



Identifying a Human Rights Approach to Roma Health Vulnerabilities and Inequalities in Europe: From Concept to Action

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Abstract

Roma communities across Europe still remain a neglected population group by way of the social and economic disadvantage that largely characterizes their lives. Roma communities continue to experience structural socioeconomic health inequalities on the grounds of their ethnic origin, alarmingly unveiling a pattern of systematic discrimination and ethnic marginalization. Without any doubt, such a highly worrying situation calls for States to incorporate Roma health rights within their law and policy agendas in a manner consistent with right to health requirements. Against this background, this paper seeks to identify an operational human rights framework for States as a driver for better informed policies and implementation as well as for Roma engagement in the deliberations about their life prospects. The paper argues that continuing, concerted, and proactive State engagement is required for effectively addressing the structural obstacles impeding Roma socioeconomic health rights realization and maximizing Roma opportunities for well-being.

Keywords Accountability · Europe · Human rights · Participation · Roma · Socioeconomic health Inequalities

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Introduction

For more than five centuries, Roma¹ have encountered widespread and enduring discrimination, violence, stigmatization, social and economic exclusion, and marginalization in all areas of everyday life worldwide and most evidently in Europe (for an overview, see UN General Assembly 2014: 2; Bhabha et al. 2017). In Europe, Roma are estimated to be more than 10 million—of whom approximately 6 million are citizens or residents of the European Union (EU)—representing Europe’s oldest and largest ethnic minority population (European Commission 2022). Despite the increase in attention to Roma socioeconomic challenges, many EU Roma still remain marginalized, often facing deep-rooted societal prejudices and discriminatory attitudes with profound life-altering effects (for example, see European Commission, 2011, 2022). Recently, on 7 October 2020, the European Commission issued a new EU Roma strategic framework that identifies a set of tangible targets to be achieved by 2030, whose primary aim is the promotion of a three-pillar approach, encompassing the effective equality, socioeconomic inclusion and meaningful participation of Roma in economic, social and cultural life, to enable Roma to achieve their full potential (European Commission 2020, 2022). On 12 March 2021, approximately one year later, the Council of the EU endorsed the European Commission’s proposal for a new EU Roma strategic framework and adopted a Recommendation on Roma equality, inclusion, and participation, which provides detailed guidance to Member States on how to shape and strengthen the implementation of their national Roma strategic frameworks for combating inequalities while engaging with Roma communities and civil society (Council of the European Union 2021). Significantly, the harmful implications of the Coronavirus disease 2019 (COVID-19) for human health and well-being, prompted the Council to caution Member States to reduce structural inequalities that seriously affect Roma health and their socioeconomic conditions: by tackling Roma limited access to clean water, sanitary infrastructure and healthcare services, involving vaccination services; and by eliminating the high levels of economic precariousness and social exclusion (e.g., segregated settlements) that many Roma experience across Europe (Council of the European Union 2021, p. 3).

Hence, this paper seeks to articulate human rights implementation towards identifying an operational framework for States as a driver for better informed policies and implementation that reflect and address the egregious socioeconomic health inequalities that many Roma communities experience across Europe. Following this introduction, the discussion first focuses on the structural obstacles that render Roma one of the most vulnerable population groups in Europe in terms of socioeconomic health disparities. Subsequently, the focus of attention

¹ Throughout the present paper, the term Roma is used to designate a heterogeneous community of Romani origin, including according to the Council of Europe: Roma, Sinti/Manush, Kale, Romanichals, Boyash/ Rudari, Egyptians and Ashkali, Eastern groups (Dom, Lom and Abdal) and groups such as Travellers, Yenish and those under the administrative term ‘Gens du voyage’ as well as persons who identify themselves as Gypsies or Tsiganes (Council of Europe 2012a).

shifts to examine the implications of a human rights approach to identifying legal obligations and policy instruments to guide and step up State action, while empowering Roma communities to enhance their standards of living and shape their future in a dignified way. As the former UN Commissioner for Human Rights has pointedly stressed “[C]learly, human rights cannot provide all the answers or make easier difficult public health choices concerning priorities and distribution of goods and services. But what other framework offers any detailed ethical, moral or legal guidance to policy-makers?” (Robinson 2007, p. 242). Thus, by employing a human rights approach to Roma health vulnerabilities and inequalities, the objective of the paper is to provide a step forward to close the national-level implementation gap in terms of operationalizing, regulating and monitoring State commitments to bring practical benefits to the Roma communities in Europe and maximize their opportunities for well-being. At the same time, by focusing attention on the most socially disadvantaged population group in Europe, this paper aims to contribute to current discourse, efforts, and practice as to how socially determined inequalities in health across countries and regions can be more effectively addressed especially in the face of tremendous public health challenges.

