# “Roma access to quality, inclusive and affordable health and long-term care in Slovakia”

## Introduction

This report was prepared by Zuzana Havírová from the Roma Advocacy and Research Center, which has long been dedicated to Roma inclusion in all areas of life. Through its research and advocacy activities, the organization contributes to the formation of public policies aimed at strengthening the rights and position of Roma in Slovakia and improving the living situation of Roma from poor and marginalized localities.

The Roma live in Slovakia in different socio-economic conditions. According to the Atlas of Roma Communities[1] about 400 thousand live in Slovakia Roma, of which 46.5% of Roma live integrally among the majority population in the same socio-economic conditions, 11.5% live in settlements within the municipality, 23.6% live in settlements on the outskirts of the municipality and 18.4% live in segregated communities. Most Roma communities are located in the Banská Bystrica, Košice and Prešov regions. In these regions we find the largest number of segregated Roma communities, in which several disadvantages and generational poverty accumulate.[2] This report focuses on a group of Roma living in marginalized Roma communities (MRC). The share of unemployed people from the MRC environment is 38%. While in the general population the median equivalent disposable income for a one-person household is € 7,462 / year, in the MRC environment it is only € 2,335. Almost 85% of MRC people live below the official poverty line. Within the general population, this share is 12.2% - almost seven times lower. About 17% of people from MRC live on less than € 3.8 per day. Children under the age of 15 make up more than a third of MRC people (36%) living below the poverty line. This fact testifies to the reproduction of generational poverty in the MRC and the considerably limited possibilities of escape from it. The share of people older than 64 years in the MRC environment is three times lower than in the general population (5% to 17%).[3]

The main aim of the report is to describe the situation in the area of Roma health, access to health care and long-term care. For processing, we chose secondary analysis as a method by which we analysed documents, research studies and public policies in the areas of public health, healthcare delivery, patients' rights and long-term care. Secondary data analysis is a suitable tool for comparing studies and data collected by other researchers. In the process of secondary analysis of research data, we analysed the results that prove the differences between the health status of the Roma and the majority population.

[1] In 2019, another geographical survey of Roma communities took place. However, due to the use of a different methodology in the detection and subsequent inaccurate interpretation of the data, we do not draw this data.
[2] Mušinka et al, *Atlas rómskych komunít na Slovensku 2013* (Bratislava: Regional Centre UNDP in Bratislava, 2013), available at: https://www.minv.sk/?atlas_2013
[3] Tatiana Grauzelová a Filip MARKOVIČ, *Príjmy a životné podmienky v marginalizovaných rómskych komunitách. Vybrané ukazovatele zo zisťovania EU SILC MRK 2018* (Bratislava: USVRK SR, 2018)

It is important to note that the data in the analyses are based on attributed ethnicity, or on data from the Atlas of Roma Communities, because in Slovakia it is not possible to record health data based on the ethnicity of patients. We supplemented the secondary analysis with information we obtained through many years of research in marginalized Roma communities.

For the more effective inclusion of people from excluded poor areas, it is important that they have access to quality and inclusive health care, as this not only affects their personal implementation, but also contributes to better public health in society as a whole.

## Roma access to health and long-term care in Slovakia

- ✓ **Social determinants of Roma health**

The health status of the Roma from the MRC is generally worse than that of the majority. Several factors affect the deteriorating health of people with MRC. The most important factor is the situation in the area of housing, because the Roma often live in houses that are not built well, are not energy-efficient and so the inhabitants are exposed, for example, to toxic gases from the combustion of various substances.

Furthermore, there are factors resulting from insufficient funds, where poor Roma families do not have money left even for the lowest fees for medicines, or fees for a visit to a doctor - a specialist and travel expenses for a visit to a doctor.[4]

Insufficient level of health awareness and lower education are also factors that affect the health status of Roma from the MRC.

Another factor is limited access to quality drinking or at least running water. The food situation is also dependent on the level of household income. Raw fruits and vegetables are consumed daily by 21.5% of Roma households, dairy products are consumed daily by 23.8%, meat and cold cuts by 34.3% and flour dishes or sweets are consumed daily by 30% of Roma households.[5] These data show that the nutritional value of the food intake is very low, which has an impact on the overall health status of the inhabitants of poor, excluded localities.

