WITHIN, WITH AND FOR ROMA COMMUNITY

"PRO Health for Roma" as a model of multi-level support at the local level addressing discrimination and improving access to public healthcare for members of the Roma national minority in Croatia and Serbia

Model outlines, key findings, lessons learned & recommendations

® Médecins du Monde / Renato Pejković

Rights, Equality and Citizenship Programme of the European Union

MEĐIMURSKA ŽUPANIJA

GRAD ČAKOVEC

ZAVOD ZA JAVNO ZDRAVSTVO MEĐIMURSKE ŽUPANIJE

Crveni krst Srbije
Crveni krst Vojvodine

srem regionalna razvojna agencija

CEUR

PRO HEALTH for Roma - Addressing discrimination and improving access to health care for ROMA communities
Funded by the Rights, Equality and Citizenship Programme of the European Union (2014-2020)

PUBLISHED BY:
Médecins du Monde ASBL - Dokters van de Wereld VZW (MDM-BELGIQUE)
Office for Croatia
Ulica Svetog Mateja 123
10000 Zagreb, Croatia
Email: info@medecinsdumonde.be
Website and Facebook page:
www.medecinsdumonde.be
MdM.HR.BiH

IN PARTNERSHIP WITH:
Međimurje County
City of Čakovec
Institute of Public Health of the Međimurje County
Red Cross Serbia Red Cross Vojvodina
Red Cross Sremska Mitrovica
Regional Development Agency of Srem
Centre for Economic Development of Roma

AUTHORS: Juliette Delescluse, Jagoda Novak, Biserka Tomljenović and Julie Cellier

PROOFREADING: Ana Irena Hudi

PHOTOGRAPHY: Renato Pejković, Médecins du Monde, CEUR and Red Cross Serbia

DESIGN: ACT Printlab d.o.o.

This publication is part of the project *"PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities"* funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020) and co-funded by the Croatian Government Office for Cooperation with NGOs.

The content of this publication represents the views of the authors only and is their sole responsibility. The European Union does not accept any responsibility for use that may be made of the information it contains.

CONTENT

KEY RESULTS -

The project "PRO Health for Roma" in numbers

Funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020) and co-funded by the Croatian Government Office for Cooperation with NGOs.

Through the project "*PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities"* (PRO Health for Roma), Médecins du Monde ASBL - Dokters van de Wereld VZW (MDM-BELGIQUE) and its seven partners in Croatia and Serbia achieved the **following main key results** in the period between November 4, 2019 and April 04, 2021:

2985 beneficiaries members of Roma national minority in Croatia and Serbia /

- ► 60% women / 40% men (N=2806[1])
- ► Median age: 31 years (from 4 months to 89 years old)

In total, **1360 individuals**

- **One human life** was saved by an MDM-BELGIQUE nurse in Roma settlement Kuršanec: a person had a heart attack and the nurse detected it on time during the info-health preventive care consultation.
- **6 Roma community workers** were hired and professionally trained/mentored for outreach work and health mediation with vulnerable groups. In total, **4 training sessions** were organized for Roma community workers (2 in each country).
- **1656 individual social/info-health prevention consultations** were organised for members of Roma national minority to inform them about their right to healthcare/ related rights and/or supporting them in accessing healthcare/related services.
- **80 info-health prevention workshops with a total of 795 participants,** members of the Roma national minority as an awareness-raising opportunity to learn about various health topics and access to the public healthcare system.
- **279 individual mental health consultations** and **40 mental health group sessions were held for a total of 255 participants,** members of the Roma national minority - as an awareness-raising opportunity to learn about mental health, addressing mental health issues with professionals, and getting support for referrals to a specialist if needed.
- **Info guide** "***I want to be healthy***" about health rights and services in both countries - produced in three languages (Croatian, Serbian and English) and disseminated among the Roma community/online.

1 179 beneficiaries did not fill in the questionnaire during workshops for logistical reasons and only signed the participants' list. Therefore, the repartition of beneficiaries by gender, median age and number of individuals who took part in the activities is based only on the number of beneficiaries who fulfilled the questionnaire during workshops and were entered in a database, totaling 2806 beneficiaries.
Also, in this publication:
N stands for the total of the sample the following assumptions were based on.
N/A stands for not available, which represents the missing data.

- **2 training sessions** held for a total of **58 health professionals** (including medical students) covering topics such as the *Socioeconomic status of Roma patients; Equality and human rights of Roma patients - with emphasis on the provision of healthcare services in an inclusive way*.
- **(Online) study trip in Belgium** for **19 participants** (Roma community workers and representatives of public health professionals and authorities, etc.) with different knowledge/experience sharing meetings held with the European Union (EU) representatives, local (healthcare) institutions and organisations working with the Roma community and other vulnerable groups.
- **4 intersectoral meetings** were held, promoting cooperation between different sectors and stakeholders directly involved in the Roma community's access to healthcare (2 in each country).
- **Feasibility study "*Free transport services to health facilities for Roma national minority and other vulnerable groups in Međimurje County, Croatia*"** developed after participatory development process and presented to different national/local stakeholders (including decision-makers) in both countries.
- Analysis of the situation regarding Roma access to healthcare in Međimurje County.
- Following the participatory development process and based on the analysis, **two Action Plans on local measures for health integration of Roma national minority** - *one* for Međimurje County and *one* for Sremska Mitrovica area, both developed in the context of the national Roma inclusion strategies and policies and supported by local officials.
- **2 datasets** detailing the findings of the fieldwork and statistics on the Roma community members achieved through outreach (one for Međimurje County and one for Sremska Mitrovica area).
- **Final publication and transnational roundtable** identifying/discussing key project results, findings, lessons learned and recommendations for replicating similar actions in the EU and beyond in the future.

Project implemented by a consortium of multi-type partners:

- Médecins du Monde ASBL (Croatia)
- Međimurje County (Croatia)
- Town of Čakovec (Croatia)
- Institute of Public Health of the Međimurje County (Croatia)
- Red Cross Serbia Red Cross Vojvodina (Serbia)
- Red Cross Sremska Mitrovica (Serbia)
- Regional Development Agency of Srem Ltd (Serbia)
- Centre for Economic Development of Roma people (Serbia)

INTRODUCTION

The healthcare mediation/support model for Roma national minority in Međimurje County, *Croatia* & Sremska Mitrovica area, *Serbia* implemented by the organisation Médecins du Monde ASBL - Dokters van de Wereld VZW (MDM-BELGIQUE) in partnership with seven partners from both countries as part of the project "*PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities"* can be considered as quite successful in terms of enabling and facilitating access to healthcare for Roma national minority.

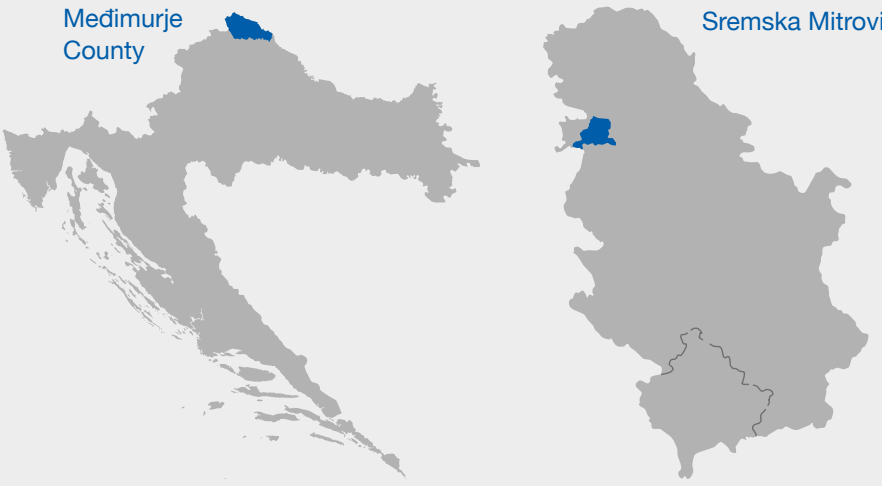
This publication, as the final project deliverable, will describe different components of this model of healthcare mediation/support, as well as key results and findings of the project. Besides, it will also bring forward the experiences, translated into policy recommendations, good practices and lessons learned both at the level of project implementation and stakeholder relations *process*, and the level of *content*. Therefore, this publication highlights the procedures, practices and measures that deliver results, but also identifies common mistakes that need to be avoided in the implementation of similar interventions across the EU and beyond.

Project "*PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities"*

Funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020) and co-funded by the Croatian Government Office for Cooperation with NGOs.

Overall objective: To support Roma communities in their efforts to integrate into society and maintain dignity.

Specific aim: To enhance Roma people's access to healthcare services in the target areas of Međimurje County, Croatia and Sremska Mitrovica, Serbia. These rural regions have high concentrations of Roma people (approximately 15 000 persons) mostly living in poverty due to their isolation from major centres, lack of access to public services, discrimination, and stereotypes.



Duration: 17 months (November 2019- April 2021)

Grant reference number: No. 849124

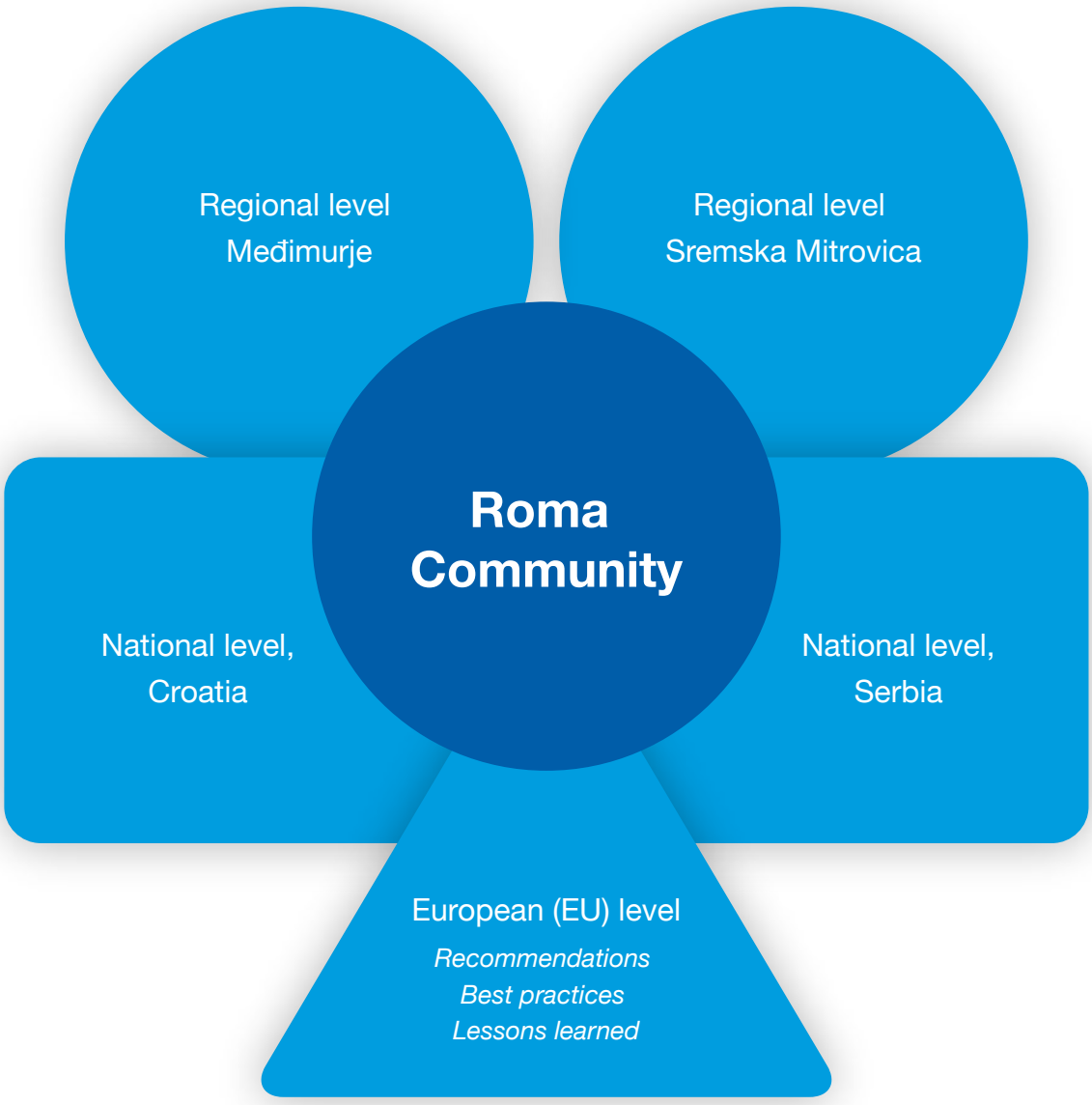


Figure 1: Interaction of different intervention levels of "PRO Health for Roma" project/model

I - PROJECT MODEL OUTLINES

Support model implemented through the project "*PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities"* at two target locations (Međimurje County, Croatia & Sremska Mitrovica area, Serbia) for addressing discrimination and improving access to public healthcare for Roma national minority is based on the following **key outlines**.

