



CENTER FOR INTERETHNIC DIALOGUE
AND TOLERANCE "AMALIPE"
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**THE HEALTH STATUS
OF ROMANI WOMEN
IN BULGARIA**

Report

Veliko Turnovo
2008

Research team

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INTRODUCTION

Background

On January 1, 2007 Bulgaria (together with Romania) joined the European Union. This crucial for the entire Bulgarian society event had dual meaning for the process of Roma inclusion and particularly for improving Romani women's health situation. From one side it meant ceasing the Annual Monitoring Reports for the Advance of Bulgaria prepared by the European Commission. It is not a secret that most of the initiatives for Roma integration undertaken by Bulgarian government were advised and recommended by the European Commission through its Regular Monitoring Reports. Most of Roma activists were afraid that all significant actions for Roma inclusion would be stopped after the end of the direct EU pressure. From the other side, Bulgarian Accession meant that Bulgaria became an object of all European mechanisms for defense of human and social rights including the rights of people belonging to ethnic minorities. Furthermore, all this meant that the European Structural and Cohesion Funds could be used for achieving social and ethnic cohesion in Bulgarian and for achieving real Roma inclusion. The crucial importance of this fact should not be underestimated: it could provide the necessary financial resources for the Roma integration process especially in the field of education, social issues and employment, and health. Moreover, the period until June 2007 was the period when the strategic documents in this direction were finally prepared and submitted for approval to the European Commission: in June 2007 the National Strategic Reference Framework was finally approved and signed and the first call for projects within the Human Resource Development Operational Program was announced.

During the reported period the governmental policy for Roma integration has continued to be passive although some positive steps need to be noted. For example, during a conference on April 15 the Prime-Minister Stanishev stated that special targeted actions for Roma integration were necessary and would be initiated. Similar statement was made by the Chair of Bulgarian Parliament Pirinski during special meeting with Roma activists. In addition, the position of the Roma health mediators was finally financially backed-up by the state budget and the Ministry of Finance.

At the same time, the high level of discrimination in attitudes and actions, including high-ranked political figures ought also to be pointed out. After the health minister Radoslav Gaydarski had proposed at the end of 2006 a law to forbid young Roma girls to give birth, the Minister of Labor and Social Policy Emilia Maslarova stated that she would do her best to stop Romani women being “incubators for children.”

Nevertheless, Bulgaria continued to chair the Presidency of the Decade of Roma Inclusion during the reported period. This initiative was backed up with small financial resources and its activities were mainly ceremonial and symbolic unless they were not financed by EU projects.

The report

The idea for the present report appeared to feel a gap existing regarding Romani women health situation in Bulgaria. Only few peaces of data are available regarding Romani women situation. They are even fewer concerning Romani women health status. At the same time, dynamic changes in the health system in Bulgaria in the recent years affected mostly Roma. This necessitates a study “mapping” the situation. The present research does not pretend to be an exhaustive study but it sets a frame that should be additionally filled up in the future. The authors will be happy if the present research provokes other research teams to continue and extend this work.

The research aimed at revealing the heath status, problems and needs of Romani women in Bulgaria with respect to factors such as type of settlement, Romani sub-group they belong to, age and marital status which would create a clearer picture. A tailored approach has been extremely important because the specifics of the different sub-groups within the Roma community, for example, define different problems. Moreover, the different Roma groups due to the difference in the intensity of their contacts with the macro-society are at a different level of modernization which also influences their attitudes towards various issues. At the same time, a number of factors have an impact on forming the perceptions and concepts of the members of a community: religion, type of settlement, type of family, educational level, socio-economic status, and so on. This could result in diversity even within a single Roma community and in contrary situation in two neighboring settlements.

The results from the research are intended to form the basis and provide opportunity for developing straightforward policy towards including Romani women health issues in the Roma policies agenda from one side, and in the agenda of health institutions and organizations from another;

The time for such a research has been well defined: a new Action Plan of the *Health Strategy for People in Vulnerable Position, Belonging to Ethnic Minorities* is

supposed to be prepared in 2008 along with an updated version of the Framework program for equal integration of Roma into Bulgarian society.

The objectives of the needs assessment have been the following:

- Study and evaluate existing literature and investigations on Romani women health situation in Bulgaria
- Evaluate current programs and policies regarding Romani women health status;
- Research and analyze Romani women health situation from the perspective of a researcher and from the position of Romani women in the fields of health care.
- Generate ideas and make recommendations for changes in existing health policies.

The research and the processing of data collected aimed at further empowering Romani women. Romani women have been the major driving force of this report; in designing and carrying out the research. In addition, Romani women with strong academic background participated in the preparation of this report and in a number of follow-up activities. As a result the report presents the Romani women point of view; the view of the insider to the problems in the field of health.

The research has been realized by Center Amalipe with the support and cooperation of partnering local Roma organizations all over the country: World without Borders Association (Stara Zagora), Future Foundation (Rakitovo), District Romani Union (Burgas), Alternative (Byala Slatina), Youth network for development (Simitli), Neve Droma (Shumen) and a number of Roma experts. The research has been financed by the Public Health Program of Open Society Institute – Budapest. Parts of it have been included in a study revealing Romani women situation in Bulgaria in the fields of family life, education, health, employment, housing and participation, prepared by Center Amalipe and published by the Roma Participation Program of the Open Society Institute – Budapest.

METHODOLOGY AND PROFILE OF THE RESEARCH

The research conducted for this report consists of two parts: desk review of existing literature, reports, programs, policies and papers, and a field survey of Romani women of age above 15 years old.

National policies and documents

The study at the national level included desk review of existing reports, analysis and papers concerning Romani women health situation. In the process of gathering empiric information different stakeholders have been covered.¹ The research at the national level aimed at the disclosure of the general policy context and tendencies, and the place and roles of the different actors.

Field survey

The field survey was designed by Expert Analyses Civic Association at the Open Society Institute – Sofia with the participation of Romani women.

The quantitative part of the research consisted of a nationally representative study of women above 15 years old living in areas with concentration of Roma population. It was carried out in September and October 2007.

The sample was a two stage cluster sample. The effective number of questionnaires carried out was 542 (at an average level of responsiveness of the respondents 86% and 5% lack of selectable respondents).

The random selection of the people included in the sample was based on the method of the geographical sample in order to include to the highest possible extent the people living in the Roma neighborhoods including those whose households are not included in the administrative territorial registers. At the national level the geographical method was applied also within the research carried out by the Open Society Institute – Sofia on the Health status of persons living in areas with high concentration of Roma population.

¹ See list of interviewees attached

The frame of the sample included the following sources:

- Lists of municipalities, settlements and neighborhoods with compact Roma population.
- Data about the Roma population in settlements and municipalities according to the data from the national census in 2001 (data from the National Statistic Institute)
- Data from the National Statistic Institute regarding the general number and gender of the population in the different settlements and municipalities (2005).
- Data of CA Expert Analyses and the Open Society Institute – Sofia about the number of compact Roma population distributed by settlements, neighborhoods, and municipalities.

The data is representative about the female population aged above 15 living in the so called “Roma areas” in the country at the following levels of standard and maximum levels of stochastic error and the respective confidence intervals.

Relative share in %	Standard error of respondents	Maximum error of respondents	Stochastic interval	
respondents	Sr	Dr	r - Dr	R + Dr
1	0,4	0,8	0,2	1,8
3	0,7	1,4	1,6	4,4
4	0,8	1,6	2,4	5,6
5	0,9	1,8	3,2	6,8
10	1,3	2,5	7,5	12,5
15	1,5	3,0	12,0	18,0
20	1,7	3,4	16,6	23,4
25	1,9	3,6	21,4	28,6
30	2,0	3,9	26,1	33,9
35	2,0	4,0	31,0	39,0
40	2,1	4,1	35,9	44,1
50	2,1	4,2	45,8	54,2

The data registration method used in the quantitative survey was a standardized *face to face* interview which took place from 1st to 20th October 2008. Most of the women in the research team have been Romani women and all of them have passed a research method training prior to the field survey.

The qualitative part of the survey included 50 in-depth interviews and 10 focus groups organized to research the in-depth characteristics of the most important issues raised by the quantitative part of the survey. The in-depth interviews have been carried out also with two specific Roma groups, the *Kaldarashi* Roma and the *Rudari* Roma whose number is rather low (especially in the Roma populated neighborhoods) to ensure that they have been covered by the random method and at the same time they are rather specific. The in-depth interviews among *Rudari* and *Kaldarashi* have been carried out by girls from the same groups who are at present university students. Focus groups were organized also with Roma women who live out of the Roma neighborhoods in order to include this specific layer of Roma community in the survey

Focus Group Interviews

The aim of the focus group interviews was to focus in details and find deeper reasons for some tendencies and phenomena which have come up from the interviews as well as to find out also the man's view to some issues. Therefore, separate focus groups were organized with men and women in the *Kaldarashi*, *Rudari*, *Yerlii*, and *Millet* groups as well as with Roma working in public administration. For the purposes of the study we have decided to research in details also the views and tendencies in the group of Roma Protestants; they are not a separate ethnic sub-group, but on the basis of their religion and the influence religion has on their way of living they tend to differ from the other Roma groups.

Due to the political situation in Bulgaria and the local elections (end of October – beginning of November 2007) most of the in-depth interviews and focus groups were carried out in the second half of November – December 2007 in order to avoid any political influence.

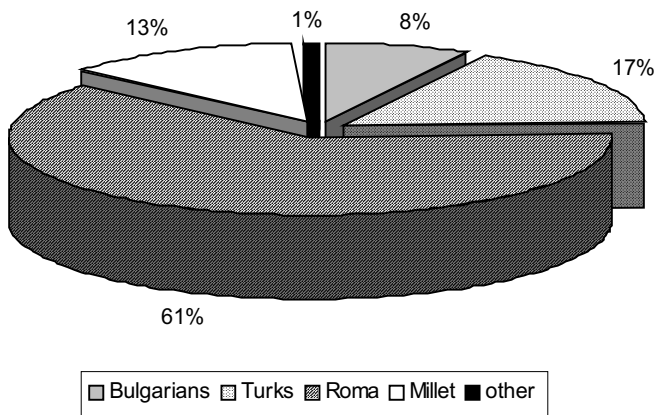
Profile of the respondents

329 of the respondents have identified themselves as Roma, 88 as Turks,² other 68 as Millet, 42 as Bulgarians and 4 as other.

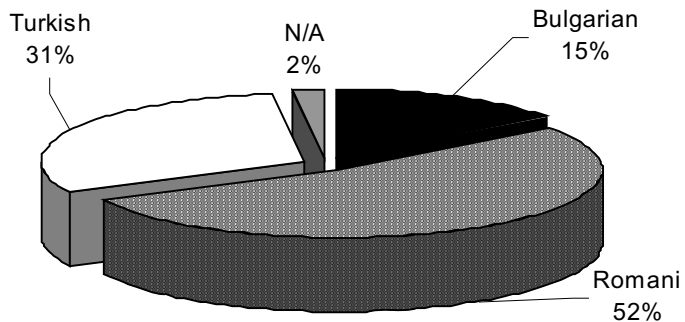
52% of the respondents have Romani as mother tongue; 31% speak Turkish at home and 15% speak Bulgarian.

² A large number of Roma in Bulgaria tend to identify (for different reasons) not as Roma at census or interviews. As a result, the Muslim Roma speaking Turkish language usually identify themselves as *Turks* or *Millet*; *Rudari Roma* identify as Romanians, Wallachians or Bulgarians (or just as 'Other'); a certain number of Christian Roma speaking Bulgarian identify as Bulgarians.

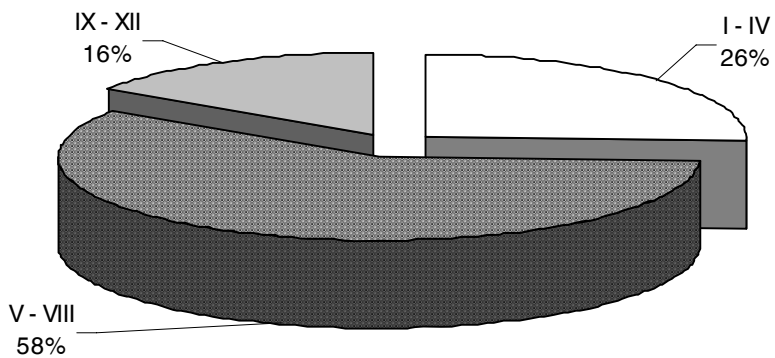
Ethnic affiliation of the respondents (self-identification)



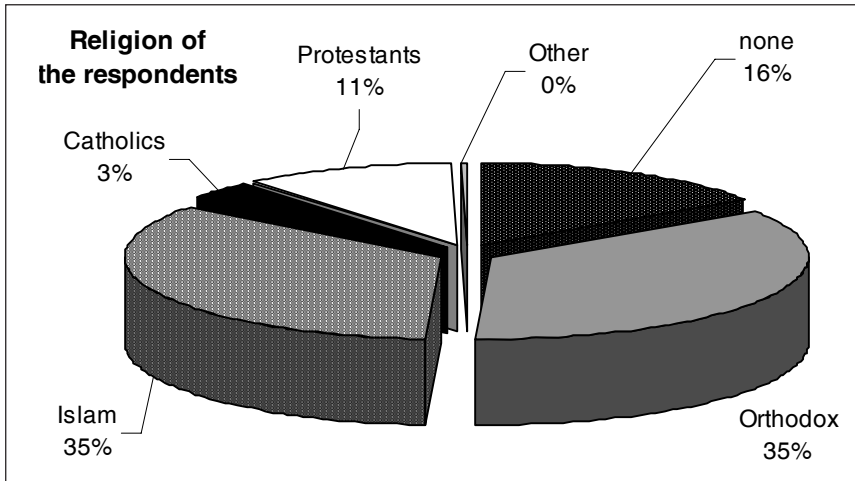
Mother tongue of the respondents



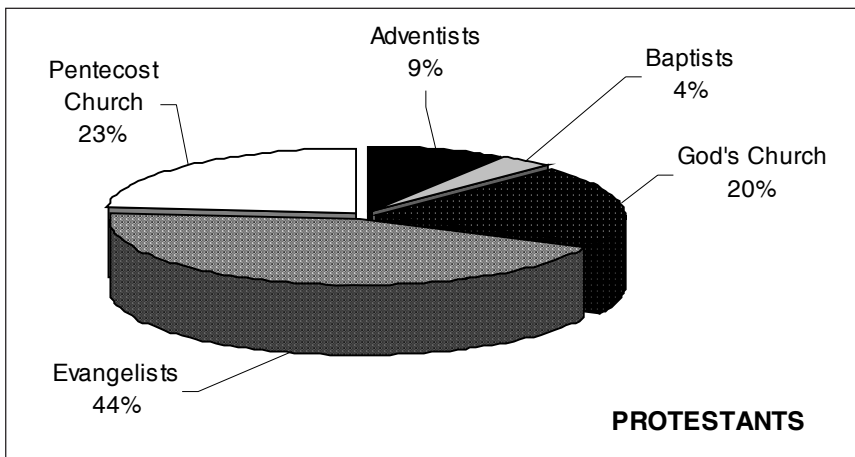
Education of the respondents (grades)



Only 16% of the respondents do not point any religious affiliation. 35% are Orthodox Christians and 35% are Muslim while 3% are Catholics and 11% Protestants.