Sewerage is mostly inaccessible in the settlements, waste export services do not work, which creates dangerous landfills in localities even with the presence of rodents, which are the source of many infections and parasitic diseases.

Research Institute of Financial Policy 2018[6] showed that life expectancy at birth in 2015 was on average six years shorter for the Roma than for the non-Roma population (69.6 years compared to 76.4 years).

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[4] Človek v ohrození, *Sú Rómovia v osadách zdravší než majorita?* (Bratislava, 2021), available at: https://clovekvohrozeni.sk/su-romovia-v-osadach-zdravsi-nez-majorita/

[5] Andrej Belák, *Úrovne podmienok pre zdravie a zdravotné potreby vo vylúčených rómskych osídleniach na Slovensku* (Košice: Univerzita P.J.Šafárika, 2020) at 55.

[6] Marcel Bojko, Slavomír Hidas, Gabriel Machlica a Martin Smatana, *Inklúzia Rómov je potrebná aj v zdravotníctve*, Komentár 2018/23, at 1-2; available at: https://www.finance.gov.sk/sk/financie/institut-

The mortality rate of Roma new-borns (i.e., children under one year of age) is almost three times higher than that of non-Roma children (12.3 versus 4.2 per thousand live births). The highest mortality of Roma new-borns was recorded in the district of Trebišov, where on average more than 27 Roma children die before the age of one.

Roma, especially Romani women, are generally more prone to chronic diseases. The most common chronic diseases among the Roma include cardiovascular diseases (29.7%), followed by respiratory diseases (14.3%), joint and bone diseases (14.3%), nervous system disorders (12.5%) and mental illnesses. (10.4%). The incidence of cardiovascular disease is 2.5 times higher among the Roma (29.7%) than in the majority population.[7]

There is a very high population density in Roma settlements. One dwelling is often shared by three or more generations of the family, and it is not uncommon for 10 or more people to sleep in one room. This, together with insufficient ventilation and overall poor hygiene, leads to a higher incidence of respiratory diseases and other airborne diseases.[8] It follows from the above that living conditions have a major impact on the health of the population and that people living in poor and socially excluded localities are significantly worse off than people living in better living conditions.

- ✓ **Health insurance coverage of the Roma**

The Constitution of the Slovak Republic declares that everyone has the right to health protection. On the basis of health insurance, citizens have the right to free health care and medical devices under a condition stipulated by law.[9] The health insurance system in Slovakia is regulated by Act No. 580/2004 Coll. on health insurance. The Act defines health insurance as 1. compulsory public health insurance, on the basis of which health care and services related to the provision of health care are provided to public health insurance policyholders, and also as 2. Individual health insurance, on the basis of which individual health care is provided to policyholders.[10]

Every person who has a permanent residence in the territory of the Slovak Republic, is employed or carries out a self-employed activity must be compulsorily covered by public health insurance. A publicly insured person is also a person who is registered as a job seeker and does not receive unemployment benefit, i.e. he or she can receive, for example, a benefit in material need, ie he / she is registered as a job seeker. Persons who have reached

financnej-politiky/publikacie-ifp/komentare/komentare-z-roku-2018/23-inkluzia-romov-je-potrebna-aj-zdravotnictve-december-2018.html

[7] *Civil society monitoring report on implementation of the national Roma integration strategy in Slovakia – Assessing the progress in four key policy areas of the strategy*, (Brussels: EC, 2019), at 49, available at: https://cps.ceu.edu/sites/cps.ceu.edu/files/attachment/basicpage/3034/rcm-civil-society-monitoring-report-2-slovakia-2018-eprint-fin-3.pdf

[8] Zuzana Paraličková, Pavol Jarčuška, Dana Hudáčková, *Infekčné choroby u marginalizovaných skupín Rómov žijúcich v osadách*, Via practica, 2015, vol. 12 (3), available at: https://www.solen.sk/storage/file/article/654fe326b8d3491f1ef0858d2624808e.pdf

