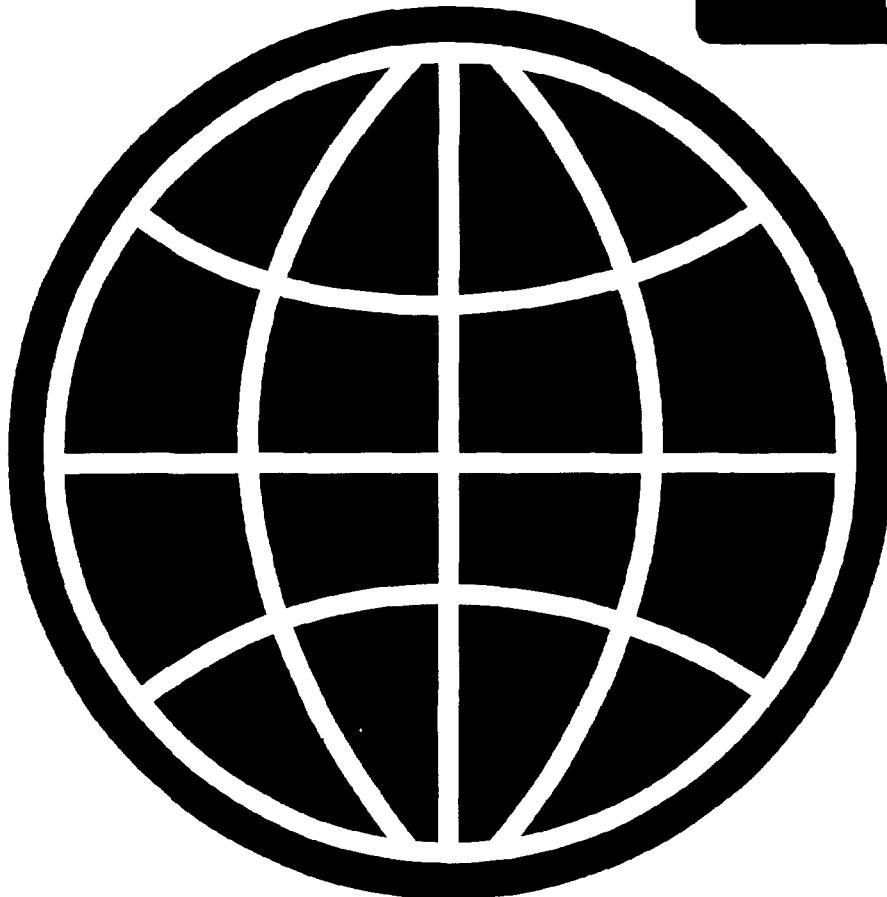


WORLD BANK REGIONAL OFFICE HUNGARY
NGO STUDIES NO.2

THE HEALTH STATUS OF ROMAS IN HUNGARY

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1999



*Lajos Puporka
Zsolt Zádori
ROMA PRESS CENTER*

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The International Bank for Reconstruction
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Table of contents

I.	<i>DEMOGRAPHIC DATA</i>	7
II.	<i>MORTALITY</i>	13
III.	<i>MORBIDITY IN GENERAL</i>	19
IV.	<i>SCHOOL EDUCATION</i>	22
V.	<i>EMPLOYMENT</i>	25
VI.	<i>HOUSING</i>	26
VII.	<i>PREGNANCY, BIRTH CONTROL AND CHILD DELIVERY</i>	30
VIII.	<i>INFECTIONS AND EPIDEMICS</i>	35
IX.	<i>CANCER AND RESPIRATORY DISEASES</i>	40
X.	<i>NUTRITION</i>	42
XI.	<i>ADDICTIONS</i>	44
XII.	<i>ENVIRONMENTAL POLLUTION AND WORKPLACE DAMAGES</i>	45
XIII.	<i>SOCIAL COHESION AND ANOMALY</i>	47
XIV.	<i>HEALTH ATTITUDES</i>	56
XV.	<i>PREJUDICE AND DISCRIMINATION</i>	59
	<i>SUMMARY STATEMENTS</i>	61
	<i>LIST OF CHARTS, TABLES AND MAPS</i>	63