Structural Obstacles: Evidence from Europe

Admittedly, Roma constitute one of the most vulnerable and marginalized population groups across Europe, facing multiple and disproportionate obstacles to the full enjoyment of their rights and to their inclusion in society—some of which appear to have become difficult to overcome—in comparison to the general population (for example, see Amnesty International n.d.; Hancock 2002; Council of Europe Commissioner for Human Rights 2011, pp. 58–61; UN General Assembly 2014; Bhabha et al. 2017). Roma marginalization stems primarily from the failure of the wider social environment to accommodate their discrete needs in virtue of their ethnic origin and to facilitate their full and active participation in society and economic activities on an equal basis with others (for example, see Amnesty International n.d.; Hancock 2002; Council of Europe Commissioner for Human Rights 2011, pp. 58–61; UN General Assembly 2014; Bhabha et al. 2017). Most notably, there is evidence that Roma inclusion efforts are adversely affected and undermined by the persisting phenomenon of anti-Gypsyism with far-reaching repercussions for the well-being of Roma that go from one generation to the next (European Union Agency for Fundamental Rights 2018). Anti-Gypsyism is defined as “a specific form of racism, an ideology founded on racial superiority, a form of dehumanisation and institutional racism nurtured by historical discrimination, which is expressed, among others, by violence, hate speech, exploitation, stigmatization, and the most blatant kind of discrimination” (Council of Europe: European Commission Against Racism and Intolerance 2020, p. 3). Indeed, a recent report by the EU Fundamental Rights Agency (FRA) affirms that anti-Gypsyism constitutes an alarmingly serious barrier that erodes any state effort and policy initiatives to enhance the life prospects and living conditions for Roma, given that many Roma

are confronted with discrimination, harassment and hate crime owed to their ethnic origin (European Union Agency for Fundamental Rights 2018, p. 7).

In parallel, the European Court of Human Rights (ECtHR) has acknowledged in its case law the substandard living conditions and the violent practices that many Roma in Europe continue to face with detrimental effects on their health and well-being.² Recently, in the case of *Hudorovič and Others v. Slovenia* the ECtHR addressed the lack of access to safe water and basic sanitation and recognized that a considerable part of the Roma population in Slovenia, who live in informal settlements without access to a public water-distribution system, “face greater obstacles than the majority in accessing basic utilities” (European Court of Human Rights 2020, para. 143). The Court went further by noting the link between the Slovenian legislation on access to water and sanitation services and the disproportionate effects on the members of the Roma community, who live in informal settlements, without though opening a discussion as to the actual adverse impact of such legislation towards that certain group, namely the discriminatory attitude of the authorities (European Court of Human Rights 2020, para. 147). Accordingly, the Court refused to issue a ruling that there had been any discrimination against Roma on racial/ethnic grounds under Article 14 of the European Convention on Human Rights (European Court of Human Rights 2020, para. 162). This might explain Pavli and Kūris reaction in their dissenting opinion, stressing that “a long-standing denial of access to safe water, especially when the persons involved live in the relative vicinity of the public water supply, amounts to an interference with the right to respect for private and family life” and concluding that ““Separate but equal” access to water is, simply, not good enough” (European Court of Human Rights 2020, pp. 50 and 56). Consequently, a significant proportion of the Roma population continue to struggle with dire living conditions involving segregated (informal) settlements in high-risk areas or hazardous environments (next to waste dumps, abandoned industrial sites or flood-prone areas) without access to the basic necessities, such as electricity, running water and waste management (European Union Agency for Fundamental Rights, 2009, 2018).

Essentially, the findings of FRA,³ in fact, emphasize that many Roma experience structural discrimination in all areas of daily life, such as in employment, healthcare, and education, on the grounds of their ethnicity compounded with persistent socio-economic aspects such as poverty, social marginalization, thereby magnifying the impact of ethnic diversity (European Union Agency for Fundamental Rights 2016a, 2020a). Importantly, FRA data highlight that on average 80% of Roma in the nine EU Member States surveyed in 2016 (European Union Agency for Fundamental

² See, for instance, European Court of Human Rights (2005) *Moldovan and Others v. Romania* (no. 2), Applications nos 41138/98 and 64,320/01. European Court of Human Rights (2009) *K. H. and Others v. Slovakia*, Application no. 32881/04. European Court of Human Rights (2010) *Oršuš and others v. Croatia*, Application no 15766/03. European Court of Human Rights (2012a) *N. B. v. Slovakia*, Application no 29518/10. European Court of Human Rights (2012b) *I. G. and Others v. Slovakia*, Application no 15966/04.

³ In 2016, the EU MIDIS II report collected data on the situation of Roma in Bulgaria, Croatia, the Czech Republic, Greece, Hungary, Portugal, Romania, Slovakia, and Spain. In 2019, the FRA's survey on Roma and Travellers collected data on the situation of Roma in Belgium, France, Ireland, the Netherlands, Sweden, and the United Kingdom.

