Health, Prevention of Addictions and Roma Youth in Europe

A Handbook and Actions for Practice
WORKGROUP

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FOREWORD

The development of this manual is framed within the European Project SRAP (Addiction prevention within Roma and Sinti communities) funded by the Health Programme 2008-2013. Led by the City of Bologna and ten more organizations¹, the overall objective of this project is to contribute to the prevention and reduction of the use / abuse of legal and illegal substances among young Roma people.

Meanwhile FSG, given its experience in the field of health services, is responsible for one of the work packages of this project: Improving the capacity of health services and addictions. The result is this handbook which provides a series of policy proposals aimed at correcting inequalities in relation to addictions and the access of Roma to the public health system.

¹ Cooperativa Sociale Societa Dolce Societa Cooperativa – DOLCE (Italy), Health and Social Development Foundation – HESED (Bulgaria), Fundatia Parada – PARADA (Romania), Fundación Secretariado Gitano – FSG (Spain), Hors la Rue Association – HLR (France), City of Venice (Italy), Forum Européen pour la Sécurité Urbaine Association – EFUS (France), Roma Public Council Kupate – RPC KUPATE (Bulgaria) – RIC NOVO MESTO (Slovenia), Trnavska Univerzita V Trnave – TU-FZS (Slovakia).
PART I: A HANDBOOK FOR PRACTICE
1) PRESENTATION

The Roma community in Europe shows great diversity. However, in general, their social and economic situation is more deficient than the average population, which strongly influences a worse health status. Also, their health is also affected by prejudice and discrimination they have suffered historically and continue to exist towards these people, situations where European health systems and professionals are also involved.

The ultimate aim of this Handbook is to help removing barriers faced by the Roma community in Europe to access to Health and Addiction Services, and thus to influence the reduction of inequalities in health that they suffer. To achieve this purpose we will provide to health professionals who work with the Roma community practical information to enable them to know and understand the specifics of this culture, in particular their relationship to health and drugs and tools to enable them to improve their skills in working with the Roma community and its youth.

The target population of this Handbook is the young Roma, which due to their own characteristics, we place between 11 and 25 years old. However, this Handbook also seeks to influence the entire Roma community on general health aspects and on the issue of addictions in particular.

It is intended to health professionals working in primary care centres in hospitals and emergency services, as well as Service Centres and/or Prevention of Drugs Consumption.

PROPOSED METHODOLOGY AND METHOD OF PREPARATION

This is a handbook that provides a theoretical framework underlying the practical proposal to be offered to work with health professionals. The methodology is based on a dialectic proposal, from the knowledge, understanding and practice of health professionals regarding the Roma community (mainly the youth), their health and drugs. From this point, the Handbook reflects and deepens their social reality, their culture and the relationship they have with health and drugs, and finally, having a better understanding of this reality, trying to offer elements for improving social care practice and facilitate access of Roma to health care.

The complete proposal consists of two integrated parts: the first, for the Handbook for Practice, which contains the basic contents and the second, Actions for Practice, which presents a didactic proposal, with which we can work the contents in groups, with Health professionals.

The structure of the Handbook coincides with the proposed Methodology:

1) The first about "what we know", "what is spoken", "health practice" in relation to Roma, based on studies that exist in this regard as well as how these ideas affect health systems.

2) A second part that provides data available on the social reality of the Roma community in Europe, key cultural elements, as well as some fundamental ideas in relation to health and drugs.
3) The third part, "Return to Practice", offers practical and theoretical tools to incorporate socio-cultural situation of the Roma community into the health systems, into the professional practice and in the design of prevention programs of drug addiction for Roma youth.

To prepare this manual existing literature has been consulted in the following areas: drug prevention, Roma and health. There have been interviews with professionals who regularly work in these areas. Finally, the contents and the methodology have been tested with a Local Stakeholder Advisory Committee composed by experts (hereinafter Advisory Committee), which has allowed completing and validating this manual².

2. HOW IS OUR RELATIONSHIP WITH THE ROMA COMMUNITY AND THE YOUTH PEOPLE? “STARTING FROM WHAT WE KNOW”

To improve care for Roma youth on health and drug abuse prevention, one of the key elements is the quality of the relationship and the rapprochement between the health professionals and

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² The handbook includes contributions made by representatives of this Committee: Piedad Perea Cañizares – Expert on Social Intervention in Cañada Real Galiana (Madrid) – FSG; Josefa García Cuerva Gómez – Social Worker in the Health Centre “El Espinillo” (Villaverde – Madrid); José Mª Peñas Pascual – Director of the Centre for Comprehensive Treatment of Drug Addicts (CAID Sur – Ayuntamiento de Madrid); Fernando García García – Expert on Social Intervention and Health Projects (Madrid) – FSG; Yolanda Nieves Martín – Consultant in the Innovation Department of Fundación Atenea (Madrid).
the Roma in Europe. Hence, the first question we must ask and the starting point of this
discussion is: **What do we know about Roma?**

Of course, we know Roma, we see them in the office, in the hospital or in unit of resources in
which we work. Our position in health systems or social care, exposes us to contact all kind of
people and to have a continuous interaction that can be fluid, indifferent or conflicting. Even if
you do not personally know any Roma we can speak of them. Our own culture is full of ideas,
judgments and emotions related to Roma, as a significant minority, often close but sometimes
strange or different: admiration, curiosity, fear, contempt, irritation. This is an issue that is not
indifferent to us, since the game between majority and minority, in any context, is a serious
game, full of consequences.

The Roma community is exposed, as social minority, to the existing opinions about them. The
image sent back by society is deformed but Roma cannot avoid it, because they find it at every
turn. That "being spoken by others" is precisely the essential feature of belonging to a minority.
What is said, then, about Roma? Studies show that social attitudes about Roma are based on
three preconceptions, sometimes enchaind in a progression:

- **Idea 1:** Roma are different.
- **Idea 2:** Roma have more problems.
- **Idea 3:** Roma are the problem.

These ideas, seemingly objective, carry visions, change attitudes and provoke reactions in our
own behaviour. They affect our work, our expectations or the way we treat people. This is
acutely perceived by Roma youth. It is worth examining in more detail these three issues.

**IDEA 1: ROMA ARE DIFFERENT, THE MOVING BORDERLINE OF DIFFERENCE**

Different is a word a little rough, even attractive. In a mass society, being different can mean
being distinguished. However, we know that it can also be a way to designate, classify and
discriminate. That is, choosing a trait (ethnicity, for example) and turning it into a border
between us and the others. The greatest virtue of the difference is its indeterminacy: it is elastic
and can promote admiration or exclusion.

In the case of the Roma, difference has historically created exclusions: legal, residential, in
employment and economy. Dwindling rights, weak citizenship, less access to social resources,
social rejection and violence, overrepresentation in social exclusion landscape, including health
problems. The Roma community’s response has varied from time to time and region, but
generally it was a complex mixture of adaptation to the circumstances and protection of the core
elements of their culture.

**Which are the differences that we use to attribute to Roma?**

Usually three major types of differences are mentioned:

1. **Cultural:** We think that they have a unique culture, which we interpret as a number of traits
and values determined, more or less stable and uniform. These may be idealized or
rejected, usually both. We find exaggerated contrasts: it can be considered a more
traditional and "backward" society, more rural, less literate, more closed to changes, but
also more cohesive, more cheerful, less individualistic or materialistic.
It is also considered a society with different cultural and demographic traits: importance of the extended family, preference for marriage between Roma and sometimes between relatives, hierarchical roles established for gender and generation, form of settlement and residence, old and new professions. These traits form a specific cultural universe.

These traits are real, but as we shall see, are neither universal nor static, nor have the same weight or are inescapably linked. As in any culture, there is a historical context that gives stability, but there is also the ability to select or transform some traits or to abandon others.

Culture is the collective sense that we give to our actions. Therefore, we too are "beings of culture" and no culture is more or less advanced or static, but an set of adaptation and creativity within cultural frameworks. The culture of a group is always pragmatic, ie helping its members to live in a particular situation, to interpret and give meaning to their lives. This does not mean that there is no conflict with other interests or that cannot be in crisis.

2. Socio-economic. The second difference perceived and attributed to Roma is the socioeconomic one, without a clear distinction in mainstream discourse of cultural difference. They are seen as poorer and less integrated, they have less access to social goods and resources. They live on the margins. The idea of margin is very powerful: it is a spatial metaphor that corresponds to the location of certain settlements or neighbourhoods on the edges of cities or villages, translated into social metaphor. In the margins there is no rule, law or social networks of belonging. It's where we want to be.

Poverty is not simply seen as an economic trait. It is not the poverty of the working class or the old decent poverty, which meant living with little. Poverty is a suspect of wanting to perpetuate or to exist because people do nothing to change, because their culture is what leads them to that situation in the margin. Hence wealth of Roma, such as poverty, is suspicious. Culture and poverty are mixed in a way that ties Roma and their own destiny. This image ignores, once again, social change and large internal differences and status existing among Roma.

3. Moral: There is no vision of the other without an ethical value: being different is being better or being worse. The old racism considered Roma not only culturally diverse and socially backward, but basically unreliable, deceitful, lazy or dangerous to the order. This traditional repertoire has changed in urban society and with the public rejection of racism. Moral defects are now different: they are dependent, they take advantage of services or benefits, they are sexist, uneducated, unwilling to integrate. The language of modernity (the values we want to attribute as a society) are reflected upside: a society that considers itself advanced, autonomous, equal and improving looks itself in the deformed mirror of its margins.

IDEA 2: ROMA “HAVE MORE PROBLEMS”

The second feature or view in our relationship with and Roma is that they have more problems than the rest. No doubt much of Europe's Roma population lives in poverty and suffers discrimination. The reality shows that they have lower income and poorer conditions regarding housing, employment, education or health. But we must distinguish the specific problems, coming from an unequal structure, and those generated by discrimination or those that are exaggerated or invented.

There are certainly a large part of Roma that is vulnerable, "exposed to disadvantages and inequalities." These inequalities are added and strengthened: the majority of Roma in Europe
and have fewer regular jobs and less properties, live in worse places and in substandard housing, have less access to resources and protection. They have less social participation and presence in places of power. Their social networks are limited and in some areas their life is spent in segregated spaces (or marginal). All these conditions have impacts on health and life expectancy, on their self-esteem and on how to address the problems.

But the Roma community also has strengths and these should be incorporated into health work: its own resources, creativity, forms of care and comfort, leadership of various kinds, social and cultural assets that any approach should value and activate. Inequality does not necessarily imply that all indicators are worse. They may have poorer health in some ways, but not necessarily more drug addiction problems. In this case, there are three conditions:

- **The relationship with the drug may be different.** The contexts in which youth Roma live, their expectations or social images, affect the type of use and the age of onset, what is considered addiction, health and disease. These differences must be considered and understood by the professionals, like any involvement with any social group.

- **The effects of drug addiction on health may be worse,** because sometimes other economic or health conditions can play a role, such as poor access to health resources, the fact that many parents are very young, living in environments where there is selling drugs activity (which makes it harder to stay out), having less leisure possibilities and alternatives to consumption, etc...

- **The image and experience of the drugs may be worse.** This means that stigma may be more severe, within and outside the community, multiplying the problems associated with addiction: labour exclusion, loneliness and networking break, violence, associated diseases, etc.

Pursuing greater social balance treating differently the people who are experiencing inequality is an action performed continuously by Social State (in its tax system, pensions, scholarships...). This fact does not mean to attribute special traits to the group that receives such support, or to stigmatize it. But when it comes to minorities, attention to the difference tone acquires a particular tone, identitarian, which can lead to stigmatize the group.

**IDEA 3: ROMA “ARE THE PROBLEM”**

The third idea is a logical step that we make often when we think about “different” groups, ie not belonging to the majority culture. It is common to move from the idea of "vulnerability" to the idea of "danger". For example, in epidemiology, the "risk groups" can be seen as groups that require special attention or vigilance. Not infrequently, this focus ends up becoming an unconscious indictment.

This shift from "group with problems" to a "problematic group" also occurs in health systems. The idea that appears in some social and professional discourses is that Roma are more demanding, go more often to services, and are worst patients. As often happens with immigrants, their presence is more visible. It is not uncommon to hear that they are noisy or demanding, they come to hospitals in groups, they do not follow the recommendations, or do not meet the rules. Two ideas feed prejudice:

- Considering negative an attitude which the group itself see as acceptable or even positive, as the family accompanying the patient.
Assign to each and every person the behaviour previously defined as inadequate, which only a part of the collective performs.

More subtly, the two most common allegations are the following:

- **Abuse.** This conception comes from the idea that the Roma community does not belong to the general community, and therefore, it is not obvious that they deserve the attention given to them as citizens. Instead of having the image of a collective pact where all have rights, another picture is drawn, where a majority grants rights to a minority but conditioned upon proper use thereof. It is not the law, but the majority who decide when such use is not appropriate and could withdraw those rights if the other takes advantage of its use.

- **Passivity.** It relates to the feeling that providing to certain groups grants and benefits can lead to their dependency and passivity. The idea of “false poor” people living on grants or doing nothing to improve their lives has pursued social work since its inception and is a classic critique of the welfare state. According to this discourse, Roma fit with this definition: it is assumed that they are given much; we see that the situation does not change substantially and they are blamed for the lack of progress.

The logical step of this argument does not hold, because the Roma community as specific group received no more than the rest. In any case, they have made less use of certain services and benefits. In other cases, no doubt they have benefited from policies addressed, for example, to eradicate slums, precisely because they are the last European citizens living in substandard housing. But the mixture of irritation towards those who does not belong to the common culture and frustration for our inability to change the social structure makes us to blame precisely those who suffer the situation.

### 2.1. WHAT IS THE IMPACT OF THESE IDEAS INTO THE BEHAVIOUR OF THE HEALTH SYSTEM?

These ideas and feelings determine many of the views of the community and health professionals as well as the rest of society. There are three classic effects generated by the distance with others in the daily work of the professionals:

- **Difficulty of identification.** If we feel that others are different we have more difficulty to be identified with them, to put us in their place or to create opportunities for communication. Common aspects disappear and we focus on the differences. So we can be surprised by the complaint or the pressure that show many patients and anxious families, but we will ascribe it to a cultural feature of the group. Our expectations worsen and we put on the defensive with Roma.

- **Stubborn defense of one's own culture.** This lack of identification breaks the necessary pact with the patient, but also prevents a critical view of their own values. It seems that only the others have a culture. But the health system, as a powerful public agent to which we belong, has values, culture, discourse and power to impose it. Two examples:
  - Individualization of the disease as a completely private matter that each individual manages and is responsible for. This is a relatively new view in History, with great advantages in individual attention but serious problems, such as the loneliness in which each person is left with his/her disease and cure. This does not happen in the Roma culture, where the disease is especially felt by the whole family, with a strong emotional component.
Separation between any spiritual aspect and the body's health. This desecration of the human body, effect of a secularized society, is not common to all cultures. It is not well understood in cultures where religion is a basic issue, and certainly it is alien to the experience of many Roma evangelicals, for whom healing has a moral and spiritual dimension (Comas, 2010).

- **Frustration.** When we define a culture or group as more backward or having serious problems, we close the door to gradual change and improvement. We put them in a situation of “all or nothing”. Among many professionals who are not Roma, but work with them, there are two opposing views:
  
  o Radical change of Roma culture and life. Some discourse argues that the only way to solve problems is substantially changing the living conditions of Roma and the cultural patterns that prevent full integration.
  
  o Defense of their identity. The other pole of discourse is to exaggerate the need for a strong Roma identity, political or social, and segregated. They should determine their lives, have their own offices, living in their neighbourhoods, maintain their language and values, etc… The discrediting of the idea of "assimilation" stimulates this idealization of the difference.

Both attitudes are relevant; they have changed attitudes in the past and determined public policies and government decisions that have had strong effects on Roma. Their problem is simplification and not respecting the change of the other:

- Simplification because they want to solve too fast problems and conflicts, with shortcuts. The only way is to choose the best moral position continuously, which needs commitment and it’s also difficult.

- Lack of respect to the possibility of change, because it ignores or forgets that the change in the groups with less power is determined by its own decisions; but in a context of adverse conditions and complexity, changing without losing the security and pride of the own group is very difficult.

When working with minorities, attention to the difference acquires a particular and identitarian tone. This cultural difference justifies an intervention tailored to the specific features of Roma and sensitive, where the incorporation of the key elements that characterize each group or individual will allow us to perform a more adequate and efficient intervention; ultimately, a higher quality intervention. This idea does not mean more work for health professionals, but to incorporate new concepts, different ways of looking at reality, new intervention methodologies that enable them to better fulfill their duties, obtaining better results in their daily work and reducing the possibility of occurrence of conflict (Garcia, 2006).

### 3. OVERVIEW OF THE ROMA CULTURE: "THINKING ABOUT THIS REALITY"

In the previous chapter we have analysed some of the metaphors that circulate regarding the Roma. In this chapter we provide some guidelines, information and ideas useful for a better understanding of their reality:

- An overview of the social reality of the Roma community and socio-cultural elements featured.
- Fundamental ideas about their relationship to health.
- More specifically, we will consider what we know about the relationship of Roma youth and drug use.

### 3.1 SOCIAL REALITY OF THE ROMA COMMUNITY

#### ORIGIN AND DIVERSITY

The European Roma are living in the continent since the fifteenth century. They migrated from a common origin (the region of Punjab in India) and dispersed in different waves in different places. This has been one of the main causes of the great internal diversity existing within the Roma, which has made anthropologists speak of “archipelago of groups.” Each group adapted to the culture and language of the country or region where they settled.

They became Christians and residents of the rural and urban populations, except in places where they were not allowed to settle or where they chose to maintain a degree of nomadic life, as the Travellers or the Gens du voyage.

Therefore, it is difficult to provide an overview for all Europe beyond a common trait: acceptance of their presence and rejection or persecution suffered by the Roma community historically, which explains largely their current situation.

#### A POPULATION BETWEEN NORMALIZATION AND EXCLUSION

These processes of settlement vary widely: from almost normal integration of families and their professions in the daily life of each region, to prohibitions, laws or racist violence (some genocide) seeking assimilation or segregation, or outright destruction, from the political trends of each period and country.

The hardness of this situation has meant that in many parts of Europe the Roma community is the poorest and with most health, housing or employment problems, compared to other social groups.

In terms of economic status, education and employment, it is necessary to speak of disparity in Europe and of some common features that are discussed below.

#### Training and educational deficits

Progress in education has been intense yet insufficient. In many countries, but not all, we can speak of complete primary schooling, which is a huge accomplishment compared to previous data of illiteracy. But there is still a clear deficit when measured with the demands of modern society and compared with other social groups (FSG Health Area, 2009):

- Among Roma aged 15 years and over, 43% have no education and only 32% finished primary education. The numbers of uneducated adults exceeded 60% in Southern European countries, compared to the East where the effort in education was for many years general and sustained.
However, in recent years, efforts by countries like Spain to promote universal schooling got positive outcomes, especially in primary education and not compulsory schooling. Progress has stalled in other European regions.

The great barrier remains in secondary education. Among youths aged 15 to 24 years, only 17% are students, compared with 60% of the European population. Roma with university degree are still a minority.

This could be linked to the fact that many Roma children and youth have been educated in segregated conditions, either in special schools, normal schools (but where they are the majority) or in classrooms or school systems not designed for Roma, but end up being the fate of minorities. This educational experience does not build trust between social groups and hampers the subsequent integration and the prevention work. The impact of these facts on youth is important, for several reasons:

- Many young Roma people (target population for drug prevention work) will be out of school, working on their own or with their family, unemployed, many of them with their own families and children.
- Their education level is very low, which affects their work and social position, but also the methods and forms of prevention with them.
- Usually they have had a short school experience, difficult or precarious. Their self-esteem, expectations or identity may be marked by that experience, either because it has been successful and strengthening, or (and this will be very common) because they felt the stigma of failure in school, educational segregation or other unpleasant experiences.

Their relationship with society, educators, government and authority, may have been negative. From our position as public actors with authority we must consider these previous experiences if we want to establish a fruitful communication with young Roma.

Worse access to the labour market

The Roma have historically worked in a kind of jobs: crafts, agriculture and services, jobs that were disrupted by urbanization and rural exodus of the twentieth century. They had to create new sources of wealth and adapt to new conditions and requirements of the labour market, as some tasks typically urban which do not require qualifications or capital (street vending or collecting scrap) and that replaced the old trades, while maintaining agricultural peonage or wage employment as construction or catering to a minority. A new world of work which is more limited today, because these tasks are more regulated and industrialized, or because there is an increased competition with other groups, where training and specialization is the element that makes the difference.

The response has been to diversify the options (through training and work experience), but only a small group has positioned itself in egalitarian positions in a labour market that is demanding, competitive and discriminatory. Unemployment, family economy more or less informal according to the laws of each country, some aids and precarious economy characterized much of the Roma world. The data are difficult to assess, because what is called work and unemployment varies in each case, according to the methodology used. A young man who helps his relatives in a scrap business, a housewife who also sells fruit, can be defined as active or as unemployed. Many people in not formalized residual activities or not regulated jobs declare that they are working, but that does not mean that they do not want to have a safer and steadier job.
In any case, the data always show a high numbers of active labour force among the Roma population and high unemployment, 23% on average in the health survey (FSG Health Area, 2009). In other surveys their unemployment rates above 50% of the active population. These data are previous to the economic crisis; in countries where data are available after 2008, we see that the situation has gotten much worse.

**Poverty and exclusion**

Researchers estimate that two-thirds of Europe's Roma population lives in poverty. Exclusion data are different from those of poverty but can be added: more isolated, with worse housing and worse health. This means that they are less able to transform their material conditions.

Public policies have had a major impact on improving life of Roma families, but they have not changed their relative position: they remain "poorest of the poor" (Foessa Foundation, 2008). In many Eastern European countries they are considered as the losers in the democratization process and that their situation has worsened since the fall of communism while the rejection of majority populations increased. The emigration of many Roma people from Eastern Europe and the Balkans to Western is one response to this situation of poverty and social rejection.

**SOCIAL STRUCTURE AND PROCESS OF TRANSFORMATION**

This point is repeated in European manuals and reports, but must be approached with rigor for not returning to the preconceptions of a unitary group and avoid the tendency to assimilate all of them with the most marginalized or poorer, which is sometimes the more visible in health services, or elsewhere.

A current feature of the Roma community is that they are living an intense process of change that some writers have called "selective modernization" (OSC, 2012). Roma are getting tools to take on the demands of modern life: urban, more individualistic and competitive, with higher education and skills, more egalitarian in terms of gender and age, etc... And all that without losing cohesion, capacity of motion and without disintegrating.

Change without losing the very essence (remaining Roma) is a historical project, complex and contradictory. It is lived with many internal tensions, has different speeds, is not unanimous. Not all Roma are in the same movement, there are differences between young and old, men and women, cultivated and illiterate. And there is no single strategy but deep divisions.

Broadly speaking, we propose three different positions to change the community (Pernas, 2005):

**A) Elites and settled groups**

The characteristic of a minority of Roma is that they propose to govern social change in their community, either through associations and politicization, either through new devices of cohesion, as the evangelical churches in many countries. Their will is to get a life "modern and Roma", translating their own values and standards to the needs of the modern world.
While facing drug use and addictions, they show a strong moral rejection and deliver their own strategies, based on family or community, to avoid its effects, cure or exclude their victims.

B) Most Roma families, usually poor, but marginal

This is the key of the future of social change. Many people are aware of being in a culture in crisis because of the difficulty to live a Roma life in an urban and globalized world. But crises can lead to more freedom or to clinging to traditional values. This majority uses two strategies:

- Individual change is favoured by many families who choose the education of children, the nuclear family model and family planning, flexibility, relying on traditional crafts and street trading in extended families, with public aid, but trying social mobility based on education.
- Other Roma families do not see any possibility of mobility and experience the crisis of their own culture as an end or a disgrace. The pessimism of adults makes more difficult the youth’s attempts to change. Melancholy, which is the feeling of powerlessness regarding their own history and their own people, dominates and limits the possibilities for change.