At the same time the distribution of the Roma in the different Protestant churches is as follows (as defined by the respondents themselves): 44% identify simply as Protestants or Evangelists, 23% belong to the Pentecost Church, 20% belong to the God's Church, 9% define themselves as Adventists and 4% as Baptists.



A terminological and methodological clarification should be made yet from the beginning of the report. Since it would be impossible for any study to cover all the diversity of the Roma community, for the purpose of this research regarding group affiliation we have decided to chose two big groups in the Roma community which

however do not have clear boundaries. The first group which we call *Dassikane Roma* ('Bulgarian' Roma) includes basically Roma who identify as Roma, usually belong to the Orthodox confession and speak Romani language. The share of Roma who do not speak Romani but have Bulgarian as mother tongue also belongs to this group. The term is conditional since *Kaldarashi* and *Burgudzhii* sometimes after identifying as belonging to the big Roma community further identify themselves as *Dassikane Roma*. They however are not included in this group since they have many different specifics defining them as separate sub-groups within the Roma community. The second big group is the group of the Roma who are Muslim. A part of them have preserved the Romani language and have expressed Roma identity (although sometimes they prefer the term 'Gypsies' in stead of 'Roma'). They are called *Horahane Roma*. In the same group we have also included the group of *Millet*. The *Millet* are Roma who have lost the Romani language and speak Turkish. They are Muslim. They prefer to identify themselves as *Millet* or *Turks* although most of them clearly realize their difference from the ethnic Turks. Nevertheless, they have very similar characteristics as tradition, customs and so on to the *Horahane Roma*.³ Although the two groups appear to be defined on the basis of a religious criterion among others, this is not the leading one. Of course, religion contributes to the unique specifics of the bigger group but it is not the major one.

As mentioned above Protestant Roma have been separated because this group appears to have specific distinctive behavior compared to the two other groups we have defined above.

At some places in the text the term *Yerlii* will be also used. This term is introduced in ethnological literature to define the Roma groups who have settled on the Balkans centuries ago and have a sedentary life in contrary to other Roma groups (like *Kaldarashi*) who were settled by the Communist party between 1958 and 1976. In Sofia and in some parts of Western Bulgaria some Roma sub-groups use the group affiliation "Erlides" but the general term *Yerlii* is used rather as an academic *terminus technicus* than as group self-identification name. Practically the terms unites *Dassikane* and *Horahane Roma* but does not include *Kaldarashi* and *Rudari*.

As a result the groups that have been studied in details within this research are *Dassikane Roma*, *Horahane Roma*/*Millet*, *Kaldarashi*, *Rudari* and the Protestant Roma. They are numerous enough to be included in a sample and at the same time there are differences between them which define different attitudes and perceptions towards the issues we are interested in.

³ For a detailed information on the ethnic identity, customs, everyday life and traditions of Millet Roma see: Kolev, D and Krumova, T. *Mezhdur Scilla i Haribda: za identichnostta na milleta* (Between Scilla and Haribda: for the identity of Millet) (Veliko Turnovo, Astarta, 2005).

HEALTH CARE SYSTEM IN BULGARIA: A BRIEF OVERVIEW

The health care reforms in Bulgaria have started in the 1990s. An establishment of a National Health Insurance Fund with a basic benefit package formed the basis of the reform. Although the insurance system is strongly socially oriented it practically resulted in the exclusion of around 1 000 000 people from the health care system. The reforms introduced also the legalization of privacy practices; the prime care was additionally reconstructed and the GPs were introduced as “gatekeepers to specialized care.” The restructuring of inpatient health care financing and provision was followed by the introduction of clinical pathways. This created better incentives for improving both quality and effectiveness of service provision. However, the actual cost of implementing clinical pathways for the hospital is higher than the price reimbursed by the National Health Insurance Fund, which causes financial instability in the inpatient sector.⁴

⁴ For additional detailed information see: Lidia Georgieva, Petko Salchev, Rostislava Dimitrova, Antoniya Dimova and Olga Avdeeva, *Bulgaria: Health System Review*, Health Systems in Transition, vol. 9, No.1, 2007.

HEALTH AND ROMA RELATED PROGRAMS AND POLICIES

The policy in Bulgaria is generally not sensitive to Romani women issues (with few exceptions), including both Roma oriented policy or mainstream gender based policies. The gender perspective has been recently introduced broadly in Bulgaria and it is gradually gaining publicity but is still perceived by authorities rather as a fashionable must required by the EU than as a need. Gender is an issue which generally lacks in the documents directed to Roma integration even in major documents as the Decade Action Plan. Romani women health situation is subjected to the same trend described above.

The approach of the Bulgarian Government towards Roma health situation is regulated by several documents: some general and some more specific in the field of health care:

- The Law for protection against discrimination
- The National action plan for protection against discrimination;
- The Framework program for equal integration of Roma into Bulgarian society;
- The Action plan for implementation of the Framework program for equal integration of Roma into Bulgarian society;
- The health care law;
- The health care insurance law;
- The National health care strategy ;
- The Health care strategy for people in disadvantaged position, belonging to ethnic minorities;
- The Action plan for implementation of the health care strategy for people in disadvantaged position, belonging to ethnic minorities;
- The National plan for the Decade of Roma inclusion;
- Operational program “Human resources development” 2007 – 2013.

1. Roma integration policies

The Framework program for equal integration of Roma into Bulgarian society (FP) and the Action Plan for the implementation of the FP

The Framework program was prepared by a coalition of Roma and Human Rights organizations and was adopted on 22 April 1999 by the Council of Ministers. Its strategic goal is eliminating all forms for unequal treatment of Roma in society and one of the major priorities is combating discrimination. Just a small section at the end of the Framework Program is devoted to the problems of Romani women. Even smaller section is devoted to health care system. It envisages two measures in this respect: improving the hygienic conditions in Roma quarters, augmentation of the number of health care educational programs and in the same time encouraging Roma participation in them. The Framework program however had been made before the Health care reform and therefore the measures it has envisaged about improving the conditions have to be reconsidered. Now there is an actualization process of the Framework program going on and it is expected these issues to be covered. Furthermore, the gender perspective is lacking in the health care section of the Framework program. None of the specific problems of Romani women in the field of health care is explicitly stated and addressed.

The Action Plan for Implementation of the Framework Program was approved by the Bulgarian Government on October 6th, 2003 and referred to 2003 and 2004. The Action Plan did not envisage a single measure targeting the problems of Romani women in any sphere including health. The same refers to the Action plan for 2006. It however has one exception: a sentence refers to the situation of Romani women and it is in the field of health care services: “Special attention needs to be paid to effective planning of measures for overcoming the cultural barriers before reproductive and family health care” (AP 2006).

Decade of Roma Inclusion – the National Action Plan of the Decade of Roma Inclusion

The National Action Plan for the Decade of Roma Inclusion has 6 priorities: education, health care, living conditions, employment, protection from discrimination and culture. Although Romani women are mention as cross-cutting issue, ***the Plan envisages measures directed to Romani women only in the field of health care***: breast cancer prevention, care for pregnant women, prevention of the early marriages, and family planning. In all other priorities actions directed to Romani women are not envisaged. At the same time the measures and actions in these spheres do not take into account the specific ways for reaching Romani women.

The National Action Plan for the Decade of Roma Inclusion envisages only 600 000 BGN (307 692 EUR) from the State budget for actions directed to Romani women (in the field of health care) that is extremely low amount for ten year period.

Policy and documents of the Ministry of Health directed to Roma health care

The Ministry of Health is one of the few institutions developing specific activities directed to Romani women, mainly within several PHARE projects. It is difficult to say that these activities form a whole policy for achieving equality of the Romani woman since they treat Romani women rather as a subject of empiric field work than as participant in designing and implementing these policies.

The policy of the Ministry of Health regarding Roma is regulated mainly by the Health Strategy for People in Vulnerable Position Belonging to Ethnic Minorities.⁵ The Health Strategy for People in Vulnerable Position, Belonging to Ethnic Minorities and Action Plan 2005-2007 were adopted by the government in September 2005. This is one of the few documents which define Romani women as one of the major target groups. Moreover, the document is not framed within purely health issues but discusses them rather in the social context tackling also problems like violence against minority (Romani) women and their equality. The strategy has five main goals, concerning health status, health information and knowledge, health care and discrimination of Roma communities predominantly. Major focus in the Program is the worsened health situation of Romani women and children, especially those related to children and mother health, reproductive health, family planning. The major fields of intervention in this respect are: *decreasing mother mortality rate* – optimizing mother health, early coverage of pregnant women, raising the reproductive culture of young people, especially girls and women, and so on; *improving sexual and reproductive health* – decrease of abortion, sexually transmitted diseases, adequate family planning; *overcoming the cases of violence against women* and providing their full equality; *providing equal access to health care for people in vulnerable position belonging to ethnic minorities (including strengthening the position of the health mediator); increasing the health knowledge and providing access to health information; overcoming the cultural barriers in communication and all forms of discrimination; and broadening the range of health insured people in vulnerable position belonging to ethnic minorities.*

Furthermore, around one fifth of the activities within the Action Plan for the Implementation of the Strategy for People in Vulnerable Position, Belonging to Ethnic Minorities are directed explicitly to minority (Romani) women. Around 90 000 Euro are envisaged for such activities for a three-year period. In addition, 4 million euro is envisaged for equipping mobile units for screenings in the Roma community.

⁵ *Health Strategy for People in Vulnerable Position, Belonging to Ethnic Minorities*, available at www.mh.government.bg.

At the end of 2008 – 2009 a new Action Plan should be elaborated.

At the same time, along with the Strategy, the policy of the Ministry of Health regarding Roma has been steered up mainly through projects and programs. They however are rarely based on the participatory approach but perceive the Roma community rather as an object of intervention. Rarely Roma organization has leading role in the implementation of these projects. In that connection there are not effective mechanisms for empowering the Roma community organizations with the partial exception of Component 5 of the Program of the Global Fund for prevention of HIV, tuberculosis, and malaria; and the health mediator initiative.

Another proactive initiative which is not however governmentally guided is the “Mother centers” initiative. Romani women are running those centers (except the one in Sandanski) with different kinds of activities: health prevention, training and so on. At present there are four working centers in the towns of Provadia, Razgrad, Simitli and Sandanski. With the help of the local authority, three of the centers are located in municipal buildings while the fourth is in a private property. The women are getting together according to a preliminary set schedule; their participation is voluntarily which aims at increasing the capacity of Romani women, their empowering and changing the attitude of the local community, reinforcing and activating their civil position, etc. This is an interesting and still a new model introduced in Bulgaria by Integro Association following the German experience.

Furthermore, we may conclude that the Bulgarian officials have not paid significant concern to the existence of people without health insurances and this problem is not directly targeted by specific measures and mechanisms for adequate reaction in case of emergency health crisis/ sickness. Due to this Roma can not regularly go to doctor and poverty is often the main reason for them to be unable to buy medicines for treatment. The result is that the chronic illnesses become more frequent and the outcrop infections in the Roma quarters also.

Another problem is that the Ministry of Health does not receive sufficient and timely information about realization of different health programs and projects in Bulgaria; this is a reason for decreasing the sustainability and efficiency. In addition, the data collection system is still not sufficient enough and there is no statistic on the issues affecting mostly the Roma community.

2. Governmental programs and projects directed to Roma health care

The health mediator concept. During the period of 2003 – 2007 within the boundaries of three projects up to 113 health mediators have been trained and certified; 92 of them work. The introducing of the health mediator is quite a new initiative for Bulgaria based on the experience of the Romanian Roma Organization “Romani

C.R.I.S.S.” As a result of the successful introducing of the position of the health mediator mayors from several municipalities (Shumen, Nikola Kozlevo, Tervel, Shabla, Kavarna, Novi Pazar, Jakimovo, Montana and so on) expressed interest in having health mediators. The mayors themselves agreed to cover from the municipal budget the training expenses of the mediators and employ them afterwards. 18 young Roma have been trained in the Medical College of Plovdiv. These were the first Roma health mediators in Bulgaria who received a medical college diploma. This shows increased interest and engagement from the side of local authorities. The same however is not valid for national authorities, who set quite high requirements for the health mediators (medical college education, for example) which do not coincide with the initial idea of the health mediators. Furthermore, the activities of the Ministry of Health clearly show lack of political will for promoting the position: delay in the employment of the health mediators already trained; problems with defining the locations of the positions and so on.

At the moment the well trained and working Roma mediators are mainly women. It is important to underline the gender aspect of this position not only as a work position but also as an opportunity for promoting Romani women participation. Roma health mediators in some of the communities organize self-support groups, consult people and contribute to the organizing of the community itself. In addition, the role “approach” stimulates the community and motivates other women as well.

Providing necessary equipment and ensuring the access of Roma (Romani women) to health care services. A number of projects (mainly pre-accession PHARE project have been directed towards providing modern equipment (including mobile cabinets) for screenings and examinations of people from the Roma populated regions. A significant part of these projects have been directed to improving Romani women and children health including Romani women from rural areas who are extremely affected by the lack of access to quality health care services.⁶ Special focus is put on health promotion and health prevention of mother’s and children’s health

EU strategic documents, Human Resources Development Operational Program

Within the process of EU accession new policies have being developed. Therefore, it has the chance to enhance significantly the Roma strategies implementation and devote significant place to Romani women issues. As a member of the EU Bulgarian authorities had to sign a set of strategic documents related to Bulgarian member-

⁶ See a detailed description of projects in the Appendix.

ship. This includes the National Strategic Reference Framework and the Operational programs in the different fields. One of the requirements the European Commission is very strict on is to have a horizontal gender policy in each document. Therefore, this has been an opportunity to mainstream the major issues concerning Romani women within the gender sections in each OP/NSRF and throughout the programs (through proper operations, activities and indicators) which could provide the necessary administrative engagement and financing respectively for the next seven years.

