The Roma Community and access to drug-use disorder treatment services

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Abstract

The United Nations Office on Drugs and Crime has done work on the relationship of vulnerable populations to Drug-use-disorder treatment services (DDTS) but have not specifically examined this relationship in the context Roma/Sinti Community who are often identified as a vulnerable population in Europe. We aim to identify if the Roma community's ability to access DDTS at a disadvantage compared to other communities and why is this is so. Applying two theoretical approaches - the Gelberg-Andersen Behavioural Model for Vulnerable Populations and Galtung´s Theory of Structural Violence – and undertaking an extensive literature review, we identified a number of potential barriers facing this community. We use Slovakia and Hungary, European countries where there is a significantly large and often isolated Roma population, as case studies and interview in a qualitative sense, experts/practitioners working in the policy area of Roma health in Slovakia and Hungary. We compare the results with the assumptions and barriers we identified and, deriving from this, we make policy recommendations for improving access to DDTS among the Roma community and clarify the role the UNODC can play in doing so.

Contents

Introduction

The international community is undergoing a shift in which drug-use is no longer viewed as a criminal problem, but rather in a medical sense; therefore, improving the provision of drug-use-disorder treatment services (DDTS) is an important policy issue. Policy approaches must be adapted to the unique needs of vulnerable populations. The UNODC and the WHO in their published guidelines, the *International Standards for the Treatment of Drug Use,* both recognise this by promulgating Principle 5: Responding to the needs of special subgroups and conditions (United Nations Office on Drugs and Crime and World Health Organization 2016, 12). This includes the needs of specific ethnic groups.

In this line, this paper concerns the access of the drug disorder treatment services by vulnerable populations, focusing on the Roma community, seeking to ascertain is the Roma community's ability to access DDTS at a disadvantage compared to other communities and why this is so. The Roma community are one of the most marginalised, vulnerable populations living in Europe. Existing literature suggests that drug-use is a growing problem within the Roma community as it is in most communities. Furthermore, it suggests that drug-users within the Roma community are less likely to access DDTS than non-Roma drug-users and that the treatment they receive is often inadequate for theirs needs as a vulnerable population.

We have chosen Hungary and Slovakia as case studies for research purposes; both countries have substantial Roma populations and Roma integration frequently appears as a policy issue before their governments. From our qualitative interviews with experts and practitioners working in this area in Hungary and Slovakia, we want to first ascertain the veracity of this result and barriers which contribute to this; in sum, our subject is the lack of effective drug treatment services for the Roma population. Rapp et al argue that the lack of effective drug treatments is rarely attributable to one determinant but to a complex interaction of different determinants (Rapp et al. 2006). Therefore, our approach is to identify the most significant barriers, while accepting this list may not be exhaustive. A case-study approach and qualitative methods are the best way to uncover these complex interactions. Some factors emerging most frequently were the importance of health literacy and levels of trust in healthcare services.

Policy recommendations will be made in relation to Hungary and Slovakia. These recommendations have extractive value for how vulnerable populations should be treated at large, including in the framework of the UNODC´s International Standards for the Treatment of Drug Use Disorders.

The research area of DDTS and the Roma community has to a large extent been overlooked by International Organisations and States. The UNODC and the WHO have published research on DDTS in relation to other vulnerable groups (World Health Organization, n.d.). However, they have not researched extensively drug-users within the Roma Community. This may be because as the Roma population is primarily based in

Europe, Roma-related issues are dealt with more under the EU.[1] Nevertheless within the broader UN framework there is engagement with Roma issues; there is a The United Nations Regional Working Group on Roma which is chaired by the UN Human Rights Office. In 2013 this Working Group highlighted the special role the UN agencies can have in advancing Roma inclusion (Roma Regional Working Group of the United Nations Development Group 2013).
Thus, this is an area of relevance for UNODC and a secondary purpose of this paper would be to promote greater UN ownership of this topic. Advantages deriving from this include the possibility that there are significant crossovers between the Roma community as a vulnerable group and the UNODC´s work on other vulnerable groups. Indeed UNODC´s work could create useful synergies with European and national efforts aimed at improving access to DDTS.

Theoretical framework

Drug-use within the Roma community

Our research question is derived from the presumption that drug-use is a health problem within the Roma population. Following the practice observed in EU policy documents and discussions, the term "Roma" here refers to a variety of groups of people who describe themselves as Roma, Gypsies, Travellers, Manouches, Ashkali, Sinti and other titles (Kearney 2017). With an estimated population of 10-12 million the Roma are Europe´s biggest ethnic minority (European Union Agency for Fundamental Rights, n.d.).

The UNODC adopts a definition of drug-use disorders which is based on a scientific approach to the problem of addiction and thus avoids discrimination and stigma towards drug-users. It is explained in the International Standards that "at the core of drug dependence syndrome is the strong and overpowering desire to take the drug and an inability to control the amount of drug taken with resulting use of excessive amounts and spending excessive amount of time on drug-related activities (United Nations Office on Drugs and Crime and World Health Organization 2016, 12)." It is important for us to embrace this definition because the Roma community are already a population which suffers discrimination and this definition avoids a kind of "double discrimination" being applied towards Roma drug- users.

According to the EMCDDA "the Roma community represents a specific ethnic group with diversified behaviours and cultural traditions that vary by the country of their residence (European Monitoring Centre for Drugs and Drug Addiction 2008, 26)." The EMCDDA stresses that "when defining group vulnerability, it is vital to underline that membership of

[1] See the work of European Roma Rights Centre and European Fundamental Rights Agency

a specific group implies no direct causal link to drug use or drug-related problems (Ibid, 9). Therefore, it is important to state the purpose of this paper is not to determine how large is the problem of drug-use within the Roma community. Nevertheless, studies have suggested that drug-use is a problem for the Roma population as it is for most populations in Europe. The most comprehensive study was carried out by the European SRAP network which "aims to improve the health of Roma communities in Europe and prevent drug addiction amongst Roma communities (SRAP - Addiction Prevention within Roma and Sinti communities, n.d.)." The report, entitled "Understanding drug addiction in Roma communities" examined eight different cases by organising focus groups (SRAP - Addiction Prevention within Roma and Sinti communities 2012). The focus groups were organised in a wide range of locations from Spain to Bulgaria. The report came in response to previous studies which concluded that generally across the Roma population in Europe "there is to higher lifetime prevalence for all types of drugs, stigma and concealment of consumption (Ibid, 6)." Kasporova also alludes to "disproportionate drug abuse" among Roma in the Czech Republic (Kašparová 2014). Cook carrying out a systematic review of Roma health disparities argues the consensus is that there are higher rates of intravenous drug use among Roma (Cook et al. 2013, 885).

