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ABSTRACT

The health inequities suffered by the Roma population in Europe represent an alarming and unacceptable source of injustice. As the main ethnic minority in Europe, the gap between the health conditions of the Roma and the rest of the population poses a challenge to human rights and public health. Many political efforts have been deployed in Europe to tackle these inequities. However, they have fallen short, even causing paradoxical consequences. In this paper, we argue that previous political efforts have failed because they were developed from a neoliberal perspective, which perceives Roma health inequities as isolated ethnic problems for which there is no political accountability. Hence, there is a need for transformative political change that results in the protection of rights and self-governance to address health inequities experienced by Roma people. We propose a framework of health governance guided by the following principles: (a) effective involvement of multiple stakeholders by building collaborative capacity; (b) infusion of health perspectives in all policies and multisectoral actions; (c) transparent monitoring and evaluation; (d) role redefinition of policy promoters; (e) prevention of institutional discrimination; and (f) assuring cultural competence among policy promoters.

Health inequities that the Roma population in Europe experiences represent an alarming and unacceptable source of injustice, manifested in an increasing gap between the health conditions of the Roma people and the rest of the population. In general, health problems in the Roma community are the result of a vicious cycle, a continual cause and effect between poor health, poor living conditions, low socioeconomic status, social rejection, and discriminatory policies and practices (García-Ramírez, Escobar-Ballesta, & Lizana, 2015). The resulting cycle has been a wicked problem for Europe. Given the prevalence of the Roma as the primary ethnic minority in Europe, Roma health inequities challenge human rights ideals and provide a source of public health risks for the whole continent (McKee, Balabanova, & Steriu, 2007).

Several efforts, such as the Decade of Roma Inclusion (DRI), 2005–2015 and the Framework for National Roma Integration Strategies by 2020 (European Commission (EC), 2011), have been developed to overcome these inequities. However, they have fallen short, causing unforeseen consequences. Although it has been proven that the precariousness of the socioeconomic status of Roma people has a very negative impact on Roma health, politicians and policymakers have been unable to overcome their own ethno-cultural perspective to explain these inequities. This view has reinforced the idea that Roma people are incapable of having successful lives, and this has been used not only to explain Roma people's health inequities, but also their disadvantaged socioeconomic status (Beauchamp, 2010). Gaps between policy planning and implementation, low participation of the Roma community, and governmental corruption have further contributed to the failure of previous efforts to alleviate health inequities (EC, 2010; McKee et al., 2007; Parekh & Rose, 2011). Therefore, it is essential that Roma health inequities be redefined politically to strategically fill in the gaps between planning, development, and implementation, assuring full participation of the Roma community in all stages.

Political governance that protects the health rights of Roma people requires transformative changes in public health policy at multiple levels. A political governance process involves "the distribution of economic, intellectual, and political resources" and the effects this resource distribution has on health (Ottersen et al., 2014, p. 630). Also, the political governance process implicates an assessment of power asymmetry in policies that limit the range of choice and constrain action in health inequity, thus triggering social injustice and oppression (Ottersen et al., 2014; Prilleltensky, 2012). In this paper, we confront the challenge of Roma health inequities by shedding light on governance for Roma people's health. In doing so, we draw upon principles of transformative political changes that will ensure the implementation and effectiveness of equitable health policies for all. By transformative political changes, we mean changes in policy that resort to the best available evidence while incorporating the views of multiple actors, aiming to accommodate their values to give them real power to influence the decisions that most affect their lives. Achieving these changes depends on three fundamental processes: (1) explicit and discussable problem framing; (2) citizen participation in policy formulation; and (3) allocation of resources necessary for policy formulation and implementation (Nelson, 2013). First, we will summarize health inequities and social determinants of inequities experienced by the Roma population. Second, we will describe recent European reactions to these inequities and reasons for the prevalence of these inequalities. And third, we will introduce principles that should guide the protection of rights and governance for Roma people's health.

This paper is the result of a collaboration established between the Center for Community Action Research at the University of Sevilla (CESPYD) and the International Organization for Migration (IOM) within the framework of the project "Equi-Health: Fostering Health Provision for the Roma, the Migrants and Other Vulnerable Groups" (please, see http://equi-health.eea. iom.int/). This project pursues improved access to healthcare services and health promotion and prevention that is suitable to meet the needs of the Roma in Europe by stimulating dialogue and capacity building among key stakeholders. Consequently, the collaboration established between CESPYD and the IOM resulted in the assessment and monitoring of the implementation of the National Roma Integration Strategies in Spain from a multi-stakeholder perspective and the empowerment of stakeholders in the improved governance of Roma health.