The four major Operational programs where Romani women issues should be mainstreamed are the Human Resources Development OP, Administrative Capacity OP, Regional Development OP and the National Plan for Rural Areas Development. After a broad advocacy campaign carried out by Center Amalipe and almost 40 other Roma NGOs significant achievements have been made: the important strategic documents contain preconditions for binding Structural funds with Roma integration issues and dedicating significant financial resources and administrative engagement for activities oriented to Roma integration and Roma participation.⁷ In addition special sections directed to Roma have been included in Human Resource Development Operational Program and the National Strategic Reference Framework; Roma are defined as specific target groups and at the same time, Roma issues are mainstreamed throughout the documents. HRD OP pays special attention to the problems Romani women face in the field of education (especially Muslim Romani women) and health.⁸ Furthermore, a table of concrete measurable indicators have been included in HRD OP where gender is also a horizontal criterion. This would allow to measure advance (or lack of advance) in the situation of Romani women in Bulgaria on the labour market and in the field of education and health care.

⁷ Amalipe, *Annual Report Roma Integration in Bulgaria 2006*, 120-134.

⁸ Amalipe, *Annual Report Roma Integration in Bulgaria 2006*, 120-134.

ROMANI WOMEN HEALTH SITUATION IN BULGARIA

In 1999 a reform in the National Health Care System bringing in a universal health insurance was realized in Bulgaria. The purpose of that system in theory has been to improve the access to health care, but because of the poverty and social exclusion of the majority of Roma in Bulgaria, the reform affected mostly unemployed Roma. Many of Roma have been left without health insurances and therefore without access to the health care system.

Self-assessment of mother's health

Generally, Roma often underestimate their health status. Often, they perceive “being in good health” as lack of serious chronic disease. Light indisposition is not perceived as health problems. Therefore, health problems become a concern only when they result into a limitation of everyday activities which sometimes is too late for reaction.

Around one third of the women questioned during the survey assess their health status as good or very good. Another one third assesses it as satisfactory (neither good, nor bad) and 27.4% evaluate their health status as bad or very bad. In total 62.7% of the women included in the survey consider their health status either satisfactory, or bad. This share is much higher than the share of Bulgarians who generally assess their health status is not very good. According to Eurobarometer 2007 around 40% of the Bulgarians have assessed their health status as ‘satisfactory’, ‘bad’ or ‘very bad’.

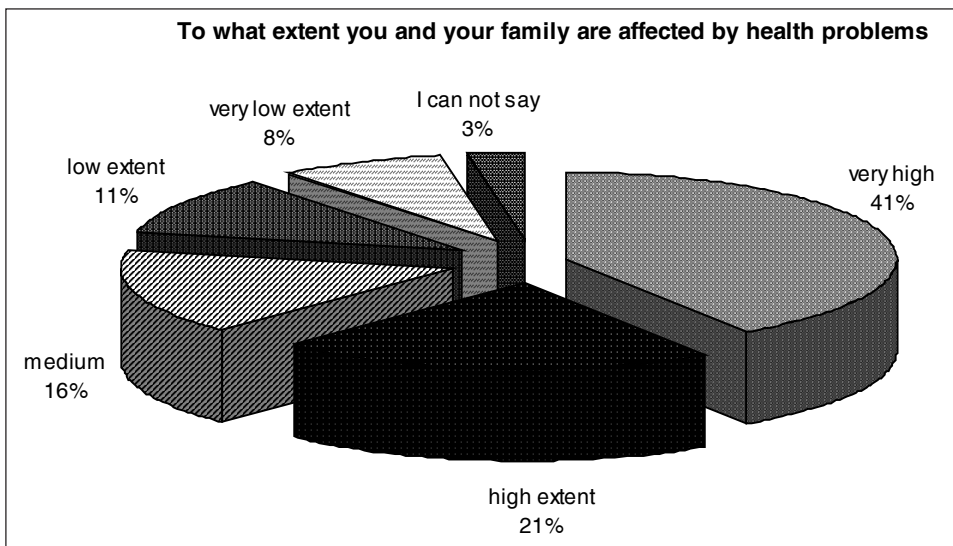
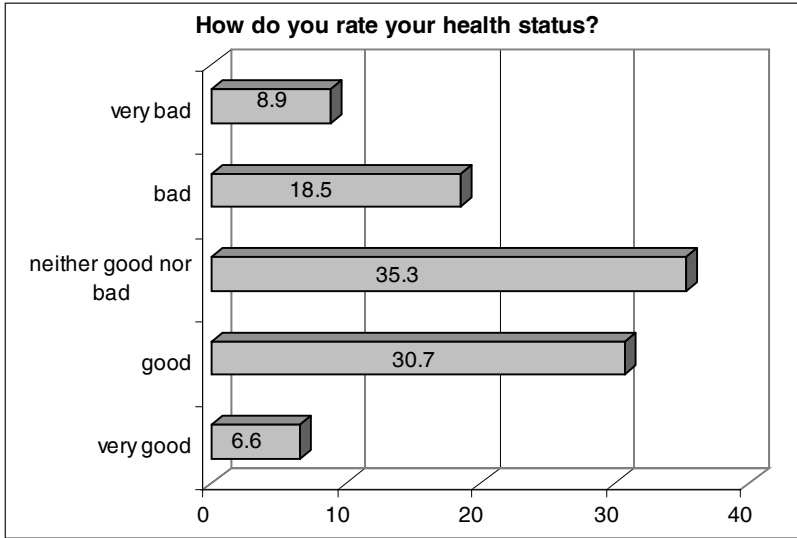
The indicator of Eurobarometer for the people in Bulgaria who define their health status as ‘good’ or ‘very good’ in 2006 is 60%. For the Romani women covered by the research this indicator is almost twice as lower: 37.3%. A little bit higher is the figure pointed by the 2007 research of Open Society Institute – Sofia “The Health Status of Roma”⁹ for the general Roma population (men and women): 45.5%.

At the same time 62% of the women included in our research consider that they or their families are affected by health problems.

Two factors should be born in mind however when comparing Roma health status with that of other ethnic groups. First, Roma are one of the youngest commu-

⁹ Health Status of Roma, Open Society Institute – Sofia, October 2007.

THE HEALTH STATUS OF ROMANI WOMEN IN BULGARIA



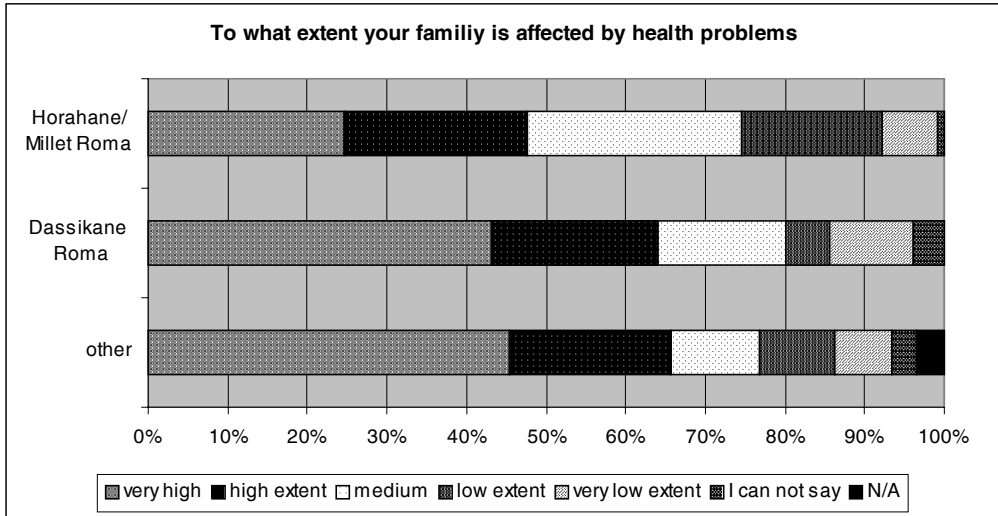
nities in Bulgaria. 55.9% of Roma are under 40 years old compared to 50.8% among Turks and 31.8 % among ethnic Bulgarians.¹⁰ Second, Roma community has lower life expectancy than Turks and Bulgarian compared to higher child mortality (24/1000 among Roma compared to 17/1000 and 9.9/1000 among Turks and Bulgarians, respectively).¹¹

¹⁰ Lilia Dimova et al., *Romite: drugoto izmerenie na promenite* (Roma: the Other Dimension of Changes). Sofia: Partners – Bulgaria Foundation (2004), table 2, p. 14.

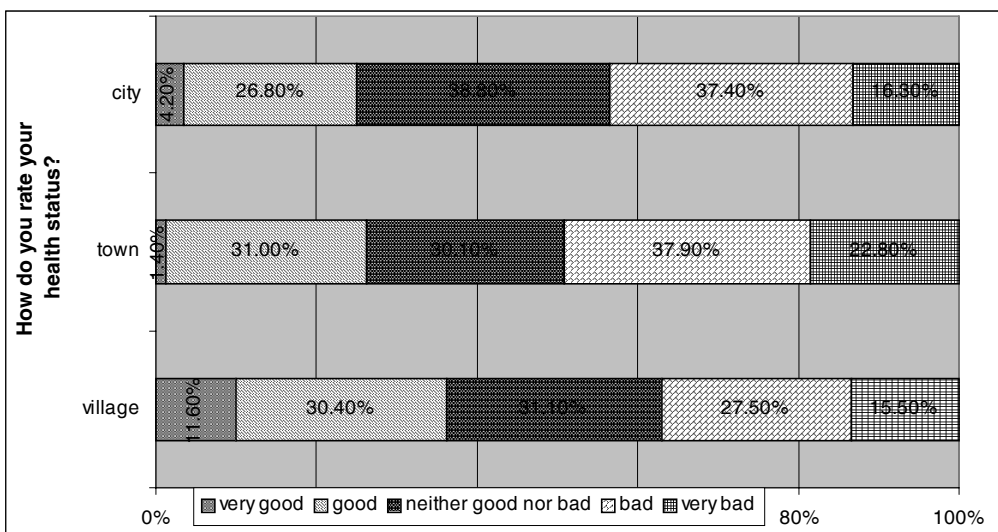
¹¹ *Health Strategy for People in Vulnerable Position, Belonging to Ethnic Minorities*, available at www.mh.government.bg.

ROMANI WOMEN HEALTH SITUATION IN BULGARIA

Differences exist also within the Roma community itself: *Dassikane* Roma consider themselves to be exposed to health problems more than *Horahane/Millet* Roma do. 64% of *Dassikane* Roma think that they are affected to a high or very high extent by health problems compared to 47.6% of *Horahane/Millet* Roma.

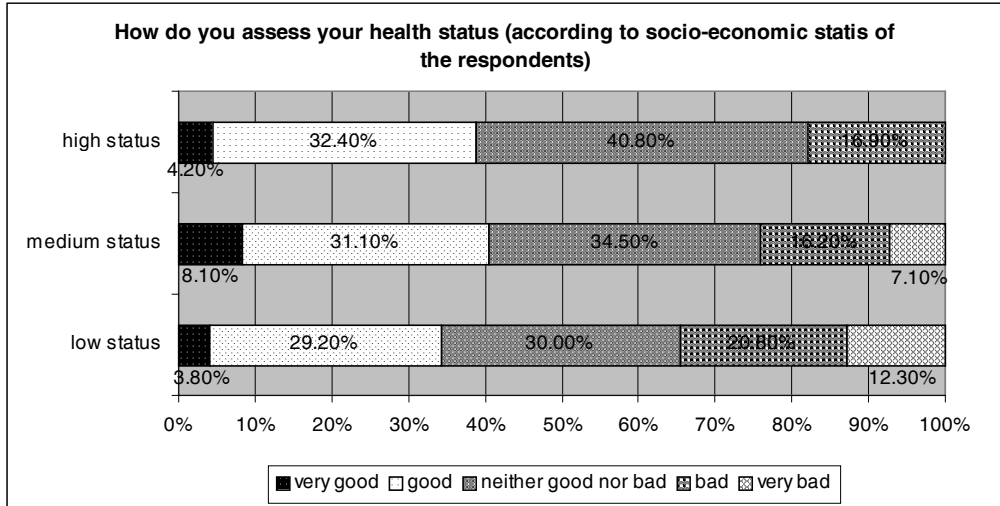


According to the place of living there is a sustainable tendency for increasing the self-satisfaction with the health status in inverse proportion to the size of the settlement. Women from rural places assess their health status as rather good compared to women from towns and cities. This does not mean that the health status of Roma in rural areas is better: on the contrary, people in rural areas have worsened



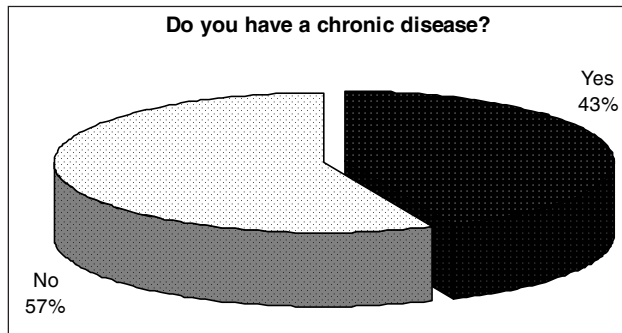
health status but they tend to be more optimistic in assessing their general status, condition and possibilities.

Respectively, the people with lower socio-economic status assess their health as worse compared to the people with higher socio-economic status.



