other health problems are more prevalent among Roma. This is especially visible as regards problems related to the respiratory system (chronic bronchitis, chronic obstructive pulmonary disease or emphysema, and asthma). As health studies suggest, these types of health problems can be connected with certain health behaviours, substandard living conditions, and especially with tobacco use. Therefore, data on smoking habits among Roma and non-Roma, assessed during the same study, is also presented in this report.

⁵ For instance when looking at the difference between the percentages of hypertension (Figure 1) additional evidence suggests a similar conclusion. Epidemiological research of Bayash Roma minority in two Croatian regions from 2005–2006 (N=423), suggests that the prevalence of hypertension among Roma is almost half of what is usually reported among the non-Roma population of Croatia. It is also lower when compared with other European populations (Zeljko et al., 2008). Although not entirely comparable, similar results were obtained from a survey on self-assessed health status (Skarić-Jurić et al., 2007).

Figure 2: Health status of Roma and non-Roma, 50 years of age and over (UNDP/WB/EC, 2011)

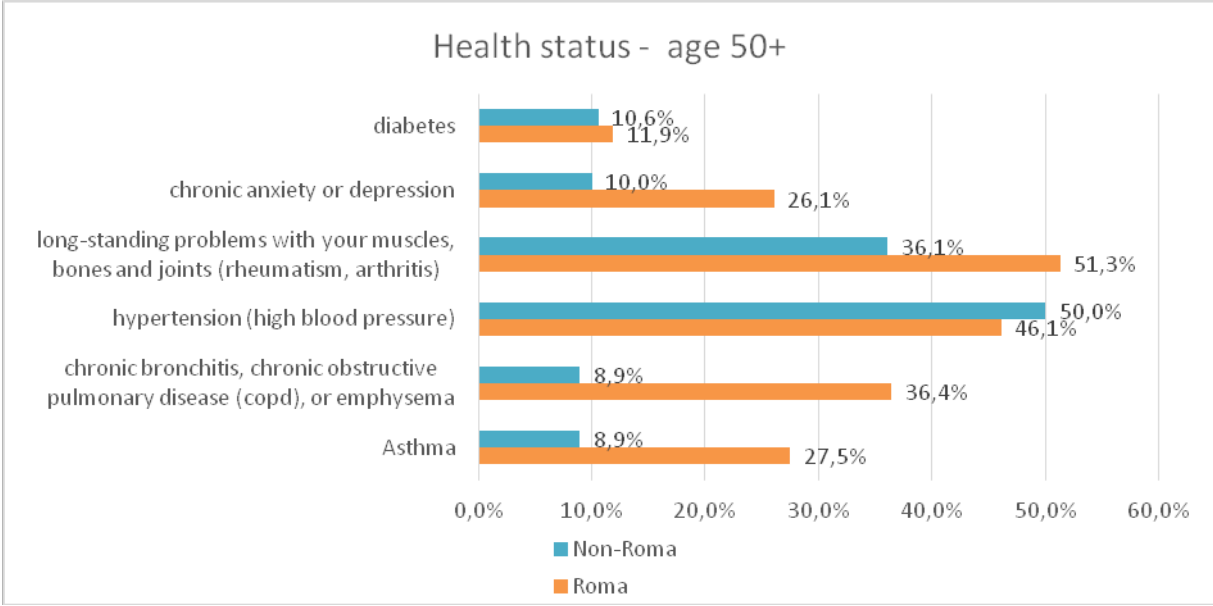
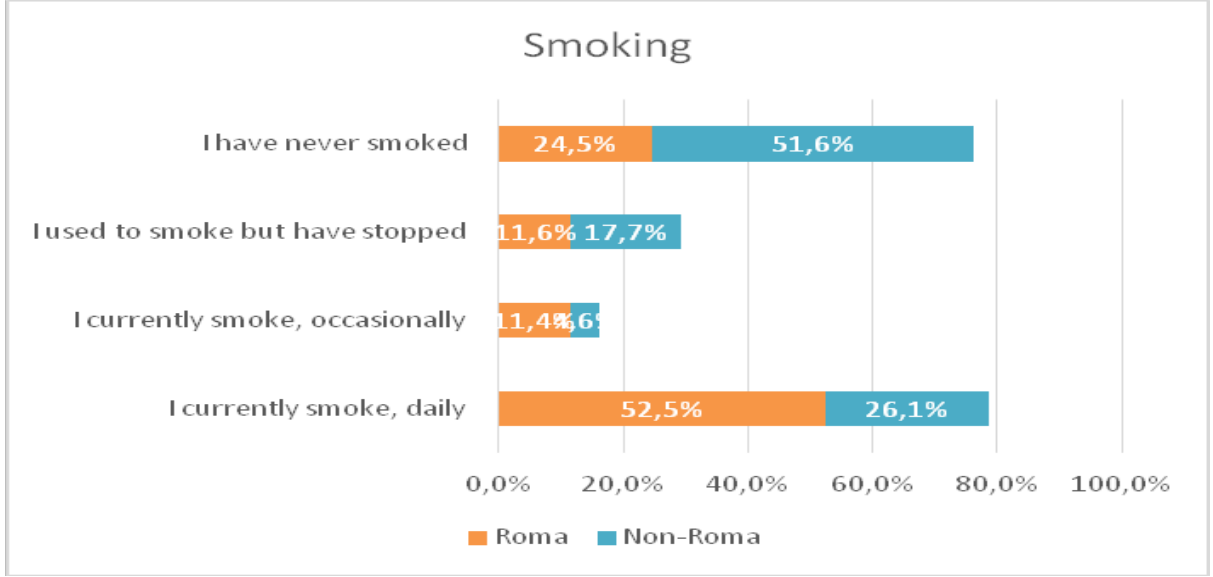


Figure 3: Smoking among Roma and non-Roma (UNDP/WB/EC, 2011)



In the survey, respondents were asked about their smoking habits (Figure 3). The overall difference between Roma and non-Roma is quite significant: 63.9 per cent of Roma smoke cigarettes, cigars, or a pipe, while among non-Roma the percentage of smokers is 30.7.⁶ There is no difference between the two groups, however, as regards the number of cigarettes smoked per day. Data concerning attempts to quit smoking is slightly different between the

⁶ It should be mentioned that the results obtained for the non-Roma target group correspond to results obtained from a survey conducted from 2003 to 2008, entitled Croatian Health Survey (CHS), on a sample of 9,070 respondents, and also to the International Social Survey Programme (Health module) study conducted on a sample of 1,200 respondents. CHS research shows that 31.25 per cent of respondents smoke (Milanović et al., 2012), which is similar to the data from the ISSP Health module where it is shown that 36.7 per cent of respondents smoke (Ančić, 2013).

two groups: some 37 per cent of Roma tried to quit smoking in the last 12 month, while around 26 per cent of non-Roma did the same. Since there are no longitudinal surveys on Roma health, it is not possible to assert whether this difference is a consequence of the awareness raised among Roma of the negative effects of smoking on health or the increased price of cigarettes. It should be mentioned that some comparative surveys have shown that Roma are not always more likely to smoke compared with non-Roma, a finding which highlights the argument against cultural prejudices that portray Roma as more frequent smokers (Bagić et al., 2014).

Within the context of UNDP/WB/EC survey, respondents were also asked about their alcohol consumption habits. Analysis of the data reveals that there was no statistically significant difference between Roma and non-Roma as regards binge drinking (5 or more alcoholic beverages per day) over the last 12 months, as well as concerning the frequency of drinking any alcoholic beverages in the last 30 days.

Health behaviour was also assessed with respect to undergoing medical tests and regular health check-ups (over the last 12 months). The types of health assessments undertaken by Roma and non-Roma are presented in Figure 4.

Figure 4: Medical tests or health check-ups over the last 12 months undertaken by Roma and non-Roma (UNDP/WB/EC, 2011)

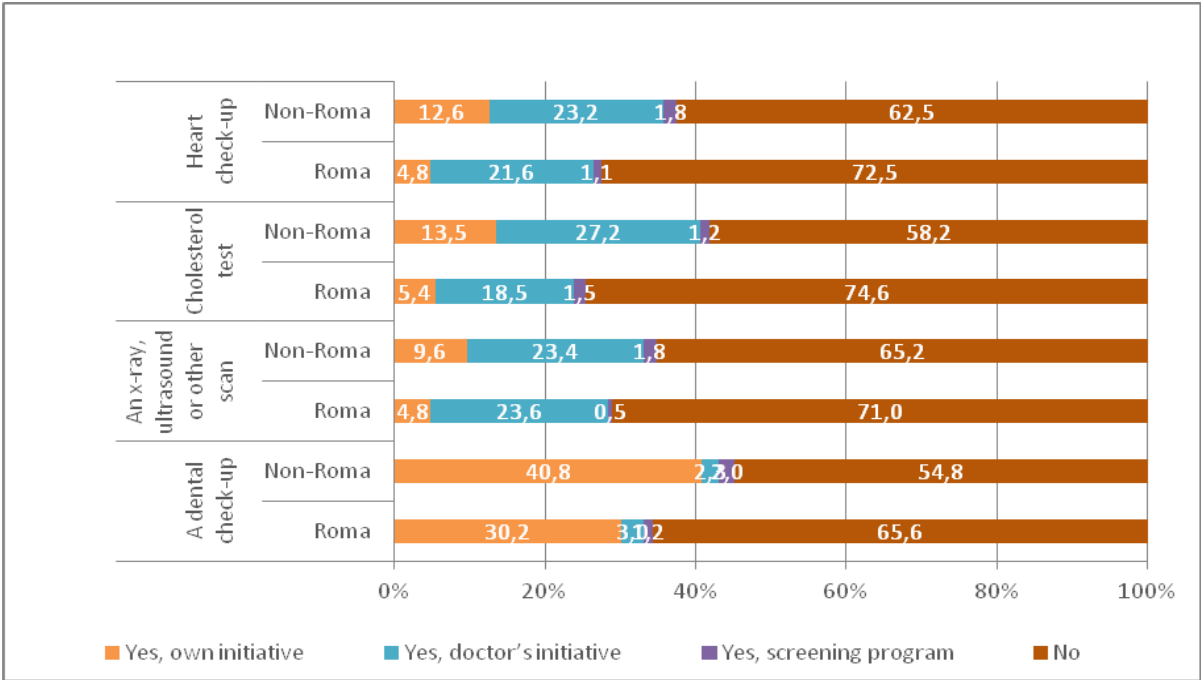
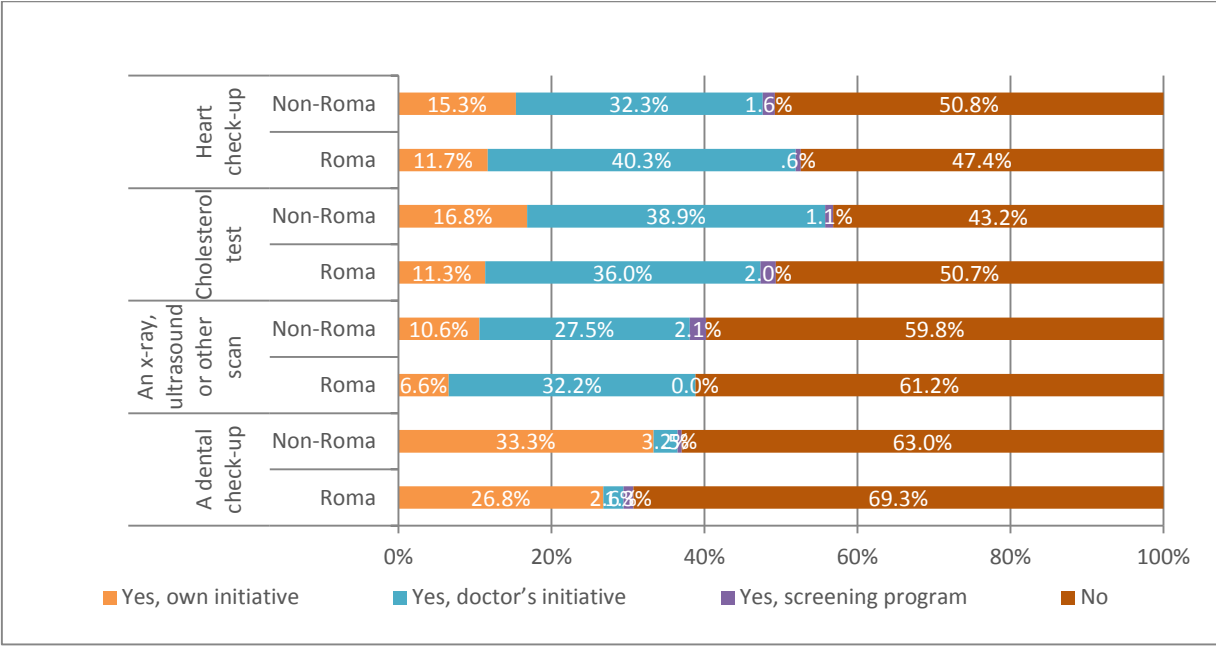