Roma, health inequities, and social determinants of health

The recent decline of the European economy, the formalization of Bulgaria and Romania as members of the European Union (EU) in 2007, and a waiver visa policy for Western Balkan citizens has resulted in an increase in mobility of citizens from Eastern Europe, many of them of Roma descent (McKee et al., 2007). The Roma are the largest ethnic minority group in Europe. Between 10 and 12 million Roma people currently live on the continent, of which around six million live spread throughout the EU. In both Eastern (e.g., Hungary, Bulgaria, Romania) and Western (e.g., Italy, France, Spain) European countries, the Roma are a significant minority population. Since their arrival in Europe, the Roma have been continuously displaced due to discrimination (Strochlic, 2011). This displacement has resulted in the formation of three distinct Roma population groups, each with its own particular characteristics: national Roma, foreign Roma, and traveling Roma. In this paper, we will focus on Spanish national Roma and foreign Roma, who unlike the traveling Roma, permanently reside in Spain. We will refer to Spanish national Roma as *Gypsies,* which although considered to entail derogatory connotations, the Spanish Roma proudly claim to be *gitanos,* which is the Spanish translation for Gypsy (FAKALI, 2013). In general, we will refer to Roma when we talk about both groups.

A wide range of characteristics shared by both Gypsies and foreign Roma—as well as other Roma around Europe—make this community a unique ethnic minority group. The Roma have the largest population of children under 16—nearly a third of the total population—and the lowest percentage of people over 65—which reveals their capacity for rapid growth and premature deaths (Fundación Secretariado Gitano (FSG) 2009; World Health Organization (WHO), 2014). Women outnumber men in all age groups and have a fundamental role within the traditional Roma family, as

they are the central figures for bearing, nurturing, care-giving, and continuing the lineage. Roma women are a potential political force with the capability to lead change and foster modernization within their communities, which still are not fully recognized within modern society (Vincze, 2014). Regarding the Roma family social structure, the extended family and the community play an important role, serving as a connecting element for foreign Roma around Europe. In the same vein, the Romany language is another unique element that identifies and recognizes Roma people as part of the same community (EC, 2004).

In general, the Roma have a life expectancy 10–15 years shorter than non-Roma, with higher mortality rates among young adults and children (Parekh & Rose, 2011; Sepkowitz, 2006; WHO, 2014). They tend to have a more negative view of their own health, experience more visual and hearing impairments, and experience more traffic and domestic accidents than the non-Roma population (Hajioff & McKee, 2000; WHO, 2014). In general, Roma adults do not use preventive care services, making them more prone to suffering from preventable chronic diseases (e.g., cardiovascular, bone, and joint diseases) and infectious diseases (e.g., tuberculosis, hepatitis, polio, measles) as well as alcohol and drug abuse (FSG, 2009; WHO, 2014). The number of Roma people with psychiatric or mental health diagnoses (e.g., stress, depression, anxiety) is six times higher than the rest of the population. These conditions are more prevalent among Roma women (Parekh & Rose, 2011), who are also at risk to be overweight or obese. Also, Roma women do not regularly visit the gynecologist due to myths and taboos surrounding sexuality, which in turn has a negative effect on their sexual health and family planning (Carrasco-Garrido, López de Andrés, Hernández Barrera, Jiménez-Trujillo, & Jiménez-García, 2010; FAKALI, 2013; Ministerio de Sanidad y Consumo & Fundación Secretariado Gitano, 2007). In addition, the tradition of having big families and early marriages means that teenage pregnancy is common, increasing the health risks of mother and child (Hajioff & McKee, 2000; McKee et al., 2007; Parekh & Rose, 2011). The rates of vaccinations or regular pediatric check-ups are low in the Roma infant population. Roma infants also tend to have a deficient or unbalanced diet, which may lead to malnutrition, poor dental health, and diabetes (FSG, 2009; WHO, 2014).

The manifestation of these health issues expresses that the Roma people are trapped in a cycle of segregation affecting their health and development in all aspects. To begin with, Roma children experience high rates of school absenteeism, school failure, and dropouts. This leads to low literacy rates among adults, contributing to low employability and reduced opportunity to obtain healthier living conditions (Brüggemann, 2012; WHO, 2014). As a matter of fact, the Roma people experience high unemployment (i.e., almost 80% are unemployed) and underemployment rates due to labor

market discrimination and segregation. There are very few occupational opportunities for the Roma to aspire to because often the available jobs are those that nobody wants, jobs where they have to work alone and which are more likely to be high risk and do not provide health insurance (Fundamental Rights Agency (FRA), 2011). Furthermore, the Roma constitute the poorest ethnic minority in Europe, being 10 times poorer than the rest of the population (Parekh & Rose, 2011). In Spain, it is estimated that 77% of the Roma live in relative poverty, and 37.5% live in extreme poverty (i.e., less than USD \$4.30 a day) (Page 5, Line 191). The Roma are repeatedly forced to move and settle in temporary, unsanitary dwellings located in ghettos far from public services, with poor urban planning and structural deficiencies (e.g., only 50% have access to running water) where the same subhuman conditions of their own countries are replicated (Parekh & Rose, 2011; WHO, 2014). Socioeconomic depravation and its consequences are far greater for foreign Roma, who carry as additional baggage the chronic poverty and social exclusion suffered in their own countries. In any case, the health status of the Roma community as a whole is much worse than that of other groups in Europe (La Parra, 2009). Due to the Roma population's social conditions, economic determinants alone are not sufficient to explain health inequities as they also experience discrimination and oppression putting at risk their wellness and prosperity as an ethnic group.