Assessment of mother’s and children’s health

More than half of the women surveyed during the research (56.7%) point that they do not have a chronic disease. This percentage is higher for the women with lower

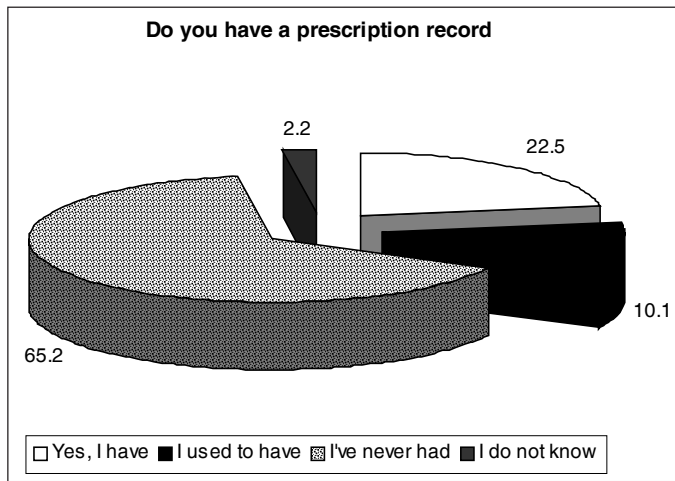


and middle socio-economic status, while 50.7% of the women with high status answer that they have a chronic disease. Most probably women with higher socio-economic status have higher sensibility for recognizing the disease and taking the appropriate measures.

At the same time only one third of the people share they have or used to have a prescription record which means that their chronic disease has been registered and treated by a doctor.

The women have pointed out during the research that the most frequent disease diagnosed by a physician is hypertonia. 29.2% have declared having high blood pressure. High blood pressure occupies the high ranking place of the ten leading risk

factor as causes for diseases burden measures in DALYs in Bulgaria according to WHO: 21.2% for men and 19.5% for women. In our research it is followed by migraine (pointed out by 18.4%), renal complaints (16.4%) and depression (12.6%). This however is not typical only for the Roma community but is a general trend also for Bulgarian Society.¹² Furthermore, the women were asked which of these diseases have affected them during the last twelve months. Their answers show there is a tendency for increasing the diseases related to their psychological condition: higher is the percentage exactly of migraine and of any kind of anxiousness or depression.



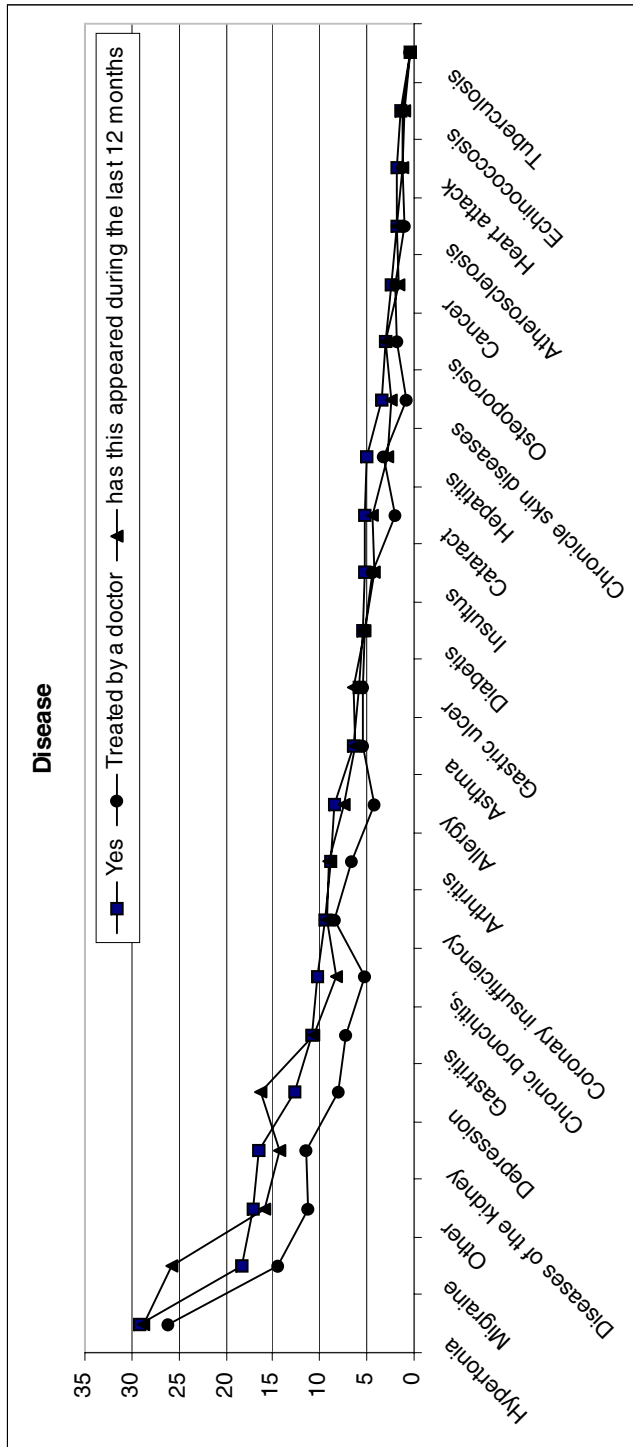
“My health condition is not very stable... I am a little bit nervous... but this is from the life we are living...” (Rudari woman, 19 years old, married, village).

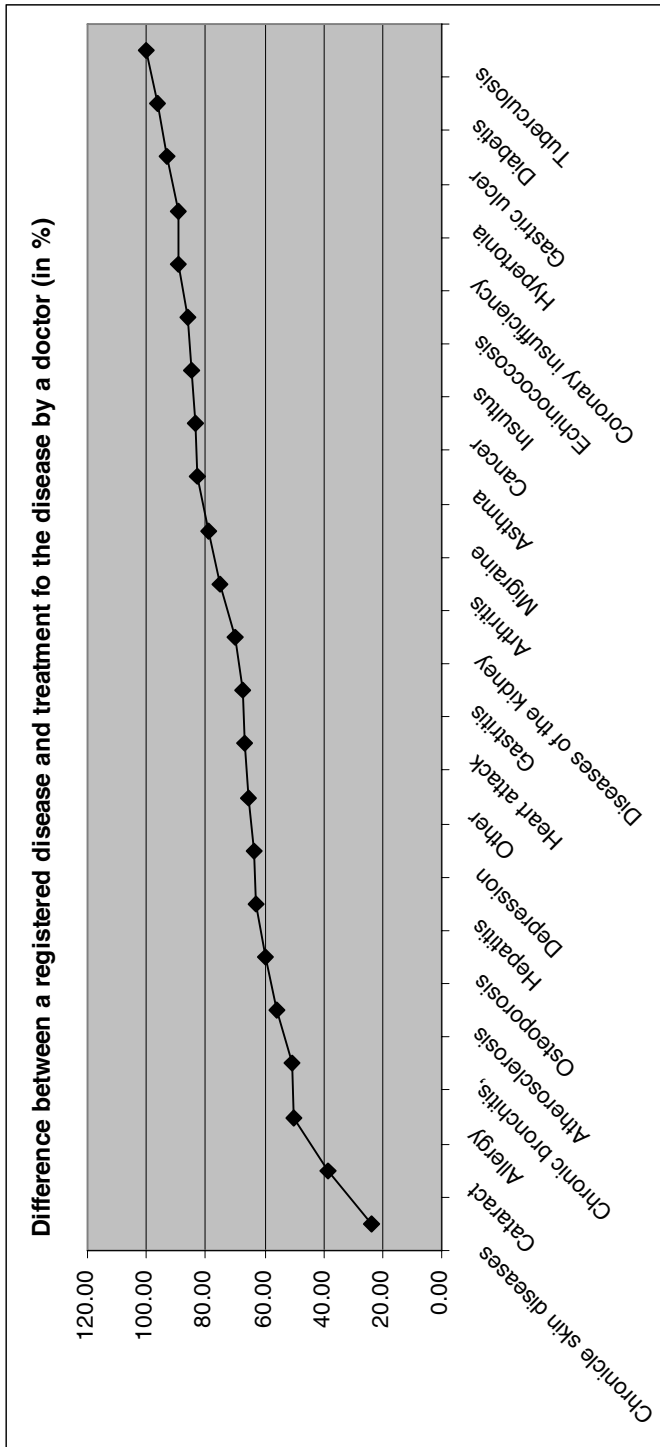
At the same time women tend to overlook the health problems connected with skin disease, cataract, allergy and chronic bronchitis. Less than 50% of the women who have declared suffering from these diseases share they had been treated by a doctor, while between 90 and 100% of Hypertonia, Gastric ulcer, and Diabetis are reported treated by medical workers.

Much more serious however is the situation of Romani women with their dental status. 81.2% declare they have rotten teeth, 64.7% point that they have missing teeth. The women share that a missing tooth is not considered a problem.

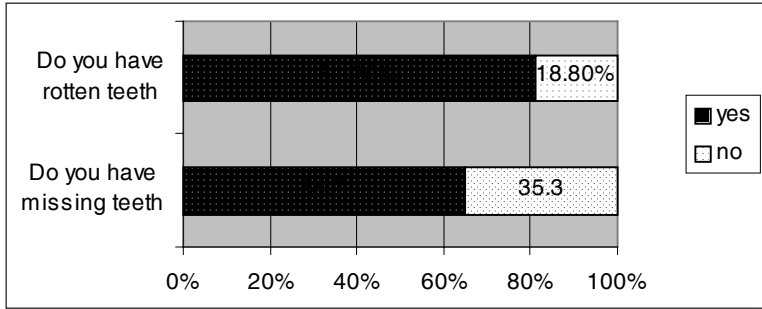
“Oh, I am absolutely healthy, I do not have any problems – it’s just the teeth but this is normal” (Rudari woman, 23 years old, married, town)

¹² Fact sheet of the World Health Organization: Bulgaria – country profile, available at who.org.

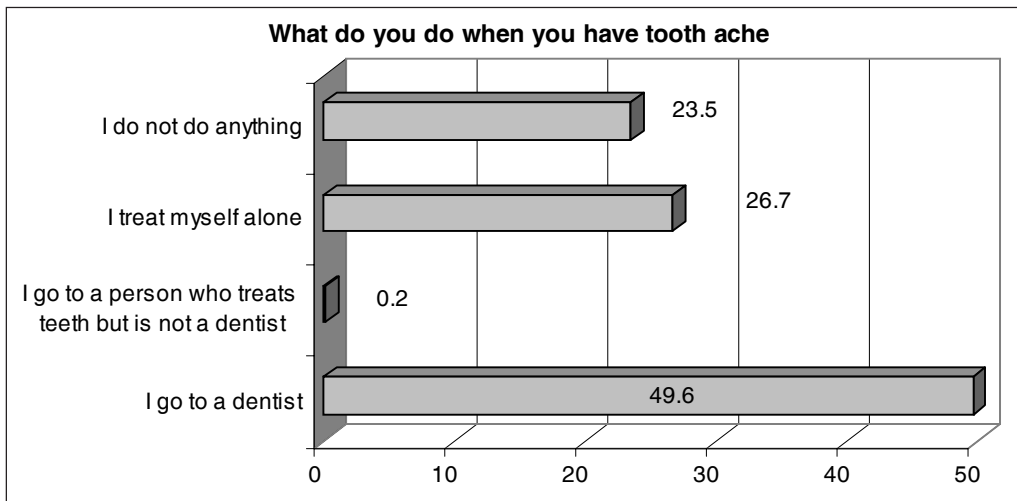




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More than half of the women have not been to a dentist for more than a year and 9.2% have never been to a dentist at all. A report by Partners Bulgaria Foundation also points that 64.7% of Roma in active working age “have rarely, almost never” been to a dentist.¹³ Less than 50% from the women surveyed in the present research share that they go to a dentist when they have tooth problems. The rest of them prefer either to treat the ill tooth themselves or to wait until the pain passes from itself.

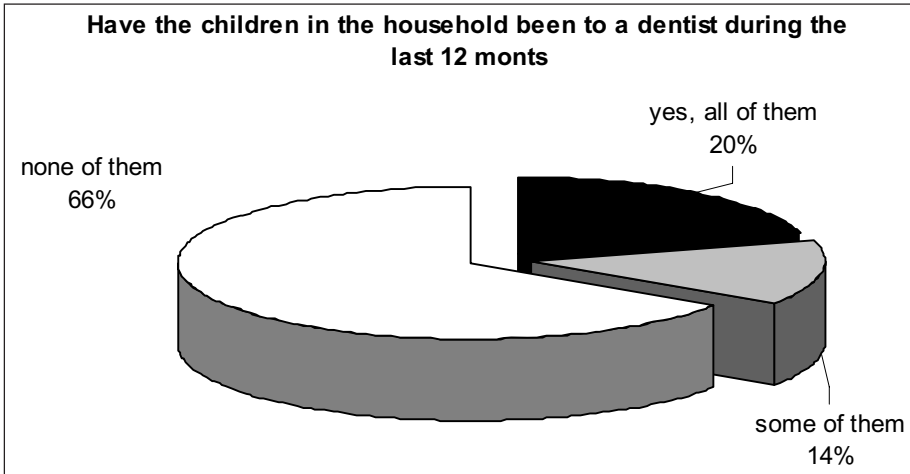


Regarding dental status and care we can see that there is also an inner group division. Muslim/ Millet Roma, for example, have not been to a dentist twice as more than Dassikane Roma: 14.7 % compared to 7.6%, respectively.

Dentist prophylaxis is underestimated when it comes to the children as well. Only 20% of the respondents have taken all the children in the household to a dentist during the last one year while more than 65% have not taken any of the children to a prophylactic examination. As a result many of the children in the Roma ghettos where

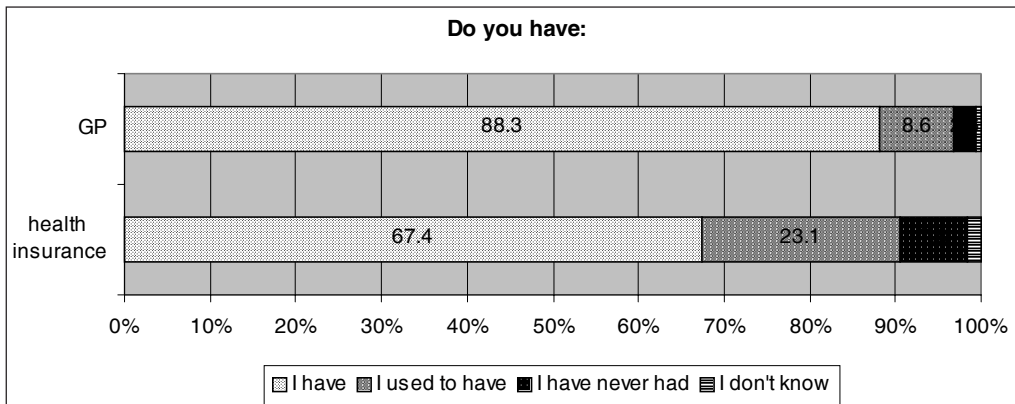
¹³ Romite..., 25.

the percentage of parent engagement with health care is even lower suffer from a diseases injuring the milk teeth.