It is appropriate and useful for the authors of this study to clarify the reason why they are involved in the investigation of the health status of Romas in Hungary, beyond the definite intention of the client. The answer is not so simple. Though it is true that based on our preliminary understanding the health status of Romas is distinct, we also know that characteristically it does not differ from that of the poorer classes. We also know that since the change of regime by and large, data concerning Romas is no longer registered separately in health-care institutions, moreover, following adoption of the data protection and the minority rights acts, nor is it possible to renew this practice. Whereas, it is precisely subsequent and in consequence of the change of regime that the elementary need to investigate the specific problems of Romas surfaced. It is undeniable that the entire health care system is ailing in Hungary, but in our experience certain groups in society, including Romas in our view, feel this pain more acutely. And of course, it is also public knowledge that Hungary is undergoing a demographic crisis, but—in spite of their increased number and although different in nature—Romas are also. We have heard often enough that no meaningful answer to the question of Romas can be given if we excerpt one element and try to find solutions for it. However, in our view this cannot be equal to a short-sighted generalisation of the problems.

Because—and we have now arrived at the very middle of the answer given to the original question—one makes no mistake by dealing with a problem that in practice is quite apparent despite the fact that it raises a number of theoretical dilemmas, namely, that the health condition of Romas is bad, worse than that of our country's otherwise lagging behind the developed world, and that Romas have more difficult access to even low quality health care than non-Romas. In this regard, the authors of this study are in a favourable position since we are carrying out the intentions of the client: to highlight the key issues of the topic, raising problems for which the solution is not our responsibility.

We attempt to present the specific features of the health status of Romas in the following pages. In the process, we try to avoid evaluations, nor do we wish to name anyone responsible or force salutary recommendations on the Reader. Our method generally is to document, to challenge facts and opinions. We have borrowed our tools from the sphere of social sciences, namely sociology and related sciences.

In the opinion of Rudolf Virchow physician, statesman and anthropologist, medicine is also a social science, and politics is nothing more than the wider application of medicine. We do not believe that Virchow would have an in-depth knowledge of the health status of Hungarian Romas, but this aphorism of his —that we hope the pages below will confirm—is right on target as regards the subject of our study.

*

According to Márta Váczi, co-worker of the National Health Protection Institute (NEVI), it is pointless and dangerous to carry out separate studies on the health status of Romas. Although in 1989 she conducted similar research with her fellow workers,¹ she came to the conclusion that identical conditions prevailed among Romas as did among the socially disadvantaged poor. In her view certain researchers may also use the statistical results to draw conclusions that can place Romas as responsible for spreading epidemics and various diseases. (We must note that we have not come across any work of this orientation in studying the technical literature produced after the change of regime.) As a result of the research it would be dangerous to declare certain diseases to be racially dependent since the tendency to disease is not dependent on race but family history.

Váczi is of the opinion that it also does not need to be proven that the life expectancy of Romas at birth is fifteen years less than the otherwise low figure of society at large. This case has already been proven for the poor segment of society and since a significant proportion of this group is made up of Romas, and the majority of Romas is poor (living below subsistence level), any further proof is unnecessary.²

Katalin Pil and György Gyukits agree with Váczi in that there is no essential difference in the health status of non-Romas in similar social situation to Romas. However, according to them the research is not without merit since its results could help verify assumptions regarding Romas and obtain reliable and new information about their contracting illnesses. In any case, inaccuracies resulting from the current practice of estimates would diminish. Based on these results, targeted preventive programmes could be launched, providing a better chance for efficient intervention. In addition, there may be numerous specific features in the relationship between Romas and health care: from discrimination—primarily among the Wallach and Bayash Roma communities, which have stronger traditional ties —through cultural idiosyncrasies, to patient attitudes that differ from the general.

“The life of most Roma groups is characterised primarily by lack, lack of a decent salary and income, good housing, satisfactory clothing and nutrition, healthy drinking water, education, and the ability to compete with the non-Romas,” in the opinion of István Kemény, academician and expert researcher of Romas in Hungary. Furthermore, there is hardly any facet of life or the material world that could not be included in this list. Such is health and health care.

Health is closely related to several “hard” sociological facts, the components of lifestyle. The more defenceless the ethnic group is concerned, the closer the relationship. Factors like GDP,

¹ The results of that research are included in: Márta Váczi: “The health status of Romas and resultant health preservation tasks” *Egészségnelvélés [Health Education]*, 1991. 2. 62-67.

² Information provided by courtesy of Márta Váczi.

education, the position of the labour market and housing conditions are important only for as long as they are at a low level or missing, but then they are very important. This is also true for Romas. Therefore, before examining what ails Romas more than the majority population, in reversal of the customary logic of studies, we must clarify the questions, the causes. In our opinion and that of the majority of researchers, the reasons are not genetic and not even cultural, but are sociological in nature.