Health vulnerability is also perpetuated by the healthcare system itself. The Spanish healthcare system implements a hospital-centered and ethnocentric model of assistance, focusing on the dominant culture and lacking cultural competence toward cultural differences and minority groups creating a culture of mistrust (e.g., few providers are trained in managing diversity, there is a lack of adaptation of services and protocols to Roma users). Furthermore, the healthcare system entails administrative and bureaucratic procedures that are the first barriers the Roma people encounter when attempting to access health services or when following stipulated procedures (García-Ramírez et al., 2015).

Concepts of health and other cultural values rooted in social persecution and stigmatization prevent the Roma from equal access to and use of health services. For instance, negative past experiences with health services facilitate Roma mistrust of healthcare providers due to programs that allegedly sought to improve women's reproductive health, which were, in fact, large-scale sterilization programs (European Roma Rights Center, 2016).

In short, the Roma are perpetually stigmatized, which has caused an internalization of their oppression, ultimately expressed through dominant cultural narratives that work to maintain the *status quo* (Balcazar et al., 2012; Martín-Baró, 1987). The precariousness and poor quality of their living conditions makes them susceptible to many health risks, thus contributing to further marginalization.

Unsuccessful European responses to Roma health inequities

The inequities explained above are sustained over time and continue to grow despite attempts to combat them. In 2003, a conference cosponsored by the Open Society Institute, the World Bank, and the EU, "Roma in an Expanding Europe: Challenges for the Future," offered the opportunity to raise awareness on the need to implement policies that enable the integration of Roma in European societies. Governments from Central and Eastern Europe, the Roma, and other international leaders, committed to inaugurating the Decade of Roma Inclusion (DRI, 2005–2015) to promote multisectoral policies for Roma integration into European society (please see http://www.anr.gov.ro/docs/deceniul/Roma_Decade_ToR.pdf). More specifically, DRI's members agreed that alleviating Roma health inequities required the following: (a) effective development and implementation of culturally responsive Roma healthcare policies; (b) greater sensitivity to the values and discourses of Roma communities; (c) involvement of all stakeholders; and (d) legitimization of the Roma population, not only as service users, but also as political subjects that contribute to the health of the society.

Despite this international effort, in 2010, the EC released a report on the economic and social integration of Roma in Europe that highlighted the progressive deterioration of Roma health status and living conditions (EC, 2010). Among the needs that this report called attention to were the need for further collaboration among EU member states, stakeholders, and Roma representatives; to translate commitments into positive changes at the local level by strengthening the capacity of stakeholders; to communicate the benefits of Roma inclusion; and to mainstream Roma inclusion issues rather than treating them as separate policies. Thus in 2011, the EC adopted the EU Framework for National Roma Integration Strategies (NRIS). European Union countries committed to reinforce the EU's equality legislation on the principle of equal treatment for all persons irrespective of racial or ethnic origin (Council Directive 2000/43/EC) by 2020 through the following actions: supporting policies and authorities at national, regional, and local levels in monitoring, sharing, and strengthening approaches to Roma health, education, employment, and housing (EC, 2011). The NRIS also sought to build a unified network to promote dialogue and participation among key stakeholders and to delineate strategies and interventions to support capacity building and cooperation to address the specific needs of the Roma. Regarding health, it was recommended that all NRIS member countries must provide the following to the Roma: (a) extend health and basic social security coverage and services; (b) ensure access to quality basic, emergency, and specialized services in the same conditions as to the rest of the population; (c) launch awareness raising campaigns on regular medical checks, pre- and postnatal care, family planning, and immunization, and ensure that preventive

health measures reach out to the Roma, in particular women and children; (d) ensure the participation of qualified Roma in their communities' health programs; and (e) improve living conditions, especially in segregated settlements (EC, 2012).

Similar to the DRI, attempts developed by the EC to incorporate NRIS are not obtaining the expected results due to ineffective implementation at the national, regional, and local levels. Both the DRI and the NRIS have sought to adapt already existing health policies rather than developing new transformative policies. Several documents support the fact that these failures—and, thus, Roma health challenges—will remain unresolved if the following obstacles are not addressed (EC, 2010; McKee et al., 2007; Parekh & Rose, 2011): (a) the gap between planning and implementation; and (b) the lack of inclusion of strategies developed and recommended in Europe into the more national and local levels; (c) the lack of economic resources and inadequate use of EU funds due to corruption in governments and institutions; (d) the low participation of Roma people and their communities in the development and implementation of policies; (e) the deficient support, commitment, and leadership of national and local institutions and respective stakeholders; and (f) the low impact of policies on public opinion and the media. The interdependent relationship between each obstacle is disrupting NRIS implementation and increasing health gaps between the Roma and the rest of the population. In summary, health gaps persist due to a lack of political accountability and community engagement.