The balance between these two groups, those who can take advantage of social change and those who live with bitterness and close, depends very much on the real options offered by society, the perceived racism and the public policy.

The idea of health of these groups and the relationship to the drug is open and determined by these positions: there can be assimilated forms of behaviour, for better or for worst, or having deep feelings of personal failure to modernization, leading to dangerous addictions.

C) Population at risk of social exclusion

This is the case of families living in segregated or degraded environments with very poor economies. Their ability to change is limited by the lack of relationship with the social environment, exclusion and its constraints. Thus they can maintain or reinvent traditions that they would like to change, as the bickering between relatives or early marriage, while other aspects of culture more dynamic and adaptive are not within reach.

The weight and configuration of the different groups vary widely across countries and regions in Europe, but the above, based on sociological analysis, can serve as a guide. As discussed in following sections, attitudes to illness, health and drug addiction have much to do with the processes of change, ambivalences and conflicts of postures.

Their relationship with illness and drug addiction is more traumatic and the effects are worst. For example, in many cases they will keep in secret issues like domestic violence or the presence of HIV in families, leading to a painful experience of social problems.
THE IMPACT OF HOUSING IN THE ROMA IDENTITY

Another factor to consider when working with Roma, which is related to the previous section, is the place of residence and housing. As discussed in the previous chapter, the metaphor of marginalization is sometimes a specific spatial translation and in the case of the Roma community they were often expelled or held in the margins of towns and cities, sometimes in places further away or unhealthy. Below we highlight the processes associated with this factor and Roma (FSG Health Area, 2009):

- **Roma with more status live in city centers or consolidated districts.** Their living conditions are similar to those of their neighbours, the young people having common problems of access to employment or independent living. That does not mean that their identity is less strong, but the opposite. Often Roma families more powerful and more integrated (in housing and lifestyles) are those who keep most their values and determine their rate of engagement with social change.

- **Less than 4% of Europe's Roma population lives in shanty towns, but almost 30% live in poor quality housing or substandard housing.** It seems relevant to note that the majority of the European population that still lives in shantytowns are Roma.

  The physical and symbolic distance from the city and having less access to the rights granted by citizenship reveals a deliberate exclusion and discrimination. Often "cultural" traits non-traditional (of Roma Culture) emerge in segregated places; they are adaptive and demoralizing, such as early marriage, fights between relatives or clans or selling drugs.

- **In many cases, Roma families have been resettled in public housing and their residential situation depends largely on the historical moment and the way these resettlements were conceived and executed. They can live in apartments, scattered among the population (usually working class neighbourhoods), or live in specific neighbourhoods. Many European Roma people live in neighbourhoods separated from cities and with very deficient in services, which affects their health.**

  Those who live in this way represent 22% of the total, but in some countries and regions account for almost half of Roma families. Some neighbourhoods so designed are much deteriorated due to the poor quality of housing and services, and to the spatial segregation, putting together very different families isolated from the rest and because they are Roma.

The districts and the residential environment, the presence of different people or the same, the feeling of mobility or social exclusion, state intervention (and its benefits) and the quality of public spaces, are phenomena that greatly affect populations. We find often processes or vicious cycles of environmental and/or social degradation. If many people with similar situations in education or employment are living together and separated from the rest, specific health problems can arise and a general demoralization, but also trends to identity reinforcement and the use of the marginal position. If there is no investment in the neighbourhood, nor trade or job opportunities, it is likely that sales networks of certain illegal drugs will appear. This can lead to a worse reputation and internal rupture, exposing youth to consume or to create certain prejudices or stereotypes.

But in other urban environments, as in normal homes in mixed neighbourhoods, there may also be serious health and social problems not so visible. Hence, knowing the social dynamics, the relationship with the neighbourhood residents, conflicts between groups, mobility trends or degradation, youth leisure patterns, is important to understand how the young people feel and how they see themselves as well as the role of drugs in these contexts.
A YOUTH POPULATION IN FLUX

The average age of the European Roma and is around 25 years, compared to the 40 years of the total population. Many of them are boys / girls and youth, fewer over 65 years and their life expectancy is less than the total population. This has a great impact on the dependency ratio, i.e. the proportion of inactive people (under 15 and over 65) in a given population. Among the Roma dependents are 62 out of 100, compared with 48 per cent of the total European population (FSG Health Area, 2009).

The implications are very interesting: while resources and concerns of European societies are increasingly oriented toward the elderly, health or social services, facilities and culture, Roma need mostly resources for youth and a strong investment in education, employment and leisure. In this sense, the drug prevention work and other tasks related to lifestyles is essential to the future health of the group.

Generational changes involve other things. The obstacles that Roma youth face are still there and can be more painful in a society that considers itself egalitarian. Roma are literate but their educational levels are well low compared to those of the general population, they suffer high unemployment, difficult access to housing and persistent discrimination. They remain poor, but their poverty, more urban and individualized, is lived differently. They may feel, like many other young people in the neighbourhoods of European cities, separated from the flows of capital, information and consumption, neglected by globalization and by the state. The answer to this may be reinventing their own identity or group identity, seeking for mobility pathways - individually or in family-, some based in camouflage (passing as non Roma) to avoid racism, or take refuge in escapism or frustration. These are dilemmas that we can see right now and where health and addictions play a prominent role.

Furthermore, the Roma teenagers live a dissonance that sometimes confuses and disorients them, as they feel trapped between Roma cultural norms and mainstream culture norms, which they do not feel as their own, and sometimes transgress. They have to live with rules that can perceive as outdated and others they fell they do not own (Santolaya Ochando, 2008).

Another feature is the recognition of adulthood at an early age. The degree of autonomy given to adolescents is in conflict with the premature age at which they are requests to assume it. This also means that they have to enter very soon the labour market or to take responsibility for which they perhaps are not prepared.
3.2. IMPORTANT SOCIO-CULTURAL ELEMENTS

Below we will present some socio-cultural factors related to the Roma community and health. These elements have to be taken within the context of a heterogeneous community in process of transformation.

KEY ROLE OF THE FAMILY

The family is central to their social organization. It articulates and develops social and personal relationships, existing in many cases a prevalence of the group or the family over individuality (Garcia, 2006).

Roma culture is traditionally pro-natalist; marriage and parenthood and motherhood have a very important place in the lives of people: being a father or a mother is the fundamental step in the transition to adult life and it plays a relevant role in the community. It is also the way to bond with a family network that has been central to the survival of the group.

Furthermore, marriage and the number of children are key elements in the status of the families, strengthening their power or prestige, access to wealth or to sources of employment (Gamella, 2000). And within the family, their own status is marked by gender (with male authority but without forgetting the great domestic power of women) and age (increasing influence along with the age of the person who has fulfilled his/her role in the group, obtaining in return care and respect).

This natalist vocation coupled with the need to contract marriage within the community and with families of confidence, to improve the position of the household, implies that marriage is early and often occurs with acquaintances, often with relatives.

Within this common framework, the experts talk about big changes in marriage strategies of Roma, being the basic feature diversity. In some environments adolescent marriages have increased, often against the advice of the families, but there are more couples delaying marriage, more singles and more mixed marriages (with non Roma). The role of the extended family also varies: there are nuclear families with independent households, although the importance of the family and its value as a net of material and symbolic safety remain.

All this must be qualified according the regions, the standard of living and access to housing. What may seem a cultural choice, living with the husband's parents, often can be a response to the lack of affordable housing for young couples (and the impossibility of independence).

Meanwhile, the Roma have made or are making a demographic transition in recent years. The reduction in mortality (particularly children) and increasing life expectancy, lead to an increase in population and to a reduction of births, with the extension of family planning methods. The current size of Roma households is still higher than the average European household: 4.49 people on average compared to 2.48, but these data hide wide differences among countries and a trend to reduced family size (FSG Health Area, 2009).
This means a growing population, more numerous than in other times in history (estimated around ten million people) and younger than the average European population.

✓ The central role of the family as the focus of social organization.
✓ Prevalence of group versus individuality.
✓ Large and extended families.
✓ Roles very marked, by sex and age.
✓ Early marriages.
✓ Current processes of change: later marriage, changing role of women and youth…

ROLE OF ASSOCIATIONS AND CHURCHES

Associations and churches have a specific influence within the Roma community, becoming an alternative space for group support and conflict resolution. As reference spaces within the community, they are very valid partners while working with Roma. These actors can serve as protective factors for Roma because they provide rules and models of behaviour health-related (García, 2006).

It is important to consider the role that different churches have had in the history of the Roma community in Europe, their Christianization and resistance to certain rules about family and marriage. But we must also recognize the influence of modern evangelical churches whose impact in some countries has been enormous and very fast.

A “Roma” church may be one of the tools chosen to build an identity adapted to modern life, with clear moral boundaries that favour internal transformations, but also the establishment of a traditionalist identity. Other Roma will choose associations and political or civic activism as a form of transform themselves and the social context. They are very dynamic processes that must be known for its close relationship with lifestyle and health.

✓ Prominent role of churches and associations in the Roma community.
✓ Respected interlocutors when working with Roma.

THE ROLE OF WOMEN

Roma women develop a key role within their community. They play a role as educators, caregivers of children and elderly, and are the transmitters of the norms and values of Roma Culture (García, 2006).

Today many women have shifted from exclusively performing household tasks and childcare to work in the labour market or to play other roles formerly assigned to men. The impact of education, demographic changes, the information technology and urban life have prompted processes of intense and ambivalent cultural transformation, reflected particularly in the younger Roma, but also in women.

At the same time, a reducing birth rate means smaller families, a new position of children and the value of education, and a new relationship between the sexes, as many women do not live
dedicated to motherhood and their potential increases because they have more time and better health.

Some studies show that women are the most important factor in explaining the adoption new values by Roma. It is also the core of culture, which plays a large part of their future. The purity of the girls and their value to the status of families is a basic factor of symbolic integration and survival of the group, so it is subject to tight controls and pressures. Thus, although both boys and girls often leave Roma studies at puberty, they do so for different reasons. Fear of rumours and the desire to keep the girls safe play an important role to take into account when working with Roma women.

It should also to be considered when working with young Roma women the fact that until recently they had a path heavily influenced by his family, and yet these paths are blurring. This causes often that they fell in a kind of no man's land and do not have positive role models (MSC-FSG, 2008).

Roma women have been the engine of change in many circumstances and their power and influence can be and has been used in many public policies. But they are in a difficult position, with all eyes on them, so to speak. Therefore, it is better not to increase or precipitate the pressure they feel, but respect their time and their strategies.

- The Roma woman in transmitting the norms and values of their community.
- Overprotection of young Roma women.
- New roles of women, change processes.
- Lack of new models for the young women.

3.3. EUROPEAN ROMA AND THEIR RELATIONSHIP TO HEALTH

To act in the field of health and prevention is important to know some specific aspects of the health of the Roma population. Information and data on their health but also concepts and attitudes that can affect prevention work. Finally, we address some aspects of access to health services and the barriers they encounter.

BRIEF DIAGNOSIS ON HEALTH

Surveys and studies at European level show some general features. The determinants of health are biological, but also environmental and social. Lower income, poor living conditions in their neighbourhoods, discrimination or worse access to health benefits, explain the presence of infectious diseases, such as tuberculosis or hepatitis, and other chronic diseases less common in the general population or that occur at younger ages.

Studies on health determinants of minority groups also highlight racism as a factor that deeply affects the welfare, care for oneself, one's perception of health and morbidity of the population who suffer it. Health data of racial minorities are systematically worse than other groups in the same social class. Racism causes stress, low expectations and risk behaviours. This fact and poverty explain the worst health of Roma. In parallel, inclusive and universal systems of health,
together with improvements in housing, standards of living and education, explain the progress of the health of the Roma population in many parts of Europe.

### SOME DATA ABOUT THE HEALTH STATUS OF ROMA

Although there is no complete demographic studies for Roma, many experts on health estimate that **life expectancy is lower among Roma**, and that this difference can exceed 7 years.

In all studies there is a prevalence of the following facts:

- **Chronic illnesses or disabilities** than in the total European population: high blood pressure, diabetes, cholesterol, allergies, respiratory problems among the elderly, and asthma among children.

- **Psychological troubles**: depression or chronic pain (particularly bones and head and migraines).

- **Accidents** (domestic, work or traffic).

Both diseases and accidents cause in many Roma disabilities or life limitations of various kinds. Both causes of poor health are associated with the residential environment and its conditions, more or less secure and integrated.

#### Women:

The data show problems associated with early and late pregnancy, lower gynaecological prevention habits (only 60% of Roma women in Europe visit the gynaecologist during pregnancies) and health problems caused by work overload.

#### Minors:

Vaccination campaigns have been very effective in many countries but major gaps (in some European regions almost half of the children have not followed the vaccination program) and infectious diseases in young adults due to lack of vaccination in childhood.

#### Different problems associated with lifestyle:

They are often over weighted and with obesity in older and younger; only half of the Roma population has a weight considered as healthy. Food less rich in vegetables and fruit and abundant in sweets and fats, along with lack of exercise (also in children) explains this prevalence, which in turn has implications for other diseases in adulthood.

#### Substance consumption:

Almost 60% of Roma men and 30% of women are current smokers, data varies between countries, especially in female consumer. A contrast that is more pronounced in the case of alcohol, also important in the adult male population. Recognition of problems with alcohol or drugs affects a minority (3.5% in the European Health Survey) but these data conceal a clear concentration of problematic consumption in marginalized or segregated places: in slum neighbourhoods or isolated the data of prevalence is from 15 to 18%, which is a big impact on the community. More than the quality of housing, the key factor shared by neighbourhoods with problems of

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3 Source: FSG Health Area, 2009.

4 The Advisory Committee addressed the appearance of health problems of Roma arising from unhealthy habits, such as poor diet or lack of exercise or sports. This is causing problems with obesity or hypertension.
alcohol or drugs is segregation, showing once again that the life experience of stigma affects clearly problematic consumer.

IDEAS ON HEALTH

The main causes of the worst health of Roma are socioeconomic and related to habitat, in a physical sense and also symbolic. Being segregated or less citizens is in itself a serious health problem. But, as we have seen, the cultural factor in relation to one’s health has also a major impact (Ayala Rubio, 2008).

Again, we must distinguish traditional elements of the culture of the body with elements of the transition to a consumer society and with the features of a culture in crisis.

As for the elements coming from the transition to a consumer society, for example, adopting unhealthy habits like smoking or eating industrial cakes is not a traditional activity, but rather an adaptive response to a consumer society whose disciplines must be learned.

Comparative studies show that tobacco is a gateway to modern consumption and its patterns: individualistic, compulsive, but also perfectly compatible with the production, is proof of status and social integration. In countries in transition, as was Spain in the 60s, mainly men of professional elites used to smoke. The rest of society has incorporated these habits later, even if their harmful effects have been proven.

A sedentary lifestyle and the automobile, easy access to cheap and satisfactory goods or the need to be integrated into the consumer society (even in its most popular strata) influences lifestyles and prevalence. In this regard, several studies have found that Roma made little or no physical activity in their free time, especially after age 25 (Arza Pozas, 2008).

There are other aspects in which this transition fails or becomes darker. Consumption can be more compulsive, the sense of loss or failure can lead to increased risk behaviours in adults or youth. In many older women this situation is manifested in depression when facing problems of one’s life. People more vulnerable such as young women and men can become drug addicts.

TRADITIONAL ASPECTS OF ROMA CULTURE RELATED TO HEALTH

<table>
<thead>
<tr>
<th>Importance given to health, coupled with the importance of family and the health of others. This fact explains the mutual support between relatives, which in the case of women becomes forgetting one's health and for men to reject the weakness and care. The importance of the elderly and the sense of vulnerability make that disease and death are very present in Roma culture, even young.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health as absence of disease and as something disabling linked to the death. The Roma community, as almost all traditional populations, only go to the doctor when they are very sick. When a person (and family) perceives that the disease has appeared, the action must be immediate and decisive, given the relationship they feel between illness and death. Fear of disease is linked to the problems of access to health services in some places. So it is logical to use emergency services instead of the regular (or preventive) and there is a tendency to self-medication and informal advice from relatives or neighbours.</td>
</tr>
</tbody>
</table>
Health and physical illness. The relationship established between health and physical sickness absence means that they do not take into account aspects of behaviour related to psychology.

The link of the idea of health with morality, making certain diseases, as HIV, a disgrace and a dishonour, so often lived in secret and with a great sense of guilt, greater in women.

Invisibility of prevention. The fear of death and denial of illness hinder the preventive work, and because Roma, as already mentioned, just go to the doctor when they are very sick. Furthermore, in environments where life is long and with uncertain future, the idea of planning and care makes little sense, while caring for others and secure the future of the group usually does. For this reason many of the behaviours of the Roma have a cultural sense that does not always coincide with the dominant culture of health.

Other distinctive features of the culture that hinder prevention:

- Immediate life (daily living), which on one hand encourages the development of guidelines for daily life, but on the other hand difficult to plan.
- The prevalence of the emotional over the rational, where the action is very present and reflection often serves to fix or remedy, but not to anticipate or prevent.

ROMA COMMUNITY AND HEALTH SYSTEM

Of course, all these attitudes change the access and use of the health system. But at the same time, the performance of health services and professionals working with Roma will transform their treatment, access and use. We should not forget that the health system is a public actor and the Roma community relations with the state have varied historically (not always been cordial). The administration in democratic countries is seen by Roma as a structure that protects their rights, but it was not always so: the arbitrary, expulsions, police persecution and ethnic profiling in arrests and incarceration are common features to the experience Roma across Europe. In this sense, the Roma community is particularly sensitive to those who want to control them, and are suspicious of institutions that they do not trust (Arbex, 1999).

Even without going that far, obligations and prohibitions, behaviour patterns and demands that we consider normal practice today, require learning and habits complex and difficult to acquire. Having the right papers and updated, make the necessary arrangements, be informed of the risks, follow the guidelines of the treatments are no obvious social habits and some populations that have survived by staying away from the state and its agents do not always have them. For example, the Roma community is wary of the bureaucracy (complete documents, files, etc...), something which is difficult and distant from their lifestyle (Arbex, 1999).

Hence, the first barrier is the degree of inclusiveness of health systems and protection. Health systems in addition to free and universal should be inclusive, adapting as far as possible the standards of access to the conditions of the population. Only in this way there will be a normalized relationship with care, immunization, prevention and the different services, reaching all groups.
Beyond this general obstacle, barriers are more subtle and have to do with cultural differences and discrimination processes. As noted, sometimes Roma makes greater use of emergency care than preventive services that. In relation to the health professionals, they may manifest anxiety or distrust which have to be managed with communication skills, and in some cases, using tools such as mediators: "The Roma do not see centers or institutions, they see people" (Arbex, 1999).

Studies on attitudes and perceived problems by health professionals explain that the greater concern is shown by the support staff, administrative and nursing, as are those dealing with the patient’s environment, and not only with the conditions specific of disease and diagnosis. We should not minimize complaints because health professionals often are overloaded and receive no support to deal with what they consider special cases or different or conflicting behaviours. Often there are no rules and no answers systematized, but different strategies and solutions to problems when they arise, especially in hospitals, where coexistence becomes long and tense. Experts say that there is a need of a more institutionalized answer, setting out rules and options that take into account differences in the population with which they work.

In the case of the Roma community, the quality of care is based on the time of care, treatment, perceived empathy, certain nonverbal messages ... These criteria are difficult to meet in the current Public Health System (Arza Pozas, 2008). In Chapter 4 of this manual we will address some strategies to help solve and anticipate these situations.

In relation to the world of drug addiction, there is no systematic study on how the Roma community access to services and resources. Information is lacking on this process. These resources are characterized by a large diversity, and the world they serve: from hospital units to specialized outpatient centers, residential and therapeutic centers (public, public-private, evangelicals, etc.), treatment programs or to reduce risks in different environments (in neighbourhoods, but also in prisons); prevention plans and projects offered in leisure places, schools, health centers, through public health campaigns, etc. And with very different actors, public and private, NGOs and churches and with very different philosophies and methods, ranging from abstinence to harm reduction.

We can assume that many of the features regarding health will be common to drug treatment. And with regard to prevention, the same ideas about the body and health, the denial of the disease or the entry into the consumer society will apply. This is the framework where we can think the relationship of Roma youth with drugs.

- Distrust of the Roma community to the public health system because of historical and life experiences.
- Distrust of bureaucracy, something which is difficult and distant from their lifestyle.
- Lack of adaptation to the specificity of the Roma community (non-flexible schedules, complex language, etc.).
- Existence of prejudice against Roma.
- Lack of resources in the public health system that hinders the inclusion of minorities (failure of intercultural mediators, etc...).
3.4. KEY IDEAS ON DRUGS

COMMON FEATURES OF EUROPEAN YOUTH

Before presenting the studies about the relationship of Roma youth with drugs, it is necessary to recall briefly some features that are common to all youth. Today they face a less scheduled world, more uncertain and with weaker institutions than in previous times (Elzo, 2002). What does this mean?

- **Each one is responsible for his/her own life.** There are no clear patterns of class or gender, but the problems and solutions are presented individually. Each one will survive in society if is able to take advantage of opportunities, both in protected or hostile environments. Institutions are not leading the way nor determine the entry into adulthood. Neither the school nor the military service, marriage or work are homogeneous rites of passage, but open and unpredictable options.

- **The public sphere is reduced and the young are "privatized".** They do not belong to the State as in the past time, they are not manpower to the industry, nor source of support for the communities. They framework is the nuclear family and networks of friendship, fragile or strong. There are no young adults to guide them because they often do not have older siblings and because young adults do not take care of directing or disciplining younger: political parties, churches, unions, clubs, all institutions where it was possible to learn to be adult with a clear moral pattern are in crisis and leisure monitors or volunteers cannot fill that role nor provide a stable framework for life.

- **Multiply the sources of information, informal networks and possibilities to move** in different environments and live different experiences much more open than in the past. This greater freedom and the construction very fragmentary of their own world is described by experts as polarization: some young people become strong and skilled, adapted to an open world, while many others are very lost.

All this would be perfectly applicable to Roma youth, but in this case, moreover, the reference is both one's ethnic group and society as a whole, where one has a place not always comfortable or egalitarian, so searching his/her own path is even more difficult.

TRAITS OF ROMA YOUTH

These general features must be completed by the traits of the culture or the situation of young Roma in Europe. There are several ideas that arise from the research conducted in the framework of this project.

**a) Cultural norms**

The key is that the culture of the group, especially in the case of youth, is set in many processes and interactions, endogenous and exogenous. Young Roma are living in several frames, and this can help them move fluidly in society, or block them. Regarding some drugs there is a great pressure of the group itself, considering drugs something wrong and harmful, along with a great permissiveness towards certain behaviours and consumption. For example, in some families and Roma children grow up in a context of permissiveness towards substance like coffee, alcohol or tobacco. Another example relates to the pattern of alcohol consumption, which has a social character closely linked to certain celebrations strongly held in the Roma
community. A contradiction to what occurs in the global society, characterized by greater moral permissiveness towards consumption, including drugs, and rejection of some drugs or specific behaviours deemed dangerous or inappropriate.

Therefore, the place where one lives, sex and age, in addition to the usual type of consumption, will determine that drug use will be held within the group or hidden from adults, according to the majority society or against it, with different consequences in each case.

Drugs constitute a complex language, starting with the difference between legal and illegal, traditional or new, every day or for leisure. Also involve different images that vary in different contexts, associated or alluding to the destruction of the race, individual independence, status and fashion, a juvenile or adult identity, promiscuity (lack of honour in the girls and manhood in boys), the “becoming gadje” or integration. Knowing the configuration and metaphors of each consumer in each context helps to deliver messages to audience and to understand preventive practices.

b) Personal and family networks

Roma youth is embedded in family networks, we must not forget that there are many young men and women, brothers and sisters, and cousins, but also wider networks of Roma that communicate with Internet or meet in parties, weddings, jobs. They also have relationships with non-Roma, in schools and neighbourhoods. They receive the messages of the media and advertising. The messages and images about drugs, its attractions and dangers come from many sources and we need to know what are significant and which are contradictory, and the effects they have.