Figure 5: Medical tests or health check-ups over the last 12 months undertaken by Roma and non-Roma, 50 years of age and over (UNDP/WB/EC, 2011)



In Figure 4, medical tests and health check-ups undergone by the respondents are presented according to individual awareness of the importance of regular medical exams, encouragement by health practitioners to undergo exams, and participation in a health screening programme. In general, when looking at all the services, their use by both groups of respondents is well below 50 per cent. However, when examining each service, there are significant differences when comparing their use by each of the two groups. The figure shows that dental health has the highest level of personal awareness, whereby individuals from both groups underwent check-ups based on their own initiative. Medical tests and check-ups related to all other health services were done based on doctors' initiative. On the whole, Roma underwent all of the listed medical tests or health check-ups less frequently than non-Roma. As shown in Figures 5 and 7, frequencies in testing are influenced by age in both groups, with individuals 50 years of age and over undergoing more frequent medical testing. However, even when the influence of the age factor is accounted for, a significant difference in the frequency of medical testing can still be observed between Roma and non-Roma, with the former undergoing less frequent testing. For instance, within the group of respondents 50 years of age and older, Roma respondents underwent cholesterol and hearth check-ups less frequently than non-Roma (Figure 5). This can be interpreted as due to a lower level of health awareness and/or limited access to these health services. Similar conclusions can be drawn as regards Roma and non-Roma undergoing tests done by a health professional to measure blood sugar, blood cholesterol and blood pressure, on the basis of data collected during the survey (Figure 6). Once again, non-Roma reported having used this service more frequently than Roma. The same is true for the group of 50 years of age and older. However, one major difference between the age groups of below 50 and 50 years of age and older is that, when examining the latter, it is evident that a majority of both Roma and non-Roma underwent these tests within the last 12 months (Figure 6). Unfortunately during the UNDP/WB/EC survey additional questions which could explain these differences were not raised, so we cannot know to what extent these discrepancies between Roma and non-Roma were caused by

differences in their confidence in the health-care system or differences in awareness of the importance of the medical tests or health check-ups, or something else entirely.

Figure 6: The frequency of blood sugar, blood cholesterol and blood pressure tests done by a health professional, among Roma and non-Roma (UNDP/WB/EC, 2011)

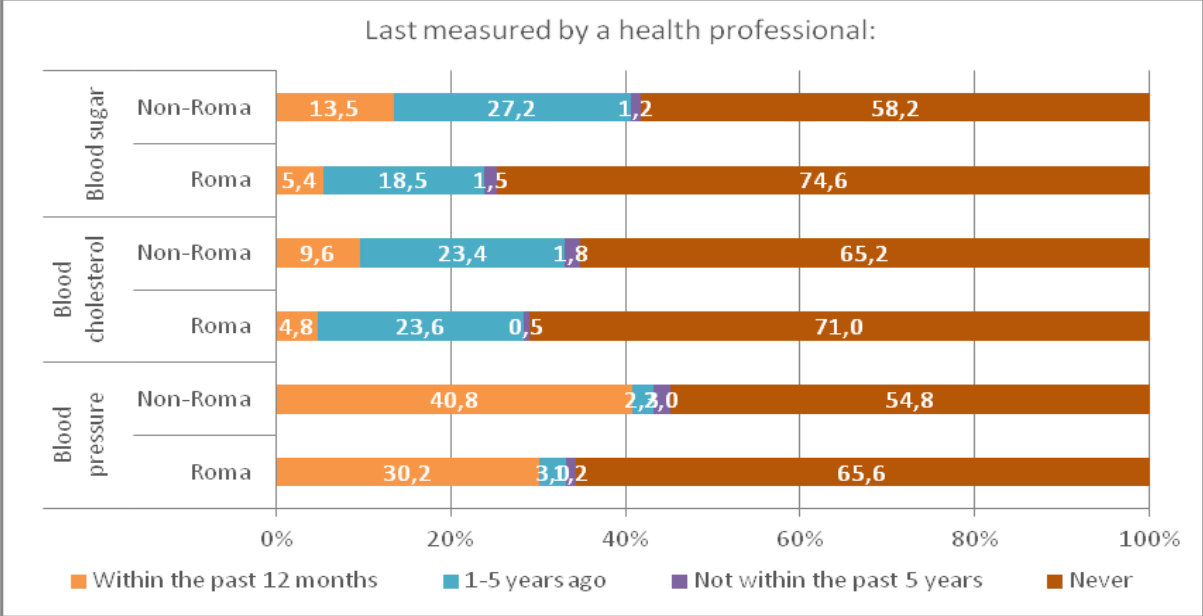
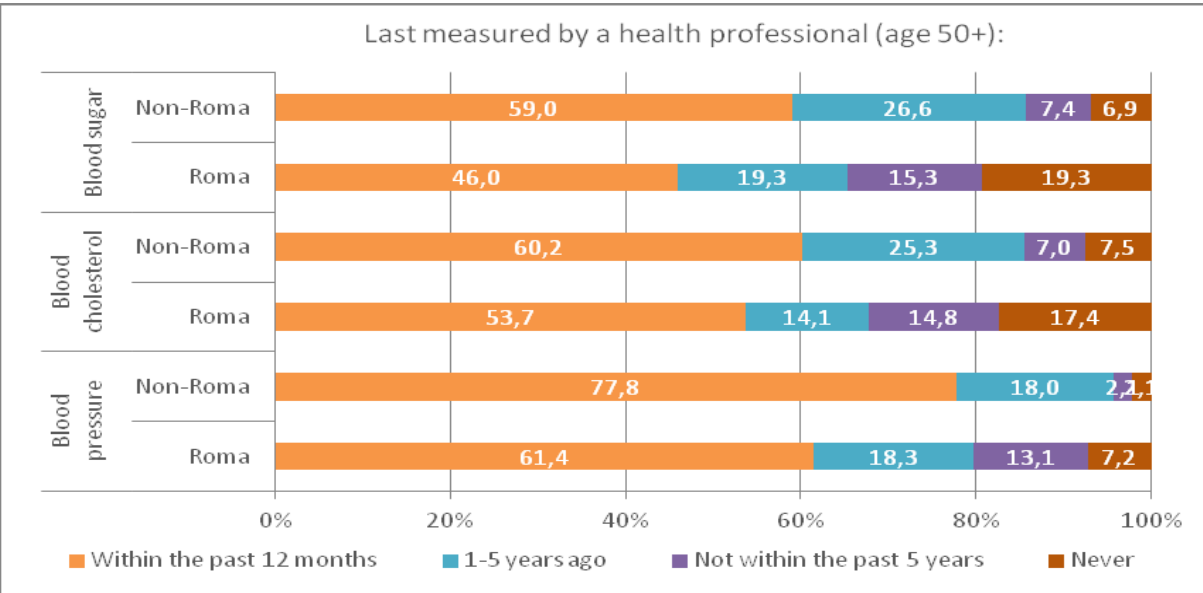


Figure 7: The frequency of blood sugar, blood cholesterol and blood pressure tests done by a health professional, among Roma and non-Roma, 50 years of age and over (UNDP/WB/EC, 2011)



Reproductive health

In addition to assessing the use of the medical services mentioned above, the UNDP/WB/EC survey also assessed specifically the use of reproductive health services. Respondents were asked if they had ever visited a gynaecologist and how often they had undergone a cervical smear (or Pap smear) test, i.e. a test for the early diagnosis of cervical cancer. The results are

presented in Figures 8 and 9. Concerning the question on whether respondents have ever visited a gynaecologist, there are no statistically significant differences between Roma and non-Roma. As regards the frequency of cervical smear tests, however, findings show that Roma women undergo these tests less frequently than non-Roma women. As the figures below show, it is an encouraging sign for both Roma and non-Roma that the majority of women in both groups have visited a gynaecologist. However, it is very worrying that over 50 per cent of women in both groups have never undergone a test for the early diagnosis of cervical cancer (this is the case for nearly two thirds of Roma women).

Figure 8: Visit to a gynaecologist for Roma and non-Roma women (UNDP/WB/EC, 2011)

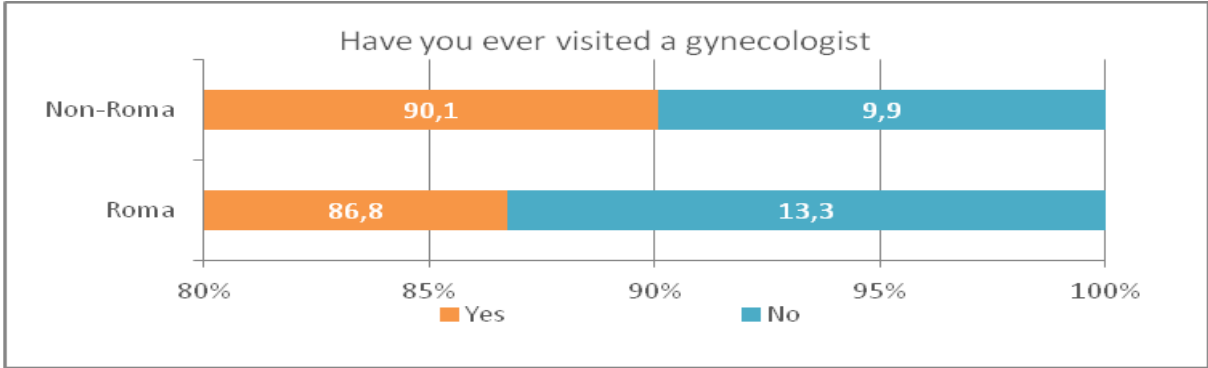
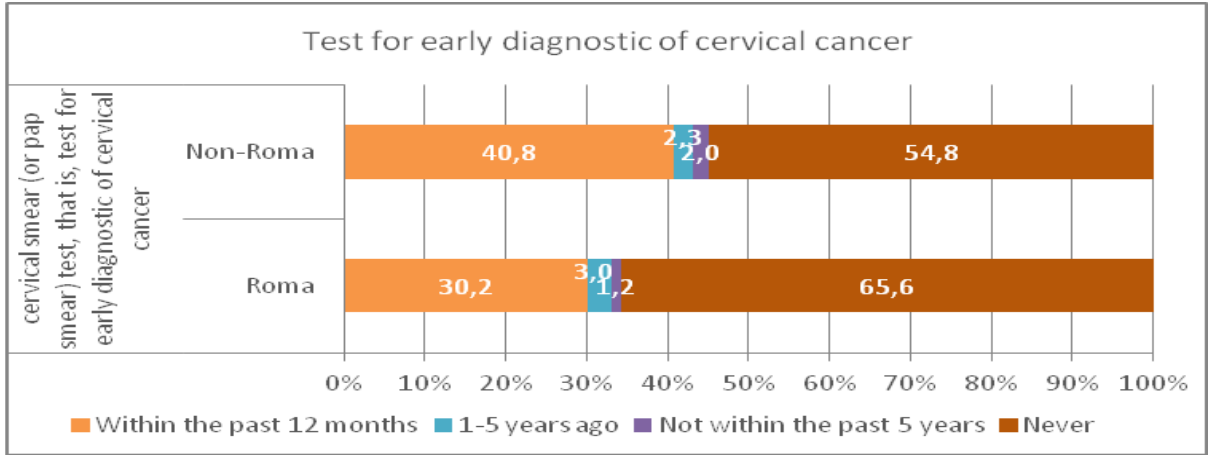


Figure 9: The frequency of Pap-smear for Roma and non-Roma women (UNDP/WB/EC, 2011)



A number of surveys and policy documents emphasize the fact that Roma communities are one of the most vulnerable groups to discrimination and social exclusion in Croatian society. This is especially true with regard to Roma women, as, within the Roma population, they are one of the groups most exposed to various forms of discrimination. Discrimination and social exclusion of Roma women as indicators for inadequate health care and poorer health status are also recognized by the NRIS 2013–2020 (GoC, 2012). However, based on the indicators used in this report, and the literature review, a lack of empirical research (especially cross-sectional and longitudinal) on Roma women and their health should be observed.

Children’s health

There is a clear lack of systematic data concerning the health of Roma children in Croatia. Based on the progress report on the Decade of Roma Inclusion Action Plan for 2009 and 2010

in Croatia, in Sisak Moslavina County, the main causes for Roma infant mortality⁷ were the following: sudden infant death syndrome (SIDS), violent death, such as choking on stomach contents, and other types of aspiration and respiratory-related ailments (most often pneumonia). The infant mortality rate for Roma was 40.9 per cent, whereas the average of non-Roma was 5 per cent. As regards the indicators related to infant's mortality outside a health institution and infants having received medical treatment prior to death, a large percentage (50%) of Roma infants did not receive medical treatment prior to death and died outside of health institutions, most often at home (63%) (Office of Human Rights and Rights of National minorities – GOHRRNM, 2011). For the same indicators, the average for non-Roma is 95 per cent of infants having received medical treatment and died in a hospital, 2 per cent of infants having received medical treatment outside of a hospital setting, and 3 per cent of infants not having received any treatment prior to death (Office of Human Rights and Rights of National minorities – GOHRRNM, 2011). Based on the same report, in 2010, 75.8 per cent of Roma children received complete vaccination, in accordance with the national vaccination schedule, 6.41 per cent, had incomplete vaccination and 17.7 per cent were not vaccinated at all. The percentage of 17.7 per cent of Roma children not vaccinated at all was reported predominantly for one settlement (Brod na Kupi), where the lowest number of visits to the doctor for vaccinations was recorded, and where the doctor in turn refuses to visit children in the settlement for the purpose of vaccinations. Over the last several years, significant progress with regard to vaccination coverage among Roma children in Croatia has been achieved (Bagić et al., 2014) since in most of the counties obligatory vaccination was introduced and organized by the public health institutes whereby health workers continuously visited Roma settlements and informed Roma parents about the importance of child vaccination due to legal requirements (GoC, 2012).

