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REPUBLIC OF SLOVENIA
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Public health approaches for the Roma ethnic community in Slovenia

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Content

Foreword

The Roma community is the largest minority in Europe. The Roma issue is a significant challenge both for the European Union and for the Member States. In 2011 the European Commission published the EU Framework for National Roma Integration Strategies up to 2020, thereby underpinning the efforts of Member States to improve the lives of Roma inhabitants. It highlighted four areas in which Member States must improve the integration of Roma, specifically education, employment, healthcare and housing policy. All countries committed to designing a common policy for these four areas.

In 2017 the Slovenian Government adopted the National Programme of Measures for Roma 2017-2021, which aims to improve the status of Roma and their social inclusion. The Programme envisages measures that extend into various sectors of life in society, with special emphasis on improving their health protection.
In Slovenia, which according to the estimates of various institutions (social work centres, administrative units, NGOs) is home to something between 7,000 and 12,000 Roma, public health experts have since 2014 been continuously focused on reducing the health inequality in the Roma community.

In the document "Strategy of boosting health and reducing health inequality in Pomurje", the authors recognised for the first time the Roma ethnic community as vulnerable, deprived in multifaceted ways and exposed to the powerful influence of socio-economic determinants on health.

A major turning point in monitoring the health of Roma in Slovenia is the first epidemiological survey of health indicators using national databases. The results presented in the present publication point to the great difference in the observed indicators between the Roma and majority population, and the notably shorter average life expectancy of the Roma population.

The issue of inequality in health far exceeds the sectoral frameworks and demands constant cooperation and connection. For this reason, I am glad that in its efforts to secure improvements in this area, the NIJZ is cooperating closely with the Ministry of Health, the Slovenian Government Office for National Minorities and representative members of the Roma community. The Roma community is an important part of our society, so we will continue to make efforts towards reducing inequality and thereby improving their status.

Nina Pirnat
Director, National Institute of Public Health

Abstract

The purpose of the present publication is to explain the causes for the health status of Roma people based on the available evidence, to present health indicators, to present selected cases of activities intended to improve the health of Roma people that have been implemented since 2016, and to make recommendations for improving the health status of Roma people.

The causes for the poor health of Roma people must be sought among the socio--economic factors, which influence health. Their interconnection and their common influence on the health of both the Roma and non-Roma population indicates the need for coordinated action by all sectors of society and particularly of all the stakeholders at the level of local communities, which is called the community approach. Data from cross-sectional surveys carried out at the regional (2005/2006) and on the national (2008) levels, including observations on the ground in Roma settlements have indicated the poor health of members of Roma community as compared to the majority population. Based on the data obtained, a range of measures was planned and implemented; these focused on various age, gender and geographical groups within the Roma ethnic community.

For the first time, the national survey from 2017/2018 obtained data on selected health indicators from national statistical databases for the residents of Roma settlements. Data on the health of Roma people in Slovenia obtained from this research have shown that the health status of Roma people falls below the average.

The Ministry of Health has been endeavouring for several years to systematically improve the health of Roma people, either by providing dedicated financial resources for activities or projects, or through cooperation and drafting of legislative documents and policies directed at eliminating health inequalities between Roma people and the majority population.

The present publication seeks to emphasise activities that have been successfully implemented recently, or in the period 2016-2018, with the objective of improving the health of the Roma population. Some activities are implemented in close cooperation with other sectors, and deserve special mention here. We believe that this is the right way to make essential changes.

The conclusions of this publication stem from qualitatively and quantitatively evaluated research results, observations and experience of working with Roma people in their environment. The recommendations also include the opinions of Roma organisations, representatives of the Roma community, health-care professionals and representatives of local communities.

Roma Community in the Republic of Slovenia

Jožek Horvat Muc

Association of Roma of Slovenia

INTRODUCTION

The members of the Roma community in Slovenia are proud of the fact that since 2004, our country Slovenia has been a full Member State of the European Union, which expressly includes the issue of minority rights in the conditions that by all Member States have to meet. Ultimately, we opted for a united Europe so that we will live better and in a democracy, and so that concern for human and minority rights will grow in all European countries.

In Slovenia, we of the Roma community realised the urgent need to improve our situation back in 1990, when as part of the Romani Union Murska Sobota we demanded that the Slovenian Constitution guarantee the protection of the Roma community.

We recognise that in recent years the Slovenian state has contributed much to improving the status of Roma. This applies in particular to legal protection of the Roma community, political participation of Roma in municipal councils and the organisation of the Roma community in Slovenia. In this way, for a number of years now 14 sectoral laws have ensured special rights to members of the Roma community (ranging from education to cultural heritage, information and political participation in local communities). National Assembly fulfilled the requirement of Article 65 of the Slovenian Constitution in 2007 and adopted an umbrella act concerning the Roma community in Slovenia. This means we belong to those few countries in the world with a high level of legal protection for the Roma community.

CONSTITUTIONAL AND LEGAL STATUS OF THE ROMA COMMUNITY

The first efforts to settle the legal status of Roma in Slovenia date back to 1989, when Constitutional amendments secured a provision that the legal status of Roma should be settled by law. The Roma community in Slovenia has no status of a national minority, but is an ethnic community or minority that has particular ethnic characteristics (our own language, culture and other ethnic features). The legal basis for settling the status of the (autochthonous) Roma community, which has inhabited Slovenia ever since the 15th century, lies in Article 65 of the Slovenian Constitution, which discusses the status and special rights of the Roma community as follows: "The status and special rights of the Roma community that lives in Slovenia shall be settled by law." Implementation of this article is being pursued principally in sectoral legislation. Protection of the Roma community is enshrined in the umbrella Roma Community in the Republic of Slovenia Act from 2007, and in 16 sectoral acts. In contrast to the Italians and Hungarians, the Constitution has modest provisions concerning the Roma, stating in Article 65 merely that the status and special rights of the Roma community living in Slovenia should be settled by law. There are no other substantive provisions. The provision of Article 65 of the Constitution includes authorisation for the legislator to provide the Roma community in Slovenia, as a special ethnic community, special rights in addition to the general rights pertaining to everyone. Slovenia is one of the

rare European countries that includes Roma in the management of public affairs on the local level. In addition to the general voting rights in the 20 municipalities where they live (territory of autochthonous Roma settlement) traditionally and historically, in local elections the members of the traditionally settled Roma community have a special voting right that enables them to elect a Roma councillor from special Roma lists (Local Self-Government Act). The other, non-traditionally settled Roma have the status of minority ethnic groups that have settled in Slovenia especially after the collapse of Yugoslavia. Their status is equal to that of members of the peoples and nationalities of the former Yugoslavia. Under the Slovenian Constitution these groups enjoy only certain special individual rights, which enable them in various ways to maintain their national, linguistic and cultural characteristics.

According to the estimates of various institutions (social work centres, administrative units, NGOs), Slovenia is home to around 10,000 Roma (and possibly up to 12,000). There are dense Roma communities in the regions of Prekmurje, Dolenjska, Bela Krajina and Posavje and in larger towns and cities such as Maribor, Velenje, Ljubljana, Jesenice and Radovljica (Jesenice and Radovljica are home mainly to families of Sinti).

NEEDS OF THE ROMA COMMUNITY

Based on the expressed needs of the Roma community and familiarity with the situation in the field, the priorities identified are living conditions, education, employment and healthcare, which require tangible short-term and long-term measures to improve the situation. In addition to priority areas, attention is focused on maintaining and developing various forms of Roma language, culture, information and publishing activities, including Roma in social and political life and raising awareness among the majority and minority population regarding the existence of discrimination and combating it, and awareness of the prejudices

LIVING CONDITIONS

Proper arrangement of Roma settlements is the most salient topic. Roma people, local communities, state institutions and NGOs are making efforts to improve the living conditions of the Roma community. There are plenty of barriers, many questions and no answers. Above all, no strategy has been created for better cooperation between the local community and the state. Political will and a financial basis could be one of the foundations for a more successful start to cooperation in this area.

Source:
http://www.vrtec-ms.si/enote-vrtca

HEALTH

Numerous factors affect the health of the individual: biology, individual lifestyles, social and societal circumstances, working and living conditions and general socio-economic, cultural and environmental circumstances. Taking into account that Roma are exposed to harmful influences (unemployment, poverty, social exclusion, discrimination, unhealthy lifestyles), their vulnerability to various illnesses is even greater.

Source:
www.vrtec-ms.si/enota/romano/novica/sodelovanje-s-krajevno-skupnostjo-pusca-301

In the area of health, Roma point out in particular the following needs:

- Creation of programmes to raise awareness of Roma in the area of health and healthcare.
- Creation of thematic programmes in the area of health for Roma.
- Conducting surveys on familiarity with diseases and other important factors and surveying Roma and health personnel on satisfaction in the area of offering health services.
- Offering vaccinations in Roma settlements.
- Programmes to assist homecare services in Roma settlements (employing young educated Roma in the health field).
- Creation of programmes to reduce dependence on smoking, alcohol, drugs, etc.

Plenty of programmes are already in place, and some have been implemented for several years via the Ministry of Health, the National Institute of Public Health, Romani Union Murska Sobota, the Association of Roma of Slovenia and health institutions.

Sources:

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Social determinants of health and vulnerability

dr. Olivera Stanojević - Jerković, dr. med., spec.
National Institute of Public Health

INTRODUCTION

Lifestyle and living and health conditions strongly affect people's health and life expectancy. Higher rates of morbidity and mortality more often occur "at the bottom of the social scale" The social gradient in health reflects material deprivation, lack of security and lack of social integration (1). The paradox of our time is that we have intensive development of all types of technologies and that we have acquired important new knowledge and at the same time, basic interaction within society has deteriorated. All of this influences the accessibility of basic conditions for health, and can cause inequalities in health. Therefore, it is no coincidence that these topics have been among the most important public health topics for several years (2).

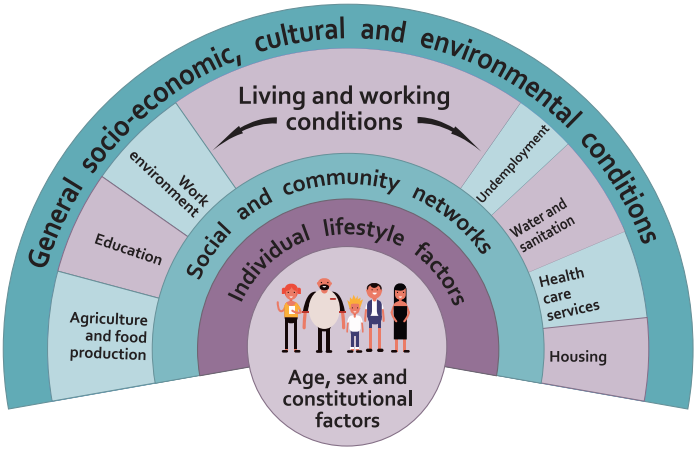

Figure 1

Model of health determinants by Göran Dahlgren and Margaret Whitehead from 1991

The unequal distribution of circumstances that compromise health is not a natural phenomenon or self-evident; it is a consequence of a combination of an unfair economic order on the one hand and of poor/inappropriate policies (including social policies) and a lack of programmes on the other. Together, structural factors and living conditions are social determinants of health and they are the reason for the greater extent of inequalities in health, both between countries and within them (Figure 1) (3). The term 'social determinants' is often associated with health aspects in a community (opportunities for walking, accessibility of recreational areas, accessibility of healthy food), which can influence healthy behaviour (4). However, social determinants include the circumstances in which people are born, in which they live, work and grow old, as well as the basic drivers of these circumstances: the distribution of power, income and resources. Only if fairness is placed at the centre of these policies when they are formed, will a shift occur in the reduction of health inequalities (5).

Therefore, primary prevention no longer suffices; we need prevention to be 'introduced' into the context of the social determinants of health. In practice, this means all sectors and policies of society.