Entities and policymakers at the European level are developing great efforts to build tailored and equitable policies for the Roma community. However, it seems that these good intentions remain at a theoretical level, being difficult to translate into realistic practices. At the national and local levels, policymakers and health providers often view Roma health inequities as irreversible, intrinsic ethnic problems and utilize this reasoning as a mechanism to avoid responsibility for poor health outcomes within the community (Beauchamp, 2010). This victim-blaming perspective has maintained and justified the cycle of segregation of the Roma (Navarro, 2013; Strochlic, 2011). For example, the Roma people live in ghettoized settlements since there are no policies or laws that provide accessibility to decent and affordable housing. Barriers to utilization of community-based health and social services are unrelated to Roma traditions or intrinsic problems in the Roma community, rather they are related to an absence of laws and policies that promote access to these services (e.g., establishing centers in the area, improving means of transport) (FRA, 2009). Therefore, social determinants of Roma health inequities are also a reflection of laws, norms, policies, and practices shaped at the hands of powerful global actors—policymakers and politicians. The actions of these actors and their institutions resulting from neoliberal policies—while not specifically aimed at harming the health of the Roma people—often forget

to focus on the social gradient of health. When inequalities worsen, these policies cause a multiplying effect on the disadvantages already suffered by the Roma, thus, indirectly causing a poorer health status in this population (Fésus, Östlin, McKee, & Ádány, 2012; Ottersen et al., 2014; Sparks, 2009).

This conveys that the previous efforts were developed through an empty declaration of intentions in a political vacuum with solutions that are not tangible or constricted by time. The neoliberal laws and policies have further prompted a reduction in social and economic public investments, where contempt toward the Roma has been constant (Navarro, 2013; Nelson, 2013; Viruell-Fuentes, Miranda, & Abdulrahim, 2012). These new public health policies have promoted and tolerated systemic health inequities by (a) seeking to cure instead of care for, (b) unfair distribution of resources, (c) increasing social cutbacks, (d) reducing states' accountability for citizens' health, thus making individuals solely responsible, and (e) transforming national healthcare systems into insurance-based systems (Marmot, 2007; Navarro, 2013). The above changes do not arbitrarily affect the whole population in the same way, but do affect more severely the most vulnerable ranks, such as the Roma. Unfortunately, these new public policies are not necessarily implemented and enforced, in part, due to the differential power relationships and oppressive ideology perpetuated by the healthcare system itself (Viruell-Fuentes et al., 2012). Moreover, lobbying organizations have legitimized and nourished this discrimination. For instance, Dalsklev and Rønningsdalen Kunst (2015) point out that when Norwegian media depicted the Roma as "filthy," it created disgust and prejudice toward this community, which resulted in feelings of dehumanization of the Roma in Norwegian society and the support of deporting them.

All of these elements lead to the conclusion that Roma health inequities are an extremely difficult problem to solve (Rittel & Webber, 1973). This challenge is neither technical nor scientific, and, therefore, does not require sophisticated resources (e.g., biomedicine, searching for new technologies). On the contrary, Roma health is a social and political problem that requires agreements and commitments among all stakeholders (e.g., mutual learning, cooperation), as well as bringing public interventions and resources to improve the Roma's health (Commonwealth of Australia, 2007; WHO, 2012). Hence, addressing Roma health inequities calls for new strategies in governance, new principles, and involvement of key actors.

Governance for Roma health through transformative political change

Sparks (2009) declared his astonishment at the ease with which policies addressing health inequities were proposed without considering the amount

of political change required to achieve them. As previously stated, there have been several recommendations, agreements, and allocations of funds over the years with little impact on Roma health. The following section describes alternative governance for Roma health guided by principles based on transformative political changes.