Rights 2016a, p. 9) and 72% of Roma and Travellers in the six EU Member States surveyed in 2019 (European Union Agency for Fundamental Rights 2020a, p. 96) continue to live below the at-risk-of-poverty threshold of their country and to be affected by high unemployment rates and low health insurance coverage, which along with the lack of civil registration and identification documents deprive many Roma of qualifying for support and welfare benefits (UN General Assembly 2014, paras. 32 and 36; European Union Agency for Fundamental Rights 2016a, 2020a). Furthermore, evidence indicates that approximately one in two Roma (41%) in the nine EU Member States surveyed in 2016 experienced intolerable levels of discrimination on the grounds of their ethnic origin at least once in one of the areas of daily life, such as at work, in education, and in healthcare, within the past 5 years, hindering their access to essential services (European Union Agency for Fundamental Rights 2016a, p. 11). Equally important, in terms of health outcomes available data reveal that Roma are vulnerable to ill health and are often exposed to serious health hazards and premature death from concomitant diseases; they disproportionately suffer from disabilities and chronic diseases, such as diabetes, hypertension, cardiovascular and pulmonary diseases, as well as from avoidable illnesses, nutritional deficiencies, and malnutrition (World Health Organization Regional Office for Europe 2012; European Union Agency for Fundamental Rights 2020b, p. 19). Life expectancy among Roma and Travellers is reportedly lower compared to that of the general population in the six EU Member States surveyed in 2019: life expectancy at birth for Roma women is 9.8 years shorter than among women in the general population, while for Roma men is at 10.2 years (European Union Agency for Fundamental Rights 2020a, p. 63).

Crucially, the COVID-19 pandemic laid bare the entrenched structural socioeconomic health inequalities to which many Roma are highly exposed on the grounds of their ethnic origin and which particularly affront Roma's dignity with long-lasting detrimental effects on their health and living conditions in general (European Union Agency for Fundamental Rights 2020b). Admittedly, while the COVID-19 pandemic threatens all members of society, Roma communities are disproportionately affected due to the structural barriers that are reproduced in the COVID-19 response (European Union Agency for Fundamental Rights 2020b). Roma communities face heightened risk of contracting COVID-19 particularly those living in socially excluded and marginalized conditions, such as, in impoverished, substandard and overcrowded housing conditions, in geographically segregated informal settlements (European Union Agency for Fundamental Rights 2020b, p. 7). The COVID-19 pandemic exacts a disproportionate toll on the lives of Roma communities, exacerbating existing long before the onset of the pandemic socioeconomic health inequalities, while revealing gaps in the capacity of local authorities to enable and practically support socially excluded and marginalised Roma by providing them equal access to all mainstream poverty reduction, employment, and other social inclusion schemes (European Union Agency for Fundamental Rights 2020b, p. 28).

All in all, this disturbing, constantly lived Roma reality largely unveils a pattern of systematic discrimination against many Roma communities which leads to a wide array of health and human rights challenges inextricably linked to their disadvantaged socioeconomic backgrounds. Not coincidentally, the Commission on the Social Determinants of Health (CSDH) established by the World Health Organization

(WHO), has pointedly noted that the ‘structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries’ (Commission on Social Determinants of Health 2008, p. 1). Attention, thereby, must be paid at the “causes of the causes”, namely on the fundamental structures of social hierarchy and socially determined conditions, in which people live, grow and work (e.g., access to healthcare, education, housing conditions, environmental hazards, and biases within society), that are eventually decisive factors for health inequalities (Commission on Social Determinants of Health, 2008, p. 42; see also, Toebes et al. 2012, pp. 213–226). Meanwhile, given that Roma in Europe constitute a heterogeneous community, ethnic marginalization intersects with various other aspects of Roma identity and unique characteristics, involving gender, age, migrant status, local identities, rendering Roma socioeconomic health inequalities even more complex that go across generations (European Commission 2020; Council of the European Union 2021). Significantly, in the case of *Oršuš and others v. Croatia* the ECtHR explicitly recognized that “[...] as a result of their history, the Roma have become a specific type of disadvantaged and vulnerable minority [...]. They therefore require special protection. [...] special consideration should be given to their needs and their different lifestyle both in the relevant regulatory framework and in reaching decisions in particular cases [...] not only for the purpose of safeguarding the interests of the minorities themselves but to preserve a cultural diversity of value to the whole community” (European Court of Human Rights 2010, paras. 147–148).⁴

Without doubt, the lesson is rather clear: Roma socioeconomic health inequalities and vulnerabilities are issues of political will that call for efficient State investment in efforts to counter anti-Gypsyism, persistent patterns of exclusion and disadvantage that are inextricably associated with the adverse Roma socioeconomic health status, while promoting effective Roma participation in decision-making processes and building trust among all the members of the society to break the vicious cycle of stigma against Roma. To this end, in literature it is asserted that there should be a shift in existing power structures between Roma and non-Roma by paying particular attention to the adverse impact of racism on Roma which undermines their socioeconomic health rights and affronts their dignity (Van Baar and Kóczé 2020, p. 21). It is within this context that Matache pointedly notes “[W]e should be able to start exploring critically the social power and privileges of dominant majority populations and their impact on the education and other social and economic rights of Romani people. We need to start exploring the language and the mechanisms of racism and whiteness in law, policy and practice” (Van Baar and Kóczé 2020, p. 21).

⁴ The ECtHR reiterated an approach earlier expressed in *Chapman v. the United Kingdom* (Application no 27238/95, 18 January 2001).