From the perspective of social position Roma population is that group in society which lives among the worst conditions in Hungary. For this reason, it can unconditionally be stated that the health status of Romas is much more unfavourable than that of the entire population, whereas Hungary is not at all in a exemplary position in this regard among the countries of Europe. The above facts are also collaborated by statistical indicators that serve to characterise the status of health.

I. Demographic Data

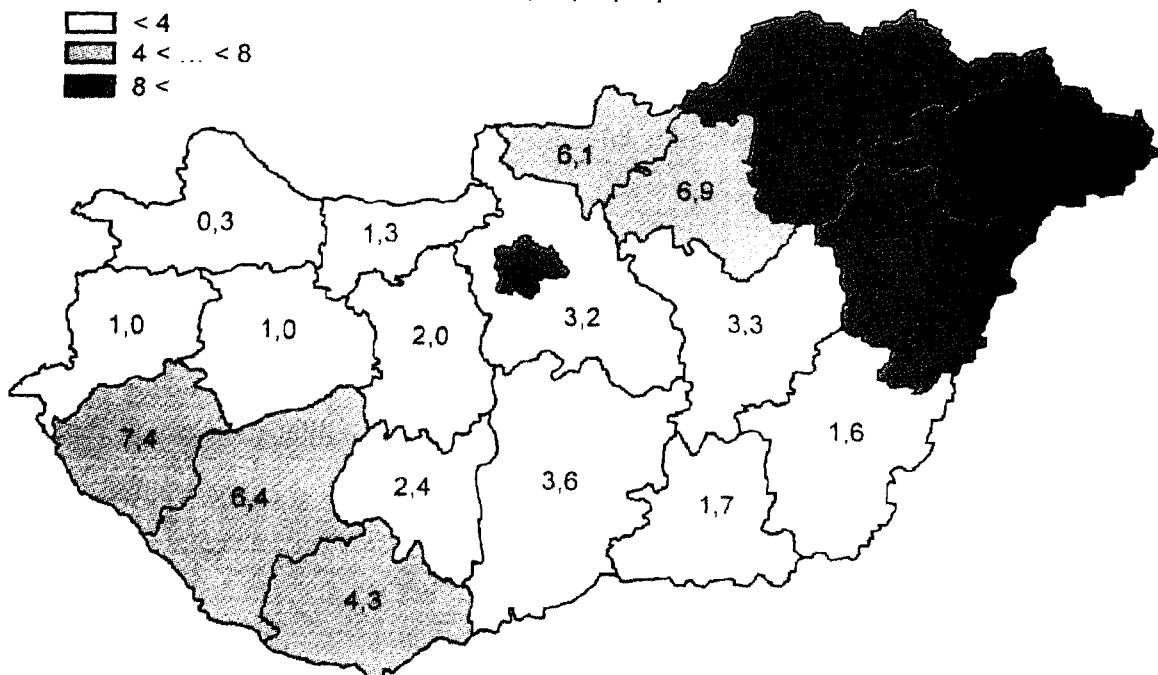
The goal of this study is to present the health status of Romas in Hungary, that is, to present its specific features that diverge from the majority. Toward this end, it is indispensable to determine the specific population group we consider the subject of our examination, the approximate number of people involved, their proportion within the total population of the country, and the demographic and lifestyle features that characterise them.

Without taking a position in the recent debate that extends beyond demographics and sociology and is partly political in nature, which has particularly attracted the interest of researchers, in the interest of the application of this study, it seems necessary—at least within the scope of this work—to refer to mostly one of the currently in use definitions and number of inhabitants with respect to Romas.