A model primarily based on the strong belief that each human being has the right to healthcare

This healthcare mediation/support model intended for the Roma national minority in Croatia and Serbia is primarily based on the strong belief that **each human being has the right to timely and adequate healthcare** as stated in article 25 of the United Nations (UN) Universal Declaration of Human Rights: "*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services*". As an international humanitarian organisation, guided by this belief as its core value, project leader Médecins du Monde-Belgique's vision is **a world where obstacles to health are overcome and where the right to health is effective through real universal health coverage**. Other project partners also share this vision. Additionally, in line with key humanitarian principles, Roma national minority communities were/are treated and/or supported by MDM BELGIQUE and partners' staff following the principles of **humanity, neutrality, impartiality** and **independence**.

A multi-level model with diverse type of consortium partners

The healthcare mediation/support model is set up at the local level and combines different complementary and coordinated levels of intervention.

The model combines **fieldwork (outreach), empowerment/capacity building actions, (transnational) information sharing activities, field research/quantitative and qualitative analysis, development of local policies/tools for Roma integration, enhancement of (intersectoral) coordination and conducting (local/national) advocacy actions**.

The model is implemented in each target area (Međimurje County or Sremska Mitrovica area) focusing on one specific vulnerable group (Roma national minority members). Only one action of the model (development of feasibility study "*Free transport services to health facilities for representatives of Roma national minority and other vulnerable groups in Međimurje county, Croatia*") has a territorially based approach focused on all categories of vulnerable groups. Categories of "vulnerable groups" to be covered through the project of free transport scheme (described in the feasibility study) were then defined in detail through conducting the participatory consultative process.

However, it can be noted that this support model can easily be extended to any specific vulnerable population group of a defined location/area/territory - using similar components and levels of intervention[2].

2 MDM BELGIQUE has been, for instance, implementing the healthcare mediation/support model focused on another vulnerable group in Zagreb - asylum seekers since 2016. For more details, see the publication: "Everyone has the right to healthcare: A model of healthcare mediation/support intended for asylum seekers in Croatia - outline, challenges & recommendations" (2020).

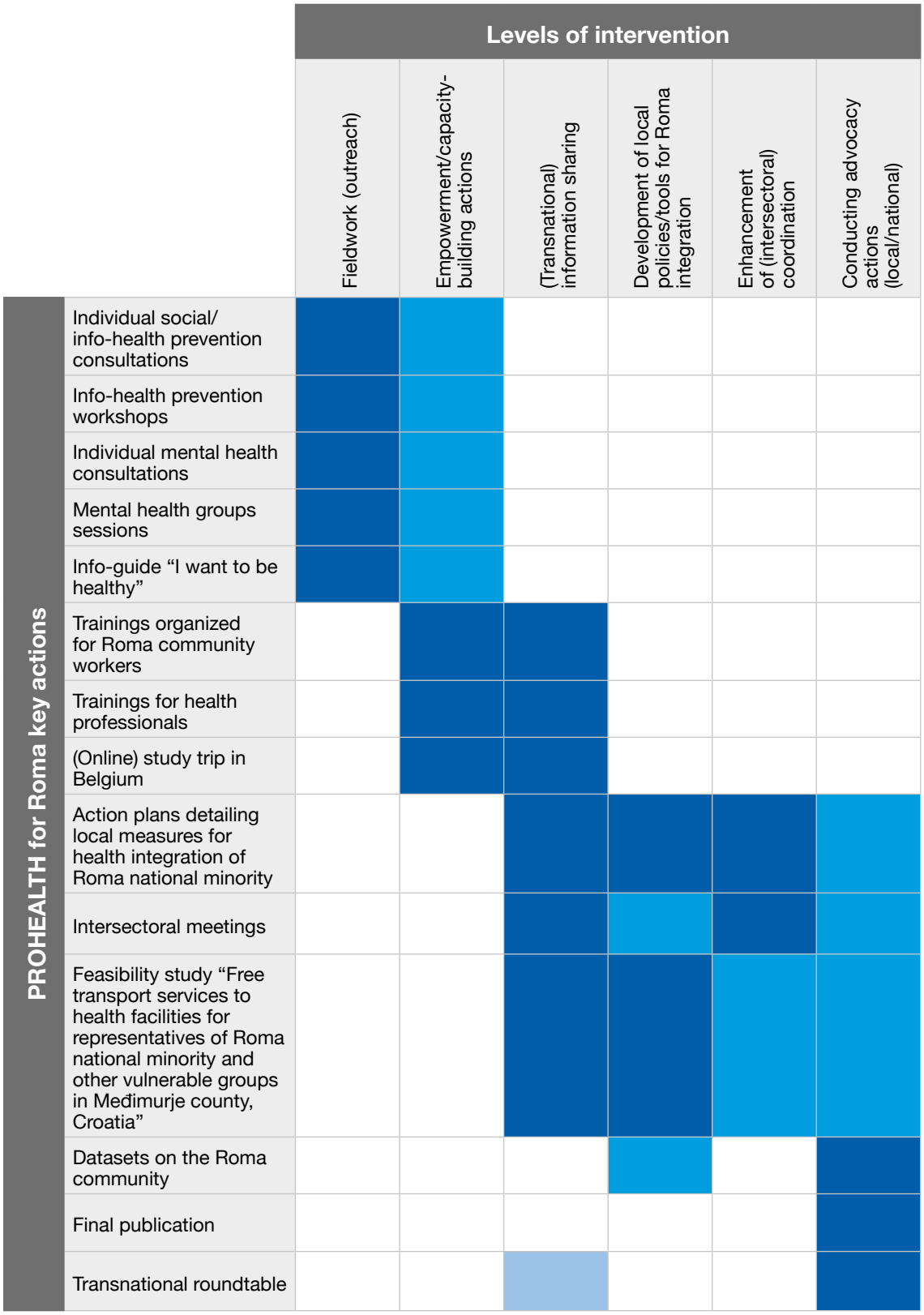


Figure 2: "PRO Health for Roma" key actions and levels of interventions (dark blue – high link; light blue – medium link; white – low link)

Another key component of the model is that, at both locations, it is conducted by **a consortium of diverse partners: local authorities** (Međimurje County, City of Čakovec), **local public health institution** (Institute of Public Health of the Međimurje County), **local development agency** (Regional Development Agency of Srem), Roma **Non-governmental organisation**(NGO) (Centre for Economic Development of Roma people), a specialist NGO (healthcare sector - Médecins du Monde ASBL) and other NGO (Red Cross Serbia Red Cross Vojvodina, Red Cross Sremska Mitrovica).

Among other benefits, each partner contributes to the intervention with their specific expertise, sphere of influence (fieldwork, policy level, etc.) and network.

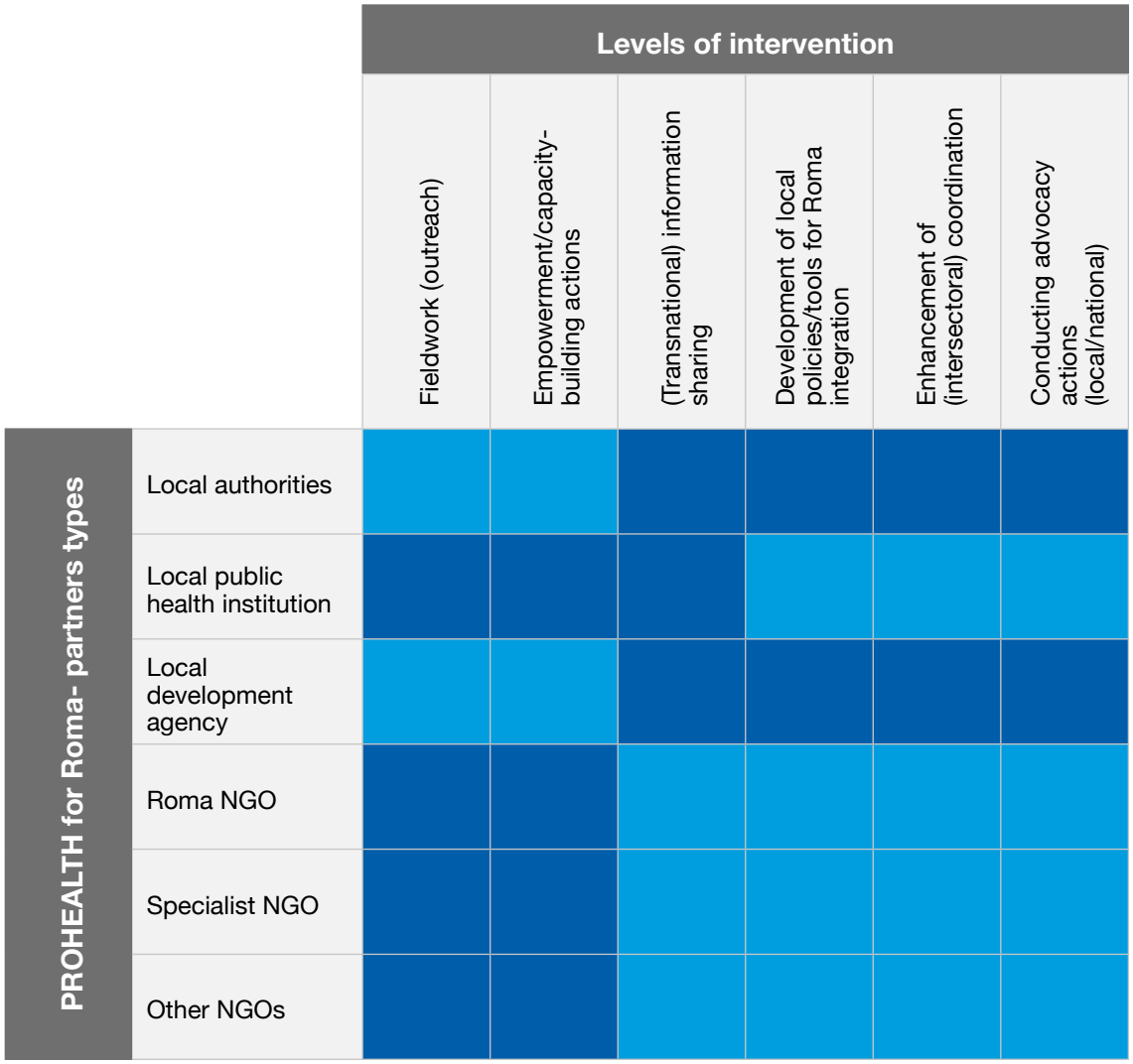


Figure 3: "PRO Health for Roma" partner types and levels of interventions (dark blue – high implication; light blue – medium implication; white – low implication)

In this model for addressing access to healthcare for Roma national minority members, it was especially important to involve an organisation representing the beneficiary target group (Roma national minority communities) and institution/ organisation as a specialist of specific topic/ sector covered by the intervention (health) as a partner.

It can also be noted that Roma NGO was involved in the consortium as a full project partner with paid members of staff. It is often not the case - unfortunately, many projects (including some of the projects funded through the EU funds) do not involve **Roma NGO/NGO representing beneficiary target group** as a **full partner,** and even when they do, it is often as "symbolic partner", relying on their willingness to "volunteer" and not taking into account the need to use the project as an opportunity to - if needed - reinforce their organisational, human and financial capacities (most of them often recently starting their activity and still not being a "professional" NGO).