If particular, individuals or groups in certain environments are systematically excluded from opportunities open to others, we speak of social exclusion. Regardless of whether this is connected to religion, race, caste, gender, age, incapacitation etc., social exclusion means a disadvantage for these particular individuals to improve the adverse conditions and a denial of rights that they otherwise hold. Social exclusion is often connected with poverty, poor living conditions, uncertainty and conflicts, which adversely affects health. Poor socio-economic conditions impose an extra burden on values and strengthen the belief of these groups of population that they are worth less, and this leads to a vicious circle. On the other hand, living in deprived (and rural) environments tends to make access to health care more difficult (either in terms of geography or because of unregulated social status and/or because of the lack of health insurance - e.g. migrants/refugees) (6).

People find themselves in unequal positions when their equality is either negated or questioned by other people, or when they find themselves in structural and institutional circumstances, that push them into an unequal position. Such structures are usually the result of long-lasting behaviours and processes that created inequality, and through time they become so strong that they seem almost natural (e.g. gender inequality). Roughly speaking, one could differentiate between the legal, political, social, and cultural dimensions of inequality, even though sometimes they are interrelated and cannot be separated. Fieldwork has shown that sources of inequality are not only interrelated and complementary, but that they also stem from inequalities in different domains at the same time. Gender inequality for example can simultaneously stem from economic regulation, political order, family arrangement and ethnic and cultural order (7).

DEFINITION OF VULNERABILITY

An unequal position in society means the deprivation of individuals and/or groups. This when we they are deemed vulnerable. Webster's dictionary indicates the following under the term 'vulnerability': "capable of being physically or emotionally wounded" and "open to attack or damage". An individual's vulnerability is often treated similarly to need, risk, susceptibility to harm or neglect, and lack of capability or durability (8). Vulnerable individuals mostly comprise children, incapacitated persons and other persons with special needs, as well as refugees/migrants (6).

Individuals and groups whose health is particularly at risk because of their living conditions or lifestyle are often the so-called grey population, which is practically not reached by existing health and social services. This includes primarily drug users (both

young experimenters and injecting drug users), prisoners, victims of violence and victims of trafficking, including sex workers, refugees, migrants and Roma people. The word vulnerability highlights the fundamental characteristic of all the above--mentioned groups and, therefore, the need for special concern and responsibility on the part of society for the whole community as well as individuals. One of the established methods enabling access and assistance to these groups is field work (2).

On the other hand, we can address vulnerable communities. Pearlin defines vulnerable communities as those sharing a stressful social disorganisation as a normative reality of life (8). Vulnerable groups of population are more susceptible to certain illnesses or conditions due to their personal characteristics, or due to their socio-economic living conditions, as well.

VULNERABILITY IN THE PAST AND NOW – WHAT HAVE STUDIES SHOWN

More than 30 years ago (1987), a special publication on the connection between poverty and health identified the following groups as vulnerable: the poor, the uninsured, the homeless, the elderly and weak, the chronically sick, and persons with special needs. This reflects the predominance of the importance of health care with regard to vulnerability, and it focuses mostly on health interventions for these persons. 8 Slovenian qualitative studies by Čebron et al. in 2014 and comparative studies in 2018 showed that employees of public institutions, health professionals, the non-governmental sector and users of health services mostly define the following groups as vulnerable: migrants, the elderly, the unemployed, precarious workers, the homeless, users of illicit drugs, persons with mental health problems, persons with special needs and Roma people. Geographical remoteness from health institutions, long waiting periods, financial barriers including co-payments for health services and a shortage of professional staff (especially in the field of mental health) are indicated as among the most frequent causes of vulnerability. The failure to adapt the health-care system to persons with different forms of disabilities are also described. Participants in the debate assessed the needs for training in the field of cultural competences, particularly because of the lack of information on the health rights of these persons and cultural and language barriers, because there is proven unequal treatment, discrimination and stigmatisation of vulnerable groups. One of the biggest barriers identified in both comparative years is access to health insurance (9).

CHARACTERISTICS, FACTORS AND TYPES OF VULNERABILITY

We now have enough scientific proof of the fact that vulnerability accumulates over the life cycle. Problems in early childhood are particularly significant for poor health results in adulthood. There is the possibility of a worse socio-economic status and a higher mortality rate due to cardiovascular diseases in adults who had a poor diet in the earliest period of life. Factors such as poverty, race, lack of social support, un-

certain connections/social networks (the most deprived are the oldest elderly), personal limitations, poorly settled or undeveloped rural areas and urban ghettos, are strongly related to vulnerability (8). Some authors distinguish the relative vulnerability of individuals (with regard to gender, age, ethnic/racial origin), in relationships (according to family structure, marital status and social networks) and in accessibility to resources available in the environment (schooling, employment, income and housing). Vulnerability can be temporary if it is caused by an acute illness, family breakdown, unemployment, environmental disasters etc., and if there are resources to overcome these problems. On the other hand, if an individual suffers a serious chronic illness, disability, and needs constant care, and the community is deprived through chronic unemployment, vulnerability becomes permanent (8).

Source:
https://www.dolenjskilist.si/2018/02/02/189935/novice/dolenjska/Predsednik_Pahor_bo_v_ponedeljek_obiskal_Brezje_Zabjak/

CHALLENGES IN THE FIELD OF VULNERABILITY

The social and economic circumstances in which people live strongly influence their health throughout their life. Welfare policy is supposed to provide for safety mechanisms to establish a balance between social classes and to mitigate deprivation, including health policy, which should be adjusted to decrease the negative influence of socio-economic health determinants (1).

It transpires that it takes much more than health care and lifestyle changes to reduce vulnerability, because it is necessary to take into account the *long-term determinants of vulnerabilities – 'upstream' factors*. Despite the development of new public health care because of changes in patterns of illnesses in the population in the last 30 years,

there are still political debates which focus on individuals more than the population, on treatment more than on prevention and on the need to change behaviour and lifestyle more than on changing the local environment in terms of structure, norms and incentives for such behaviour (8). Since behaviour is a reflection of a socio-economic situation, policies should be directed towards structural measures and reasons or determinants which cause inequalities, and not only towards individual behavioural patterns (10). Public attitudes to individual forms of vulnerability are important and can influence political decisions. There is evidently a lot more public concern for children, persons with disabilities and older people, compared to addicts, single women and ex-prisoners (presence of stigma) Anything related to a personal decision is thus 'under control' and therefore treated as a matter of personal responsibility. This is why the public shows no understanding or tolerance, as it does for those who are not responsible for their situation. However, *mass media* play an important *role* here (e.g. lung cancer used to be treated as a consequence of smokers' own irresponsibility, and nowadays, the accountability of the tobacco industry in the development of the disease in strongly underlined). The prioritisation of different vulnerabilities or their negation reflects (temporary) social values (8).

Source:
http://www.skupajzaznanje.si/vecnamenski-centri/

MEASURES TO REDUCE HEALTH INEQUALITIES BETWEEN SOCIAL CLASSES

In the field of social determinants of health, it is necessary to further expand the base of knowledge and evidence of health impacts (establishment of regular monitoring and supervision and provision of adequate resources for research). It is necessary

to continually train professionals, policy-makers and interest groups and to ensure better public awareness of the importance of the social determinants of health (3, 10). Present practice has taken t*hree approaches to reduce health inequalities* and to thus improve the health of vulnerable groups of population. A combination of all three approaches is the most effective (10):

- the population approach with universal policies in the field of education, employment and health and social protection which provides for equal access to *all* the population;
- *the reduction of gaps* between the socially and economically weakest and the most privileged group of population and/or the average (a policy to reduce social exclusion, social transfers, active employment policy ...);
- Targeted measures for *particularly vulnerable groups* of population (long-term unemployed, homeless, Roma people ...).

CONCLUSION

It will be possible to secure progress when the general society becomes aware that special attention for vulnerable persons benefits not only vulnerable persons; on the contrary, it improves the safety and quality of life of all the population of every society (8). A prerequisite for this includes shifts in the minds of every resident of the Republic of Slovenia to perceive the problems of vulnerable groups, which can only be possible with support and a unified policy and responsible and proper media reporting.

"Social injustice is killing people on a grand scale, and the reduction of health inequities, between and within countries, is an ethical imperative."
M. Marmot (11)

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The community approach to health - theoretical basis and effectiveness

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National Institute of Public Health

COMMUNITY AND THE COMMUNITY APPROACH

When discussing the community approach, it is necessary to first define the term 'community', as approaches which include raising awareness, empowerment and cooperation with the community cannot be used without a clear definition. These definitions vary according to the individuals who make them, their cultural environment, education and, within professional circles, their professional background.

In general, communities are defined in terms of geography, i.e. the area where they live. In the present case, we mean local communities. A local community is a form of community which is 'legally' established in a certain geographical area, and an authentic local community is established through time after a certain period of common activities of the people in that particular geographical area.1 Local communities are important particularly in the light of common interests, as they constitute a territorial community in which the communal needs of the population occur at the lowest level, and these needs can only be met jointly (1). Thus, we have communities arising from an association which is not based on 'free choice' and which mainly concerns the satisfaction of particular interests. These communities benefit from closer cooperation, which is related to increased connectedness between their members. In sociological terms, a local community is a social community formed because of long-term social processes in a particular geographical area (1). The term 'community' was clarified in a study in which individuals were asked what the word community meant to them. The term may also be understood as referring to "*a group of people with different characteristics who are connected through social links, who share common beliefs, and who cooperate with each other within a geographical location or institution*" (2).

In addition to local communities, special attention should also be paid to ethnic communities. The terms ethnic community, people and nation refer to groups of people which recognise their connection on the basis of certain common characteristics. They identify with each other on the basis of a shared cultural heritage (language, cultural creativity); they often share a religion, and they have common ancestors. This is where the importance of the interconnection between the members of an ethnic community stems from. In addition to the identification of a connection, an additional factor in the recognition and awareness of one's ethnic origin is the recognition of differences relative to the ethnic communities of 'Others', which greatly limits an ethnic community as 'Us' (3). In one way or another, a certain level of connection derives from all the defined forms of community; the more a community is connected, the more it can handle challenges and pursue the common interests of its members. An individual may be a member of one or several communities, and their perception depends on the individuals themselves.

A community as such is also an important determinant of health, as it relates to interrelations on the one hand, and influences the behaviour of individuals on the other.

Namely, this behaviour is a result of values, knowledge and an individual's attitude, and the social effects of the environment (4). In addition to the immediate social environment in which we are active, remote social environments can also influence us, i.e. indirectly, and our behaviour connected with health and health itself.

In public health and prevention, we often encounter socio-ecological models of prevention (5) (*Figure 2*). The basic unit is the individual, with their biological and social characteristics (gender, age, education, income). The second level is comprised of relationships within the closest social circles (friends, partners, family members) and which influence individuals' behaviour and contribute to their experience. The third level is comprised of the community, which connects the structures in which people have social relations (school, workplace, neighbourhoods). In terms of health and prevention, orientation targets the characteristics of community structures that influence health. The fourth level refers to a broader range of social factors which improve or exacerbate health (cultural norms, health and economic policies, policies to reduce health inequalities). If measures function on all four levels, health improvement and the impact on factors influencing the deterioration of health are more effective (5).

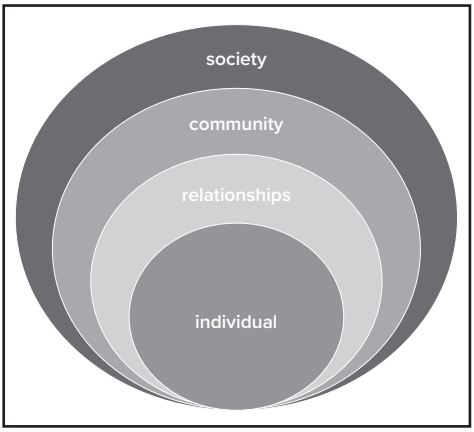

Figure 2
Socio-ecological model in terms of prevention (summarised from 5)

The inclusion of individuals in activities is defined by a number of classifications, which are graphically represented by means of a scale, whereby greater and more active inclusion ranks higher. The use of this image can give the false impression that a particular higher ranked level of co-operation is also better; however, the relevance of an individual level of inclusion should be understood within the context of time, appropriateness and interests (6). Although, admittedly, some of the more inclusive activities also proved more effective, which is illustrated later in this chapter. Figure 2 represents one such classification. By carrying out individual phases of activities/

interventions, one can move from one level of participation to another, and when several stakeholders are included, they can be on different levels (6).