In the 1990s six well documented scholarly examinations were conducted in order to determine the number of Romas living within the country, five of them with this specific goal in mind. The goal of the 1990 national census was naturally first and foremost to count the country's population and to investigate the demographic, societal, asset, educational and employment relationships therein; a “useful by-product” was the collection of data concerning the number and circumstances of Romas. In the census people were considered to be of Roma nationality (that is, of Roma mother tongue) who declared themselves such. According to the 1990 data, 48,072 persons declared themselves to be of Roma mother tongue and 142,683 persons acknowledged themselves as of Roma nationality (less than 1.4% of the total population). The rapidly changing data in the censuses, as well as the various sources of estimates, but in all cases with divergent results, prompted the Central Statistical Office (KSH) to carry out a new survey in 1993 that

investigated the number and living conditions of Romas exclusively, and which was not based on self-declaration. The reason being that researchers consider as among classification systems self-qualification the most unreliable.³ “There are Romas living in large numbers in Hungary who clearly differ in their lifestyle from the non-Roma environment surrounding them, precisely for which reason the non-Roma environment considers them Roma, while at the same time for one reason or another [in some or another life situation, P.L.—Z.ZS.] they do not consider themselves Roma.”⁴

Map No. 1 Regional distribution of Roma lifestyle people in 1993



Source: KSH

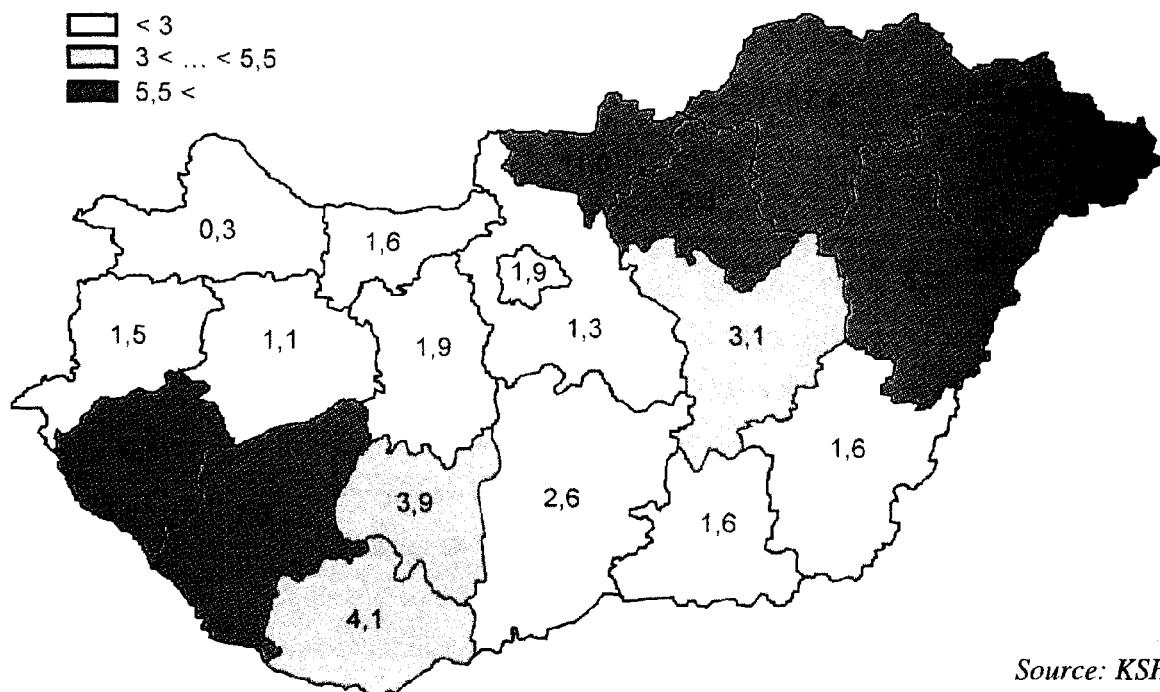
In the examination conducted by the KSH in 1993, “census-takers with good local knowledge” classified households by lifestyle (into Roma lifestyle, interim [uncertain], non-Roma types). According to this survey, 3.9% of the Hungarian population lives a Roma lifestyle.⁵

³ János Ladányi – Iván Szelényi: Who is Roma? Kritika, 3.12.1997

⁴ István Kemény: Roma population in Hungary. István Kemény: Sociological works. Replika Books 1., Szeged, 1992. 157.

⁵ The situation and living conditions of Romas 1993. KSH, Bp., 1994. 11.