Governance for Roma health should adopt a perspective based on the principles of social justice, focusing on socio-political determinants of health linking individual factors (e.g., gender, ethnics, migrant status) and the unequal power relationships that underlie these (Moane, 2003). The subsequent policies would be aimed at challenging the *status quo,* redistributing power, and redefining structures within the community and institutions. Hence, new public health policies will be designed without favoring the treatment of some inequities—and groups—above others, and the resulting plans, strategies, and actions would be more effective in tackling the gap in health between the Roma and the rest of the population (Palencia, Malmusi, & Borrell, 2014). Ultimately, these policies would require the development of a wide range of interventions at multiple levels, and they also need to be sustainable so that political, ethical, and social barriers in health can be overcome (Beauchamp, 2010; Ottersen et al., 2014; Palencia et al., 2014). Thus, governance for Roma health should be guided by the following principles:

Effective involvement of multiple stakeholders by building collaborative capacity

Sustaining and strengthening stakeholders' engagement should be an action-oriented process that gives a voice to marginalized groups and focuses on strengths and capacity building to change systems. The pursuit of change in systems often requires engaging multiple stakeholders across multiple sectors in joint action to produce desirable and quality changes in the community (Allen et al., 2013). Governance for Roma health between multiple stakeholders (e.g., Roma leaders, civil society, policymakers, researchers, healthcare providers, local officials, etc.) allows for the acquisition of fundamental skills, procurement of resources, and engagement in the decision-making process. Indeed, prioritizing the Roma community in policymaking is an ethical and moral imperative: "giving people a voice in matters that affect their lives is an act of fairness" (Prilleltensky, 2014, p. 152). Also, it turns Roma stakeholders into legitimate political agents and leaders, thus implying greater effectiveness and recognition for this community within a paternalistic sector that has traditionally assumed the inability of the Roma to successfully lead their own policies (Case et al., 2014). Among the intangible benefits, bringing together all stakeholders will not only entail major changes in the structures and practices of participating organizations, but also in the stakeholders´

attitudes, beliefs, and perspectives over time. This will allow organizations to be ready for change, ensuring the successful implementation of innovative measures increasing the resilience of the community. Building collaborative capacity also promotes interdisciplinary work, allowing for the advancement of scientific knowledge through creative solutions based on stakeholders' different sensitivities and worldviews. Moreover, the Roma will be progressively included in the lobbies responsible for planning and implementing policies, thus increasing the consistency of policies with their needs as well as the diversification and flexibility of their roles. At the same time, the Roma community will increase their health literacy and will become active agents of their health, developing skills and motivation to address health challenges and to defend their rights to promote and maintain good health (Balcazar et al., 2012; Case et al., 2014; Reich & Reich, 2006).

Health in all policies

The Roma health challenge must be defined from an intersectional perspective. This view recognizes that the Roma are not more at risk for health inequities because of their ethnic background, but are more susceptible to inequities due to other social determinants (e.g., low educational, socioeconomic, and employment levels; racism; and segregation) and individual factors (e.g., age, gender, migrant status) that interact and render this group more at risk for vulnerability in comparison with the rest of society (Palencia et al., 2014). Therefore, systemic policies from a multisectoral perspective are required to effectively tackle these inequities. Consequently, governance for Roma health requires infusion of health in all policies and multisectoral actions (i.e., education, employment, housing, mobility, justice, culture, environment, etc.) to collaboratively assume social responsiveness by incorporating the goal of influencing health determinants so as to improve, maintain, and protect health (Mannheimer, Gulis, Lehto, & Östlin, 2007).

Transparent monitoring and evaluation

The Jakarta Declaration on Health Promotion highlighted social responsibility for health and the need of a comprehensive, equity-focused health impact assessment at the community level as essential for constructing socially responsible health policies and practices (Mittelmark, 2001). Consequently, governance for Roma health should encourage and assure better monitoring, reporting, and evaluation capacity among stakeholders. This vision implies the assumption of shared political accountability, social responsiveness, and proactivity toward Roma health by all stakeholders, institutions, and the Roma community (Mannheimer et al., 2007). Evaluation should be

an ongoing routine embedded in stakeholders' activities and practices. Stakeholders must be aware of the importance of participatory and inclusive evaluation and develop competencies to become involved in the evaluation process. At the same time, community settings and institutions need to promote transparency, leadership for evaluation and accountability, as well as to provide resources to support these processes and an accountability oversight process (García-Ramírez, Paloma, Suarez-Balcazar, & Balcazar, 2009).

Role redefinition of stakeholders

These key stakeholders must become instigators of change, mediators and advocators of Roma health (Balcazar, Garate-Serafini, & Keys, 2004). Stakeholders need to develop critical thinking as well as specific skills to take action to address the needs of the Roma population. Such skills may involve learning about the Roma people, creating capacity for culturally responsive care and for evaluating the impact of their policies on Roma's people health, and creating a process of accountability. They also have to build trust as well as provide mentoring support among the Roma, liaising between the community and political systems to better access resources and supports. And, finally, they have to assume responsibility to guide research and action toward social justice by developing equitable and fair policies to promote Roma health. These roles should be considered in terms of power redistribution, thus enhancing members' critical awareness, information, social relationships, willingness to become involved, interpersonal competences, persistence, experience, and advocacy skills (Balcazar et al., 2004; Suarez-Balcazar, Balcazar, García-Ramírez, & Taylor-Ritzler, 2014).