Outreach and early on-site care/support

Outreach and direct **provision of on-site services** are key and basic components of this model. Healthcare mediation/support interventions take place in Roma settlements and even - if needed – at the users' homes. Services are available/provided as close as possible to the patients/beneficiaries.

MDM-BELGIQUE experience has shown that access to basic info-health prevention care/services, as well as mental health and psychosocial support (MHPSS) and early on-site treatment/support, besides being a **fundamental human right**, is not only beneficial for any vulnerable population - in this model the Roma national minority communities - but it is also cost-efficient (in both the short and long term) as it reduces demand for emergency care by providing more affordable and more effective primary care and preventive measures.

"*PRO Health for Roma*" **individual social/info-health prevention consultations** were provided by field team members (nurse, health staff - GP, paediatrician, gynaecologist, psychologist; Roma community workers; social worker/mentor for Roma community workers) in Roma settlements and mainly consisted in providing information to Roma national minority communities about their rights to healthcare/related rights and/or supporting them in accessing healthcare/related services. In more concrete terms, support consisted in for instance: informing them about their healthcare rights/services (and related rights/services), support in filling in forms to get public health insurance/complementary health insurance, support in registering with a GP/gynaecologist/paediatrician, advising on (healthcare) referrals, support in making an appointment for specialist consultations/other referrals, accompanying them if needed during (health) referrals, support in buying medicines in a pharmacy (transport to the pharmacy, but not paying for the medicine), provide info-health prevention advice through, for instance, measurement of blood pressure and blood glucose levels, explaining to them how to take medicines, etc.


® Red Cross Serbia

Information/support provided regarding related rights/services consisted, for instance, in the provision of information on the rights regarding social welfare aid/ parents allowance, etc., support in filling in forms to get an identity (ID) card (or a new one if they lost their ID), support in enrolling to kindergarten/school or in applying for a job, etc.

This support for related rights/services indirectly improve access to public healthcare for Roma national minority community but also helps build trust/confidence with the community – which means that they might see the team as a service/professionals from whom they can get multiple and various kinds of support, and this can be especially important for most vulnerable groups among them. It is also important since the provision of information/support regarding related rights/services is often the opportunity to identify lack/needs in accessing the public healthcare system for the same beneficiary. For instance, through the provision of support for kindergarten/school enrolment, the outreach team has often observed that the childhood vaccination schedule has been delayed and/or the child is not registered with a paediatrician. Likewise, providing information about their right to healthcare and/or supporting them in accessing healthcare services is also a way to reciprocally identify their needs concerning other related rights/services.

Consultations were conducted in Roma settlements and more precisely in a **mobile unit, private houses of beneficiaries or in-built facilities** available at the local level. This required mobility, adaptability and flexibility of the team - but it can be considered as a key precondition for successfully reaching out to persons in need and having a clear positive impact on their health status and socio-economic living conditions.

Lastly, it can be noticed that group info-health prevention workshops and mental health group sessions with healthcare professionals were often followed by individual social/info-health prevention consultations - since beneficiaries, after group workshops/sessions, got the opportunity to raise awareness about their health needs/rights/existing services/support they can get; and might also feel more at ease to ask for individual support.

Health needs (including mental health needs) of Roma national minority communities (as vulnerable population) represent "**invisible emergencies**" whose treatment is easy and relatively inexpensive to deliver before they escalate into irreversible complications. Early treatment is also important for tackling and protecting against the deterioration of mental health especially weaken due to poor socio-economic conditions. It is also a way to prevent gender-based violence (GBV) among service users, especially towards children, since "*violence is a continuum and taking care of the parent's mental health is beneficial to all the family members and can thus contribute to decreasing exposure to violence for partner or children*", as described by MDM-BELGIQUE psychologist. Early detection of potential infectious diseases is also an important benefit of continuous health monitoring services for both Roma national minority members and the local population.

® Médecins du Monde / Renato Pejković

Global and multidisciplinary care/support by a diversified team

The model is based on the multidisciplinary dimension of the outreach team. It is related to the concept of global health that takes into consideration not only physical but also mental and social components of health. Consequently, the outreach team that has been set up is deliberately **multidisciplinary and diverse** in its composition. The team is composed of persons with different profession backgrounds (GP, paediatrician, gynaecologist, psychologist, social worker, community worker etc.), different educational/work experience backgrounds (from high school to university level, from no previous work experience to more than 15 years of work experience, etc.), different socio-economic and cultural backgrounds - including members of vulnerable groups or national minorities, etc. In this model, diversity of the team is considered as a value and it directly contributes to service provision that is global and multidimensional, improving the impact and quality of the model. Communication between the professionals and their incessant joint efforts allows a holistic assessment and response to different needs of Roma national minority communities (physical, mental and social).

As part of the "*PRO Health for Roma*" project, mental health support was provided in Roma settlements in Croatia and Serbia by psychologists with the support of Roma community workers. Activities combined conducting **individual mental health consultations** and **mental health group sessions** for members of Roma national minority - raising awareness about mental health, addressing mental health issues with professionals, and support for referrals to a specialist if needed. Topics covered during group sessions included self-esteem, motivation, anti-bullying, social competences, enhancing empathy, the importance of education, recognising and expressing emotions (emotional intelligence), prejudice and discrimination, etc.

Experience from MDM-BELGIQUE psychologist in Croatia, Sunčica Lazanski

"Mental health does not only mean the lack of mental illness but is defined as an ability to lead a prosperous, productive and fulfilling life. There are many obstacles that Roma people must overcome to even begin accessing mental health treatment. Some of them are visible, the others stay under the radar. However, both of them highly influence this population. As it is widely known, the Roma community faces triple discrimination - ethnical, language and class. Roma women face additional discrimination because of their gender. When talking about the mental health of Roma people it is advisable to start from the causes and not the symptoms, which is how it usually goes with the treatment of mental health issues in general. A typical day of a Roma woman consists of doing several chores even before her family wakes up. Faced with the burden of emotional labour at home, being available either for her many children or husband, continuing with the unpaid household work as well as consequential financial dependence, she cannot afford to care about her physical, let alone mental health. So, her status in the community is jeopardized when compared to men around her. When she feels anxious, when she has too much on her mind, when she cannot stop crying and does not want to wake up in the morning… What can she do? But let's put these obstacles aside for a second and consider that she is free and educated enough to recognise her feelings as symptoms of mood disorders such as depression or anxiety (even though she is not in most cases). What are the next steps she needs to take? Does she know what services she can get? Does she know how to reach them? The answer is probably no - because of the reasons mentioned above. But she is also facing additional systemic obstacles and discrimination. First, she

might have problems finding and registering with a general practitioner (GP). Even if we put this aside, imagine that she found a doctor and got to see him/her - even if in many cases women tend not to go see a doctor. Because of hormonal fluctuations, they are more used to physical changes and mood swings, so they often dismiss their psychological symptoms of distress. If the doctor takes her seriously, they could recommend her to see a psychiatrist. It is also important here to distinguish between rural and urban population. To see a doctor or a psychiatrist is not an easy task, since many people from the Roma community must go to the city by car or take a taxi, which is expensive, because bus lines are often not connected with their villages. Once she finally gets to ask for psychiatric help, the question is if she has enough education to understand her condition? Does she have an internet connexion/sufficient IT knowledge to get additional information and support? And in the end, will she have enough money to cover the costs of medication? Most probably not. Let's not forget the general stigma - more or less present in some communities - about mental health being treated as less important than physical health and stereotyping the people seeking mental help as ''crazy" or ''lunatic".

After explaining a typical day in a Roma community for one member - a woman, I will explain a bit about my experience of working inside the Roma community as a mental health provider.

One thing that is immediately evident the moment you step into the community is that people are using many destructive ways of self-medicating either through alcohol, drugs or participating in violence as a method of emotional relief. This behaviour leads to addiction and it soon becomes a vicious circle of mental health issues leading to abuse, leading to violence which then leads to more severe mental health issues. There is a prevalent idea among the Roma men of a strong macho man stereotype that must provide for the family, own his wife and can treat her in all sorts of way. Out of insecurity and lack of understanding from the general population, their frustration is often taken out on women and children. Their mental health is extremely fragile, and they are scrutinized even more than women if asking for a mental health professional. They are also facing the huge stress of being unemployed, which leads to learned helplessness as a mode of behaviour. Many of these men have untreated or wrongly self-treated depression which is hidden and manifests as anger issues, rage outbursts and violence. Concerning children whom I have worked with, many have witnessed some shockingly violent scenes very early in their life. They come from impoverished backgrounds (educational and financial). They have huge issues with verbally expressing themselves and by consequence, this leads to a lack of understanding of their personal needs. Many people who joined my counselling sessions were often facing a huge amount of violence and trauma, with depressive and anxious consequences for their health. Gender roles and expectations play a big role in mental health and it is seen from a very early age. As from my experience, many children had attention deficit disorder, attention deficit and hyperactivity disorder or untreated intellectual, behavioural and learning difficulties. Many of them do not know who or how to ask for help and what rights they have. Coming from families with a lot of members, they often lack time and attention to care about their own needs. This combination of factors has brought them to counselling sessions with me. The mental health support that we provided had them set their goals, recognise their needs and empower them both for education and life. Many times we were facing difficult emotions and trauma consequences as well as another huge burden - prejudice and discrimination. Having witnessed all this, I would conclude that the continuous regular presence of a psychologist in Roma settlements combined with different support activities for accessing public healthcare - is of great benefit for the Roma community (they often expressed it themselves) and would highly contribute to their fragile and poor mental health."

Prevention and proactive approach

Raising awareness and info-health prevention activities represent a large component of this model. This includes conducting individual info-health prevention consultations, conducting info-health prevention workshops, elaborating (multilingual) info prevention material (info guides, brochures, flyers, etc.), and offering information/advice throughout the activities (social consultations, referrals, etc.).

Conducting on-site info-health prevention activities has not only directly contributed to raising awareness of Roma minority members about their health but also proactively reduced the existing gap between Roma minority population - physically segregated, socio-economically excluded and discriminated - from global population regarding access to the healthcare system. With this prevention component, the model goes a step further in terms of access to healthcare, not only by facilitating access to healthcare in case of disease (or suspicion of disease) but also by preventing in advance the occurrence of health problems.

Partnership with local public health institute in conducting most of the **info-health prevention workshops** in Croatia as part of the project "*PRO Health for Roma*" can be considered as a good practice. The outreach staff supported local public health institute health staff with the preparation of workshops including inviting Roma participants, helping with translation to Roma language when needed, etc. On the other hand, health expertise from local public health institute staff allowed to conduct high-quality workshops and advice directly to the community.

Info-health prevention workshops were a great success among the Roma community and the reasons for this could be the following:

- The variety of topics covered allowed to reach different categories of the public (teenagers, pregnant women in early stages of pregnancy, elderly population, etc.) as well as the fact that workshops were conducted by persons of different profiles in both countries (health professionals from different project partners).

Examples of topics discussed during the workshops: healthy lifestyle, stress management, health preventive measures, dentistry, family planning and reproductive health, sexually transmitted diseases, pregnancy, firefighting and first aid, vaccination and most common childhood diseases, anger management, parenthood, cardio-vascular diseases, drug addictions, the impact of food on health, meal preparation and cooking for children (addressed to parents), diabetes, health risk factors, cancer prevention, availability of drinking water, etc.

- Format of workshops was short in terms of duration (a maximum of one hour, with an average of 45 minutes), interactive - privileging oral presentations with simple explanations and discussion/exercises instead of formal PowerPoint presentations. Workshops also took place at hours of the day that matches the best different obligations of participants (for instance: for mothers, the most convenient time is after lunchtime). If needed, children were looked after by some members of the team while the parent(s) attended the workshop.
- Team was flexible regarding the conditions in which workshops took place: for example, if necessary, workshops were held outdoors (especially due to CoVID-19 epidemiological measures or when the hard built facility was not available).
- When relevant, workshops were sometimes linked with conducting artistic recreational activities such as art (music, drawing) or sports activities.
- Apart from the content of the workshops that was defined to be attractive and interesting for Roma national minority members, it can be noticed that attending workshops was not an issue mainly due to the support of Roma community workers that previously informed and invited participants within the community to attend the workshop- explaining them the content and why it is important/interesting for them to attend it.
- Active participation in workshops was on a voluntary basis and never mandatory. The objective was also to make sure that all participants felt welcome and at ease during workshops - the idea was to create an atmosphere of reciprocal respect, trust and confidence where participants felt particularly at ease to ask questions (during the workshop or afterwards, during individual consultations). At the workshops, participants could also get information about other existing project activities and services/support they can access/get.