[9] Art. 40 of the Constitution of the SR

[10] §2, Act no. 580/2004 Coll. on health insurance

retirement age but are not entitled to a pension are also covered by public health insurance. This also applies to persons who do not have a permanent residence in the Slovak Republic but are employed by an employer based in the Slovak Republic. Other publicly insured persons are asylum seekers, students of another Member State, or foreign students studying at a school in the Slovak Republic on the basis of international agreements, minor foreigners who reside in the Slovak Republic without a legal representative or natural person responsible for their upbringing, court-appointed facilities and other groups as defined by law.[11]

This means that, for example, Roma who are not employed but are registered as jobseekers are publicly insured and the state pays insurance for them. The problem may arise if the Roma are self-employed. In that case, they have to pay for their own health insurance, which is regulated by special regulations.[12] These payments need to be made on a monthly basis, and our experience from other field surveys shows that some self-employed Roma do not fulfil this obligation and thus incur debts on compulsory public health insurance. Such a situation means that the debtor on public health insurance is not entitled to free health care other than urgent health care (this can be, for example, post-accident treatment).[13]

It follows from the above that if a Roma is born in Slovakia and has a permanent residence in the territory, he is automatically covered by public health insurance. At the same time, if a Roma is employed or registered in Slovakia as an unemployed person, he or she is also covered by public health insurance. If he is employed, the employer pays him an amount from his gross monthly salary from the relevant health insurance company and also pays health insurance for him in the amount specified by law. If the Roma are registered as unemployed, the state pays for the public health insurance.

People excluded from health insurance are only those who are voluntarily unemployed and who do not pay their health and social insurance. There are no statistics on how many Roma there are, but most are either registered as unemployed or receive benefits for material need (minimum income).

Participation in the compulsory public health insurance system is a basic condition for access to health care for pregnant women, including regular medical examinations. A woman who has unpaid health insurance debts is only entitled to urgent health care until the 34th week of her pregnancy. After this date, her health insurance is covered by the state and thus she has access to standard health care. This condition lasts until the child reaches the age of three, or six if the child has a disability.[14]

[11] §3, Act no. 580/2004 Coll. on health insurance

[12] Act no. 576/2004 Coll. on health care, services related to the provision of health care, Act no. 577/2004 Coll. on the scope of health care reimbursed on the basis of public health insurance and on reimbursements for services related to the provision of health care, Act no. 363/2011 Coll. on the scope and conditions of reimbursement of medicines, medical devices and dietetic foods under public insurance

[13] §9, Act no. 580/2004 Coll. on health insurance

[14] *Civil society monitoring report on implementation of the national Roma integration strategy in Slovakia – Assessing the progress in four key policy areas of the strategy*, (Brussels: EC, 2019), at 51, available at: https://cps.ceu.edu/sites/cps.ceu.edu/files/attachment/basicpage/3034/rcm-civil-society-monitoring-report-2-slovakia-2018-eprint-fin-3.pdf

- ✓ **Access to health / care services in Roma communities**

According to IFP data from 2018, Roma use health care services 30% less compared to the non-Roma population. According to the data, the cost of public health insurance for young Roma men aged 5-29 is 40% lower than for the majority population. The only demographic group in which the cost of public health insurance is higher for the Roma than for the majority population are young Roma women aged 20-24, which is related to the higher number of births. According to a 2012 UNDP study, Roma are less likely to seek health care due to a range of factors that include low self-awareness and the belief that their health problems do not require professional help (33%); another 22% of Roma believe that their problems will go away on their own and the remaining 18% gave financial reasons.[15]

High transport costs and surcharges limit access to health care for the poor. As many as 18% of Roma respondents to the UNDP survey 2012 who did not seek health care when they needed it cited financial unavailability as a reason, compared with 1% in the majority population living in their vicinity. Patients' financial participation in health care financing represents an average of 2.4% of household consumption, which is slightly below the EU average (2.8%).