Map No. 2 Proportion of Roma lifestyle people in the population in 1993



Source: KSH

A research led by Iván Szelényi and Donald Treiman reached similar results the same year: according to their data 3.9% of those interviewed between the ages of 20 and 70 were qualified as Romas.⁶

The 1996 Szonda Ipsos survey produced significantly different results, as did the 1992 Hungarian household panel: the former estimated the proportion of Romas at 6.6%⁷ in the population over 18 years of age, while the latter at 3.1% among those over 16.⁸

With regard to the above, we hold the data and conclusions drawn by the Sociological Institute of the Hungarian Academy of Sciences in the study led by István Kemény, Gábor Havas and Gábor Kertesi in the winter of 1993/94 to be the most reliable and useful with respect to this study. First, because besides the KSH, this is the only survey that examines the total number of Romas irrespective of age; and second, because it can stand on the results of a previous survey conducted with the same methodology in 1971, which has not been refuted so far. For our purposes, neither is it the least criterion that the survey is also the best documented and processed.⁹ The survey qualified people as Roma if they were considered Roma by the non-Roma environment. This classification method, which may be subject to criticism in some cases, serves our purpose since we know that a specifically Roma patient does not appear in the health care system as a "freely

⁶ János Ladányi: Romas in Central and Eastern Europe. Társadalmi Szemle, 1996. 4. 32.

⁷ Quoted by János Ladányi – Iván Szelényi: Who is Gypsy? Kritika, 4.12.1997

⁸ Endre Sik („András Lapos”): The longitudinal Gypsy. Replika, June 1995, 247.

⁹ Other examples: István Kemény – Gábor Havas – Gábor Kertesi: Report on the research completed between October 1993 and February 1994 on the situation of Roma (Gypsy) population in Hungary. Hungarian Academy of Sciences Institute of Sociology, 1994; Gábor Havas – István Kemény: About Romas in Hungary. Szociológia, 1995. 3.; Gábor Kertesi: Two surveys of Romas. Szociológiai Szemle, 1996. 1.; István Kemény: Romas and the school. Educatio, spring 1996; Gábor Kertesi: Humiliated and saddened. Esély, 1996. 3.; István Kemény: About Roma (Gypsy) population in Hungary. Magyar Tudomány, 1997. 6. Gábor Kertesi – Gábor Kézdi: The Roma population in Hungary, Socio-typo, 1998

elected identity,” but as a member of a certain group with particular life circumstances and lifestyle and identified by the (non-Roma) environment as such. Moreover, Kemény was the first, at the beginning of the 1970s, to articulate in sociological terms that Romas in Hungary break down into separate lifestyle groups and that in their formation and segregation the degree and nature of their participation in the social distribution of work was the primary determinant factor.¹⁰

In the course of this study we shall attempt to rely primarily on these research results, but naturally as a control, or to supplement the deficiencies in the representative survey of the Sociological Institute of the Hungarian Academy of Sciences we shall also use other data.¹¹

On 1 January 1994, this was the theoretically fixed date of the survey, in the event of a one hundred percent listing Roma population in Hungary would have been 433,814 living in 97,050 households. (The average number of members living in households was 4.47 persons). With a margin of error of ten percent, the estimated number of Roma households was 102,158 and the number of Roma population was 456,646 persons. Taking into account the results of the 1971 survey of almost 320,000 people, based on similar principles, this represents an increase of more than 44% in a little more than 20 years, compared to the yearly 1-3 per mil reduction in the overall population from 1981. In 1971 the Roma population made up 3% of the total population of the country, now it is 4.4%. Further shift is to be expected in the future according to Kemény et al. Currently, the birth rate is 28.7 per thousand persons in the case of Romas, while it is only 9.9 for the overall population, while the mortality rate is steady at a range of 13 to 14. Based on population prognoses, whereby the number of inhabitants in the country will be 9.6 to 9.7 million, Kemény et. al. are of the opinion that the number of Romas, around 700,000 may make up more than 7% of the population of Hungary. The data concerning births is even more significant: every eighth child born in Hungary today is of Roma origin,¹² despite the fact that family planning is becoming increasingly more general in Roma families and they have fewer children. From a health survey conducted in a Roma settlement of Kiskundorozsma, it is clear that the number of births has decreased dramatically since the change of regime even among under-educated Romas living in Roma settlements: there are only two or three children born each

¹⁰ István Kemény: The Gypsy population in Hungary. = István Kemény: Sociological works. Replika Books 1., Szeged, 1992. 158.

The work of Péter Szuhay is similarly revealing who proves with the means of cultural anthropology and ethnography that Romas do not form a unified conglomerate, what is more, segregation and closure is even greater between Gypsy groups of different culture than between the majority society and Romas. Péter Szuhay: Gypsy culture. About the cultural integration of the Gypsy ethnic groups in Hungary and the formation of the national culture. BUKSZ, 1995. 3.