Support		Offering support to others to achieve their goals through advice, support, grants.
Joint implementation	Significant participation	In addition to cooperation on decision making, there is also cooperation in implementation.
Co-determination		Motivation of others to propose additional ideas and options, and joint decision-making.
Consultation		Sending information and accepting responses.
Providing information		Sending information to people.

Table 1

Levels of participation according to Wilcox (6).

To a certain extent, it is possible to recognise elements of the model of participation shown in the table above in one model which more precisely deals with the community approach and health – figure 3 (7). The higher the level of participation, the greater the effects on health, which can be achieved in various ways. One of the ways is to improve services is through an *improved flow of information*, which contributes to a more precise recognition of obstacles and to the formation of more appropriate and more accessible services or interventions. Proper advocacy also contributes to this, with the support and promotion of the inclusion of the community. Through community inclusion, interrelations are also strengthened, and links between individuals are created, which contributes to improving *social capital*. The inclusion and empowerment of the community enables the community to change material, social and political circumstances, which may result in an improvement in health and a reduction of inequalities at the level of the individual, the community or society (7).

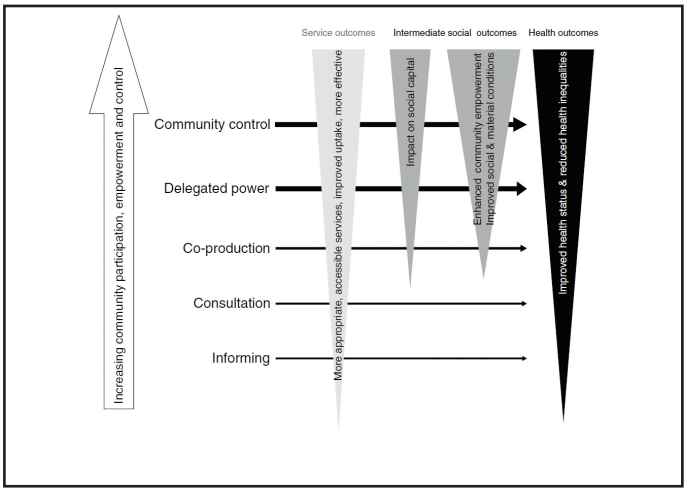

Figure 3
A model of the community approach in health (7).

THE COMMUNITY APPROACH IN HEALTH

Definitions of the community approach vary. Thus, the American CDC defines it as: *"the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people»* (8). A slightly broader and more health-oriented definition in terms of content can also be found in Slovenian strategic documents. In the Resolution on the National Health Care Plan 2016-2025, *the community approach is presented as slightly more health-oriented, namely as "activities in the prevention and treatment of patients within a community. These include health promotion and disease prevention, diagnosing patients, the treatment and management of chronic diseases, rehabilitation and care at the end of life. A community approach to treatment combines many experts, i.e. social workers, nurses, pharmacists, public health experts, doctors and others"* (9).

Regarding the community approach to health, various forms can be combined into two larger sets or forms. Regarding "the approach of health care to the health of the community", health-care institutions start implementing activities in environments where people live and work in order to resolve a professionally identified problem. Therefore, the health-care system is the promoter of activity. The more it includes communities in its activities and the greater role it gives them, the more such an approach shifts to another form. Namely, on the other hand, the community approach to health is understood as the "approach of a community to health", and thus, the community operating through the interconnection of all of its members is the promoter of activity (10).

THE COMMUNITY APPROACH TO IMPROVING HEALTH IN DECLARATIONS AND STRATEGIC DOCUMENTS

The community approach is set out in a number of strategic documents connected with health. Already at the World Health Organisation (WHO) conference in Alma-Ata in 1978 (11) the participation of the population was recognised as an important element in the protection and promotion of the health of all people, and one that can simultaneously be understood as a right and duty. Even nowadays, community participation and inter-sectoral cooperation present key challenges for those dealing with inequalities in health; therefore, despite the fact that years have passed, the declarations are still important and topical with respect to the effectiveness of the health-care system (12). The community approach is also recognised in the Resolution on the National Health-Care Plan 2015-2025. Activities implemented in the local environment should be designed so as to cover the widest possible population, and care for vulnerable groups and socially and economically disadvantaged people is particularly emphasised (9).

THEORETICAL BASES OF THE COMMUNITY APPROACH TO HEALTH

Researchers have found that the community approach in the field of health can be combined into four models (13). The basic steps for implementing activities follow one another, from the recognition of a need to the planning of activities, their implementation and then their assessment. Individual needs may be recognised by individuals/communities, who are then mobilised (model 1), or they can be recognised by professionals, who then include the community in planning. Thereafter, the community may be included only as a consultative stakeholder (model 2), or it may participate more actively in formulating an intervention (model 3). In Model 4, the community is not necessarily included in the formulation and planning of interventions, but it is included in their implementation. Of course, a combination of the above-mentioned approaches is also possible.

EFFECTIVENESS AND EXAMPLES OF COMMUNITY APPROACH TO HEALTH

Strategic guidelines and the principles of the community approach are based on abundant evidence in the published literature. One of the most extensive systematic surveys (13) covered 131 publications from member states of the Organisation for Economic Co-operation and Development (OECD) published after 1990. Most were carried out in the United States of America, with 5 (3.8 %) in Canada, 5 (3.8 %) in the United Kingdom and 8 (6.1 %) in other OECD member states. The target population for interventions consisted of ethnic minorities (42.7 %) and groups with a lower socio-economic status (26 %). Most of the issues addressed by interventions were associated with reducing cardiovascular disease risk factors, reproductive health, addiction (alcohol, smoking, drugs) and cancer prevention (education and the management of risk factors, inclusion in screening tests). With regard to the form

of interventions, education predominated (80.2 %), followed by consultations (54.2 %), social support (44.3 %), training courses on developing personal skills (38.9 %) and community activities (e.g. fairs) (35.9 %). Since any intervention could include several elements, the total exceeds 100 %. Those engaged in direct intervention were usually community members (44 %), peers (37.4 %), health-care professionals (18.3 %), community workers (13.7 %) and professionals in the field of education (13 %). On the basis of these data, it can be argued that in most cases the community approach to health is clear, because members of the community were the main providers. The authors of the survey combined the results of individual subject areas, namely: behaviours linked to health (healthy diet, physical activity, consumption of alcohol, smoking, breastfeeding, etc.), implications for health (medical conditions and physiological consequences: hypertension, excessive weight and obesity, cardiovascular disease, etc.), the self-efficacy of participants with regard to health-related behaviours, social support of participants, results in the community (local environment) and other results for the people included. The most significant results were found in the improvement of self-efficacy of individuals and in the increase of social support; slightly less significant results were found in the field of health-related behaviours, and the least significant results were found in direct effects on health. Certainly, the latter is linked to the duration of observation, because these effects require the most time. The greatest effect was found when a community was also included in the implementation of activities (13).

A systematic review paper which surveyed the effect of the community approach on disadvantaged groups of the population established positive effects in the majority of the surveys analysed (14). These effects comprised positive effects on health-related behaviours (healthy diet, physical activities), accessibility of health care, health literacy, and a set of health outcomes (body weight, waist measurement, mental health) (14). The greater involvement of the community in the form of cooperation and partnership has proved most effective compared to lower levels of participation (14).

A systematic review article (15) concentrated on the effectiveness of interventions carried out by providers of health services in the community (community health worker) to improve the treatment of chronic illness for vulnerable groups of people. In the different interventions (education, workshops, intervention counselling) which took place in institutions and at locations in local communities (medical stations, places of worship, homes), an increased responsiveness was found with regard to screening programmes and the improvement of metabolic control of diabetic patients, lipid profile and blood pressure (15).

Systematic checks which focused explicitly on community interventions related to cardiovascular diseases (16) included 32 publications; interventions most often

included education, counselling, support and exercise groups. According to the literature, interventions resulting in lower blood pressure are most promising, while those directed at changing behaviour pose the greatest challenge (16).

In a Canadian programme to prevent cardiovascular diseases, which was intended for the population of an urban neighbourhood with extremely low incomes, a high incidence of crime, alcoholism and unemployment, and with a high prevalence of risk factors, an extremely low response to programme activities occurred (17). **Thus, programmes prepared for slightly more privileged communities are not necessarily appropriate for disadvantaged communities**, because discrepancies in values occur and differences in concerns that affect a particular group of population in the light of day-to-day survival.

The community approach also proved effective in interventions which promote physical activities. In a review paper, half of the 55 studies included yielded positive results with regard to physical activities; personal contact and the appropriate formulation of interventions (with regard to the target population in terms of gender or ethnic origin) are important features of interventions (18). However, not all researchers confirmed that the community approach is very effective with regard to health-related behaviour. A review paper (19) studied interventions (promotion of healthy diet and physical activities) for adults between the ages of 18 and 74 from low socio-economic groups. Individual publications note statistically significant increases in the consumption of fruit and vegetables, as well as self-reported physical activity, whereas in other publications, no significant changes were noted or results were mixed (e.g. increased consumption of fruit and unchanged consumption of vegetables). None of the studies reported negative effects (19). An important finding of the qualitative part of the survey is that proper resources must be provided, and that persons providing an intervention **need specific knowledge and understanding of the community or should be community members** (19).

The community approach is not a particularly new discovery. A project in Northern Karelia, the beginnings of which date back to 1972, included elements of the approach (20). By including and organising communities in a number of preventive activities to promote health, cardiovascular disease risk factors were reduced. Since 2012, the mortality rate due to these diseases among people able to work has decreased by 82 % among men and 84 % among women (20). Scandinavian countries were among the first to start introducing such interventions; the above-mentioned Northern Karelia was followed by some others (e.g. Healthy Villages, Finnmark, Norsjoe).

Publications about the effectiveness of interventions which dealt with responsiveness to screening programmes have become more frequent, which is connected to a relatively greater availability of accurate data and the fact that, compared to other health effects, an increase in responsiveness can be seen more quickly. Namely, it

takes significantly more time for these other health effects to be seen, and at the same time, health is also a matter of a combination of a number of factors, and it is harder to ascribe the share of an effect to individual forms of community intervention. Since it takes a long time for the final effects and results to become evident, effectiveness needs to be evaluated on the basis of intermediate effects. This means that the effectiveness of reducing mortality rates with regard to particular states is evaluated on the basis of changes in risk factors (21). When evaluating effects, it is important to strictly capture the data on all effects. This means that with potentially insufficient results, there is a distinction between successful interventions on the one hand and merely an unsuccessful evaluation on the other. Namely, we can assess a completely successful intervention as an insufficient one precisely because not all of its effects are sufficiently captured (22). In addition to the direct impact on health, the community approach also contributes to wide-ranging changes in the environment, and thus also to changes in social health determinants, which is also illustrated by figure 2.

The foregoing mentions a number of studies that report on the effectiveness of such interventions and describe potential obstacles in terms of effectiveness. However, data on assessing such interventions' suitability or efficiency from the point of view of their users, i.e. people for whom they are basically intended, were fairly limited. Although user satisfaction surveys are one of the components of activity evaluation, they are rarely included in the literature. In the analysis of studies containing information on the subjective experience of individuals, including communities, the majority of respondents noticed the benefits to their physical and mental health, self-awareness, self-respect, the feeling of empowerment and social relationships (23). As well as having various positive effects, community approach may also have undesirable ones. Among these effects, researchers found exhaustion and stress, since, in particular cases, inclusion caused individuals to become exhausted in terms of energy and finances (23).

All the above-mentioned publications dealt with the community approach and effectiveness in different countries around the world. The above may give the false impression that the community approach is something completely new in Slovenia. Unfortunately, no such systematic surveys have been carried out which provided similarly structured results. However, a number of interventions and activities have been carried out which have had several recognised and described effects. The community approach and/or elements of it has/have been more or less present in Slovenia in the past, although these elements have not been so systematically included in interventions. A manual on the community approach describes a number of practices in Slovenia (24). Thus, the Svit Programme includes a number of stakeholders (associations, religious communities, local communities, prominent individuals – ambassadors) in order to raise awareness of the importance of participating in screening programmes. The community approach was an important element in

the project Let's Enjoy Health, which deliberately connected different stakeholders and resources from the local environment in order to deal with the problems of a healthy life style and obesity for children and adolescents in a comprehensive and far-reaching manner. Elements of the community approach can also be recognised in the Healthy Schools programme, in which the common interests of the education and health-care sectors are combined. The community approach is also taken in the activities of a number of self-help associations (e.g. Kings of the Street) (24).