Apart from prevention workshops, different written **info-health prevention material** was developed throughout the project. Additional material was also produced due to the CoVID-19 outbreak - presenting key prevention measures in the Roma language.

Examples of material produced and shared among Roma community (printed and/or online versions): a) Info-guide "I want to be healthy" available in English, Croatian and Serbian presenting how to access healthcare services in Croatia and Serbia but also other useful health-related advice. b) Publication "Healthy snacks" addressed to children population encouraging them to eat healthily. c) Different flyers/posters with health-related advice focusing on prevention of COVID-19 or related to info-health prevention topics. Flyers/posters were also translated into Roma language by Roma community workers. d) Individual medical folder (A5 format) where patients can compile their medical records but also write down their blood pressure and blood glucose levels daily. Relevant flyers and other relevant information (on rights/services, project activities, etc.) were added to the folder.

Community-oriented approach and community empowerment

Experience from Međimurje County Roma community worker in Croatia, Violeta Kalanjoš

"It was the first time I worked on a project since as a member of the Roma community I never had the opportunity to work with such an experienced team. Even though I finished high school, I only worked once in the past as a waitress. I learned a lot throughout the project. I became self-confident. I also learned about my own values […] and I can keep learning and developing new skills now."

MDM-BELGIQUE and partners have a comprehensive and community-oriented approach to providing care/support, which means that the organisation's staff focus on the person, not just on their (health) issues/needs, and participation of the communities is encouraged.

In this respect, this model includes the following components: - beneficiaries are encouraged to give their feedback ("feedback box" facilities/mobile unit, regular satisfaction surveys of beneficiaries, focus groups, etc.), - **project partners hired members of the vulnerable group supported (Roma national minority) as team members**; - detailed surveys of beneficiaries are conducted to include their needs/information about their health in different reports/publications; etc.

More globally, and related to this point, this approach is based on the following core beliefs/principles:

- behaviour does not occur in a vacuum, but is affected by the wider context of culture and society at large, as well as the local community and its institutions;
- cultural competencies involve three broad dimensions: health staff's cultural knowledge, health staff's attitudes and beliefs towards socio-economic/culturally diverse clients and self-understanding, and health staff's skills and use of (culturally) appropriate interventions;
- social justice perspective in care is rooted in the belief that all people have a right to equal treatment, a fair allocation of societal resources, and a share in decision-making processes.

Each person is seen as a human being, and this is the starting point and the purpose of this model.

The "*PRO Health for Roma*" project allowed for **hiring six Roma community workers** with different profiles. Community workers were mostly women. Some had no previous work experience and only a high school diploma, while others were trained nurses or had a university degree. It can also be noted the interesting situation in Croatia regarding the hiring of Roma community workers. One was hired by Međimurje County, the second by the City of Čakovec and the third one by MDM-BELGIQUE. The selection process was conducted jointly by three partners and daily management of Roma community workers was ensured by MDM-BELGIQUE (social worker/mentor for Roma community workers position). Apart from getting skills on the provision of support to vulnerable groups, Roma community workers got great skills and knowledge regarding, for example, project monitoring, data collection, relations with external partners (local institutions for instance or media), etc. In the early days of fieldwork, Roma community workers went to both countries through **training programs** preparing them for fieldwork specifically by raising their awareness about healthcare public system/rights, socio-economical dimensions of health, etc. Altogether, the project largely improved its impact thanks to Roma community workers and **hiring members of the vulnerable group targeted by intervention needs to be a pre-condition for any integration project. The EU (or any other donor) shall even put it in calls for proposals as a mandatory condition to be fulfilled by applicants.**

® Médecins du Monde / Renato Pejković

An individualised healthcare mediation/support model complementing the public health system

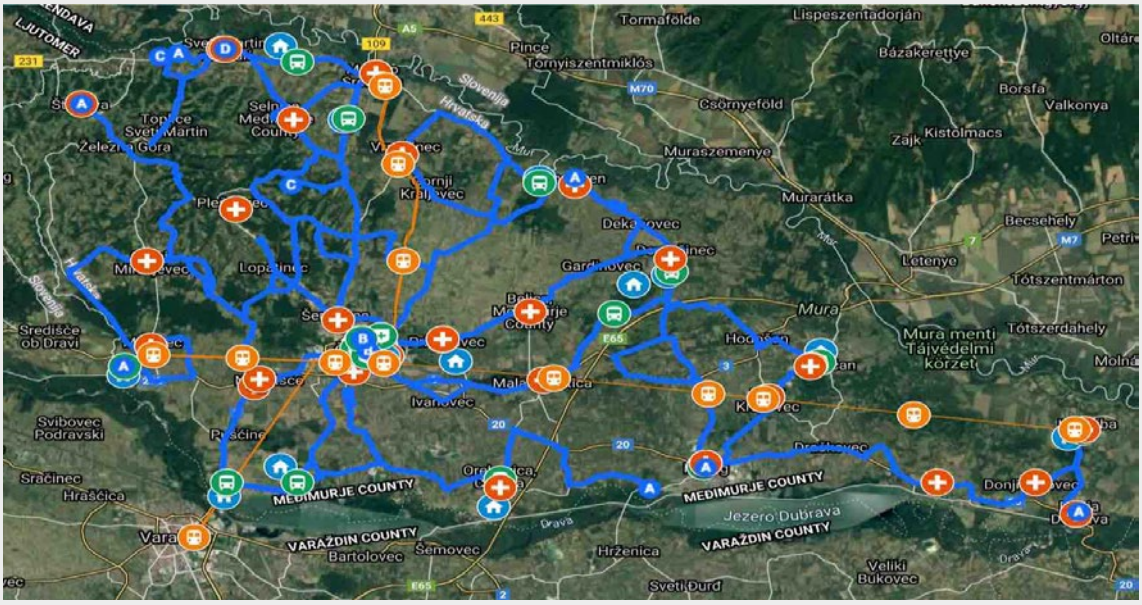
As previously described, care/support provided through this model is tailored according to the person's specific needs and mostly based on a **one-to-one approach**. Most services provided are individual, and it can be noted that group sessions often lead to individual consultations. Interpretation and/or (cultural) mediation is ensured by Roma community workers. However, their presence is not required if the beneficiary prefers to have a private conversation with health professionals. Support provided follows the existing standards, procedures and guidelines; but is personalised and, as much as possible, adapted to complex and multidimensional individual needs of beneficiaries. As a consequence, the model ensures **individualised, linguistically adapted and culturally aware care/support**. It can also be noted that a certain number of beneficiaries also needs tailor-made case management support from the outreach team since most complex cases (*like for instance teen pregnancy or youth with drug addictions*) or persons who never get registered with the relevant services (*like children who need to start a preschool programme, those who had never been vaccinated, or those who had not registered with a paediatrician and his/her parents have missing or no administrative documentation*) and need support with multiple referrals to healthcare facilities and/or other services, as well as a regular follow-up.

Another important aspect of this model is that field teams are acting as health mediators/facilitators between members of the Roma national minority (beneficiaries) and public health institutions and/or other service providers. This model is thus **complementing the public healthcare system** and is based on (sometimes daily) communication/coordination with local (healthcare) institutions, local authorities and other governmental institutions. This network of partners is crucial in responding to sometimes multiple and complex (health-related) needs of beneficiaries. Referral pathways have been identified, and beneficiaries informed/supported in accessing these services. However, it can be noted that access to these services is still quite difficult - despite significant improvements

® Médecins du Monde

achieved by the project "*PRO Health for Roma*". Members of the Roma national minority in both countries are still facing physical and socio-economic barriers in accessing healthcare as well as discriminations. As a consequence, further joint efforts must be made to make sure those gaps are addressed.

As an example of the effort to address physical barriers in accessing healthcare facilities, "*PRO Health for Roma*" project partners produced a **feasibility study** document called "*Free transport services to health facilities for representatives of Roma national minority and other vulnerable groups in Međimurje county, Croatia*". Developed after a participatory process, the study presents the outlines of the transport scheme that could be implemented to reduce the physical gap between Roma national minority/other vulnerable groups and the public healthcare system (facilities). The study was presented to different key stakeholders to conduct its pilot realisation phase. Apart from the study, an online map of Međimurje County was also created showing Roma settlements, nearest bus stops for each Roma settlement, bus and train lines as well as health facilities.



MAP LEGEND

- ROMA SETTLEMENT
- HOSPITAL
- GENERAL PRACTITIONER
- PEDIATRICIAN
- GYNECOLOGIST
- BUS STOP
- BUS LINE
- TRAIN STATION
- RAIL WAYS

Figure 4: Global Map of healthcare facilities/ health professionals, public transportations, and Roma settlements in Medjimurje County, Croatia

Data collection and experience-sharing activities to improve policy framework, enhance coordination and address discrimination

Apart from service provision, data collection for policy development/monitoring or advocacy purposes is a key part of this model. Collecting data during fieldwork not only allows monitoring services provided but also monitoring the health status and needs of the target population - members of the Roma national minority. This kind of data is particularly useful for public health authorities and national/local authorities, especially for national/local policies development, monitoring and revision. Data collected also serves as an important potential for research purposes especially in the field of health and social inclusion.

In "*PRO Health for Roma*" project, data and experience from fieldwork directly contributed to improving the local policy framework – as a bottom-up participative process. In both countries, key local stakeholders and project partners (including field staff) were involved in the development of two **Action plans detailing local measures for health integration of Roma national minority** - one for Međimurje County and one for Sremska Mitrovica area. Data and experience were also mobilised for advocacy purpose with the development of this **final publication** presented at a **transnational roundtable event** - attended by numerous stakeholders/specialists from Croatia, Serbia, other EU countries/abroad. The project also helped create two **datasets** with the findings of the fieldwork and statistics on the Roma community members reached through outreach (one for Međimurje County and one for Sremska Mitrovica area) - to be used by different policymakers, representatives of institutions, researchers, etc.

Another key component of the model is the maximization of experience sharing at local and transnational levels as a learning process (taking stock of experiences) but also to improve cooperation and coordination. Experience sharing was also used for promoting dialogue and addressing discriminations - especially for instance by conducting training and meetings involving both health staff and representatives of the Roma national minority (Roma community workers and/or other representatives of the Roma community).

Addressing discrimination was the main goal of **two training sessions for health professionals** organised in the "*PRO Health for Roma*" project in Međimurje County and Sremska Mitrovica. On this occasion, Roma community workers (and/or other representatives of the Roma community) could share with health staff their own experience in accessing the healthcare system but also provide more information about the socio-economic status of the Roma community. Trainers went also through topics such as equality and human rights of Roma patients (with emphasis on the provision of healthcare services in an inclusive manner). Medical students - as future health professionals – were also invited to attend the training.

Among other project activities promoting experience sharing and coordination, conducting **(online) study trip in Belgium** for 19 participants (Roma community workers and representatives of public healthcare professionals and authorities, etc.) held with EU representatives, local (healthcare) institutions and organisations working with Roma community members and other vulnerable groups is worth mentioning.

Last but not least, the organisation of 4 **intersectoral meetings** (two in each country) was also a way to promote cooperation between different sectors and stakeholders that work directly with the Roma community's access to healthcare. In Croatia, it can be noted that meetings were organized at the level of one Roma settlement to promote cooperation between different sector representatives (including Roma representatives) and find concrete local solutions at the settlement level for specific healthcare topics - solutions that are also to a certain extent relevant at the County level and other locations in the country. Meetings also served as an opportunity for participants to provide feedback on the County measures dealing with healthcare opportunities for the Roma community.

A flexible model to adapt to the evolving context

The model requires identification of new needs and flexibility of adaptation to changing context in which the project partners were able to prove their abilities to continue to meet the healthcare needs of Roma national minority members in the context of the CoVID-19 outbreak pandemic. In other words, the model constantly strives to offer adequate response with a proactive and solution-oriented approach.