Prevention of institutional discrimination

Governance for Roma health must develop laws and policies that advocate for the prevention of institutional discrimination within healthcare services. Imbalanced power relations within the system involve a subtle discrimination against minority populations such as the Roma. Therefore, dismantling discrimination is a systems-change intervention designed to change the underlying infrastructure within an institution to be more fair, just, and equitable (Griffith et al., 2007, Phillips, 2010).

Assuring cultural competence among stakeholders

Culturally competent health providers must empower themselves to promote equal enjoyment of community resources, acquiring new competences, and

promoting changes in their organizations that support overcoming of dispa-rities and asymmetries (García-Ramírez, de la Mata, Paloma & Hernández-Plaza, 2011). The key is to link individual cultural competence training with organizational support, culturally sensitive practices, policy planning, and community engagement. In the same vein, governance for Roma health should promote models of care that ensure the institutionalization of community health mediation. Health mediation would connect the healthcare system and its services with Roma communities, thus promoting health literacy among users. Consequently, the Roma community should be given the educational resources, information, and abilities to understand and to be empowered to adjust their behaviors to improve their own health and well-being (Napier et al., 2014).

Conclusion

This paper recommends strategies of governance to fill in the gap between the Roma health and that of rest of the population by emphasizing the need to develop transformative political change based on the principles of social justice and equity. Despite the fact that the Roma have been living in Europe for nearly a thousand years and represent the largest ethnic minority group in the continent, the inequities in health and the unacceptable living conditions they endure have become a significant challenge for fundamental rights and public health (Hajioff & McKee, 2000; McKee, Balabanova, & Steriu, 2007; Parekh & Rose, 2011). The current governance for Roma health has resulted in maintaining privileges for the mainstream society and condemning misfit groups to living conditions and related health inequities that hamper their progress and thriving. Moreover, these policies have served as smokescreens that have perpetuated the greed and impunity of governments and public institutions, which, in turn, have systematically masked inequities and their real consequences for excluded ethnic minority groups in terms of health and well-being (Navarro, 2013; Ottersen et al., 2014).

In addition, all stakeholders are also called upon to play a central role in reducing the Roma's suffering, thus overcoming the unacceptable per-secution, discrimination, and inhumane life that they suffer in opulent Europe. How can we walk this fine line without our work being allied with the dominant structures that uphold existing inequities and perpetuate dis-crimination and prejudice? First, our task is to erase the "social inequalities kill" misconception by bringing up the issue of power, pointing out that those who kill are responsible for, and the ones who benefit from, the inequalities that kill (Navarro, 2013). Second, we are obligated to help Roma communities to live day-by-day, to strengthen their critical thinking, and to build expectations of prosperity among people whose situation prevents them from recognizing their own potential for liberation and happiness.

These can be overwhelming tasks. However, both endeavors are an example of how all stakeholders involved need to be committed to the pursuit of meaning for Roma people and their communities (Prilleltensky, 2014). With this overall objective in mind, this paper hopes to humbly, but firmly, provides a critical example of the complexity of overcoming inequities in well-being and health through transformative politics and policies when conditions of inequity seriously jeopardize the dignity that all groups deserve as human beings.

Note

1. Decade for Roma Inclusion 2005–2015 http://www.romadecade.org/.

Funding

References

Allen, N. E., Todd, N. R., Anderson, C. J., Davis, S. M., Javdani, S., Bruehler, V., & Dorsey, H. (2013). Council-based approaches to intimate partner violence: Evidence for distal change in the systems response. *American Journal of Community Psychology*, *52*, 1–12. doi:10.1007/s10464-013-9572-8

Balcazar, F. E., Garate-Sarafini, T. J., & Keys, C. B. (2004). The need for action when conducting Intervention research: The multiple roles of community psychologists. *American Journal of Community Psychology*, *33*, 243–252. doi:10.1023/b:ajcp.0000027009.01838.f2

Balcazar, F., Suarez-Balcazar, Y., Adames, S. B., Keys, C. B., García-Ramírez, M., & Paloma, V. (2012). A case study of liberation among Latino immigrant families who have children with disabilities. *American Journal of Community Psychology*, *49*, 283–293. doi:10.1007/s10464-011-9447-9

Beauchamp, D. E. (2010). Public health as social justice. In M. T. Donohoe (Ed.), *Public health and social justice*. San Francisco, CA: Jossey Bass-Wiley.

Brüggemann, C. (2012). *Roma education in comparative perspective. Analysis of the UNDP/world bank/EC regional Roma survey 2011* (Roma inclusion working papers). Bratislava: United Nations Development Programme.

Carrasco-Garrido, P., López de Andrés, A., Hernández Barrera, V., Jiménez-Trujillo, I., & Jiménez-García, R. (2010). Health Status of Roma women in Spain. *European Journal of Public Health*, *21*(6), 793–798.