It is known that the peer group is important in adolescence, which determines many behaviours and acts that can be a risk factor, leading to shared behaviours that do not have the same effect on everyone, but also can be a protective factor, to raise controls and limits about what should or should not do. Acting on these networks involves understanding its structure and its messages, knowing, for example, how Roma youth use new technologies.

Equally important are family relationships. Very restrictive or permissive environments can cause harmful effects on youth, breaking trust or create generational gaps that frustrate parents’ opportunities to intervene and help their children.

c) Factors of risk and protection

There is debate about the role of culture. Many studies show that having strong moral values is a protective factor against drug abuse, but it is clear that the Roma Cultural always offer this protection. Depend on the environment, group cohesion, its ability to update modern ethical values, communication between generations for transmission and other items that can only be observed in precise contexts.

Studies on vulnerability show that unemployment, racism and the low educational level can influence drug consumption or abuse, to escape the difficulties or because these conditions affect other psychological dimensions, such as lack of confidence in self, low self esteem, or impulsivity that appear as risks. Other risk factors are drug availability (or money to buy them) and the lack of alternative leisure.
It seems clear that the risk and protective factors are the same in young Roma and non-Roma, but its manifestation, presence and strength depends on many contextual variables. In marginal environments and segregated, with closed networks, easy access to drugs and lack of leisure and relationship, it is likely that many young people and adults Roma begin pernicious consumption. But they can also occur in other unhealthy habits integrated environments where other messages circulating and other drugs.

**d) Consumption patterns**

As we said before, consume of tobacco is early and is extended, although there are large differences between sexes. A small number of Roma acknowledges problems with alcohol or other drugs, but that number may be concentrated in certain communities generating a serious social and family problem.

The SRAP project study showed a great variety in the position of the drug in the imaginary and large regional differences in consumption and habits. These are worrying trends revealed by the investigation: the early onset in tobacco, alcohol exposure among adults, and presence of heroin in some regions or underestimation of risk of some drugs (such as cannabis or medicaments). Similarly, these drugs are associated with night life and friendly relations with non-Roma and patterns common to other social groups. The consumption of certain drugs is a way to feel part of society and the peer group or is associated with fame and money, as the case of cocaine.

In the case of **young Roma women**, although there are certain protective factors against substance use, in recent years there is a progressive increase in drug use. We encountered an increase in consumption of tobacco alone, which constitute a greater risk. In this regard, the Advisory Committee stressed the need to incorporate a gender perspective as they have detected differences between boys and girls in consumption patterns and how we must address prevention (different communication, how to transmit information...).

**Many Roma youth do not know devices and programs** for the prevention or treatment of addictions. Services are seen as distant, physically and symbolically, except for some specialized in the environment. These services often generate mistrust, are not associated with the very problems or barriers are perceived such as waiting lists.

The results recommend performing programs and interventions designed specifically for certain objectives and environments that take into account the differences mentioned, but also demonstrate the lack of experience in prevention and intervention with young Roma. In the final sections of the next chapter we come back to the practice of prevention with Roma youth and their determinants.
4. HOW TO IMPROVE OUR INTERVENTION: "BACK TO PRACTICE"

How do we incorporate the characteristics of Roma and their youth to our practice? There are critical reflections that we can assume at a personal level or as health professionals. These processes of training and analysis are necessary, and increase the quality of our work and our own resistance to frustration and burnout.

First, we propose two skills that we consider essential in all health work with Roma (also be extended to the rest of the population). Then we will briefly address some ideas of how to incorporate the characteristics of the Roma community in professional practice and in the organization of primary care centres and hospitals. Finally, we will address drug prevention with Roma youth and some principles for intervention.

4.1. SKILLS TO WORK ON HEALTH WITH ROMA COMMUNITY

The skills presented here are universally valid for all population groups, including minorities. However, due to the characteristics of the Roma community in Europe, is especially relevant considering them. We refer to communication and empathic relationship, development of mediation attitudes and how to deal with conflicts.

COMMUNICATION AND EMPATHY

To facilitate communication and the ability to connect with the other person, to perceive how he/she feel and understand, that is, be empathetic, raises the following proposals:

- **The professional should be surprised by the reality and user.** On many occasions we have glasses to see deficits but not to see the strengths of the people and the problems they really have.

- **Use the pedagogy of questions, listen more than talk:** what do you know ...?, What do you think about ...?, What questions do you have ...?, What do you think ...? What do you imagine...?

- **Young people in particular like to talk and to be heard.** We must try they to feel heard and respected when they decide to go to a health center (Arbex, 1999).

**ELEMENTS FOR LISTENING**

<table>
<thead>
<tr>
<th>GOOK FOR LISTENING ...</th>
<th>Body posture (open, forward), eye contact and blinking, gestures (nod), turned to the person, asking, touching the person, reflecting back what he/she says, repeating and react to what is said to me, following the rhythms of conversation, show emotions...</th>
</tr>
</thead>
</table>
BAD FOR LISTENING...

- **Establishing a relationship of equals, not imposing.** The intervention and the relationship must arise from the natural.

- **Adapting the information and the message** (taking into account age, gender...). Use a readable and understandable language, using key ideas and the least possible technicalities. Convey information clearly and simply, make sure that you have understood the information: diagnoses, treatments, procedures for appointment, etc...

- **Professionals often take for granted concepts or ideas that we thought the patient or user understands.** The Advisory Committee has highlighted this aspect, because sometimes people do not understand the treatments or what the professional wanted to convey. This may be a reason why the person does not return to the center or not follow the indications (treatment, appointments, etc...).

- **Importance of the first meeting, to be a reference.** In care centers or preventing centers professionals should meet the young people and gain their trust. If they connect emotionally in the first meeting are treated with affection, the person who made the host becomes a reference: “They need someone who inspires trust” (Arbex, 1999: 19).

- **Knowing people.** His/her character, his/her name, what has led them to go downtown (Arbex, 1999). They usually go to places where they know they are welcome and where others are Roma. The health center image is formed from the experiences, positive or negative, from others who have gone downtown (Arbex, 1999). The Advisory Committee also stressed the importance of understanding the specific nature of each person and situation.

- **Create a trust relationship.** The Advisory Committee has pointed this idea as one of the best ways to capture and provide access to health resources, to make people to keep the appointments, to follow treatment and to work on prevention and to delve into other key factors.

### COMMUNICATION SKILLS

- Be aware of potential biases and perceptions that can determine and influence the interpretation of the way people communicate and the behaviour of others.
- Consider the different meanings of gestures, exhibition, and physical distances of people from different cultural groups.
- Speak clearly and accurately.
- Avoid colloquial expressions that can be misinterpreted.

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5 Source: *Retos en los contextos multiculturales, competencias interculturales y resolución de conflictos de la FSG (FSG, s/f).*
Repeat affirmations differently to strengthen comprehension.
Active listening, rephrasing what the patient said it to check correct understanding.
Identify and solve communication problems using cultural mediators to facilitate the comprehension and understanding.
Do not try the patient as if he/she were not an adult.
Maintain a sense of humour and relaxed tone, as it facilitates the acceptance and communication.

In recent years strategies have been developed to address communication that takes into account the experiences and specific aspects of each context, which determine the relationship between the patient with the healthcare provider. We refer to patient-centred communication, especially suitable for working with the Roma community.

The communication model of patient-centred is based on six elements:

1. **Exploration of the disease and how it is experienced by the patient**: In addition to the exploration of symptoms, taking into account the following aspects:
   - The idea of the patient about the disease.
   - The feelings it produces (anxiety, fear, etc...).
   - The expectations he/she have on the professional and the usefulness of treatment.
   - The impact of symptoms on daily life.
   - The nonverbal communication.

2. **Understanding the whole person**: Taking into account other environmental, social and family factors of the patient such as living conditions in which he lives, relationships and family support, economic needs, etc.

3. **Agreements with the patient**: The patient must actively participate in their health-disease process. To do this, the clinician should seek acceptance in both diagnosis and therapeutic treatment proposed.

4. **Incorporation of prevention or health promotion**: prevention and promotion to include harm reduction, early detection of diseases and reduction of their consequences.

5. **Take care of the patient-professional relationship**: The professional should seek to improve relationship with the patient at every encounter.

6. **Realism**: All of the above must take into account the real possibilities of the service in which the clinician works: resources, time available, etc... It is known that many health professionals have to see too many patients; they may only assess aspects of this model that are most important for the process and for the patient.

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6 This picture is an adjustment of: *Guía para la actuación con la comunidad Gitana en los Servicios Sanitarios* (García, 2006). Though it is focused on the primary care, we think that it’s an interesting model of reference in drug prevention.
DEVELOPING MEDIATION ATTITUDES AND TALKING CONFLICTS

First of all professionals should ask themselves some key questions, to know what is his/her starting point. This can determine the relationship to be established with the Roma. Questions like: What is a youth? What is a Roma? Is it good to take drugs or smoking? What is prevention for me? This will help to be honest in the objectives working with Roma and particularly with youth.

The appearance of conflict is natural in any relationship and any aspect of life. Hence the importance of knowing how to work with them, fix them and prevent them. There is a series of measures that can help in this regard:

- **Find and create the right atmosphere.** Spaces adapted to Roma (spacious room, sufficient chairs, etc.), Remove barriers and obstacles (no tables, open spaces). The architectural structure sometimes limits the actions.

- **Avoid generalizing.** The Roma community is very heterogeneous and behaviour of one of its members or a family cannot be extrapolated to the rest. We must banish the misconception that all Roma are identical (Garcia, 2006).

- **Adapt language and symbols:** Show closeness (express feelings, shaking hands ...), perform symbolic events. All actions are symbolic, have meaning and convey something.

- **Reaching agreements or covenants relating to punctuality, responsibility, commitment.** Roma have negotiation skills, something that always works is "you give me, I give you in return" (Arbex, 1999: 20).

- **Do not try to control.** The professional should not seem a punitive or coercive figure. We must remove the control aspect that Roma attribute to professionals and centers, avoiding as far as possible the records, penalties, etc.. This does not mean that there are no rules or regulations, established clear tasks and objectives. The directivity is accepted as a sign of authority and wisdom (Arbex, 1999).

### KNOWLEDGE, SKILLS AND ATTITUDES OF THE MEDIATOR

<table>
<thead>
<tr>
<th>To show that the person will be a reference moderator.</th>
</tr>
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<tbody>
<tr>
<td>Maintain adequate distance (emotional closeness must be very controlled, to gain respect, as they understand it).</td>
</tr>
<tr>
<td>Information should be significant, related to experiences and expectations.</td>
</tr>
<tr>
<td>Keep agreements, especially those set with the group (keep your word, fulfill commitments). But also be conciliatory and flexible.</td>
</tr>
<tr>
<td>Communicate information effectively.</td>
</tr>
<tr>
<td>Manage conflict resolution techniques.</td>
</tr>
<tr>
<td>Be impartial.</td>
</tr>
</tbody>
</table>

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7 This picture is an adjustment of: Retos en los contextos multiculturales, competencias interculturales y resolución de conflictos de la FSG (FSG, s/f).
Transmit serenity.
Show sensitivity and concern about what others feel and express.
Openness attitude.
Show closeness and concern for the other person.

4.2. AWARENES OF CULTURAL FEATURES OF ROMA DURING HEALTH PRACTICE AND IN HEALTH CENTERS

In this section we point out some characteristics of Roma that must be present both in the organization of health centers and in the professional practice.

Understanding these cultural patterns will give us a greater understanding of the person and context and enable the professional to tailor the intervention. This will result in higher quality intervention and better outcomes. Furthermore, knowing the truth is the best way to break preconceptions that can distort or hinder intervention, as noted by the Advisory Committee.

We've included some general ideas and recommendations that should be adapted to the various contexts of preventive practice and health care:

- **Know the socio-cultural characteristics of the Roma community**, especially those that affect health positively or negatively:
  - Mutual support between relatives, respect and care for the elderly, the importance of mourning.
  - Gender-related issues: The role of women as caregivers and the fact that she tends to forget about her own health; the man can reject weakness and health care.

- **Detect possible referents in families**. The cultural perspective of Roma is family interdependence, so familiar authority figures, parents, grandparents or uncles should be involved in treatment or therapy (Arbex, 1999).

- **Group intervention with the family**. It is better to be done separately, with specific groups of parents, because roles and separation of sexes can be very pronounced. Being together hampers communication produces a lack of spontaneity (Arbex, 1999).

- **Set clear and firm limits, from prevention or care centers**. It is necessary to involve the Roma families in compliance. Sometimes it is difficult for them, as they usually have a small establishment of rules and boundaries within the family unit. It requires significant pedagogical work and the need to establish agreements (Arbex, 1996).

- **Women's entrepreneurship**. For the work of prevention, or treatment of diseases, the field of addictions, to work with Roma women and mothers is a key element, and taking advantage of their entrepreneurial capacity (Arbex, 1996).

- **Sexuality**. This is a topic that Roma women find difficult to speak about. In general, they have little information and this fact generates shame. It is recommended that the health professional who receive a Roma woman be a woman as well, and using a language (verbal and nonverbal) to facilitate communication (Arza Pozas, 2008). If there is a need to carry out tests that may be perceived as a threat to some aspect of the girl's virginity, is necessary to explain in detail its importance (Arza Pozas, 2008).
- Heterogeneity. The Roma population is very diverse: different levels of resources, people from different countries, etc. This means putting the focus on the person, to understand and comprehend the context and circumstances (family status, resources, level of integration, etc...).

Here are some guidelines that can improve the relationship and dealing with the Roma community, especially families, and will serve for potential conflicts of interest during the contact with hospitals and emergency services (Garcia, 2006):

- Establish information points clearly marked, where verbal information is offered to applicants.
- Provide, at the time of admission, written information in a clear and simple: the rules of use of the center; rights and obligations of patients, visiting hours, care and consultation...
- The above information must be provided orally by qualified personnel with training for diversity and not by the security services of the center, as these persons will generate distrust.
- When the Roma extended family is present in the center, recognizing the highest authority (usually older men or older women) to convey important messages. For example about: the status of patients, the disease progression or the news of the death of the person. In the latter case, maintaining an attitude of understanding and respect to expression of pain.
- Adapt some common public spaces, as waiting rooms, to the permanence of the extended family.
- The presence of intercultural mediators is useful because it promotes understanding with the medical staff, facing situations that can become contentious.

In this regard, the Advisory Committee has highlighted the mediator, as he/she facilitates to understand the person and his/her culture. This increases the efficiency and quality of the intervention: facilitates mutual understanding.

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**Intercultural mediation**

Intercultural mediation is a resource available to people of diverse cultures, which acts as a bridge to promote constructive change in the relationships between them. Mediation in relations between culturally diverse people, acts preferentially to cultural conflict prevention, promoting the recognition of a different person, the rapprochement between the parties, communication and mutual understanding, learning and development of coexistence, search alternative strategies for cultural conflict resolution and community involvement.

Mediation, understood so professionalized, is a resource that acts as a bridge between the Roma community and the majority society to promote constructive change in their relations. It is a process and not a tool "to put out fires" when conflicts occur.

**Mediation in the health field** with the Roma community have among its

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8 Source: García, 2006
**functions:**

- Facilitate the access of Roma to social and health resources.
- Know the needs felt.
- Facilitate communication between professionals and the Roma community by promoting their access to these resources in equal opportunities.
- Reduce cultural barriers.
- Advise Roma users in relation to health service professionals.
- Advise healthcare professionals for appropriate attention to the needs and interests of the Roma population.
- Promote community revitalization.
- Support personally Roma users.

The benefits of intercultural mediation have an impact on the health services staff and on Roma users as well:

**For health workers:**

- It helps interpersonal relationships reducing interpersonal communication barriers.
- Allows decipher and understand some cultural patterns. For example, in the care of Roma widows, or Roma girls unmarried.
- Helps prevent conflicts in certain situations, for example, after the death of a Roma person.
- Promotes better outcomes in treatments and prescriptions.
- Makes effective prevention programs and health promotion.

**For the Roma:**

- Promotes a better understanding of the diagnostic and therapeutic treatments increasing success to cure diseases.
- Allows for greater understanding of the rules and health system performance.
- Contributes to the normalization of the use of health services.
- Generates a greater sense of security and confidence to the health institutions and health personnel.

Including intercultural mediation in hospitals and primary care centers would allow to work with Roma related issues such as:

- The health education.
- Proper use of health services.
- The improvement of relations between health professionals and Roma patients.
- The prevention of potential conflicts of interest.
4.3. HOW TO TACKLE DRUG ABUSE PREVENTION WITH ROMA YOUTH?

We have seen in previous chapters that the relationship with drug use of youth (Roma or not) is determined by long-term processes, quite universal, as the expansion of individualism and the consumer society to all social groups, but also contexts, social and cultural, very concrete and located in time and space. Hence any intervention with the Roma youth must do a double exercise to understand what is common to the whole society (and all prevention programs) and what is particular, not of Roma, but that precise context of intervention.

Knowing the context and their relationship will allow to design the program that youth need, or to adapt older programs to new contexts (EMCDDA, 2008).

PREVENTION: WHY AND WHAT FOR?

The first question is why do we need a prevention project, or put another way, what are the risks that we must prevent. To answer this question we follow three steps: diagnosis, defining objectives and analyse resources and forces.

Diagnosis

Definition of objectives

Resources and forces

Diagnose the area / neighbourhood or city is basic, beyond determining the consumer precise problem. We are working prevention with youth, which requires us to anticipate emerging trends or tendencies.

To prevent behaviours we have to anticipate possible risks to empower people when facing these risks. Being in the field and have alarm systems is the best recommendation, as well as research and surveys.

The diagnosis must include socio-demographic aspects and other aspects relating specifically to drug addictions. The former are often the best basis for the latter work. For example, we know that promote healthy leisure, integration in networks beyond family or ethnic network, or autonomous mobility, to name a few factors, is positive for young Roma, irrespective of the specific consumption that may threaten them. But along with this, they can having a high intake of alcohol, smoking early or a tendency to use any recreational drug that requires a focused approach by the health system.

✓ Start working broader health programs allow us to be prepared, with local knowledge and support when necessary to identify a problem. But it can also happen in reverse: a much focused program or plan to stop a negative situation can have capacity to grow, seek alliances and undertake wider policies relating to the health of the community.
In addition to diagnosis, we need a philosophy and objectives of our intervention, we are aware that this approach will not always necessarily partial and will articulate with the culture or values of the Roma population.

- We must differentiate if we fight against the consumption of one or more substances, if against excessive consumption, or against the social effects thereof. We approach the project from the health promotion, regardless of any drug, or to equip young people with tools to combat a particular consumer that has prevalence in the community.

- The objectives should be explicit and more comprehensive projects that are useful, some goals should be concrete. It is not the same searching abstinence than reducing consumption or associated risks. It is not the same attempt that young people do not drink alcohol, delaying the age of first use, than prevent from driving when they drink, or the influence of alcohol in school absenteeism.

There are programs intended to delay the entry into consumption and others to avoid progression, ie prevent the step of some young people from more accepted drugs (such as tobacco or marijuana) to more dangerous, either because greater addiction or health effects, either by social stigma.

These decisions are often strongly influenced by the philosophy of anti-drug of public and health authorities, the legality or prosecution of the same, its availability or the social image. But not always these images or philosophies are the same for the Roma community. Risk reduction can make much sense to certain people and environments, while others only a stronger moral stance (abstinence, for example) have a cultural sense. Knowing these values and identifying the strengths of the community and its health sources, including those that are foreign to us, is an important step for our language and intentions to make sense. It does not mean that we take as a public instance, the position of the other, but that we dialogue with it, we have it in mind, as part of the program and not ignored.

The third step, after diagnosis and definition of the objectives is to analyze and strengthen the place where we will intervene. Any diagnosis of problems of a neighbourhood or community must be accompanied by an analysis of their strengths and resources: values, leadership, forms of healing or comfort, internal and external relationships, skills for coping, support at their disposal... Study the "assets" and activate them is a step that must be included in the operation from the beginning. There are programs intended to delay the entry into consumption and others to avoid progression, i.e. prevent the step of some young people from more accepted drugs (such as tobacco or marijuana) to more dangerous, either because greater addiction or health effects, either by social stigma.

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**PREVENTION: WITH WHOM?**

This is another crucial issue. Although it seems clear what we mean when speaking of Roma youth, it is not always the case. Not only because of the difficulty of identifying and defining the boundaries of the group, but rather for the convenience, or not, to do so. Again, we have different options:

- **Programs to all citizens or part of this**, but they have a special strategy to reach Roma youth or to deal with them.
- **Specific programs** aimed at improving communication with Roma families and environments, for example through cultural mediators.
- **Mixed programs** that have multiple lines to enable different people to find their place and can leverage resources.

Another key element is related to Roma youth themselves, we must consider at least two differences: **age and sex**. Normally youth programs differ with the younger group of 11 to 15 years old (there are programs that begin before) and 16 and older. These limits cannot be arbitrary, as they may vary in the case of Roma: a young Roma 18 years old behaves in many respects the same way that a Roma not the same age, but it is quite possible that the young Roma is already married and have assumed adult responsibilities (as we have seen in previous sections, the Roma youth assume adulthood before). The young Roma becomes a young adult before than the non-Roma.

It is also important to consider the **gender** as it plays an important role in the Roma (and all), for two reasons:

- **Different roles** of men and women, mothers and fathers, in the Roma family. This involves different forms of freedom and control, leisure and consumption. Some young women are very protected from consumption (but not from other risks) by the existence of a strong moral sanction, but others will be more exposed to the stigma for women of a consumption accepted in males. Boys and girls have ways of being and relating with male and female expected roles that intervention should know.

- **Social change**. Roma women are under observation and with double requirement: switch to more egalitarian forms, because they are interested and because society demands it, sometimes legally (in relation to compulsory schooling) and also feel responsible for maintaining certain traditions which are the core of Roma culture. Young men, in turn, may be comfortable with a less macho identity or feel fear or reluctance to changes that society calls them to assume, often with some hypocrisy, as if there were only male chauvinism or violence within Roma. Relations between the sexes are a key issue for the advance or the closure of the community and any program should think about it.

The question of with whom to intervene does not end here. Resources can be individual, for a group, for families or neighbourhoods. Each level will require an accurate design and a particular strategy. If you choose to deal with new and conflicting consumption for the community, it may not be time to bring together young people with their parents or other authorities of the community, it will not talk or be comfortable.
Moreover, working with families, health education and improving communication skills of parents, can be important tools of prevention with youth.

Some approaches require the complicity community and its leaders, religious or civic. In other cases, the resource will be most useful if you have to be outside the Roma world networks. A woman who has a drug problem or HIV or violence at home will more readily seek advice from a nearby service but general, to a hospital or outpatient unit, rather than a drug device afraid of the stigma associated. Young people come without problems a leisure activity in the neighbourhood, while they will be perhaps reluctant to participate in a drug prevention program in an after-school hours. All these aspects are important for the design of the program and its activities.

The Advisory Committee has stressed the importance of preventive actions to adapt to the characteristics of the target group, so as to achieve effective capture their attention. This can be accomplished, for example, knowing how they relate or interests (concerns, leisure, etc.). Prevention is complicated work with any young, be Roma or not, due to the low perception of risk in the short term. The question of with whom intervene does not end here. Resources can be individual, for a group, for families or neighbourhoods. Each level will require an accurate design and a particular strategy. If you choose to deal with new and conflicting consumption for the community, it may not be time to bring together young people with their parents or other authorities of the community, it will not talk or be comfortable.

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WHERE SHOULD WE INTERVENE?