The 2010 study carried out by Gerevich et al on Roma adolescents in Hungary "indicated a significant association between Roma ethnicity and higher lifetime prevalence of tobacco use, alcohol intoxication, and illicit drugs use (Gerevich et al. 2010, 432)." They found "Roma boys as compared to Roma girls displayed a disproportionately higher increase in prevalence of illicit drug use as compared to non-Roma subjects (Ibid, 434)."

There are many micro-cases where drug-use was not identified as a problem. Kolarcik et al carried out a cross-sectional study in Eastern Slovakia and found that Roma adolescents of both genders were significantly less likely to have experience with drug usage in comparison to non-Roma (Kolarčik et al. 2010, 1043). Additionally, Belak et al studied a rural segregated Roma settlement in Slovakia and found no incidences of drug abuse (Belak et al. 2017, 128). However, Vazan and all have identified a chronic toluene misuse problem (inhaling insolvents) among Roma youth in Eastern Slovakia (Važan et al. 2011, 57-61).

There are cases in which drug-use is prevalent in the Roma community and there are cases which are not. It is therefore important to pay attention to context; this is why we have chosen to do in-depth case studies on Slovakia and Hungary. Nevertheless, it should be stressed that many of these studies are more than five years old and that drug-use can decline and rise in short periods. Thus, our research will help to identify the prevailing situation in Hungary and Slovakia currently.

Access to Drug-use-disorder treatment services

Drug-use is generally speaking tackled by the twin forces of drug-use prevention and drug-use disorder treatment services. The UNODC identifies three goals of drug-use disorder treatment services:

1) reduce drug use and cravings for drug use,
2) improve health, well-being and social functioning of the affected individual,
and

3) prevent future harms by decreasing the risk of complications and relapse (United Nations Office on Drugs and Crime and World Health Organization 2016, 8).

In general, ensuring people who need treatment access that treatment is a recurring problem in health policy. The Treatment Gap is described by Kale as "the number of people with an illness, disease, or disorder who need treatment but do not get it (expressed as a percentage) (Kale 2002, 31-33)." Essentially drug-use is concerned as a health issue in which the treatment gap is high. It is possible that for drug-use within the Roma community, the gap is even bigger.

This is best explained by the concept of vulnerable population, a concept which has been used in a number of contexts but in terms of healthcare has been defined by Waisel as "Vulnerable populations are at risk for disparate healthcare access and outcomes because of economic, cultural, ethnic or health characteristics. Vulnerable populations include patients who are racial or ethnic minorities, children, elderly, socioeconomically disadvantaged, underinsured or those with certain medical conditions. Members of vulnerable populations often have health conditions that are exacerbated by unnecessarily inadequate healthcare.". DDTS should be tailored to the needs of vulnerable populations. This is reflected by Principle 5 of the UNODC International Standards for the Treatment of Drug Use Disorders– "Responding to the needs of special subgroups and conditions" (Waisel 2013). The Roma community as an ethnic minority, who are normally socioeconomically disadvantaged, fit this description of vulnerable population. We hypothesise therefore that the Roma are at a disadvantage when it comes to accessing DDTS.

Many other studies have come to this conclusion. The SRAP Network Report identified three types of barriers preventing Roma access to DDTS: administrative, orientation in health services and lack of access to information (SRAP - Addiction Prevention within Roma and Sinti communities 2012, 6-7). As the cases had a wide geographical range the results were not all the same; they found in some cases these barriers were very influential while in others not so influential. Nevertheless, they identified a number of cases where Roma people were disadvantaged in accessing DDTS due to these three types of barriers.

However, there are also again micro-cases where scholars have found no significant disparities regarding Roma access to DDTS. Racz et al compared the experiences of Roma and non-Roma intravenous drug-users in the 8th district of Budapest and found no significant difference in the rate of access (Rácz et al. 2012). In this sense they do not find that Roma represent a special group within drug-users. Nevertheless, they did find that Roma in general are more likely to be socially excluded. As Racz et al point out this runs counter to the findings of most other studies which identify a number of barriers preventing Roma from enjoying equal access to DDTS.

Barriers

The primary research purpose of this paper is to identify the barriers which place the Roma community at a disadvantage regarding accessing DDTS. We apply two theories - the Gelberg-Andersen Behavioural Model for Vulnerable Populations and Galtung´s theory of Structural Violence - to generate, broadly speaking, two different kinds of barriers: behavioural barriers and structural barriers. We do this only for the sake of clarity - as has been already propounded, complex interactions exist between all of these barriers.

Behavioural barriers

The Gelberg-Andersen Behavioural Model for Vulnerable Populations is developed from the Behavioural Model for Health Services Use which suggested "that people's use of health services is a function of their predisposition to use services, factors which enable or impede use, and their need for care (Andersen 1995, 1)." In a study of homeless peoples´ use of health services, Andersen and Gelberg updated the model to apply to "vulnerable populations (Andersen, Gelberg and Leake 2000)."

Their model is structured around what they term the "traditional domain" and the "vulnerable domain (Ibid, 1276)." Factors specific to vulnerable populations that affect their use of health services are outlined in the "vulnerable domain." Each domain is made up of three different components to further explain these factors: Predisposing, Enabling and Need. The Predisposing component focuses on the demographic background of the subject; the Enabling component focuses on the resources available to the subject; while the Need domain focuses on self-perceptions (perceived need) and objective evaluations (evaluated need) of general population health conditions (Ibid, 1277).

Crucially they are differentiated according to which domain is considered. Thus, for example the Predisposing Traditional Domain examines characteristics such as age, gender and social structure; but the Predisposing Vulnerable Domain examines additional characteristics such as literacy and immigration status. The Enabling Traditional Domain examines resources such as income, insurance status while the Enabling Vulnerable Domain also considers the availability of information sources and services in general for vulnerable populations. Lastly the Needs Traditional Domain and Needs Vulnerable Domain differ because Vulnerable Population´s self-perception may be more likely to be erroneous and the general health conditions of Vulnerable Populations, may be more dire.

	Traditional Domain	Vulnerable Domain
Predisposing	Age, gender, social structure	Literacy, immigration status
Enabling	Income, insurance status	Availability of information services, resources
Need	Self-perception (evaluated need)	Perceived need (may be erroneous)

The Gelberg-Anderson Model predicts that, as a vulnerable population, the Roma community may be precluded from accessing DDTS by additional factors which only exist in the vulnerable domain. The Roma community may be less predisposed to access DDTS due to factors deriving from their vulnerable status such as a lower literacy. They also may be less predisposed on account of a lack of trust of healthcare services. The Roma community may be less enabled in accessing DDTS due to a lack of resources (access to information, access to health insurance) on account of their social and often geographical marginalisation. The Roma may be less able to evaluate their health needs due to a lack of education and their perception towards drug-use e.g. drug-use being a taboo subject.