Despite the **CoVID-19 pandemic**, "*PRO Health for Roma*" project partners managed to continue with their fieldwork activities. Prevention measures were however reinforced in line with national recommendations, such as ensuring adequate and sufficient personal protective equipment for staff and activities beneficiaries, conducting activities outdoors as much as possible, limiting the number of participants in workshops, etc. Transnational experience-sharing activities and some of the meetings were conducted online. CoVID-19 represented a challenge for project partners but also, on the other hand, pushed the team to find/test some innovative solutions - such as conducting study trip online. Even if nothing can replace face to face contacts, the CoVID-19 pandemic showed that some activities can reach the target impact even when they are held in a modified format.

II - PROJECT KEY FINDINGS

This section of the publication will present the key findings of data collected through fieldwork activities of the project "*PRO Health for Roma*".

A total of three questionnaires were administered to the Roma national minority members as project beneficiaries. The first one allowed to shed some light on the number of people who have benefited from the project and to gather some socio-demographic information about them. They filled in the questionnaire every time a beneficiary took part in a field activity of the project (N=2806). The second one, more detailed, regarding the health-related topics, was administrated on a smaller sample of the beneficiaries since due to circumstances in the field it was not always possible to fill them in by the teams (N=536). Finally, the third questionnaire was related to the mental health of the beneficiaries, their overall distress level, and their previous experience in mental health support. It was created with questions extracted from the PHQ-9 Questionnaire - Patient Health Questionnaire and Refugee health screener and was administrated once on the first mental health consultations conducted by psychologists (N=211). Data were gathered by community workers and/or health workers (questionnaires 1 and 2) or psychologists for questionnaires 3 - from February 2020 to February 2021. Data were analysed by using RStudio 4.0.2, some of the results are not detailed in this analysis as they were mostly used to monitor the project, or their results were relevant enough to be exploited.

® Médecins du Monde / Renato Pejković

I - General activities and beneficiary profiles

In total, project activities generated **2806 entries in the database in both countries (1422 in Croatia and 1384 in Serbia)** with **1360 individual beneficiaries** (607 in Serbia and 753 in Croatia). It can be noticed that some people came back multiple times, either for the same activities, or another activity proposed in the project.

Under the spectrum of activities planned in the project to improve access to healthcare and other social services to the Roma national minority in Serbia and Croatia, fieldwork has been found to gather a major interest from the target population. The number of beneficiaries who attended these activities is shown below:

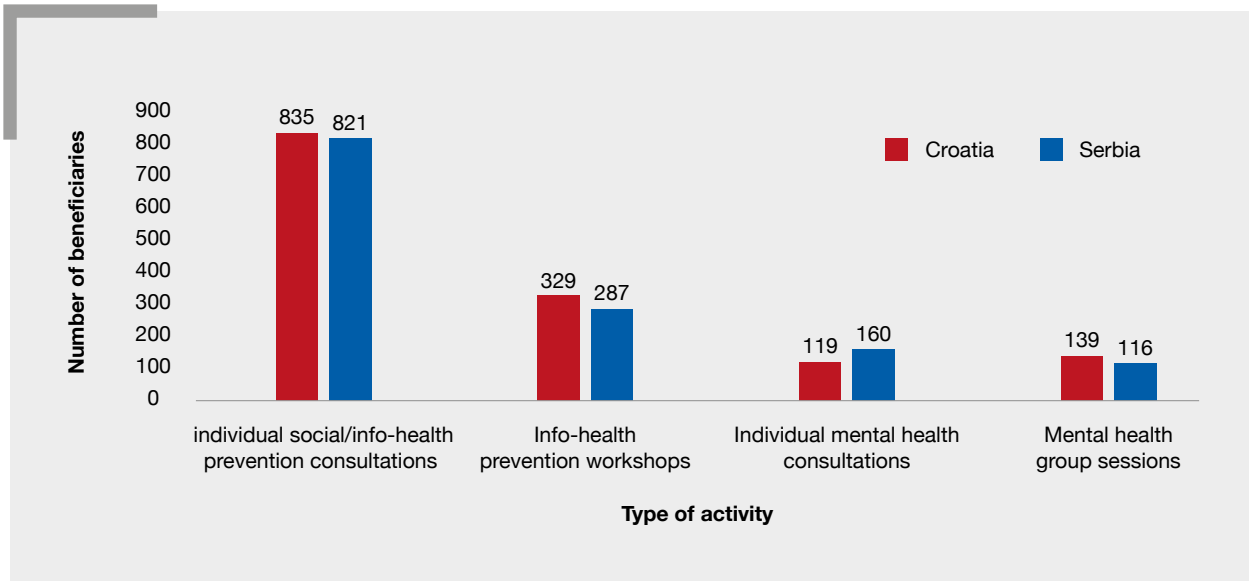


Figure 5: Number of beneficiaries by type of activity in « PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities » project, breakdown by country (2020-2021) N=2806

In addition, it is important to note that **a majority of the individual social/info health prevention consultations were attended by women**, i.e. 61.32% in Croatia and 54,45% in Serbia. Also, 37.96% in Croatia and 43.61% in Serbia of the people who took part in this activity were under the age of 29.

When it comes to the profile of all beneficiaries of the project – all activities are taken together, most of them were women (60% in Croatia and 59% in Serbia) with a **median age of 26 years of age in Croatia and 36 years in Serbia**. Below is the age group distribution of the population in both countries, as expected, this population is mostly composed of young people[3] but we can notice a slight variation in the age group distribution. It could be explained by the context in each country or some differences in the implementation of activities, such as the topics of info health prevention workshops.

3 (Government of the Republic of Croatia, 2012; UNDP et al., 2018)

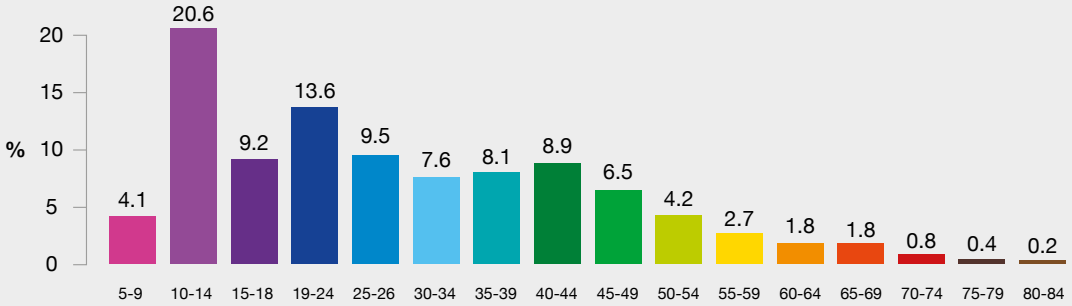


Figure 6: Age pyramid of the beneficiaries of the project « PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities » in Croatia in 2020-2021 in percentages (N=1422)

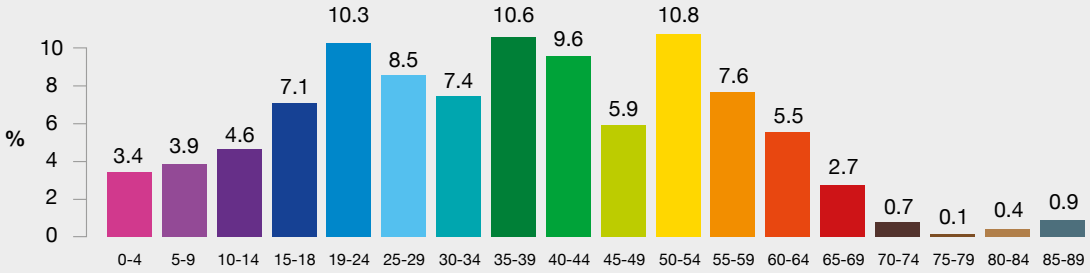


Figure 7: Age pyramid of the beneficiaries of the project « PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities » in Serbia in 2020-2021 (N=1384)

Among women beneficiaries, 5.5% of them in Serbia and 2.8% women in Croatia were pregnant at some point during their participation to project activities, and 2.1% of the beneficiaries in Serbia and 1.3% in Croatia were disabled.

In Croatia, the beneficiaries of the project were mostly from Kuršanec Roma settlement (81.2%) followed by Parag (12.2%), Orehovica (2.7%), Piškorovec (2.2%), Sitnice (1.2%), Gornji Kuršanec (0.1%), Kvitrovec (0.1%), Kotoriba (0.1%) and other localities (0.1%).

Beneficiaries in Serbia mostly lived in Mačvanska Mitrovica (35.3%), Sremska Mitrovica (26.1%), Laćarak (24.1 %), Jarak (14.4%) and Šašinci (0.1%).

II - General health status and barriers to accessing healthcare

A sample of 536 persons answered the questionnaire 2 after participating in a different type of project activities (143 in Croatia and 396 in Serbia). Beneficiaries in this sample were mostly women (68% in Croatia and 52% in Serbia) and the median age was 29 years (aged between 10 and 72) in Croatia and 19 years old in Serbia (aged between 0 and 89).

The first part of the questionnaire looked into the general health status of members of the Roma national minority and how it can be affected. The first finding is that the perceived health status of beneficiaries is generally great as 82% (NA=7) declare themselves as "healthy" in Croatia and 84% (NA=7) in Serbia. This high rate can seem unexpected since many studies showed a deteriorated health status among Roma national minority[4] but since this health status is "reported" by the people themselves this rate can be explained by an overestimation of their health, previously shown in reports from EU[5]. An actual worse health status than reported among Roma national minority can be suspected and is supported in the project questionnaire by the number and type of diseases which affected people during the past year, as we can notice that 20.28% of beneficiaries in Croatia got more than one disease in the twelve previous months, and this percentage amounts to 10% in Serbia. The most common diseases in both countries were musculoskeletal disorders and high blood pressure which affected 29% and 21% of the beneficiaries in Croatia, while it was 8.7% and 14% respectively in Serbia.

The CoVID-19 pandemic and related epidemiologist measures to prevent it had a direct impact on members of Roma national minorities in both countries.

- Restriction of movement measures (such as the interdiction to leave its municipality territory in Croatia in March-June 2020) largely impacted the economic situation of Roma national minority members involved in the black-market activity and/or collecting metal/plastic in neighbourhood municipalities/city.
- Due to the economic crisis provoked by the pandemic, an important number of Roma national minority members who had a job and an employment contract lost their jobs.
- A large part of the Roma population lives in facilities with a lack or absence of adequate conditions for maintaining basic hygiene (no toilets, bathrooms, running water, etc.). Their homes often do not have enough rooms that could meet the necessary needs for self-isolation if prescribed for a family member (in large families it is common for several children to sleep in one bed).
- School shutdowns and transition to a virtual form of teaching was an issue for most Roma households that do not have Internet or necessary equipment for a child to attend their classes (computer, television). Additionally, the low educational level of parents limited the support they might provide to their children during this period.
- Difficulties to access healthcare and facilities were increased (for instance, the GP could be reached only by phone, bus lines were temporarily suspended, etc.). and buying protection equipment almost impossible due to insufficient financial resources.

It has been observed by outreach teams that, globally, Roma national minority members in the Međimurje County and Sremska Mitrovica area were less affected by CoVID-19 in terms of the number of sick persons. This may – to a certain extent – be explained by geographical segregation/exclusion but in a way by the work conducted on daily basis by "*PRO Health for Roma*" teams (info-health prevention activities and support in accessing healthcare). However, it also interesting to notice that **unfortunately, Roma persons who get CoVID-19 had more severe symptoms than the average of the global population**. This might be explained by a higher frequency of chronic diseases and globally lower health state.

4 (European Commission et al., 2014violence and social exclusion. This has intertwined consequences across a range of sectors and these consequences have a negative impact on health. This is why it is often necessary for international agencies (intergovernmental, governmental and non-governmental)

5 (Dotcho Mihailov, 2012; Partners for Democratic Change Slovakia. et al., 2009)

® Médecins du Monde / Renato Pejković

When it comes to risks factors affecting health, as the consumption of psychoactive substances, the questionnaire brought forward some high rates regarding tobacco consumption with 52% (N/A=2) of beneficiaries reporting a daily consumption in Croatia and 34% in Serbia (N/A=30). Yet, these consumption rates were found to be surprisingly low in both countries for drugs/opioids and alcohol consumption with less than 1% of beneficiaries reporting a daily consumption in Croatia and Serbia. These results strongly differ from what previous studies reported5 in these countries among the Roma national minority or even field workers experience. However, it is possible to assume that people who engaged in the activities are those who are more concerned about their health, are less marginalised, or who experienced fewer addictions or risky behaviours. Also, it could be explained by an information bias which often occurred in the case of a sensitive topic while filling in a questionnaire. Moreover, since this questionnaire was assessed by health workers with the support of community workers, persons that they know in their community.