Space is another important element to consider in prevention with Roma youth. The neighbourhood is a good indicator of the social status of the Roma community, usually on their level of income and education, but especially for its internal and external relationships. Marginalization has a spatial brand but not always, because there are social problems and exclusions in better neighbourhoods. But what is certain is that segregation always has clear effects on consumption and access to health facilities.

But besides knowing the environment and define the limits of intervention, it is important to know in what context the program will offered. The following questions can help us: Where do
they meet the young Roma, in school, in church, on the street, in their homes? The messages
will reach them by computer, by television, by a teacher, through posters in the health centre or
by their parents?

The educational environment is perfect if the young people are in it and are comfortable in
egalitarian relationships. Programs of health promotion find in the school a partner with a
complete and captive population. But from some age this is not the case, or are in a position of
segregation: here messages and programs will have a special nuance. Moreover, the school
may be saturated with requirements. Its role is to strengthen the individual (and group) in
general, rather than providing in a short time all the information that society decides to transmit
to minors.

Health centres can take advantage of its importance and its proximity to families and
neighbourhoods, but knowing that many young people seek support or advice in places where it
is not so easy to find a relative or a neighbour. Hence the specific youth centres also have their
place, information centres, leisure, reproductive health. Each resource can play a role knowing
the audience and its limitations.

There are other places, virtual and real, to work on prevention. A clear space is free time, either
street (parks and squares), or public places where boys and girls spend their time, the bars or
nightclubs where they go, if they go out, and spend their leisure time. But they are also useful
spaces or activities that are offered in the district, through public facilities (libraries, community
centres, etc.) or leisure or educational programs run by non profit organizations.

For this reason, discover places of influence in the neighbourhood and leisure of Roma youth is
an important step. And of course knowing barriers they find to the use or presence in any of the
areas mentioned above: where will they never go, where they do not feel welcome or don’t feel
entitled to enter.

**HOW TO INTERVENE?**

As for the content of prevention, we think that the areas that have proven most effective are the
same for young Roma and non-Roma, although there are no studies or assessments thereon.
However, as has been explained in this manual, it is necessary to adapt or reinterpret the
messages. The idea is that the channels and content should be meaningful to Roma youth and
respond to their practical situation (and everyday), and their moral sentiments.

What are these areas? Normally there are three stages or types of prevention that correspond
to the motivational structure of individuals and to be addressed in prevention programs:
**information, work in personal and social skills, and general prevention** (eg, leisure
programs).

**Information**

Information is important but not sufficient. This opens the door to other interventions and
prepares the subject from the cognitive point of view. But the information that we provide must
compete with a large number of alternative sources, favourable or unfavourable, on drugs:
media, parents, friends, the experience, report on the virtues and problems of addiction and all
that configure the symbolic universe where this information makes sense.
Therefore, informing is not only providing data, but doing so in a useful and influencing manner for the subject. Hence arise the idea of transforming the ways of delivering guidelines, based on the messages and peer references, or through health workers reporting from within, so to speak, with the language and values of the target group.

In public health work there are experiences of community health workers who can provide inspiration for prevention programs, and to comply with some of the basic purposes: to have people trained, allied health systems which in turn are learning of them, and they are both an information channel in both directions and a strong social tool. They are not necessarily cultural mediators, nor need to be only Roma, and their strength comes mainly from a transformation capacity in both directions. That is, they will be useful to the extent that they can force the system and its professionals to open up and understand the problems and resources of a neighbourhood or community.

**Personal and social skills**

This means increasing the ability of subjects to tackle problems, overcome frustration, control impulsivity, or resist peer pressure, ie improving the psychosocial factors that appear to influence the abuse or drug problem. What the experts call resilience, the ability to rebuild or strengthen their own subjectivity even when it has been damaged by bad experiences, is based on three steps (Dillon, 2007):

1. **A cognitive** level, young people need information relevant to be aware of what they are and of the effects of drugs. It is necessary to know the reasons of youth to consume or not, the importance of the views of influential people for them, the fear of legal consequences or health, etc.

2. **On a motivational** level, they must understand or assume that the consumption or the abuse is incompatible with their aims or morals. For this, the subject must have a self-image, feasible and credible targets, and a stable moral framework.

3. The third aspect is to reinforce what some call **self-efficacy**, ie, the ability to carry out what is thought or decided, for example, not to take drugs when they are considered incompatible or negative for the person or group. This capacity should be worked in various contexts and not necessarily in the context of the prevention of addiction, it is a life skill.

Young Roma need, like everyone else, useful information for their life, opportunities to develop themselves achievable goals, ability to carry them out or at least try. Clearly, this framework involves working not only the individual, but the group and the community. If the young people feel well integrated in school, if the family can provide a moral framework although comprehensive, discipline and affection, if the community offers opportunities for fun, drug problems (which will not cease to exist) will be less harmful or more isolated.

Furthermore, programs need to be consistent, be stable over time, based on good theory and implemented through meaningful personal relationships. Evaluation will help to improve them and to adapt them to changing circumstances.
4.4. SOME CRITERIA TO INTERVENE WITH ROMA YOUTH

There are obvious principles in the prevention or treatment of addictions, such as confidentiality, empathy, understanding others or be patient to accommodate the expected slow progress, but also the need to have clear goals and boundaries to guide youth and do not leave them alone with their problems. Otherwise, in cultures not so individualized, the idea that drugs are bad for health, without any community or moral support, will be a message very weak.

But there are other principles that must be present when working with a minority: to know from where it comes, activate contextual resources, respecting the progress and propose small achievable goals, to support individual processes, but discuss the social structure; learning from margins.

KNOWING FROM WHERE DO WE SPEAK

As health professionals we represent a public authority, and as non Roma, we represent a hegemonic culture. Hegemony is something that we do not need to explain, that is assumed, given as granted; only those who are not in the norm are asked for explanation. It is essential to be aware of it. Many misunderstandings of social work and work with minorities are based on the comfortable assumption that the other shares our views (or should do) and that just with an understanding attitude we have made the job of communication. Understand that another person may have other values or give a different weight to them is as important as understanding our own values.

Health work is not neutral. Our idea of the body, disease, morality is so culturally and materially determined as that of other groups. That is what unites us: that it is arguable that the personal welfare is the aim of all medical practice, it is arguable that having two children (no more, no less) and an independent home separated from parents is the only family model advantageous and modern, it is arguable that the disciplines of the consumer society are always liberating and rewarding, or always negative and immoral.

ACTIVATING RESOURCES OF THE ENVIRONMENT

Individuals and groups have their own forms of care and caring, strengths and ideas that programs should not overlook. It is what is usually called empowerment, although the meaning of this term is not always clear. If one recognizes the other’s power and authority, this must be done seriously, given the opportunity to participate in their progress, accepting a degree of dissatisfaction with their guidelines or pathways (always within the limits of democratic principles) and leaving transform their life situation or at least be open to discuss about it. It is always a difficult road, but all prevention plans must seriously engage with the power and resources of others, highlight them and strengthen them. This implies some rebalancing between the public authority and the authority and knowledge of Roma youth.

- See the positive, strengths and potential of people
- View and analyze the causes of the problems and their consequences.
- From the community level, we must know all significant neighbourhood or useful resources for the child.
- Consider Roma associations in the neighbourhood, because they can give us ideas and suggestions for prevention.

PROPOSING ATTAINABLE AIMS

Another key element of the intervention with minorities or people who have less power than the institution that wants help them is the importance of setting achievable goals and respect the small advances. If you are looking for big changes, or changes outside the structural reality, the result is frustration both for the professional and the user. It is not about making modest programs, they can and should be ambitious, but must be defined in a manner that will provide concrete progress cementing the confidence of youth on themselves. If developments are not seen and are not held, if we only respect the ultimate or ideal of change, people who have worked hard for a particular purpose will withdraw their excitement and confidence.

The Advisory Committee has stressed the idea that the professional must be aware of the difficulty of achieving short-term goals. Achieving results involves work and continued effort, usually accomplished in medium or long term.

SUPPORTING INDIVIDUAL PROCESS AND DEBATING SOCIAL PROCESS

This entails taking into account the weight of the structure. In situations of social inequality, progress often will be frustrated, the young people will not respond as expected, the reality of marginalization and poverty will prevail. The result is often the disappointment of the professional and to blame unconsciously to the users of their problems or their inability to overcome them.

There are two ways to avoid this: to support individual processes of change when a person has his/her own ambitions or wants to go further in training, information or prevention. But above all it is necessary to discuss with the team and with young people themselves, the limits of the intervention, the material conditions of his/her life. This politicization of social intervention prevents us to consider young people fully accountable for the results, but not completely unrelated.

Reflection on the structural limits of the work itself and the institution or organization in which we are can help professional teams to take a more transformative approach and more balanced with their own work.

LEARNING FROM THE MARGINS

The last recommendation is to learn and transfer what we learned to the places where we work. We live in a risk society, where everyone could be in the cracks and breaches of social integration. At the same time, we see that people are able to improve their life in very difficult environments. Social innovation, one of the principles of European action, should be tested in all programs. It is necessary to risk with reasoned and complex projects, knowing that the results will be useful for the health institution. What is learned in the supposed "margins" or with minorities shall apply to the general population, which is becoming less homogeneous and more plural.


PART II: ACTIONS FOR PRACTICE
A) INTRODUCTION

The aim of the second part of the Guide, *Actions for Practice*, is to present in a pedagogical way the content published in the first part (*Manual Practice*). Therefore, the dynamics are linked to the content addressed in the first part, in order to complete the training process designed in an entertaining and practical way. For this reason, we recommend reading the first part before addressing the training exercises.

This second part also aims, through different dynamics and techniques, create spaces for reflection on the perceptions, attitudes and other aspects present in our health professional practice, with the idea of improving our intervention.

The purpose of this manual is to improve health and health intervention on the Roma community, and thus contribute to reducing inequalities affecting them on Health.

B) STRUCTURE OF THE DOCUMENT

The proposal of the Shares for practice structure, in content, in the same way that the first part (*Practice Manual*):

- Block 1: arises from the practice of various health professionals regarding the Roma community
- Block 2: We analyse the reality of this population in terms of content and dynamic proposal.
- Block 3: To return to your practice with new elements to improve it.

The proposal consists of a total of 10 sessions (grouped in three thematic blocks), lasting approximately one hour each session. Within each session will include a series of dynamic, which will address the contents.

Perform the 10 sessions will address the 3 blocks all contents of this manual, so as to get a comprehensive education through a logical sequence of sessions and dynamic.

However, the training process designed also contemplates other alternatives, as itineraries, which can adapt to different contexts or situations in relation to the existence of possible constraints (of time or resources) to address all sessions or dynamic. These alternative routes will allow the proposed work separately, depending on the profile of the participants, the time you have and / or want the content to be addressed (with varying degrees of completeness). They pose two types of training itineraries or routes:

1. **Transverse**: will be addressed, with varying degrees of completeness, the entire contents of the manual, completing comprehensive training. We have designed three routes cross:
   a. **Minimum**: duration of 2 hours and 35 minutes, will have a very global view of the contents of the Manual.
b. **Medium**: From duration of 5 hours and 20 minutes, will have a more complete view of the main contents, including enabling dynamic reflect more deeply on the concepts and main ideas.

c. **Full**: In a period of 10 hours, all sessions will be held and referred dynamics, which is the recommended setting.

2. **Theme**: These address blocks or thematic sessions so that training can focus on the aspects of greatest interest to the recipients list and training (Each session addresses a specific topic and lasts 1 hour).
Then (Section C: Schematic Summary of Actions and Sessions), a summary table is included with all sessions and actions proposed under the name of the action, a brief description of the activity, duration and form of identification (eg 1A: where the number (1) corresponds to the session and the letter (a) is the unique identifier).

Later (Section C: Training Itineraries), provides a detailed explanation of each of the sessions and dynamic, with the following headings: name, duration, target, technical, and material required detailed procedure how to perform dynamic.

Finally, a relation of Annexes is included with documentation and complementary necessary information to realize the exercises, between which they are included:

- Cards summarize of the contents that they must work in the exercises and sessions (that develop with major depth in the Handbook for Practice)
- Material of specific work of the exercises (SWOT, Determinants of Health and Social Tree).
- Others materials (evaluation or news).

### TRANSVERSAL PATHS: Minimum, Medium and Full

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<td>8C</td>
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<td>10D</td>
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<td>10E</td>
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</tr>
</tbody>
</table>

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9 The bibliography included in the Annexes is in the Bibliographical References of the Part I (Handbook for Practice) or of the Part II (Actions for Practice).
## C) SCHEMATIC SUMMARY OF ACTIONS AND SESSIONS

<table>
<thead>
<tr>
<th>BLOC</th>
<th>EXERCISE</th>
<th>ACTION</th>
<th>DURATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1A</td>
<td>Welcome and presentation of participants and trainers</td>
<td>5 min.</td>
<td>Brief presentation of the audience (through the technique of the ball or the skein of wool).</td>
</tr>
<tr>
<td>1</td>
<td>1B</td>
<td>Introduction to exercises</td>
<td>10 min.</td>
<td>Presentation of contents and aims of the training. A question will be asked, to assess at the end of the training the change of perception produced among the audience.</td>
</tr>
<tr>
<td>1</td>
<td>1C</td>
<td>¿What do we know about Roma?</td>
<td>15 min.</td>
<td>Brief self-diagnosis, through a list of questions, about our knowledge of Roma and their culture.</td>
</tr>
<tr>
<td>1</td>
<td>1D</td>
<td>A little bit of history</td>
<td>25 min.</td>
<td>Knowing the history and identity of Roma, through a video, or reading a text, and later discussion.</td>
</tr>
<tr>
<td>1</td>
<td>2A</td>
<td>Introduction to the perception about Roma</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>1</td>
<td>2B</td>
<td>Perception of society about Roma</td>
<td>5 min.</td>
<td>Group reflexion about what is thought / said usually about Roma.</td>
</tr>
</tbody>
</table>
| 1    | 2C       | Prejudices and stereotypes | 20-30 min. | Through a test, thinking about our perception and...
<table>
<thead>
<tr>
<th>BLOC</th>
<th>EXERCISE</th>
<th>ACTION</th>
<th>DURATION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2D</td>
<td>Reflexion on differences and problems</td>
<td>15 min.</td>
<td>Theoretical reflexion (from the contents of the Handbook for Practice) about how do we meet Roma.</td>
</tr>
<tr>
<td>1</td>
<td>2E</td>
<td>¿Do we have prejudices?</td>
<td>5 min.</td>
<td>Main conclusions or ideas about prejudices and stereotypes, as a final synthesis.</td>
</tr>
<tr>
<td>1</td>
<td>3A</td>
<td>Introduction to the relationship of Roma with the Health System</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>1</td>
<td>3B</td>
<td>Our relationship with Roma as Health professionals</td>
<td>25 min.</td>
<td>Though role-playing we will think about what are the relationships that we find in our daily work.</td>
</tr>
<tr>
<td>1</td>
<td>3C</td>
<td>Thinking about the relationship between Roma and Health professionals</td>
<td>20 min.</td>
<td>Through a theoretical presentation and group analysis we will tackle what is the relationship that we use to have with Roma.</td>
</tr>
<tr>
<td>2</td>
<td>4A</td>
<td>Introduction to Roma culture in Europe and their social reality</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>2</td>
<td>4B</td>
<td>How to analyse the information</td>
<td>10 min.</td>
<td>Knowing a way to analyse the reality, through the Social Tree technique.</td>
</tr>
<tr>
<td>2</td>
<td>4C</td>
<td>Reality of Roma in Europe</td>
<td>20 min.</td>
<td>Presentation of some of the main elements of the social reality of Roma in Europe.</td>
</tr>
<tr>
<td>2</td>
<td>4D</td>
<td>Analysis and understanding of social reality</td>
<td>25 min.</td>
<td>Analysis of the main elements of the social reality of Roma, through the Social Tree technique to a better understanding of this reality.</td>
</tr>
<tr>
<td>BLOC</td>
<td>EXERCISE</td>
<td>ACTION</td>
<td>DURATION</td>
<td>DESCRIPTION</td>
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</tr>
<tr>
<td>2</td>
<td>5A</td>
<td>Introduction to Roma and Health</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>2</td>
<td>5B</td>
<td>How to analyse information on Health</td>
<td>10 min.</td>
<td>Presenting a procedure to analyse information, through the technique of Health determinants.</td>
</tr>
<tr>
<td>2</td>
<td>5C</td>
<td>European Roma related to health</td>
<td>20 min.</td>
<td>Presentation about the situation of health of Roma and some ideas related with health and relationship with Health System.</td>
</tr>
<tr>
<td>2</td>
<td>5D</td>
<td>Analysis and understanding of reality regarding health</td>
<td>25 min.</td>
<td>Analysis of reality through the technique of Health Determinants, and conclusions.</td>
</tr>
<tr>
<td>2</td>
<td>6A</td>
<td>Introduction on drugs and Roma youth</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>2</td>
<td>6B</td>
<td>How to analyse information on drugs and youth</td>
<td>10 min.</td>
<td>Presenting a way of analysis of information, with SWOT technique.</td>
</tr>
<tr>
<td>2</td>
<td>6C</td>
<td>Socio-cultural factors in the context of drugs</td>
<td>20 min.</td>
<td>Knowing some socio-cultural factors of Roma to a better understanding of their relationship with health and drugs.</td>
</tr>
<tr>
<td>2</td>
<td>6D</td>
<td>Analysis of information regarding youth and drugs</td>
<td>25 min.</td>
<td>Analysis of reality using SWOT technique, and attaining conclusions.</td>
</tr>
<tr>
<td>2</td>
<td>7A</td>
<td>Summary of blocks 1 and 2</td>
<td>20 min.</td>
<td>Summary of blocks 1 and 2.</td>
</tr>
<tr>
<td>2</td>
<td>7B</td>
<td>Main learning and conclusions</td>
<td>30 min.</td>
<td>Main conclusions of the processes of learning and contents addressed</td>
</tr>
<tr>
<td>BLOC</td>
<td>EXCERCISE</td>
<td>ACTION</td>
<td>DURATION</td>
<td>DESCRIPTION</td>
</tr>
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<td>------</td>
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</tr>
<tr>
<td>3</td>
<td>8A</td>
<td>Introduction to communication and empathic communication</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>3</td>
<td>8B</td>
<td>What is our starting point?</td>
<td>10 min.</td>
<td>Reflexion about the communication barriers and the relationship that can exist between Roma and health professionals.</td>
</tr>
<tr>
<td>3</td>
<td>8C</td>
<td>Some guidelines to achieve an empathic communication and relationship</td>
<td>15 min.</td>
<td>Presentation of some guidelines that can help to achieve an empathic communication and relationship.</td>
</tr>
<tr>
<td>3</td>
<td>8D</td>
<td>Implementation</td>
<td>25 min.</td>
<td>Implementation of guidelines on communication and empathy.</td>
</tr>
<tr>
<td>3</td>
<td>8E</td>
<td>Producing conclusions</td>
<td>5 min.</td>
<td>Main conclusions about empathy and communication.</td>
</tr>
<tr>
<td>3</td>
<td>9A</td>
<td>Developing attitudes of mediation and tackling conflicts</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>3</td>
<td>9B</td>
<td>Guidelines to develop attitudes of mediation and how to tackle conflicts</td>
<td>15 min.</td>
<td>Providing some Guidelines to allow developing attitudes of mediation and how to tackle the origin of conflicts.</td>
</tr>
<tr>
<td>3</td>
<td>9C</td>
<td>Analysis of situations of conflict</td>
<td>15 min.</td>
<td>Critical analysis of a real situation of conflict.</td>
</tr>
<tr>
<td>3</td>
<td>9D</td>
<td>Looking for alternatives</td>
<td>25 min.</td>
<td>Looking for solutions and actions that allow us to develop attitudes of mediation and how to tackle conflicts.</td>
</tr>
<tr>
<td>3</td>
<td>10A</td>
<td>Introduction to other aspects in my practice</td>
<td>5 min.</td>
<td>Brief presentation.</td>
</tr>
<tr>
<td>BLOC</td>
<td>EXERCISE</td>
<td>ACTION</td>
<td>DURATION</td>
<td>DESCRIPTION</td>
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<tr>
<td>3</td>
<td>10B</td>
<td>Socio-cultural patterns to work with Roma</td>
<td>15 min.</td>
<td>Knowing some socio-cultural patterns to improve the health work.</td>
</tr>
<tr>
<td>3</td>
<td>10C</td>
<td>How to include socio-cultural factors into my professional practice</td>
<td>20 min.</td>
<td>Designing strategies and concrete actions to include socio-cultural factors into my professional practice.</td>
</tr>
<tr>
<td>3</td>
<td>10D</td>
<td>Final conclusions of Actions for Practice</td>
<td>15 min.</td>
<td>Main conclusions and key ideas obtained during the training.</td>
</tr>
<tr>
<td>3</td>
<td>10E</td>
<td>Evaluation</td>
<td>5 min.</td>
<td>Evaluation of Actions for Practice</td>
</tr>
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</table>
D) TRAINING PATHS

BLOCK 1: HOW DO WE MEET ROMA AND THEIR YOUTH?: "STARTING FROM WHAT WE KNOW"

SESSION 1: WHAT DO WE KNOW ABOUT ROMA?

AIMS:
- Thinking about the degree of knowledge that we have about Roma and their culture: knowing their history and starting to understand their identity and ways of relationship.

EXERCISE 1A  Welcome and presentation of participants and trainers

DURATION • 5 minutes.

AIM • Presentation of the audience to create a pleasant and relaxed atmosphere to start the training.

TECHNIQUE • Dynamics of presentation: Ball or skein of wool (or other objet to pass the word).

MATERIALS • Small ball, skein of wool, or similar object.

PROCEDURE
1. Welcome to participants.
2. Commenting briefly the theme and aims of the training.
3. Brief presentation of participants and trainers through the ball technique, or the skein of wool. Some themes for the presentation could be:
   - Answering to some questions such as: name, place of birth, hobbies, favourite sport, what is more interesting in his/her job.
   - Profession, where do you work, etc.
   - Other questions can be added depending on the level of knowledge of participants.
4. To pass the word they can use the ball, or the skein of wool. The trainer must explain that the presentation has to be quick.
## EXERCISE 1B  
**Introduction to exercises**

| DURATION | • 10 minutes. |
| AIM | • Explaining briefly the aim of the training to implement with the health professionals of the centre. |
| TECHNIQUE | • Oral Presentation of summary sheet: *Annex: Introduction to training*.  
• *Initial exercise:* Asking a question to participants. This exercise will be repeated at the end of the training (see [exercise 10D](#)), to know and compare if the perception of participants have changed during the training. The trainer must keep the answers.  
The aim of this information will not be explained to participants. |
| MATERIALS | • Summary sheet: *Annex: Introduction to training*.  
• Folios and pens. |
| PROCEDURE | 1. The trainer will introduce the course using the summary sheet.  
2. Explaining the *Beginning exercise*:  
   - Using blank sheet, participants will ask briefly the following question, individually and anonymously: *What can I do to improve my health work with Roma?*  
   - The answer will be delivered to the trainer, who will keep it (it will be used again in the [exercise 10D](#)). |
**EXERCISE 1C**

**What do we know about Roma?**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>15 minutes.</th>
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<tbody>
<tr>
<td>AIM</td>
<td>Performing a brief self-diagnosis of the knowledge that we have about Roma and their culture.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>This exercise can be done with two techniques or alternatives:</td>
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<tr>
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<td>- Alternative 1: Working group (4 or 5 persons per group). It will allow a deeper and thorough analysis.</td>
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<tr>
<td></td>
<td>- Alternative 2: Brainstorming (<em>alternative</em>). This option is faster (and needs less time) but the analysis is less deep. The group provides their ideas or opinions on the issue in a quicker way.</td>
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<tr>
<td>MATERIALS</td>
<td>Flipchart with sheets, marker, scotch tape; or blackboard and chalk.</td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>1. The trainer will present briefly the exercise and its aim.</td>
</tr>
<tr>
<td></td>
<td>2. The exercise can be done by two alternative ways:</td>
</tr>
<tr>
<td></td>
<td>- Alternative 1, working groups. Participants will split into groups of 4-5 people, they will answer the questions and draw the main ideas in a sheet. Each group will explain its work to the rest.</td>
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<tr>
<td></td>
<td>- Alternative 2, brainstorming. The group, in plenary, will answer the questions.</td>
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<tr>
<td></td>
<td>3. The questions are the following:</td>
</tr>
<tr>
<td></td>
<td>- <em>What do you know about Roma?</em></td>
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<td></td>
<td>- <em>What are their habits?</em></td>
</tr>
<tr>
<td></td>
<td>- <em>What are the differences between being Roma and being gadje?</em></td>
</tr>
<tr>
<td></td>
<td>- <em>What is the origin of Roma?</em></td>
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<tr>
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<td>4. For both alternatives, the trainer will write down in a blackboard (or flipchart) the main ideas, as synthesis (or final summary), in order to visualize the key ideas.</td>
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</table>
EXERCISE 1D  

<table>
<thead>
<tr>
<th>A little bit of history</th>
</tr>
</thead>
</table>

**DURATION**  
- 25 minutes.

**AIM**  
- Presentation of history and identity of Roma

**TECHNIQUE**  
This exercise can be done with two techniques:
- **Technique 2:** Video: *Itinerancies, the Roma trip* (Video).
  - Alternative 1: see Introduction and steps 1, 2, 4 y 6.
  - Alternative 2: see introduction and steps 1, 2 y 7 (in the case of Spain).