From Standard-Setting to Practice

Article 28 of the Universal Declaration of Human Rights (UDHR 1948) provides that “[E]veryone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realized”. Under this provision it becomes clear that a structural modification of social and international conditions is required so as everyone’s rights and freedoms, including socioeconomic health rights recognized in the UDHR, can be fully realized (Universal Declaration of Human Rights 1948, Articles 22–25; see also, Eide 2001). Against this background, the International Covenant on Economic, Social and Cultural Rights (ICESCR) elaborated further this requirement by way of standard-setting. Since its adoption in 1966, ICESCR has provided an important global standard for ensuring socioeconomic health rights.⁵ Article 12 paragraph 1 ICESCR (1966) recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” (right to health), which is broadly interpreted by the UN Committee on Economic, Social and Cultural Rights (CESCR), the oversight body for the implementation of the ICESCR, as embracing the right to healthcare as well as a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life, and thereby extending to the underlying determinants of health (such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment) (UN Committee on Economic, Social and Cultural Rights 2000, para. 4). In addition, Article 2 paragraph 2 ICESCR (1966) sets out that the rights enunciated in the Covenant should be exercised without discrimination, a critical component of human rights law (Vandenhole 2005). Thereby, within this context, the precarious situation of Roma across Europe raises issues of great concern from a right to health lens relative to the increasing socioeconomic health inequalities detected in many Roma communities, as earlier mentioned, and calls for the transformation of structural conditions affecting the realization of Roma health rights.

Delineating Roma Health Rights Obligations

The General Comment No. 14 on the right to health, issued by the UN CESCR to assist State parties with the implementation of their health obligations, is particularly important when it comes to addressing socioeconomic health inequalities and discriminatory practices which obstruct the equitable enjoyment of the right to health by all people (UN Committee on Economic, Social and Cultural Rights 2000). In this regard, the UN CESCR provides guidance on the scope of the legal state obligations to respect, to protect and to fulfill the right to health for all individuals and groups (UN Committee on Economic, Social and Cultural Rights 2000, paras. 33–37). Drawing primarily on this source and particularly, on the basis of this

⁵ As of 5 January 2022, 171 States are parties to the International Covenant on Economic, Social and Cultural Rights.

tripartite typology of legal obligations, we can discern an overarching framework that can operate as a tool by which to identify the types of state measures required for effectively addressing Roma health inequalities and vulnerabilities at all times.⁶

In particular, the obligation to respect the right to health requires the State itself, *inter alia*, to refrain “from denying or limiting equal access for all persons”, especially for vulnerable groups to preventive, curative and palliative health services; and to abstain “from enforcing discriminatory practices as a State policy” (UN Committee on Economic, Social and Cultural Rights 2000, para. 34). Viewed in this light, the obligation to respect can generate active engagement of civil society to put pressure on States to refrain from imposing discriminatory practices based on prejudice and bias against Roma especially in the provision of state welfare services. In other words, under their obligation to respect, States are obliged to ensure that their actions do not impede Roma access to welfare services and benefits; and to revisit or repeal or even avoid adopting laws and policies that might create an environment for entrenching the root causes of Roma health inequalities and vulnerabilities, such as abuse against Roma patients, Roma segregation in healthcare facilities (UN Committee on Economic, Social and Cultural Rights 2000, para. 50; UN General Assembly 2014, para. 32). In practice, potentially the operationalisation of the obligation to respect can be achieved on the part of the States by undertaking health rights impact assessments. Before the finalization and introduction of state Roma health-related policies, social impact assessments can be used as an administrative measure for ensuring that the proposed policies operate in a manner consistent with human rights principles, particularly with the general principle of non-discrimination while reducing potential negative effects (Generally, see Gostin and Mann 1999; UN General Assembly 2007, para. 37; Potts 2008a, p. 20). It is within this context that the former UN Special Rapporteur on the right to health, Paul Hunt, has underscored that “vulnerability and disadvantage are among the reasonable and objective criteria that must be applied when setting priorities” (UN General Assembly 2007, para. 26).

At the same time, States have an obligation to protect the right to health of individuals and particularly vulnerable populations from violations by third parties (UN Committee on Economic, Social and Cultural Rights 2000, paras. 33, 35, and 51). The obligation to protect requires States to ensure appropriate legislative and regulatory control over the behaviour of predominantly non-State actors (e.g., private health professionals) (UN Committee on Economic, Social and Cultural Rights 2000, paras. 35 and 51). As part of the obligation to protect, States primarily need to adopt and/or revisit the oversight policies of third parties towards the prevention of practices in State institutions and broader society (e.g., private health professionals) that may jeopardize the equitable enjoyment of the right to health by Roma communities. In fact, in terms of Roma-targeted measures it can be

⁶ See for an analogous approach, namely the application of the human rights typology of State obligations to respect, to protect and to fulfill in terms of identifying a national framework for action against health sector corruption, Alexiadou E A (2022) Advancing right to health considerations in national responses against health sector corruption: the case for action. *International Journal of Human Rights in Healthcare*. <https://doi.org/10.1108/IJHRH-06-2022-0054>.