Another topic affecting health and presenting the financial situation of households is nutrition, more specifically, the share of people who reported going to bed hungry multiple times during the past month, this concerns 36% of respondent in Croatia when the share in Serbia is only 5.4% (N/A=2). Once again, these rates are lower than expected in these regions[6] and could also be explained by an information bias regarding financial issues or a sampling issue since it is most likely to be only some members of the household who will be food deprived to allow for the younger ones to have a proper meal.

Concerning access to healthcare, 97% of respondent have a GP in Serbia and 94% in Croatia. This is linked to being already registered to health insurance which concerns 95% (N/A=107) of respondents in Serbia and 93% (N/A = 25) in Croatia. Among this 95% of people insured in Serbia, 38.38% are women while among the 93% of insured people in Croatia 64.55% are women.

Still, an important gap has been noticed regarding healthcare consultations between members of the Roma national minority and the majority population. Indeed, when it comes to the **number of visits to a doctor in the past four years**, the median in Serbia and Croatia is **6** for the members of the Roma national minority while the average number of consultations **per year** is ranged between **4.4 and 10.0** in most EU Member States [7], which is far higher than what the beneficiaries of the project answered.

Also, regarding specialists, a difference was noticed between what was reported from the beneficiaries of the project and the recommendations when it comes to dentist exam and gynaecologist and pap test. In fact, as in the general population, consultations with a specialist are less frequent than those with a GP. In Croatia, 76% (N/A=2) of respondents have not seen a dentist at least once a year as recommended[8], including 23% who have not seen a dentist in the last 5 years or even **20% who never went to see this healthcare professional**. In Serbia, 57,9% (N/A= 3) of respondents have not seen a dentist at least once a year including 21% who have not seen a dentist in the last 5 years or even 18% who never went to this healthcare professional.

Also, 39% (N/A=4) of women aged over 25 years (N=57) did not have a pap-smear for at least 3 years[9] in Croatia and 47% (N/A=3) in Serbia(N=91). Still, among them, only 17% and 15% respectively never had one. As well, among women aged over 15 years (N=79) in Croatia 30,7% (N/A=1) have not seen a gynaecologist in the past 3 years in Croatia, while in Serbia among the women aged 15 years (N=124) this percentage amounts to 43% (N/A=3).

If it is truly noticeable that access to healthcare can be challenging for members of the Roma national minority, it was also shown that a non-negligible part of the respondents had to give up

6 (European Commission et al., 2014; Parekh & Rose, 2011; UNICEF Serbia, 2007violence and social exclusion. This has intertwined consequences across a range of sectors and these consequences have a negative impact on health. This is why it is often necessary for international agencies (intergovernmental, governmental and non-governmental)

7 (Eurostat, 2020)

8 (Eurostat, 2019; Šiljak et al., 2019)the Netherlands ranked first, with 2.8 consultations of a dentist on average per year, followed by Czechia and Lithuania (1.6 each

9 European Union recommendations (Haute Autorité de Santé, 2010)

on accessing care. In fact, this group belongs to **23%** (N/A=1) of the project beneficiaries in Croatia and **27%** (N/A=4) in Serbia which declared that, in the 12 past months, **they did not contact the doctor although they required medical attention**. A study from Jarcuska et al. (2013) supports these findings regarding a lower and delayed use of care since, in their study, members of the Roma national minority were less likely to seek medical help immediately for a health problem when needed, which often led to emergency.

The barriers to accessing healthcare were shown in several studies[10], such as the impact of financial resources. This determinant of health[11] is still a major issue for Roma national minority since **41%** (N/A=1) in Croatia and **31%** (N/A=12) in Serbia reported **having already been in a situation when insufficient financial resources stood in their way to pay for medicine or healthcare**.

Another barrier is the lack of health literacy[12]. The literacy level was expressed in the questionnaire by this sentence "**If I need medical assistance I know where I can get it**" and to which 95% of respondents (N/A=4) in Croatia and 96% (N/A= 11) in Serbia answered they mostly or completely agree. However, this finding can be contradicted by the chosen reaction in case of a health issue adopted within the household which are mostly going to a **GP (47%)** or **calling emergency services (40%)** in Croatia (N/A=2) and **calling emergency service (79%)** as a priority in Serbia (N/A=3) followed **by self-treatment (15%)**. Indeed, the high tendency to use emergency services in both countries and the use of self-treatment support the hypothesis of a low level of health literacy among the members of the Roma national minority, as was found in previous studies[13].

Moreover, among the barriers to healthcare can be discussed the discriminative experiences in healthcare towards members of the Roma national minority which was found in various studies[14]. Thus, some questions were elaborated to gather satisfaction when accessing healthcare from facts and feelings experienced by members of the Roma national minority. Regarding experiences when visiting a doctor, **36% (N/A=4) in Croatia agree with the fact that they had some negatives experiences with doctors** while 11.4%(N/A=14) of the beneficiaries reported it in Serbia. Indeed, in Croatia, 48% (N/A=3) of the beneficiaries report having to wait longer for an appointment with a doctor than other patients, when globally the satisfaction expressed through this survey was higher in Serbia. Nevertheless, 83% (N/A= 4) declare to be very or mostly satisfied with their GP in Croatia and 93% (N/A= 14) in Serbia. As explained above, fear of stereotyping, and information bias could restrain respondents to provide their real experiences and satisfaction regarding healthcare providers.

10 (Jarcuska et al., 2013; McFadden et al., 2018)

11 The determinants of health include: education, physical environment, employment and working conditions, social support networks, culture, genetics , personal behaviour and coping skills, health services, gender. (World Health Organization, 2017)

12 Health literacy is the capacity of « Knowing how to access and navigate health systems and being able to access and understand health information ». (McFadden et al., 2018)

13 (Vacková et al., 2020)

14 Hanssens et al., 2016vulnerable populations experience more problems in accessing health care. This also applies to the Roma-population. In the City of Ghent, Belgium, a relativly large group of Roma resides more or less permanently. The aim of this study is to explore the barriers this population encounters in their search for care.\n\nMethods\nIn this qualitative study using in-depth interviews the barriers to health care for the Roma in Ghent are explored. We interviewed 12 Roma and 13 professionals (volunteers, health care providers,…

III - Mental health

In total, 211 persons were involved in mental health activities (155 in Serbia and 56 in Croatia) and answered questionnaire 3. These beneficiaries were mostly women in Serbia (63%) and men in Croatia (57%). The median age of beneficiaries was 12 years old in Croatia and 40 in Serbia, this difference is explained by different field context since in Croatia a partnership was made with the local family centre to have mental health activities in their premises and therefore children and teenager – main users of this centre - were more likely to see a psychologist.

Among those who answered the questionnaire, 6 beneficiaries (10,7%) in Croatia and 3 (1,94%) in Serbia scored positive for minor or major depressive disorders, with the presence of depressive symptoms more than half of the days or almost every day during the last 2 weeks. On another hand, this questionnaire has shown that **21 beneficiaries (38%) in Croatia and 128 (84%) in Serbia (N/A=2) scored positive for currently experiencing a state of distress.**

Keeping in mind the fact that those who participated in mental health activities in the project where those who felt the most comfortable/ aware of their mental health situation and that the needs could be even greater.

Regarding the previous experience in mental health, only 12% of beneficiaries in Croatia declared having sought help from a professional in the past, they mostly get help from the school psychologist, an institution such as the centre for employment or hospital or at their workplace. **In Serbia, on the other hand, despite the high level of people reporting an overall state of distress, none of the respondents have sought help from a mental health professional in the past.**

It can be concluded that those results show some improvement regarding the health care of the Roma national minority but also point to the remaining inequalities faced by this population. Data obtained also bring forward the potential of a partnership with universities since collected data and information were very helpful in gaining a better insight on the status and needs of the Roma national minority and what leverage could be used to further improve their socio-economic and health situation.


® Médecins du Monde / Renato Pejković

III - LESSONS LEARNED AND RECOMMENDATIONS

Lessons learned

What works and does not work in the efforts to improve and create more equal access to health care for members of the Roma national minority?

- This last section of the publication will present at different levels the lessons learnt identified throughout the implementation of support model set-up through the project "*PRO Health for Roma*" as a learning process but also with the objective to share experiences for its eventual replication in other geographical locations.

1. At the level of team management (lessons learned for the team leaders)

To make any community-based project a success, it is crucial to connect, motivate the **outreach team(s) working in the field** and make them effective. "*PRO Health for Roma*"'s team leaders from Croatia and Serbia consider that the key to a successful team is making sure that the following values are there:

- Team's shared **values**: Define the values and goals that the project stands for and see whether they match the values and goals of the team members, and then put them into practice in everyday communication and daily work and implement them systematically.
- **Multinational, mixed gender and multisectoral teams**, preferably including different age groups. It is always important and necessary to involve Roma from the community, who will work for their community, who know their community, its people and the language and customs, as well as professionals working in the team. Finally, there is no good team without women- the team thus needs to be *at least* gender-based balanced. The best mobile teams are those that, in addition to the Roma community worker (m/f), also include a health worker (at least a community nurse must always be involved), as much as possible, a doctor, a social worker and psychologist; and occasionally when available an epidemiologist (public health worker), paediatrician and gynaecologist.
- Be open and willing to **get to know** the team members who work with us, as well as allowing them to get to know us.
- **Building trust** within the team: every piece of information needs to be shared with every member of the team, everyone in the team should feel that we care about each other and the previously established project (team) values.
- As much as possible, the **mental health support of the team members shall be ensured** with the support of an external mental health specialist (through individual and/or group mental health support). Listening to difficult stories on daily basis and trying to find solutions can deteriorate the mental health of staff so It is important to prevent this.

- **Team synergy**, which is created as a result of combining all the above-mentioned elements, when the synergy exists, there are no obstacles that cannot be overcome, which means that the most difficult fieldwork and the most complicated administrative situations in the project implementation can be solved.

2. At the level of project management (lessons learned for the project leaders and managers)

- The biggest challenge at the level of project management is how to achieve all the goals and remain flexible for dealing with all unforeseen obstacles, but also unforeseen opportunities and/or needs that might arise during the project. A good example of unforeseen situations during project implementation and against which the project team had to build resilience was the outbreak of the CoVID-19 pandemic. It started in early March 2021 until project end (first quarter 2021), with an epidemiological situation slightly improving over three months in summer 2020.
- **Project flexibility** must also be reflected in the ability to quickly modify the format of activity, change its course or even sometimes completely remove it.
    - In the project, for example, some workshops and in-person interviews were replaced by video calls and online meetings. The same was done for transnational meetings and study visit that also took place online.
    - On the other hand, an excellent example of this type of flexibility is the situation when a small surplus of project funds not spent on international travels, with the help of the local community (Međimurje County), was used to organise ad hoc sewing workshop for Roma women – which resulted in the production of face coverings for the local population in Međimurje County during the CoVID-19 pandemic.
    - The third example is a determined response by MDM-BELGIQUE, which delivered fully equipped mobile facilities to Roma settlements where public spaces for community interaction – community centres were not available. This paved the way for socializing and learning opportunities that helped the community become more welcoming, and perfectly adapt to the specific CoVID-19 situation.
- The above-mentioned **project reactivity** and flexibility that results in better **resilience** and stronger purpose of the project must be both **operational** (the team/project leader must recognize it and always be prepared to react) and **budgetary**. Based on this experience, civil society organizations that work on project proposals, but also the **European Commission** (EC) **and other donors/ sponsors** involved in the budget approval process would need to allow the so-called “discretionary expenses” and more flexible budget reallocation possibilities with supporting documentation, to be able to respond to the circumstances and needs of project beneficiaries**.** There will be a growing number of unpredictable situations of this kind due to communities living in poverty struggle, health and climate situations, natural disasters and similar circumstances.
- Thirdly, it can be concluded that this kind of Roma integration projects aiming at improved access to public services for Roma (health, education, etc.) always need to be prepared through a **multisectoral** approach and partnership between the Roma community, the public sector, the civil sector, and the involvement and accountability of authorities at the local and national level. In Međimurje, MDM-BELGIQUE, as project leader, was able to efficiently involve Roma community workers, associations and public institutions in the project - the Institute of Public Health, health centres, City of Čakovec and Međimurje County as a regional government authority.
- Last but not the least, field and project work help to **collect the necessary data** which later help to prepare *follow-up* projects, but also public policy measures in healthcare (data concerning diseases, problems and problem tackling techniques in the community, conditions

such as addiction, etc.). They should always be systematically addressed in evaluation, analysis and project reports and, if possible, presented to the public and decision-makers.