The literature corroborates many of these conclusions and identifies key behavioural barriers. As alluded to above, with policy problems like accessing healthcare this is more likely to be a complex interaction of factors.

Education/Health Literacy

In a Romanian case study on Roma drug-users not enrolled in treatment, identified barriers to treatment included a lack of education and the greater likelihood to have criminal records or not to have the requisite identity documents. The researchers concluded Roma drug users have an increased risk of social exclusion and drug-use exacerbates this (National Antidrug Agency 2015). Kosa et al recommend that "Besides tackling the socioeconomic roots of the poor health of Roma people, specific public health interventions, including health education and health promotion programs, are needed (Kósa et al. 2007, 853).

Perception towards drug-use

Winjard and Felja found in Great Britain that drug use was treated as a taboo in the Roma community. They also found usage was significantly more prevalent among men than women (Winjard and Felja 2010, 20). They further highlighted a notable generation gap problem regarding drugs. They found young people were vulnerable because they are often reliant on their parents for social education and many Roma parents "were almost completely unaware of any issues related to drugs" (Ibid, 20). Thus, many young people begin taking drugs without any knowledge of the consequences or available treatment. They point to the successes of the Roma Support Group in East London in bringing young

drug-users and their parents into a dialogue on drug-use, thus promoting greater direct involvement of the Roma community (Ibid, 21).

Social/Geographical Marginalisation

In another study by Belak et al poor material circumstances and difficulties in accessibility to healthcare services on account of their geographical location were identified as reasons for Roma community's low limited access to health services in general (Belak et al. 2017, 128). At the same time, tackling financial inequalities and improving accessibility of healthcare services in rural areas is not considered to be enough.

Structural Barriers

The Behavioural Model for Vulnerable Populations is a subject-focused theory; in our paper we also have recourse to a more systemic analysis by using the Theory of Structural Violence. This term was developed by Johan Galtung who expanded the definition of violence to include social, economic and political conditions which undermine the existing health care, education and financial systems. The consequentialist effects of these systemic arrangements are their failure to prevent negative outcomes as the very system of functioning disposes to discrimination, restrictions and limitations to access institutions to satisfy people's needs and suppresses the problematization of the issue. "Violence is the cause of the difference between the potential and the actual" (Galtung 1969, 168). Following this definition allows for the possibility to depart from the traditional understanding of this concept as inflicting direct harm on a person. Instead, it embraces numerous factors and aspects "increasing the distance between what could have been and what is" (Ibid).

The concept is by no means idealistic. Rather, it puts a strong emphasis on the possibility to prevent or avoid the negative outcomes of human actions or inactions. Thus, if a person died from drugs in times of the absence of any medical treatment, we might perceive it as having been unavoidable. In contrast, today, with the development of health care systems, medical treatment and technologies, lack of access to such facilities and the cases of people dying for this reason seem to be avoidable and thus well fit the definition of violence (Ibid). However, it constitutes a different type of threat as it does not come from an individual or a particular institution that threatens to jeopardize other people's lives.

There are specific social arrangements constituting an integral part of the existing social, economic or political structures that pose such a danger. Consequently, being interwoven into the existing social system, certain social arrangements create risks to state, societal and individual security and well-being. This includes poverty, inequality, discrimination that have impact on people's access to facilities and resources (Farmer 1999, 1488). Poor access to DDTS may stem from poor public service provision, unequal access to medical treatment and facilities, factual restrictions on the required scope of medical assistance, economic mismanagement, and poor governance. Unequal access to DDTS may be indirectly caused by particular state policies marginalizing national minorities and representatives of vulnerable communities. The other important aspect related to the

concept of structural violence is the social stigma of drug use that may impede people's access to treatment services. Failure to deliver the required level of medical assistance can be related to the societal divisions and further widen the gap between population groups.

Thus, in the framework of the concept of structural violence we focus on the state and society level factors impeding access to DDTS. It includes the analysis of states' policies, openness of health care system and availability of its resources, economic factors like the price of medical treatment and its affordability, societal perception of the problem and its understanding of the reasons and possible solutions to the problem of the Roma communities' access to DDTS.

This theory does not only identify more explanatory barriers to DDTS but also explains how behavioural barriers can arise. For example, poor governance can lead to low levels of health literacy; again, all of these barriers have complex interactions. Applying structural violence to this research area we can hypothesise that social arrangements contribute to poverty within the Roma community which in turn affects pejoratively access to DDTS. Furthermore, social arrangements contribute to discrimination against the Roma community which is filtered through the provision of healthcare services. It is also possible that poor governance or a lack of funding in healthcare services can further restrict the access by the Roma community.

Poverty

In a study by Gyarmathy et al. on injecting drug users, it was identified that the primary cause of the spread of drug-related was poor living conditions. The study found out that homeless Roma were much more vulnerable to having drug-related infections primarily because of poor hygienic conditions and low level of social integration. Therefore, the authors argue that drug use and infection risks necessitate a more structural intervention (Gyarmathy, Neaigus and Ujhelyi 2009). Schaaf has found that similar barriers might prevent access by Roma to health services in general. She sees lack of knowledge of services, lack of insurance and social insurance benefits and inability to cover costs are prominent barriers (Schaaf 2010, 236).

Poor governance

Adany has also found inequalities between Roma and non-Roma population related to social insurance. She identified social exclusion of Roma and their lower standards of living as potential barriers to access health services. Adany also pointed to insufficient attention to this problem from researchers and policymakers because of the difficulties with collecting data. As many representatives of the Roma community prefer to hide their identity, the statistical data on the issue is often unclear and may not reflect the real state-of-the-art (Ádány 2014, 702-703). Barany argues in the communist period in Hungary, assimilation programmes including health-related improved the objective conditions of many Roma (Barany 2000, 421). Cooper argues "In Eastern Europe, the fall of communism led to a precipitous decline in living conditions for the Roma" (Cooper 2001, 71). She states the plight of Roma is the Eastern Europe´s major human rights problem (Ibid, 69).

In their study on the Roma community in Central and Eastern European countries Arora et al. came to the conclusion that the worse health status of the Roma is not solely the result of poor access to healthcare services. She argued that there are differences across the countries with the specific conditions that have to be taken account. Inequalities in access to healthcare system may stem from barriers in the healthcare system itself as well as poor public policy conducted by the government (Arora, Kühlbrandt and McKee 2016, 737-742). Ballesta did research on Spain and the role of the European Union Framework for National Inclusion Strategies for tackling the Roma issue. It indicated that the main obstacle to successful implementation of the national strategy was lack of political commitment and inappropriate allocation of resources (Escobar-Ballesta, García-Ramírez and De Freitas 2010).