Case, A. D., Byrd, R., Claggett, E., DeVeaux, S., Perkins, R., Huang, C., … Bailey, M. (2014). Stakeholders´ perspective on community-based participatory research to enhance mental health services. *American Journal of Community Psychology*, *54*, 397–408. doi:10.1007/s10464-014-9677-8

Commonwealth of Australia. (2007). *Tackling wicked problems*. Available from: http://www.apsc.gov.au/__data/assets/pdf_file/0005/6386/wickedproblems.pdf

Dalsklev, M., & Rønningsdalen Kunst, J. (2015). The effect of disgust-eliciting media portrayals on outgroup dehumanization and support of deportation in a Norwegian sample. *International Journal of Intercultural Relations*, 47, 28–40. doi:10.1016/j.ijintrel.2015.03.028

European Commission (EC). (2004). *The situation of Roma in an enlarged European union*. Luxembourg: Office for Official Publications of the European Communities.

European Commission (EC). (2010). *The social and economic integration of the Roma in Europe*. Available from: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52010DC0133&from=en

European Roma Rights Center. (2016). Sterilisation and its Consequences for Romani Women in the Czech Republic (1966–2016). Budapest: ERRC.

European Commission (EC). (2011). *An EU Framework for National Roma Integration Strategies up to 2020*. Available from: http://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:52011DC0173&from=en

European Commission (EC). (2012). *National Roma Integration Strategies: a first step in the implementation of the EU Framework*. Available from: http://eur-lex.europa.eu/legalcontent/EN/TXT/PDF/?uri=CELEX:52012DC0226&from=en

FAKALI. (2013). *Guía de estrategias de intervención en materia de salud con la mujer gitana*. FAKALI: Seville.

Fésus, G., Östlin, P., McKee, M., & Ádány, R. (2012). Policies to improve the health and well-being of Roma people: The European experience. *Health Policy*, 105, 25–32. doi:10.1016/j.healthpol.2011.12.003

FRA—European Union Agency for Fundamental Rights. (2009). *Housing conditions of Roma and travelers in the European Union*. Available from: http://fra.europa.eu/sites/default/files/fra_uploads/703-Roma_Housing_Comparative-final_en.pdf

FRA—European Union Agency for Fundamental Rights. (2011). Poverty and employment: The situation of Roma in 11 EU Member States. Luxembourg: Publications Office of the European Union. Available from: http://fra.europa.eu/sites/default/files/fra-2014-roma-survey-employment_en.pdf

FSG—Fundación Secretariado Gitano. (2009). *Health and the Roma community, analysis of the situation in Europe. Bulgaria, Czech Republic, Greece, Portugal, Romania, Slovakia, Spain*. Madrid: FSG.

García-Ramírez, M., de la Mata, M., Paloma, V., & Hernandez-Plaza, S. (2011). A liberation psychology approach to acculturative integration of migrant populations. *American Journal of Community Psychology*, 47, 86–97. doi:10.1007/s10464-010-9372-3

García-Ramírez, M., Escobar-Ballesta, M., & Lizana, A. (2015). *Progress report from a multi-stakeholder perspective on the implementation of the NRIS (National Roma Integration Strategy) and other National Commitments in Spain. International Organization for Migrations and University of Sevilla*. Available from http://equi-health.eea.iom.int/images/NRIS_Spain_final.pdf

García-Ramírez, M., Paloma, V., Suarez-Balcazar, Y., & Balcazar, F. (2009). Building international collaborative capacity: Contributions of community psychologists to a European network. *American Journal of Community Psychology*, 44, 116–122. doi:10.1007/s10464-009-9247-7

Griffith, D. M., Mason, M., Yonas, M., Eng, E., Jeffries, V., Plihcik, S., & Parks, B. (2007). Dismantling institutional racism: Theory and action. *American Journal of Community Psychology*, 39, 381–392. doi:10.1007/s10464-007-9117-0

Hajioff, S., & McKee, M. (2000). The health of the Roma people: A review of the published literature. *Journal of Epidemiology and Community Health*, 54, 864–869. doi:10.1136/jech.54.11.864

La Parra, D. (2009). *Towards equity in health: Comparative study of national health surveys in the Roma population and the general population in Spain, 2006.* Madrid: Ministerio de Sanidad y Consumo.

Mannheimer, L. N., Gulis, G., Lehto, J., & Östlin, P. (2007). Introducing health impact assessment: An analysis of political and administrative intersectoral working methods. *European Journal of Public Health*, *17*(5), 526–531. doi:10.1093/eurpub/ckl267

Marmot, M. (2007). Achieving health equity: From root causes to fair outcomes. *The Lancet*, *370*, 1153–1163. doi:10.1016/s0140-6736(07)61385-3

Martín-Baró, I. (1987). El latino indolente: Carácter ideológico del fatalismo latinoamericano. En M. Montero (Coord.), *Psicología política latinoamericana* (pp. 135–162). Caracas, Venezuela: Editorial Panapo.