The community approach also had an important role in the Together for Health project. Its principles are included in the work and life of local communities also in the framework of the operation "Upgrade, development and implementation of prevention programmes in primary health care and local communities". The title itself indicates that principles of the community approach are included. Community activities are directed at strengthening and preserving the health of the population and reducing health inequalities; local groups organised to strengthen health are important stakeholders in formulating and carrying out these activities. The project is being carried out in 25 medical centres in Slovenia, which means that, taking into account the three environments in the pilot phase, the working method has been carried over into the implementation phase in more than half of the medical centres in Slovenia.

CONCLUSION

The community approach has proved to be a successful method in promoting and strengthening health, preventing diseases and reducing health inequalities. The effectiveness of individual interventions does not guarantee the effectiveness of the same intervention in another cultural or social environment. Therefore, the formulation of interventions through the use of the community approach needs to take into account the characteristics of the environment, and the prediction of potential obstacles, and activities need to be properly pilot tested.

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Roma in Slovenia and health

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LEGAL BASIS AFFECTING THE HEALTH OF ROMA

Roma* in Slovenia have the status of an ethnic community as laid down in law in Article 65 of the Constitution of the Republic of Slovenia and in the Roma Community in the Republic of Slovenia Act of 2007. The Slovenian Office for National Minorities cites the following laws which additionally address the status of Roma: Local Self-Government Act, Local Elections Act, Voting Rights Record Act, Organisation and Financing of Education Act, Primary Education Act, Pre-School Institutions Act, Media Act, Act Governing the Promotion of Public Interest in Culture, Libraries Act, Promotion of Balanced Regional Development Act, Radiotelevizija Slovenija Act, Municipal Financing Act, Cultural Heritage Protection Act, Public Interest in the Youth Sector Act, Slovenian Press Agency Act, Criminal Code (1). The precursors to this legislation are the Government programme of assistance to Roma of 1995 and Government resolutions from 1999 (2).

The need for legislative provisions for each individual social area in relation to Roma is in itself an indication of the complexity of the relationship between the majority population and Roma in Slovenia. In order to fulfil the multisectoral legal basis, the Slovenian Government drafted a National Programme of Measures for Roma (NP) for 2010-2015, which contained six priority areas. The activities under this programme were continued with the drafting of a National Programme of Measures for Roma 2017-2021.

The Government's National Programme of Measures for Roma 2010-2015 covers the following priority areas: 1. improving living conditions and arranging Roma settlements; 2. improving the educational structure and greater inclusion in education programmes; 3. reducing unemployment among members of the Roma community and increasing their social inclusion and access to the labour market; 4. improving healthcare; 5. maintaining and developing various forms of Roma language, culture, information and publishing activities; 6. raising awareness and combating discrimination.

The National Programme of Measures for Roma up to 2015 was followed by the drafting of the Government's National Programme of Measures for Roma 2017-2021, involving the same priorities as in the previous period. According to the coordinator of the programme drafting and interested circles, it is hard to assess progress in fulfilling the measures to improve the status of Roma.

In view of the actual state of affairs it was assessed that differences exist both within an individual Roma community and notably between Roma settled in different geographical regions, which is covered by a special chapter in this publication.

* The word Roma in this text is used to denote all members, both male and female, of the Roma ethnic community in Slovenia.

Strategic objective 4 of the new NP reads as follows: "To improve healthcare services and make them more available to the Roma community, and to increase the community's awareness of health- and healthcare-related issues, with emphasis on women's and children's health." In the area of health and healthcare, the programme sets out two goals. The first is to eliminate barriers in using healthcare services and formulating and communicating health education content in a way that can be received by Roma. The second goal is aimed at strengthening health and raising the health literacy of members of the Roma ethnic community, and improving the competences of health workers to work with Roma (9).

A very illustrative feature of the area of strategic planning of measures to improve Roma health is the visible progress from providing basic rights to healthcare as a priority in the 2010–2015 period towards measures to strengthen health and promote participation and involvement in the National Programme 2017–2021.

These priorities influence each other and all together have an influence on health. The selection of key areas aligns with the urgent preconditions for health, which were identified back in 1986 by the World Health Organization and which include peace, security, education and appropriate living conditions (Figure 4) (3). Fulfilment of the set goals in all priority areas is being monitored by a multidisciplinary Government group.

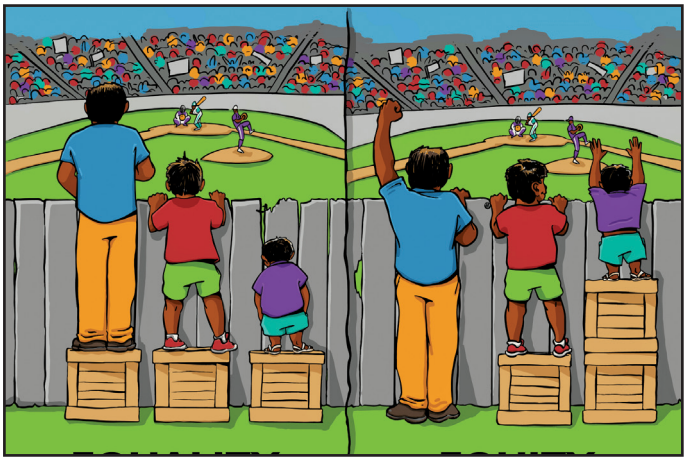

Figure 4
Example of equality and equity

Source:
Google Images (https://artplusmarketing.com/equality-equity-freedom-55a1d675b5d8)

EXAMPLES OF PUBLIC HEALTH ACTIVITIES 2008-2015

Measures in the area of public health may be universal, intended for the entire population, or targeted, intended for a certain target group. Examples of universal measures are the Restriction on the Use of Tobacco and Related Products Act or the rights under compulsory health insurance (4, 5). When universal approaches do not meet the needs of a certain target group, targeted measures are planned to bring certain services to an individual group. In other words, universal approaches enable equality among people, but targeted approaches are those, which reduce inequity (figure 5).

The Restriction on the Use of Tobacco and Related Products Act contributed to reducing smoking among the general population. Among members of the Roma ethnic community, a need was identified for additional measures, since in that group smoking is twice as prevalent as in the majority population. The target measures for the Roma community that support anti-tobacco legislation involve for instance activities to boost the health of the Roma population, to promote non-smoking and to promote non-smoking in closed spaces, during pregnancy or in the presence of children.

In the 2010–2015 period, major steps were taken in priority area 4. improving healthcare of Roma. In the area of public health the Murska Sobota Healthcare Institute laid the foundation for sustainable and partnership cooperation with representative members of the Roma community, particularly with the Association of Roma of Slovenia. Two surveys were conducted on adult lifestyles and the use of health services. The results of the surveys pointed to priority health problems among Roma, and at the same time enabled a comparison of the indicators of health with the majority population.

The survey on the health and lifestyle of Roma in Pomurje revealed worse indicators among the Roma compared to the majority population. Particularly striking is the large proportion of smokers and a tolerant attitude to smoking, a low level of physical activity and a greater proportion of persons with obesity (6).

A survey of the use of health services in the population of Roma women from 2008/2009 showed that more than 90 percent of Roma women have basic health insurance, with no differences between regions. In Pomurje a total of 74.2 % of women have supplementary health insurance, with the figure standing at 69 % for Roma women elsewhere in Slovenia. More than 90 % of the women have a chosen personal physician, and 80 % their chosen gynaecologist. Respondents from the Pomurje region for the most part (91 %) take the view that they receive the same health assistance as other women. Unfortunately this percentage is notably smaller in other regions (74.2 %) (7). We therefore conclude that access to the health system for Roma women is below the average.

In addition to occasional field activities there is a prominent and continuous media health education programme entitled "Khetaun ži sastipe" (Together for Health). The programme includes regular broadcasts on Roma radio Romic and articles in the Roma newspaper Romano them. The issue of health is presented in a comprehensive way, with topics of individual broadcasts being aligned with activities for the majority population, taking into account seasonal issues, objective needs and the wishes of Roma listeners (6, 7).

In southeast Slovenia (the Dolenjska region and Bela Krajina) the activities intended to improve Roma healthcare have for the most part been carried out by Roma societies, health centres, NGOs – principally the Red Cross – and other institutions such as Novo Mesto Development and Education Centre. The majority of activities to improve the healthcare of Roma were carried out in the Pomurje and Dolenjska regions and Bela Krajina, i.e. in areas with the majority of Roma settlements. Roma who live in towns and cities are spread out among the majority population and are therefore not very accessible.

Projects were carried out with the aim of increasing accessibility to health services in various regions, and were financed by the Ministry of Health. This served to establish on a pilot level approaches adapted to this target group, examples of best practices were created and cooperation, provision of information and mutual trust were strengthened (7, 8, 9).

Five national conferences were held on the health of Roma to raise awareness both among the Roma and majority populations about the complexity of the issue of Roma health. The topic of the first conference, which took place in 2008 in Radenci, was reducing inequality in health, as an introduction to understanding the differences in health between individual population groups. The second national conference, held in 2009 in Novo Mesto, was focused on the health of Roma women. The third national conference was held in Kočevje in 2010, and addressed the health of Roma children (8). The fourth national conference, in 2014 in Murska Sobota, provided a comprehensive presentation of the various influences on the health of Roma and examples of best practices (9). The topic of the fifth conference in 2016 in Brdo pri Kranju was the socio-economic determinants of Roma health (10). All the conferences were organised by the Ministry of Health, the Association of Roma of Slovenia, the Murska Sobota Institute of Public Health, and since 2014 by the National Institute of Public Health.

SERVICES OF BOOSTING AND PROTECTING HEALTH

The area of access to health services remains one of the priority challenges in improving Roma health. Accessibility was also considered a value in Slovenia in the past. In a 2003 book on health reform accessibility ranks among the four fundamental values

of reform and is considered to be a civic right for all (12). In the Resolution on the National Healthcare Plan 2016-2025 "Together for a Society of Health", accessibility is stated as a Slovenian and European value (13).

The rights under compulsory health insurance enable access to healthcare for all insured inhabitants of Slovenia (5). The system of compulsory health insurance is founded on solidarity between the healthy and sick, young and old and rich and poor. This means that each individual can exercise their rights depending on their needs. If society wishes to have healthy individuals and in strategic documents declares itself to be a society of health for all, each person must be afforded the extent of health services they need and in a manner that is appropriate or accessible for that individual or group. Those individuals or groups with greater needs should be offered more services. There is a need to plan targeted measures and services that represent an agreement to specific or additional needs, as shown graphically in Figure 4. Examples of targeted measures to improve accessibility to compulsory health insurance are providing information to Roma inhabitants about the possibility of obtaining health insurance and bringing health services under primary healthcare closer to Roma in the settlements where they live.

The issue of access to health services and services to strengthen and protect health is addressed directly by the project "Upgrading and developing preventive programmes and their implementation in primary healthcare and local communities", which is financed by the European Social Fund. In part, the project seeks to make services of boosting and protecting health more accessible to vulnerable groups and at the same time to create new paths to better health by means of a community approach to health. The project, which is financed from the European Social Fund, has six objectives, one being the inclusion of vulnerable groups. Based on an assessment of the needs of users and providers of preventive programmes for adults, Roma are identified as a vulnerable group due to their multifaceted deprivation, cultural characteristics and language barriers (14).

CONCLUSIONS

Research shows that the majority of Roma have a selected physician on the level of primary healthcare and health insurance (7, 8). This publication presents data that speaks of the greater use of health services by Roma. Nevertheless, mortality and morbidity among Roma are markedly higher than in the majority population.

The effect of multigenerational unemployment, present in many Roma families, has to date not been addressed in any depth, but certainly requires special attention.

We may summarise by stating that vulnerability among Roma as a consequence of socio-economic factors is apparent in greater morbidity and mortality and in their poorer health overall. Although the level of hospitalisation is higher, access to certain health services is at a low level both in geographical and financial terms, since Roma settlements are often quite a distance from health institutions, there is scant or no provision of public transport to these settlements and many Roma do not have their own transport. A low level of general and health literacy is widespread, as are a poor understanding of Slovenian and unhealthy lifestyles.