¹¹ The results of the survey completed by the Institute of Sociology do not include county level data. When we use such data, in every case we use the results of the representative survey related to the labor force survey of the Uniform Household Data Collection System (ELAR) of the KSH in 1993.

¹² István Kemény – Gábor Havas: Being Gypsy. = Társadalmi Jelentés 1996. Századvég – TÁRKI, Bp. 1996. 354-355.

year in a settlement of around 160 people. The generation of 0-5 years now makes up only 6.5% of the community, while in the mid-1980s it reached as high as 30%.¹³

If we accept that the health status of Romas in Hungary is much worse than that of society at large, we have to accept the bitterly accurate statement by György Gyukits wherein increase in the Roma population also means that in Hungary there is a process of increased reproduction in a social group with bad health status.¹⁴

The above mentioned survey—similar to the 1971 research—showed that Romas live throughout the country, however, their distribution is far from even. In the 1970s, Kemény et. al. divided the country from this aspect into six regions: north (Borsod-Abaúj-Zemplén, Heves and Nógrád Counties); east (Szabolcs-Szatmár-Bereg, Hajdú-Bihar and Békés Counties); the Great Plain (Csongrád, Bács-Kiskun and Jász-Nagykun-Szolnok Counties); the industrial area around Budapest (Budapest, Pest, Fejér and Komárom-Esztergom Counties); South-Transdanubia (Baranya, Somogy, Tolna, Veszprém and Zala Counties); and west (Vas and Győr-Moson-Sopron Counties).

Table No. 1 Number of Romas in Hungary by region, according to the data of the 1971 and 1994 representative surveys of Romas.

Region	Number	Number	Proportion to Roma population	Proportion to Roma population	Proportion n to total population	Proportion to total population
	1971	1994	(%)	(%)	n (%)	(%)
North	65 thousand	119 thousand	20.4	24.3	6.5	9.0
East	75-80 thousand	90 thousand	23.0	19.8	5.0	6.3
Great Plain	50 thousand	55 thousand	16.0	12.0	3.0	4.1
Bp. ind. rea	60 thousand	83 thousand	19.0	18.2	2.0	2.4
South Transd.	65 thousand	104 thousand	20.0	22.8	4.0	6.5
West	5 thousand	13 thousand	1.4	2.9	1.3	2.0

Source: Kemény - Havas

It is clear from the above that the proportion of Romas compared to the total population has increased in all regions, but to various degrees. The main cause for this shift is certainly migration and immigration. The rate of migration was quite high from the eastern region to the northern, closely aligned with forced industrialisation. In absolute numbers it is less, but migration was similar in proportion from the Great Plain region towards the northern and South-

¹³ Zoltán Szirtesi: The health status of Romas. Agroinform Publishing House, Bp., 1998. 20.

¹⁴ Information provided by courtesy of György Gyukits.

Transdanubia regions, and to the industrial area around Budapest. The number of Romas has almost tripled in the two western counties.

There have also been shifts between types of settlements. In 1971, 25,000 Romas lived in Budapest, today their number is 51,000. The shift is even greater in favour of towns in the countryside. In 1971, 45,000 Romas lived in towns, now three times as many do, and the proportion compared to the total Roma population increased from 14% to 30.3%.

Table No. 2 *The distribution of Romas among the different types of settlement.*

Type of settlement	Number in 1971	Number in 1994	Proportion in 1971 (%)	Proportion in 1994 (%)
Budapest	25 thousand	51 thousand	7.9	9.1
Town in the countryside	45 thousand	129 thousand	13.9	30.4
Village	250 thousand	277 thousand	78.4	60.5

Source: István Kemény – Cákó Havas

The urbanisation of Romas was therefore strong, but it was not only the result of Romas moving into towns, as several villages received the title of town during the period examined. The actual distance between Romas and non-Romas is greater than is evident from the above: while only 36% of non-Romas live in villages, 60.5% of Romas do. The difference is even more striking if we consider that 40% of Romas live in settlements where the total number of inhabitants is below one thousand, while for the total population this rate is 17%.