Supplements for medicines make up the largest share of co-payments. Although drug categorization allows physicians to prescribe drugs at no extra charge (typically generics), in practice many prefer to prescribe more expensive original drugs, for which patients have to pay extra. Socially disadvantaged patients, who are often less informed, may not be aware of the possibility to choose a free alternative and therefore do not exercise this freedom of choice in practice. At the same time, the financial burden for poor people can be many times higher than the national average. Slovak legislation exempts pensioners, the disabled and children under the age of 6 from the obligation to pay extra.[16] Since January 2022, legislation has been in place that exempts people from co-payments for medicines if their income is less than € 680 per month. This adjustment applies to the prescription of the cheapest medicines.[17]

One of the reasons for the low consumption of health care in Roma communities is the distance of health facilities from the place of residence. In municipalities belonging to Roma communities, the proportion of Roma living 10 kilometres or more from the nearest ambulance is almost three times higher than the majority population. The biggest problem is with the availability of gynaecological clinics, where up to a quarter of the population of Roma communities have to travel 10 kilometres or more.[18]

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[15] Ibid, at 53

[16] Tomáš Hellebrandt, *Revízia výdavkov na skupiny ohrozené chudobou alebo sociálnym vylúčním*, (Bratislava: UHP, IVP, 2019), at 68, available at: https://www.minedu.sk/data/att/14208.pdf

[17] Všeobecná zdravotná poisťovňa, *Uhrádzanie doplatkov za lieky po prekročení limitu spoluúčasti – zmena zákona od 1.1.2022,* available at: https://www.vszp.sk/poistenci/zdravotna-starostlivost/uhradzanie-doplatkov-za-lieky.html

[18] Tomáš Hellebrandt, *Revízia výdavkov na skupiny ohrozené chudobou alebo sociálnym vylúčním*, (Bratislava: UHP, IVP, 2019), at 69, available at: https://www.minedu.sk/data/att/14208.pdf

The most important tool in Slovakia, which is explicitly focused on social inclusion in the field of health, is the national project Healthy Communities. The project is implemented by the state-subsidized organization Healthy Regions established by the Ministry of Health in December 2016. It is basically a form of field social work, which is focused more on improving the health situation of excluded groups, especially MRC. With the help of health education assistants who work in the field with the target group, the organization implements education activities in the MRC environment as well as health mediation (e.g. communication between MRC residents and medical facilities). The main goals of these activities are to reduce barriers to access to health care, increase health literacy and improve health-related behaviour. Preventive dental health screenings are free for everyone in Slovakia. However, follow-up dental care is chargeable and therefore people who live in marginalised environments or are poor do not have the money for such care.

- ✓ **Roma with disabilities**

Slovak legislation does not recognize the definition of a person with a disability. Disability can be defined as any mental, physical, temporary, long-term or permanent disorder or disability that prevents people with disabilities from adapting to the normal demands of life. Disability involves a number of functional limitations that occur in society in every country in the world. It can be physical, mental and combined. The origin and existence of a disability is a social event that fundamentally affects the life of every person. The impact of this situation is felt not only by people with disabilities, but also by their families and today's society.[19]

Financial compensation, a severely disabled person's card and a parking card are compensations that are awarded on the basis of the degree of functional impairment. The state supports the social integration of people with severe disabilities into society by providing them with assistance in the form of one-off and recurring financial contributions to compensate for severe disabilities.[20]

Based on our experience in the field, we have not noticed any problems in accessing the disability compensation benefits that the Roma would face. The problem may arise in the case of medical assessment, but in-depth interviews with selected respondents would be needed in this specific area, which would require greater time and financial capacity.

- ✓ **Roma mental health**

Long-term stress significantly contributes to the development of mental and civilization diseases, especially cancer and cardiovascular, but also metabolic disorders. In particular, repeated psychological traumas can easily cause behavioural or personality disorders in individuals and lead to social conflicts and even isolation, associated with other negative consequences for health in general.

[19] See more: https://www.employment.gov.sk/sk/rodina-socialna-pomoc/tazke-zdravotne-postihnutie/kontaktne-miesto-prava-osob-so-zdravotnym-postihnutim/zdravotne-postihnutie.html

[20] Act no. 447/2008 Coll. on cash benefits to compensate for severe disabilities

In addition, higher levels of stress or the frequency of psychological trauma in populations tend to increase the presence of various risky behaviours (e.g. substance abuse, as such behaviours are effective means of coping with excessive mental strain in the short term).

Despite the fact that at least 15% of the population (almost 625,000 people) suffered from mental illness in Slovakia in 2018, mental health care has long been underestimated and neglected. Anxiety and depressive disorders are most prevalent. A significant barrier is the stigmatization of mental illness, which often stands in the way of identifying a problem and seeking the necessary help.