discerned that under this obligation States are required, *inter alia*: (1) to adopt or revisit legislation that regulates both the public and private health sector (e.g., health insurance companies, health professionals, and other health service providers) in order to refrain from harmful practices and (verbal or physical) abuse against Roma people, involving Roma segregation in healthcare facilities, substandard healthcare in conjunction with the imposition of excessive informal payments, forced, coercive, and otherwise involuntary sterilization of Roma women, and even refusal of medical treatment. Alarming, FRA research project LERI (Local Engagement for Roma Inclusion), which examined the situation of Roma in the city of Pavlikeni (Bulgaria) as a case study in 2016, reported that informal additional payments were requested from Roma patients by service providers (such as general practitioners, doctors), when Roma sought care, thereby seriously impeding their accessibility to affordable and of good quality healthcare services, such as preventive healthcare services (European Union Agency for Fundamental Rights 2016b, p. 7). At this stage, it is essential to note that over the years the ECtHR has increasingly engaged with Roma health-related issues, primarily as regards to cases of forced sterilization of Roma women.⁷ In the case of *V. C. v. Slovakia* the Court held that “the absence at the relevant time of safeguards giving special consideration to the reproductive health of the applicant as a Roma woman resulted in a failure by the respondent State to comply with its positive obligation to secure to her a sufficient measure of protection enabling her to effectively enjoy her right to respect for her private and family life” (European Court of Human Rights 2011, para. 154). Nevertheless, the Court decided not to examine the applicant’s complaint under Article 14 of the European Convention on Human Rights (prohibition of discrimination) and as such it refrained from recognizing the systemic shortcomings in the legislation as a (direct or even indirect) mechanism of discrimination against Roma on racial/ethnic grounds (European Court of Human Rights 2011, paras. 178–180); (2) to adopt monitoring mechanisms aimed at supervising State and non-State actors conduct in healthcare settings in such a way that potential unethical, discriminatory conduct, maltreatment, abuse of Roma patients as well as other harmful acts or omissions that have an adverse impact on Roma access to healthcare and health-related services may be detected, and practices to the detriment of Roma health rights may be prevented; (3) to establish accessible redress mechanisms for Roma people to complain about failures or malpractice associated with unethical and discriminatory practices in healthcare settings; (4) to establish participatory mechanisms for the actual engagement of Roma (and their representatives, such as supporting Roma NGOs) in all stages of the health-related policy-making cycle, namely from design to policy implementation to address their specific needs and challenges and to bring a positive long-lasting change in Roma life (UN Committee on Economic, Social and Cultural Rights 2000, paras. 33, 35, and 51; UN General Assembly 2014, paras 32, 58 and 101; for example, see World Health Organization Regional Office for Europe 2016; World Health Organization Regional Office for Europe 2019).

⁷ See, for instance, European Court of Human Rights (2009) *K. H. and Others v. Slovakia*, Application no. 32881/04. European Court of Human Rights (2012a) *N. B. v. Slovakia*, Application no 29518/10. European Court of Human Rights (2012b) *I. G. and Others v. Slovakia*, Application no 15966/04.

The obligation to fulfill the right to health—entailing the “obligations to facilitate, provide and promote”—requires States “to give sufficient recognition to the right to health in national, political, and legal systems” by way of undertaking proactive measures (such as legislative, administrative, budgetary, judicial, and other measures) that facilitate the unimpeded enjoyment of this right by all individuals and communities (UN Committee on Economic, Social and Cultural Rights 2000, paras. 33, 36–37 and 52–56). In relation to Roma, the obligation to fulfill therefore requires States, among other things: (1) to adopt a national Roma-targeted strategy that encompasses equity considerations and the principles of non-discrimination, accountability and participation so as to ensure that Roma communities remain visible in all stages of the strategy-making process (see in relation, UN Committee on Economic, Social, and Cultural Rights 2000, paras. 12(b), 36, 43(f), 52–56 and 62). This national strategy should formulate corresponding socioeconomic health policies that are context sensitive and respond to the special needs and experiences of Roma communities by virtue of their marginalized social status (UN Committee on Economic, Social and Cultural Rights 2000, para. 53). Additionally, this strategy must be accompanied by appropriate Roma context-sensitive indicators and benchmarks to periodically monitor and assess its progress to the benefit of Roma communities (European Commission 2020, annex; UN Committee on Economic, Social, and Cultural Rights 2000, paras. 43(f), 53 and 56–58). Equally important, it is widely acknowledged that the collection of disaggregated data can also help ensure effective Roma policy design, assessment and monitoring of progress (Mirga 2017, p. 123). At the same time, States must provide the necessary financial and human resources to implement and monitor this national strategy in virtue of their general requirement for allocating “the maximum of their available resources” under Article 2 paragraph 1 ICESCR (International Covenant on Economic, Social and Cultural Rights 1966; UN Committee on Economic, Social and Cultural Rights 2000, para. 53); (2) to establish participatory procedures for Roma engagement in decision-making processes in order to determine the nature and form of such strategies and as such to foster a vibrant space for the active involvement of Roma communities themselves (and their representatives, such as supporting Roma NGOs) by way of providing open access to public information about the formulation and implementation of health-related programmes and policies (UN Committee on Economic, Social and Cultural Rights 2000, paras. 12(b) and 54; UN General Assembly 2014, paras 58 and 101; World Health Organization Regional Office for Europe 2016). Admittedly, socioeconomic health policies and strategies are most meaningful when the intended beneficiaries of such measures are involved in all aspects of policy and strategy development, implementation and evaluation (World Health Organization Regional Office for Europe 2016). In literature, it is argued that participation primarily aims to acknowledge and respect difference and diversity within the population by ensuring inclusiveness in the development and implementation of health policies (Potts 2008b, p. 20). In fact, the Council of the EU (2021, p. 11, paras. 11–13) recommended all EU Member States to enhance the operation of national Roma contact points in order to facilitate the participation and involvement of Roma civil