The view continues to prevail that the majority of Romas live in extended families of complicated structure, with several generations and a large number of family members. In fact, this statement is true only in part today. A survey of Roma households covering five counties in eastern Hungary and the town of Debrecen, conducted on request by the Ministry of Welfare, established that although the number of households comprising 1-3 persons is in fact relatively low (16%), and that in villages households of five or more members represent a proportion of nearly two thirds, the situation in the cities is however different. An urban lifestyle fundamentally influences the size of Roma households and greatly approaches that of non-Roma urban households. Traditional extended families, several generations living together, are no longer characteristic in villages either; whereas nuclear families (comprised of parents and children) make up 62% of Roma households.¹⁵

¹⁵ Pál Bánkay: Survey of Gypsy families. Ministry of Welfare, Family, Children and Youth Policy Division, Family Protection Department, [Bp.], 1993, 21-23.

II. Mortality

The health status and demographic position of the population in Hungary are strikingly bad. The number of live births is low; while in 1970 its value was 14.7 per thousand inhabitants, in 1997 it was an all-time low at 9.9. Coupled with the calculation of a decrease of 13.7 persons per thousand inhabitants, this means a natural reduction of 3.8 persons per thousand inhabitants. The trend that started in 1980 continued to gain strength in the 1990s, the population of the country continued to diminish.¹⁶ The absolute number of foetal losses is high despite a decrease in the tendency in foetal death. Low weight babies, below 2500g, are born in approximately 8.5% of live births.¹⁷ The number of abortions is diminishing slightly, but still high (with 74,000 in 1997); and this is especially so if we compare figure to one hundred live births: last year it was higher than ever, at 74.¹⁸ The mortality rate is increasing while the fertility rate declines. Death is particularly frequent among middle-aged men, in this respect we are almost world leaders. The life expectancy of those born in 1996 is 66.1 for men and 74.7 for women, much below the European average.¹⁹

Among health indicators the most decisive are the mortality data. Mortality rates are quite stable indicators, reflecting well the health status of a population. However, in evaluating them, it must be taken into account that the underlying reasons go back 10 to 15 years, so the mortality values are related primarily to that period. The leading causes of death in Hungary show an order similar to that of developed countries: malignant tumours; heart disease; cerebrovascular disease; arteriosclerosis; bronchitis; pulmonary emphysema and asthma; liver disease; accidents; suicide and self-mutilation. The high number of deaths caused by disease of the digestive organs, particularly atrophy of the liver, can be considered a Hungarian characteristic, which can be attributed to excessive alcohol consumption.²⁰

¹⁶ Hungarian Statistical Booklet 1997. KSH, Bp., 1998. 17.

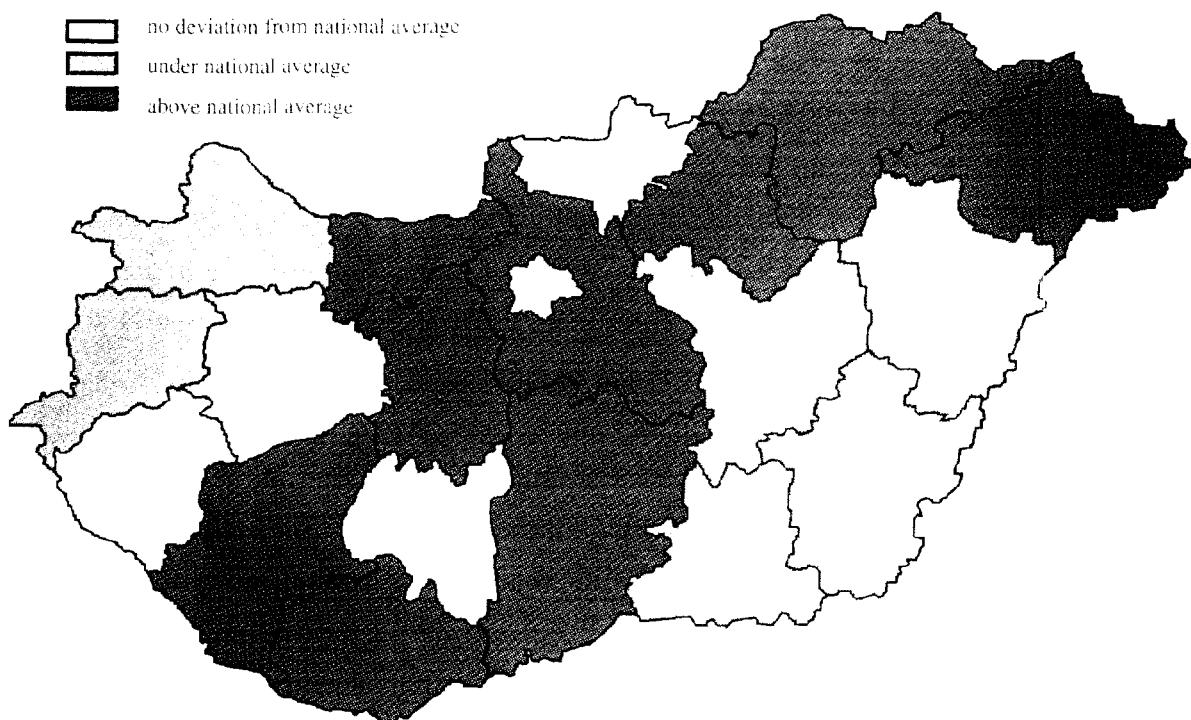
¹⁷ Hungarian Statistical Booklet 1997. KSH, Bp., 1998. 19.