More than 80% of people in Slovakia aged 15 to 64 suffering from anxiety disorders or alcohol dependence, and almost 70% of people suffering from depressive disorders, were not provided with any professional care. In 2019, about 85,000 people were examined in psychiatric outpatient clinics, of which more than 20,000 were for neurotic, stress-related and somatoform disorders.[21]

To increase the need for mental health, the Council of the Government of the Slovak Republic for Mental Health was established in February 2021 as an advisory body of the Government of the Slovak Republic, which performs coordination, consultative and professional tasks in the field of mental health protection and prevention, psychological disorders, follow-up care for patients with mental disorders, mental health research, training of mental health professionals and services, mental health policy-making and quality monitoring in these areas.

In October 2021, the Council of the Government of the Slovak Republic for Mental Health adopted the WHO Athens Summit Declaration on Mental Health Care Measures in the Consequence of the COVID-19 Pandemic, a Proposal for the Establishment of a National Mental Health Centre as well as proposal for the implementation of the project Collection and processing of mental health data.[22]

According to research from the Level of Health and Health Needs Research in Excluded Roma Settlements in Slovakia in 2020, in the year under review most households suffered for a long time and experienced stress due to debt (37.6%), serious illness of themselves or loved ones (24.8%) and winter in the house (23.9%). Other stressors included lack of food and hunger (13.5%), experience of discrimination (12.9%), disputes outside the home (12.1%), prosecution and imprisonment of a loved one (10.7%), loss of home and forced evictions (10.1%).[23]

[21] Martina Adamčíková a Zuzana Zavarská, Skrytá pandémia: kríza duševného zdravia ako dôsledok COVID-19, (Bratislava: Inštitút pre stratégie a analýzy, 2021), available at: https://www.vlada.gov.sk/share/uvsr/isa/komentare/skryta_pandemia-_kriza_dusevneho_zdravia_ako_dosledok_covid-19.pdf

[22] https://www.health.gov.sk/?rvdz

[23] Andrej Belák, *Úrovne podmienok pre zdravie a zdravotné potreby vo vylúčených rómskych osídleniach na Slovensku* (Košice: Univerzita P.J.Šafárika, 2020) at 76.

In the case of mental health problems, according to research from 2021, half of the people would choose a psychologist, a third as their general practitioner. Every eighth would not look for anyone. The general practitioner would be followed by older people and those with a basic education. On the contrary, most young people would go mainly to a psychologist. On average, people would look for psychiatrists and psychotherapists second in line.

Overall, only a third of respondents chose more than one specialist to visit in case of mental health problems. The most common connection in people's minds is a visit to a general practitioner first and then a psychologist.[24] As there are no data on the Roma's approach to tackling mental illness, it can be assumed that the situation is much worse, as overall health literacy among the Roma is at a much lower level and this type of problem is assessed as less serious than other diseases.

- ✓ **Older Roma and their health needs**

As we mentioned above, the Roma of the MRC live to a much younger age than the majority. The share of people older than 64 years in the MRC environment is three times lower than in the general population (5% to 17%). This finding is in line with previous research, which points to a significantly lower life expectancy in MRC (71 years in MRC compared to 76 years in the general population).[25]

The approximate share of older people in excluded Roma settlements is around 5.9%, while the share of children is 44.8% and the share of adults in the MRC is 49.3%.[26] Poverty and social exclusion significantly affect the quality of life of Roma seniors. Due to the fact that most Roma seniors receive a very low pension, they cannot afford to buy vitamins or healthy food, for example. Almost 27% of the population from the MRC, including the elderly, do not consume fruit and vegetables before payment or state benefits.

Almost 14% of MRC residents declare that they suffer from food shortages or hunger for a long time during the year.[27] This is an area that deserves more public policy attention, and the state should ensure that seniors with the lowest pensions receive a financial contribution for vitamins and healthy foods. As we mentioned above, an amendment to the law has been in force since January 2022, which abolishes the payment of co-payments for medicines for all seniors, but these are medicines that are cheaper according to the categorization. However, there are no statistics yet to compare whether seniors have chosen more over-the-counter or under-the-counter medicines.