Discrimination

Stigma has also been proposed as another possible barrier. Cooper states this discrimination is strongly embedded, arguing that "groups, the Roma have been caught in a cycle of poverty, illiteracy, dependency, and petty crime that has kept them marginalized and is in turn used to justify further discrimination (Cooper 2001, 72).

Kosa et al researched people living in settlements in Hungary, where the population was almost exclusively Roma. As well has finding that in comparison to the general population they suffered from poorer health and a lack of access to health services, they also found that 35% of those who had utilised health services experienced discrimination in the process (Kósa et al. 2007, 853). Belak et al find that societal discrimination might contribute to a lower utilisation of health services among Roma in general (but not with regards DDTS). They argue Non-Roma ideologies, become internalized by Roma into a racialized ethnic identity through socialization which creates an avoidance of health services (Belak et al. 2018). Schaaf also finds that many Roma have reported suffering discrimination in using health services, something which may discourage them from using them again (Schaaf 2010, 227). Kende et all studied anti-Roma attitudes and found the widely spread prejudices against the Roma community that lead to their social exclusion. It results in justification of the cases of Roma discrimination on the grounds of the accepted stereotypes (Kende et al. n.d.). A linkage between illicit drug use and the social exclusion faced by Roma people was identified by the Roma Health Report 2014 (European Commission 2014, 8).

Research Design and Strategy

For the purposes of our research we have chosen the experiences of Roma in Hungary and Slovakia. Both countries have substantially large Roma populations in which the Roma are to a large extent settled rather than nomadic.

Hungary

The Council of Europe estimates that there are approximately 700,000 Roma living in Hungary (European Commission, n.d.).

Between 2005 and 2015 the Hungarian Government participated with other European states in what was termed the Decade of Roma Inclusion, aiming to improve among other things Roma health status. The success of this program has been questioned. Sandor et al found that despite an increase in health care utilisation the self-perceived status of young Roma declined during this period and that in general the Roma remained in a disadvantaged state (Sándor et al. 2017). A Civil Society Monitoring Report found in 2012 that significant discrepancies and vulnerability still existed in terms of drug-usage; finding for example 22% of 13–16-year-old Roma teenagers had already used some kind of drugs, while 2% of the non-Romani teenagers had done so (Balogh et al. 2013, 86).

The European Commission oversees a Framework for National Roma Integration Strategies up to 2020. Hungary´s contribution to this Framework, the National Social Inclusion Strategy is not aimed specifically at Roma but all vulnerable groups. There is a pledge within the Strategy to:

"In the interest of the security of both urban and rural communities and the conflict-free co-existence of their populations, programmes must be launched with the cooperation of the police, the Roma minority self-governments and civil organisations in the areas of issues related to the civil guards, community and neighbourhood crime prevention, drug prevention and conflict management, with regard to the specific local features, by involving the local public to the fullest possible extent, in particular, in localities encumbered with conflicts" (Ministry of Public Administration and Justice 2010, 104).

The parameters of Hungary´s drug policy have been set by the National Anti-drug Strategy 2013-2010 (Hungarian Parliament Resolution 2013). The strategy recognises that the local government, local civil society organisations and government-led organisations are all important participants in this effort (Ibid 65). The policy does not explicitly identify the Roma community as a vulnerable population in this regard but recognises "in the case of people belonging to the Roma minority, the mental health protection and the prevention and treatment of problems caused by substance abuse is a specific problem" (Ibid, 63).

In line with these pledges, we hope from our interviews with practitioners to ascertain to what degree do drug-treatment services involve local bodies (especially those led by the Roma) and to what extent do they adapt to the recognition of the treatment of problems caused by substance abuse as a "specific problem."

Slovakia

As the European commission estimates, Slovakia's Roma community comprises of around 500 000 people, which is 9% of the total population (European Commission, n.d.).

Along with Hungary, Slovakia participated in the Decade of Roma inclusion between 2005-2015. The Roma Decade focused on the certain priority areas such as education, employment, health, and housing. In addition, it committed governments to take into account the other core issues of poverty, discrimination, and gender mainstreaming (Roma Integration 2020 – Regional Cooperation Council, n.d.). As for the case of Hungary, the success of this initiative is rather doubtful for Slovakia as well. The Roma inclusion index does show some positive changes in literacy levels, completion of primary education and

accessing health insurance, however "the daily life of Roma remains a struggle no other ethnic group in Europe faces (Jovanovic 2015).

The strategy of the Slovak Republic for integration of Roma up to 2020 constitutes the major framework of the Slovak Republic in relation to the social inclusion of Roma community. It also corresponds to the needs and challenges of Roma inclusion on the EU level (Ministry of Labour, Social Affairs and Family of the Slovak Republic 2011).

The main tasks of the Strategy include: halting the segregation of Roma communities; facilitating a significant positive turn in the social inclusion of Roma communities; fostering non-discrimination; and changing the attitude of the majority population toward the Roma minority.

The strategy recognizes the deteriorating nature of health conditions of Roma community in Slovakia. It oversees certain reasons for this problem and, also, mentions a few programs that have been conducting in order to deal with this issue. Moreover, the strategy acknowledges the lack of commitment towards Roma health issues and the insufficiency of health support program.

In the light this, there are several goals the strategy aims to accomplish, namely: "To ensure accessibility of healthcare services, improve their real accessibility by removing obstacles (both geographical and financial), introduce a program of minimal dental care, and improve communication between MRK members and medical personnel in the provision of healthcare, with a potential impact on improving the provision of healthcare in the communities" (Ibid 36).

"Also, to carry out educational activities focused on the prevention of drug addiction and socio-pathological effects including violence against women, domestic violence, sexual abuse and human trafficking, increase awareness by establishing conditions for specialized consultancy services targeting the elimination and prevention of violence against women and domestic violence, support of good health, disease prevention and a healthy lifestyle" (Ibid, 37).

An anti-drug strategy for the period of 2013-2020 of the Slovak Republic represents the main document defining Slovakia's anti-drug policy issues. It is structured around two areas of anti-drug policy – reduction of demand and reduction of supply, and three cross-cutting issues – coordination; international cooperation; research, information, monitoring, and evaluation. The strategy does not specifically mention Roma community as a vulnerable population, however, it aims "to establish effective and differentiated measures for reduction of drug demand aimed at minimizing of number of people who start using drugs and/or postpone the age when they start using drugs and which respond to the needs of specific groups in a due manner and ways and frames of drug use while a special attention should be paid to vulnerable and marginalized groups" (Ministry of Health Of the Slovak Republic 2013, 39).

Methodology

Experts and practitioners in this area were interviewed to gauge: whether or not Roma are at a disadvantage when it comes to accessing DDTS; what barriers might be influencing this; what policy recommendations could be made.