Health insurance, GPs

The results from this research support the data already available. Almost one third of the Romani women above 15 years old included in the survey do not have health insurance which means they practically do not have access to health care services unless they are able to afford to pay for it. 7.8% have never had a health insurance. This confirms a stable tendency for the last couple of years that every third Roma does not have a health insurance. Just to compare the percentage of uninsured Bulgarians according to a research carried out by the Open Society Institute – Sofia, and the World Bank (2007) is 6%.¹⁴ At the same time, since the data have been

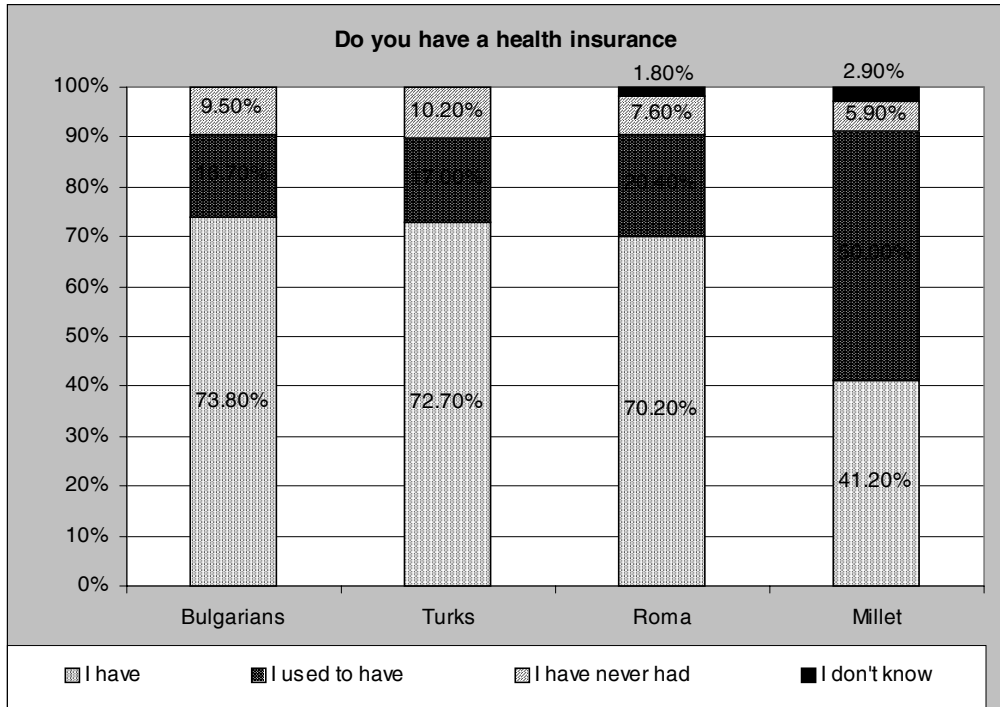


¹⁴ Roma in Bulgaria: an Information guide, Open Society Institute – Sofia, 2008, 41 (in Bulgarian).

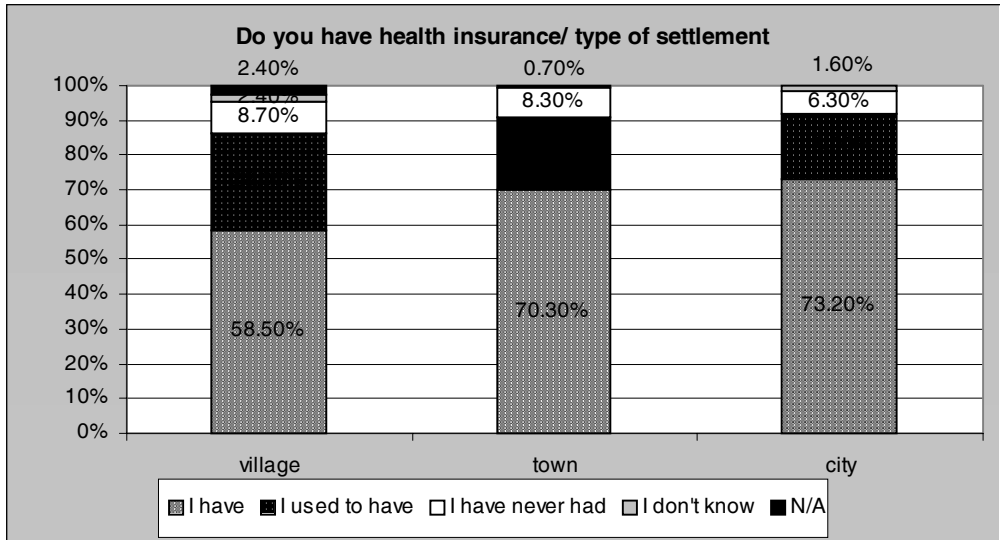
extracted on the basis how the women themselves have answered to this question, it should be analyzed cautiously. The in-depth interviews carried out within this research revealed a general misunderstanding that if the person had been included in any kind of labor program or had started work recently this meant that s/he would automatically become health insured. This is impossible however because in order to get insured people have to cover and pay back in time for the uninsured period which they usually do not do.

One of the reasons for the unemployed people not to pay their health insurances is financial. Of course, the reasons are complex and unawareness and lack of understanding for the necessity of having a health insurance should be added as well.

In this respect the most affected group among Roma themselves is the *Millet* Roma who are often left outside either from the Romani speaking community or from the ethnic Turks community. As a result they end up with the worst living and socio-economic conditions which has an impact on their health status.



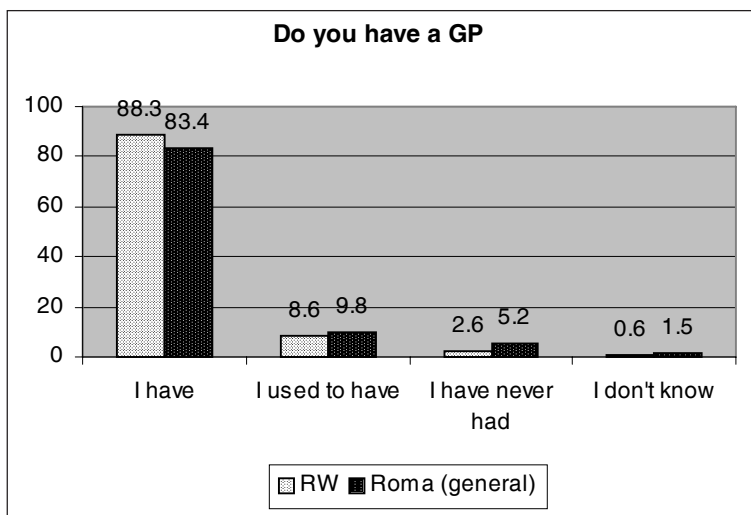
The data from the research confirms once more the fact that Roma in the rural areas and Roma living in villages are in the worst position regarding their access to health care services. Only 58.50% of the Roma living in villages have pointed that they have a health insurance while this share is 70.30% and 73.20% for towns and cities, respectively. Moreover, while 28% of village Roma have lost their health insurances,



this percentage is significantly lower for towns and cities: 20.7% for the towns and 18.9% for the cities.

At the same time education is definitely a factor influencing the availability of health insurance: the share of people having health insurance is the highest among people with secondary education (86.70 %).

Comparatively lower is the share of women who do not have a GP (a general practitioner). Most of the women included in the survey have one (88.3%). A comparison with the results from the OSI – Sofia study on Roma health issues shows that

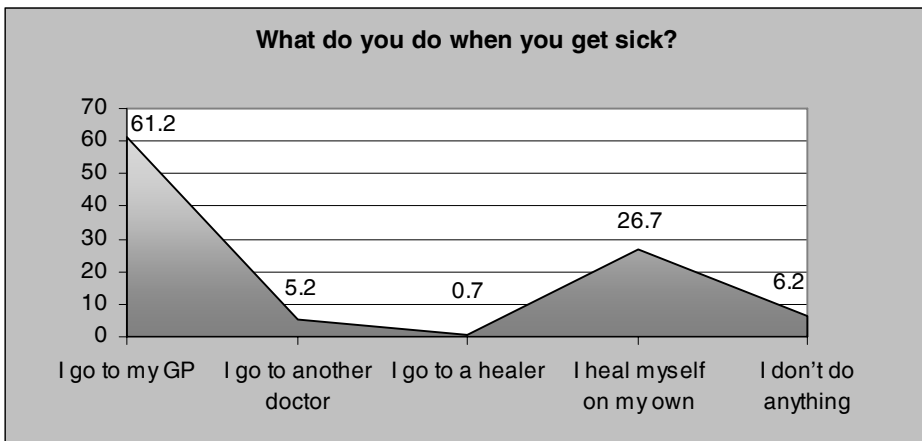


“Do you have a GP” – the Romani women data is result from the research of Amalipe; General data about Roma – after OSI – Sofia, “The health status of Roma, 2007)

women are slightly more concerned with health issues (have a GP, have a health insurance) than the average for Roma. A comparison with general data for Bulgarians however shows that Roma are still behind: almost 97% of the Bulgarians have a GP.

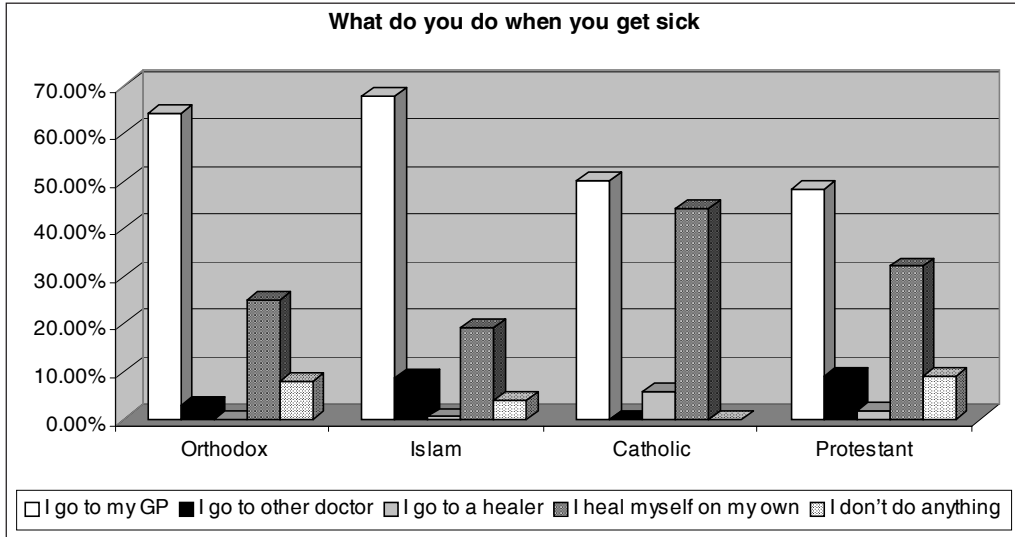
Visits to the doctor

Almost two thirds of the respondents of the research share that they pay a visit to the doctor when needed. Nevertheless, the share of those who prefer to take any actions on their own to get better is still high – 26.7%. Other 6.2% answer that they do not do anything but wait for the disease to pass from itself. Only few women have answered that they go to a healer. It is interesting to note that among Catholic and Protestant Roma the percentage of those using self-treatment or no treatment at all is higher than the average result in this research (32.1% and 8.9% respectively for Protestant Roma compared to 26.7% and 6.2% for average Romani women and 44.4% using self-treatment among Catholic Roma).

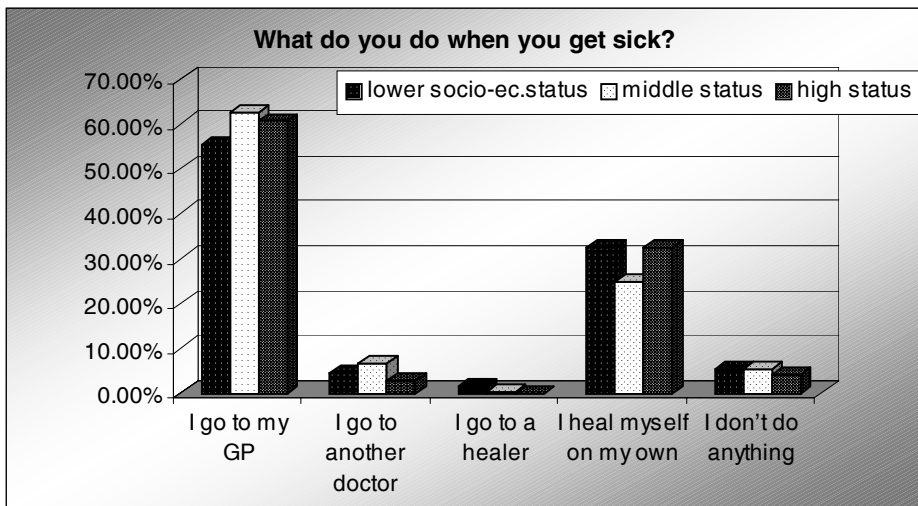


At the same time people with lower socio-economic status are more inclined to act on their own in stead of visiting a doctor than people with higher status. 46.6 % of the respondents have answered that they can not afford to go to a dentist. Almost half of the women (49.2%) share that they do not have money to buy the medicines prescribed by the doctor. 23.5% point that they often or almost always do not have even the minimum money for the patient fee (1.80 BGN = 0.90 Euro)¹⁵. Additional factor for not regularly going to doctors is the fact that according to Bulgarian health system in order to visit a specialist the patient should be directed by her/his GP through a medical

¹⁵ Since the patient fee is 1% of the so-called “minimum salary” it is raising up every year. In 2008 the patient fee is 2.20 BGN or 1.10 euro.