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[24] Liga za duševné zdravie, Postoje k duševnému zdraviu – Slovensko 2021 (Bratislava: Liga za duševné zdravie, 2021), available at: https://dusevnezdravie.sk/novy-prieskum-ligy-kazdy-stvrty-az-piaty-slovak-hlasi-caste-prejavy-uzkosti-a-ine-tazkosti-casto-su-podrazdeni-maju-obavy-a-problem-uvolnit-sa-rastie-pocet-ludi-s-uzkostou/

[25] Tatiana Grauzelová a Filip MARKOVIČ, *Príjmy a životné podmienky v marginalizovaných rómskych komunitách. Vybrané ukazovatele zo zisťovania EU SILC MRK 2018* (Bratislava: USVRK SR, 2018)

[26] Andrej Belák, *Úrovne podmienok pre zdravie a zdravotné potreby vo vylúčených rómskych osídleniach na Slovensku* (Košice: Univerzita P.J.Šafárika, 2020) at 43.

[27] Ibid, at 53.

What can be considered positive is the fact that only a minimal percentage of seniors use facilities for seniors. The most important reason is that the inhabitants of the MRC live in multi-generational families, or live in a very small geographical area, so they are in constant contact with their loved ones. Another reason is that these services are very expensive (approximately 350-500 EUR / month), which is not available if you receive a pension of about 300 EUR per month. Given the king of care provided for seniors in Slovakia, it is much better that they remain in the family. This also brings more money to the household budget. When health complications arise, many Roma seniors do not go to hospital because of the poor quality of services and distrust of the health care system.

- ✓ **Roma sexual and reproductive health and rights**

This area is generally considered taboo among the Roma and is not publicly discussed. We also encounter a similar controversy in Andrej Belák's research, where Roma respondents were not asked direct questions due to their sensitive nature. The values were therefore determined solely on the basis of the direct experience and knowledge of the administrators about the individual settlements or families included in the REPRE samples. On the other hand, as this is an area in which interested administrators often directly assist residents of excluded settlements in cooperation with local health professionals, they generally considered their estimates to be accurate.

Qualified estimates of administrators were to be less accurate only in cases (significantly less frequent), when they were men, for settlements in which the administrators themselves did not live for a long time, and for settlements with more than 500 inhabitants. This survey shows that an estimated 4.2% of households have people who have sex with more than one partner in the same period. Furthermore, in 2.8% of households a child was born to adolescent parents in the last year and 7.7% are parents who are secondary or close relatives. The research also provides qualified estimates of the number of households in which 9.5% of adult women have undergone abortion, 2.7% are using hormonal contraception, and 12.9% of women have an intrauterine device.[28]

A much greater shift occurred in the area of forced sterilizations, which were performed on Romani women in the 1970s and continued after 1992 until 2004. In practice, these sterilizations were performed in various ways. These were mainly acts without proper informed consent, but there are also documented cases where women were often manipulated, deceived, or sterilized under the threat of receiving social benefits. Sterilizations were often performed after various gynaecological procedures or operations, when the woman only subsequently learned that she had also been sterilized. Physicians, nurses, other medical staff, as well as social workers participated directly or indirectly in the sterilization with the support of the state. Women were offered a financial reward for sterilization. The exact number of women and people whose rights have been violated and thus experienced gross abuse of physical integrity is unknown. Some women may not even have learned that they have undergone sterilization.[29]

[28] Ibid, at 63

[29] Michaela Pisova, *Rómske ženy sa aj na Slovensku dočkali ospravedlnenia, na odškodnenie za sterilizácie čakajú*, (Bratislava: Menšinová politika, 2021)

In November 2021, the Slovak government apologized to Romani women for their violent sterilizations. Several injured women seek justice in the European Court of Human Rights and in Slovak courts.[30]

- ✓ **Roma and Covid-19**

More people from marginalized socially vulnerable groups have been affected by the pandemic in terms of infections and mortality, also due to poorer lifestyles and living conditions. The pandemic in Slovakia in the first and second wave claimed significantly more victims in the MRC population compared to the majority. Compared to the average in the period from 2015 to 2019, the number of deaths of people from MRC increased by up to 44% in 2021, compared to 21% in the majority.