Insufficient research on Roma health in Croatia (lack of cross-sectional and longitudinal data) does not allow us to have a clear and indicative set of concluding remarks on the basis of which it is possible to develop a national policy framework. Information presented above results in a somewhat unclear picture on Roma health (most of the data on Roma health behaviour and status presented is based on one survey). While it would be imprecise to say that Roma health is inferior compared with non-Roma health, it should be noted that, when looking at certain health indicators, Roma clearly exhibit worse health conditions when compared with non-Roma. The improvement of Roma health is possible through the implementation of a wider social agenda, framed within a national policy. The next part of this report presents an overview of policy developments at national level.

⁷ The data were collected in seven infirmaries in Sisak Moslavina County (Bagić et al., 2014).

3. OVERVIEW OF POLICY DEVELOPMENTS AT NATIONAL LEVEL

3.1. Roma health in Croatia – policy framework

In most countries in Europe, general aspects regarding the quality of life of Roma have been on the margins of public discussions and interest of policymakers. This is equally true in Croatia, where the lack of systematic government engagement as regards problems faced by Roma is manifested in the limited scientific research on the sociocultural and socioeconomic characteristics of the Roma population.⁸ Likewise, in the political arena, Roma issues have never been high on the political agenda nor have there been efforts to develop a relevant policy approach at national level, targeting challenges related to being Roma in Croatia, prior to EU accession (including the pre-accession period).

Qualitative data collected for this report indicate the partial exclusion of Roma from the Croatian health-care system and a high perception, among Roma, of discrimination as regards the provision of health-care services. A Roma CSO representative described one such example of discrimination:

“If we talk about how ambulances come to the settlements? If we talk about in which way gynaecological examinations are being conducted in the case of Roma women. How Roma are discriminated against in infirmaries... A Roma woman was scheduled at the gynaecologist’s office for examination at 8 o'clock in the morning, and she was the last one to be examined. She waited the whole day. Why? So as not to contaminate the gynaecological examination table...”

National Roma Programme (2003)

The first national policy document focusing on the systematic problems faced by Roma and their lagging behind the general population due to their economic, cultural, political and physical marginalization and deprivation, was the National Roma Programme, adopted by the Government of Croatia in 2003 (GoC, 2003). This document provided for a number of measures to be implemented by the government and local authorities to ensure that Roma have access to and are able to exercise their civil, political, social, economic and cultural rights.

Measures from National Roma Programme 2003

- Health education and raising health awareness among Roma;
- Implement the survey concerning Roma health;
- Increase the number of vaccinated Roma children;
- Improve the working conditions of visiting nurses who provide health care services in Roma settlements;
- Combat alcoholism, tobacco smoking and other addictions;
- Monitor the fulfilment of the right to health for all Roma, especially children and women.

⁸ Although the first social science research concerning the life of Roma was conducted in 1982, by the Institute for Social Research in Zagreb, scientific interest towards the life of Roma in Croatia has been sporadic.

This programme was actively implemented each year since its inception until the NRIS for the period 2013–2020 was launched.

Decade of Roma Inclusion/Action Plan for Roma Inclusion (2005–2015)

Since 2005, Croatia has been a member of the Decade of Roma Inclusion⁹ and, in this context, the government developed an Action Plan for Roma Inclusion 2005–2015 (GoC, 2005) with a focus on the main issues addressed by the National Roma Programme, developed in 2003. As regards health, the main goal of the National Roma Programme was the greater inclusion of the Roma population in the health-care system and especially the implementation of compulsory vaccination for Roma children (See measures listed above).

The Action Plan for Roma Inclusion included goals, measures, indicators, and public bodies responsible for its implementation in the areas of Roma education, housing, employment and health.

Goals of the Action Plan for Roma Inclusion (2005–2015) – Health

- Ensure equal access to health-care services by informing Roma about their rights and opportunities to obtain health insurance;
- Promote and protect Roma children's health and reduce infant mortality rates;
- Provide health education and promote protection related to safe motherhood, family planning and reproductive health;
- Improve health and sanitary conditions in Roma households and settlements;
- Provide financial support for education of Roma who want to be health professionals.

Based on the analysis of the non-governmental organization (NGO) Centre for Human Rights, while it was reported that measures towards achieving the above-mentioned goals were implemented, the lack of systematic data collection concerning Roma health made it impossible to evaluate the impact (Novak et al., 2011). For instance, the Croatian National Institute for Public Health (CNIPH) and the Croatian Health Insurance Fund (CHIF) conduct routine health research, but they do not have basic data on the health status or access to health care for particular ethnic groups, because the data collected are not disaggregated in this manner. Therefore, at national, regional and/or local level it is not possible to obtain specific data on the implementation of the action plan for any of the above health-specific objectives, except for areas in which regional public bodies have ensured funding for the enforcement of measures provided for in the action plan (i.e. health education activities) (Rodin, 2010). Without collecting data on the access to health-care services and health status of Roma, it would be impossible to say whether the main goals of the action plan were achieved or not. The Croatian Government issued two monitoring reports – Monitoring report on the National Roma Programme, for 2007, 2008 and 2009. (Ured za nacionalne manjine Vlade Republike Hrvatske, 2011b), and Monitoring report on the Action Plan for Roma inclusion, 2009 and 2010 (Ured za nacionalne manjine Vlade Republike Hrvatske, 2011a). Both

⁹ Croatia held the presidency from 1 July 2012 to 30 June 2013. Other participating countries were: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, the former Yugoslav Republic of Macedonia, Montenegro, Norway, Romania, Serbia, Slovakia, and Spain, while Slovenia and the United States maintained observer status.

reports conclude that some improvements as regards Roma health have been achieved and are empirically supported, such as the vaccination coverage of Roma children (data mentioned previously). Concerning other goals and measures related to Roma health, such evidence is missing, mainly due to the above-mentioned lack of systematic collection of ethnically disaggregated data.

Joint Memorandum on Social Inclusion of the Republic of Croatia (JIM) (GoC, 2007)

Within the context of the policy framework concerning Roma, it is important to mention the JIM (GoC, 2007), a joint initiative of the Republic of Croatia and the European Union (EU). The initiative, which addresses the areas of combating poverty and social exclusion, was launched with the signature of the memorandum in 2007, during the EU pre-accession period. The JIM is a platform that includes the main political and economic measures that Croatia has to implement in order to achieve common EU objectives in these areas. Although problems related to Roma are mentioned a number of times in the JIM, Roma health is only alluded to as regards a need to improve the access of the Roma population to health-care services. Progress reports on the implementation of the measures provided for in the memorandum were presented annually to the EC by the GoC, while the EC was assessing the progress of Croatia in terms of the country's accession to the EU. In the reports on the implementation of the JIM in 2011 and 2012, one of the topics covered was the improvement of the access to health care for Roma. As regards this last point, both reports mentioned specific activities implemented in Međimurje County and the City of Zagreb, namely, the increased vaccination coverage of Roma children in Međimurje and the organization of gynaecological exams specifically for Roma women in Zagreb, although the impact of the latter is questionable.¹⁰

The policy framework addressing the issue of Roma health is now based on two national strategies. The first is the National Strategy of the Development of Public Health (NSDPH) 2012–2020, and the second is the National Roma Inclusion Strategy (NRIS) 2013–2020.

National Strategy on the Development of Public Health (2012–2020)

The NSDPH named the MoH as one of the “key” stakeholders responsible for proposing and carrying out the measures included in the Action Plan for Roma Inclusion 2005–2015.

During the period from 2008 until 2011, the MoH was involved in various coordination activities as regards the strategy and the action plan mentioned just above, which are outlined, as follows, in the NSDPH:

1. Health insurance – the coverage of health-care services is financed by the Croatian Health Insurance Fund and covers all Croatian citizens, including Roma. Under the Health Insurance Act, which allows Croatian citizens and foreigners with permanent

¹⁰ This is a quotation from the report on gynaecological examinations (from the reports on the implementation of the JIM) organized in Zagreb: “The MoH tackled the prevention of uterine and breast cancer in women members of the Roma national minority who do not have health insurance and reside in the area of the City of Zagreb. In 2011, (under activity no. A789006, item 3235) the amount of HRK 50,000 was provided for gynaecological examinations, including a Pap test, a palpatory breast examination, and a medical history questionnaire. Roma women's associations, the councils of the Roma national minority in the City of Zagreb, and visiting nurses from health centres in the east, west and centre of Zagreb were contacted and disseminated information among women in Roma settlements regarding the place and time where they could receive a free examination, and the importance of such an examination for their health. By the end of 2011 only 19 women responded. In consequence, only HRK 5,700.00 was spent on this activity.

residence in the Republic of Croatia to register for insurance, several ways of applying for health insurance are provided for, such as registration pursuant to the employment status, through a family member who is the holder of the health insurance, within 30 days from the termination of employment, within 90 days following the end of regular schooling, and so on. The NSDPH 2012–2020 states that often members of the Roma minority cannot apply for health insurance as they do not fall into any of the categories mentioned in the act. In this case, application for health insurance is possible by way of the social service system.

2. Improving the vaccination coverage among Roma children – there is a noticeable improvement in the vaccination coverage among preschool Roma children living in settlements. Epidemiology teams from the county institutes of public health regularly visit Roma settlements and educate parents on the importance of vaccinations and medical examinations necessary for the good health of children. In cases where parents do not respond to doctors' calls for vaccinations, additional vaccinations for children who are not vaccinated regularly are carried out, in cooperation with selected doctors and visiting nurse services. These processes are monitored by the county offices of public health (network of institutes of public health). The NSDPH strategy states that in the city of Zagreb the vaccination coverage among Roma children is between 90 per cent and 99 per cent, based on general practitioners' (GP) medical records.
3. Improving the health and sanitary conditions in Roma settlements – as proposed by the Action plan for Roma Inclusion, measures for DDD were carried out in the City of Zagreb. Emergency pest control was carried out upon notification from citizens or the epidemiology service staff of the Institute of Public Health.
4. Combating alcoholism, tobacco consumption and other forms of addiction.
5. Raising awareness among Roma women in relation to family planning – visiting nurses conduct regular monthly visits to Roma settlements with the goal of providing health-care services to pregnant women, new-borns, infants, preschool children, school children and youth. They also visit chronically ill adults, people living with disabilities and alcoholics. In 2010 and 2011, there was a programme to provide free gynaecological examinations, breast examinations and Pap smear tests for Roma women.
6. Raising awareness of health issues among parents and implementing measures of preventive and curative health care.

In the NSDPH 2012–2020, the systematic lack of data concerning Roma health is also addressed. It states: “the main carriers of routine health statistical research in the country – the Croatian National Institute for Public Health and the Croatian Health Insurance Fund, do not have data on the health status, access to health care and compulsory health insurance as regards Roma”. This gap in data is also visible from the activities listed above as there are no indicators relative to their implementation. Due to the absence of statistical evidence based on empirical findings, it is not possible to show progress with respect to MoH implementation of measures provided for in national Roma strategies and action plans.

National Roma Inclusion Strategy (2013–2020)

At the end of 2012, the Croatian Government adopted a National Roma Inclusion Strategy (NRIS) covering the period 2013 to 2020. In April 2013, a National Action Plan (AP) for the

implementation of the aforementioned strategy was adopted for the period 2013–2015. The NRIS¹¹ represents an effort of the GoC to align its national policy on the integration of the Roma national minority with the Communication from the EC to the European Parliament, the Council of Europe, the European Economic and Social Committee, and the Committee of the Regions on an EU Framework for National Roma Integration Strategies until 2020. In general, the NRIS addresses most of the issues and challenges faced by the Roma minority in Croatia, and promotes positive discrimination in favour of the Roma community with the goal of ensuring equal access to social service assets. In particular, the NRIS focuses on working towards the non-discrimination and desegregation of the Roma population in the country from theoretical, legislative and strategic perspectives, on the basis of which the challenges faced by Roma in Croatia can be addressed. Thus, the following areas have been prioritised in the strategy: education, employment and economic inclusion, health care, social welfare, physical planning, housing and environmental protection, inclusion in social and cultural life, status resolution, combating discrimination and assistance to the Roma minority in the exercise of their rights, and improvements in statistics gathering.

As Roma health is affected by various social determinants, it is strategically framed within all the mentioned areas; access to health care is specifically mentioned and addressed in a separate section. The overall goal of the NRIS as regards health is the improvement of Roma health, including the quality and availability of health-care services.