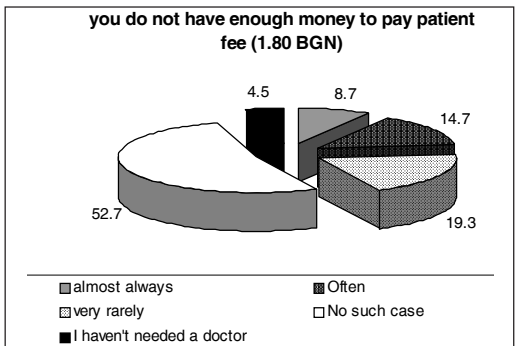
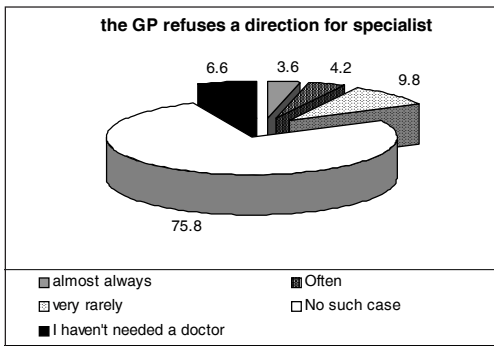
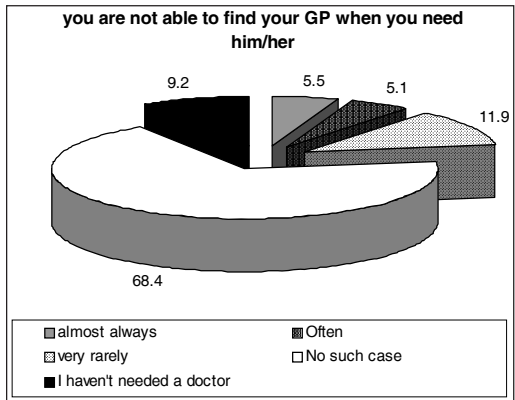
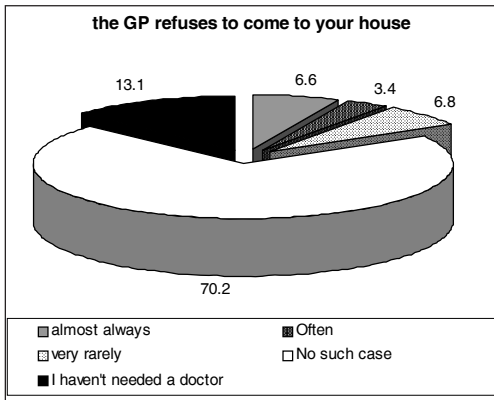
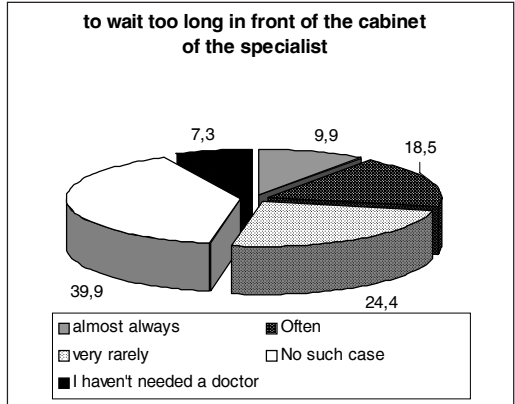
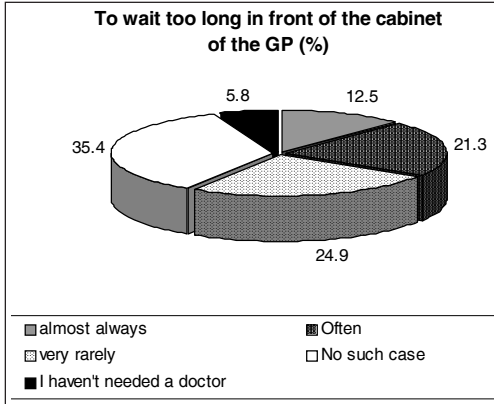
pathway. Every GP has a limited number of ‘medical pathways’ and it is not a rare case when such one is refused. 7.8% of the women included in the research share that they have been refused a direction for a specialist often or almost always. This (together with economic reasons), for example, turns to be one of the basic reasons for *Rudari* Roma (who in general have been used to visiting a doctor) not to do it so often recently.



“We do not go to doctors recently. In order to go you have to have a direction from your GP. They do not always give you... that’s why the women don’t go much. Moreover, when you go – they prescribe you medicines... they are expensive, so...” (*Rudari* woman, focus group, small town).

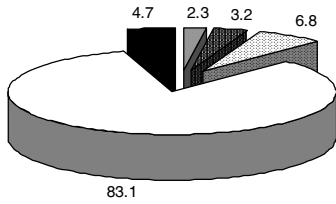
Problems before access of Romani women to health care (in %)

“Have you ever encountered the following problems?”



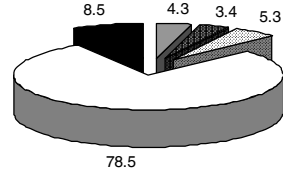
ROMANI WOMEN HEALTH SITUATION IN BULGARIA

to pay your GP more than the amount of the patient fee for a cabinet visit



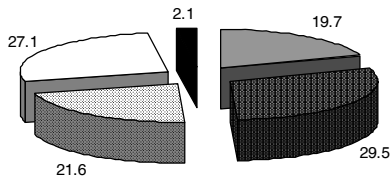
almost always Often
 very rarely No such case
 I haven't needed a doctor

to pay your GP more than the amount of the patient fee for a home visit



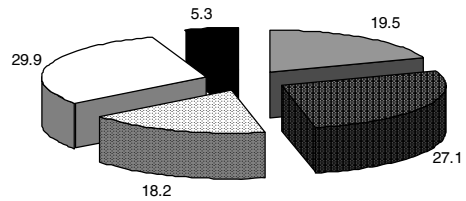
almost always Often
 very rarely No such case
 I haven't needed a doctor

you do not have enough money to buy medicines



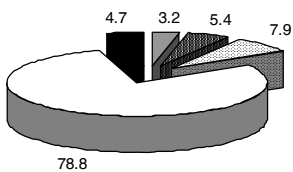
almost always Often
 very rarely No such case
 I haven't needed a doctor

you can not afford a dentist



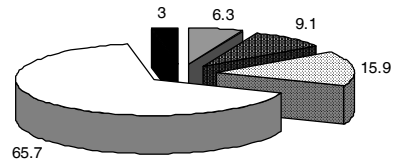
almost always Often
 very rarely No such case
 I haven't needed a doctor

to pay a specialist in hospital more than the patient fee



almost always Often
 very rarely No such case
 I haven't needed a doctor

the medical staff treats you badly because you are Roma



almost always Often
 very rarely No such case
 I haven't needed a doctor

At the same time, with some groups within the Roma community visiting a doctor has already turned into a sustainable practice. *Rudari* and *Kaldarashi* are two of these groups. Both have built up a positive attitude towards health care system, especially among *Rudari* (no matter of the age of the woman). Even *Kaldarashi* women who are more conservative regard it normal to visit a doctor when you have a problem:

“I am quite OK with my health condition. But if I get sick I go to a doctor, he examines me, I take the pills he prescribes me...” (Kaldarashi woman, 38 years old, married, small town).

This however refers mostly to young or middle-aged women. Older women still tend to be suspicious to health care workers and often use traditional medicines or medicines on their own.

“We have a doctor’s assistant in the village. But I would not go even if I am dying. What he would do to me: he would give me pills to poison me quicker. I have analgin here and when something hurts me I take analgin. For the children too. The youngest child – he knows himself. When he starts to cough he says: ‘Grandma, give me analgin.’ I break it into two and give it to him. I don’t take them [the children] to the doctor. But I take them to immunizations.” (Kaldarashi woman, 76 years old, widow, village)

Regarding younger women from the two groups however they are even ready to give money when they are not insured:

“I am absolutely healthy, no problems... but if I have to look for medical help – then it becomes complicated: I am not insured. When I was going to school the school used to insure me but since I postpone several years they do not do it any more. So now if I get sick I have to pay; this service costs me a lot – 20 leva for the examination, then for medicines... but what else to do – health is the most important thing.” (Rudari woman, 23 years old, married, small town).

“For me, the important thing is that the doctor is a specialist, even if I have to pay more for this.” (Horahane Roma, 55 years old, married, village)

At the same time people rarely make the difference when it is legal to pay for the treatment and when not. It is perceived normal to pay in order to receive better treatment:

“The medical treatment – it depends on the doctor – how he treats you. If it does not help or if there is no GP direction, then you go to a private clinic, to another doctor: it is just a matter of finances.” (Rudari woman, 45 years old, divorced, small town)

“There is no problem – we have GPs. If they don’t pay you the necessary attention, you pay money and everything is OK.” (focus group with Kaldarashi men)

Regarding the children women are more likely to have a medical consultation or service than for them themselves.

“I am not sick now; I am healthy like stone. The children get sick from time to time. When they are sick I would take them to the doctor; I would not do it for myself; I would heal myself at home.” (Kaldarashi woman, 30 years old, married, village)

Satisfaction with health services

The observations and the data from the in-depth interviews show that people are more satisfied with medical services and attitude of health workers in the smaller-size settlements. Exceptions, of course, exist, but sometimes they confirm the rule. *Rudari* women in a small village shared during the focus group that they had a very kind doctor in the village who was always polite and helpful to them. After this he was replaced by a GP from the capital who had very discriminative attitude towards Roma.

“He behaved badly with the people and the people had very negative attitude towards him. He hated Gypsies. He could not stand it here. We behaved his way with him. So he left. Now we are very happy with the new doctor. She is a good woman.”

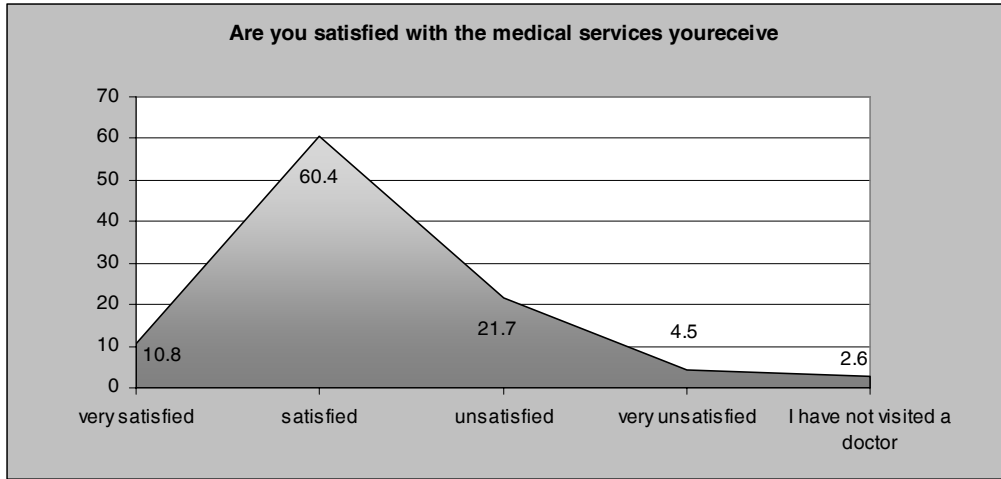
If the doctor or the doctor’s assistant (in many of the smaller settlements, even in towns, there is not a doctor but a doctor’s assistant) manages to establish good personal relations with his/her patients the barrier ‘community – health worker’ is quickly overcome. Women from the places where such relations have been established share that in their case they do not need a health mediator: they trust their doctor and they regularly visit her.

“The women are very satisfied with our doctor. Even if they are not insured she would not return them: she would make the examination. But now she is going to another place and we are very sorry about this.” (focus group, women, small town).

However the situation in the big cities, especially if there is a concentration of Roma population who live in the ghetto conditions is different:

“My GP is doctor D. Ha has been my GP for long time. But the first thing he asks about is the fee.” (man, *Horahane Roma*, focus group, big city).

A common perception is that attitude of health workers to Roma is still discriminative and disparaging and it should change. Around 15% of the respondents share this opinion.



The data from the quantitative part of the survey shows that most of the people report to be satisfied with the health services they have received. 24.4% share that they are unsatisfied or very unsatisfied.

At the same time women trust more a female doctor although if a male is a good one, they would go to him as well. The former is shared even by educated Romani women.

“I prefer to go to a woman doctor; I would feel more relax with her.”
 (Rudari woman, 36 years old, secondary education, married, village).