All these factors in connection with socio-economic factors create negative synergy effects on health.

Source:

Archive of the Murska Sobota Institute of Public Health, author Zdenka Verban Buzeti

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National programme of measures for Roma of the government of The Republic of Slovenia for the period 2017-2021 from the viewpoint of the Ministry of Health

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INTRODUCTION

The National Programme of Measures resulted from cooperation between the responsible ministries and government offices and the Council of the Roma Community of the Republic of Slovenia as the umbrella organisation of the Roma community, which was established based on the Roma Community Act. The main goals of the national programme "include the preparation and adoption of measures for the improvement of the position of, and for the promotion of social integration and the reduction of, the social exclusion of Roma community members in all those areas where it is deemed necessary based on previous experience by the national authorities, the authorities of self-governing local communities, the Roma community and civil society organisations" (1). The National Programme identifies priority areas of action, and forms eight strategic objectives:

1. to improve the educational structure of Roma and to improve the attendance of Roma children at pre-school institutions, and to increase the number of Roma children in compulsory education and increase the integration of young people and adults in continuing educational processes in accordance with the lifelong learning principle;
2. to increase the employment/reduce the unemployment of Roma, with an emphasis on the employment activation of the long-term unemployed and on removing obstacles upon (re-)entry to the labour market;
3. to prevent and eliminate the exclusion of Roma, particularly women, children and young people; to promote various programmes of social security, namely information and advisory programmes, field work, day centres, programmes of assistance and self-help, and to strengthen awareness among Roma of such programmes;
4. to improve health-care services; to bring them closer to Roma, and to improve their awareness of issues relating to health and health care, particularly emphasising the health of women and children;
5. to improve the housing situation of Roma; to speed up the arrangement of settlements with majority Roma populations; to provide access to public goods, such as access to water and electricity, in accordance with national legal requirements, and to encourage the elimination of actual spatial segregation resulting from the historical settlement of Roma and their long-term exclusion from social life;
6. to promote the preservation and development of cultural, informative and publishing activities of the Roma community and strive to preserve and develop (various forms of) the Romani language as a minority language;
7. to increase the awareness of the Roma community and the majority population of the positive effects of the integration of Roma in society and of the wealth that Roma cultures bring to Slovenian society, and the importance of non-discrimination, and to enhance the fight against anti-Roma rhetoric, hate speech and stereotypes and prejudices;

8. to reinforce dialogue and cooperation with local communities inhabited by the Roma, and to establish an active partnership between the local and national level and the Roma community.

Strategic objectives are aimed at improving the wider socio-economic determinants that influence health and, in a targeted manner, improving health literacy, as well as increasing the accessibility of the health-care system, with an emphasis on the health of Roma women and children.

ACCESSIBILITY OF HEALTH CARE

At the national level, the rights and access to health-care services, both curative and preventive, are the same for all citizens of the Republic of Slovenia. The strategic guidelines and bases in this area are provided by the central programming document, the Resolution on National Health Care Plan 2016–2025 "Together for a Healthy Society", and one of the main prerequisites is to provide good-quality public health services, accessible to all, which puts the user and the provider at the centre, pursues better health and well-being for all, and strives to reduce inequalities in health, which is a particularly important starting point with regard to Roma as one of the most vulnerable groups of the population.

The basic starting point is that Roma covered by health insurance approach their doctors or the health-care system in the same way as any other insured person. If they are not covered by health insurance, the health-care system in Slovenia provides for accessibility to emergency medical treatment, regardless of the status of the insured person. Thus, in cases of emergency, the state enables persons not covered by health insurance due to various complicated and unresolvable circumstances to be treated by a doctor.

The state ensures the right to make payments of contributions for compulsory health insurance to citizens of the Republic of Slovenia and foreigners with indefinite duration residence entitlement if they are eligible for social assistance benefit in cash, or if they meet the conditions to obtain social assistance benefit in cash, where fault-based reasons are not taken into account, and if they have permanent residence in the Republic of Slovenia and are not insured on any other basis stipulated by the Act governing health insurance. Regardless of whether they meet the conditions for obtaining social assistance benefit in cash, persons placed in a foster family or an institution in compliance with the Act governing family relations are eligible to have their compulsory health insurance paid if they are not insured on any other basis laid down in the Act governing health insurance. These persons are eligible for health services under the same conditions as children insured as family members. The persons mentioned above are registered in, and deregistered from, compulsory health insurance by the Health Insurance Institute of Slovenia based on a decision on the recognition of the right to the payment of the contribution for compulsory health insurance, and the contribution for compulsory health insurance is paid by the municipality of the persons' permanent residence.

Persons holding the status of socially disadvantaged persons, and prisoners and detainees are insured for supplementary payments by insurance companies (Vzajemna, Triglav, Adriatic) offering complementary health insurance. Because of their status, socially disadvantaged persons receive a decision from a Social Work Centre. In the records of the Health Insurance Institute, such persons are accorded the status of socially disadvantaged persons. When a person is socially disadvantaged, their insurance policy is at a standstill, and thus they do not make monthly payments to the insurance company for complementary payments. Their insurance policy becomes active again after the expiry of the aforementioned decision. On the basis of a person being categorised as either a socially disadvantaged person, a detainee or a prisoner, providers of health services do not issue invoices/claims for complementary payments (this is the part of the total cost of health services not covered by compulsory health insurance, i.e. from contributions for health insurance). Because of the standstill of the insurance policy for supplementary payments, the Institute also receives invoices/claims for supplementary payments, and this part of each service provided is included twice a year in claims settled by the Ministry for Health. Thus, in 2017, the Ministry of Health paid €13,674,083.81 on behalf of all the persons subject to decisions from social work centres on the status of socially disadvantaged persons.

MEASURES IN THE FIELD OF HEALTH AND HEALTH CARE – REALISATION OF THE STRATEGIC OBJECTIVE

To provide accessibility to health care to the most disadvantaged members of the population, Roma are provided with accessible proactive thematic areas integrated in the community, whereby the providers take the first step concerning people in need in their environment, rather than waiting for Roma to begin looking for their services, in order to raise awareness about health services and programmes, and for the recipients to be better included in health services and to use them more.

The main activities include:

- Delivering information on health, programmes, workshops, training and the transfer of best practices tailored for Roma in communities where they live;
- Education and awareness raising among specialised public and medical staff about Roma and health; implementation of surveys and evaluations;
- Improving health workers' competences, integration and strengthening cooperation between health workers and Roma assistants, and promoting a healthy lifestyle among the Roma population.

The Ministry of Health is also the national organiser of thematic conferences on the health of Roma, such as 'Roma women - from childhood to parenthood' (2015) and 'Socio-economic determinants of the health of Roma' (2016). The conferences are organised in cooperation with partners, as in 2017, when one was organised in cooperation with the National Institute of Public Health – 'The accessibility of the health-

-care system for members of the Roma ethnic community'. In 2018 the conference was organised in cooperation with the Roma Union of Slovenia (2018) on the health situation of Roma in Europe.

A particularly important role of the Ministry is enhancing cooperation and interconnections between all stakeholders operating to improve health among Roma in Slovenia, such as health-care centres, non-governmental organisations and associations, and the National Institute of Public Health. In this way the resources available are used in more efficiently, and activities are targeted and planned.

In compliance with the National Programme of Measures for Roma of the Government of the Republic of Slovenia for the period 2017–2022, the Ministry of Health issued a call for proposals for co-financing health-care programmes with an emphasis on the health of adolescent Roma girls, women and children (Official Gazette of the Republic of Slovenia [*Uradni list RS*], No. 43/2017 of 11 August 2017). It amounted to a total of €110,000.00.

Activities in the framework of the call for proposals took place in Roma settlements, or where it was possible to include the target groups to the maximum extent. Three providers applied:

- The Romani Union Roma association with the programme: Romska ženska zdrava, enakopravna, odločna (Roma woman – healthy, equal, determined);
- Red Cross of the Republic of Slovenia, Regional Unit Novo Mesto with the programme:
- Zdravstveno ozaveščanje Rominj - Zdravo (Raising awareness of Roma women in health care – Healthy)
- National Institute of Public Health, Regional Unit Murska Sobota with the programme: Reproduktivno zdravje in zdrava spolnost - program osveščanja in izobraževanja romskih pomočnikov (Reproductive health and healthy sexuality – programme to raise awareness and education of Roma assistants)

Main activities:

- Implementation of a programme of assistance and consultancy to, and for, the care of disadvantaged persons in different Roma settlements; mobilna svetovalna služba za Rome,
- Prevention programmes for boys and girls;
- Mobile advisory service for Roma;
- Raising awareness of Roma women about a healthy and safe sex life, with an emphasis on preventing early pregnancies;
- Health education consultancy in the field.

Programmes concerning the health of Roma have also been financed from the funds of the Operational Programme for the Implementation of the EU Cohesion Policy in the period 2014-2020 (2).

The thematic areas and measures presented are thus based on personalised and non-discriminatory paradigms integrated in the living space. The thematic area implemented annually will be arranged by the implementing body and the participating partners competent for implementation.

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Rights of Roma from compulsory health insurance

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COMPULSORY HEALTH INSURANCE SYSTEM

The Health Insurance Institute of Slovenia (hereinafter: ZZZS) is the insurance institution for compulsory health-care insurance, which exercises public powers and uses the provisions of the General Administrative Procedure Act in making decisions on rights. The Health Care and Health Insurance Act (hereinafter: ZZVZZ) lays down the compulsory inclusion in compulsory health insurance of all persons meeting particular conditions. For every category of insured persons, the ZZVZZ Act also lays down the scope of rights, persons subject to compulsory health insurance coverage, and persons who are obliged to pay contributions. Roma are included in compulsory health insurance under the same conditions, on the same basis for insurance (arising under paragraph 1 of Article 15 of the ZZVZZ Act), and have the same rights as other insured persons. All insured persons have the right to access health-care and dental services, rehabilitation, medical devices, medicinal products, health spa treatments, ambulance transport and transport by other vehicles, planned treatment abroad, and to be reimbursed travel and other expenses. Only certain categories of insured persons are also eligible for wage compensation for the period of temporary inability to work.

A substantial proportion of the Roma population qualifying under the Exercise of Rights from Public Funds Act (ZUPJS) is covered by compulsory health insurance as referred to in point 21 of paragraph 1 of Article 15 of the ZZVZZ (basis for insurance No. 099) The right to be included in compulsory health insurance on this basis is decided by the social work centre competent for the residence of the person by means of a decision; the registration of compulsory health insurance is made by means of electronic data exchange in the records of the ZZZS, and the municipality of the permanent residence of the person is obliged to pay their compulsory health insurance contribution. A person applying to exercise rights from public funds is entitled to this type of insurance if they have a permanent residence in the Republic of Slovenia and if they do not meet the conditions for insurance under any other points of Article 15 of the ZZVZZ, but they do meet the conditions for social assistance benefit in cash, whereby fault-based reasons which would otherwise prevent the person from being entitled to social assistance benefit in cash are disregarded. The insurance enters into force on the first day of the month following the submission of the application and is applicable for the period for which the right is granted, but no more than one year. The person must submit the application to extend the right on time; otherwise, the right may be terminated and consequently, compulsory health care insurance may cease. The highest number of Roma live in regional units of ZZZS Maribor, Murska Sobota and Novo Mesto, and thus for these three regions, the percentage of persons is shown for persons included in compulsory health insurance under the basis for insurance 099 (together with their family members) and in comparison with the Slovenian average. The ZZZS has no information on the number of Roma among these persons.

Table 2

Number of persons entitled to health insurance from public funds

Regional Unit	The number of persons insured on the basis for insurance 099 and their family members	Share of the total number of insured persons
Maribor	11,112	3.5 %
Murska Sobota	4,917	4.6 %
Novo Mesto	3,907	3.3 %
ZZZS as a whole	54,344	2.6 %

A substantial percentage of Roma are employed in the Republic of Slovenia and some of them also in neighbouring EU countries. Roma employed in other EU member states arrange their application for foreign health insurance funds on the basis of EU legislation, based on which they can access, together with their family members, the same range of services with their Slovenian health insurance cards in Slovenia as Slovenian insurance holders, and the share of health services, medicinal products or medical devices covered by compulsory health care insurance is charged by the ZZZS to foreign insurance holders twice a year. Every insured person receives a health insurance card when their compulsory health care insurance is arranged for the first time, or after the expiry of its ten-year service life. Most Roma take great care of their cards, and before the expiry of its service life, only few individuals frequently lose their cards and have to order a new one, which is chargeable.