The following specific objectives, related to achieving the overall goal, have been defined:

- Objective 1:** To increase the health insurance coverage among the Roma population.
- Objective 2:** To increase the availability of health-care services for the Roma population with an emphasis on the elderly, persons living with disabilities, and mobile Roma groups.
- Objective 3:** To raise the level of awareness among Roma of the responsibility for their own health.
- Objective 4:** To improve the protection of Roma women’s reproductive health, and the health of pregnant women and children in general, and to reduce the pregnancy rate among minors.
- Objective 5:** To increase the sensibility of health-care professionals with respect to working with the Roma population, and improve the Roma population’s communication with family physicians.
- Objective 6:** To reduce the incidence of diseases caused by poor sanitary standards and vaccine preventable diseases.

¹¹ NRIS was developed through coordination among various stakeholders: Office for Human Rights and Rights of National Minorities of the GoC, other governmental agencies and national institutions, local and regional self-government representatives, the Association of Municipalities and the Association of Cities, Roma community representatives from the Members of Roma National Minority Councils and Roma CSOs, and independent experts. The strategy states the following: “The working draft of the Strategy was subject to a public debate, including a series of consultative meetings held with key stakeholders, in particular, representatives of the Roma national minority and the relevant bodies of local and regional self-government units inhabited by Roma communities. Consideration was also given to contributions made to the public debate about the Strategy on dedicated websites”.

Objective 7: To reduce the widespread consumption of all addictive substances among the Roma population, with an emphasis on children and adolescents, and to raise awareness of the harmful effects of addictive substances.

In the narrative of the strategy, each specific objective is accompanied by a broader definition, progress indicators, baseline values and sources of data or methods for gathering data if they do not exist. The implementation of the NRIS is monitored by a Committee appointed by the government. The Committee is comprised of a president (Vice-President of the government who is also the Minister of Social Policy and Youth), vice-president (representative of the Roma national minority in the Parliament) and 14 members (seven representatives from Romani councils or CSOs, and seven representatives from various governmental bodies, such as the GOHRRNM, Ministry of Regional Development and EU Funds, Ministry of Construction and Physical Planning, Ministry of Science, Education and Sports, Ministry of Social Policy and Youth, Ministry of Health, Ministry of Labour and Pension System).

A report on the implementation of the EU Framework for National Roma Integration Strategies (Communication from the EC to the European Parliament, the Council, the European Economic and Social Committee, and the Committee of the Regions, 2014) measured progress made in the four key areas of education, employment, health care and housing, as well as in the fight against discrimination and the use of funding in the 28 Member States of the EU. Since Croatia joined the EU on 1 July 2013, the NRIS has been the only Roma national strategy assessed so far. The EC underlined two key elements in the health component of the NRIS that require further development: 1) measures aiming to improve the health of Roma, especially women and children; and 2) Roma health-care assistants. The EC underlined the need to develop more specific measures within an integrated approach, with expected outcomes and mechanisms to monitor progress, in order to improve the health conditions as regards these two elements (Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee, and the Committee of the Regions, 2014).

The specific objectives on health in the NRIS are also listed in the Action Plan for the Implementation of the National Roma Inclusion Strategy 2013–2015 (AP), along with specific measures, implementing agency/participants in the implementation, output indicators, data sources and collection methods, baseline information, implementation timeframe, and financial resources. The AP links the following measures to each of the NRIS specific objectives:¹²

Specific objective 1: To increase the number of Roma covered by health insurance.

Measure 3.1.1. To implement routine awareness raising of Roma within the existing public administration bodies on exercising their right to health care and on related health status issues.

Measure 3.2.1. To create an education programme for Roma mediators on the issue of health in Roma communities and on providing support in exercising the right to health care.

¹² Since health-care protection is the third chapter in AP, all the enumerations of the measures start with the number 3.

Specific objective 2: To increase the availability of health-care services to the Roma population, with an emphasis on elderly persons, persons living with disabilities and mobile Roma groups.

Measure 3.2.1. To continuously provide health-care services through visits to Roma settlements, and to increase the standard of these services.

Measure 3.2.2. To increase the availability of health-care services for the Roma population, and to encourage greater inclusion of Roma persons in health-care prevention programmes through actions implemented by Roma mediators in Roma communities.

Measure 3.2.3. To implement programmes that increase the access of marginalised Roma communities to health-care services (transportation, assistants to elderly persons ("gerontohosts"), mobile teams, availability of drugs, etc.).

Specific objective 3: To raise the Roma population's awareness of the responsibility for their own health.

Measure 3.3.1. To design and implement education programmes and information campaigns (media shows, leaflets, printed materials, public discussion forums, lectures, workshops, and playrooms) aimed at raising the Roma population's awareness of the responsibility for one's own health.

Measure 3.3.2. To implement education activities targeting populations in Roma settlements on the prevention of diseases, and healthy lifestyles.

Measure 3.3.3. To support projects of Roma associations, aimed at raising awareness of disease prevention, healthy lifestyles and mental health protection.

Specific objective 4: To improve the protection of women's reproductive health rights, and the health of pregnant women and children, and to reduce the number of teenage pregnancies.

Measure 3.4.1. To organize programmes involving health education, campaign activities and preventive programmes in Roma settlements, aimed at protecting the reproductive health rights of women, pregnant women and children.

Measure 3.4.2 To implement education sessions on family planning, venereal diseases and risks related to teenage pregnancies.

Measure 3.4.3. To implement programmes and projects aimed at organizing specialist medical examinations for Roma women, including transportation for such purposes.

Specific objective 5: To sensitise health-care workers with respect to working with the Roma population, and to improve the communication between the Roma population and general practitioners.

Measure 3.5.1. To implement specific education sessions for health workers, especially in locations with a large number of Roma residents, and to encourage health workers to cooperate more extensively with social services, especially in cases where there is possible abuse and neglect of children's health.

Measure 3.5.2. To analyse the health status of persons who have chosen their general practitioner within the Roma community.

Measure 3.5.3. To encourage Roma to choose their general practitioner and exercise their right to primary health care through health mediators and visiting nurse services.

Specific objective 6: To decrease morbidity resulting from poor sanitary standards and vaccine-preventable diseases.

Measure 3.6.1. To put in place systems to control the safety of drinking water in Roma settlements.

Measure 3.6.2. To implement activities and increase the vaccination coverage of Roma children in accordance with the mandatory vaccination programme, including mobile Roma groups.

Measure 3.6.3. To implement disinfection, disinsection and deratisation (DDD) preventive measures.

Measure 3.6.4. To implement education and information sessions on good hygiene habits.

Specific objective 7: To reduce the extent of narcotic drug abuse within the Roma population, with a special emphasis on children and youth, and to raise awareness of the harmful effects of narcotic drugs.

Measure 3.7.1. To carry out research on the extent of narcotic drug abuse within the Roma population, with a special emphasis on children and youth.

Measure 3.7.2. To include members of the Roma national minority in national campaigns aimed at raising awareness of the harmful effects of narcotic drug abuse.

Measure 3.7.3. To implement education sessions for children, youth and their parents on the harmful effects of narcotic drugs, and the harmful social and health effects of addiction.

Measure 3.7.4. To encourage and support NGO projects addressing the prevention of addiction.

3.2. Existing practices, obstacles and challenges in NRIS and AP implementation

3.2.1. Insufficient cooperation in implementing NRIS and AP

NRIS highlights the importance of cooperation among all State and local institutions and organizations responsible for its implementation. However, administrative practices used by institutions and organizations that are described in this report reflect inconsistencies in addressing issues faced by the Roma minority at national and local levels in Croatia. The narrative of the NRIS was drafted and issued by the GOHRRNM. As was pointed out during interviews with representatives from the GOHRRNM, the Office can notify and report problems to the Government, ministries and CSOs, but it does not have the authority to influence the work of NRIS implementing agencies and/or other participants in the implementation process. The GOHRRNM also recognizes the low level of involvement of Roma in the process of drafting the document, which has a negative impact on the overall implementation of the strategy.

The majority of the interlocutors interviewed for this country situation report perceived that engagement, communication and good will at the political level are satisfactory, but that political agreements are not adequately implemented at the operational level. They frequently pointed out that communication within and between ministries, and from State to local level are marked by a lack of coordination.

A similar observation was confirmed by an interlocutor from an umbrella organization of Roma CSOs in Zagreb. Based on his experience, he concluded that State institutions operate better

at horizontal level, *“at the highest level, between ministers.”* He also added: *“That lady from the MoH came...she is excellent...we had a successful meeting in the Parliament, various ambassadors came, we wanted to try to initiate better coordination...”*, but also pointed out poor communication between some institutions: *“the weakest cooperation is between the Ministry of Social Welfare and the Ministry of Science, Education and Sports. They do not cooperate at all.”*

Another leader from a Roma CSO explained:

“Those at the top have a really positive attitude. We attended various meetings (author’s note; meetings regarding Roma integration), some of them at the CNIPH. There are some people who want to support Roma health programmes. They do not have to be persuaded to be supportive. The problem becomes evident at the operational level, with various operating officers (author’s note: hampering implementation)...”

On the other side, a municipal officer explained the position of the local administration:

“It is strange that they consider us as part of the national strategy. We receive requests to report on various strategies; sometimes it is the first time that I have seen a certain strategy, where the local self-government unit is indicated as a participant, and then we squeeze money out of our budget to try to do something in line with that strategy because we do not want to report that nothing was done. It would be nice if someone could tell us about their intentions in advance, and then we could tell them whether we can do it or not, and what, in our opinion, is not possible to do.”

In order to improve the quality of life and health of Roma, a revision process of NRIS and AP is planned. The *GOHRRNM representative stated:*

“We will revise the NRIS action plan. We realised that there is a problem because, in the area of education, there are 135 indicators, which nobody has the capacity to monitor or analyse. We will try to simplify the AP. Furthermore, we will try to be more realistic as regards some measures – some have changed structurally, and some things that are an integral part of the strategy were not included in the action plan, such as segregation, which is one of the key problems that no one deals with.”

“We will start the revision process in the fall. The action plan is a working document spanning three years, and it is envisaged that it should be updated.”

In order to reduce problems related to the implementation of the NRIS, the GOHRRNM proposed to the government a draft of the *Strategy against Poverty and Social Exclusion in the Republic of Croatia (2014 to 2020)*, for the period from 2014 to 2016. This draft contains anti-discriminatory measures targeting Roma. The overall aim of these measures is to increase the accessibility of health-care services, one of the key problems as regards Roma health. A specific aim is to develop and expand health care in Roma communities by ensuring a continuous education of health-care workers in fighting against discrimination and ensuring

equal access to health care. Implementing agencies for these measures will be the GOHHRNM, the MoH, local and regional health centres, and CSOs active in human rights protection. Funds for these activities will be secured from the State budget allocated towards the implementation of the aforementioned strategy.

During interviews with key stakeholders, it became clear that different State and local entities addressing specific issues concerning the Roma population intervene in parallel, and do not communicate with each other. Individual enthusiasm and commitment are sometimes very successful but they cannot substitute a systematic, integrated approach employed by all State actors, as well as a close collaboration between regional and local authorities, CSOs and the Roma community itself.

3.2.2. Financing the implementation of the NRIS and the AP

As regards the implementation of the National Roma Programme and the Decade of Roma Inclusion/Action Plan for Roma Inclusion 2005–2015, funding is planned for and ensured through the State budget of the GoC, as well as through international donors such as the Roma Education Fund, Open Society Foundations, and the EU pre-accession funds.¹³ The allocated funding has increased continuously from 2003 on. In 2004, it amounted to EUR 122,000, in 2005 it increased to EUR 374,000, in 2006 to EUR 1.6 million, in 2007 to EUR 1.9 million, in 2008 to EUR 2,383,300, while in 2009, including EU funding, it reached the amount of EUR 5,287,400.

In 2009 and 2010, the State budget provided a total of 20,666,014HRK, or about EUR 2,750,000, for the implementation of the National Roma Programme and the Decade of Roma Inclusion/Action Plan for Roma Inclusion 2005–2015. In the next biennium, 2011 and 2012, funds from the State budget allocated for the implementation of the Action Plan increased by almost 50 per cent and amounted to 29,702,682,06HRK or nearly EUR 4 million. For the period 2013-2015 the State has allocated 45,947,870HRK, slightly over EUR 6 million.

It should be noted that these funds represent uniquely the allocation from the State budget directed towards the implementation of the NRIS and AP, and do not include financial resources planned for the implementation of other national strategies oriented towards protection of human rights and the advancement of the quality of life for all Croatian citizens. Financial allocations at local level are not included in the above-mentioned State budget provision either.