Our research is limited in the sense that we could not, on account of several obstacles, directly interview Roma drug-users. Nevertheless, we chose interviewees based on their first-hand experience with this topic. Some have researched this topic in an academic sense, often with state-sponsored grants, while other interviewees have direct contact with Roma drug-users.

We have an equal number of experts who work in Slovakia and who work in Hungary; all of them have more than five years' experience working with the Roma community or studying this topic. We identified them through a number of avenues including personal contacts and familiarity with their academic work. All interviewees signed an informed consent in which they have allowed their responses to be published. They are:

Hungary:

1. Interviewee 1, Laurus Association
2. Interviewee 2, Eötvös University, Institute of Psychology, Department of Counselling Psychology
3. Interviewee 3, Kek Pont (Blue Point) Drug Counselling Centre

Slovakia:

1. Interviewee 4- Researcher at Department of Health, Psychology Faculty of Medicine, P.J. Safarik University
2. Interviewee 5- Graduate School Kosice Institute for Society and Health Scientific Director

This was achieved through the creation of a questionnaire which was designed in such a way to address all relevant factors which arose from the literature review and our theoretical framework, but which gave space for other factors and ideas to arise. We did not implement word counts so interviewees had the space to describe in detail their experience. The questionnaire is structured that even if the correspondent does not have expertise in the area of DDTS, they can still answer with their knowledge of Roma access to healthcare services in general.

In this sense the questionnaire is mostly qualitative in nature although some questions require the correspondent to answer by means of ranking. We corresponded with these experts by email on four occasions and by skype call on one occasion (which was later transcribed). The questionnaire is located in Appendix A.

The method of grounded theory is utilised to analyse our questionnaires. This has been applied before for analysing questionnaires in the health sector.[2] Essentially grounded theory means analysing the content rigorously until common themes emerge. Since we are interviewing exclusively experts it is more important to focus on the substance of their insights. For some questions in our questionnaire such as 2.3 it will be easy for us to collect

[2] E.g. Bodil Wilde et al, "Quality of care: development of a patient-centred questionnaire based on a grounded theory model," *Scandinavian Journal of Caring Sciences* 8.1 (1994): 39-48.

and compare answers because they are multiple choice questions. Most questions however require explanatory responses which in turn, from us, require coding. It entails reviewing the responses rigorously and "giving labels (names) to component parts that seem to be of potential theoretical significance" (Bryman 2012, 568). This process is continually revised as further questionnaires are analysed and compared with each other. The process ends when *theoretical saturation* is reached and no further theoretical significance is expected to be found (Ibid).

In the questionnaire we have asked a broad range of questions, but we have separated the responses into five sections, sections which match the steps of our research:

1. Drug-use in the Roma community
2. Access to DDTS
3. Barriers to Treatment
4. Policy Recommendations
5. Other questions

Using the coding process, we were able to identify within each section themes, subthemes and sample quotations indicating how the themes were identified. Themes are identified according to the analysing the vocabulary in its used context e.g. dropping out of school would be under the theme education whereas not being able to go to school on account living too far away would be more apt under the theme isolation. Subthemes clarify the different elements constituting the theme and thus making it relevant.

We assess the themes also in terms of frequency – that is how many correspondents identified it as relevant and how many did not. In this way we can assess what for the interviewees were collectively the most important or recurring barriers. In this way we can account for differences in opinion/experiences between the interviewees.

Grounded theory allows us to assess interviewee´s responses to the questions of drug-use in the Roma community and Access to healthcare services but most importantly coding allows us to generate a number of themes which we can assess against the same assumptions about barriers which emerge from the literature and our theoretical framework. Analysis of the results will be done separately for Hungary and for Slovakia and then the results will be compared between the two cases to see for similarities. Coding, furthermore, helps us collect the policy recommendations identified by the experts.

Analysis of Results

Analysis of Slovakia

The use of drugs constitutes a problem in the Roma community

- Our results show that drug-usage among the Roma gives causes for concern that supports the arguments made in the literature. Roma in Slovakia are described as being much more vulnerable compared to the mainstream population. The

situation is mostly typical of segregated and marginalized Roma who face psychological, material and societal barriers to medical treatment services.

Accessing DDTS:

- Results indicate that there is no factual difference in the access to treatment services between Roma and non-Roma communities. However, as explained by the interviewees, the difference is present at the material level. Financial constraints pose limits to accessing the necessary treatment and getting to hospitals. There are other barriers putting the Roma into a much more vulnerable and disadvantaged position.

Behavioural barriers:

This type of barriers does play its part in the Roma accessing and using DDTS.

- Lack of trust comprises one of the main barriers as the Roma consider health system institutions to be discriminatory and having an inferior approach to them as a minority group. This idea has not been studied and analyzed in the literature yet.
- Poor health literacy and unawareness by the Roma of the services available.
- Interestingly, language was not described as a barrier, and the majority of the Roma do not experience language difficulties when accessing health services.

Structural barriers:

Structural factors have a limiting effect on Roma access to DDTS:

- One of the main reasons presented is poverty and, thus, inability of the Roma to get to hospitals and buy the necessary treatment.
- Related to the first one is the factor of geographical isolation. The fact that many Roma in Slovakia live in rural and remote areas has additional constraints on their access to health services. Segregation and marginalisation cause much more difficulties in accessing DDTS.
- Discrimination has also been mentioned as an influential factor. Different treatment of the Roma and non-Roma constitutes a problem and provokes a set of above-mentioned behavioral barriers.

Analysis of Hungary

Drug-usage is present in the Roma community

- Results indicate that drug-use is a growing problem within the Roma community. Our results then confirm the general conclusions of the literature and do not conform with select micro-cases which find little to no drug use. However, this should not be generalised; this is to a greater extent among marginalised Roma.

- The use of synthetic drugs is on the rise.

Accessing DDTS

- Results indicate that the Roma are at disadvantage. This is in line with the literature. Services are technically as available to Roma as to non_roma (although less so in the rural areas where Roma live) so there must be different barriers explaining this.

Behavioural Barriers

Results indicate behavioural barriers play a role.

- A lack of trust towards healthcare services (this was not identified in previous literature). The Roma´s sense of distrust towards the healthcare sector has many possible sources.
- Poor health literacy.
- Poor general education levels. The level of education does seem to have affected Roma drug-users´ decision to access treatment; many delays in doing so until the symptoms are unbearable.
- Geographical isolation
- Results indicate that taboo against drug-use was not identified as present.

Structural barriers

Results indicate behavioural barriers also play a role.