VOLUNTARY HEALTH INSURANCE AND ADDITIONAL PAYMENT COVERAGE

Compulsory health-care insurance funds cover the following services in full: treatment and rehabilitation due to occupational diseases and injuries, prevention, treatment and rehabilitation for children, pupils and students attending regular education, children and adolescents with physical and mental disabilities, children and adolescents with accidental injuries to the head and brain damage, prevention and women's health care in relation to consultancy with regard to family planning, contraception, pregnancy and childbirth, treatment and rehabilitation of certain diseases (malignancies, muscular and neuromuscular diseases, paraplegia, tetraplegia, cerebral palsies, epilepsy, haemophilia, mental illnesses, developed forms of diabetes, multiple sclerosis and psoriasis), emergency medical treatment, including emergency transportation and some other services. Only a certain share of other services is covered from compulsory health insurance, and the difference is covered by voluntary health insurance or the budget of the Republic of Slovenia if the person has been granted the right to the payment of supplementary payments on the

basis of Rights from Public Funds Act. Insured persons and their insured family members are entitled to the coverage of supplementary payments if the above rights are not guaranteed in whole from compulsory health care insurance on another basis, and if they are entitled to obtain social assistance benefits in cash.

Voluntary health insurance in the Republic of Slovenia is provided by Vzajemna zdravstvena zavarovalnica, Adriatic Slovenica and Triglav Zdravstvena zavarovalnica. If an individual has no voluntary health insurance, or if they are not entitled to the coverage of supplementary payments from the budget, they must pay a percentage of the costs not covered by compulsory health care insurance. Most employed or retired Roma have voluntary health insurance coverage. Roma entitled to social assistance benefit in cash may also have the right to the coverage of supplementary payments from the budget by means of a decision from the competent social work centre. Social work centres' personnel are devoted to informing applicants, and they help Roma to complete their applications.

GEOGRAPHICAL ACCESSIBILITY OF HEALTH-CARE SERVICES

Roma settlements are usually remote from urban centres and important health institutions, especially tertiary institutions (both university medical centres, oncology institute). Because of this, Roma often address requests to their personal physicians in clinics to provide them with ambulance transportation to providers of health services. Based on the current health status of the insured person, decisions on the right to transportation and the determination of the type of transportation fall within the competence of the relevant physicians (family or referring physicians).

The right to be reimbursed travel expenses means less to them than ambulance services or health-care transport, because it is deducted every month from the calculation of mileage allowance, i.e. deduction or own contribution, and often there is no payment of reimbursement. In addition, insured Roma have no transport of their own or family members who could give them proper transportation to a provider of health services.

Insured persons are guaranteed the right to be reimbursed travel expenses when they have to travel to a physician or a health institution in another location to be diagnosed, treated or rehabilitated, or if they are called by their personal physician, a health institution, an appointed doctor or a medical committee to a location outside the location of their residence or employment of the person insured. Insured persons are entitled to travel expenses only if they travel to providers in other locations and in relation to the rights defined under points 1, 2 and 3 of paragraph 1 of Article 23 of the ZZVVZZ, and therefore, not for all health services. In no case is an insured person entitled to claim travel expenses for so-called 'weekend passes' and 'technical dismissals' during hospital treatment. Insured persons are entitled to travel expenses when they travel to the nearest provider trained in the services to which

the insured person was referred, and when this article was prepared also to providers who perform exclusive activities (Institute of Oncology Ljubljana, Valdoltra Orthopaedic Hospital, Institute for Rehabilitation, Republic of Slovenia, psychiatric hospitals in Ormož, Vojnik, Begunje and Idrija and Ljubljana University Psychiatric Hospital).

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Presentation of selected indicators of health and health care in the Roma ethnic group in Slovenia

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INTRODUCTION

The assessment of the health of the Roma population in Slovenia in the last decade is based on the results of two surveys carried out by the Institute of Public Health Murska Sobota. The first survey is a cross-sectional transparent epidemiological survey of adult residents of the Roma community in Pomurje in relation to health-related behaviour. The results showed that the lifestyle of adult residents of the Roma community is unhealthy. What stands out are the higher level of smokers, insufficient consumption of fruit and vegetables and a high proportion of respondents who consume sweetened non-alcoholic beverages every day (1). The second survey focused on researching health and the use of health services by Roma women in Slovenia. The research results showed regional disparities in health between Roma women in Pomurje and other parts of Slovenia in favour of those living in Pomurje, and an increased vulnerability of women as well as experiences of stress and loneliness as compared to men (1).

A comparison of information on the behaviour of adults among the general population of Pomurje and the members of Roma community reveals worse indicators for Roma. It must be emphasised that in the comparative period, the health and behaviour indicators for residents of Pomurje tend to generally be less favourable than the average values in Slovenia (2).

In the 2017-2018 period, the National Institute of Public Health carried out a survey titled "Prikaz koriščenja zdravstvenih storitev Romov v sistemu zdravstvenega varstva Slovenije" (Representation of the use of health services by Roma in the health-care system of Slovenia). The purpose of the survey was to contribute to reducing the health inequalities of the Roma population in Slovenia and to obtain an overall insight into the health needs of Roma in Slovenia in order to define needs and identify obstacles to these services.

SURVEY METHODOLOGY

The survey took place in two stages: qualitative and quantitative. The first phase included the implementation of data analysis regarding data from the databases of the National Institute of Public Health on the birth rate, morality rate, hospital treatments and use of medicinal products among Roma from 2012 to 2014. The target population included persons registered as Roma, i.e. the population of selected settlements which were designated based on the data available on the settlement of Roma community members in Slovenia. Thus the target population comprised persons aged between 0 and 89 with a permanent residence in the following five regions: Pomurska, Savinjska, Spodnjeposavska, Osrednjeslovenska and Jugovzhodna Slovenia. The target population of Roma recorded in this way amounted to 6,500 persons. The second phase of the survey took place in the form of semi-structured interviews with important stakeholders active in various levels of health care for Roma, including representatives of the Roma community of Slovenia.

SURVEY RESULTS

FIRST PHASE OF THE SURVEY

Roma mortality

The survey showed that the average life expectancy for male Roma is 48 years and for women 63 years, which on average (55 years) is more than 20 years less, comparing to the general population of Slovenia (77 years). The proportion of premature mortality of Roma is significantly higher and amounting to 69 % (the average for Slovenia is 19 %).

The detailed mortality analysis showed that in the observed period the age-standardized mortality rate of Roma population up to 65 years old was almost twice higher as in the general population of Slovenia. The greatest difference was noticed in infants up to 1 year of age (mortality rate for Roma is 4 times higher) and for children aged 1 to 4 (mortality rate for Roma is 7 times higher). After the age of 30 the mortality rate of Roma grows significantly; it reaches a peak for the ages between 40 and 49 (4 times higher) (Table 3).

The assessment of the age-specific mortality rate of Roma by statistical regions in the observed period shows that, if children aged 0 to 9 and young adults aged 20 to 29 are considered, the Jugovzhodna Slovenia and Spodnjeposavska statistical regions deviate the most. In the Pomurska region, the mortality rate starts rising after the age of 40 (Figure 5). Regarding the distribution of mortality among Roma based on diagnosis, mortality due to cancer (C00-D48), diseases of the circulatory system (I00-I99) and diseases of the respiratory system (J00-J99) are particularly notable. In children under 5 years of age, there are congenital malformations, deformations and chromosomal abnormalities Q00-Q99 (two cases of six), unexplained causes R00-R99 (two cases of six), pathology of the perinatal period P00-P96 and diseases of the nervous system G00- G96 (one case per group). The interpretation of the results should take into account the fact that this is a very small number of cases in the Roma population. The reason for this is probably due to several factors. In order to determine the exact causes of high child mortality and general mortality in the Roma, we would definitely need a more in-depth study.

Table 3

Age-specific rate[1] of mortality between the Roma and general population of Slovenia (per 1000 inhabitants), 2012 – 2014

Age groups	Roma, 2012-2014			General population, 2012-2014			p-value
	Number of deaths	Number of people in the population	Mortality rate	Number of deaths	Number of people in the population	Mortality rate	
Up 1 year	4	456	8,77	137	65315	2,10	
1-9	3	3963	0,76	53	556049	0,10	
10-19	0	3480	0,00	99	568475	0,17	
20-29	2	5895	0,34	337	760528	0,44	
30-39	7	2856	2,45	642	928419	0,69	
40-49	14	2325	6,02	1510	908641	1,66	
50-59	24	1812	13,25	4659	916531	5,08	
60-64	12	615	19,51	4009	407462	9,84	
65 and more	30	822	36,50	46031	1065285	43,21	
Standardized mortality rate[2] (od 0 do 64 let)	355,87			223,93			0,0002
Standardized mortality rate (65 let in več)	3649,63			4321,01			0,344

[1] The age specific mortality rate is the ratio between the number of persons in a particular age group, the deaths in the observed calendar year, and the total population of this age group in the middle of the same year, multiplied by 1000.

[2] The age standardized mortality rate is a direct standardization method where the calculation of the mortality rate per 100,000 population divided by five-year age groups is calibrated to the standard population. This method eliminates differences in the population with respect to the age of the population of individual countries / regions / territories. This procedure enables direct comparison of mortality rates by individual populations, irrespective of differences in age structure of population of individual countries or different population groups (Source: Zdravstveni statistični letopis Slovenije 2016, NIJZ). Standardized on ESP 2013.

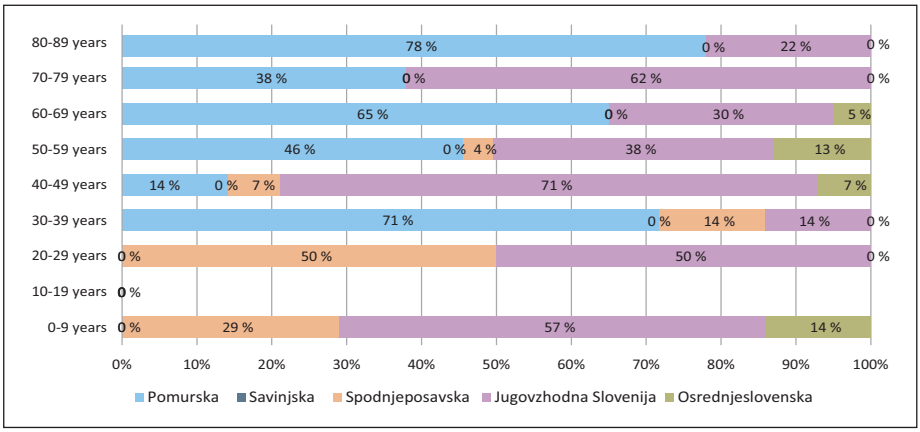

Figure 5

Age-specific rate of mortality among the Roma population of Slovenia by statistical regions (per 1000 inhabitants), 2012 – 2014

Roma hospital treatments

A comparison of the level of hospital treatments of Roma shows that the 2 – times higher morbidity rate. A detailed examination by age groups shows markedly higher rates for infants up to 1 year of age (3,5 times higher) and younger children aged 1-3 (2,6 times higher) compared to the same age groups of non-Roma children. The assessment of the hospital treatments rate of Roma by statistical regions shows that Spodnjeposavska (2 times higher) and Pomurska (2,4 times higher) regions are especially notable regarding hospitalisations, compared to the general population of Slovenia in the same regions.

Comparison by diagnoses shows that the highest rate of hospitalisations among Roma is due to respiratory diseases (J00-J99), certain infectious and parasitic diseases (A00-B99), diseases of the circulatory system (I00-I99), diseases of the digestive system (K00-K93) and diseases of the genitourinary system (N00-N99). The highest rate of hospital treatments of Roma was found in the Z00-Z99 group (Factors influencing health status and contact with health services) (Table 4).