The overall funding for the implementation of the National Roma Programme and the Decade of Roma Inclusion/Action Plan for Roma Inclusion 2005-2015 exceeds the amounts allocated through the State budget. As mentioned above, aside from State budget funds, during the pre-accession period 2007-2013, Instrument for Pre-Accession Assistance (IPA) funding was also

¹³ Based on the document titled “Using EU funds for integration in the Republic of Croatia: experiences and challenges” which was a result of the conference Using EU funds for integration in the Republic of Croatia: lessons learned and perspectives for the period 2014–2020, held in Zagreb in 2013. Available from www.pgfh.org/images/Docu/Romi_EU%20fondovi_11%20studeni%202013.pdf. The conference was organized by the Centre for Peace, Legal Advice and Psychosocial Assistance, and by the Roma National Council.

earmarked towards the implementation of the afore-mentioned programme and action plan – around EUR 9.9 million out of a total IPA amount of EUR 11.468 billion).

During the pre-accession period, the GOHRRNM benefited the most from IPA funds, followed by State agencies, while regional and local level public bodies and Roma associations received very little. For instance, prior to 2013, only one municipality implemented an IPA-funded project as the main coordinator, while two other municipalities were involved in the implementation of IPA-funded projects as partners. During the same period, only four Roma CSOs participated in the implementation of projects financed through IPA programmes - two as project leaders and two as partners. The total amount of IPA funding allocated towards programmes targeting the Roma population was around EUR 9.9 million. Out of that amount, most of the resources were spent on improving Roma education (42.50%) and housing (39.45%), and to a lesser extent for employment (9.9%), culture and tourism (5.37%), and status issues (2.69%). No funding was allocated towards improving Roma health. Recommendations presented at the conference Using EU funds for integration in the Republic of Croatia: lessons learned and perspectives for the period 2014–2020, emphasized the following as necessary steps towards greater Roma integration:

- Building and strengthening organizational and personal capacity of Roma stakeholders;
- Intensification and effective participation of Roma in the development, implementation and evaluation of public policies;
- Strengthening horizontal and vertical cooperation and partnership of Roma stakeholders with non-Roma Roma stakeholders, especially local and regional governments and relevant development agencies, associations and interest groups;
- Proper positioning and highlighting Roma needs in the process of programming and programme documents for the financial period of the EU 2014–2020.

3.2.3. Challenges in the routine collection of ethnically disaggregated health statistics

During the drafting process of the health component of the NRIS and the AP, the CNIPH expressed its concerns to the MoH (via internal communication) about possible problems in collecting baseline data and in monitoring outcomes of the activities because routine health statistics were not disaggregated by ethnic origin. The problem of collecting ethnically disaggregated health data along with organizational and financial problems were outlined by a CNIPH official interviewed for the purpose of this report:

“Process indicators in the NRIS are not in concordance with proposed measures in the Action Plan, as well as with the NRIS general objectives. On the other hand, some indicators were not well-defined. All of these things point to the fact that we are not able to evaluate the whole process (author’s note: the implementation of the various programmes and strategies addressing Roma health). How can we evaluate the results, if they cannot be linked to the right objectives? In Croatia we have had the same problem since the beginning of the project – the issue of ethnic self-identification and declaration of Roma people. The Croatian health-care system does not allow for inquiring about an individual’s ethnic origin. It is not well organized.”

“... In the NRIS we are named as the institution that can implement certain measures, but we do not have the capacity to do so due to a number of organizational and financial problems.

The CNIPH provided comments to the GOHRRNM and the MoH on several occasions during the drafting process of the NRIS. However, health issues and objectives were not defined as they should have been, according to our opinion.”

Furthermore, the Croatian primary and secondary (hospital) health-care systems keep records of the total number of medical procedures, services, visits, measures, morbidity rates, and so on, aggregated for the entire served population. The MoH also pointed out in the NRIS that the method for collecting health-related data is defined by the Croatian Bureau of Statistics' Annual Statistical Activities Programme, which does not allow for the collection of ethnically disaggregated data, and that any changes to accommodate such a requirement for monitoring purposes cannot be achieved without legislative changes and allocation of funding. Despite the afore-mentioned problems with the routine collection of health statistics in the country and the resulting obstacles in monitoring baseline and progress health indicators linked to the NRIS objectives, ways to improve the methods for gathering the necessary data and funding sources are not adequately specified in the NRIS.

“Health-related objectives (author’s note: objectives in the NRIS) are not defined in a manner allowing us to monitor them. Furthermore, indicators were not available and that was stated in the NRIS and in the Action Plan. Also, process and output indicators were not defined in a clear manner. All of these things imply that we will not be able to evaluate any of the measures. How are we to evaluate the results if the indicators are not corrected? There is also the issue of ethnic self-identification, a problem that has been identified through various studies and that concerns all sectors, including health. ... In routine statistics records in the health system, we do not have data based on national belonging. Neither from hospital statistics, nor from primary health care...”

It can therefore be inferred from the various interviews conducted that a significant number of Roma health progress indicators will not be monitored and reported on. When a health official from Zagreb was asked about specific NRIS and AP measures (apart from education workshops, vaccination and DDD activities that target Roma), she explained that *“all other activities related to health promotion in local communities target the entire Croatian population”*, that is, activities target the general population and not Roma specifically. Therefore, without mapping all Roma communities in Croatia and collecting Roma-specific health statistics, it is not possible to establish a baseline and monitor progress health indicators.

Most stakeholders interviewed for this report agree that the lack of data on Roma health is one of the major obstacles to a successful NRIS implementation. Therefore, the routine collection of ethnically disaggregated health data is imperative, though governmental officials have not been able to agree on how to introduce and integrate this aspect into the current system of health data collection.

The CNIPH reports all health statistics on an annual basis. Health statistics from primary health care are obtained automatically from the Croatian Central Health Information System (CEZIH). However, the visiting nurse system and the hospitals are still not integrated by the CEZIH. Therefore, annual reports are made for each hospital separately, through a system of paper-based forms summarizing information about specialist health care (e.g. the reasons for seeking specialist medical treatment, the type of medical services rendered to all patients, number of days spent in hospitals, etc.). Additional problems include the more limited information technology capacity of the CNIPH compared with the primary health-care system and the CHIF (for example, CNIPH is not able to access information exchanged between the primary health-care system and the CEZIH due to its software programme limitations). The CNIPH is aware of these limitations, especially as regards preventive measures among the paediatric population, which are not adequately monitored and reported on through the current CEZIH reporting system. Recently, the CHIF expressed its willingness to allocate funds towards resolving the problems in collecting health data electronically and linking the different systems, but not specifically in relation to Roma health care.

The issue of collecting ethnically disaggregated health data does not present only software and funding challenges, but also challenges in terms of understanding specific problems related to Roma health. Introducing an additional category, such as the question of ethnicity, in the CEZIH data collection system is costly. An additional challenge is that the project intended to provide electronic records for all patients in Croatia is not yet finished, although it started in 2002. The CNIPH suggested that the ethnicity question be incorporated in the patient electronic record. If funding is secured for the implementation of the electronic patient record system, then it would be important that the MoH take appropriate steps to integrate ethnicity-related information in the patient electronic record. However, gathering such information in the health-care system is complex because health workers in Croatia do not receive relevant, systematic education and training on the issue. Additionally, health-care officials do not agree on what type of information they should request – direct questions regarding ethnic self-identification and/or a combination of proxies such as address, surname and mother tongue.¹⁴

Health professionals in local hospitals interviewed for this report complained about problems as regards collecting Roma health statistics. One doctor said:

"At the national level this (author's note: records of patients according to ethnic belonging) is not possible. On some protocols, to facilitate tracking of patients, we just mark it (author's note: Roma ethnic identity). However, this is not actually

¹⁴ Data on addresses and surnames are available in primary health care and hospital records. Health practitioners in local and rural communities are aware which settlements and streets are primarily settled by Roma. The list of all Roma settlements, including streets, is not available at the State level but it is assumed that the majority of Roma councils have information about Roma in their respective counties, disaggregated by settlement and street. It should also be mentioned that some surnames are indicative of Romani origin, whereas others are not. For example, in Međimurje (County or City) surnames such as Oršuš, Balog, Ignac, and Kalanjoš are almost exclusively Romani, whereas others are very frequent among Roma (e.g. Horvat and Bogdan), but also present among non-Roma (Martinović Klarić, 2009:61). In Baranja (County or City), typical Romani surnames are: Petrović, Mišković, Mihajlović, Đurđević, Todorović, and Bugarinović (Martinović Klarić, 2008:61). The Ministry of Health assumes that health workers are trained to ask questions that are traditionally considered to be part of the patient's anamnesis. However, at the present, questions about ethnicity or mother tongue are not considered to be part of the health anamnesis.

allowed. If you (author's note; doctors on local level) want to draw out some statistics related to health, we should be facilitated the task of recording patients' ethnic identity. This would be very useful for us, as it would allow us to monitor our Roma patients...."

On the other hand, doctors keep some kind of ethnically disaggregated patient records as part of their professional responsibility and scientific engagement:

"When we publish our work in medical journals ... starting from maternity wards onwards, we face problems because patients are not registered as Roma. Sometimes we rely on surnames of Romani origin, such as Oršuš, Kalanjoš, Balog, which are common in Medimurje (City or County?). However, the surname Horvat is common both among Roma and non-Roma, which complicates things".

According to a Roma CSO representative, the trust that health-care providers enjoy among the general and ethnic minority populations can be used as an advantage in the collection of health related data, if health professionals receive instructions and support from the MoH:

"The health-care system has immense authority. An ordinary person listens to the doctor. And what the doctor says, it is seen as a rule. If a doctor is instructed and is given the ability to collect and record ethnically disaggregated health data, he/she will most likely carry out this task. I have spoken to some doctors who say that they don't foresee any obstacles to collecting data in such a way because patients listen to their doctors. There should, however, be clear procedural instructions from the MoH, including as regards the inclusion of regional Roma councils."

Examples of good practices in collecting ethnically disaggregated data

Various Croatian institutions collect Roma-specific statistics in relation to their work. However, since keeping statistical data disaggregated by ethnicity is not regulated, this type of data is not collected in a uniform way, and, unfortunately, it is not shared among institutions. The stakeholders interviewed for this report stressed that relatively precise data on Roma is collected and recorded by the Ministry of Science, Education and Sports (MoSES), and the Croatian Employment Service (CES). Valuable information can also be obtained through electoral registration, which is available to institutions, and, until recently, to the public, for periods of time following elections or referendums.

The MoSES, for instance, funds various programmes targeting Roma children and youth. These programmes include funding for kindergartens, extended stay in primary schools, supplemental school lessons of the Croatian language in primary schools, and a number of scholarships (500HRK/month) provided in the secondary schools. Roma university students receive financial assistance through the National Foundation for the Support of Student Living Standard (for example, in the City of Zagreb the scholarship is equal to 30 per cent of the average net salary in the city for the previous year). The entitlement to these privileges is based on the provision of one of various types of documents proving Roma ethnic identity, such as declared ethnicity in an official document (birth certificate of a pupil/student or one

parent, school report), one parent's affidavit of belonging to the Roma national minority certified by a notary, excerpt from the electoral registration of a parent in which Roma self-identification is evident or a recommendation from Roma CSO. Based on these documents, schools keep records of their Roma pupils and send this data to the local administration in cities and counties, who in turn report it to the MoSES. With this information the ministry keeps its database up to date, including data on Roma pupils. For example, in September 2014, MoSES was capable of providing information on the number of Roma pupils enrolled in primary schools and secondary schools at the beginning of the academic year 2013–2014.

According to school record kept by the MoSES, during the period between 1 January and 31 August 2014, 268 Roma children (130 girls, 138 boys) were enrolled in 49 kindergartens across Croatia, and 232 Roma children were enrolled in 1-year pre-school programmes. The National Foundation for the Support of Student Living Standard provided financial assistance to 23 Roma students in higher education institutions for the academic year 2013–2014 (the number of Roma students supported by the foundation fluctuates between 23 and 25 students each year).

CES collects and records ethnically disaggregated data based on information provided from its regional offices. For instance, when CES consultants in regional offices create a file for an unemployed individual, including a work profile, they ask questions regarding spoken languages, including English and Romani. This information is recorded and shared with the central office. CES also uses information on ethnic identity obtained from electoral registration in election years.

A number of unemployed Roma are registered with CES for the purpose of actively seeking employment and as a prerequisite to receiving social service benefits. This registration comprises of a signed affidavit (not certified by a notary) and can be used as proof of entitlement towards participation in employment and training programmes for Roma. Currently, CES officials are discussing ways to upgrade their system of keeping ethnic-specific records. They estimate that the CES software system is efficient and flexible enough, and that an additional question can be integrated into the questionnaire used to create the work profile of unemployed individuals, such as: “Would you like to be included in the NRIS employment and training programmes for Roma?” The information shared by regional offices is compiled and analysed by the CES central office in Zagreb, which maintains “up-to-date” statistics on unemployed and employed Roma.