society in the design, implementation, monitoring and evaluation of national Roma strategic frameworks and local action plans. Nevertheless, as some commentators pointedly observe, EU Member States “must ensure the engagement of Roma themselves as active agents of change rather than passive recipients of help” (Mirga 2017, p. 126).; (3) to take measures, pursuant to the general requirement for “international assistance and cooperation” on the basis of Article 2 paragraph 1 ICESCR (1966), towards generating and strengthening transnational cooperation related to Roma access to healthcare and other welfare services to the benefit of Roma communities and society at large. This requires States to act collaboratively, for instance, in procedures regarding the formulation of Roma-targeted strategies by means of repealing discriminatory laws and policies that encourage Roma segregation from mainstream society; and to share and adopt best practices in promoting Roma inclusion.

In fact, at regional level, in terms of ensuring Roma equal and unimpeded access to quality healthcare and social services, the Council of the European Union (2021, p. 10, para. 9(k)) recommended the exchange and transfer of best practices related to public health for Roma people, for instance by employing the public health framework of the European Commission and the Member States in the Steering Group on Health Promotion, Disease Prevention and Management of Non-Communicable Diseases; as well as the Committee of Ministers of the Council of Europe suggested its Member States to design and develop cooperative appropriate Roma inclusive strategies and structures through transfers of knowledge, processes and mechanisms, such as the promotion of Roma (health) mediation towards tackling Roma health inequalities and vulnerabilities (Council of Europe 2012b). Accordingly, for reducing socioeconomic health inequalities the CSDH made three overarching recommendations addressed to all responsible actors, namely: (1) to enhance daily living conditions-circumstances; (2) to tackle the inequitable distribution of power, money, and resources, namely the structural drivers of socio-economic health inequalities; and (3) to measure and understand the problem and assess the impact of action and raise awareness about the social determinants of health (Commission on Social Determinants of Health 2008, p. 2), whose implementation can generate considerable lasting changes for Roma by breaking the vicious cycle of marginalization and poverty with positive society-wide outcomes.

Last but not least, when it comes to fulfilling the human rights obligations towards tackling Roma health inequalities and vulnerabilities on the part of States, due attention should also be paid to the effective implementation of four interrelated right to health elements, namely availability, accessibility, acceptability and quality (collectively AAAQ) (UN Committee on Economic, Social and Cultural Rights 2000, para. 12). Specifically, the AAAQ, as set out by the CESCR in its General Comment no. 14, require health services, programmes and goods: to be available in adequate quantity-numbers; to be physically, geographically, and financially accessible as well as accessible on the basis of non-discrimination and information accessibility; to be acceptable, namely respectful of the culture of individuals, minorities, and communities, gender sensitive and sensitive to life-cycle requirements; and to be of good quality (UN Committee on Economic, Social and Cultural Rights 2000, para. 12). Accessibility constitutes an important parameter to health equity as it

encompasses non-discriminatory access, which requires inclusion of the most vulnerable and marginalized sections of the population, like Roma communities; geographical accessibility which requires health facilities, services and supplies to be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups in rural and remote areas; and affordability which requires health services to be equitable and affordable for all, including socially disadvantaged groups (UN Committee on Economic, Social and Cultural Rights 2000, para. 12(b); World Health Organization Regional Office for Europe 2019, p. 4). Interestingly, in light of the aforementioned, the AAAQ can operate as a guidepost for the formulation and eventually for the assessment of Roma access to health services and goods (e.g., access to affordable healthcare, to health insurance coverage, vaccination services, medicines, and other medical products), while at the same time detecting potential acts or omissions that fuel Roma segregation and discriminatory attitudes against Roma communities when seeking needed care. States therefore need to ensure that the AAAQ framework is not negatively influenced by societal prejudices that tend to perpetuate Roma segregation from mainstream society and eventually erode any effort for noticeable change in the position of Roma, namely the four interrelated elements are not infringed due to discriminatory practices against Roma people (Council of the European Union 2021, pp. 9–10, para. 9). Speaking practically, States should ensure that the availability, accessibility, acceptability and quality of health facilities, services and goods are guaranteed at all times and at all levels, primarily at the allocation of sufficient (financial and human) resources for the implementation of Roma-targeted health policies and programmes; at the equal distribution of health facilities, services and supplies to reach out to Roma communities in marginalized and remote localities; and in the relationships of health professionals with Roma patients (Council of the European Union 2021, pp. 9–10, para. 9). Within this context States need to train health professionals for recognizing and addressing discrimination and its root causes, involving unconscious bias, as well as to establish and promote Roma health mediation so as to reduce (communicative and other) obstacles between Roma and public institutions in relation to their health insurance coverage, healthcare and vaccination access, and ultimately to improve quality of life for Roma communities (Council of Europe 2012b; European Commission 2020, Annex; Council of the European Union 2021, p. 9, para. 9(b) and (c)).