Table 4

Rate of hospital treatments of Roma and the general population in Slovenia with regard to the main diagnosis by MKB-10 groups (rate per 1000 inhabitants), 2012 – 2014

ICD-10 diagnosis	Roma	General population
Factors influencing health and contact with health services (Z00-Z99)	65.1	7.1
Diseases of the respiratory system (J00-J99)	47.8	15.5
Pregnancy, childbirth and the puerperium (O00-O99)	45.1	3.0
Infectious and parasitic diseases (A00-B99)	19.9	5.7
Symptoms, signs and abnormal clinical and laboratory findings (R00-R99)	17.8	7.6
Diseases of the circulatory system (I00-I99)	15.6	20.8
Diseases of the digestive system (K00-K93)	15.6	13.4
Injury and poisoning (S00-T98)	14.1	15.7
Diseases of the genitourinary system (N00-N99)	12.9	10.5
Mental and behavioural disorders (F00-F99)	9.7	5.6
Diseases of the nervous system (G00-G99)	8.4	4.5
Endocrine, nutritional and metabolic diseases (E00-E90)	7.6	3.6
Neoplasms (C00-D48)	6.8	17.9
Certain conditions originating in the perinatal period (P00-P96)	6.1	1.0
Diseases of the musculoskeletal system and connective tissue (M00-M99)	5.6	10.2
Diseases of the skin and subcutaneous tissue (L00-L99)	5.1	2.2
Diseases of the blood and blood-forming organs (D50-D89)	3.3	1.8
Diseases of the ear and mastoid process (H60-H59)	2.7	1.1
Congenital malformations and chromosomal abnormalities (Q00-Q99)	2.0	1.4
Diseases of the eye and adnexa (H00-H59)	1.2	2.1

Consumption of medicines of Roma

The analysis of the medicines consumption between Roma and the general population of Slovenia shows that on average Roma use 9 % more of these. A comparison

of DDD (defined daily dose per person) by ATC classification groups shows 188 % higher consumption of medicines under group P (antiparasitic products, insecticides and repellents), 98 % higher for the respiratory system diseases, 50 % higher for the systematic treatment of infections, 20 % higher for the treatment of the skin diseases and 10 % higher consumption of medicines acting on the nervous system. An assessment of the number of recipes prescribed for the Roma population by statistical regions shows that Roma in the Pomurska region use the highest amount of medicines (56 % of all prescriptions for Roma), which accords with the high indicator of hospital treatments rate in this region. It followed by the Jugovzhodna Slovenia region (32 % of prescriptions). A comparison by ATC classification shows an extreme deviation of the Jugovzhodna Slovenia region in group P – Antiparasitic products, insecticides and repellents (66 %) and in group V – Various products (65 %). The Pomurska region deviates the most in the use of medicines in group H – Systemic hormonal preparations (65 %), in group G - Genito urinary system (64 %), group L – Antineoplastic and immunomodulating agents (63 %) and group N – Nervous system (60 %). In the Osrednjeslovenska region the highest consumption of medicines from group A – cardiovascular system.

Fertility of Roma

A birth-rate analysis shows that the birth rate of Roma women is almost twice higher than the general population. With almost two thirds of Roma's births was at the age of 15 to 24 (on average 24 % in the age group up to 19, 31 % in the age group 20-24, 22 % in the age group 25-29 and only 6 % and 1 % in groups aged 35-39 and 40-45 respectively). The youngest Roma women in the observed group were aged 14, and the oldest 44. The average age of giving birth Roma women was almost five years below (24.6 years) the age of Slovenian women (29.1 years). The total birth rate, showing the average number of children per woman in her reproductive years, was 2.75 on average for Roma women (the highest value was 2.84) while in Slovenia women it was 1.58 children on average. An assessment of the birth rate of Roma women by statistical regions shows that Jugovzhodna Slovenija and Spodnjeposavska deviate the most regarding the number of births (59 % and 65 % more, respectively). It can be noted that the birth rate of Roma women in the Pomurska region is significantly lower than in Dolenjska and Posavje. The birth rate of Roma in the Osrednjeslovenska region is close to the birth rate of the general population of Slovenia (with the lowest values in the group aged up to 19, and high values in the group aged 35-39).

SECOND PHASE OF THE SURVEY

Detailed analyses of results of the second phase of the survey, which took place in the form of interviews, have explained the view of the stakeholders from various levels of health care for Roma on the particular features of their lifestyle, the influence of these features on health and their relationship to their health and the health-care system in Slovenia. Most of the interviewees agreed that, in general, Roma live an

unhealthy life style: they smoke a lot, they are not active enough, they consume high-energy food, which is less nutritious and vitamin depleted, and they drink a lot of coffee. The following were mentioned as the key health problems: respiratory diseases, type 2 diabetes, cardiovascular disease, obesity (especially of children), cancer, poor mental health (depression, stress, psychosis) and an increase in various addictions (alcohol, gambling, sedatives). They also reported that the socio-economic status of most of the Roma population in Slovenia is low; a considerable proportion of them live below the poverty line, in inappropriate living conditions and poor residence infrastructure, which is reflected in their poor health. In the field of health care, interviewees emphasised financial and geographical inaccessibility, lack of understanding and powerlessness regarding the passage through the complex system of health-care organisation, unequal treatment and lack of trust of Roma patients in providers of health services. Regarding women's attitudes to gynaecologists and reproductive health, respondents agreed that all Roma women are very shy and dislike gynaecologists and, in most families, discussing contraception is taboo. They often mentioned the subordinate social position of women in the Roma community, and its concomitant adverse impact on their self-perception and health.

Respondents expressly underlined that Roma in Slovenia differ very much among themselves. They agreed that the overall position of Roma in Prekmurje is better, because they have lived there since the 19th century, they are integrated in the local community, and they take up the habits of the majority population. In Dolenjska and Bela Krajina, the situation is completely the opposite: a large proportion of Roma settlements have poor infrastructure, many of them live in campers or barracks without electricity or drinking water. Families often have no employed members; they live off social support or engage in occasional seasonal work. On the other hand, Roma in Prekmurje also have a very respectful and positive attitude to medical institutions; most of them are covered by health insurance; they have personal physicians, paediatricians, and women have their selected gynaecologists, and use contraception. In the Jugovzhodna Slovenia region, trust in doctors is still a significant problem, since Roma still fear official institutions which had a negative attitude to Roma for years.

CONCLUSIONS

The research results show that the health status of Roma falls below that of the majority population of Slovenia. The findings show that the health of Roma groups in Slovenia differs significantly, which needs to be considered in the preparation and implementation of public health measures.

Based on the fact that statistically significant differences between indicators of regions with Roma populations favour Roma in the Pomurska region, it can be concluded that better integration into the environment and general society, better living conditions and acceptance by the majority population positively influence the health of the Roma community, too.

Juvenile birth rates and reproductive health are priority public health problems that require multi-sectoral cooperation.

The higher mortality rate of infants despite a more frequent use of health services requires additional in-depth analysis of each individual case. However, it can be emphasised that the infant mortality rate is particularly influenced by socio-economic factors.

The premature mortality rate is often linked to preventable causes which are the result of unhealthy lifestyles and low use of existing precautionary and screening programmes.

The health of Roma in Slovenia is particularly influenced by socio-economic factors, such as inappropriate living conditions, low general and medical literacy, multigenerational unemployment, poverty, multi-layer deprivation and social exclusion.

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A good practice example of successful cooperation aimed at health promotion of Roma ethnic group

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INTRODUCTION

The project "Successful integration of Roma into the environment – healthy lifestyle", carried out from 2016-2018, is financed from the European Structural Fund. The project's activities are directed towards improving information and awareness raising among members of the Roma ethnic community in the field of health promotion and disease prevention. The objectives of the project include educating Roma assistants, who will have a dual role: they will educate school children and they will be role models in the community. For this purpose, a programme of education for a group of Roma assistants has been prepared and a pilot implemented.

The purpose and main objective of the programme is to promote and protect health and to promote a healthy life style among members of the Roma community (Roma assistants, children, school children and parents).

Roma in Slovenia are among the most marginalised and deprived groups for several reasons: poverty, their subculture, and because they are different. Many factors influence the achievements of Roma children in education and teaching. Several authors point out these factors in various analyses of the school system and school performance, and they note that socio-cultural circumstances deprive Roma of opportunities in education equal to other Slovenian citizens. "We often hear complaints that Roma children in schools are problematic, aggressive, violent, passive, inflexible, and neglected in terms of education, and that they terrorise and negatively influence non-Roma school children, etc. However, we too rarely ask ourselves what they are going through and what Roma children feel in a crowd of peers foreign to them. And if we view things from their side, we can see a series of factors pointing to discrimination, deprivation and thus violations of children's rights." (1)

Children and adolescents are presumed to be a relatively healthy population. They are mostly affected by the distinctive features of their way of life. According to data from the survey on behaviour related to health throughout school, more than a half of adolescents do not have breakfast, and do not eat fruit and vegetables on a regular basis; a quarter of them drink sweetened beverages every day, and more than a quarter of them are also not physically active enough, while more than a half of them spend more than two hours a day watching TV. Less than a third sleep as per the recommendations (2). The risk factors in this period can also include unhealthy leisure time activities, eating disorders, drug abuse, mental disorders, problems communicating with peers and adults and other (3).

In addition to family, **school** is the key environment in the development of children and adolescents. Children and adolescents spend a substantial proportion of their lives at school. In addition to obtaining knowledge, they develop skills, self-esteem and values. On the one hand, school can be a source of healthy lifestyles, and if the school environment is supportive, it is thus a 'protective factor', making it a support environment

in terms of prevention and the promotion of health. On the other hand, a child or an adolescent may experience feelings of dissatisfaction and failure.

In cooperation with parents and the wider social community, schools can develop long--term programmes to promote health which are harmonised and development oriented. By helping young people develop skills to resolve problems in life, these programmes offer more than merely the dissemination of information on health. They teach youngsters to be capable and skilled at resolving problems related to a healthy lifestyle.

When addressing connections and relations between lifestyle and health, it is important especially regarding school children to consider how social impacts influence individuals' behaviour and attitude to health.

An example of unhealthy diet of parents, teachers and other adults shows that these factors contribute to the formation of values, thinking and behaviour of children and adolescents about eating. Thus, school children obtain their first information on health during socialisation at home, at school and in the wider environment. This is the fundamental framework in which individuals place new knowledge and evaluate it. It is thus necessary to emphasise that school children do not acquire experience about health only at school, but also in the wider family and social environment, and that they are strongly influenced by modern media.

Therefore, health is constructed in the diverse environments in which people live, work and spend their free time. And school is the key environment for promoting health.

Health education or education for health is not only a matter of the regular curriculum taking place in class. The concept of schools promoting health is based on the fact that, with the support of the school, family and social community, the effectiveness of teaching in the class increases. This is what is meant by **"hidden curriculum"**. When materials addressed in class are not confirmed in practice and the safety system of the school, family and social community, its expressive value strongly decreases in the mind of a school child, who is susceptible to external influences.

How to create an encouraging school environment or climate that promotes health

- By using values and ideas, on which the organisation, programme and staffing in schools are based (school food, relations between children and teachers and between teachers themselves, as well as equal evaluation for equal contributions, regardless of intellectual abilities or educational achievements of learners...).
- By creating stronger links with parents and family; these contacts can be encouraged in diverse ways, e.g. with the development and use of joint materials for school and family. Thus, we also include parents in activities and connect them more closely to the endeavours of their children and school in the field of health promotion.

- By making closer connections and through cooperation between school and the local social community.
- With support from the political and legislative 'environment'.

The heart of a school promoting health consists of the teacher and their professional work. It is necessary to emphasise the meaning of a pragmatical approach, because material changes can be achieved through small steps. Perseverance should be the main guideline of a teacher-innovator in education for health.