4. NRIS IMPLEMENTATION AT LOCAL/MUNICIPAL LEVEL

Roma CSOs regard the implementation of the NRIS health component as unsatisfactory. A Roma CSO representative stated: *“I would dare to say that it (the health component) has been the worst element in the national strategy,”* and *“Have you seen the reports on health services? Five to six sentences...”* Apart from recognizing the problem, Roma CSOs also call for coordinated action: *“I think it is the right time for all of us to start to truly act together”* and *“I think we are in the last moment for starting better in Roma health problems.”*

Furthermore, CSOs recognize the specificity of health-related problems, the need for targeted actions by health-care specialists, insufficient funding allocated towards addressing Roma health issues and the low capacity at local level to write and submit projects to obtain EU and State funding. A Roma CSO representative emphasised the following:

“Health is a very specific area. You cannot use general models in health; they have to be sector-specific and it is necessary for health specialists to be involved. Health actions need to be targeted.”

“From my point of view, the Ministry of Health allocated an insufficient amount of funding towards Roma health. I think that we should all work together to increase the availability of funds for Roma communities.”

“Health is included in the national strategy (NRIS) but even when there are tenders for health, nobody applies because people are not familiar with the health situation...”

Below is an analysis of NRIS implementation at local level by each NRIS objective. **The first objective of the NRIS health component** is to increase the health insurance coverage for the Roma population. Health officials estimate that 99 per cent of Croatians have health insurance and assume that health care is equally available to all people living in the same area, including Roma.¹⁵ Data on the number of Roma individuals without health insurance is not available and Roma CSOs witness daily problems related to access to health-care insurance:

¹⁵ UNHCR estimates that approximately 1,000 people of Romani origin are at risk of statelessness, while 500 Roma are stateless mainly because they lack birth registration and documentation, following the dissolution of Yugoslavia. UNHCR recognizes the problems of accessing State services incl. health care faced by these persons and the need for more efforts to inform them about their right to health care under Article 65 of the Aliens Act (minutes of the first coordination meeting – Roma Inclusion in Croatia, organized by the UNDP and held in Zagreb on 29 April 2014, with the participation of Romani civil society organizations, representatives of the government, parliament, UNDP, UNICEF, UNHCR and IOM). In fact, the NRIS itself underlines that very few Roma are not registered as citizens of any State in order to exercise their right to health care in accordance with the Aliens Act (p. 61). Based on the Health Insurance Act, Roma registered as Croatian citizens and aliens with permanent residence can obtain health insurance through any of the following: employment, through a family member who is a policy holder, within a 30-day period following the end of an employment contract, within a 90-day period following the completion of regular schooling, etc. However, in reality, Roma often cannot obtain health-care insurance based on these grounds due to lack of regular employment, regular schooling, etc.

“My impression is that the problem is linked to obtaining health insurance. Sometimes people do not go to get the insurance card and they do not register their child on time. At times there are cases where a few children in one village use the same health insurance card and then a doctor might conclude that the owner of the card has had every possible disease.”

“I think it is important to discuss vaccination because there are many Roma without health insurance and with unresolved status issues. We (author’s note: representatives of this specific Roma CSO) attended a meeting with representatives from the Institute of Anthropology, social services, and others, where we discussed that there are Roma people who are third generation in Croatia and still do not have health insurance. They do not have documents. They do not identify as Croats and do not have health insurance, yet somehow women manage to deliver their babies in hospitals and to raise their children from an early age without insurance. This means that these children are not getting vaccinated.”

One of the major problems related to access to health insurance for Roma derives from an insufficient knowledge among Roma of their rights to health insurance. A Roma nurse stated the following regarding her community: *“The lack of knowledge has always been a problem in my village. People are not aware of their rights to health insurance. They do not know where to go to register babies.”* In order to better inform Roma on exercising their rights to health insurance and other health-related rights, the MoH drafted and published a booklet, entitled “My rights”, in Romani and Croatian languages. This booklet contains information about rights related to health care. A number of these booklets were distributed to visiting nurses and to Romani councils in various counties. Unfortunately, due to lack of funding, specific workshops were not organized to ensure that Roma CSO and Roma council representatives, as well as the general Roma population, understand the information in the booklet and more effectively exercise their rights to health, including health insurance.

The second objective of the NRIS health component is to increase the availability of health-care services for the Roma population with an emphasis on the elderly, persons living with disabilities, and mobile Roma groups. Data on the number of visits and types of health-care services provided in Roma settlements is available only for a limited number of counties across the country. For instance, information is available for Međimurje County where nineteen visiting nurses from the local Health Centre Čakovec carry out routine medical activities in the 12 Roma settlements and for Roma populations living outside of the settlements. Nurses visit Roma settlements in the county 1–3 times per week. A Roma nurse described her childhood memories of a visiting nurse who was working in her village:

“She came regularly to our village. People were glad to receive her. I remember that when my mom would have a baby, she would receive a visiting nurse and would make a feast for her. We were visited by the same nurse for two years, but any visiting nurse was welcome because she was important to the community. The visiting nurse came mostly to provide care for newborns. She also came to raise awareness of the importance of human papillomavirus (HPV) vaccination for teenage girls.”

Unfortunately, the system of providing out-of-hospital health services is not equally available to all Roma settlements because some people living in Roma settlements resist the system of visiting nurses.

Information on baseline health data on the elderly, persons living with disabilities and mobile Roma groups was not available at the time of the writing of this report. A Roma nurse gave her point of view concerning the vulnerability of the elderly:

“There is nothing specific for older people. When a Roma person is 60 people usually dismiss him/her as being old because not many live to be that age. It is rare that someone lives to be 70 years old. In my village, there are only a few people who are 60 years old. There is a big problem with diabetes mellitus type II among older people in my village. For instance, my grandmother is affected by this type of diabetes and doctors tried to explain to her that food can have a negative influence on her disease but she does not understand that. Sometimes her body becomes very exhausted; with the right diet perhaps she could have been healthier and be able to live longer. My parents take care of my grandmother but some elderly persons have no one to take care of them.”

The third objective of the NRIS health component is to raise the awareness level among Roma of their responsibility for their own health. This objective foresees the implementation of education programmes and campaigns aimed at raising the Roma population's awareness of the responsibility of one's own health, and activities to educate the population in Roma settlements on the prevention of diseases and promotion of healthy lifestyles, as well as supporting Roma CSO projects aimed at raising awareness of disease prevention, healthy lifestyles and mental health protection.

Research conducted for this report showed that flyers, presentations and workshops are the most common types of education methods used in the Croatian health system to inform the Roma population. Presentations and workshops (verbal and practical methods of providing information) are more helpful than flyers (printed methods of providing information) in health education for Roma. A medical doctor interviewed for this report stated:

“After the presentation, I gave the participants a questionnaire about traffic accidents involving child and infant injuries and/or death. The participants answered the questions I asked and I realized that they had memorized everything I had presented. They were an attentive audience. Education has to be continuous. With continuous education, we could make significant progress. I have never seen a situation where Roma people are not interested in learning.”

Other medical professionals have used different educational methods. One of them described her experience during an interview:

“When we were using leaflets, we had asked a teacher’s assistant from a nearby school to translate the text into Romani. However, the majority of the Roma population are illiterate. We asked an educated Roma girl to read both the Croatian and Romani versions of the flyer, and let us know what she thought

about it. She said that Romani is a spoken language and that terms like mother, person, and parent are expressed differently when spoken and written. She suggested that it would be more useful to speak directly to the target group, as we usually do in the hospital. We have since ceased using the flyers."

Based on interviews conducted for the purpose of this report, we concluded that verbal forms of health education with personal contact between medical practitioners and the Roma population are the most useful Roma health education methods. We therefore recommend and support verbal health education in both Romani and Croatian languages.

Doctors interviewed for this report highlighted the need for awareness-raising among Roma of the importance of quitting smoking, especially during pregnancy and lactation, health and balanced nutrition, good hygiene practices, and a more sanitary living environment. One of the medical doctors from Međimurje described her experience with health education:

"Roma attend health related workshops, and Roma appreciate workshops and participate actively. This is what has always attracted me to all of this. Education needs to be continuous, however. Continuous education can lead to a significant change. Furthermore, when working with Roma communities you need to use a sensitive approach. For instance, I always compliment their breast-feeding techniques and criticize their smoking."

Interview respondents provided us with some details on health education activities in Međimurje County. In 2013, visiting nurses conducted individual preventive counselling of Roma parents and children to improve the health of infants and children, including preventive measures as regards health care, hygiene and nutrition, and the importance of vaccination, as well as encouraging parents to respect the schedule of mandatory vaccinations. They also worked with specific groups (i.e. pregnant women, children, and girls). As part of routine health education activities in schools, all Roma children attending school receive health education on the topics of puberty and reproductive health (education about sexually transmitted infections and protection against unwanted pregnancies) in the 5th and 8th grades, and the first and second year of high school.

In schools with a significant representation of Roma children, information sessions were organized for parents on the topics of good hygiene practices, healthy and balanced nutrition and protection against infectious diseases. In addition to health education in primary and secondary schools, instructive activities are also carried out in the students' homes, in settlements where a substantial number of Roma pupils live, with a particular emphasis on reproductive health and protection against sexually transmitted diseases, as well as prevention of addictive behaviour. Roma parents and children participated in the design of activities related to the prevention of cervical cancer within the programme "Education and vaccination against the human papilloma virus (HPV)" implemented by the CIPH, in collaboration with the Međimurje County local administration. Presentations and workshops for children and parents were organized in all schools in Međimurje County with a significant representation of Roma students. Presentations focused on the importance of responsible sexual behaviour, routine gynaecological examinations, and vaccinations to prevent HPV infections.

As regards supporting Roma CSO projects aimed at raising awareness of disease prevention, healthy lifestyles and mental health protection, the MoH publishes annual calls for proposals on health education. In 2013 one Roma CSO received a grant (about 10,000HRK) and organized a health education workshop, in cooperation with health workers. A Roma CSO leader described this workshop:

“Regarding health, we are trying our best by organizing workshops on health education. The workshop in question took place here, in the city district Trešnjevka North, and was organized by thirty Roma organizations. It was planned that the majority of participants would be women. However, men ended up coming alongside the women as they drove them to the workshop. This presented a motive for them to attend. The 2-day workshop included speakers who were physicians from the hospital Vrapče, experts on addiction, drugs, alcohol, and a nurse that held a class on sexual education issues, such as contraception and pregnancy. These were the main topics of the workshop.”

In 2014, none of the Roma CSOs in Croatia were able to satisfy the requirements of the MoH call for proposals and, therefore, no funding was allocated for the purpose of supporting Roma CSO health education activities. The MoH does not have any programmes aimed at building the capacity of Roma CSO to apply for and use MoH funds for promoting prevention and health activities among Roma.

The fourth objective of the NRIS health component is to improve the protection of Roma women’s reproductive health, and the health of pregnant women and children, and to reduce the pregnancy rate among minors. No data is available on the total number of past and existing programmes involving health education and campaigns, educational and preventive programmes in Roma settlements aimed at protecting the reproductive health of women, and the health of pregnant women and children, education sessions on family planning, venereal diseases and risks related to teenage pregnancies, and encouraging gynaecological examinations among Roma women. The problem of Roma teenage pregnancies is widespread in Croatia. The issue of Roma teenage pregnancies was described by a local doctor from Međimurje as follows:

“Roma girls are younger and younger when they come to give birth. The child's mother is usually a child herself. A girl who is at the hospital currently became pregnant at the age of 13. She is by all definitions a child, and that is exactly how she behaves. Today is the third day after she gave birth, and she is adapting to motherhood a little bit better. Yesterday she wanted the child to be bottle-fed. For some reason she was placed in a foster family, a Roma family, but I did not have time to get in contact with social services. She completed the 8th grade, which is very rare for Roma. They usually complete the 5th grade, and then they get married and get pregnant. Another pregnant Roma girl came in today and she is not even 14 years old...”

Roma pregnancy is a complex question that involves not only the parents-to-be but also the larger family network, and includes the issue of child support as a valuable source of family income. The same medical doctor continued:

"I believe that the social service strategy in Croatia is partly to blame for Roma teenage pregnancies. There was a case involving a 15 year old pregnant Roma girl with a dead embryo inside her uterus. Gynaecologists treating were faced with her family who complained that as there was no longer a baby, they would not get any money for that child. They said that they need the social benefits to be able to live. My impression is that women are under a lot of pressure to have children. A woman who was discharged today already has 8 children; she just had her ninth."

The health of Roma children is a complex issue as well. In Croatia, according to the experience of a paediatrician from Međimurje County, poor nutrition, or malnutrition, is one of the leading problems related to Roma child health.

"The birth weights of Roma children are nearly the same as compared to the rest of the population. It used to be that the average weight at birth of Roma children was inferior to that of the rest of the population but this is no longer the case. The main problem stems from complementary feeding starting at 6 months of age. Very few receive adequate complementary feeding. We compared the growth of Roma 5-year-olds to the rest of the population according to the 2007 standards published by the World Health Organization's (WHO). The growth curve of Roma children shows that they are lagging behind in growth compared with other children, and this is very much linked to inadequate complementary feeding after 6 months of age."