Towards Accountability

When employing a human rights approach it is also critically important to generate accountability for Roma health equity efforts to serve as check on the exercise of power of responsible actors for realizing Roma entitlements. Interestingly, in human rights discourse several accountability forms, ranging from judicial, quasi-judicial (e.g., national human rights institutions), administrative (e.g., human rights impact assessment), political (e.g., parliamentary procedures), to social (e.g., public hearings), are identified for their potential to monitor rigorously the progress of health-related policies and laws and their compliance with human rights requirements (UN Committee on Economic, Social and Cultural Rights 2000,

paras. 55 and 59; Potts 2008a, pp. 13–17; Yamin 2008; World Health Organization 2017). Furthermore, the UN CESCR in its General Comment No. 9 acknowledged the state obligation to provide appropriate means of redress or remedies while ensuring governmental accountability as part of the general obligation to give effect to the rights recognized in ICESCR (UN Committee on Economic, Social and Cultural Rights 1998, para. 2). Equally important, in 2000 the UN CESCR particularly underscored in its General Comment No. 14 that States have a duty to promote accountability associated with the realization of the right to health as well as information accessibility, a crucial element for driving accountability process to redress, remedy, policy review and ultimately to the enforcement of health rights (UN Committee on Economic, Social and Cultural Rights 2000, paras. 12(b), 55 and 59; Potts 2008a, p. 13; World Health Organization Regional Office for Europe 2019, p. 5). Meanwhile, in 2017 the UN High-Level Working Group on the Health and Human Rights of Women, Children and Adolescents called on all States “to ensure that national accountability mechanisms (for example, courts, parliamentary oversight, patients’ rights bodies, national human rights institutions, and health sector reviews) are appropriately mandated and resourced to uphold human rights to health and through health. Their findings should be regularly and publicly reported by States” (World Health Organization 2017, p. 9).

At the same time, the former UN Special Rapporteur on the right to health, Paul Hunt, has also explicitly raised the issue of accountability within the context of health rights realization: (1) by identifying several existing diverse forms of accountability mechanisms, such as national human rights institutions, health commissioners, democratically elected local health councils, public hearings, patients’ committees, impact assessments, and judicial proceedings; and (2) by further underlining the need for effective, transparent, accessible, and independent accountability mechanisms for driving accountability for the right to health (UN General Assembly 2008, para. 11). Nevertheless, the Special Rapporteur’s approach might denote that accountability mechanisms often fail to capture and remove the barriers that vulnerable groups, such as Roma, experience in pursuing remedies for breaches of their rights. Interestingly, FRA data highlight that only one third of respondents (33%) of Roma and Travellers in the six EU Member States surveyed in 2019 were aware of at least one institution to claim their rights by using available legal remedies, which might justify the low rates of reporting anti-Roma discrimination, despite the high prevalence rates of such discrimination and the significant disadvantages encountered by Roma across Europe (European Union Agency for Fundamental Rights 2016a, pp. 40–41; European Union Agency for Fundamental Rights 2020a, p. 17). Here, it is essential to mention that pursuant to the EU Racial Equality Directive States are required to raise people’s awareness of anti-discrimination legislation and ensure appropriate and (financially, geographically and linguistically) accessible remedies (including compensation) in the event of failed/harmful policy or implementation (Council Directive 2000/43/EC, pp. 22–26; see also, European Union Agency for Fundamental Rights 2020a, p. 17).

Meanwhile, in addition to building on domestic accountability systems, existing regional mechanisms, such as the European Committee of Social Rights (ECSR) with its collective complaint procedure, represent forms of accountability which can be employed by victims of rights violations as a means for redress.⁸ Over the years, the ECSR—a quasi-judicial body responsible for monitoring the application of the (revised) European Social Charter (1961, Revised European Social Charter 1996)—has increasingly addressed the issue of Roma health inequalities under the system of collective complaints in terms of challenging domestic policies and legislation that perpetuated structural discrimination owed to ethnic origin. In the Complaint No. 46/2007, brought by the European Roma Rights Center (ERRC) against Bulgaria, the ECSR (2008) explicitly addressed Roma socioeconomic health inequalities. The Committee underlined that Roma communities in Bulgaria encountered disproportionate health risks partly attributable to their poor and unhealthy living conditions, while acknowledging that their health status was “inferior to that of the general population” (European Committee of Social Rights 2008, paras. 46–47). Crucially, the Committee concluded that the failure of the authorities to take appropriate measures to tackle the exclusion, marginalization and environmental hazards to which Roma communities were exposed in Bulgaria, as well as the difficulties encountered by many Roma in accessing health care services constituted a violation of Roma rights (European Committee of Social Rights 2008, para. 51). Further, in 2009, in the case of Complaint No. 48/2008, which was lodged by the ERRC against Bulgaria, the Committee once again affirmed the particular disadvantaged status of the Roma in Bulgaria, by noting the serious impediments faced by Roma in gaining access to the labour market and the increased dependence of Roma on social assistance (European Committee of Social Rights 2009, para. 45). The Committee therefore decided that the amendments to the Bulgarian Social Assistance Act would have had a considerable negative impact on unemployed Roma in terms of living in a manner compatible with their human dignity (European Committee of Social Rights 2009, para. 43). Surprisingly though, the Committee merely addressed the difficulties of Roma in accessing the labour market without going further to consider the overall context of prejudice and discrimination (indirect discrimination as a minimum) against Roma, namely the root causes of their substandard treatment in Europe (European Committee of Social Rights 2009, pp. 16–17 and 11, paras. 45–46).