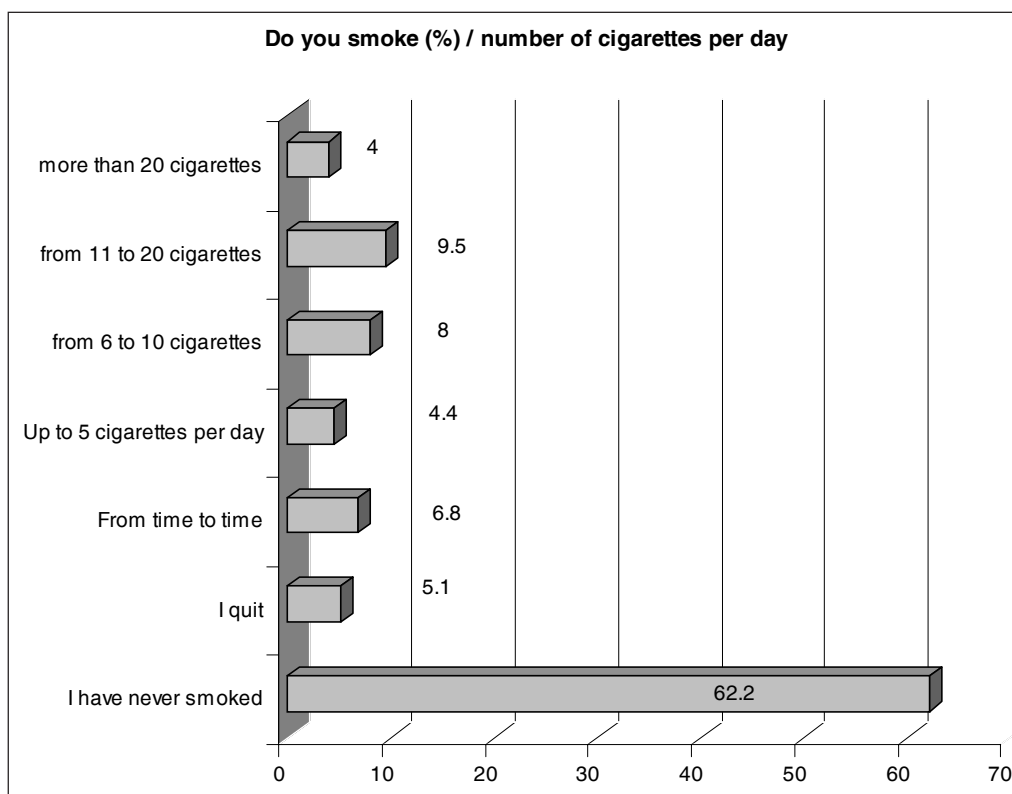
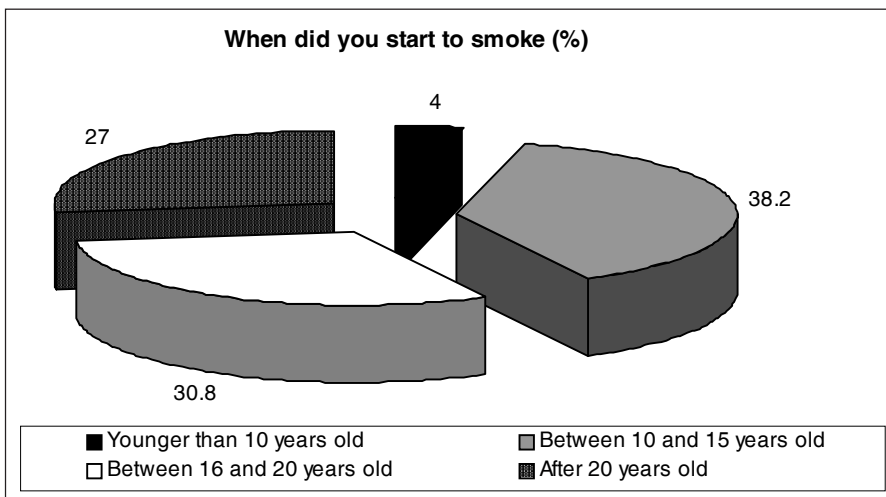
This refers especially to gynecologists. Old women however would rarely go to a gynecologist. They still consider him/her only a doctor for pregnancies and abortions.

“We, the old women, do not go. It’s for the young women to go...”

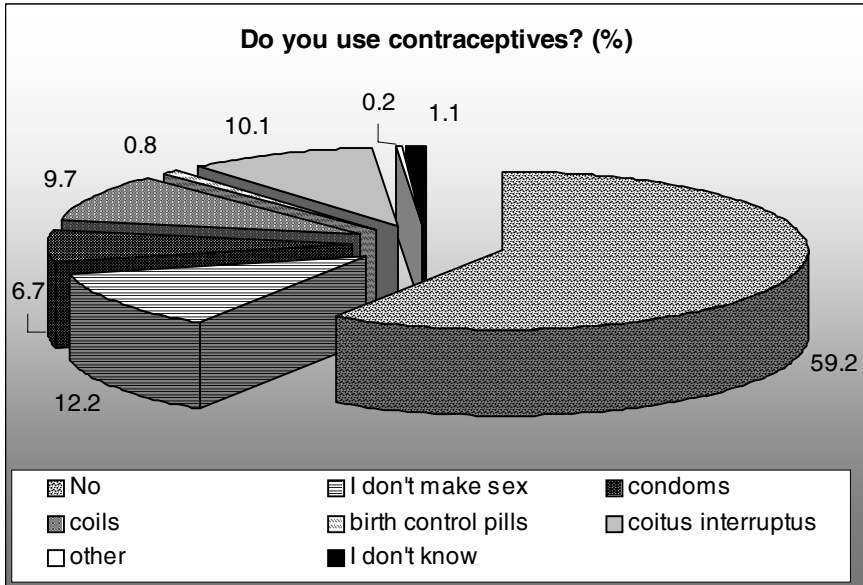
Smoking

25.9 % of the women interviewed smoke actively and other 6.8% smoke from time to time. Just for comparison 55 % of the Bulgarian population smokes. At the same time Roma are “young smokers”: 96.4 % of the women have started smoking under the age of 35, while 62% of the Bulgarian population aged up to 35 are smokers.¹⁶ The earliest age for lighting the first cigarette among the Roma respondents have been registered at the age of 7 while the oldest – at the age of 55.

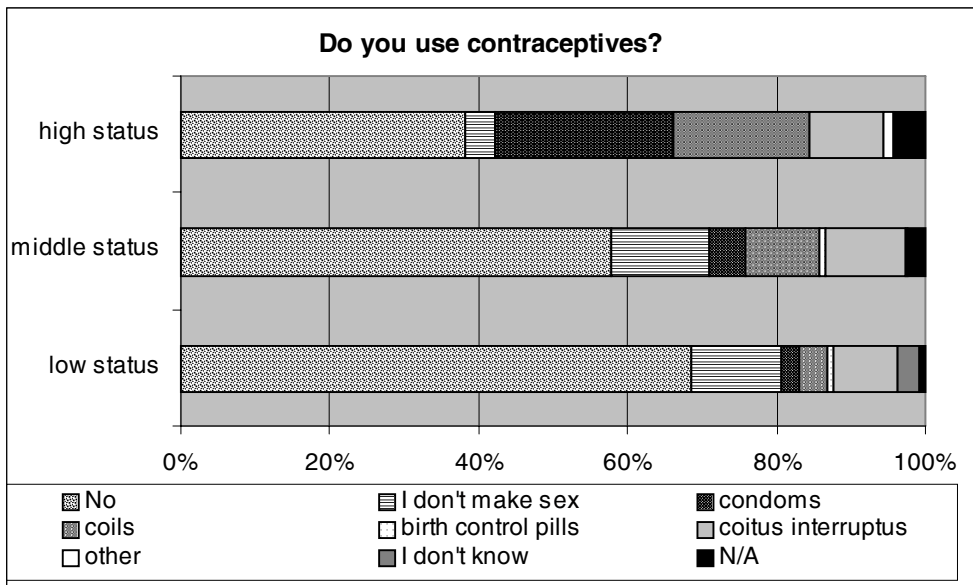
¹⁶ EUROPEAN NEWS BULLETIN 212: 17-23 August 200 (the European Network for Smoking Prevention (ENSP), available at <http://www.ensp.org/files/enb212.pdf>)



Knowledge and use of contraception

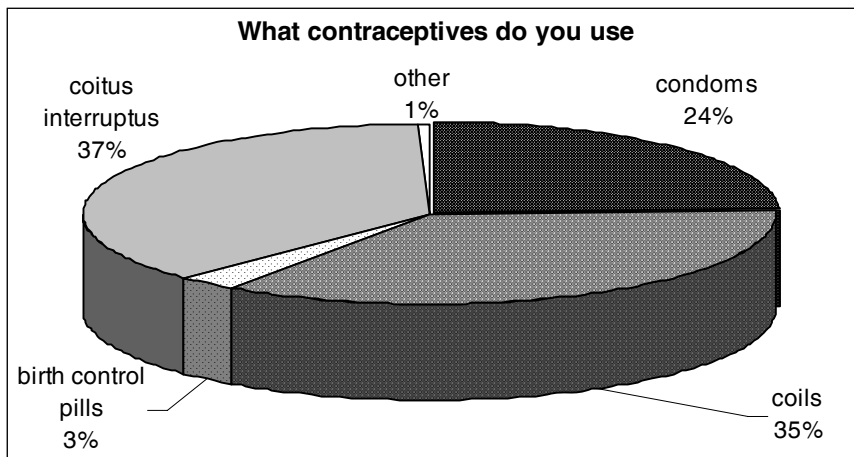


Use of contraceptive is still not a wide spread practice among the Roma community. 59.2% of the women surveyed answer that they don't use any contraceptives. Other 12.2% do not make sex at all. This share is in inverse ratio to the socio-economic status and the level of education.



People with higher socio-economic status and higher level of education have higher culture of using contraceptives. Only 35% of the people with secondary education do not use any contraceptives. At the same time for those women who share that they use any contraceptives coitus interruptus is the most popular one (37% from those who use contraceptives) followed by coils (35%) and condoms (24%). Coils and condoms are more spread among women with higher socio-economic status and higher educational degree. For example, 30% of the women with secondary education use condoms while for the women with incomplete elementary education the share is 1.7%. The basic reason for this is that for the majority of Roma (both men and women, but mostly men), especially those with lower level of education the condom is an attribute only of prostitutes. It is believed that if you use a condom you have sexual relations with more than one man. No such stereotype exists about coils so they are preferred instead of condoms. Pills are still not a preferred method of contraception because women are afraid to use them due to the number of external effects and the more complicated way of usage.

Still, it is highly believed that it is man's responsibility to protect the woman. That is why the share of coitus interruptus is the highest among the other methods. Nevertheless, the abortion is still one of most spread methods for ceasing a pregnancy which will be discussed in details below.



The knowledge and culture of speaking about contraception is different within the different Roma groups and the extent they are integrated. The in-depth interviews with the *Rudari* women revealed that the younger and more educated women openly speak about contraceptives and have significant knowledge about this.

“There are a lot of contraceptives today, science has given us a lot and we are thankful to it – there are condoms, coils, and so on. Now we can not

say that we can not protect ourselves: we can go to the doctor, there are many things there. I myself use condoms and I intend to go and put a coil. I'll start to live with my boyfriend from next year when he comes back and I intend to put a coil then because we still don't plan to have a baby." (Rudari woman, 21 years old, single, small town, secondary education).

The women from different Roma groups and different age share that speaking about sex and contraception used to be a taboo in the past but now, in our modern world, it is impossible, no matter what the community values are.

"Now, everything is on the television, there is nothing hidden. Everything the girls want to know they learn from the television. So they know everything." (Kaldarashi woman, 76 years old, widow, village).

Elderly women highly disagree with this situation.

"They [young people] adapt to the modern life – they go to the city and catch up everything, even drug habits. They see that their friends use condoms and they themselves use them. But they catch also the negative things besides this." (Rudari woman, 49 years old, married, village).

Another factor which influences the sexual culture is the extent to which Roma health organizations work in the given community, the existence of Roma health mediators or proactive health worker. The focus group in Stara Zagora for example, where the local Roma organization "World without Borders" have been working for years on raising the sexual culture, women freely speak about sexual relations and different methods of contraceptives. A good example is also the situation in the Roma neighbourhood in Kyustendil where the efforts of the Roma health center, the Roma organization (L.A.R.G.O) and the local health workers are combined.¹⁷

Abortions: Deciding on abortions; frequency of abortions

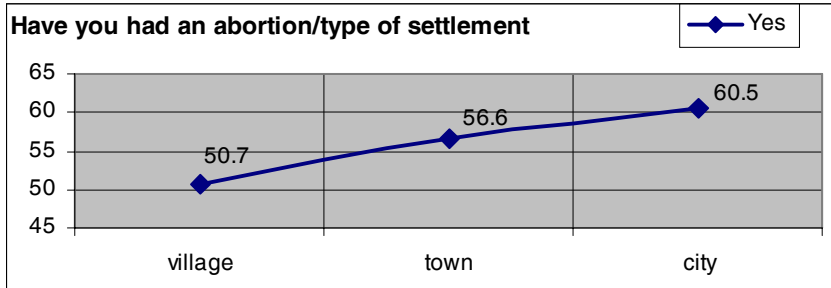
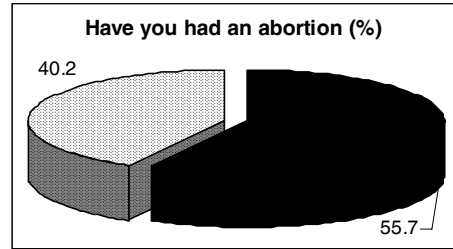
Nevertheless the tendency for increasing the awareness about contraception among Romani women, abortion is still the most widely used method for prevention of unwanted births.

"Some of the girls do not know much: they prefer abortions. There are some women with more than 20 abortions" (focus group, Rudari women, small town).

¹⁷ More detailed information on the Kyustendil case can be found in the report "Health status and access to health care service of Roma in Iztok neighborhood" (2007)

55.2% of the women sampled share that they have had an abortion when obviously in villages where moral values are stronger and more resistant this share is lower than in towns and cities.

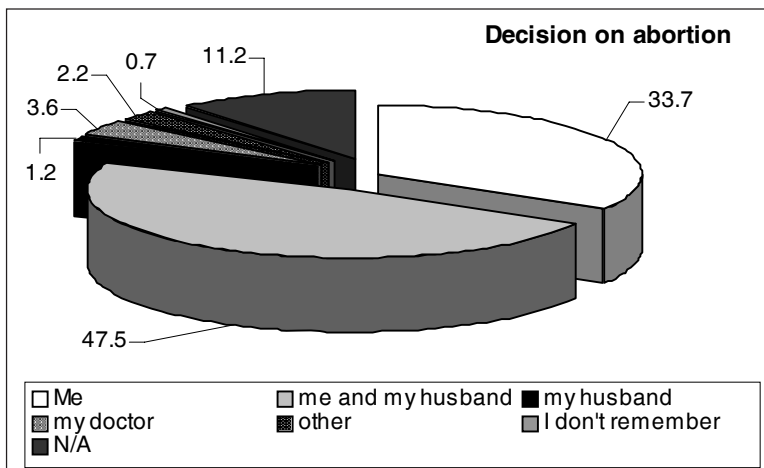
According to the present research the average age for first abortion is 22.15 years.



The lowest age of first abortion in our sample is 14 years while the upper age level for first abortion is 45 years. The highest percentage of abortions is between 18 and 23. Around twelve percent of the women sampled share that they had their first abortion at the age of 20, followed by the nineteen-year-old women (9.6%), and eighteen-year-old girls (7.9%). At the same time women with higher educational degree have less abortions.

Around 25 % of the women who have had abortions had more than 3 abortions, 29.8% had one abortion, another one third have had two abortions.