Another important problem affecting Roma child health and that usually occurs after 12 months of age is linked to the increased rate of parasitosis in children. Infections with parasites also contribute to the malnourishment and underweight of children because the presence of parasites in otherwise health digestive tracts leads to the malabsorption of food. Furthermore, unhealthy habits such as smoking during pregnancy and lactation cause frequent respiratory infections among Roma children, as explained by a paediatrician from Međimurje:

"Sometimes in the ward we have up to 15 Roma toddlers. They smoke through their mother's milk and they live in an environment where everybody smokes. Even their clothes smell of nicotine. Given this, it is unfortunately normal that even the smallest viral infection of their respiratory system leads to bronchial obstruction, and that children have to be kept in the ward with oxygen masks on."

However, there are also elements in Roma culture that have a positive effect on health and could serve as a model for the rest of the population. One doctor said: *"I take the time to pay them compliments. I tell them 'look how clean and healthy your child is, that is so great'. They expect this and appreciate it."* It is important to acknowledge and encourage positive health behaviour that is found in the Roma culture, as explained by a medical doctor interviewed for this situation report: *"When it comes to breastfeeding, we never have a problem with Roma women. They live in a community in the village, and they see moms and neighbours breastfeeding. They should receive help and support."*, and *"Roma women are perfect breast-feeders. I always use them as an example during consultations with pregnant women. Roma*

women breast-feed their children until the age of 2, 3 or 4, as needed and as long as children remain interested.” Another doctor from Međimurje, with 27 years of paediatric experience, described an important quality of Roma parents: *“You do not have to teach Roma about personal attachment. They demonstrate it and one can spot it immediately. Roma parents know what to do with their ill children when they come to the hospital – they are attentive and stay close to them. Other parents act in a very different manner – they bring their laptops because they have to do some work. These differences are very obvious.”* These good practices need to be further encouraged to improve Roma health.

The fifth objective of the NRIS health component is to increase the sensibility of health-care professionals with respect to working with the Roma population, and improve the Roma population’s communication with family physicians. No information is available on how and whether this objective is achieved at the municipal and county level. There is no data on the number of education sessions for health workers and on if and how health workers are encouraged to cooperate with social services, especially in cases where there is possible abuse and neglect of children's health. There is no data on how Roma are encouraged to choose their general practitioner, the health status of Roma who have chosen their general practitioner from within the Roma community, and how Roma exercise their right to primary health care through mediators and visiting health services.

The sixth objective of the NRIS health component is to reduce the incidence of diseases caused by poor sanitary standards and vaccine preventable diseases. Out of all NRIS objectives this one was most successfully fulfilled by the MoH.

Based on reports by local institutes of public health, some information is currently available regarding vaccination and DDD. In Međimurje County, a total of 17 immunisation sessions have been carried out targeting Roma children identified through active search for under immunised children in four Roma settlements. Children were invited to paediatricians’ offices for immunisation and those who did not respond to invitations were immunised in the Roma settlements by mobile teams from the County Institute of Public Health. 220 Roma children were immunised through the targeted mop-up immunisation campaigns. Based on information collected, the vaccination coverage among Roma children in Međimurje County is estimated by the County Institute of Public Health as follows:

- DTP + POLIO primary vaccination: 90 per cent;
- DTP I. Booster dose: 85 per cent;
- DTP II. Booster dose: 85 per cent;
- MPR primary vaccination: 90 per cent;
- Hepatitis B primary vaccination: 90 per cent.

Some Roma children of pre-school age, who were not vaccinated regularly due to the non-response of parents, were vaccinated in accordance with the current compulsory vaccination programme. Health professionals in schools do not officially keep separate records on the vaccination of Roma children, but every child who has not been vaccinated at school is summoned. Thus, in 2013, nearly 100 per cent of vaccination coverage was achieved in Međimurje:

- Td vaccination 1st grade: 98.79 per cent;
- Td vaccination 1st grade: 98.93 per cent;

- Td vaccination final classes: 97.19 per cent;
- Poliomyelitis 1st grade: 98.7 per cent;
- Poliomyelitis 8th grade: 99.01 per cent;
- MPR: 99.48 per cent;
- TB vaccine: 99.49 per cent;
- Hepatitis B: 98.33 per cent.

In Primorje-Gorski Kotar County (including Rijeka city), an assessment of the immunisation coverage of Roma children was carried out in 2013 by the County Institute of Public Health. According to the assessment, 69.3 per cent children were fully immunised, in accordance with the national childhood immunisation schedule, 20 per cent children were partially immunised, 3 per cent children were not immunised at all, and the immunisation status of 7.7 per cent of children was unknown. Based on available information regarding children without access to health care in Primorje-Gorski Kotar County, the MoH allocated 109,000 HRK to the County Institute of Public Health towards the vaccination of children and DDD activities.

County institutes of public health are responsible for carrying out primary health-care activities that are not fulfilled within their territory. These activities are carried out directly in Roma settlements, and usually include vaccination campaigns targeting Roma children not vaccinated through the paediatric health-care system and DDD preventive activities. In Primorje-Gorski Kotar County, in 2013, DDD activities were implemented during three seasons in all Roma settlements with inadequate sanitary, hygienic and communal living conditions and included expert epidemiology supervision. Based on previous surveys, DDD activities conducted during the summer included fumigation to combat mosquitoes.

In Bjelovar-Bilogora County, an assessment of the immunisation coverage of Roma children was carried out in 2013 in 17 locations by the County Institute of Public Health. According to the assessment 79 per cent (478/602) of Roma children were fully immunised, in accordance with the national childhood immunisation schedule, 13 per cent of children were partially immunised, and 8 per cent of children were not immunised. Roma children attending school had higher immunisation rates compared to preschool children and school-aged children not attending school. In Bjelovar-Bilogora County, an assessment was conducted separately for children coming from migrant Roma families, who do not have a permanent residence in the county. Within these migrating communities, the immunisation coverage is substantially lower than among resident Roma children. The assessment showed that only 19 per cent of migrant Roma children were fully immunised, 29 per cent were partially immunised and 52 per cent were not immunised. Many were not accessible for the assessment. The mobile epidemiological teams visited Roma migrant settlements and managed to immunise a few children and provided individual counselling on immunisation to parents.

Along with increasing the immunisation coverage of Roma children, additional health-care interventions have been implemented to improve the health status of Roma children. In the context of a few school-based outbreaks of head lice, instructions for and treatment were distributed to the affected families. During an outbreak of scabies, instructions for and treatment were also distributed.

Furthermore, epidemiological investigations and chemoprophylaxis for exposed contacts have been performed following the occurrence of single cases of pertussis and pulmonary tuberculosis.

The seventh objective of the NRIS health component is to reduce the widespread consumption of all addictive substances among the Roma population, with an emphasis on children and adolescents, and to raise awareness of the harmful effects of addictive substances. No data is available on the extent of narcotic drug abuse among Roma, on the number of Roma included in national campaigns aimed at raising awareness of the harmful effects of narcotic drug abuse and the harmful social and health effects of addiction, or on CSO projects dealing with the prevention of addiction. National campaigns aimed at raising awareness of the harmful effects of narcotic drug abuse and the harmful social and health effects of addiction are routinely carried out through regular public health programmes for the general population, but data on Roma participation is unknown.

5. CASE STUDY: ROMA HEALTH MEDIATION PROGRAMME

5.1. The Roma health mediation programme initiative

The MoH recognizes that health mediators can be a valuable link between the Croatian health system and the Roma population and is therefore committed to launching the Roma health mediator programme and developing it gradually until 2020. According to the Action Plan for the Implementation of the National Roma Inclusion Strategy for the period 2013–2015 (AP), the MoH is responsible for developing and implementing an education programme for health mediators by the end of 2015, and for keeping track of the number of education sessions implemented and the number of mediators who complete the programme. Additional education for health mediators is also planned for and their work plans and written reports are listed as data sources and collection methods, without the specification of a precise deadline, however (AP, specific objective 2, measure 3.2.2). In the AP, Roma health mediators are also mentioned in relation to the organization of specialist medical examinations for Roma women and transport for such purposes (AP, specific objective 4, and measure 3.4.3). Reports submitted by the mediators are listed as data sources related to the implementation of education activities for health-care providers working with the Roma population (AP, specific objective 5, measure 3.5.1), as well as for the purpose of analysing the status of persons who have chosen their general practitioner (GP) within the Roma community (AP, specific objective 5, measure 3.5.2). Mediators will also be responsible for encouraging Roma to choose their GP and exercise their right to primary health care (AP, specific objective 5, measure 3.5.3), for helping to increase vaccination coverage of Roma children (AP, specific objective 6, measure 3.6.2), and for the implementation of education activities on good hygiene habits (AP, specific objective 6, measure 3.6.4).

Experts in the MoH explained that initially it is planned to start with a pilot project in one or a few Roma settlements, to analyse the effectiveness of the approach, and, if found to be successful, to expand the project to all counties with Roma settlements. Officials from the MoH have attended various regional meetings on the topic and will apply experiences and good practices with health mediators from neighbouring Serbia.¹⁶ The MoH considers that the health mediator should be an individual who lives in a Roma settlement and is familiar with the local communities and culture. Education qualifications for health mediators have not been decided on yet, but it is very likely that secondary education will be required. According to the Croatian Employment Service (CES), temporary employment through public works¹⁷ is the only current means available for funding the work of health mediators.

During the pilot period, Roma health mediators will be responsible for collecting health related data in Roma settlements, preferably in those with or in proximity to primary health-care

¹⁶ Serbia launched a Roma health mediator programme and has already promoted 75 women. These are women who have children, come from Roma settlements and do not have a formal education.

¹⁷ The public works programme is the most frequently used means by CES for hiring Roma. However, the programme provides only a temporary contract and a low wage (depending on local taxes, approximately net 280 EUR/month), usually for 6 months out of one year or a maximum of 18 months out of three years. If there are several applicants for the job, priority is given to the person that has not yet been employed through public works. Exceptions to the general rule are contracts for teachers' assistants for Roma pupils that last 10 months, or the duration of a school year.

centres. Health mediators will communicate and work closely with visiting nurses, and will use the information technology infrastructure of primary health-care centres to input data collected in the settlements. However, at the time of the writing of this report, neither the MoH nor Roma CSOs had a list of all Roma settlements with an approximate number of households in each that should serve as the baseline for the collection of health-related data by health mediators.¹⁸

A detailed description of the health mediation programme has not been developed yet. However, linking the work of visiting nurses and Roma health mediators is seen as a strategy that will benefit the Croatian health-care system, at least according to some officials. Currently, there are contradictory opinions among health-care officials as to whether visiting nurses, in order to perform their work in Roma settlements, should work closely with health mediators or not. Some health officials claim that the presence and support of a health mediator would be beneficial during the initial period, until a visiting nurse is accepted by the community. Roma CSO leaders gave examples of positive experiences by visiting nurses in Roma settlements and their care for newborn children and mothers, but also cases in which local “sheriffs/sharks” in Roma communities sabotage the activities of the nurses if not conducted through them.

The health mediation pilot project and the collection of reliable Roma health data are both positive steps towards understanding and improving Roma health. However, at this point, there are no adequate initiatives to ensure the financial sustainability of the Roma health mediation programme and to improve the communication between Roma patients and health-care providers.

5.2. The first case of a Roma health mediator in Croatia – a local initiative

Although the pilot project on Roma health mediation has not been launched by the MoH yet, there is at least one example of good practice involving a Roma health mediator employed temporarily through the CES public works programme in 2013 at the paediatric ward of the County Hospital in Čakovec. This young Roma woman was trained by the health practitioners employed at the ward on the basic functioning of the ward and on working with paediatric patients. Her role was to assist and comfort Roma paediatric patients, and to explain to them and their parents, in mother tongue, information regarding their condition and required medical procedures. The initiative to employ the health mediator through the public works programme came from the director of the paediatric ward (for details on how the public works programme functions, please see footnote 13). The appointment of the health mediator was approved twice (each time for a period of six months) and declined the third time, in line with CES regulatory procedures regarding entitlement to the public works programme. The director of the ward described the experience of working with the health mediator as follows:

¹⁸ With funding from the Open Society Foundations, UNDP prepared and published the Međimurje County Atlas of Roma Settlements. Atlas is designed as an interactive database that contains detailed social and economic data on all 12 Roma settlements in the county. Atlas is published on the websites of Međimurje County, the city of Čakovec, the GOHRRNM and UNDP Croatia. This is an example of a good practice that supports meeting the objectives of the NRIS and the AP.

“First of all, she was very neat and a role model. We trained her on how to behave in the ward, especially regarding the transmission of infections, and on her duties. Naturally, some Roma children do not speak Croatian. She also worked as a translator and explained to child patients what type of medical procedures they needed to undergo. These days the hospitalisation of children is demanding and children have the right to be informed – she explained the medical procedures to the children and their parents, participated in the care for the children, communicated with the parents. She was a real mediator between the Roma population and us (the ward staff). This experience was so precious. She completed elementary school, but it would have been good if she had secondary school education as well. I asked for her contract to be extended. I called Zagreb and our local employment service. They told me that the extension cannot be approved for a third time and that I should send a formal request, which I did, immediately.

We are introducing new methods for humanising hospital child care, playing games with children and the creativity of children is so important, and she was so good at this, but the funding for her position is still not guaranteed.