3. At the level of Roma community - participation and openness (lessons learned for the Roma and majority population community leaders and project leaders)

- **Adequate and comprehensive participation of the Roma community in the project or a programme** is a key element of a successful project or programme in the Roma community, with the tendency and ultimate goal that, over time, Roma men and women get to be the leaders of most activities, in some cases in cooperation with institutions and other associations.

  The question is how this can be achieved: a) in the community in which there is a high incidence of poverty and unemployment, in which case people want to get paid for their work and they are less likely to volunteer?; b) in the community in which there is a low rate of people who completed high school or university education due to previous discrimination and marginalization in education?; c) in the community that is currently going through transition and changes, but remains largely traditional, so women must prove themselves as project participants or team/activity leaders?; and d) in the community that, for many historical reasons, still tends to show mistrust and rejects the interventions of the majority population?

  Throughout the project, the project consortium came across several answers and applicable practices.

  - First of all, the **wages** that are available to **non-Roma must match those available to Roma members of the team**, which means that **equality for Roma men and women involved in the project must be facilitated** in every single aspect, including finances.
  - If we want to **encourage volunteering of Roma men and women in the project**, they must be either employed members of the community who already have an income from other sources, or they need to be given an opportunity after the end of the project, such as a job, an internship, an employment certificate, etc. Another consideration to bear in mind is that volunteering should not be reserved for Roma community members, as this happens in too many projects.
  - The lack of **formal education** in this community can be compensated by shorter, yet structured education programmes (organised in the project "PRO Health for Roma" in the form of training- transfer of knowledge on, for example, fieldwork, disease prevention and promotion of the right to health, informing the members of the public on the steps one needs to take to get health insurance in Croatia/ Serbia, how to assist people from the Roma community, etc.) which need to gather all those who completed some sort of vocational secondary or higher education, with clearly defined tasks in the project. **Roma men and women team members need continuous encouragement and mentoring** and they must feel free to share their questions and concerns.
  - As for the **participation of girls and women** (their participation in our project was very successful, and the percentage of educated young women in this community is increasingly higher compared with their male peers), It should be bear in mind that not only are women a vital part of the team, but they also need to be supported by a representative of the institution (nurse, social worker, psychologist and other representatives, where necessary) in all their activities to strengthen their role as a figure of authority at the beginning and to support them in developing that role. Tasks must be clearly defined, and always remain feasible and realistic.

- Finally, "openness of the community" was crucial for project success. This process is primarily driven by **getting to know each other and socializing** outdoors, in a community centre and at people's homes. It **leads up** to the actual project activities and **at the same time serves as a good introduction to those activities**. Once trust has been built, communities will be open to new experiences and activities, even those they had previously avoided or considered uncomfortable (gynaecological and specialist examinations, vaccinations, management of cardiovascular disease, etc., resolving bureaucratic problems regarding insurance, etc.)

4. At the level of the stakeholders' participation - regional and national institutions and policy changes (lessons learned for the national and local stakeholders - cities, counties, regions, ministries, offices, as well as public institutions)

- For the development of this publication, It has been asked to the stakeholders having experience in project implementation and working with national and local government to share their opinions **on how long it took in average to make a real change at the public policy level** (health care, social inclusion, education, social policy), design the implementation, "polish" a policy practice and, last but not the least, make sure that it is "accepted" by the system. Indeed, the question is how to turn the project into a **long-term public policy**, or a **set of policy measures** given the gaps that include lack of implementation or "neglect" of useful activities and measures.

  Indeed, two symptomatic things often tend to occur with such projects: a) First of all, there is a very modest project "legacy" in a way that the community and/or authorities and institutions adopt (systematize) successful practices and activities established by the project once the project is over; or b) international actors and donors expect to see dramatic results at the policy level in an unrealistically short amount of time. Therefore, practitioners involved in project implementation and donors need to be aware of the importance of **continuity of implementation and gradual, organic development of community-based initiatives that ultimately drive social change**. For instance, all previous initiatives launched by various actors in more than twenty years of active work on Roma inclusion in the area of Međimurje have significantly contributed to the efficient implementation and efficacy of "PRO Health for Roma" project activities. The **previous initiatives** have helped build **experiences** and **partnerships** on which the project has relied heavily. **Changes in the community do not happen overnight**, and in order for them to take root, they need to receive continuous support.

  - MDM-BELGIQUE representatives, along with Croatian and Serbian experts involved in the project, shared an interesting **estimation of the timeframe for true change at the policy level**. In general, **MDM's experience** in projects implementation so far has shown that: preparation and fundraising will take one to two years; pilot field implementation will take two years; negotiations and piloting the model in cooperation with the authorities that will later adopt it will take two years; and finally making a successful policy change will take two more years - meaning a **total of 7-8 years**. All this will happen of course if there are sufficient financial resources, trust in the community, experienced leaders, etc.

    This experience is consistent with those of some other civil society organisations in Croatia (e.g. it took 7-8 years of efforts by a range of civil society actors and institutions until a minimum satisfactory system of free legal aid has been established, involving civil society organisations and assisting economically disadvantaged citizens in accessing justice; it also took 15 years until a safe house system where women experiencing domestic abuse can stay, has been established, etc.).

Serbian colleagues shared their experience of **about 12 years of a semi-system in which project interventions were provided by very persistent organizations and individuals, which were needed for a real shift in a public policy to take place** until a measure or practice that benefits both society and the marginalized group has a **continuity**.

- In conclusion, it takes **at least 7 to 12 years until the policy change is achieved, assuming that there are no major systemic shocks** (such as the recession, the CoVID-19 pandemic or some other change for which we cannot guarantee it will not happen again). This is an important lesson for international actors such as the EC/EU, UN agencies and other international actors and their partners - local civil society organisations.

- It is also important here to address the dilemma between two options – a community or civic initiative, which is the activist drive characteristic of the **bottom-up approach**, or the **top-down approach,** in which the decision-makers recognise project's value, make sure the project initiative is properly enshrined in the system, and facilitate its funding from relevant (local or national) sources and incorporate it into legislation or procedures.

  - Based on the project participants' opinions, It can be concluded that this is indeed a false dilemma because **both approaches are needed to create lasting policy change**. The solution is that both approaches are well connected and that only bringing together several *bottom-up* initiatives (without whose passion and activism the change would not be possible) and stakeholders representing the system and those at relevant positions (*top-down*) can result in making a change that would entail changes in legislation, practices and funding. According to partners' points of view, the combination of the two principles seems to be a prerequisite for change. Once there is a **synergy of several successful bottom-up initiatives and good legislation**, a real policy change will be possible. Then we will not need to rely solely on projects that normally end when the first tangible results are achieved (the problem of discontinuity has been discussed above). A good example of this is the quality two-year preschool programme for Roma children, which was set up in cooperation with the community, professionals and donors (sponsors) in some local areas in the field; this initiative has become part of all key Roma integration strategies and EU programmes and it is now very likely that it would become required by law in the upcoming period.

- The same goes for the dilemma about which of the two levels - **national or local - should be the leader** in driving policy change - the local government that is in the best position to know the community and its problems, have more flexibility and respond more swiftly, while the national government can apply policies in a more comprehensive, systemic and egalitarian way. The combination of both approaches and dimensions is exactly what is needed here, so that the problems can be addressed properly and that there is **no "shifting" of liability for health and education for Roma communities from one level of government to another**, which was also observed by the partners.

- Serbian partners also brought up a specific problem, which is well known to Croatian activists and institutions too. This is a problem of inadequate **budgeting**, or general recognition and introduction of measures to national and regional/local strategies (especially national strategies and action plans for Roma integration at regional and local levels), followed by non-inclusion of necessary allocations/ specifications in local and national budgets. On this issue, it was emphasized that civil society and international partners constantly need to call for accountability and implementation of measures by talking about them at different events and in the media, and offer to support the implementation through financial partnership, so that the authorities can gradually take over the funding of donor-supported programmes.

5. At the level of the stakeholders' engagement and impact of the policy changes - a short case study of the MDM's impact on the quality of project's implementation and participation of the stakeholders: Lessons learned for the international actors – EU, UN, Council of Europe(CoE) and other actors

- There is a question that often arises in the context of international and intergovernmental actors involved in the projects for marginalized communities – do they serve as an added value that helps "open the door" in the national institutions and get in contact with decision-makers and **"light the spark" of change**, or are they rather **imposed** to local communities without intrinsic motivation to make a change?
    - The project partners are inclined to believe that international organizations with reputation and authority are very important drivers of change because of the reputation they enjoy among decision-makers. They see particularly MDM - BELGIQUE as an actor that "opens the door" and prepares local and national authorities for dialogue and change. The above-mentioned discontinuity of implementation is recognised as a problem. Namely, once international actors are absent or left, local authorities or the community tend to "neglect" some of the valuable project activities and practices, sometimes for subjective, but most often for objective reasons, such as lack of funds for specific activities.
- This brings us to the question of **sustainability, systematicity or consistency** of some practices, regardless of whether their implementation requires financial resources, expertise and effort or all three of them, which is usually the case. Project partners consider that sustainability can be achieved, taking into account all the lessons learned, as well as the time interval of 7 to 12 years required for permanent public policy change.
    - A good example is a collaboration between mobile health teams in Međimurje County and Roma community workers who serve as the link and make an indispensable part of the team. In total, 8-10 years after the first attempts and different projects that were implemented with a clear lack of continuity, local authorities may only now introduce mobile teams as a permanent practice in improved policy framework thanks to the "PRO Health for Roma" project, while the official adoption of the Action Plan for the Roma access to health is expected soon.

Best practices short manual

What works?	What does not work?
Multi-sector interventions (public institution, Roma community initiatives and NGO international actors, local authorities) with active Roma role and involvement and/or lead	One - sector of two-sector interventions / those having as stakeholders only international organisations, without the active participation of the Roma community workers/leaders, public health institutions, doctors and nurses from the field, people from local and national administration, independent experts, etc.
Long-term projects and programmes associated with the negotiation process about gradually stronger involvement of the local and national stakeholders	Isolated short-term interventions and one-shot actions; Project patterns that proved as inefficient in the past
The flexible structure/format of the project (activities) and budgeting of the projects, in order to adapt the project to the unpredicted needs and/or crises	Highly bureaucratised and non-flexible implementation of the activities and budgets, who do not take into account real needs or changed circumstances in the field
Time spent on getting to know people from the communities, time spent in capacity building of team leaders and community leaders	Projects that do not put emphasis on the human dimension, on getting to know people from the community and who do not invest in community and team leaders be it Roma and/or non-Roma
Data and policy strategies collected during interventions/projects	Data collection in Roma communities as isolated activity (“for its own sake”)
International organisations/institutions and experts are those who “open the doors”, facilitate and prepare local and national authorities for the policy changes and assist the community and consistently supervise the process	International organisations/institutions and experts always repeat some patterns of projects approaches and “clichés”, without real incentive to empower the Roma community, local and national stakeholders to “do this for themselves”

RECOMMENDATIONS

Recommendations for the decision-makers - Equalising access of Roma to the quality healthcare in Croatia and Serbia, including recommendations for the EU institutions.

1. Recommendations for policymakers at the local/ regional level

Recommendation 1. 1: Introduce and systematically support initiatives that will provide stable employment of Roma mediators/ community workers, as a trusted link for cultural, linguistic and professional matters, and include them in the regular work of mobile teams that help detect, prevent common illnesses and monitor health status in Roma community, help with health insurance and access to the healthcare system, dependency issues of all provenances, children/women's health problems and cases of domestic violence.

This recommendation may include measures such as *employment of 1-3 Roma mediators/ community workers according to employment coefficients defined for the local government units* and comparable positions.