The MRC population has a younger age structure than the majority population. If the proportion of older people over the age of 60 in this population were similar to that in the majority, the number of deaths would have tripled. The deaths were the result of a significant infestation, which is estimated to have reached at least 30% of the population in the MRC.

Due to the very low level of vaccination in the MRC population, the impact of the pandemic is likely to be significantly worse than the EU average in the third wave of the pandemic. The overall vaccination rate of people from MRC in Slovakia appears to be even lower than the average of the general population, which lags behind the average of EU countries. This is shown by the significantly declining vaccination coverage in municipalities with a higher share of the MRC population. For example, with the share of people from MRC in the municipality above 30%, the vaccination rate drops to a two-thirds of the vaccination rate of the general population. Some municipalities with a more significant share of the population from the MRC achieve single-digit vaccination rates.

Monitoring of the Healthy Regions organization indicated in November 2021 the average vaccination with the first dose in the MRC at an alarming level of 10%. Even taking into account the significantly higher proportion of the population under the age of 18, the vaccination rate of the adult population reaches only about 20%.[31]

In connection with the spread of the virus, several MRCs were closed during the pandemic. In April 2020, the Government of the Slovak Republic adopted the Plan for the Solution of the COVID-19 Disease in Marginalized Roma Communities, which also contained a 10% limit on the number of infected, at which it is possible to close the entire settlement. However, even this criterion was not applied consistently and several settlements were closed even without its verifiable fulfilment.

[30] See more: https://poradna-prava.sk/aktuality/slovenska-vlada-sa-dnes-ospravedlnila-za-nasilne-sterilizacie-romskych-zien-dalsim-krokom-musi-byt-ich-odskodnenie-slovenska-vlada-sa-dnes/

[31] Slavomír Hidas et al., *Vplyv pandémie na marginalizované rómske komunity* (Bratislava: IFP, 2022), available at: https://www.mfsr.sk/files/archiv/80/2022_1_Vplyv-pandemie-na-MRK_final.pdf

The Ombudsman also pointed out the legal problems and uniqueness of this approach in the EU context in her analysis. Local quarantines have a higher potential to mitigate the effects of COVID-19 in areas with a higher standard of living, in poorer areas without the necessary infrastructure they have not been effective. In smaller closed areas where quarantine measures will worsen access to the necessary infrastructure (supply, health, education) and where people at risk of poverty or exclusion live, restrictions have not had the desired results. In addition to lower testing availability, higher deaths from other reasons may be the reason for the ineffectiveness of local quarantines in a weaker socio-economic environment. The coronavirus pandemic has led to reduced prevention and worsened access to acute care. In segregated communities, which, even without quarantine, face many barriers to accessing healthcare, this effect could have been even stronger.[32]

- ✓ **Discrimination and antigypsyism**

In 2017, the Counselling Centre for Civil and Human Rights published a study entitled Vakeras Zorales - We speak out loud, in which it documented the experiences of Roma women with reproductive health care in Slovakia.[33]

In the study, for example, Ms. Viola confided in her experience when she visited a gynaecologist who stalked, shouted and cursed Roma women from MRC that they were dirty, smelly and that they went to the doctor unwashed. She also confided in her how she was treated in the maternity ward when she had her first child. However, the nurses and doctors cursed her and other Roma women for gypsies and left her in pain, even though she gave the majority women a painkiller. Romani women have rooms in some maternity wards where there are no majority women, as well as food in other areas than the majority women. The staff does not clean the rooms in which the Roma are located. In addition to Viola, other women shared their experiences. Almost all of them stated that they had experienced segregation in maternity wards due to their Roma origin. This consisted of separate rooms in the wards, the provision of meals in separate areas or dedicated tables for Roma women in the dining room.

This study points to humiliation, and almost all women said in interviews that they had been exposed to ill-treatment and violence by some health professionals in the gynaecology clinic and maternity ward. The Roma women described various forms of behaviour that they considered unresponsive: from heightened voices and shouts, degrading and abusive addresses and actions, to vulgar verbal expressions, including racially motivated statements and physical violence. Some women have repeatedly said that the contraceptive methods they would prefer are unaffordable. In addition, they expressed the view that doctors did not always respect their decision to change a particular method of contraception. Some women also said that their gynaecologist did not respect their decision to have an intrauterine device removed before it expired.