**MATERIALS**  
- Technique 1: Photocopies of the text (*Annex: The Roma in Europe, a brief history*), blackboard or flipchart, pens.
- Technique 2: Video with DVD (PC, TV and video, etc.), projector, blackboard or flipchart, pens and scotch tape.  

**PROCEDURE**  
1. Brief introduction to the exercise History of Roma, pointing out the idea of knowing who are the Roma.
2. According to the election:
   - Technique 1 (reading): Individual reading of the paper, or in small groups.
   - Technique 2 (video): Watching the video in group (according to both alternatives).
   - For both proposals, the trainer will ask the following questions to be answered in brainstorming, in plenary.
   - What is this about? What caught your attention and why? What are the things that you did not know about Roma?
   - Why do you think that Roma are persecuted?
   - Do you think that it is important to know the Roma Culture?, why?
3. The trainer will write down the main ideas, as a synthesis, in a flipchart. The trainer must keep this product, because he/she will use in **session 7A**.
## EXERCISE 1E

### PRESENTATION OF THE HANDBOOK

<table>
<thead>
<tr>
<th><strong>DURATION</strong></th>
<th>5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIM</strong></td>
<td>Brief presentation of the handbook <em>Health, prevention of addictions and Roma youth in Europe: a handbook and actions for practice.</em></td>
</tr>
<tr>
<td><strong>MATERIALS</strong></td>
<td>Summary sheet: <em>Annex: Presentation of the Handbook</em>.</td>
</tr>
<tr>
<td><strong>PROCEDURE</strong></td>
<td>1. Brief presentation of the handbook using the summary sheet, as closing of Session 1.</td>
</tr>
</tbody>
</table>
SESSION 2: WHAT IS THE PERCEPTION THAT WE HAVE ABOUT ROMA?

**AIMS:**
- Describing and thinking about how we perceive Roma and possible prejudices or stereotypes.

### EXERCISE 2A
**INTRODUCTION ABOUT THE PERCEPTION OF ROMA**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Linking with previous session (nº 1) and commenting the aim of this session (2).</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>Brief presentation by the trainer.</td>
</tr>
<tr>
<td>MATERIALS</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>1. Brief explanation of the work of the previous session (Session 1). We will inform that we will keep talking about Roma, without deepening the issue.</td>
</tr>
</tbody>
</table>

### EXERCISE 2B
**PERCEPTION OF ROMA BY SOCIETY**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Knowing the existing perceptions in the society about what means being Roma.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>Brainstorming in plenary.</td>
</tr>
<tr>
<td>MATERIALS</td>
<td>Flipchart, markers/pens, scotch tape.</td>
</tr>
</tbody>
</table>
| PROCEDURE | 1. In plenary participants will be asked about: *What is thought and/or said usually about Roma?*  
2. The trainer will write down the ideas coming from the brainstorming in the flipchart, clustering them in groups as positives and negatives (this division will not be explained). The trainer will keep the product of this exercise as he/she will use in the session. |
## EXERCISE 2C  
### PREJUDICES AND STEREOTYPES

<table>
<thead>
<tr>
<th>DURATION</th>
<th>20 - 30 minutes (alternative 1: 20 min; alternative 2: 30 min.).</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Starting to break some possible stereotypes related to Roma Culture.</td>
</tr>
</tbody>
</table>
| TECHNIQUE      | Test of Stereotypes and Answers (Annex). 
|                | Two possible techniques of analysis of the Test:  
|                |   - Alternative 1: Brainstorming. Need less time but provide a lighter analysis. 
|                |   - Alternative 2: Analyses by groups, needs more time but allows a deeper analysis. |
| MATERIALS      | Flipchart, markers and scotch tape. 
|                | Annex: Test of Stereotypes and Answers (Campaign: Get to know them before judging them. FSG). |

### PROCEDURE

1. Test of Stereotypes will be answered individually:  
   - They do not want to integrate.  
   - They do not want to work.  
   - They are not interested in studying.  
   - It is a sexist culture.  
   - They take advantage of social resources.  
2. The analysis can be done by two alternatives:  
   - Alternative 1: Brainstorming. In plenary, participants will explain their thinking.  
   - Alternative 2: Analysis in groups. In couples, each participant will think and argue her/his answers. This point is optional (but recommended, as the work in group should be progressive).  
   Later, in groups of 4 - 6 persons, the answers will be commented to get conclusions. Each group will present to the rest of participants (in plenary) the main conclusions or ideas.  
3. The trainer will write down in a blackboard the main ideas of the groups, as a kind of “final synthesis”.  
4. The "final synthesis" will be compared with the information issued from the answers of the Test (see annex).
### EXERCISE 2D

**THINKING ABOUT DIFFERENCES AND PROBLEMS**

**DURATION**
- 15 minutes.

**AIM**
- Theoretical thinking about differences and having or being the problem.

**TECHNIQUE**
- Oral presentation of the summary sheet *(Annex: How do we meet Roma and their youth)*.

**MATERIALS**
- *Annex: How is our relationship with the Roma and their youth.*

**PROCEDURE**

1. The trainer will present briefly the summary sheet. The contents presented are linked to chapter 2 of the Handbook (without part 2.1).
   The trainer can ask the following questions during the presentation, to promote thinking and/or participation of participants:
   - Roma are different? In what?
   - ¿Do they have more problems than the rest of population?, What are they?
   - Are they the problem?, Why?
<table>
<thead>
<tr>
<th>EXERCISE 2E</th>
<th><strong>DO WE HAVE PREJUDICES?</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION</strong></td>
<td>• 5 minutes.</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
<td>• Thinking if we have prejudices when we have relationships with Roma.</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
<td>• Question and thinking.</td>
</tr>
</tbody>
</table>
| **MATERIALS**        | • Folios, flipchart sheets and markers.  
                        • Participants will be asked to read the following bibliography and links (to complete the training).  
                        This bibliography is about Roma persons relevant in society or press news about Roma:  
                        - 50 mujeres gitanas en la sociedad española (book by FSG):  
                          http://www.gitanos.org/publicaciones/50mujeres/  
                        - Romas en Prensa:  
                          http://www.gitanos.org/boletines/Romas_en_la_prensa/  |
| **PROCEDURE**        | 1. Participants are asked to write anonymously in a sheet a word or sentence of what remains from this session 2 (main key idea or conclusion).  
                        2. The trainer will write down the main ideas in a flipchart sheet, at the end of the session. The trainer will keep this product as he/she will have to use it in session 7A.  
                        3. To complete the session, they will be asked to read the additional bibliography (included in MATERIALS), and the following question will be asked to an individual thinking:  
                        *It could be possible that our conception of Roma is biased with prejudices?* |
SESSION 3: HOW ARE THESE IDEAS INFLUENCING THE BEHAVIOUR OF THE HEALTH SYSTEM?

**AIMS:**
- Thinking about the main difficulties that we face in our daily health practice with Roma, and how they can be influenced by what we know and by our perception of Roma.
- Trying to see the situation from the point of view of Roma and thinking about solutions.

### EXERCISE 3A
**INTRODUCTION TO THE RELATIONSHIP OF ROMA WITH THE HEALTH SYSTEM**

<table>
<thead>
<tr>
<th><strong>DURATION</strong></th>
<th>5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIM</strong></td>
<td>Link with the previous session (nº 2) and presentation of session 3.</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
<td>Brief oral presentation by the trainer.</td>
</tr>
<tr>
<td><strong>MATERIALS</strong></td>
<td></td>
</tr>
</tbody>
</table>

**PROCEDURE**

1. Brief presentation of the work of the previous session (nº 2).
   The trainer will explain that during this session they will talk about Roma and their relationship with the health system.

### EXERCISE 3B
**OUR RELATIONSHIP WITH ROMA AS HEALTH PROFESSIONALS**

<table>
<thead>
<tr>
<th><strong>DURATION</strong></th>
<th>25 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIM</strong></td>
<td>Thinking about the relationship that can be between Roma and the health professional in a daily situation at the work centre.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>TECHNIQUE</strong></th>
<th>Role-playing: Exercise where each participant assumes a given role, representing a particular situation. Note: It is important that the performance be respectful, taking into account the perspective of a Roma, common situations such as: ignorance of the centre or of some norms or protocols, his/her personal situation in this moment, etc.</th>
</tr>
</thead>
</table>
Time will be given to volunteer participants to prepare the “performance”.

<table>
<thead>
<tr>
<th>MATERIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brief explanation of the exercise: what is Role-playing. Pointing out that the aim of the exercise is to look at a common situation, the way it happens, and from this point to be able to think about it.</td>
</tr>
<tr>
<td>2. The starting point will be a daily situation and some characters assumed among participants who volunteer. Characters can be: a youth Roma (or any other person: elderly, adult...), doctor, patient, etc. One of these situations will be performed:</td>
</tr>
<tr>
<td>- Situation 1: primary health care to Roma. This can be the access of a Roma to a centre of primary health care, his/her first appointment with a Family doctor, etc.</td>
</tr>
<tr>
<td>- Situation 2: Service of Emergencies or Hospital. A common situation of assistance of emergency (waiting, asking for information, etc.).</td>
</tr>
<tr>
<td>- Situation 3: Care Centre for Drug Addicts; a common situation in the centre involving Roma.</td>
</tr>
<tr>
<td>3. Giving some minutes to volunteers to prepare the “performance”.</td>
</tr>
<tr>
<td>4. Performing the “performance”.</td>
</tr>
<tr>
<td>5. After the &quot;performance&quot;, the “actors” will think about how they felt.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PROCEDURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brief explanation of the exercise: what is Role-playing. Pointing out that the aim of the exercise is to look at a common situation, the way it happens, and from this point to be able to think about it.</td>
</tr>
<tr>
<td>2. The starting point will be a daily situation and some characters assumed among participants who volunteer. Characters can be: a youth Roma (or any other person: elderly, adult...), doctor, patient, etc. One of these situations will be performed:</td>
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<tr>
<td>- Situation 2: Service of Emergencies or Hospital. A common situation of assistance of emergency (waiting, asking for information, etc.).</td>
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<tr>
<td>- Situation 3: Care Centre for Drug Addicts; a common situation in the centre involving Roma.</td>
</tr>
<tr>
<td>3. Giving some minutes to volunteers to prepare the “performance”.</td>
</tr>
<tr>
<td>4. Performing the “performance”.</td>
</tr>
<tr>
<td>5. After the &quot;performance&quot;, the “actors” will think about how they felt.</td>
</tr>
<tr>
<td>EXERCISE 3C</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>DURATION</td>
</tr>
<tr>
<td>AIM</td>
</tr>
<tr>
<td>TECHNIQUE</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>MATERIALS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

1. Participants will be divided in 4 groups: two groups will work with the Health Professionals’ point of view and two groups Roma’s point of view (thinking from both perspectives). They will be asked to answer the following questions (and write down answers on the flipchart):
   - **Groups A:** What are the difficulties that the health professional encounters during his/her relationship with Roma?; what are the causes of these difficulties?
   - **Groups B:** What are the difficulties that the Roma person encounters during his/her relationship with the health professionals?; what are the causes of these difficulties?
     * Each group will work ignoring the activity of the other group.

2. Each group will present their answers to the rest: first A and then B.
3. There will be a reflexion in plenary, from these questions:
   - *It is possible to combine both perspectives?*
   - *What can be done?*
5. To finish, participants will think about the main key idea or conclusion they keep in mind. They have to write...
down this idea in a paper and give it to the trainer. If it is considered timely, some of the ideas can be read.

Later (after the end of the exercise), the trainer will draft a summary of the main ideas and will write down on the flipchart. He/she will keep this product as he/she will have to use it during session 7A y 8B.

**BLOCK 2: OVERVIEW OF ROMA CULTURIEN EUROPE: "THINKING ABOUT THIS REALITY"**

**SESSION 4: OVERVIEW OF ROMA CULTURE IN EUROPE**

**AIMS:**

- Thinking and deepen knowledge about the social reality of Roma in Europe.

**EXERCISE 4A INTRODUCTION TO ROMA CULTURIEN EUROPA AND TO THEIR SOCIAL REALITY**

<table>
<thead>
<tr>
<th><strong>DURATION</strong></th>
<th>➢ 5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIM</strong></td>
<td>➢ Link with the previous block (nº 1) and presentation of block 2 and aim of this session (4).</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
<td>➢ Oral presentation.</td>
</tr>
</tbody>
</table>

**MATERIALS**

**PROCEDURE**

1. Reminding the work done in block 1, and explaining the aim of this session 4: thinking and deepening the social reality of Roma in Europe.

   It is recommended to the trainer reading the introduction of chapter 3 of Handbook for Practice.
## EXERCISE 4B

### HOW TO ANALYSE INFORMATION

<table>
<thead>
<tr>
<th>DURATION</th>
<th>• 10 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>• Presenting a way to analyse reality.</td>
</tr>
</tbody>
</table>
| TECHNIQUE | • Social tree (adaptation of the Social Tree Technique: “Techniques of participation for popular education; authors: Graciela Bustillos and Laura Vargas). The Tree is presented as a whole, a system with life composed by 3 parts interlinked (they need each other to survive) with the following functions:  
  a) Root: it serves the tree to absorb from the soil the substances to feed it.  
  b) Trunk: it gives strength to the tree, keeps it physically, and provides structure.  
  c) Foliage or Leaves: they cover the tree, and the leaves and fruits allow us to identify it and to reproduce. We can compare the parts of the tree with the levels of a society:  
  - The root is the economy, where the production of goods and services take place, is distributed and consumed: work, employment, trade, productive sectors, etc.  
  - The trunk is politics, where power becomes organized, as institutional and legal form: laws, political parties, government, church or school.  
  - The foliage is the ideology, where the relationships of society are reproduced, explained or justified: education, religion, culture, relationships with other groups, etc. |
| MATERIALS | • Flipchart, markers and paper.  
  • Annex: Social Tree. |
| PROCEDURE | 1. The trainer will explain the technique to be used to analyse the information: the technique of the Social Tree.  
  2. The trainer will explain that they will make an oral presentation (in exercise 4C) and that they shall analyse the information according to the results of the social tree. |
3. To perform this analysis participants will split in 3 groups. Each group will analyse a given aspect (economics, politics or ideology).

<table>
<thead>
<tr>
<th>EXERCISE 4C</th>
<th>SOCIAL REALITY OF ROMAIN EUROPE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION</strong></td>
<td>• 20 minutes.</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
<td>• Knowing some of the key elements of the social reality of Roma in Europe.</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
<td>• Oral presentation of the Summary Sheet (<em>Annex: Social reality and socio-cultural elements</em>).</td>
</tr>
<tr>
<td><strong>MATERIALS</strong></td>
<td>• <em>Annex: Social reality and socio-cultural elements</em> (corresponding to chapters 3.1 and 3.2 of the practical handbook).</td>
</tr>
<tr>
<td><strong>PROCEDURE</strong></td>
<td>1. Using the Summary Sheet, the trainer will make an oral presentation, looking for the participation and thinking of the group. The themes addressed will be the following:</td>
</tr>
<tr>
<td></td>
<td>• Origin and diversity.</td>
</tr>
<tr>
<td></td>
<td>• A population between normalization and exclusion.</td>
</tr>
<tr>
<td></td>
<td>• Social structure and transformation process.</td>
</tr>
<tr>
<td></td>
<td>• Impact of residence on Roma identity.</td>
</tr>
<tr>
<td></td>
<td>• A youth population in flux.</td>
</tr>
<tr>
<td></td>
<td>• Important socio-cultural elements.</td>
</tr>
<tr>
<td><strong>EXERCISE 4D</strong></td>
<td><strong>ANALYSIS AND UNDERSTANDING OF SOCIAL REALITY</strong></td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>DURATION</strong></td>
<td>• 25 minutes.</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
<td>• Analysis of the information to a better understanding of reality.</td>
</tr>
</tbody>
</table>
| **TECHNIQUE**  | • Analysis of the information using the Social Tree technique (to make this exercise it is necessary to have made before exercise 4B y 4C).  
• Working group (3: root, trunk and foliage/leaves). |
| **MATERIALS**  | • Flipchart, markers and scotch tape.          |
| **PROCEDURE**  | 1. Each group (following the division made in exercise 4B) will analyse the information issued from exercise 4C, taking notes of the main ideas on the flipchart.  
2. Each group will present the analysis to the other groups.  
3. The trainer will ask the following questions, which will be analysed in plenary:  
   o What are the relationships among the different parts of the Social Tree?  
   o Does this exercise help us to understand the social reality of Roma in Europe?  
   o What conclusions can we learn?  
4. The trainer will write down the main ideas on the flipchart, as summary. He/she will keep this product, to be used in session 7A. |
SESSION 5: ROMAOF EUROPE AND HEALTH

AIMS:

• Thinking and deepen knowledge about European Roma and their relationship to health and health services.

EXERCISE 5A INTRODUCTION TO ROMA AND HEALTH

DURATION

• 5 minutes.

AIM

• Linking with previous session (nº 4) and commenting the aim of the session (5).

TECHNIQUE

• Brief oral presentation

MATERIALS

• This presentation can be completed with chapter 3.3 of the Handbook for Practice.

PROCEDURE

1. Reminding the work of the previous session and set up the particular aim of session 5.

EXERCISE 5B HOW TO ANALYZE THE INFORMATION ON HEALTH

DURATION

• 10 minutes.

AIM

• Presenting a procedure of analysis information on health.

TECHNIQUE

• Oral presentation of the Determinants of Health Technique. Health is determined by a cluster of factors called “health determinants”. These determinants produced some methods of analysis, such as the multi-level model of health determinants, which is described below:

  o Biological Factor: A set of genetic factors are involved in the production of some health problems: infectious, cardiovascular, metabolic, mental, cognitive and behavioural. These factors include the age and sex of the person.

10 Source: Determinantes de la Salud; María Angélica Gomes. OPS/OMS Nicaragua.
- **Lifestyle**: Individual's behaviour, beliefs, values, historical background and world perception, risk attitude and vision of their future health, communication skills, stress management and adaptation/control over life circumstances that determine their preferences and lifestyle.

- **Influence of the community and social support**: Pressure of the group, cohesion and social trust, social support networks and other variables associated with level of social integration and investment in social capital.

- **Access to services of health care**: The way health care is organized and sanitary aspects in its promotion, protection and recovery of health and the prevention, control and treatment of disease in a population.

- **Life and work conditions**: Housing, employment and education are basic conditions to the health of a population.

- **Socio-economic and cultural conditions**: At this level operate large macro-determinants of health that are associated with the structural features of society, the economy and the environment and, therefore, linked to political priorities of government decisions and ways of dealing with the social agenda. For example: the scope of the current legal framework and the strategies of poverty reduction...

**MATERIALS**

- **Annex: Determinants of Health**.

**PROCEDURE**

The trainer will present Determinants of Health Technique. Using the factors of this technique, health of Roma will be analysed (the explanation will be given in exercise 5C).

1. Participants will split into 4 groups, which will analyse one of the following determinants:
   - Biologic and lifestyle.
   - Influence of the community and social support.
   - Access to services of health care.
   - Conditionings of life and work; and socio-economic.

The trainer will explain that in the following exercise (5C) they will make a presentation and afterwards (exercise 5D) an analysis will be performed.
<table>
<thead>
<tr>
<th><strong>EXERCISE 5C</strong></th>
<th><strong>EUROPEAN ROMA RELATED TO HEALTH</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION</strong></td>
<td>• 20 minutes.</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
<td>• Initial diagnosis of the situation of health among Roma, knowing some ideas about health and how they face the health system.</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
<td>• Oral presentation of the summary sheet (<em>Annex: Relationship to health</em>).</td>
</tr>
<tr>
<td><strong>MATERIALS</strong></td>
<td>• <em>Annex: Relationship to health.</em></td>
</tr>
<tr>
<td></td>
<td>• This presentation is linked to chapter 3.3 of the Handbook for Practice.</td>
</tr>
<tr>
<td><strong>PROCEDURE</strong></td>
<td>1. In this presentation (summary sheet) participants will be asked to participate. The themes to be addressed will be the following:</td>
</tr>
<tr>
<td></td>
<td>• Brief diagnosis of health.</td>
</tr>
<tr>
<td></td>
<td>• Ideas on health.</td>
</tr>
<tr>
<td></td>
<td>• Roma facing the Health System.</td>
</tr>
</tbody>
</table>
## EXERCISE 5D

### ANALYSIS AND UNDERSTANDING OF REALITY REGARDING HEALTH

<table>
<thead>
<tr>
<th><strong>DURATION</strong></th>
<th>Analysis and understanding of reality.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AIM</strong></td>
<td>Technique: Determinants of Health (to perform this exercise it is necessary to have finished exercises 5B and 5C). Analysis in groups.</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
<td>Flipchart, markers and scotch tape.</td>
</tr>
</tbody>
</table>
| **MATERIALS**| 1. Each group will analyse the information according to the determinants (following the division made in exercise 5B).  
2. Each group will present the main ideas to the other groups.  
3. After the end of each group, they will have the opportunity to complete the information delivered.  
4. The trainer will ask participants about the conclusions or final reflexions than we can obtain.  
5. The trainer will write down the information in a flipchart sheet, as a synthesis. He/she will keep this product as it will be used in session 7A. |
| **PROCEDURE**| Analysis and understanding of reality. |
## SESSION 6: KEY IDEAS ON DRUGS

### AIMS:
- Training health professionals about socio-cultural factors to a better understanding of the relationship between Roma youth and drug use.

### EXERCISE 6A  
**INTRODUCTION ON DRUGS AND ROMA YOUTH**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Linking with previous session (nº5) and explaining the aim of this session (6).</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>Oral presentation.</td>
</tr>
<tr>
<td></td>
<td>The trainer can complete the presentation with chapter 3.4 of the Handbook for Practice.</td>
</tr>
<tr>
<td>MATERIALS</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>1. Reminding the work of previous session (nº 5) and explaining the aim of this session 6, as well as the way to proceed.</td>
</tr>
</tbody>
</table>

### EXERCISE 6B  
**HOW TO ANALYSE THE INFORMATION ON DRUGS AND YOUTH**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>10 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Presenting a procedure to analyse information on drugs and youth.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>Technique SWOT 13: this is a tool that facilitates the analysis of reality and making decisions. The procedure is to analyse external and internal factors that can affect reality, in this case Roma youth and drugs.</td>
</tr>
<tr>
<td></td>
<td>o External factors, from the context:</td>
</tr>
<tr>
<td></td>
<td>▪ Opportunities offered by the environment and how to take advantage of them.</td>
</tr>
<tr>
<td></td>
<td>▪ Threats of the context and how to avoid or eliminate them.</td>
</tr>
<tr>
<td></td>
<td>o Internal factors of Roma youth:</td>
</tr>
</tbody>
</table>

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98
- Own strengths of Roma youth and how to maximize them.
- Weaknesses and how to reduce or eliminate them.