GENERAL OBJECTIVES OF THE PROGRAMME:

1. Promoting the mental health of Roma children and school children through the promotion of positive self-esteem, the development of decision-making abilities, promotion of values which influence decisions on health, communication skills, learning ways to cope with stress.
2. Formulation of positive opinions about a healthy lifestyle (for adults: the importance of preventive programmes; for school children: non-smoking and promotion of positive decision-making and help in saying "NO" in the framework of drug and alcohol abuse; recognition of the role of sexuality in health as a whole and its acceptance as a relation to the self and to others).
3. To influence eating habits, motor activities and thus health and healthy lifestyle promotion through training workshops on a healthy and balanced diet and the importance of physical activities of children and school children.

GENERAL REASONS FOR THE PROGRAMME AND METHODOLOGY

The programme is based on theoretical starting points based on different studies. One of the significant surveys used in the creation of the programme was done within the framework of the European Network of Healthy Schools, in which the World Health Organisation, the Commission of the European Communities and the Council of Europe participated. Educational activities and materials for training workshops to promote the mental health of adolescents were researched.

As a result, the basis for the programming also includes methodological materials from Amnesty International, which is a set of successful and tested courses and manuals from different countries with a long-standing tradition in the field of learning person-to-person communication (4).

Approaches developed for cooperation in the school environment are encouraging and appropriate for the particularly vulnerable group of school children. Namely, conceptual starting points for the health protection of vulnerable groups include: the concept of overall perception of health, the concept of a "broad social perspective" and the concept of protective factors.

When adolescents endeavour to achieve autonomy, they are confused as a result of a series of development hardships; they are dissatisfied with themselves and with others, and they are uncertain about fields where they have no appropriate incentives or where they were once hurt by unpleasant experiences, and thus they unconsciously build their self-esteem.

Therefore, it is important to help adolescents become aware of their own reasoning and emotions in the promotion of their mental health. For this reason, we cannot teach them how to become physical healthy and to remain that way if we fail to take their emotional and social needs into account.

The appropriateness of the programme with its priorities is intricately linked to education for health and the promotion of mental health. This kind of interconnection makes learning an active educational process in which the mentor first learns about the needs, emotions and experience of their pupils and encourages them to take responsibility for their own development, to become aware that they can influence their life and that they can make their own decisions, to be responsible for themselves and to show initiative.

In the field of education for health, we consider the following modern economic, social, political, cultural and environmental trends:

- changes in childhood and growing up, the phenomenon of the "ageing of societies" and changed intergenerational relations;
- changes connected to gender equality and equality in the family;
- changes in knowledge, technology and work;
- changes in the general lifestyle and in consumption and new forms of inequality arising.

As in the general educational system, education for the health of adolescents concerns not only changes in the method of working, but orientation and the creation of conditions for lifelong learning, which means: learn to know; learn to know how to work; learn to know how to live in a community; and learn to be.

The promotion of mental health through active learning of health education contents includes the creation of conditions to enable the process of forming overall personalities, focusing on knowledge, critical judgement, cooperation, responsible behaviour and effective performance in the field of health.

The basic initial question of the programme is:
How to talk to adolescents to make them understand better and to accept contents from the field of health protection.

It has been proven that by developing a sense of self-worth we can influence an adolescent's success and effectiveness, reduce negative behaviours and addictions and increase opportunities for every individual to succeed in personal life and at school. The sense of self-worth is a foundation, based on which adolescents can be delivered the most sensitive health education material.

The sense of self-worth contains components of perception, value and emotions: how we see ourselves, how we evaluate ourselves and what we feel about ourselves; and it is mostly based on a feeling of capability and effectiveness in dealing with the future.

Special attention needs to be paid to:

- becoming used to respecting oneself and others,
- becoming used to trusting oneself and one's abilities,
- being aware of a sense of power, energy and vitality,
- the ability to give recognition and love, to becoming more open to feedback, being prepared to accept criticism and proposals,
- coping with stress and worries,
- learning a sense of safety, identity, affiliation, meaningfulness and ability.
  - Lecture and discussion: Let us learn about a healthy lifestyle
  - Workshop: Ten steps to improving one's self-esteem (4)
  - Workshop: Let us learn about a healthy diet and physical activities (7)

To achieve the purpose of the project, the following has been used: the workshops of the This Is Me (To sem jaz) programme and workshops for the promotion of healthy food among children and adolescents, which have already been evaluated, and the evaluation of the programme for the promotion of a healthy lifestyle of early school leavers.

TARGET POPULATION

The target population includes Roma assistants, Roma children and school children and their parents.

The selection of the population included in the programme is based on information on the health of Roma presented in other chapters of this publication.

Roma assistants play a significant role in the Slovenian educational system (6). Their role consists of several layers. On the one hand, they are the person at school or kindergarten to whom Roma children can turn for help to overcome various problems, and in this framework, they cooperate with professional workers at school or kindergarten; on the other hand, their role is to help the parents of Roma children in

their contacts with schools or kindergartens. Roma assistants thus form the main link between schools or kindergartens and the Roma community.

The main tasks of Roma assistants include:

- giving assistance to Roma children to overcome emotional and language barriers;
- establish and maintain contact with Roma children's parents in their communication with qualified staff at school or kindergarten;
- cooperate with qualified staff at school or kindergarten in the formulation and implementation of measures to improve Roma school children's performance;
- cooperate with qualified staff at school on activities intended to improve the integration of Roma children with other children;
- promote the importance of education in Roma communities;
- independently implement activities for Roma children and their parents in the environments in which they live;
- cooperate with providers of project activities of Roma educational incubators and extracurricular activities. The training of Roma assistants in different fields plays a significant role in the quality of their work and the encouragement of Roma children and school children in different fields.

The programme of education will give Roma assistants new knowledge and skills which significantly influence health and the reduction of health inequalities, the health of Roma children and school children and, indirectly, on the environment and the families in which these children live.

Source:
https://sobotainfo.com/novica/lokalno/po-celotnem-naselju-pusca-mozno-prikljucevanje--na-kanalizacijo/414937

PROGRAMME IMPLEMENTATION IN THE GROUP OF ROMA ASSISTANTS AND RESULTS

The programme was implemented in the form of a training course titled "Education for health". Educational materials were produced and two training courses organised. The educational programme "Education for health" dealt with the following topics: *Healthy lifestyle, healthy diet of school children, mental health of children and adolescents, discussion of current problems in the work of Roma assistants and evaluation*.

Thus, the training course for Roma assistants was implemented at two locations: in Maribor and in Novo Mesto. Their implementation was organised with the help of the Centre for School and Outdoor Education, which coordinates and leads the group of Roma assistants. The cooperation with the Centre is an example of good cross-sectoral cooperation in approaching the target group. Education took place in the form of interactive workshops where participants could actively participate and influence the course and conduct of the workshop. Thus, for example, in the framework of the workshop on healthy diet, they were able to calculate sugar content in drinks and other foods by using sugar cubes and learning to read food declarations.

The evaluation of training courses demonstrated the need for training courses on health and also that knowledge and education in this field was lacking, and that a fear existed concerning how Roma assistants could talk to children and adolescents about health. These findings point to the need for additional trainings for Roma assistants who are in direct contact with Roma children and their parents. By improving health literacy, sovereignty is also improving in this field, which is a part of general education and not only an exactly specified activity within the curriculum implemented by Roma assistants within their regular work programme. It was emphasised that good cooperation of experts with Roma assistants is an important link to further cooperation with Roma children, adolescents, parents and Roma community.

CONCLUSIONS

The promotion of a healthy lifestyle must be included in the continuing education and training of Roma assistants. The same topic needs to be included in the training of managers of multi-purpose Roma centres which are in direct contact with Roma in the settlements.

The introduction of material to promote a healthy lifestyle in the permanent professional training of Roma assistants, the professional training of managers of multi--purpose Roma centres in healthy lifestyle and mental health promotion, which then support the operations of Roma assistants.

The inclusion of local communities to enable an improvement in the living conditions in Roma settlements is a prerequisite for activities to promote the health of the members of Roma community. Proper living conditions have a major influence on the work of Roma assistants, who form the link between Roma children, school children, their families and the environment in which they live.

Poor living conditions and deprivation prevent the improvement of the health of the Roma community members. In addition to improving living conditions (living quarters, hygiene of the immediate and wider environment), it is necessary to continually act in the field of promoting a healthy lifestyle.

We see continued activities in the cross-sectoral cooperation of health-care institutions, especially health centres, and educational institutions, local governments, etc.

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Recommendations

This publication presents the public health measures and activities aimed at securing better health for Roma that have been carried out in the period since the last economic crisis.

It presents the causes affecting the creation of differences in health between different groups of the population.

It also offers an example of an integrated community approach to health.

The Ministry of Health continued its interdepartmental cooperation and the promotion of targeted activities aimed at Roma health using project finance funds. Project activities were directed mainly towards raising the health literacy and boosting and protecting the health of Roma women, an especially vulnerable sub-group. We should highlight the cooperation with the Slovenian Government Office for National Minorities and the cooperation with the representatives of local authorities and non-governmental organisations.

The National Institute of Public Health carried out activities to boost health and raise the health literacy for the group of Roma assistants, who are an especially important and influential group within the Roma community, and continued the media activities aimed at raising awareness, providing information and motivating in the area of health. We highlight the NIPH research conducted in 2017-2018 entitled "Presentation of the use of health services by Roma in the healthcare system in Slovenia" as a turning point in the area of monitoring Roma health. The research used quantitative data from national databases and qualitative data in the form of interviews. We show an example of a programme to raise the health literacy of Roma assistants, who are important members of the Roma community and a link between the Roma community and the education system. We explain the rights under health insurance and the means of making these rights more accessible to Roma.

Based on the data presented we may conclude that the economic crisis had a stronger impact on the Roma than on the majority population, with accessible indicators of health deteriorating more seriously among the Roma. It is important to note the difference in the health indicators between the Roma who live in Dolenjska and Bela Krajina and those who live in Pomurje, the difference favouring the latter.

In view of the results of research, available data on the geographical differences in health among Roma and the observations from field work, we may conclude that the

area of Roma health is strongly impacted by socio-economic determinants, especially the multifaceted and multigenerational deprivation, unsuitable living conditions and the absence of certain other preconditions for health identified by the World Health Organization. This is followed by a markedly lower level of educational achievement and consequently a very high level of unemployment.

In view of the valid legislation covering Roma health, and taking into account data on the use of health services and other public health activities for Roma, we may conclude that in the area of Roma health there already exist functioning and effective measures for their improved health. Additional improvements are needed mainly in the area of raising health literacy and of communication between health workers and Roma.

No improvement in Roma health will be attained without an improvement in the socio-economic determinants, principally living conditions, education level and employment. Early start in life is of outmost importance, hence involvement of Roma children in preschool education system.

Basic living conditions (appropriate hygiene in the living space, drinking water, sewers and electricity) facilitate equality between Roma and other children at the start of life. Creating these basic life conditions would contribute positively to the early inclusion of Roma children in the pre-school education system.

With deficient support for uneducated and widely deprived parents, as a social and educational support Roma assistants play a key part in supporting Roma children to achieve success in learning, to continue studying and to complete essential primary education. Roma assistants are a model in the community, especially among children, and at the same time proof that it is possible to break the vicious cycle of poverty and social exclusion.

The level of education is a decisive factor in searching for and gaining employment. Multigenerational unemployment as the majority pattern in the community probably also affects attitudes to employment.

Based on research results and the opinion of experts, the recommendations for improving the health of Roma are as follows:

1. Facilitate basic living conditions in Roma settlements: drinking water, sewerage, electricity and basic hygiene conditions along the lines of already arranged settlements
2. Increase the enrolment of Roma children in pre-school education institutions in line with already existing best practices
3. Achieve enrolment and completion of primary school education for all Roma children
4. Increase enrolment, reduce the drop-out rate and increase the number of Roma with further education
5. Increase the employment of Roma in the public sector in areas that directly affect the life of the Roma community (mainly in the health and education sectors)
6. Boost work in raising health literacy by means of consistent implementation of a community approach and making preventive health services more reachable in settlements where Roma live
7. Continue periodical monitoring of the health status of Roma in the manner conducted in the NIPH research
8. Strengthen interdepartmental cooperation between the health, education and social protection spheres by means of regular, in-depth exchange of information, joint planning and coordinated activities
9. In planning measures, the active involvement of Roma from the very start of the process is essential.

List of figures and tables

Source: Archive of the Murska Sobota Institute of Public Health,
author Zdenka Verban Buzeti