[32] Ibid.

[33] Vanda Durbáková et al., *Vakeras zorales – hovoríme nahlas* (Košice: Poraňa pre občianske a ľudské práva, 2017), available at: https://www.minv.sk/swift_data/source/romovia/publikacie/kniznica/vakeras-zorales-hovorime-nahlas-skusenosti-romskych-zien-so-zdravotnou-starostlivostou-o-reprodukcne-zdravie-na-slovensku%20(1).pdf

Despite the fact that Slovak legislation guarantees that health care should be provided to its recipients in good quality and without discrimination on the grounds of gender, gender and race, the experience of Roma women with reproductive health care points out that state institutions need take effective measures to ensure the consistent application of this legislation in practice. Many of the experiences described by women point to human rights violations and include repeated discrimination, segregation and violence in gynaecological, obstetric and postnatal care.[34]

## Conclusions and Recommendations

Roma from marginalized and poor backgrounds have significantly worse health, leading to deaths at a younger age than the majority. Poverty and social exclusion cause inequalities in access to health care, even though laws and public policies guarantee equal rights for all their citizens. The field of health is very important, because it depends on the extent to which a person is able to participate in the work process and earn the funds necessary for life. The good health of individuals also reflects the good overall state of public health, which results in less state budget expenditure. And the money saved can be used to eradicate social exclusion and poverty.

However, as our findings show, the Roma from the MRC also face disadvantages in terms of health and a healthy lifestyle. According to the data we present, the Roma are exposed to the adverse effects of the poor environment from an early age. In the area of housing, Roma from the MRC live in unsuitable and unhealthy dwellings, which worsen their health. Due to low funds, they cannot afford to buy healthy food and e.g. fruits or vegetables are consumed only occasionally. The overall low level of knowledge means that they have very poor knowledge of health and disease prevention. MRC Roma also have a low awareness of preventive check-ups, and if they don't really feel bad, they don't go to the doctors at all. It often happens that seniors visit the hospital for the first time in their lives.

This behaviour is to some extent related to the distrust that Roma feel towards health care, doctors and nurses. This mistrust stems from the negative experiences of health facilities that Roma women still face during this period. These manifestations of antigypsyism are most common in maternity hospitals and gynaecological facilities, as our report shows.

- ✓ **Roma health in the National Roma Strategic Framework**

The Government of the Slovak Republic is aware that antigypsyism exists in this area and therefore the Action Plan for Health in the Strategy for Equality, Inclusion and Participation of the Roma by 2030 sets a global goal to reduce health inequalities among the Roma, specifically the MRC, and the general population. Measures include, for example, prolonging life expectancy by reducing neonatal mortality or also improving the knowledge of MRCs about the system of reporting suspected discriminatory behaviour in the process of receiving health care services. The strategy also contains a separate action plan to eliminate discrimination and antigypsyism in all areas, including health.

[34] Ibid

✓ **Recommendations**

To improve the health of the Roma, access to health care and the suppression of antigypsyism, it is necessary to:

- put in place an effective system of reporting discriminatory practices and at the same time start tackling more effectively reported discriminatory practices
- introduce a system of monitoring compliance with the anti-discrimination law in health care facilities, hospitals and other institutions that provide health care
- The Slovak government should compensate Romani women who have undergone illegal sterilization
- Doctors, nurses and health professionals should be familiar with anti-discrimination legislation during their studies, as well as learn about antigypsyism and its manifestations.
- every hospital should have a code of compliance with the anti-discrimination law, part of which should also be devoted to the fight against antigypsyism
- expand the scope of education in primary schools to include sex education, which will also include information on contraceptive methods
- adopt legislation to make contraception more affordable for women in material need and receiving the minimum wage, or to be covered by compulsory health insurance
- it is necessary to improve the quality of housing of the inhabitants of the MRC and to solve problems with the availability of drinking water in all dwellings
- improve access to healthcare in marginal rural areas
- making health care financially accessible even for those who are poor, living below the minimum living standard

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