At the same time, these factors don’t apply only to present, but also to the opportunities and threats that can arise in the future and its influence on youth. In this sense, to analyse threats and opportunities the following factors can be considered: demographic, economic, political, legal, sociological, environmental, technological or cultural.

### MATERIALS
- Annex: Technique SWOT

### PROCEDURE

The trainer will explain the SWOT Technique, to use it to analyse information presented in exercise 6C.

1. Participants will split in 4 groups, each group will analyse one of the following factors: weaknesses, threats, strengths and opportunities.
2. The trainer will explain to participants that in the next exercise an oral presentation will be made (exercise 6C) and afterwards they will implement the analysis using SWOT Technique (6D).
<table>
<thead>
<tr>
<th>EXERCISE 6C</th>
<th>SOCI-CULTURAL FACTORS IN THE CONTEXT OF DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURATION</td>
<td>• 20 minutes.</td>
</tr>
<tr>
<td>AIM</td>
<td>• Knowing some socio-cultural factors of Roma for a better understanding of their relationship with health and drugs.</td>
</tr>
</tbody>
</table>
| TECHNIQUE | • Oral presentation of the summary sheet (*Annex: Relation to drugs*).  
• This summary sheet is related to chapter 3.4 of the Handbook for Practice. |
| MATERIALS | • *Annex: Relationship with drugs*. |
| PROCEDURE | 1. Presentation of the Summary Sheet, addressing some key socio-cultural elements of Roma which help us to understand their relationship with health and drugs.  
Themes:  
• Cultural attitudes.  
• Social network.  
• Factors of risk/protection.  
• Patterns of use.  
• And common features of European youth. |
<table>
<thead>
<tr>
<th>EXERCISE 6D</th>
<th>ANALYSIS OF INFORMATION REGARDING YOUTH AND DRUGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURATION</td>
<td>• 25 minutes.</td>
</tr>
<tr>
<td>AIM</td>
<td>• Analysis of information providing a better understanding on issues regarding youth and drugs.</td>
</tr>
</tbody>
</table>
| TECHNIQUE  | • Technique SWOT (to perform this exercise exercises 6B and 6C must have been performed).  
             • Working groups. |
| MATERIALS  | • Flipchart, markers and scotch tape.            |
| PROCEDURE  | 1. Analysis of information in 4 groups (according to division made in exercise 6B).  
             2. Each group will analyse one of the factors and will present to the rest of the groups.  
             3. Each group can complete the presentation made by the others.  
             4. The trainer will ask participants what are the final conclusions that we can obtain. The trainer will write down the information in a flipchart sheet, as a synthesis. He/she will keep this product as it will be used in sesión 7A. |
SESSION 7: CONTRAST BETWEEN DIAGNOSIS AND INFORMATION

AIMS:
- Comparing the initial self-diagnosis and the thinking about the information.

EXERCISE 7A

SUMMARY AND SYNTHESIS OF BLOCKS 1 AND 2

DURATION
- 20 minutes.

AIM
- Reflexion and checking between the initial self-diagnosis and the conclusions issued from exercises.

TECHNIQUE
Oral presentation of different products (exercises: 1D, 2E, 3C, 4D, 5D and 6D) and conclusion issued.

MATERIALS
- Final products of exercises: 1D, 2E, 3C, 4D, 5D and 6D.

PROCEDURE
1. Presentation of the aim of the session.
2. Presentation to participants of products issued from sessions of self-diagnosis and thinking-deepening. The aim is to draft a participative summary, pointing out the key ideas.
   To facilitate thinking (and make it more visual and evident), some products issued from the 6 exercises can be displayed in the walls.
# EXERCISE 7B

## MAIN LESSONS AND CONCLUSIONS

<table>
<thead>
<tr>
<th>DURATION</th>
<th>• 30 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>• Reflexion about knowledge, valuations and needs detected.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>• Working groups.</td>
</tr>
<tr>
<td>MATERIALS</td>
<td>• Flipchart (or blackboard), markers.</td>
</tr>
</tbody>
</table>

### PROCEDURE

1. Participants will split in groups of 4 or 5 persons and will ask the following questions:
   - *What did we learn so far?*
   - *Can we draw some conclusions?*
   - *Can we think solutions to the different needs/difficulties that we have found?* (they can be proposals for improving such as: change attitudes, need of training, different ways of organizing the service, etc.).

2. Each group will present their conclusions in plenary.

3. The trainer will draft, as a synthesis, the main ideas on a blackboard or flipchart.
### SESSION 8: COMMUNICATION AND EMPATHIC RELATIONSHIP

**AIMS:**
- Providing communication tools to improve the relationship between Roma and health professionals; ie. communication focused on the patient.

**EXERCISE 8A**

<table>
<thead>
<tr>
<th><strong>INTRODUCTION TO COMMUNICATION AND EMPATHIC RELATIONSHIP</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION</strong></td>
</tr>
<tr>
<td><strong>AIM</strong></td>
</tr>
</tbody>
</table>
| **TECHNIQUE** | • Oral presentation.  
• This presentation can be completed with the introduction to chapter 4 of the Handbook for Practice. |
| **MATERIALS** | |
| **PROCEDURE** | 1. Brief reminder of main ideas worked in previous blocks (1 and 2), as well as the aim and contents of this new block 3 and this session. |

**EXERCISE 8B**

<table>
<thead>
<tr>
<th><strong>STARTING POINT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION</strong></td>
</tr>
<tr>
<td><strong>AIM</strong></td>
</tr>
</tbody>
</table>
| **TECHNIQUE** | • Brainstorming, from final product of exercise 3C and from conclusions of previous sessions.  
• Contents of this exercise are linked to chapters 2.1 and 3.3 of the Handbook for Practice. |
**MATERIALS**
- Flipchart, markers and scotch tape; or blackboards and chalks.
- Final product of exercise 3C.

**PROCEDURE**
1. Presentation to participants the product issued from exercise 3C.
2. Using brainstorming, find a consensus about the main difficulties existing in communication and relationship between health professionals and Roma.
3. The trainer will write down the main ideas on a flipchart. He/she will keep the product to be used in exercise 9A.

---

### EXERCISE 8C

**SOME GUIDELINES TO ACHIEVE AN EMPATHIC COMMUNICATION AND RELATIONSHIP**

**DURATION**
- 15 minutes.

**AIM**
- Providing some guidelines to contribute to an empathic communication and relationship.

**TECHNIQUE**
- 15 minutes.

**MATERIALS**
- Annex: Communication and empathic relationship.
- These contents are related to the first part of chapter 4.1 “Communication and empathic relationship” (including the tool of the interview focused on the patient).

**PROCEDURE**
1. Presentation using the summary sheet, on Communication and empathic relationship.
### EXERCISE 8D  IMPLEMENTATION

| **DURATION** | • 25 minutes. |
| **AIM** | • Implementing guidelines to achieve a better communication and empathic relationship. |
| **TECHNIQUE** | • Role-playing. |
| **MATERIALS** | • Flipchart (or blackboard), markers and scotch tape. |

**PROCEDURE**

1. Participants will split in groups of 5 or 6 people. Each group must perform, from their professional practice, the situation of a first contact with a Roma.

   The aim of this experience is to implement different guidelines and tools to establish a good communication and empathic relationship.

2. Later each group will explain to the others the exercise performed, as well as the main ideas produced.

3. The rest of groups will explain their own comments and ways of improvement.

4. The trainer, as a synthesis, will write down the main ideas (to support the key ideas).

### EXERCISE 8E  DRAWING CONCLUSIONS

| **DURATION** | • 5 minutes. |
| **AIM** | • Drawing main conclusions on empathy and communication. |
| **TECHNIQUE** | • Brainstorming. |
| **MATERIALS** | • Flipchart, markers and scotch tape; or blackboard and chalks. |

**PROCEDURE**

1. From the work performed in exercise 8D, the group in plenary will think about the importance, need and feasibility of incorporating this skill and this tool to our health practice.

2. The trainer, as synthesis, will write down the main ideas and conclusions on a flipchart or blackboard.
SESSION 9: DEVELOPMENT OF MEDIATING ATTITUDES AND THE BOARDING OF CONFLICTS

AIMS:
• Providing guidelines and tools to health professionals to prevent conflicts or tackle them properly.

EXERCISE 9A

<table>
<thead>
<tr>
<th>INTRODUCTION TO THE DEVELOPMENT OF MEDIATING ATTITUDES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURATION</td>
</tr>
<tr>
<td>AIM</td>
</tr>
<tr>
<td>TECHNIQUE</td>
</tr>
<tr>
<td>MATERIALS</td>
</tr>
</tbody>
</table>

PROCEDURE
1. The trainer will remind the work done in session 8, posing again the theme of this session: developing mediation attitudes.
   The main issue will be the importance of preventing and/or tackling properly a conflict.
2. The final product of exercise 8B, on conflict situation that can arise during the health relationship with Roma.
<table>
<thead>
<tr>
<th>EXERCISE 9B</th>
<th>GUIDELINES TO DEVELOP MEDIATION ATTITUDES AND HOW TO TACKLE CONFLICTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURATION</td>
<td>• 15 minutes.</td>
</tr>
<tr>
<td>AIM</td>
<td>• Providing some concrete guidelines to develop mediation attitudes and tackling conflicts.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>• Oral presentation of the summary sheet (<em>Annex: Mediation attitudes and tackling conflicts</em>).</td>
</tr>
<tr>
<td>MATERIALS</td>
<td>• <em>Annex: Mediation attitudes and tackling conflicts</em></td>
</tr>
<tr>
<td></td>
<td>• Contents are related to the second part of chapter 4.1, “Developing mediation attitudes and tackling conflicts”, as well as second part of chapter 4.2 “Incorporation to health practice and health centres” regarding hospitals, in Handbook for Practice.</td>
</tr>
<tr>
<td></td>
<td>• Additional bibliography: <em>Handbook to care Roma in Health Centres</em> (Cristina García García). Chapter of good practices: The experience of Hospital Clínico San Carlos of Madrid, “Área de Informadores”.</td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>1. The trainer will present the summary sheet.</td>
</tr>
<tr>
<td>EXERCISE 9C</td>
<td>ANALYSIS OF CONFLICT SITUATIONS</td>
</tr>
<tr>
<td>------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>DURATION</strong></td>
<td>• 15 minutes.</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
<td>• Critical analysis of a real situation of conflict.</td>
</tr>
</tbody>
</table>
| **TECHNIQUE** | • Critical analysis of a piece of news (Annex: Analysis of a piece of news)<sup>14</sup>.  
It is recommended to analyse in each country a piece of news happened in the country. In Spain the news proposed is “Altercado en la Paz por el fallecimiento de un Joven” (Analysis of a piece of news). |
| **MATERIALS** | • Annex Analysis of a piece of news.  
• Flipchart, markers and scotch tape; or blackboards and chalks. |
| **PROCEDURE** | 1. The piece of news will be presented in group (reading individually, in group or in plenary).  
2. In plenary, as a Brainstorming, the piece of news will be analysed using the following questions:  
   - What are the main elements of the piece of news?  
   - What was the trigger of the conflict?  
   - What was the background of the Roma family?  
   - How started the conflict situation?  
   - What are the solutions proposed? Main reactions? |

---

<sup>14</sup> This piece of news and its analysis have been taken from: *Guía para la actuación con la Comunidad Gitana en los Servicios Sanitarios* (García, 2006).
<table>
<thead>
<tr>
<th>EXERCISE 9D</th>
<th>FINDING ALTERNATIVES</th>
</tr>
</thead>
<tbody>
<tr>
<td>DURATION</td>
<td>• 20 minutes.</td>
</tr>
<tr>
<td>AIM</td>
<td>• Seeking solutions for problems or situations.</td>
</tr>
</tbody>
</table>
| TECHNIQUE  | • Critical analysis of a piece of news (<i>Annex: Analysis of the piece of news</i>).  
|            | • Working groups.   |
| MATERIALS  | • <i>Annex: Analysis of news</i>.  
|            | • Flipchart, Markers and scotch tape. |
| PROCEDURE  | 1. Participants will split in groups of 4 or 5 people. Each group will analyse the piece of news.  
|            | 2. From this piece of news, they will have to think about possible actions that could have been taken to prevent or cope better the conflict situation addressed in the news.  
|            | 3. Each group will present to the rest of participants and groups the actions planned.  
|            | 4. The trainer will write down the information in a flipchart sheet, as a synthesis. Emphasis will be placed on the importance, necessity and / or feasibility of incorporating this competence to our health practice. |
SESSION 10: INCORPORATING OTHER ASPECTS OF ROMA INTO MY PRACTICE AND / OR HEALTH CENTRE

AIMS:
- Providing to health professionals guidelines to work with Roma, to include some socio-cultural characteristics of their population.

**EXERCISE 10A**

**INTRODUCTION TO OTHER ASPECTS INTO MY PRACTICE**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>5 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Linking with session 9 and presenting the aim of this session (10)</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>Oral presentation.</td>
</tr>
<tr>
<td></td>
<td>Presentation can be completed with the first part of chapter 4.2 of the Handbook for Practice.</td>
</tr>
<tr>
<td>MATERIALS</td>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
<td>1. Reminder of work done in previous session (n 9) and explaining the aim of session 10.</td>
</tr>
</tbody>
</table>

**EXERCISE 10B**

**SOCIO-CULTURAL GUIDELINES TO WORK WITH ROMA**

<table>
<thead>
<tr>
<th>DURATION</th>
<th>15 minutes.</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIM</td>
<td>Providing some guidelines to work on health taking into account the socio-cultural characteristics of Roma.</td>
</tr>
<tr>
<td>TECHNIQUE</td>
<td>Oral presentation of the summary sheet (<em>Annex: Incorporating into health practice</em>).</td>
</tr>
<tr>
<td>MATERIALS</td>
<td><em>Annex: Bringing into health practice</em>.</td>
</tr>
<tr>
<td></td>
<td>This information is linked with the following chapters of the Handbook for Practice:</td>
</tr>
<tr>
<td></td>
<td>- Sub-chapter, “Ideas on health” (part 3.3).</td>
</tr>
<tr>
<td></td>
<td>- Part 4.2, “Annex: Incorporating into health practice and into health centres” (first part). (The last two chapters are related to the work on health in general).</td>
</tr>
<tr>
<td></td>
<td>- Part 4.4, “Some guidelines to work with Roma youth” (this part is related to the work on Youth and Drugs).</td>
</tr>
</tbody>
</table>
**PROCEDURE**

1. There will be a brief presentation of the summary, which addresses some of the cultural elements of Roma that allow to understand their relationship to health and drugs.

**EXERCISE 10C**

**HOW TO INCORPORATE SOCIO-CULTURAL FACTORS INTO MY PROFESSIONAL PRACTICE**

**DURATION**

- 20 minutes.

**AIM**

- Define and plan a strategy to incorporate into my practice health socio-cultural elements of Roma Culture.

**TECHNIQUE**

- Individual and group work.

**MATERIALS**

- Flipchart (or blackboard), markers and scotch tape.

**PROCEDURE**

1. Each participant will think briefly ideas and / or specific strategies to include some of the socio-cultural characteristics of the Roma into their health practice.

2. To this end, participants will be divided into groups of 4 or 5 people.

3. Each group will discuss the ideas and strategies of each, creating a catalogue of ideas / strategies.

4. Each group will present it to the rest.

5. Each group will make appropriate comments or reflections.

6. The trainer will write down the information in a flipchart sheet, as a synthesis. If possible, he/she will classify these ideas or strategies by common categories (to facilitate understanding and analysis).
### EXERCISE 10D

<table>
<thead>
<tr>
<th>FINAL CONCLUSIONS OF ACTIONS FOR PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DURATION</strong></td>
</tr>
<tr>
<td>• 15 minutes.</td>
</tr>
<tr>
<td><strong>AIM</strong></td>
</tr>
<tr>
<td>• Main conclusions of training: Actions for Practice.</td>
</tr>
<tr>
<td><strong>TECHNIQUE</strong></td>
</tr>
<tr>
<td>• Oral presentation.</td>
</tr>
<tr>
<td>• Final question of conclusions.</td>
</tr>
<tr>
<td><strong>MATERIALS</strong></td>
</tr>
<tr>
<td>• Folios and pens.</td>
</tr>
<tr>
<td>• Final product of exercise 1B (Initial exercise).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PROCEDURE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. There will be a brief review of what worked in sessions and exercises, with emphasis on the results obtained in block 3 (&quot;Return to Practice&quot;).</td>
</tr>
<tr>
<td>2. Subsequently, the participants must answer individually and anonymously on a paper, the following question (which will be given to trainer): What I can do to improve my practice with Rome?</td>
</tr>
<tr>
<td>3. The trainer will read all the answers both of this exercise and of exercise 1B (Initial Exercise). The aim is to compare both answers so participants can see the evolution experienced from the beginning to the end of the training, being well aware of the changes that have been produced.</td>
</tr>
<tr>
<td>- First reading of answers of exercise 1B.</td>
</tr>
<tr>
<td>- After the answers of this exercise (10D).</td>
</tr>
<tr>
<td>4. Closing the session and thanking participants.</td>
</tr>
<tr>
<td>EXERCISE 10E</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>DURATION</td>
</tr>
<tr>
<td>AIM</td>
</tr>
<tr>
<td>TECHNIQUE</td>
</tr>
<tr>
<td>MATERIALS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>PROCEDURE</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY (ACTIONS FOR PRACTICE)

- Gomes, M. A. Presentación de los Determinantes de la Salud. Nicaragua: OPS/OMS.
- Seminario de Educación para la Paz. (1990). La alternativa del juego II.

COMPLEMENTARY RESOURCES

- www.educacionenvalores.org
- www.educarueca.org
- www.gitanos.org/conocelas
- www.gitanos.org/la_comunidad_gitana/index.php
- http://www.gitanos.org/publicaciones/50mujeres/
- http://www.gitanos.org/boletines/gitanos_en_la_prensa/
- www.pangea.org/aecgit
- www.unionromai.org/index_es.htm
## LIST OF ANNEXES

<table>
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<tr>
<th>Annexes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mediation attitudes and tackling conflicts</td>
</tr>
<tr>
<td>Analysis of the news</td>
</tr>
<tr>
<td>Social Tree</td>
</tr>
<tr>
<td>How is our relationship with Roma and Youth</td>
</tr>
<tr>
<td>Behaviour of the Health System</td>
</tr>
<tr>
<td>Communication and empathetic relationship</td>
</tr>
<tr>
<td>Determinants of Health</td>
</tr>
<tr>
<td>Evaluation sheet</td>
</tr>
<tr>
<td>Bringing into Health Practice</td>
</tr>
<tr>
<td>Introduction to Training</td>
</tr>
<tr>
<td>The Roma in Europe, a brief history</td>
</tr>
<tr>
<td>Presentation of the Handbook</td>
</tr>
<tr>
<td>Social reality and socio cultural elements</td>
</tr>
<tr>
<td>Relationship with health</td>
</tr>
<tr>
<td>Relationship with drugs</td>
</tr>
<tr>
<td>SWOT Technique</td>
</tr>
<tr>
<td>Test of Stereotypes and Answers</td>
</tr>
</tbody>
</table>
The appearance of conflict is natural in any relationship and aspect of life. Hence the importance of knowing how to work with them, fix them and prevent them.

- **Find and create the right atmosphere.** Spaces adapted to the Roma (open spaces, sufficient chairs, etc.), remove barriers and obstacles (open spaces, no tables in between).

- **Avoid generalizing.** The Roma community is very heterogeneous and the behaviour of one of their members or a family cannot be extrapolated to the rest.

- **Adapt language and symbols:** Show closeness, perform symbolic events. All actions are loaded with symbolism and have a meaning.

- **Reaching agreements or covenants relating punctuality, responsibility, commitment.** Roma have a good mood for negotiation and "you give me, I give you in return" always work (Arbex, 1999: 20).

- **Do not try to control.** The professional cannot seem a punitive or coercive figure. Proceedings, penalties, etc. should be avoided. This does not mean that there are no rules or regulations that establish clear tasks and set objectives.

### KNOWLEDGE, SKILLS AND ATTITUDES OF THE MEDIATOR

- Explain that the moderator will be an example
- Maintain adequate distance (emotional closeness must be very measured to gain respect, as they understand it).
- Information should be significant, related to experiences and expectations.
- Keep the agreements, especially those set with the group (keep one’s word, fulfil commitments). But be conciliatory and flexible as well.
- Communicate information effectively.
- Manage conflict resolution techniques.
- Be impartial.
- Transmit serenity.
- Show sensitivity and concern about what others feel and express.
- Openness attitude.
- Show closeness and concern for the other person.

Here are some guidelines that can improve the relationship and dealing with the Roma community, especially families, and that will serve for potential conflicts during their contact with hospitals and emergency services (García, 2006):

- Establish information points clearly marked, where verbal information is offered to applicants.

---

15 This picture is an adjustment of: *Retos en los contextos multiculturales, competencias interculturales y resolución de conflictos de la FSG (FSG, s/f).*
- Provide, at the time of admission, written information about the rules of the center, rights and obligations of patients, visiting hours, attention...

- The above information must be provided orally by personnel trained on attention to diversity and not by the security services of the center.

- When the Roma extended family is present in the center, recognizing the highest authority (usually older men or if not, older women) to convey important messages (status of patients, the disease progression or the news of the death). In the latter case, maintaining an attitude of understanding and respect to pain expression.

- Adapt some common public spaces, as waiting rooms, to the permanence of the extended family.

- The presence of intercultural mediators in the center promotes understanding with the medical staff.

**Intercultural mediation**\(^\text{16}\):

Intercultural mediation is a resource available to people of diverse cultures, which acts as a bridge to promote constructive change in the relationships between them. Mediation in relations between culturally diverse people, acts preferentially to cultural conflict prevention, promoting the recognition of a different person, the rapprochement between the parties, communication and mutual understanding, learning and development of coexistence, search alternative strategies for cultural conflict resolution and community involvement.

Mediation, understood so professionalized, is a resource that acts as a bridge between the Roma community and the majority society to promote constructive change in their relations. It is a process and not a tool “to put out fires” when conflicts occur.

**Mediation in the health field** with the Roma community have among its functions:

- Facilitate the access of Roma to social and health resources.
- Know the needs felt.
- Facilitate communication between professionals and the Roma community by promoting their access to these resources in equal opportunities.
- Reduce cultural barriers.
- Advise Roma users in relation to health service professionals.
- Advise healthcare professionals for appropriate attention to the needs and interests of the Roma population.
- Promote community revitalization.
- Support personally Roma users.

\(^{16}\) Source: García, 2006
ANNEX: ANALYSIS OF THE NEWS

This news and the analysis has been taken from this book:


NEWS:

**Altercations in La Paz for the death of a young man.**

About fifty members of his family, Roma, wanted to take his body. Riot troops had to go to the scene. A brother of the deceased, who pulled a knife, suffered a skull fracture in the struggle.


The doors of the ICU of the hospital of La Paz on Tuesday became the scene of a battle between the family of a recently deceased young and several riot troops. It all started in the afternoon, with the death –by natural causes- of a young Roma who was admitted to the hospital.

After reporting the death of the young, in his thirties, family members who were inside the hospital, about fifty police sources said, insisted on carrying the corpse. Tempers flared up to the point where several doctors decided to alert the security service center, which also failed to contain the “fury” of the massive Roma family. In fact, not only arrived polices from the police station of Fuencarral-El Pardo, it was also necessary to riot troops intervened. (...).

Apparently, this is not the first time that this family stars in altercations. In fact, two weeks ago security of the center was reinforced given the conflict demonstrated by some of its members.