Recommendation 1. 2: Ensure outreach info-health prevention activities to the community, the population at risk of poverty and exclusion, and especially the Roma population.

Proposal of an appropriate measure would be: *Work of Mobile Teams* tasked with community outreach visits in Roma settlements. The team would at least consist of a Roma community worker (salaried), a representative of the County Institute of Public Health (within their prevention and fieldwork activities), a nurse, and a social worker, doctor and psychologist, assisted by other professionals (gynaecologist, paediatrician) and trained volunteers, where applicable. This measure implies that the following elements have been previously

® Médecins du Monde / Renato Pejković

defined: a) role of the mobile team for targeted cross-sectoral interventions and campaigns in which coordination is key, and all professionals take part in the fieldwork, and b) defined 3-5 key critical topics on which the mobile team would need to focus in its work, including women's health, in its broader sense, mental health, prevention and treatment of drug addiction, especially in the population aged 12-19 years old, prevention and treatment of alcohol dependence, prevention of infectious diseases and implementation of national or EU programs for early detection of cancer and cardiovascular diseases in Roma settlements.

Recommendation 1. 3: Systematically plan and introduce targeted public health education programmes and interventions, methodically adapted to the Roma population, focusing on a multisectoral approach and science-based preventive intervention, which would be done by the Mobile Team referred to in Recommendation 1.2.

This may include measures such as: Hiring community workers, i.e. paid or volunteer trainers in Roma settlements (within the existing or future EU or County projects) and delivering initial training for them; Using resources of primary and even secondary schools - including premises, teachers and school staff, inviting professionals from the County Institute of Public Health to speak at regular educational and training events (preferably related to initial examinations); In advertising and implementation of educational activities, strongly rely on IT (YouTube, Instagram, Facebook, local radio stations with popular music, local shows in minority languages, etc.)

Recommendation 1.4: It is necessary to put continuous efforts into bringing professionals closer to the Roma community, bringing two communities closer together, and combating stereotypes and discrimination against Roma, as well as blame-shifting between the majority and minority communities.

This includes measures such as Implementation of educational and stereotype awareness programmes (*anti-bias* programmes); Encouraging students studying at different universities to participate in internship programmes focused on Roma communities, to intern at different associations, institutions, the local mobile team; Organizing interdisciplinary targeted education programmes aimed at acquiring skills for successfully working with the Roma population, in cooperation with professional chambers and associations.

Recommendation 1. 5: It is necessary to ensure physical accessibility of health services to persons from remote and isolated (Roma and/or rural) settlements through improved public transport or a special transport scheme.

Recommendation 1. 6: It is important to make sure that there is a functional exchange of information, ideas and actions that need to be taken to solve priority problems affecting the health of the local population and falling within the responsibilities of community wardens.

This includes measures such as: Holding regular (quarterly) coordination meetings with local authorities, representatives of the police, community warden services/community wardens and other related services, and representatives of Roma NGOs and/or minority councils.

Recommendation 1. 7: Set goals related to the health of vulnerable groups at the local level - especially the Roma national minority - as a priority when applying for EU, UN and other donor funding, and establish a connection between funds received from international and national sources.

2. Recommendations for policymakers at the national level

Recommendation 2.1: It is necessary to provide public health insurance to all groups of people at risk of poverty as a guaranteed constitutional right, without unnecessary administrative steps that require involving several institutions. By allowing the automatic application for health coverage upon registration as an unemployed jobseeker, or upon getting one's proof of citizenship, this mechanism should be established and applied by state authorities, rather than individuals, which would help reduce the unproductive use of human resources and improve the response to health needs.

Recommendation 2.2: Strengthen the human capacities in primary health care (community nurses and family medicine doctors/GP). The human capacities of local/county Institutes of

Public Health also need to be strengthened, so that they can do more preventive activities and home visits in the area with a larger share of the Roma population and join the regular mobile teams that work in Roma communities.

Recommendation 2.3: Ensure inclusion in quality and integrated two-year early childhood/preschool education and quality primary education as a long-term, science-based public health preventive measure that helps protect the health and well-being of children, through the consistent implementation of National Documents for Roma Integration in Croatia and Serbia, the *EU Roma strategic framework for equality, inclusion and participation 2030.*

3. Recommendations for the NGO actors, Roma activists and leaders

Recommendation 3. 1: It is necessary to work systematically on capacity building and exchange of experiences between associations in the regional/local community and Roma associations working on national women's health programmes, in the field of women and reproductive rights programmes, and domestic violence and youth addiction prevention. This may include concrete measures, for example, having Roma members/employees or Roma volunteers or Roma programme beneficiaries could carry additional points to associations as they apply through a local call for proposals.

Recommendation 3. 2: It is necessary to ensure the provision of information to the Roma population in their mother tongues, both regarding social/cultural activities, service information and public health matters. This includes measures such as financial support for starting a radio station or a show in the Romani languages on some of the existing radio and TV stations; starting a Roma channel on YouTube for video clips and videos of this type, produced by Roma associations and initiatives and funded by local authorities, the EU and other donors.

4. Recommendations for the EU/UN and other institutions

Recommendation 4. 1: It is necessary to support long-term project initiatives of civil society and international organizations, as well as local and national authorities, those with a clear vision of desired policy change, timeframe, methods, and actors they want to work with. When setting project performance indicators, the realistic amount of time needed to achieve social change in communities at the local level needs to be taken into account and the indicators need to be adjusted accordingly.

Recommendation 4. 2: A flexible budget/activity framework should be encouraged to simplify reallocations/format changes for necessary *ad hoc* activities, unforeseen activities that need to be implemented due to objective circumstances, and activities that strengthen community resilience to change (pandemic, poverty and economic inequality, climate change, natural disasters, etc.).

Recommendation 4. 3: Process mechanisms that will allow partners from the local or national government to gradually take over a part of the project activities until they become an integral part of policy practices in the system (healthcare, social care, education) need to be integrated into the project. Such mechanisms should be integrated into the project in advance, all stakeholders must be aware that they exist, and they need to have a legal framework, at the end of each year, the results achieved must be compared against the results expected and it must be made clear that the project may be suspended if local or national authorities fail to meet the project objectives.

Recommendation 4.4.: Hiring members of the vulnerable group targeted by intervention shall be a pre-condition for any integration project. The EU (or any other donor) shall put it in calls for proposals as a mandatory condition to be fulfilled by applicants.

CONCLUSION

Ensuring access to healthcare for Roma national minority members and other vulnerable groups shall be an absolute priority since **each human being has the right to timely and adequate healthcare** as stated in article 25 of the UN Universal Declaration of Human Rights: "*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services*".

Access to health and diminishing poverty - core project goals - are also among the most important UN Millennium Development goals (MDGs): 1, 4, 5 and 6, - adopted by both Croatia and Serbia.

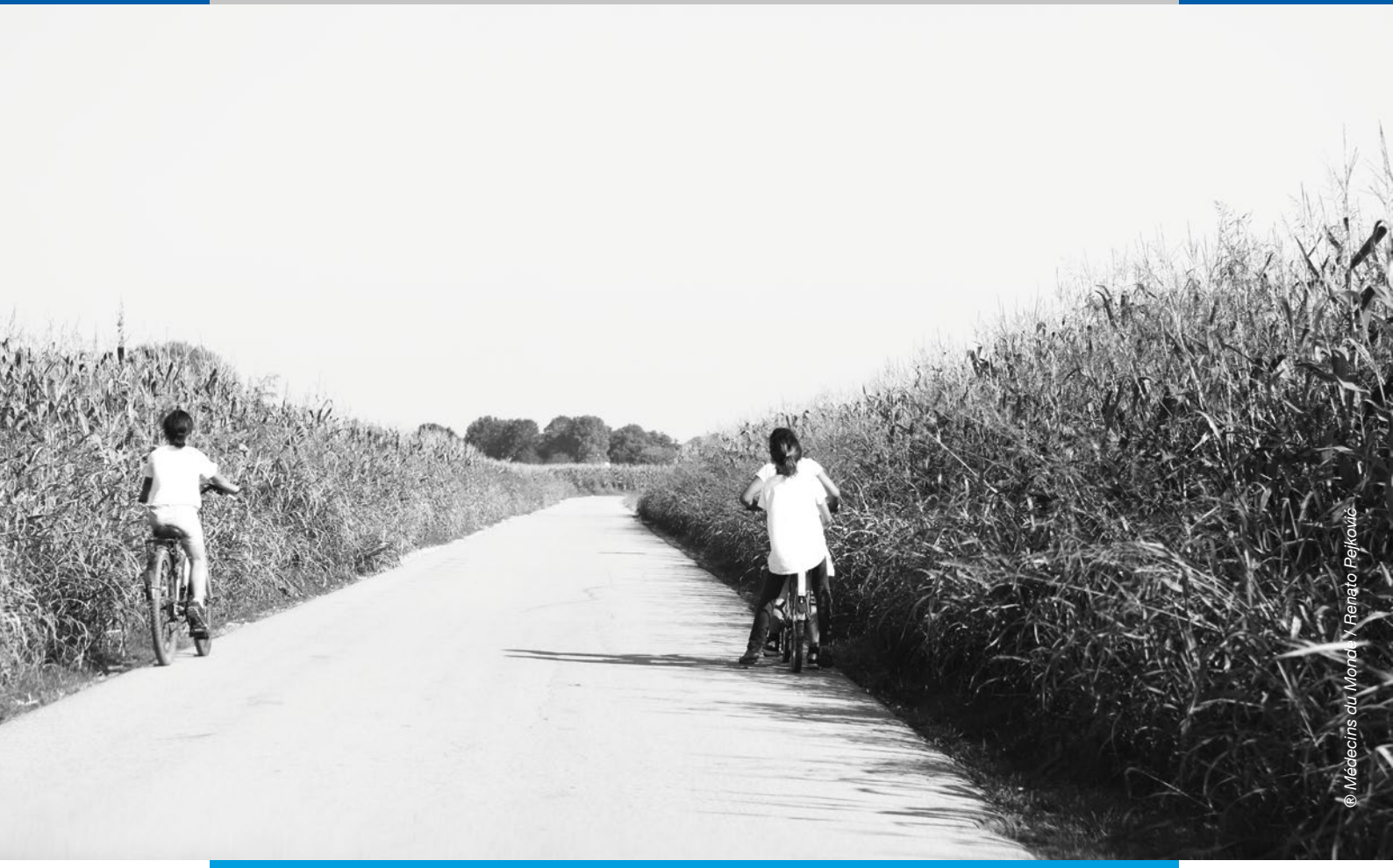
Moreover, access to health is strongly interconnected with other European and national integration strategies - in education, social care, environment, anti-discrimination/ gender and housing area - and the project model emphasizes those links by making them concrete.

The „PRO Health for Roma" project can therefore be considered as a step forward towards the achievement of this basic human right - the right to health - of course, at the level that can be impacted by the project, but with a clear, effective and promising model that could be replicated across different locations, successfully supporting/empowering vulnerable groups.

Abbreviations

COE	*Council of Europe*
EC	*European Commission*
EU	*European Union*
GBV	*Gender Based Violence*
GP	*General practitioner*
ID	*Identity card*
IT	*Information Technology*
MDGs	*UN Millennium Development goals*
MDM BELGIQUE	*Médecins du Monde - Belgique*
MHPSS	*Mental health and psychosocial support*
M/F	*Male/Female*
N	*Total of the sample*
N/A	*Not available*
NGO	*Non-Governmental Organisation(s)*
UN	*United Nations*

This publication is part of the project *"PRO Health for Roma - Addressing discrimination and improving access to health care for ROMA communities"* funded by the European Union's Rights, Equality and Citizenship Programme (2014-2020) and co-funded by the Croatian Government Office for Cooperation with NGOs



® Médecins du Monde \ Renato Pejković

Rights, Equality and Citizenship Programme of the European Union

MEĐIMURSKA ŽUPANIJA

GRAD ČAKOVEC

ZAVOD ZA JAVNO ZDRAVSTVO MEĐIMURSKE ŽUPANIJE

Crveni krst Srbije
Crveni krst Vojvodine

srem regionalna razvojna agencija

CEUR

PRO HEALTH for Roma - Addressing discrimination and improving access to health care for ROMA communities
Funded by the Rights, Equality and Citizenship Programme of the European Union (2014-2020)