Additionally, in the Complaint No. 67/2011, brought by the Médecins du Monde-International against France and concerned migrant Roma from Romania and Bulgaria living in France in extremely precarious situation, the ECSR pointedly noted that in democratic societies diversity is not perceived as a threat but as a source of enrichment (European Committee of Social Rights 2013, para. 39). The Committee thereby held that special consideration should be given to the needs and different lifestyle of the Roma, by also affirming that Roma are a specific type of disadvantaged group and a vulnerable minority (European Committee of Social Rights 2013, para. 40). As a result, the Committee reached its decision by considering the specific problems encountered by Roma communities due to their often substandard living conditions and difficult access

⁸ Articles 1–2, 5 and 8(1), Additional Protocol to the European Social Charter Providing for a System of Collective Complaints, ETS No. 158, adopted on 9 November 1995, entered into force on 1 July 1998.

to health services (European Committee of Social Rights 2013, para. 144). In a similar vein, in 2016 in the case of European Roma and Travellers Forum (ERTF) v. the Czech Republic, the ECSR addressed Roma socioeconomic health inequalities. The Committee considered that the Czech Republic had not sufficiently ensured “healthcare for poor or socially vulnerable persons who become sick, such as Roma who have lost health insurance” and encountered disproportionate health risks (European Committee of Social Rights 2016, paras. 119–120). Once again, the Committee critically pointed at the State’s failure to take reasonable steps to address the specific problems endured by Roma communities that stem from their often unhealthy living conditions and the difficulties in gaining access to health services compounded by the exclusion and marginalization in the field of health to which Roma communities are often exposed (European Committee of Social Rights 2016, paras. 127–128). And in the recent decision of European Roma Rights Centre (ERRC) v. Bulgaria, which concerned Roma women access to maternity services in Bulgaria, the ECSR placed emphasis on the overall discrimination that Roma still suffer in accessing health care, while making the further point that this alarming situation has not been redressed the last 10 years following its decision in ERRC v. Bulgaria (Complaint No. 46/2007) (European Committee of Social Rights 2019, para. 85). Evidently, the Committee established that healthcare for Roma is inferior to that of the rest of the population on account of “the overall lower health status of Roma reflected in official statistics, the higher amount of uninsured Roma as compared to the rest of the population and the difficulties in accessing public hospitals as a consequence of geographical distance and other barriers” (European Committee of Social Rights 2019, para. 85). Overall, it is plausible to discern that in its aforementioned case law the ECSR has taken an explicit stance for the cumulative effects and interrelationships between Roma health and Roma socioeconomic status by considering their financial hardship; the poor living conditions; the high unemployment rate; the extent of access to health services and social protection schemes; the persistent social exclusion and ethnic marginalization, as factors that determine the health status and outcomes of Roma communities across Europe.

Conclusion

The preceding analysis markedly affirmed that Roma communities still remain a neglected population group across Europe. Roma communities continue to experience structural socioeconomic health inequalities on the grounds of their ethnic origin, alarmingly unveiling a pattern of systematic discrimination and ethnic marginalization which affronts their dignity with far-reaching repercussions for their health and human rights. Without any doubt, such a highly disturbing situation calls for States to incorporate Roma health rights within their law and policy agendas with specific implementation in a manner consistent with right to health requirements by: (i) regulating and assessing State and non-State performance through focusing on equity and non-discrimination considerations; (ii) placing explicit attention to the experiences and concerns of Roma communities throughout the processes of design and development of Roma-targeted policies; (iii) promoting consultation with and participation of Roma communities (and their representatives) in the

design and determination of Roma-targeted policies; (iv) employing an effective data monitoring system (on a disaggregated basis) to assess implementation progress and impacts of state efforts on Roma health and life outcomes so as to generate corrective action whenever necessary; and (v) introducing, independent, effective, accessible, and enforceable complaints mechanisms and legal remedies to be employed in the event of Roma rights violations, while also raising awareness among Roma communities about the existence of such mechanisms. All in all, it must be conceded that it is through continuing, concerted and proactive State engagement that the structural obstacles impeding Roma health rights realization could be more effectively addressed in the future.

Declarations

Conflict of Interest The author declares that there is no conflict of interest.

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