According to the medical director of La Paz, the problems began on day 7, when the young man deceased entered the ICU. Efe reported. "The families brought blankets to sleep in the hall and relieved themselves in the entrance," said the head doctor, who confirmed that on occasion they had threatened a guard. (...).

A new security plan

The Minister of Health, yesterday described the events of "regrettable" and said that despite being an unusual case which is motivated by "emotional reasons", this does not justify violent and aggressive attitude against health workers and against the Centre itself "that belongs to all the people of Madrid. "He also reported the development of a security plan that has a budget of 9 million Euros, to ensure the safety of patients and medical personnel in hospitals in the region.

Reactions

- S.A.E. (Auxiliary Nursing):
The union claimed yesterday the implementation of the security plan for health professionals to increase the active and passive safety of personnel, the creation of a support unit for workers who may be attacked as well as specific legal advice.

- **C.E.S.M (Doctors)**

The majority union between physicians made yesterday appealed to the "good sense and respect" between society and health professionals. In their view, the conflict situations are being repeated too often. Therefore, they "ask" to understand that doctors are the first to cooperate actively to overcome the situation.

**NEWS ANALYSIS:**

If we make a detailed analysis of the information transmitted in this news we can see that it is possible to implement various measures to prevent the occurrence of such conflicts.

Analyze the text of the news focusing on the sentences and paragraphs that are underlined in the news, as they contain the key ideas to address the resolution and prevention of these conditions:

"After reporting the death of young, they insisted on taking the body"

Death and the figure of the deceased have a special meaning in the Roma culture. When this event occurs, or is likely it will happen, it is necessary to implement the following strategies:

- To transmit the information to the people of greater recognition in the group.
- Prepare, in advance, to the family for the outcome.
- Maintain an attitude of understanding and respect for the manifestations of pain.
- Report the subsequent actions necessary to perform.

"This is not the first time that this family stars in altercation. The problems began on day 7, when the young man deceased entered the ICU”

If there is a conflict situation before, you need to put in place mechanisms that reduce the appearance of worse consequences. The functions of the intercultural mediation (with the participation of a Roma mediator) will improve:

- The understanding between health professionals and the Roma family.
- An understanding of the rules of the hospital by the family.
- Increased security and trust of Roma family about the hospital and its professionals.

“The families brought blankets to sleep in the hall and relieved themselves in the entrance.”

Compliance with the rules of use of public spaces is a task that can also be worked with mediation. Enabling adequate spaces where the extended family can stay, especially when it comes to long hospital stays, would be appropriate to prevent inappropriate use of other spaces.

**REACTIONS:**
“He further reported the development of a safety plan”

- S.A.E. (Nursing assistants). The union claimed yesterday the implementation of the security plan for health professionals to increase the active and passive safety of personnel, the creation of a support unit for workers who may be attacked as well as specific legal advice.
- C.E.S.M (Doctors). The majority union between physicians made yesterday appealed to the "good sense and respect" between society and health professionals.

The development of a safety plan is insufficient. Rather developing plans for prevention and care to potential conflicts, including:

- The strengthening of security in the provision of health services.
- The exercise of the rights of citizenship.
- Strengthening host functions and information to the users to ensure understanding of the rules and practices by them, with specific actions for ethnic and cultural minorities.
- The awareness of society about the work of health professionals.
- Training professionals for conflict resolution.
ANNEX: SOCIAL TREE

This diagram has been obtained from the following source: Frankfurt School and Social Tree: Frankfurt School and Social Tree.

ANNEX: HOW IS OUR RELATIONSHIP WITH THE ROMA AND THEIR YOUTH

To improve care for Roma youth on health and drug abuse prevention, one of the key elements is the quality of the relationship and the rapprochement between the health professionals and the Roma in Europe. Hence, the first question we must ask and the starting point of this discussion is: What do we know about Roma?

Studies show that social attitudes about Roma are based on three preconceptions:

**Idea 1: Roma are different**

Usually three major types of differences are mentioned:

1. **Cultural:** We think that they have a unique culture, We find exaggerated contrasts: it can be considered a more traditional and "backward" society, more rural, less literate, more closed to changes, but also more cohesive, more cheerful, less individualistic or materialistic. Other traits: importance of the extended family, preference for marriage between Roma and sometimes between relatives, hierarchical roles established for gender and generation, form of settlement and residence, old and new professions.

2. **Socio-economic:** They are seen as poorer and less integrated, ie they have less access to social goods and resources. They live on the margins. Poverty is not simply seen as an economic trait. Poverty is a suspect of wanting to perpetuate or to exist because people do nothing to change, because their culture is what leads them to that situation in the margin.

3. **Moral:** The old racism considered Roma not only culturally diverse and socially backward, but basically unreliable, deceitful, lazy or dangerous to the order. This traditional repertoire has changed in urban society and with the public rejection of racism. Moral defects are now different: they are dependent, they take advantage of services or benefits, they are sexist, uneducated, unwilling to integrate.

**Idea 2: Roma “have more problems”**

There are certainly a large part of Roma that is vulnerable, "exposed to disadvantages and inequalities": the majority of Roma in Europe and have fewer regular jobs and less properties, live in worse places and in substandard housing, have less access to resources and protection. They have less social participation and presence in places of power. Their social networks are limited and in some areas their life is spent in segregated spaces (or marginal). All these conditions have impacts on health and life expectancy, on their self-esteem and on how to address the problems.

But the Roma community also has strengths and these should be incorporated into health work: its own resources, creativity, forms of care and comfort, leadership of various kinds, social and cultural assets that any approach should value and activate. Inequality does not necessarily imply that all indicators are worse. They may have poorer health in some ways, but not necessarily more drug addiction problems.
Idea 3 Roma “are the problem”.

It is common to move from the idea of "vulnerability" to the idea of "danger". This shift from "group with problems" to a "problematic group" also occurs in health systems. The idea that appears in some social and professional discourses is that Roma are more demanding, go more often to services, and are worst patients. As often happens with immigrants, their presence is more visible. It is not uncommon to hear that they are noisy or demanding, they come to hospitals in groups, they do not follow the recommendations, or do not meet the rules. Two ideas feed prejudice:

- Considering negative an attitude which the group itself see as acceptable or even positive, as the family accompanying the patient.
- Assign to each and every person the behaviour previously defined as inadequate, which only a part of the collective performs.

More subtly, the two most common allegations are the following:

- Abuse. This conception comes from the idea that the Roma community does not belong to the general community, and therefore, it is not obvious that they deserve the attention given to them as citizens.. It is not the law, but the majority who decide when such use is not appropriate and could withdraw those rights if the other takes advantage of its use.
- Passivity. It relates to the feeling that providing to certain groups grants and benefits can lead to their dependency and passivity. According to this discourse, Roma fit with this definition: it is assumed that they are given much; we see that the situation does not change substantially and they are blamed for the lack of progress.

The logical step of this argument does not hold, because the Roma community as specific group received no more than the rest. In any case, they have made less use of certain services and benefits. In other cases, no doubt they have benefited from policies addressed, for example, to eradicate slums, precisely because they are the last European citizens living in substandard housing.
ANNEX: BEHAVIOUR OF THE HEALTH SYSTEM

These ideas and feelings determine many of the views of the community and health professionals as well as the rest of society. There are three classic effects:

- **Difficulty of identification.** If we feel that others are different we have more difficulty to be identified with them, to put us in their place or to create opportunities for communication, and we focus on the differences or on the pressure that show many patients and anxious families, that we will ascribe it to a cultural feature of the group. We put on the defensive with Roma.

- **Stubborn defense of one’s own culture.** This lack of identification prevents a critical view of their own values. It seems that only the others have a culture. But the health system, as a powerful public agent to which we belong, has values, culture, discourse and power to impose it. Two examples:
  - Individualization of the disease as a completely private matter that each individual manages and is responsible for. This does not happen in the Roma culture, where the disease is especially felt by the whole family, with a strong emotional component.
  - Separation between any spiritual aspect and the body's health. It is not well understood in cultures where religion is a basic issue and where healing has a moral and spiritual dimension

- **Frustration.** When we define a culture or group as more backward or having serious problems, we close the door to gradual change and improvement. We put them in a situation of “all or nothing”. Among many professionals who are not Roma, but work with them, there are two opposing views:
  - Radical change of Roma culture and life, which implies changing the living conditions of Roma and their cultural patterns.
  - Defense of their identity, based on exaggerating the need for a strong Roma identity, political or social, and segregated.

Both attitudes have determined public policies and government decisions that have had strong effects on Roma. Their problem is simplification because they want to solve too fast problems and conflicts, with shortcuts, and a lack of respect to the possibility of change of the other, because it ignores that changing in a context of adverse conditions is very complex.

When working with minorities, attention to the difference acquires a particular and identitarian tone. This cultural difference justifies an intervention tailored to the specific features of Roma and sensitive, where the incorporation of the key elements that characterize each group or individual will allow us to perform a higher quality intervention.

This idea does not mean more work for Health professionals, but to incorporate new concepts, different ways of looking at reality, new intervention methodologies that enable them to better fulfill their duties, obtaining better results in their daily work and reducing the possibility of occurrence of conflict (Garcia, 2006).
ANNEX: COMMUNICATION AND EMPATHIC RELATIONSHIP

- **The professional should be surprised by the reality and user.** Not see only deficits but also the strengths of the people.

- **Adapting the information and the message** (taking into account age, gender...). Convey information clearly and simply, make sure that you have understood the information: diagnoses, treatments, procedures for appointment, etc...

- **Use the pedagogy of questions, listen more than talk:** what do you know ...?, What do you think about ...?, What questions do you have ...?, What do you imagine...?

- **Importance of the first meeting.** In care centers or preventing centers if professionals connect emotionally in the first meeting and they feel treated with affection, the person who made the host becomes a reference. (Arbex, 1999).

- **Knowing people.** His/her character, his/her name, what has led them to go the center (Arbex, 1999). They usually go to places where they know they are welcome and where others are Roma. Creating a trust relationship.

- **Establishing a relationship of equals, not imposing.** The intervention and the relationship must arise from the natural.

- **Young people in particular like to talk and to be heard.** We must try they to feel heard and respected (Arbex, 1999).

**COMMUNICATION SKILLS**

- Be aware of potential biases and perceptions that can determine and influence the interpretation of the way people communicate and the behaviour of others.
- Consider the different meanings of gestures, exhibition, and physical distances of people from different cultural groups.
- Speak clearly and accurately.
- Avoid colloquial expressions that can be misinterpreted.
- Repeat affirmations differently to strengthen comprehension.
- Active listening, rephrasing what the patient said it to check correct understanding.
- Identify and solve communication problems using cultural mediators to facilitate the comprehension and understanding.

In recent years strategies have been developed to address communication that takes into account the experiences and specific aspects of each context, which determine the relationship between the patient with the healthcare provider.

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17 *Source: Retos en los contextos multiculturales, competencias interculturales y resolución de conflictos de la FSG (FSG, s/f).*
The communication model of patient-focused is based on six elements:\footnote{18}

1. Exploration of the disease and how it is experienced by the patient: In addition to the exploration of symptoms, taking into account the following aspects:
   - The idea of the patient about the disease.
   - The feelings it produces (anxiety, fear, etc...).
   - The expectations he/she have on the professional and the usefulness of treatment.
   - The impact of symptoms on daily life.
   - The nonverbal communication.

2. Understanding the whole person: Taking into account other environmental, social and family factors of the patient such as living conditions in which he lives, relationships and family support, economic needs, etc.

3. Agreements with the patient: The patient must actively participate in their health-disease process. To do this, the clinician should seek acceptance in both diagnosis and therapeutic treatment proposed.

4. Incorporation of prevention or health promotion: prevention and promotion to include harm reduction, early detection of diseases and reduction of their consequences.

5. Take care of the patient-professional relationship: The professional should seek to improve relationship with the patient at every encounter.

6. Realism: All of the above must take into account the real possibilities of the service in which the clinician works: resources, time available, etc... It is known that many health professionals have to see too many patients; they may only assess aspects of this model that are most important for the process and for the patient.

\footnote{18}{This picture is an adjustment of: \textit{Guía para la actuación con la comunidad Gitana en los Servicios Sanitarios} (García, 2006). Though it is focused on the primary care, we think that it’s an interesting model of reference in drug prevention.}
ANNEX: DETERMINANTS OF HEALTH

The source of this explanation is the following book: *Presentación de los Determinantes de la Salud, María Angélica Gomes. OPS/OMS Nicaragua.*

Diagram of multi-level model of determinants of health (Dahlgren & Whitehead, 1991):

- Biological Factor: A growing number of genetic factors is involved in the production of various health problems: infectious, cardiovascular, metabolic, mental, cognitive and behavioural.
- Lifestyle: The individual's behaviour, beliefs, values, historical background and perception of the world, attitude to risk and the vision of his/her future health, communication skills, stress management, control and adaptation to the circumstances of his/her life determine preferences and style of living.
- Influences of the community and social support: We refer to peer pressure, cohesion and social trust, social support networks and other variables associated with level of social integration and investment in social capital.
- Access to health care services: how is organizes health and medical care in aspects of promotion, protection and recovery of health and the prevention, control and treatment of disease in a population.
- Living and working conditions: housing, employment and educational facilities are basic prerequisites for the health of populations.
Socio-economic conditions, social and cultural rights: At this level operate large macro-determinants of health, which are mainly related to the structural characteristics of society, the economy and the environment and, therefore, linked to policy priorities, decisions of governance and management of social agenda. For example: the scope of the current legal framework, the strategies of poverty reduction, the intensity of redistributive policies, opportunities for the development of citizenship, etc....

ANNEX: EVALUATION SHEET

FINAL QUESTIONNAIRE: EVALUATION OF TRAINING ACTIVITIES

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. From most specific to most general, what are the tools, capacities, or knowledge that you have learned from training and exercises?</td>
<td></td>
</tr>
<tr>
<td>2. What do you like to comment on exercises, sessions, techniques and contents?</td>
<td></td>
</tr>
<tr>
<td>3. Do you think that contents, techniques and exercises meet your needs and contributed to improve your professional practice?</td>
<td></td>
</tr>
<tr>
<td>4. Other comments:</td>
<td></td>
</tr>
</tbody>
</table>
ANNEX: BRINGING INTO HEALTH PRACTICE

Understanding these cultural patterns will give us a greater understanding of the person and context and enable the professional to tailor the intervention.

- **Know the socio-cultural characteristics of the Roma community, especially those that affect health positively or negatively**: Mutual support between relatives, respect and care for the elderly, the importance of mourning. Gender-related issues (role of women as caregivers and the fact that she tends to forget about her own health; the man can reject weakness and health care).

<table>
<thead>
<tr>
<th>TRADITIONAL ASPECTS OF ROMA CULTURE RELATED TO HEALTH</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Importance given to health, coupled with the importance of family and the health of others.</strong> The importance of the elderly and the sense of vulnerability make that disease and death are very present in Roma culture, even young.</td>
</tr>
<tr>
<td><strong>Health as absence of disease and as something disabling linked to the death.</strong> When a person (and family) perceives that the disease has appeared, the action must be immediate and decisive.</td>
</tr>
<tr>
<td>Fear of disease is linked to the problems of access to health services in some places. So it is logical to use emergency services instead of the regular (or preventive) and there is a tendency to self-medication and informal advice from relatives or neighbours.</td>
</tr>
<tr>
<td><strong>Health and physical illness.</strong> The relationship established between health and physical sickness absence means that they do not take into account aspects of behaviour related to psychology.</td>
</tr>
<tr>
<td><strong>The link of the idea of health with morality,</strong> making certain diseases, as HIV, a disgrace and a dishonour, so often lived in secret and with a great sense of guilt, greater in women.</td>
</tr>
<tr>
<td><strong>Invisibility of prevention.</strong> The fear of death and denial of illness hinder the preventive work, and because Roma, as already mentioned, just go to the doctor when they are very sick</td>
</tr>
</tbody>
</table>

- **Detect possible referents in families.** The cultural perspective of Roma is family interdependence, so familiar authority figures, parents, grandparents or uncles should be involved in treatment or therapy (Arbex, 1999).

- **Group intervention with the family.** It is better to be done separately, with specific groups of parents, because roles and separation of sexes can be very pronounced. Being together hampers communication produces a lack of spontaneity (Arbex, 1999).

- **Set clear and firm limits, from prevention or care centers.** It is necessary to involve the Roma families in compliance. Sometimes it is difficult for them, as they usually have a small establishment of rules and boundaries within the family unit. It requires significant pedagogical work and the need to establish agreements (Arbex, 1996).

- **Women's entrepreneurship.** For the work of prevention, or treatment of diseases, the field of addictions, to work with Roma women and mothers is a key element, and taking advantage of their entrepreneurial capacity (Arbex, 1996).
- **Sexuality.** This is a topic that Roma women find difficult to speak about. In general, they have little information and this fact generates shame. It is recommended that the health professional who receive a Roma woman be a woman as well, and using a language (verbal and nonverbal) to facilitate communication (Arza, 2008). If there is a need to carry out tests that may be perceived as a threat to some aspect of the girl's virginity, is necessary to explain in detail its importance (Arza, 2008).

- **Heterogeneity.** The Roma population is very diverse: different levels of resources, people from different countries, etc. This means putting the focus on the person, to understand and comprehend the context and circumstances (family status, resources, level of integration, etc...).

Regarding **addictions**, there are obvious principles in the prevention or treatment of addictions, such as confidentiality, empathy, understanding others or be patient to accommodate the expected slow progress, but also the need to have clear goals and boundaries to guide youth and do not leave them alone with their problems. But there are other principles that must be present when working with a minority:

- Knowing from where do we speak. Health work is not neutral. Our idea of the body, disease, morality is so culturally and materially determined as that of other groups. Understanding that other person can have other values, or give more importance to some of them, is as important as understand our own values.

- Activating the resources of the environment. Individuals and groups have their own forms of care and caring, strengths and ideas that programs should not overlook. It is what is usually called empowerment, although the meaning of this term is not always clear. If one recognizes the other's power and authority, this must be done seriously, given the opportunity to participate in their progress, accepting a degree of dissatisfaction with their guidelines or pathways (always within the limits of democratic principles) and leaving transform their life situation or at least be open to discuss about it. This implies some rebalancing between the public authority and the authority and knowledge of Roma youth.

- Proposing attainable aims. It is the important setting achievable goals and respect the small advances. If you are looking for big changes, or changes outside the structural reality, the result is frustration both for the professional and the user. It is not about making modest programs, they can and should be ambitious, but must be defined in a manner that will provide concrete progress cementing the confidence of youth on themselves

- Supporting individual processes and discuss social processes . In situations of social inequality, progress often will be frustrated, the young people will not respond as expected, the reality of marginalization and poverty will prevail. The result is often the disappointment of the professional and to blame unconsciously to the users of their problems or their inability to overcome them. To avoid this situation it is necessary to discuss with the team and with young people themselves, the limits of the intervention, the material conditions of his/her life. This politicization of social intervention prevents us to consider young people fully accountable for the results, but not completely unrelated.

- Learning from the margins. It is necessary to learn and transfer what we learned to the places where we work. We see that people are able to improve their life in very difficult environments. Social innovation, one of the principles of European action, should be tested in all programs. It is necessary to risk with reasoned and complex projects, knowing that the
results will be useful for the health institution. What is learned in the supposed "margins" or with minorities shall apply to the general population, which is becoming less homogeneous and more plural.
ANNEX: INTRODUCTION TO TRAINING

Rationale. The Roma community in Europe shows great diversity. However, in general, their social and economic situation is more deficient than the average population, which strongly influences a worse health status. Also, their health is also affected by prejudice and discrimination they have suffered historically and continue to exist towards these people, situations where European health systems and professionals are also involved.

Aim of the Handbook. The ultimate aim of this Handbook is to help removing barriers faced by the Roma community in Europe to access to Health and Addiction Services, and thus to influence the reduction of inequalities in health that they suffer.

To achieve this purpose we will provide to health professionals who work with the Roma community practical information to enable them to know and understand the specifics of this culture, in particular their relationship to health and drugs and tools to enable them to improve their skills in working with the Roma community and its youth.

Aim of the training. Presenting in a pedagogical way the contents described in the first part of the Guide to Health Professionals.

This involves presenting the information in a light and practice way the content addressed, but not only, as it seeks to create spaces for reflection that influence perceptions, attitudes and practices of professionals.
1. The current situation of Roma in Europe cannot be fully understood without an understanding of the history of the treatment of Roma in Europe. The history of Roma is not well documented, mainly due to the fact that Roma have left behind few written records related to their communal existence. Although the historical origins of Roma have at times been in dispute, it is now largely a matter of consensus -- particularly on the strength of linguistic evidence-- that the Romani people are descended from groups who left the Indian sub-continent towards the end of the first millennium C.E. Romani groups were noted in the European part of the Byzantine Empire by the eleventh century and probably entered Spain from North Africa at around the same time. Areas located in what is today southern Greece were noted as centres of Romani settlement in the fourteenth and fifteenth centuries and it is thought that Roma lived throughout the Balkans by that time.

2. Following a period of relative tolerance in the late Middle Ages, Roma were subjected to the first of a series of episodes of persecution in Europe. There is some consensus among historians that, prior to its long decline and the episodes of repression accompanying it, the Ottoman Empire was a more tolerant realm than Christian pre-Enlightenment Europe generally, and that this tolerance extended to Roma. The relatively higher numbers of Roma in areas of Europe today, which formerly comprised Ottoman possessions, would seem to bear out this contention, although Ottoman authorities as a matter of policy discriminated against non-Muslims, and even within the Muslim community Roma appear to have been particularly discriminated against.

3. Within the Ottoman Empire, Roma would seem to have fared worst in areas of the Empire considered relative backwaters, such as in areas today located in Romania, where local landowners and clergy enslaved Roma. Professor of Romani Studies Dr. Thomas Acton has
commented of Romani history in Europe in the 16th and 17th centuries: "When Romani people from Eastern Europe meet Romani people from North-Western Europe today, it is the descendents of the survivors of slavery meeting the descendents of the survivors of genocide."

4. The Enlightenment brought with it a series of new approaches toward Roma. In the mid-18th century, the first in a series of efforts was undertaken attempting to compel Roma to conform to the norms of the wider society. It is unclear to what extent these early orders were even obeyed at a local level, but in the subsequent two centuries Roma have frequently been removed from their families by force and placed with non-Romani families, or placed in institutions, in an effort to rid them of what have been perceived as deviant traits, and to end the common existence of the ethnic group itself. The development of modern police practices brought with it the development of ideas of "Gypsy crime", and with it, comprehensive police registers of Roma.

5. Roma were targeted for race-based persecution during the Hitler regime in Germany, 1933-1945, and in Nazi-occupied countries. In a number of countries, the Romani Holocaust -- referred to by some as the "Porraimos" -- was implemented by both German authorities as well as by local officials. In some countries it was implemented by the armies of governments collaborating with the German-led effort to reshape the demography of Europe whilst in others the Romani Holocaust was implemented without German prompting. In a number of areas, such as on the territory of today's Czech Republic, most of the Romani community was killed during the war, either by being interned at German-run death camps, or by being incarcerated in domestically administered internment camps.

6. In the post-war period in Central and Eastern Europe, efforts to forcibly settle Roma, and to end what were seen as anti-social traits, were redoubled. The governments of Poland and Czechoslovakia, for example, undertook extensive efforts to end nomadism among Roma, and to convert Roma to a homogenised "proletariat". Intense assimilation efforts under state socialism produced both some of the first generations of Roma in the elite, as well as further high numbers of Roma in state institutions, removed from their families. Its official discourse notwithstanding, post-war state socialism did not succeed in eradicating racism. Some governments undertook policies of coercive sterilisation of Romani women, and schooling in many countries became segregated.