McKee, M., Balabanova, D., & Steriu, A. (2007). A new year, a new era: Romania and Bulgaria join the European Union. *European Journal of Public Health*, *17*(2), 119–20. doi:10.1093/eurpub/ckm021

Ministerio de Sanidad y Consumo & Fundación Secretariado Gitano. (2007). *Health and the Roma Community. Analysis of action proposals.* Madrid: Ministerio de Sanidad y Consumo.

Mittelmark, M. B. (2001). Promoting social responsibility for health: Health impact assessment and healthy public policy at the community level. *Health Promotion International*, *16*, 3. doi:10.1093/heapro/16.3.269

Moane, G. (2003). Bridging the personal and the political: Practices for a liberation psychology. *American Journal of Community Psychology*, *31*(1/2), 91–101. doi:10.1023/a:1023026704576

Napier, D., Ancarno, C., Butler, B., Calabrese, J., Chater, A., Chatterjee, H., … Macdonald, A. (2014). Culture and Health. *Lancet*, *384*, 1607–1639. doi:10.1016/s0140-6736(14)61603-2

Navarro, V. (2013). What we mean by social determinants of health. In M. T. Donohoe (Ed.), *Public health and social justice*. San Francisco, CA: Jossey Bass-Wiley.

Nelson, G. (2013). Community psychology and transformative policy change in the neo-liberal era. *American Journal of Community Psychology*, *52*, 211–223. doi:10.1007/s10464-013-9591-5

Ottersen, O. P., Dasgupta, J., Blouin, C., Buss, P., Chongsuvivatwong, V., Frenk, J., … Leaning, J. (2014). The political origins of health inequity: Prospects for change. *The Lancet*, *383*, 630–667. doi:10.1016/s0140-6736(13)62407-1

Palencia, L., Malmusi, D., & Borrell, C. (2014). *Incorporating intersectionality in evaluation of policy impacts on health equity.* Available from: http://www.sophie-project.eu/pdf/Guide_intersectionality_SOPHIE.pdf

Parekh, N., & Rose, T. (2011). Health inequalities of the Roma in Europe. *Central European Journal Public Health*, *19*(3), 139–142.

Prilleltensky, I. (2012). Wellness as fairness. *American Journal of Community Psychology*, *49*, 1–21. doi:10.1007/s10464-011-9448-8

Phillips, C. (2010). Institutional racism and ethnic inequalities: An expanded multilevel framework. *Jnl Soc. Pol.* (2011), *40*, 1, 173–192. doi:10.1017/S0047279410000565

Prilleltensky, I. (2014). Meaning-making, mattering, and thriving in community psychology: From co-optation to amelioration and transformation. *Psychosocial Intervention*, *23*(2), 151–154. doi:10.1016/j.psi.2014.07.008

Reich, S. M., & Reich, J. A. (2006). Cultural competence in interdisciplinary collaborations: A method for respecting diversity in research partnerships. *American Journal of Community Psychology*, *38*, 51–62. doi:10.1007/s10464-006-9064-1

Rittel, H. W. J., & Webber, M. (1973). Dilemmas in a general theory of planning. *Policy Sciences*, *4*, 155–169. doi:10.1007/bf01405730

Sepkowitz, K. A. (2006). Health of the world's Roma population. *The Lancet*, *367*, 1707–1708. doi:10.1016/s0140-6736(06)68746-1

Sparks, M. (2009). Acting on the social determinants of health: Health promotion needs to get more political. *Health Promotion International*, *24*(3), 199–202. doi:10.1093/heapro/dap027

Strochlic, N. (2011). Unravelling the Gypsy myth. E*thos Magazine*. Available from: http://ethosmagonline.com/archives/8702

Suarez-Balcazar, Y., Balcazar, F., García-Ramírez, M., & Taylor-Ritzler, T. (2014). Ecological theory and research in multicultural psychology: A community psychology perspective. In F. T. L. Leong (Ed.), *APA handbook of multicultural psychology* (pp. 535–552). Washington, DC: APA. doi:10.1037/14189-029

Vincze, E. (2014). The racialization of Roma in the 'new' Europe and the political potential of Romani women. *European Journal of Women's Studies*, *21*(4), 443–449. doi:10.1177/1350506814548963

Viruell-Fuentes, E. A., Miranda, P. A., & Adbulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine*, *75*, 2099–2106. doi:10.1016/j.socscimed.2011.12.037

WHO. (2012). *The new European policy for health—Health 2020.* Available from: http://www.who.int/workforcealliance/knowledge/resources/Health2020_long.pdf

WHO. (2014). *Roma health report health status of the Roma population data collection in the member states of the European union.* Available from: http://ec.europa.eu/chafea/documents/health/roma-health-report-executive-summary-2014_en.pdf

World Bank. (2005). *Roma in an expanding Europe: Breaking the poverty cycle.* Washington, DC: World Bank.