- Poverty. Roma are disproportionately poor and this has a negative impact on their accessing DDTS.
- Some correspondents felt that Roma did not have disadvantages when accessing social insurance.
- Results indicate that discrimination does not play a large role. However perceived discrimination within the healthcare system may have arisen from discrimination in other areas.
- Results indicate that the health system in Hungary is overburdened and there is insufficient funding.

Additional information:

- Familiarity with the UNODC/WHO International Standards is low.
- Accessing drug treatment is not a direct indicator of well-being because there are many incidences of dropping-out of treatment.

- Roma living in rural, marginalised areas maybe more vulnerable. This distinction is crucial to recognise.

Policy Recommendations

- Educational programmes aimed at Roma regarding the dangers of drug-use should be launched. They should be aimed at achieving greater health literacy i.e. Roma drug-users should be better able to recognise when they should go to treatment.
- There should be greater efforts to include more Roma members among healthcare staff; this should increase levels of trust.
- Make DDTS more accessible in rural areas in which there are high numbers of Roma.
- Social policies of the respective countries should specifically address the problem of marginalization of the Roma community. Housing policies and employment strategies should take into consideration the vulnerability of the Roma and promote better opportunities and inter-communication between the mainstream society and the Roma.
- Greater support of NGOs is needed. They should not be under the pressure from the government and able to conduct their activities in a broad range of problems and issues related to Roma health.
- More support treatment services which treat drug-use as an illness e.g. harm reduction programs.
- As we have observed no factual discrimination when it comes to access to DDTS, the behavioral barriers can be partly addressed by introducing special trainings of doctors and medical staff. Vulnerability of this group and misperceptions of their treatment in hospitals require a different ethics-guided approach.
- All of these measures are linked to the lack of funding. Governments need to invest more in DDTS in general.
- More attention should be paid to the government's policies towards minority groups. There should be more cooperation between national and international actors, including IOs on this matter.
- Since barriers, both behavioural and structural, work in complex interactions with each other we suggest these barriers must be targeted in a holistic manner.

Conclusions

Slovakia and Hungary have both made strong commitments to Roma integration; however, our results indicate that Roma remain marginalised, especially regarding accessing DDTS. Despite the absence of formal obstacles to DDTS access by the Roma community, inequalities in the use of treatment services are largely caused by a number of behavioural and structural barriers.

One of the main problems limiting access to DDTS both in Hungary and Slovakia consists in the long-term lower socio-economic situation. Poor economic conditions combined with marginalisation of the Roma and their likelihood to live in remote rural areas hinder them from receiving proper treatment health services in general, and DDTS specifically. Moreover, worse education indicators influence the community's perceptions of the health treatment and, thus, abstain the Roma from accessing DDTS. The other significant factor that impedes access to treatment services in both countries is the behavioural attitudes of the population and the general mistrust towards health services and perceived discrimination, largely because of the lack of adequate education. Roma community was described as vulnerable in terms of their access to health services by all our interviewees. However, the problem is not sufficiently addressed on the level of the government as well. Inflexible and oftentimes discriminatory practices exacerbate the situation. While the problem of structural discrimination is discussed the national and EU level, there is not enough interaction between national and international players.

The UNODC, like many UN agencies, needs to take more ownership of problems facing the Roma community. Through the *International Standards* and the embracing of a specialised approach to vulnerable population, they have the opportunity to occupy a vital advocacy role in encouraging states to spend more and take action to facilitate greater access of DDTS within the Roma community.

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Appendix:

A. Questionnaire

Questionnaire for Practitioners	
1. General questions (1.1. – 1.4.)	
Questions	*Answers*
1.1 In what country/countries do you work?	
1.2 For which organisation do you work and what is your position/role in it?	
1.2 How many years of experience do you have working with the Roma community?[3]How does your work relate to the Roma community?	
1.3 Is your organisation independent or linked to the government? Is your organization independently funded or funded by the government (fully or partially)?	
1.3.1 If you answered independent to Q 1.3 please describe any interactions your organisation has with the government on a regular basis as it relates to the work with the Roma community.	

[3] Following the practice observed in EU policy documents and discussions, the term "Roma" here refers to a variety of groups of people who describe themselves as Roma, Gypsies, Travellers, Manouches, Ashkali, Sinti and other titles

1.3.2 If you answered "linked to the government" to Q 1.3 please describe the nature of the relationship between your organisation and the government?	
1.4 Do you identify as part of the Roma community	
2. Health issues that ARE NOT related to drug-use (2.1. – 2.11.)	
2.1 Do you have experience working with Roma communities on health issues? If so, are these health issues related to drug-use? Please describe this experience (please also included second/hand i.e. "observed" experiences.)	
N.B. If your answer Q 2.1 pertained to a health issue <u>other</u> than drug-use then please continue to answer Q 2. If your answer to Q 2.1 concerned drug-use within the Roma community then please skip what remains of Q 2. and begin answering Q 3. If your answer covers <u>both</u> drug-use and other health issues other than drug-use within Roma communities, please proceed to answer questions in Q2 followed by questions in Q3.	
2.2 In your opinion are the Roma community "a vulnerable population" in terms of this health issue. Please explain. [4]	
2.3 In your opinion how effective are government policies in treating the relevant health issue(s) across the Roma community? In the absence of a specific health policy for the Roma please consider the application of the general government policy on the Roma population.	Very effective ☐ Effective ☐ Somewhat effective ☐ Not at all effective ☐
2.3.1. Please explain on what basis you made your rating. Please identify if there is a specific policy for the Roma population. (max. 100 words).	
2.4 In terms of the relevant health issue(s), what is	

[4] While the UNODC uses the term "vulnerable population" there is no definition available within the International Standards for the Treatment of Drug-use Disorders. The definition given by The National Collaborating Centre for Determinants of Health gives a general definition: "Vulnerable populations are groups and communities at a higher risk for poor health as a result of the barriers they experience to social, economic, political and environmental resources, as well as limitations due to illness or disability." http://nccdh.ca/glossary/entry/vulnerable-populations;

your perception of the access to health services within the Roma community in comparison to the non-Roma population?	
2.4.1 Please explain your rating. What do you identify as the main obstacles to a higher rate of access and the main reasons for low or no access?	
2.5. In terms of awareness and/or education how well-informed do you believe the Roma community to be regarding the relevant health issue(s)?	
2.6 If applicable, how would you characterise the attitude of members of the Roma community on average towards government health services? i.e. trust, mistrust, satisfaction, discrimination etc. How do you think this compares to the general population? Please share examples.	
2.7 If applicable how would you characterise the attitude of members of the Roma community towards independent or NGO-led health services?[5]	
2.8 If applicable, to what extent are members of the Roma community involved with the administration of these health services?	

[5] NGO (Non-Governmental Organization) is defined by World Bank as 'Private organizations that pursue activities to relieve suffering, promote the interests of the poor, protect the environment, provide basic social services or undertake community development.