7. The early post-World War II history of Roma in Western Europe appears remarkably similar to that in Central and Eastern Europe. In Norway, Sweden and Switzerland, for example, concerted efforts were undertaken to end the communal existence of Roma and related groups through measures including forced sterilisation of both men and women, as well as through the systemic removal of Romani children from families and their placement in state care. In recent years, the Swedish and Swiss governments have undertaken and made public comprehensive studies of the issue, and Sweden has made available compensation for victims. The impact of these policies continues to be felt today, however, and Roma as a group still suffer extensive trauma as a result.

8. The post-1989 era in Europe has seen an outbreak of intense anti-Romani sentiment in both Eastern and Western Europe. In Eastern Europe, governments in some countries blamed Roma collectively for a breakdown in public order or for fears that a breakdown in public order was imminent. Systematic persecution of Roma took place in countries including Albania, Bulgaria, Germany, Hungary, Poland, Romania, Russia, Slovakia, Ukraine and Yugoslavia. Racist movements have also arisen and targeted Roma for attack. In some countries, such as in the Czech Republic and Slovakia, violence against Roma remains at alarming levels. In general, criminal justice authorities have reacted inadequately to the dramatic rise in racially motivated violent crime and public officials have failed, or been slow, to condemn anti-Romani violence.
9. In Western Europe, anti-Romani sentiment has frequently broken out following the arrival of Roma from Eastern Europe. Belgium, Finland, France, Germany, Ireland, Italy, the Netherlands, Norway, Spain, Switzerland and the United Kingdom have all featured episodes of public panic, fuelled by alarmist media reports of "Gypsy invasions" and similar. These measures have frequently been followed by racially discriminatory measures by public authorities, often including collective expulsions.

10. In 1999, the Romani community of Europe suffered the worst catastrophe it has endured since World War II when, following the end of NATO military action in the Federal Republic of Yugoslavia and the withdrawal of Yugoslav forces from Kosovo, ethnic Albanians undertook a campaign of ethnic cleansing against Roma and other persons perceived to be "Gypsies". Despite four years of UN administration in Kosovo, violence, including periodic grenade attacks and the regular destruction of property, has continued. Today, an estimated four fifths of the pre-bombing Romani population of Kosovo (probably around 120,000 persons) is displaced within Kosovo and in rump Serbia and Montenegro, or is in exile in countries bordering Kosovo or in the West. Most live in extremely poor conditions, whilst their arrival in EU states has raised important issues surrounding asylum and immigration, dealt with later in this report.

11. In the face of a history of discrimination and persecution, and despite centuries in Europe without any visible autochthonous institutions, Roma have maintained a distinct identity. Communal solidarity is frequently affirmed and reinforced by close extended family bonds. Family celebrations feature prominently in social priorities. Cultural traditions are respected and adhered to diligently, and may include pollution taboos and, in some communities, autonomous systems of individual and community justice. Pollution taboos are traditional within many cultures but are also frequently associated with the development of strategies by marginalised groups to maintain identity against the forces of oppression and/or cultural assimilation. As Judith Okely says, “One way of remaining different is by pollution beliefs which both express and reinforce an ethnic boundary. The Gypsies’ beliefs not only classify the Gorgio (non-Roma) as polluting, but also offer the means to retain an inner purity. If certain observances are maintained, the Gypsies can enter Gorgio territory unscathed”.

12. The Romani population in Europe today is estimated at around ten million people, although some observers put the figures even higher at twelve million. Precise demographic data is not, however, available due in large part to the stigma associated with the Romani identity and the reluctance of many Roma to identify themselves as such for official purposes, and the refusal of many governments to include Roma as a legitimate category for census purposes. Despite
demographic uncertainties, there is little doubt that the total number of Roma in Europe is many times greater than the total population of a number of the Member States.

13. At present, anti-Romani sentiment is present in most, if not all, European societies and is extremely high in some countries. According to one recent survey, 79% of Czechs would not want Roma as neighbours.4 A poll conducted in 1992 by the Allensbach Demoscopic Institute indicated that 64% of Germans had an unfavourable opinion of Roma - a higher percentage than for any other racial, ethnic or religious group.5 A survey conducted in 1994 by the EMNID Institute indicated that some 68% of Germans did not wish to have Sinti and Roma as neighbours.6 Mr. Trevor Phillips, the Chair of the United Kingdom's Commission for Racial Equality (CRE), recently stated, "As a Briton, I am ashamed of the way we treat Gypsies and Travellers. Things need to change and they need to change now".

14. The treatment of Roma both in the European Union and beyond its current borders has become a litmus test of a humane society. The treatment of Roma is today among the most pressing political, social and human rights issues facing Europe.
ANNEX: PRESENTATION OF THE HANDBOOK

After having known the rationale and objective of the Manual and having reflected on the history of the Roma community from their origins until their arrival in European lands, including difficulties, persecution and violence they suffered, we end up exposing the Presentation of the Handbook.

**Target population and theme:** young Roma, between 11 and 25 years old. However, this Handbook also seeks to influence the entire Roma community on General Health aspects and on the issue of addictions in particular.

**To whom is the training addressed:** to health professionals working in primary care centers in hospitals and emergency services, as well as service centers and / or Prevention of Drugs Consumption.

**Methodology:** providing a theoretical framework underlying the practical proposal to be offered to work with health professionals. The methodology is based on a dialectic proposal, from the knowledge, understanding and practice of health professionals regarding the Roma community (mainly the youth), their health and drugs. From this point, the Handbook reflects and deepens their social reality, their culture and the relationship they have with health and drugs, and finally, having a better understanding of this reality, trying to offer elements for improving social care practice and facilitate access of Roma to health care.

The **structure** of the Handbook coincides with the proposed Methodology:

1) The first about "what we know", "what is spoken", "health practice" in relation to Roma, based on studies that exist in this regard as well as how these ideas affect health systems.

2) A second part that provides data available on the social reality of the Roma community in Europe, key cultural elements, as well as some fundamental ideas in relation to health and drugs.

3) The third part, "Return to Practice", offers practical and theoretical tools to incorporate socio-cultural situation of the Roma community into the health systems, into the professional practice and in the design of prevention programs of drug addiction for Roma youth.
Starting from what we know: what is said

Thinking about this reality: deepening, providing data about social reality

Back to practice: improving our intervention
ORIGIN AND DIVERSITY

The European Roma are living in the continent since the fifteenth century. They migrated from a common origin (the region of Punjab in India) and dispersed in different waves in different places. This has been one of the main causes of the great internal diversity existing within the Roma.

A POPULATION BETWEEN NORMALIZATION AND EXCLUSION

Training and educational deficits. In many countries we can speak of complete primary schooling, but there is still a clear deficit: Among Roma aged 15 years and over, 43% have no education and only 32% finished primary education. Among youths aged 15 to 24 years, only 17% are students, compared with 60% of the European population. Roma with university degree are still a minority.

Worse Access to the labour market. Unemployment, family economy more or less informal, some public grants and precarious jobs are the main features of their economy. The unemployment rate is very high, 23% as average according of the health survey (FSG Health Area, 2009), or more than 50% of the active population according to other researches.

Poverty and exclusion. Researchers estimate that two-thirds of Europe's Roma population lives in poverty. Public policies have had a major impact on improving life of Roma families, but they have not changed their relative position: they remain "poorest of the poor" (Foessa Foundation, 2008).

SOCIAL STRUCTURE AND PROCESS OF TRANSFORMATION

A current feature of the Roma community is that they are living an intense process of change that some writers have called "selective modernization" (OSC, 2012). Change without losing the very essence (remaining Roma) is a historical project, complex and contradictory. We can find 3 positions facing the change:

a) Elites and settled groups. The characteristic of a minority of Roma is that they propose to govern social change in their community, either through associations and politicization, either through new devices of cohesion, as the evangelical churches.

b) Most Roma families, usually poor, but not marginal. Many people are aware of being in a culture in crisis because of the difficulty to live a Roma life in an urban and globalized world. But crises can lead to more freedom or to cling to traditional values.

c) Population at risk of social exclusion. This is the case of families living in segregated or degraded environments with very poor economies. Their ability to change is limited by the lack of relationship with the social environment, exclusion and its constraints.
THE IMPACT OF HOUSING IN THE ROMA IDENTITY

- Roma with more status live in city centres or consolidated districts. Their living conditions are similar to those of their neighbours, the young people having common problems of access to employment or independent living.

- Less than 4% of Europe’s Roma population lives in shanty towns, but almost 30% live in poor quality housing or substandard housing. The physical and symbolic distance from the city and having less access to the rights granted by citizenship reveals a deliberate exclusion and discrimination.

- In many cases, Roma families have been resettled in public housing. Those who live in this way represent 22% of the total, but in some countries and regions account for almost half of Roma families. Some neighbourhoods so designed are much deteriorated due to the poor quality of housing and services, and to the spatial segregation, putting together very different families isolated from the rest.

A YOUTH POPULATION IN FLUX

The average age of the European Roma and is around 25 years, compared to the 40 years of the total population. Many of them are boys / girls and youth, fewer over 65 years. The implications are very interesting: while resources and concerns of European societies are increasingly oriented toward the elderly, health or social services, facilities and culture, Roma need mostly resources for youth and a strong investment in education, employment and leisure. In this sense, the drug prevention work and other tasks related to lifestyles is essential to the future health of the group.

Furthermore, the Roma teenagers live a dissonance that sometimes confuses and disorients them, as they feel trapped between Roma cultural norms and mainstream culture norms, which they do not feel as their own, and sometimes transgress.

IMPORTANT SOCIO-CULTURAL ELEMENTS

Central role of the family

- The central role of the family as the focus of social organization.
- Prevalence of group versus individuality.
- Large and extended families.
- Roles very marked, by sex and age.
- Early marriages.
- Current processes of change: later marriage, changing role of women and youth…

Role of associations and churches

- Prominent role of churches and associations in the Roma community.
- Respected interlocutors when working with Roma.

The role of women
- The Roma woman in transmitting the norms and values of their community.
- Overprotection of young Roma women.
- New roles of women, change processes.
- Lack of new models for the young women.
ANNEX: RELATIONSHIP WITH HEALTH

**Brief diagnosis on health.** Lower income, poor living conditions in their neighbourhoods, discrimination or worse access to health benefits, explain the presence of infectious diseases and other chronic diseases less common in the general population or that occur at younger ages.

**SOME DATA ABOUT THE HEALTH STATUS OF ROMA**

Although there is no complete demographic studies for Roma, many experts on health estimate that *life expectancy is lower among Roma*, and that this difference can exceed 7 years.

In all studies there is a prevalence of the following facts:

- **Chronic illnesses or disabilities** than in the total European population: high blood pressure, diabetes, cholesterol, allergies, respiratory problems among the elderly, and asthma among children.
- **Psychological troubles**: depression or chronic pain (particularly bones and head and migraines).
- **Accidents** (domestic, work or traffic).

Both diseases and accidents cause in many Roma disabilities or life limitations of various kinds. Both causes of poor health are associated with the residential environment and its conditions, more or less secure and integrated.

**Women:** The data show problems associated with early and late pregnancy, lower gynaecological prevention habits (only 60% of Roma women in Europe visit the gynaecologist during pregnancies) and health problems caused by work overload.

**Minors:** vaccination campaigns have been very effective in many countries but major gaps (in some European regions almost half of the children have not followed the vaccination program) and infectious diseases in young adults due to lack of vaccination in childhood.

**Different problems associated with lifestyle**

They have often overweight and obesity in older and younger; only half of the Roma population has a weight considered as healthy. Food less rich in vegetables and fruit and abundant in sweets and fats, along with lack of exercise (also in children) explains this prevalence, which in turn has implications for other diseases in adulthood.

**Substance consumption:** Almost 60% of Roma men and 30% of women are

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19 Source: FSG Health Area, 2009.

20 The Advisory Committee addressed the appearance of health problems of Roma arising from unhealthy habits, such as poor diet or lack of exercise or sports. This is causing problems with obesity or hypertension.
current smokers, varying data between countries, especially in female consumer. A contrast that is more pronounced in the case of alcohol, also important in the adult male population. Recognition of problems with alcohol or drugs affects a minority (3.5% in the European Health Survey) but these data conceal a clear concentration of problematic consumption in marginalized or segregated places: in slum neighbourhoods or isolated the data of prevalence is from 15 to 18%, which is a big impact on the community. More than the quality of housing, the key factor shared by neighbourhoods with problems of alcohol or drugs is segregation, showing once again that the life experience of stigma affects clearly problematic consumer.

**Ideas on health:** we must distinguish traditional elements of the culture of the body with elements of the transition to a consumer society and with the features of a culture in crisis.

As for the **elements coming from the transition to a consumer society,** for example, adopting unhealthy habits like smoking or eating industrial cakes is not a traditional activity, but rather an adaptive response to a consumer society whose disciplines must be learned.

There are **other aspects in which this transition fails** or becomes darker. Consumption can be more compulsive, the sense of loss or failure can lead to increased risk behaviours in adults or youth. In many older women this situation is manifested in depression when facing problems of one's life, and in young women it can lead to drug abuse.

**TRADITIONAL ASPECTS OF ROMA CULTURE RELATED TO HEALTH**

**Importance given to health, coupled with the importance of family and the health of others.** This fact explains the mutual support between relatives, which in the case of women becomes forgetting one's health and for men to reject the weakness and care. The importance of the elderly and the sense of vulnerability make that disease and death are very present in Roma culture, even young.

**Health as absence of disease and as something disabling linked to the death.** The Roma community, as almost all traditional populations, only go to the doctor when they are very sick. When a person (and family) perceives that the disease has appeared, the action must be immediate and decisive, given the relationship they feel between illness and death.

Fear of disease is linked to the problems of access to health services in some places. So it is logical to use emergency services instead of the regular (or preventive) and there is a tendency to self-medication and informal advice from relatives or neighbours.

**Health and physical illness.** The relationship established between health and physical sickness absence means that they do not take into account aspects of behaviour related to psychology.

**The link of the idea of health with morality,** making certain diseases, as HIV, a disgrace and a dishonour, so often lived in secret and with a great sense of guilt, greater in women.

**Invisibility of prevention.** The fear of death and denial of illness hinder the preventive work, and because Roma, as already mentioned, just go to the doctor
when they are very sick. Furthermore, in environments where life is long and with uncertain future, the idea of planning and care makes little sense, while caring for others and secure the future of the group usually does. For this reason many of the behaviours of the Roma have a cultural sense that does not always coincide with the dominant culture of health.

Other distinctive features of the culture that hinder prevention:

- Immediate life (daily living), which on one hand encourages the development of guidelines for daily life, but on the other hand difficult to plan.
- The prevalence of the emotional over the rational, where the action is very present and reflection often serves to fix or remedy, but not to anticipate or prevent.

**Roma and health system.**

The performance of health services and professionals working with Roma will transform their treatment, access and use.

The first barrier is the degree of inclusiveness of health systems and protection. Health systems in addition to free and universal should be inclusive, adapting as far as possible the standards of access to the conditions of the population. Only in this way there will be a normalized relationship with care, immunization, prevention and the different services, reaching all groups.

Beyond this general obstacle, barriers are more subtle and have to do with cultural differences and discrimination processes. In relation to the health professionals, they may manifest anxiety or distrust which have to be managed with communication skills, and in some cases, using tools such as mediators: “The Roma do not see centers or institutions, they see people” (Arbex, 1999: 19).

We should not minimize complaints because health professionals often are overloaded and receive no support to deal with what they consider special cases or different or conflicting behaviours. Often there are no rules and no answers systematized, but different strategies and solutions to problems when they arise, especially in hospitals, where coexistence becomes long and tense. Experts say that there is a need of a more institutionalized answer, setting out rules and options that take into account differences in the population with which they work.

In relation to the world of drug addiction, there is no systematic study on how the Roma community access to services and resources. Information is lacking on this process. These resources are characterized by a large diversity, and the world they serve.
ANNEX: RELATIONSHIP WITH DRUGS

COMMON FEATURES OF EUROPEAN YOUTH

- Each one is responsible for his/her own life. There are no clear patterns of class or gender, but the problems and solutions are presented individually. Each one will survive in society if is able to take advantage of opportunities, both in protected or hostile environments. Institutions are not leading the way nor determine the entry into adulthood. Neither the school nor the military service, marriage or work are homogeneous rites of passage, but open and unpredictable options.

- The public sphere is reduced and the young are "privatized". They do not belong to the State as in the past time, they are not manpower to the industry, nor source of support for the communities. They framework is the nuclear family and networks of friendship, fragile or strong. There are no young adults to guide them because they often do not have older siblings and because young adults do not take care of directing or disciplining younger: political parties, churches, unions, clubs, all institutions where it was possible to learn to be adult with a clear moral pattern are in crisis

- Multiply the sources of information, informal networks and possibilities to move in different environments and live different experiences much more open than in the past. In this situation some young people become strong and skilled, adapted to an open world, while many others are very lost.

TRAIYS OF ROMA YOUTH

a) Cultural norms. The key is that the culture of the group, especially in the case of youth, is set in many processes and interactions, endogenous and exogenous. Young Roma are living in several frames, and this can help them move fluidly in society, or block them. Regarding some drugs there is a great pressure of the group itself, considering drugs something wrong and harmful, along with a great permissiveness towards certain behaviours and consumption. Therefore, the place where one lives, sex and age, in addition to the usual type of consumption, will determine that drug use will be held within the group or hidden from adults, according to the majority society or against it, with different consequences in each case.

b) Personal and family networks. Roma youth is embedded in family networks, we must not forget that there are many young men and women, brothers and sisters, and cousins, but also wider networks of Roma that communicate with Internet or meet in parties, weddings, jobs. They also have relationships with non-Roma, in schools and neighbourhoods. They receive the messages of the media and advertising. It is known that the peer group is important in adolescence, which determines many behaviours and acts that can be a risk factor, leading to shared behaviours that do not have the same effect on everyone, but also can be a protective factor, to raise controls and limits about what should or should not do. Equally important are family relationships. Very restrictive or permissive environments can cause harmful effects on youth, breaking trust or create generational gaps
c) **Factors of risk and protection.** Many studies show that having strong moral values is a protective factor against drug abuse, but it is clear that the Roma Cultural always offer this protection. Depend on the environment, group cohesion, its ability to update modern ethical values, communication between generations for transmission. Unemployment, racism and the low educational level can influence drug consumption or abuse, to escape the difficulties or because these conditions affect other psychological dimensions, such as lack of confidence in self, low self esteem, or impulsivity that appear as risks. In marginal environments and segregated, with closed networks, easy access to drugs and lack of leisure and relationship, it is likely that many young people and adults Roma begin pernicious consumption.

d) **Consumption patterns:** There are worrying trends revealed by the investigation SRAP: the early onset in tobacco, alcohol exposure among adults, and presence of heroin in some regions or underestimation of risk of some drugs (such as cannabis or medicaments). Similarly, these drugs are associated with night life and friendly relations with non-Roma and patterns common to other social groups. In the case of young Roma women, although there are certain protective factors against substance use, in recent years there is a progressive increase in drug use. We encountered an increase in consumption of tobacco alone, which constitute a greater risk.

Many Roma youth do not know devices and programs for the prevention or treatment of addictions. Services are seen as distant, physically and symbolically, except for some specialized in the environment. These services often generate mistrust, are not associated with the very problems or barriers are perceived such as waiting lists.

The results recommend performing programs and interventions designed specifically for certain objectives and environments that take into account the differences mentioned, but also demonstrate the lack of experience in prevention and intervention with young Roma.
The SWOT technique is a tool that facilitates the analysis of reality and making decisions. The procedure is to analyse external and internal factors that can affect reality, in this case Roma youth and drugs.

- External factors, from the context:
  - Opportunities offered by the environment and how to take advantage of them.
  - Threats of the context and how to avoid or eliminate them.

- Internal factors of Roma youth:
  - Own strengths of Roma youth and how to maximize them.
  - Weaknesses and how to reduce or eliminate them.

At the same time, these factors don’t apply only to present, but also to the opportunities and threats that can arise in the future and its influence on youth. In this sense, to analyse threats and opportunities the following factors can be considered: demographic, economic, political, legal, sociological, environmental, technological or cultural.

(Note: Translation Diagram: Positive factors, negative factors, internal factors, external factors, strengths, weaknesses, opportunities, threats.)
ANNEX: TEST OF STEREOTYPES AND ANSWERS

This test belongs to the Campaign: Get to know them before judge them, directed by Fundación Secretariado Gitano. It is available in the website www.gitanos.org

QUESTIONS OF THE TEST

ROMA ..........

ROMA ..........

1. Don’t want to integrate

Strongly agree

Agree

Disagree

2. Don’t want to work

Strongly agree

Agree

Disagree

3. Are not interested in studying

Strongly agree

Agree

Disagree

4. Is a sexist culture

Strongly agree

Agree

Disagree
5. They monopolize the social resources

ANSWERS TO THE TEST

1. Don’t want to integrate

Despite the structural barriers that still exist, the Roma community and particularly women and youth, are highly participatory, there is now a growing number of associations very active. Their road is difficult, because when access spaces for citizen participation they do not find any recognition of their culture and they hardly find references with which to identify.

It is not true that Roma families prefer to live, be educated and work in spaces only for them. As has happened with other minority cultures, centuries of persecution and attempts to erase differences have led to resistance and survival strategies.

In the case of the Roma community they have suffered constant persecution in many European countries, as the terrible Holocaust (over half a million Roma were exterminated) or laws like Idlers and Criminals during Franco dictatorship or scandalous cases of forced sterilization of Roma women in Eastern Europe, or more recently the expulsions of Roma families by the French government.

2. Don’t want to work

In Spain, before the crisis, 7 out of 10 Roma people, aged over 16 years, had an occupation: half with a salary and half as self-employed. These data show that it is a community particularly hard-working. Moreover today we find Roma men and women working in all professional fields: legal, medical, literary, educational, in all kinds of positions and trades. One example is the book 50 mujeres gitanas en la sociedad española (50 Roma women in the Spanish society).

But still too many Roma suffer discrimination in employment; often they are not hired just because they are Roma. As a result, there are recent European directives and recommendations urging member States to ensure the promotion of equal treatment, especially in employment.

3. Are not interested in studying

Today, in many European countries (but not all), almost all Roma children go to primary schooling, which is a great achievement, both for education systems and to the Roma community itself, when compared to the high number of illiterate people in the past. This shows that Roma families are fully aware of the need and importance of formal education for their own progress.
However, the major barrier remains in the step towards secondary school: among young people 15 to 24 years old, only 17% are students, compared to 60% of the average of the European population. One of the reasons of this situation is a low quality education for Roma in primary school in many countries, in conditions of segregation, in special schools or regular schools (but where are the majority) and where they receive an education of poor quality.

4. **Is a sexist culture**

Although it is true that women, in many cases, still support an unbalanced distribution of tasks, and that family hierarchy in the Roma community are patriarchal, we also hear increasingly the expression "Roma women are the engine of their people."

Despite the fact that women bear most of the weight of tradition and the maintenance of customs, they are responsible of a greater integration of Roma families, joining social life in all its fields. They are also the defenders of the need for education for children and perhaps even more for girls.

Furthermore, through training courses that offer different types of organizations, and access to other studies, many Roma women are assuming the role of mediators, resolving conflicts that make them new respected women.

5. **Overuse social resources**

Even today, there is a part of Roma who lives serious social exclusion situations. For them there are no privileges of any kind, but rather the opposite: they have to access to social resources providing the same evidence that other citizens and the criteria used for social aid does not recognize the ethnic identity.

Behind the images of TV that show us slums and forced evictions of Roma families, there are personal dramas and social situations that it is difficult to think that are chosen voluntarily. This extreme poverty is affecting nearly 30% of Europe’s Roma population, who is living in poor quality housing or substandard housing, although less than 4% live in shantytowns. Although these numbers are high, this situation does not affect most people, but a minority. To remedy these situations welfare programs on housing, basic care, health, employment are implemented.

Therefore, in order that society could have a more just and right image of the Roma community it is important to note that such situations are not inherent to the Roma Culture (historically persecuted and discriminated against), but to the culture of poverty and marginalization.