Indeed we need to define certain parameters for choosing such a person, including education requirements, and we do not want a new person every 6 months. We could really use the services of a health mediator and this one was really good. She would comfort the children when their parents were not there; she would talk to them and play with them. She filled that space that non-Roma health-care staff cannot, in a way that is familiar to Roma children. Children and parents benefited so much from her presence. She would explain things very patiently, especially if a child was aggressive. She fit in very well.”

The case of education mediators for Roma pupils in elementary schools

Another good practice regarding mediation comes from a project implemented in the education system, specifically the use of education mediators for Roma pupils in elementary schools. This project commenced in 2002 when the first 26 mediators were recruited and their positions were financed by the Ministry of Science, Education and Sports (MoSES). At the beginning of the project, the education and training requirements for mediators were not defined. The project was not well received by certain teachers because some of the recruited mediators had insufficient education (e.g. some mediators had only three years of vocational training not related to education, making them unfit to perform their duties in the classroom). Nowadays, successful completion of secondary school is a requirement and a training curriculum has been developed. An additional 46 education mediators were recruited in recent years. These mediators are employed through temporary contracts with local authorities (counties or municipalities). Some have been trained to become education mediators and some have not been trained. The majority of education mediators are employed through the CES public works programme for a period of 10 months which corresponds to the duration of one academic year.

By combining information on the number and work of education mediators with evidence of enrolment and achievement of Roma pupils, it is possible to assess the impact of the education mediators' programme for Roma pupils. In the MoSES there are two differing opinions regarding the programme. On one hand, some officials refer to positive trends as

regards the total number of Roma pupils enrolling in primary school on a yearly basis, as well as a greater interest towards secondary education, particularly for vocational schools offering programmes for professions in trade (although the problem of a high student dropout rate remains). On the other hand, some education experts are of the opinion that the education system itself should have the appropriate level of sensibility and ability to adapt to the needs of working with vulnerable groups, including the Roma minority.

A CSO representative with experience in implementing education and health programmes for various vulnerable groups, including Roma, spoke about the positive impact of the school mediators' programme:

“We had some projects in Međimurje county. Back in 2004–2005 one of the main issues was hygiene. Roma classroom mediators were introduced and they were the only link between the school and the Roma community. They were persons of trust for the Roma community. They could communicate to the school information about what's going on, especially within the family context and so on. That model seemed great to me. There was a school with lots of problems, where Roma children were bathed when they entered the school. There was a separate entrance for Roma children and Roma children were called Gypsies. I remember this one project we worked on that was about health education. We organized workshops for Roma parents and when they came to the school to attend the workshops, we realised that for some of them it was their first time entering the school. Then we were faced with the problems of illiteracy, poor knowledge of Croatian, lack of understanding of their role as parents of children going to school and so on, and I was very alarmed.”

I know that many have had to face this problem. What I found out later, a few years ago, was that the school decided to implement a new approach and decided to teach their teachers Romani. They also went to the Roma community and they spent time with them, which was also a little bit difficult because it was a closed community. It's amazing how much this approach increased the number of Roma children attending the school, improved parental involvement and so on. In general, I think that the work with Roma classroom mediators is something great.”

Alongside the positive aspects of the programme, there are various problems related to the unequal education levels of school mediators, the unresolved long-term financing of the programme and the inadequate working conditions of mediators and Roma CSO volunteers, who are sometimes forced to use their homes for work. One Roma CSO leader highlighted some of these problems:

“We have an excellent example of an unsuccessful classroom mediators' project, where they (author's note: MoSES) identified people, appointed them and secured some funding... Later MoSES introduced minimum education requirements for mediators, and now we might not have the space for the new and educated mediators. The problem is that if you lose qualified people because of the low salary and the issue of the 6 month contracts, than your alternative is to choose anyone, regardless of their qualifications.”

You have to provide people with general and specific skills, and sometimes you have to teach them how to use computers. The majority of Roma CSO volunteers do not have these skills at the start. Have you seen the living conditions where some of the mediators live? We have visited the houses of some mediators and their situation is very dire. It is not their fault; unfortunately these are realities in Roma settlements. But if a person is to be a mediator, he or she has to live in that community.”

5.3. CSO and community feedback recommendations

The education mediation programme and the socioeconomic realities in Roma communities, have to be considered if the Roma health mediation initiative is to be successful and sustainable. Roma CSO leaders feel that the MoH is under pressure to launch Roma health mediation because of the general consensus that little progress has been made in the health sector:

“It seems to me that this project is a result of pressure because they (Ministry of Health) realised that they are doing nothing and that at some point they have to do something. And so then, I do not know how, but they came up with that story about health mediators...”

Furthermore, Roma CSO leaders insist that the Roma health mediation programme should be truly useful to its beneficiaries:

“It could mean that we will have a situation so that someone might be called a ‘mediator,’ that someone will maybe speak Romani and will be capable of taking three women to see a doctor, telling them to vaccinate their children and similar things. This would not have an impact any more significant than that of local translator or of a transporter of people from point A to point B – that would be the extent of such mediation...”

Roma CSO leaders suggest additional options for meeting the health-related goals of the NRIS and its Action Plan:

“My personal opinion is that we have to have an educated Roma coordinator. At the State level, therefore in the Ministry of Health, and/or in the local and regional self-government units. We have to have at least one Roma! That person would be a link between the Roma communities and institutions. Without at least one such professional in the country, we will not be able to make any improvements to Roma health. It is 100 per cent that everything else is just superficial and putting out fires...”

Roma CSO leaders are aware of the limitations of the Roma community in Croatia related to the low number of Roma activists and educated people in Roma communities, and the even lower number of those willing to specialise in health mediation. However, there is a group of young people with formal health education, such as in nursing and radiology. Some young educated Roma were supported and followed by Roma CSOs throughout their education, from

elementary school to secondary school and higher education. One young Roma health professional stated:

“I prefer that health mediators are Roma health workers, I understand that there are not so many of us, but I made a list of us who graduated from health vocational schools, and there are ten of us who went to Međimurje, Rijeka, and Slavonia. Later, I graduated from the University of Applied Medical Studies along with another friend, and a girl also recently enrolled there.”

Some of these young and educated Roma people are no longer close to their communities. One of them explained:

“I did not like that place (his home village). Later I realised that I should not be hiding from my people, and that I should help as much as I can instead.”

If young and educated Roma are encouraged to find a way back to their communities and to (re)establish trustful relationships with people, they would need long-term support through sustainable programmes. Therefore, Roma leaders recommend that a full-time health education professional of Roma ethnicity be hired as the main health coordinator at the MoH and a few at the institutes of health in counties with the highest population density of Roma.

Another problem related to the limited involvement of young and educated Roma in governmental initiatives (as is also the case with the majority of young, educated, and unemployed people in Croatia) is temporary or permanent emigration because of the problems with unemployment in the country. One of the interviewed municipal officers from a county with a significant Roma population described her experience:

“This morning a Roma nurse visited me at the office. She really wants something more out of her life. She finished nursing school and passed the State licence exam. Actually, in our municipality, we have two Roma nurses and both are now attending the University for Medical Studies and are looking for jobs. The county hospital is not allowed to employ anybody at the moment. Now, both of them want to immigrate to Germany and work there.”

The availability of full-time employment for young and educated Roma people would be helpful for the continuous and professional improvement of Roma health and for the successful implementation of the Roma health mediator programme. This would also send a strong signal to the Roma community that efforts in education pay off with employment and better living standards, claims one of the interviewed Roma CSO activists:

“They (Ministry of Health) should make it public knowledge how many Roma are employed in the Croatian health-care system. If there aren’t any Roma employed, let’s open two positions. That would be the right message. If that Roma boy with the university degree in medical radiology cannot find a job who will be motivated to go to school? Actually, one nurse got a job, and that virtually made the entire Roma community more optimistic.”

The perspective of the employed Roma nurse confirms a positive effect in the community when young educated Roma find jobs:

“I am some kind of a role model now – everybody wants to go to a vocational school for nurses. My sister also plans to enrol in the University for Applied Medical Studies.”

However, the capacity of educated Roma to ensure the success of health mediation will not be fully utilised if adequate and long-term financing is not secured. One of the activists employed at a Roma CSO describes her experience from one of the meetings in which the concept of health mediation was discussed:

“I went there with one Roma radiologist and one Roma nurse. They told me, 'oh, this is so great, we wish we could do it; that would be so good.' They would love to work with their Roma people. At the end of the meeting, one of them told me, 'but, I have a better salary'.”

The interconnectedness and interdependence between various life domains, in this case education, employment, and Roma health, is summarised by a school teacher with experience in working with Roma pupils and on various projects involving Roma:

“Let's say we are working on education through various projects. This means little to Roma because in their value system education has little or no value. We have two Roma women in Međimurje who completed college but this does not mean much since they cannot find work. And then you actually have a counter-effect. That is, all those who worked hard, those who made sacrifices for their children, those who invested in their education and struggled, finished some sort of schooling, are now without employment and depend on social welfare – just the same as those people who stayed home and did nothing. What kind of a message is that to younger generations, when the link between education and better life is missing in this society?”

6. CONCLUSION AND RECOMMENDATIONS

In the last ten years, issues and challenges concerning the Roma population have come to the attention of civil society and political actors, and public bodies. In some areas of Roma social life, namely education, there has been a visible improvement. Still, other spheres lag behind. Roma health, in particular, seems to improve much slower, with many challenges and issues that still need to be addressed. Therefore, based on the literature review and empirical findings of this study, some problems regarding the implementation of measures within the national policy framework on Roma integration as regards health seem to have a considerable merit and should be tackled. Below are recommendations on how these problems should be addressed and resolved.

Recommendation 1: Improve coordination within the public administration regarding Roma health issues. Various stakeholders have stressed the low level of coordination between respective stakeholders interested in and responsible for Roma health.

Recommendation 2: Strengthen stakeholders' active participation in securing EU funding. Partial analysis of EU funding utilization presented above clearly implies an insufficient usage of those resources. From 2007 to 2013, none of the IPA financial opportunities were used for Roma health projects. This denotes the need to strengthen the respective stakeholders' (especially Roma CSO and local administration) ability to write project proposals to receive funding for improving Roma health. This is of significant importance for all of the challenges in implementing the health aspects of the NRIS and AP.

Recommendation 3: Systematic gathering of ethnically disaggregated health data. Literature review, findings based on interviews conducted, and various policy documents all stress the need to collect ethnically disaggregated health data in a systematic manner. Although the topic of systematic data gathering is a complex one, we conclude that the problem should be approached in a twofold manner. On the one hand, the regulatory framework needs to be reassessed in order to enable medical workers and professionals to gather data concerning Roma health. On the other hand, investigators (from epidemiology to social scientists engaged in health research) must conduct more research, with quantitative, qualitative, and mixed methodology designs, thus enabling scientific analysis regarding the health of the Roma population. Data collected would consequently allow for meta-analytical and longitudinal analyses and synthesis of findings, thus enabling evidence-based policy re-evaluation.

Recommendation 4: Detailed and sustainable Roma health mediation programme. In launching this programme, the MoH needs also to account for the specifics of the Croatian health system, the capacity of Roma people to participate in health mediation programmes, as well as the lessons learned from the classroom mediators' participation in the education of Roma pupils. Specific recommendations for the Roma health mediation programme are:

Recommendation 4a: It is necessary **to create a database of Roma settlements** in all counties with Roma populations, preferably by following the example of Međimurje County ATLAS.

Recommendation 4b: **Needs assessment and social impact assessment** should be conducted before launching the Roma health mediation programme. Needs assessment is necessary to appraise what is required from the Roma health mediator programme to alleviate specific health problems in various Roma settlements in different counties. It is important to determine the health needs of communities and to avoid focusing on the general health needs of the entire Croatian Roma population. Social impact assessment is necessary to determine the potential benefits of the Roma health mediation programme for various groups of beneficiaries in different communities.

Recommendation 4c: **Full-time employment of educated Roma in health and health care as State and county coordinators** will help reach the NRIS objective of improving Roma health, and could additionally help in the development, implementation, and sustainability of the Roma health mediation programme.

Recommendation 4d: The phase of direct action and intervention in the Roma health mediation programme should consist of the **development of a concrete plan**, including timetable and a list of Roma settlements with approximate number of households to be included in the programme, the adoption of a budget, and a list of potential candidates for health mediation training.

Recommendation 4e: **Detailed description of health mediation duties** should be developed. In line with the duties description, the minimum prerequisite education level of health mediators should be specified, as well as their training curriculum and expected competences.

Recommendation 4f: **The system of supervision and support should be provided to health mediators** as well as possibilities for their continuing education.

Recommendation 4g: Unstable funding is an obstacle to the long term success of the Roma health mediation programme in Croatia. Therefore, temporary employment could be used for the pilot project and the initial phase only and **long-term financing and full-time employment of health mediators** should be secured.

Recommendation 4h: **A formal assessment of the various phases of the health mediation programme** should be carried out to determine the extent to which the programme is able to bring about real change and to improve the overall health of Roma.

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