2.9 In your opinion what policy improvements could be made to improve the rate of access to health services occurs within the Roma community?	
2.10 In your opinion what policy improvements could be made to improve the quality of health services occurs with regards the Roma community?	
2.11 To what extent do you think is a tailored approach for the Roma community is required for health services in general?	
3. Health issues that ARE related to drug-use (3.1. – 3.13.)	
3.1 In your opinion are the Roma community "a vulnerable population" in terms of drug-use. Please explain.	
3.2 In your opinion how effective are government policies in treating drug-use among the Roma community? In the absence of a specific drugs policy for the Roma please consider the application of the general government policy on the Roma population.	Very effective ☐ Effective ☐ Somewhat effective ☐ Not at all effective ☐
3.2.1 Please explain your answer (max. 100 words). Please identify if there is a specific policy for the Roma population.	
3.2.2. The Hungarian National Anti-Drug Strategy 2013-2020 states"In the case of people belonging to the Roma minority, the mental health protection and the prevention and treatment of problems caused by substance abuse is a specific	

problem".[6] To what extent do you think the government of Hungary has addressed in recent years the specific nature of this problem in terms of the Roma community receiving treatment?	
3.3 In terms of treating drug use what is your perception of the access to health services within the Roma community in comparison to the non-Roma population?	
3.3.1 Please explain your rating. What do you identify as the main obstacles to a higher rate of access and the main reasons for low or no access?	
3.4. In terms of awareness and/or education how well-informed do you believe the Roma community to be regarding the relevant health issue(s)?	
3.5 If applicable, how would you characterise the attitude of members of the Roma community on average towards government drug-treatment services? i.e. trust, mistrust, satisfaction, discrimination etc. Please share examples.	
3.6 If applicable how would you characterise the attitude of members of the Roma community towards independent or NGO-led drug treatment services?	
3.7 If applicable, to what extent are members of the Roma community involved with the administration of these drug treatment services?	
3.8 In your experience what are the substances that are used most within the Roma community?	
3.9 If applicable to what extent has the status of vulnerable groups been considered with regards drug treatment services in your work?	

[6] *Parliament Resolution No. 80/2013 (X. 16.) on the National Anti-Drug Strategy 2013-2020 Clear consciousness, sobriety and fight against drug crime*: 63.
http://www.emcdda.europa.eu/system/files/att_229620_EN_HU_The%20National%20Anti-Drug%20Strategy%202013-2020%20%28EN%20version%29.pdf

3.10 In your opinion what kind of attitude(s) towards drug-use disorders is present in the Roma community?	
3.11 In your opinion what policy improvements could be made to improve the rate of access to drug treatment services occurs within the Roma community?	
3.12 In your opinion what policy improvements could be made to improve the quality of drug treatment services with regards the Roma community?	
3.13 To what extent do you think is a tailored approach for Roma community is required for drug treatment services?	
4. UN-Related Questions (4.1)	
4.1 Are you familiar with UNODC/WHO´s "International Standards for the Treatment of Drug Use Disorders. If so, does it influence your work in any way? If no, would you be interested to learn about them and possibly use them in your work	

B. Results

Hungary

Hungary			
1. Drug-usage in the Roma Community			
Themes	Subthemes	Frequency	Sample Quotations
Synthetic Cathinones and Cannabinoids	Most common drug	1 and 3	
NPS (new psychoactive substances)		1 and 2	
Prescription drugs		1 and 3	
Opiates	Rare	1	
Growing usage in Rural areas		1 and 2	
2. Access to DDTS			
Themes	Subthemes	Frequency	Sample
Access is lower than non-Roma	poverty of Roma discrimination	1 and 3	Access is the same if you can pay the monthly insurance. (3) Access is the same, what can differ is the quality of the service. (3)
Availability of treatment	Access is available but the people prefer not to	1	The problem is not that they do not have access to services but that they do not prefer to do so. (1)

3. Barriers to Treatment			
Themes	Subthemes	Frequency	Sample Quotation
Health Literacy	Lack of recognition of symptoms.	1	In other cases, mainly because of unbearable symptoms. (1)
Overburdened health system	Reduction of harm reduction services Lack of street interventions Lack of financial resources No anonymous system Lack of clinics	1 and 3	The overload of the healthcare system [mentioned as an obstacle to a higher rate of access to DDTS] (1) There are very few addiction clinics, rehabilitation centres (3)
Lack of trust	Anti-psychiatry sentiment. Distrustful Think they are police officers Often trustful of individual doctors. Leads to inobservance of orders. Mistrust because of poorly functioning system Mistrust because of the administrative role performed by the staff	all the respondents	We needed 2-3 years of continuous attendance to gain the trust of the community. (1) Hungarian health care system is currently not functioning well. There is a mistrust towards institutions in general because of this. Fear, Trust, discrimination. (3) The mistrust is towards social services because they have administrative roles (e.g. decision on social aids, decision on child placement) (2)
Isolation	Government has not supported the more easily accessible programmes launched in Roma areas	1	
General Education	Lack of awareness. Do not access treatment until	1 and 2	most of them do not dispose of the minimal

	significant effects. Starker in rural areas Lack of information Lack of motivation: want fast relief not long process (problem is not just accessing treatment but staying in treatment) Children at school receive more treatment than those not at school General Public poor education		healthcare, basic biological knowledge. They have no information about diseases spread by needles, neither about organisations nor hospital wards taking part in recovery, treatment. (1) Not well. PWID are not aware of harms or HIV and HCV symptoms or how they can get infected. The general public is not well informed (2)
Discrimination	Prejudice against addicts within healthcare, social services But perceived discrimination can create resistance segregation	1 and 2	During our work we do not experience any discrimination on behalf of healthcare toward Romas, neither do our clients inform us about similar cases. (1) Geographic and social segregation (2)
Poverty	Lacking social insurance	1 and 3	This is an own experience that because of this fact those who do not have insurance often do not visit the medical consultations we advise them. (1) The countryside is even poorer and they often lack local GPs meaning they have to travel more to get proper health-care. This is also a question of poverty, not only racism (3)
Taboo	Addiction is less hidden Stigma	1 - it is not an issue 3	Addiction is a huge stigma in Hungary, if one can avoid addiction

			services, it will do so
Unwise policies	pressures on NGOs	3	Addiction treatment is underfunded, the government prefers to support police measures and policy making solutions and avoids professional opinions. Also, the government set the goal of a drug free country by 2020 in the national anti-drug policy. Because of this any awareness raising tactics that would prove the goals are wrongfully set could raise hostile reactions from the government. In Hungary we have a severe situation which cannot be solved with advocacy and awareness-raising tools. The government sees the problems, the awareness has been risen, but it decides not to act or to use punishment instead. I do not think that any international standards or logical reasoning would make a difference. (3)
4. Policy Recommendations			
Themes	Subthemes	Frequency	Sample Quotation
Improving awareness among Roma	This would have greatest impact.	1	More serious modifications would be necessary to increase the independency, self-consciousness,