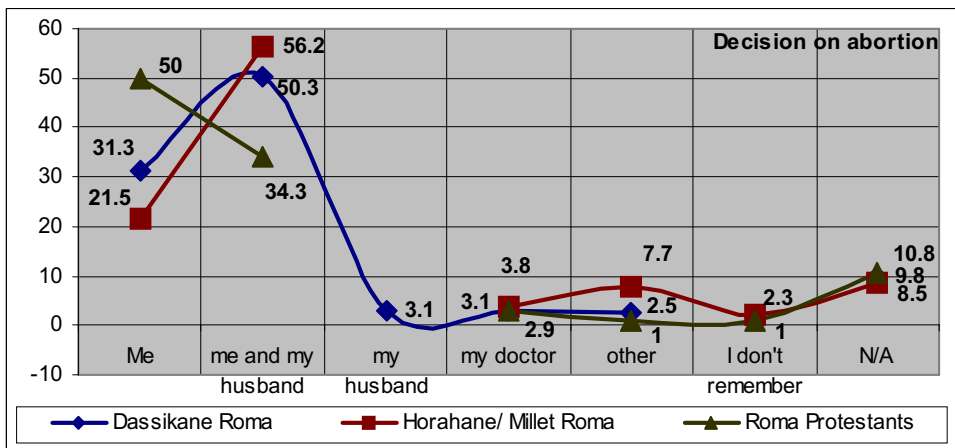
81.2 percent of the women declare that they have taken the decision for abortion together with their husbands or on their own and only 3.4 % share that the decision was taken by their husband or other member of the family.



It's possible however that the women would not feel very comfortable to share that they had been forced to make an abortion and some of the answers "me and my husband" might be hidden answers of forced abortion since during the interviews one of the women has said:

"I have had abortions; we both took the decision. Two of us decide on the abortion: if my husband agrees – I make the abortion; if he does not – I don't." (woman, 38 years old, married, small town).

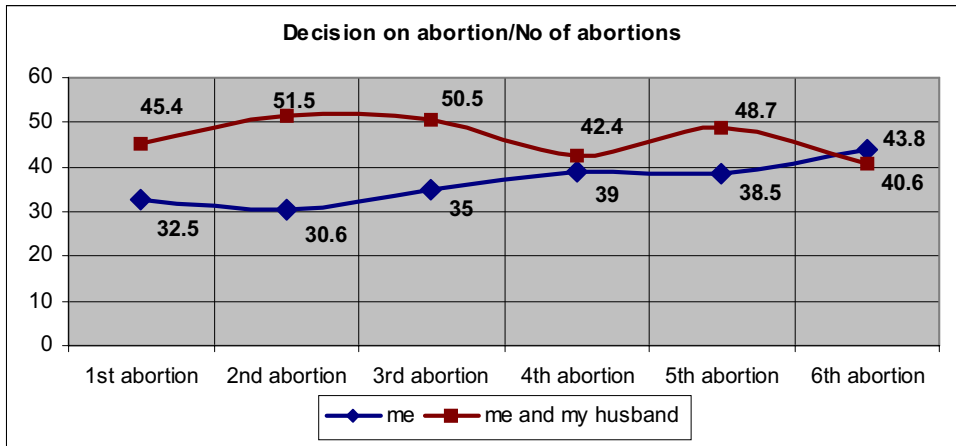
In line with the fact that in the Protestant Roma communities women have more rights and are more equal to men, 50% of the protestant Romani women sampled declare that they have taken the decision on abortion on their own. 34.3% share that their husbands have also taken part in this decision. They however do not give an answer that the decision was taken solely by the husband. Within the other two big Roma groups (*Dassikane Roma* and *Horahane/ Millet Roma*) the joint decision (or at least the one presented as such) prevails.



It is interesting to note that with raising the number of abortions the woman participates more in the decision than her husband.

The reason for deciding on abortion is either very basic economic reasons (*"We can not feed one more child"*) or a deliberate, well-considered decision. One of the women interviewed shared that she had only one abortion when she was quite old and already had three grown up children. Another young woman pointed:

"When I was a child I wanted to have many children; my grandmother raised me, my sister and my cousins – we were many children at home, you know – the children are joy. But growing up I have realized that a



child is a big responsibility – extremely many cares, not only financial: you have to educate it, to give it everything which I can not always manage. That’s why for now I will not have a second child – I want but I can’t. (Rudari woman, 23 years old, married with one child).

Most of the women during the interviews and the focus groups said that they would not do an abortion on a first child. They would consider the possibility for the second but would definitely not do it on the first pregnancy.

Many of the *Rudari* women during the focus group with them shared that they personally consider the abortion a murder of a child. So they prefer to take measures in advance (different methods of contraception) instead of making an abortion.

“For me the abortion is a sin; it is a murder of a child. I can not imagine that I can make an abortion. It is not that I accuse the people who do it – I have friends who have had abortions. Now I have one child. If I get pregnant again I would leave it. I don’t want a second child at the moment because I don’t have means to raise it, but if I get pregnant I would leave it: a child comes with its luck.” (Rudari woman, 23 years old, married with one child).

APPENDICES

ROMA ORIENTED PROJECTS IN THE HEALTH CARE SYSTEM

➤ **Providing equal access to health services for minorities (Phare 2001)**

General framework of the program: In December 2003 a Consortium of four organizations – Open Society Foundation – Sofia, Bulgarian association for family planning – Sofia, Minorities Health Problems Foundation – Sofia and Diversity Balkan foundation for cultural dialogue started the project implementation. One of the main purposes of the project was elaborating a training program and conducting a series of trainings in which 51 health mediators, 30 doctors and 30 nurses took part. The following places were included in the project: Dupnica, Asenovgrad, Pazardjik, Plovdiv, Haskovo, Stara Zagora, Jambol, Kazanlak, Burgas, Shumen, Dobrich, Silistra, Lovech, Vidin, Lom. In most of them health centers in Roma neighbourhoods were built and furnished.

Strengths of the program: the health mediators are people from the community who know the community inside, improve the dialogue and the level of communication doctors/patients. Most of the health mediators are motivated and well trained. Roma experts participated in the training team so they have paid special attention on cultural community specifics.

Weaknesses of the program: Health mediators are included in different programs and projects. The educational level, skills and knowledge is not unified (the reason is the different training teams and programs). The work of the health mediators in the small villages is harder because of manipulations and assigning them other responsibilities than those in the job description of the health mediator. Health mediators are not well paid and this decreases their motivation.

Recommendations and comments:

- The sustainability of the position of the health mediators suffers from the drawbacks of the health system and the lack of engagement from the side of the institutions.
- The health mediators should work together with another health mediator.
- The profession “Health mediator” should be popularized on the national level.

- An external monitoring and evaluation of the health mediators should be carried out including the opinion of the mediators, the opinion of general practitioners, municipal representatives and health institutions about the quality of the performed activities.

➤ **“Improving the accessibility of Romani women and children to health services in rural areas”**

General framework of the program: The Project was financed by the MATRA program of the Ministry of Interior of the Netherlands and was realized by CARE – Netherlands, CARE International-Bulgaria, Minorities Health Problems Foundation. The aim of the project was to contribute to improving the health status of Roma population in 16 towns and villages in the rural areas of Montana, Blagoevgrad, Razgrad, Ruse and Yambol by raising the accessibility of Romani women and children to health services. The project worked in four fields: training 16 health mediators, raising the level of health education of Romani women, raising the level of educated Roma youths in connection with reproductive health and other health problems, social support and media publications including creating new policies, regional and national campaigns.

Strengths of the program: For first time the selection of health mediators was from rural areas. They were trained after a certified program by the Ministry of Health (following the PHARE 2001 project). Mediators started to work immediately after their training, receiving help by the project team. The activities included preventive examinations with tuberculosis tests in the areas of Ruse and Razgrad.

➤ **Component 5 “Prevention and control of AIDS in Roma community” of the Global Fund for AIDS, TB and Malaria (GFATM)**

General framework of the program: The model was first tested in Kyustendil, Sofia, Vidin, and partly in Ruse and after that was multiplied in ten Bulgarian cities. The logic of intervention is to execute the best practices for restricting risky behavior associated with anal sex, men having sex with men, commercial sexual workers and intravenous drug users. Some of these risky behaviors are often seen in the group of 15 – 25 years old, others are more often among specific Roma groups. The Roma component within the program was implemented mainly by Roma organizations (with one exception). The successful project development has been guaranteed by: taking into account the local conditions in the different

communities; the participation of Roma organizations; local organization's experience; the existing system of consecutive steps for selection of mobile field workers, trainings, personnel exchange, monitoring and supervision from national experts. The teams are compiled of Roma community representatives. The services provided within the project are connected with youth trainings in health – educated and leader groups, individual and group health consultation, motivation and escorting for AIDS tests, sex transferring infections, directing to health and social institutions, creating proper conditions and organizing epidemiological screenings in the community. 5 social–health centers in the Roma neighbourhoods in Burgas, Varna, Stara Zagora, Pazardjik and Vidin have been built within the project.

Strengths of the program:

The implementation of the program is planned with the participation first of the leading team of local Roma NGOs and after that the whole project team according to the National strategy for working with vulnerable groups;

The cultural specifics of the groups are taken into account;

The mobile field workers have the trust and respect of the community and they are well known by the health, municipal and local authorities which is possible because of the professional trainings and team work.

Monthly reports give timely information about the clients approached by gender, age, settlements and by risky behavior, trained youths, motivated and accompanied persons for voluntary AIDS and STD examinations.

Weaknesses of the program:

The intervention is wide-ranged which limits the financing.

It is necessary on a political level to report about the different factors which have influence the effectiveness of a given program. Therefore, it is necessary to focus not only on the consequences but also on the causes. It assumes introducing parallel programs targeting the factors of vulnerability: low level of education; unemployment; poverty and social exclusion.

Until now the program has not been financially supported by the municipalities even though the program aims at social changes too. Gradually the program financing narrows which makes it inefficient due to limited financial and subsequently human resources.

There is still lack of enough flexibility and coordination between the different activities in the health field at the national level.

Comments/recommendations:

- The successful HIV/AIDS prevention in the Roma community supposes wider financing, including resources from municipalities and state budget and joint activities financing by social and educational programs and projects.
- The well trained human resource and infrastructure should be used in a proper way in each of the policies for improving minority integration.

➤ **Project BG 2003/004-937.01.03 „Educational and medicine integration of vulnerable ethnic minorities with special focus on Roma”: Component 3 „Health protection”**

Program general framework: the beneficiary of the project is the National Council for Cooperation on Ethnic and Demographic Issues. It is realized in 5 regions: Sofia, Kyustendil, Vratsa, Yambol and Pazardzhik. One of the project phases is providing health services: motivating people for diseases prophylaxis and diagnostics in the five mobile offices, training health mediators and informational campaigns. 53 Roma representatives were included, 50 of them were trained, 47 became health mediators as most of them were women. In addition, an accredited program for health mediators was introduced to Medical Colleges.

➤ **“Decreasing the health inequality in the Roma community” project**

Framework of the project: This is an international project with twelve partners from nine countries as the main organization is FSG, Spain. The partners from Bulgaria were “Health initiative” and “The Health of Roma” Foundation - Sliven. Identical activities with the ones pointed above, mainly analyzing the situation and different trainings, were implemented in each of the countries. 22 people have been trained, 14 of them are women.

➤ **“Health promotion and health prevention of mother’s and children’s health” (Phare 2004 BG2004/016-7.11.03.0001)**

General framework of the project: The project is connected with the implementation of the Framework program for equal integration of Roma into Bulgarian society. It is 14 months project (28.09.2007- 30.11.2008) realized in the regions of Yambol, Montana, Dobrich and Pazardjik. The partners are: Open Society Institute (Sofia), “Bulgarian association for family planning and sexual health” (Sofia), “Health problems of the minorities” (Sofia) and “ICAN Institute” (Germany).

The main purposes of the project are directed to ensuring a better health status of the population and improving the prophylaxis health services for women and children from ethnic minorities with special focus on Roma. It is expected within the project 60 families to be trained with the active participation of Romani women who will consult and inform people from the community.

CONCLUSIONS AND RECOMMENDATIONS

- Develop and implement straightforward clearly targeted information campaigns promoting health issues among Romani women and girls
- Increase the number of Romani women health mediators employed and achieve sustainability of their position with regard to funding
- Increase the number of Romani girls and women studying in medical universities and colleges through scholarship schemes and other positive action measures.
- Create and support community health centers and mother centers in Roma populated areas
- Create mechanisms for access to health care for Roma (and in particular Romani women) without health insurances
- Create community-based and community-run programs for prevention of early births and for prevention of abandoning children in institutions
- Sex education (including contraceptive methods) should be promoted in school curriculum. These programs should take into consideration the specific attitudes and barriers about sex-talking in the Roma community
- Ensure that health-oriented measures in Human Resource Development Operational Program address aching problems of Romani women health situation
- Create programs (both in medical institutes and outside them) for acquainting health workers with the specifics of the Roma community
- Create programs for free screenings of pregnant women for Dawn syndrome and other inherited diseases
- Create programs for free two- and three-month screenings of pregnant women for sexually transmitted diseases and HIV/AIDS
- Create packages of measures and interventions for pregnant women without health insurance
- Create a program for providing free/partially reimbursed coils for women in vulnerable position

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List of interviewees regarding the national policies on Romani women health situation:

- Dr. Elena Kabakchieva – a long-term consultant of Program “Prevention and control of AIDS” in Roma community, “Health and social development” Foundation, Sofia;
- Prof. Dr. Ivajlo Tarnev – “Health problems of the minorities” Foundation, Sofia
- Dr. Nikolaj Chervensky – municipality manager of Program “Prevention and control of HIV/AIDS”, Stara Zagora;

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- Gancho Iliev – coordinator of Component 5 “HIV prevention of Roma community”, “World without borders” Association, Stara Zagora;
- Anna Ljubenova – “Health initiative” Foundation, Sofia;
- Lilia Kolova – Social practices center, Sofia;
- Anna Ilieva – Health mediator, Sofia;
- Fidanka Ruseva – Health mediator, Stara Zagora
- Dr. Desislava Georgieva - major expert of Regional Health Protection Center, Stara Zagora

ABBREVIATIONS

AP	action plan
CA EA	Civic Association Expert Analyses
FP	Framework program for equal integration of Roma into Bulgarian society
GFATM	the Global Fund to fight AIDS, Tuberculosis and Malaria
GP	General practitioner
HRDOP	Human Resource Development Operational Program
NSRF	National Strategic Reference Framework
OP	Operational Program
OSI	Open Society Institute
PHP	OSI Public Health Program
RHP	OSI Roma Health Project
STD	sexually transmitted diseases
WHO	World Health Organization

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