			awareness, health-consciousness of Romas and, as a result, to increase their demands. (1)
Harm Reduction	Prejudice against this should be terminated	1 and 3	funding harm-reduction and prevention (the number of drug experts working in schools is decreasing and the number of programs conducted by the police is increasing) (3)
Supporting NGOS		1 and 3	More funding for NGOs
Treating drug use as an illness rather than a crime		1 and 3	
Improving accessibility of services in rural areas		1	
More roma working in healthcare	Has already started and can create trust and information flow	1	It has been a positive tendency that recent years have seen more and more Romas working in healthcare – for the present, only as nurses or home visitors. This can strengthen more their trust toward healthcare and the flow of information toward Roma communities. (1)
Education of medical professionals	Sensitivising them to Roma needs	all the interviewees	There may be a need for the sensitization of those working in healthcare in order to diminish various prejudices. (1)

			Training for doctors on doctor-patient communication (also in universities), sensitivity training (3) Training, empowering the local workers, disjoint the administrative and helping roles of the services (2)
Healthcare system reform	should cover all people	2 and 3	increase the percentage of GDP spent on health-care, , more local GP's HCV treatment for all without insurance (3) There is no accessible institutional system (addiction-oriented services, social work, civil organisations) dealing with Roma drug use. (2)
5. Other Questions			
Question	Response		Sample Quotation
Are the Roma a Vulnerable Population?	Helga Yes Kek Pont Foundation - yes		The Romas living in the area with poorer financial state are the most vulnerable A lot of young roma people are being taken from their families because of low income which alone should not be a factor. Less children are being taken from other families because of low income. They drop-out from society after that. Child care is extremely underfunded and a lot

		of times causes severe traumas. After that, lot of young roma people start using drugs and/or become homeless. they are starting to use at an earlier age, more potent drugs, that are considered by the general public to be even worse than older drugs deepening the prejudice against roma drug users (3)
In your opinion how effective are government policies in treating the relevant health issue(s) across the Roma community?	1- somewhat effective 2 and 3 - not effective at all	We do not know any health policy concerning the Romas. (1) I do not know of any projects related to health that focused on helping roma people in any ways. (3)
Do you have experience working with Roma communities on health issues?	1 and 3 yes	In service of addicts – we face the consequences of drug use: contagious diseases (HIV, Hepatitis C), somatic and mental illnesses. In our prevention programmes we face problems concerning the youths and children. (1) Yes, and they are related. There is a big number of PWID whom are infected with HCV. Currently only people who pay the national insurance (about 22EUR/month) can get HCV treatment.

		(3)
Specific government policy for Roma	1 - no 3 - needed	There is only problem raising but no drug policy customized for Romas. (1) Very much. There should be a linkage (drop-in centres and other programs for roma people) between roma communities, roma people and health-care providers. (3)
Familiarity with UNODC International Standards	1 - No but will look at it for future usage 2 - no	

Slovakia

Slovakia			
1. **Drug-usage in the Roma Community**			
Themes	Subthemes	Frequency	Sample Quotations
Synthetic Cathinones and Cannabinoids			
Prescription drugs			
Opiates			
Growing usage in Rural areas			
1. **Access to DDTS**			
Themes	Subthemes	Frequency	Sample
Equal access to health facilities		2	there is no difference in access to health facilities between Roma and non-Roma (2)
Availability of treatment	material constraints	2	from a material point of view such a difference does exist: non-Roma go by car, bus or tram to a health facility; Roma walk this distance (2)

1. **Barriers to Treatment**

Themes	Subthemes	Frequency	Sample Quotation
Health Literacy		all the respondents	Health literacy is poor (1) [it is necessary] to educate Roma (specifically regarding health literacy) (2)
Lack of trust	Anti-psychiatry sentiment. Distrustful Think they are police officers Leads to inobservance of orders.	1	people don't trust they will be treated well. there is on top of the barriers mistrust deriving from discriminatory practices (1)
Poverty	Segregation	1	Face poverty so many are unable to pay. They live in rural areas - cannot pay for transportation (1)
Language barrier		1 - not salient	not as salient as literacy barrier. Many Roma are bilingual. Healthcare staff identify language as no great problem but rather poor knowledge. *(1)*

Absence of strategy for drug treatment		1 and 2	There is no real strategy for drugs treatment in Slovakia. Nor NGOs working exclusively with these communities (1) As far as I know, the only policy issue which is fruitful (is somewhat effective) is the health-mediation program for Roma. Here are two problems: * the program is effective because other things are performed than should be * the program has no solid financing (2)
Monopoly of one NGO		1	Zdrave komunity is an organisation that deals Roma health care. Has a monopoly on this question almost. It has shifted their work from the field to more advocacy. (1)
Discrimination		2	It would be very good if the Slovak government understood that (Slovak) Roma are inhabitants of Slovakia! (2)
1. **Policy Recommendations**			
Themes	Subthemes	Frequency	Sample Quotation

More Roma working in healthcare system		1	The most successful strategy in our experience is to employ minority people within the regular healthcare system; this is not being promoted (1)
Improving health literacy of Roma	Health education of both Roma and non-Roma	both	The most successful strategy in our experience is to employ minority people within the regular healthcare system; this is not being promoted. (1) Not only educate Roma (specifically regarding health literacy), but also non-Roma (regarding seeing all their patients as their clients) (2)
Better education and employment opportunities for Roma		2	To offer education and jobs would help enormously to close the gap. -Better education (as far as I know Roma are working on better primary education, resulting in less school dropout) and to offer jobs (few examples are going on) would help enormously to close the gap in access to hc facilities (2)

1. **Other Questions**

Question	Response	Sample Quotation
Are the Roma a Vulnerable Population?	1 - Yes	Lotus Foundation found drug use was quite common among Roma – report was "Different Realities." Our

		experience was similar to theirs. There are some communities were drug use becomes an epidemics. (1)
In your opinion how effective are government policies in treating the relevant health issue(s) across the Roma community?	both - not effective at all	There is no real strategy for drugs treatment in Slovakia (1)
Do you have experience working with Roma communities on health issues?	1 - Yes 2 - No	I have worked on a project where there almost no drug use among Roma-just experimentation with soft drugs. Then I worked for Health Group where I had discussion with health professionals. (1)
Specific government policy for Roma	1 - Needed	Needed- the projects on health literacy are just started (1)
Familiarity with UNODC International Standards	1 - No 2 - No	