¹⁸ Hungarian Statistical Booklet 1997. KSH, Bp., 1998. 21.

¹⁹ Hungarian Statistical Booklet 1997. KSH, Bp., 1998. 22.

²⁰ Alán Pintér -- Mihály Csanády -- Amanda Horváth: Environmental health implications of regional inequalities. = Public health, physician, society. Editor Ferenc Glatz. Hungarian Academy of Sciences, Bp. 1998. 153-155.

Map No. 3 Total male mortality by counties, 1981-1984.

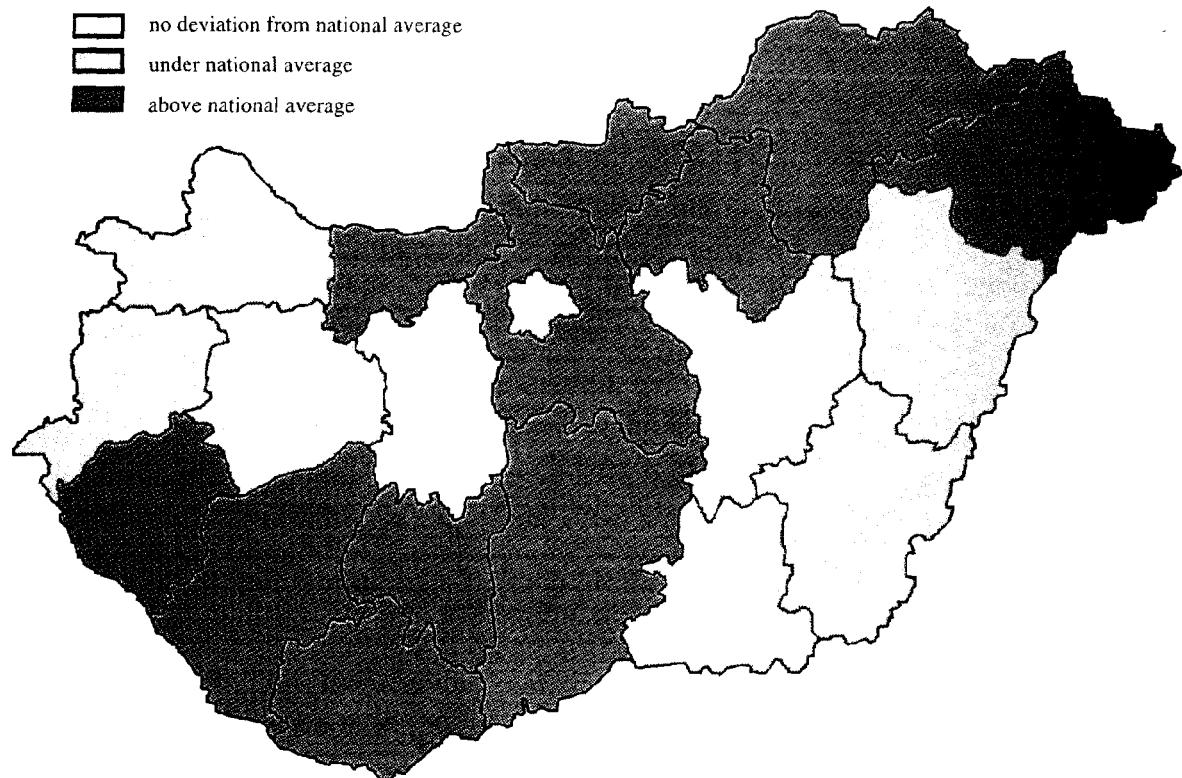


Source: Hungarian Academy of Sciences

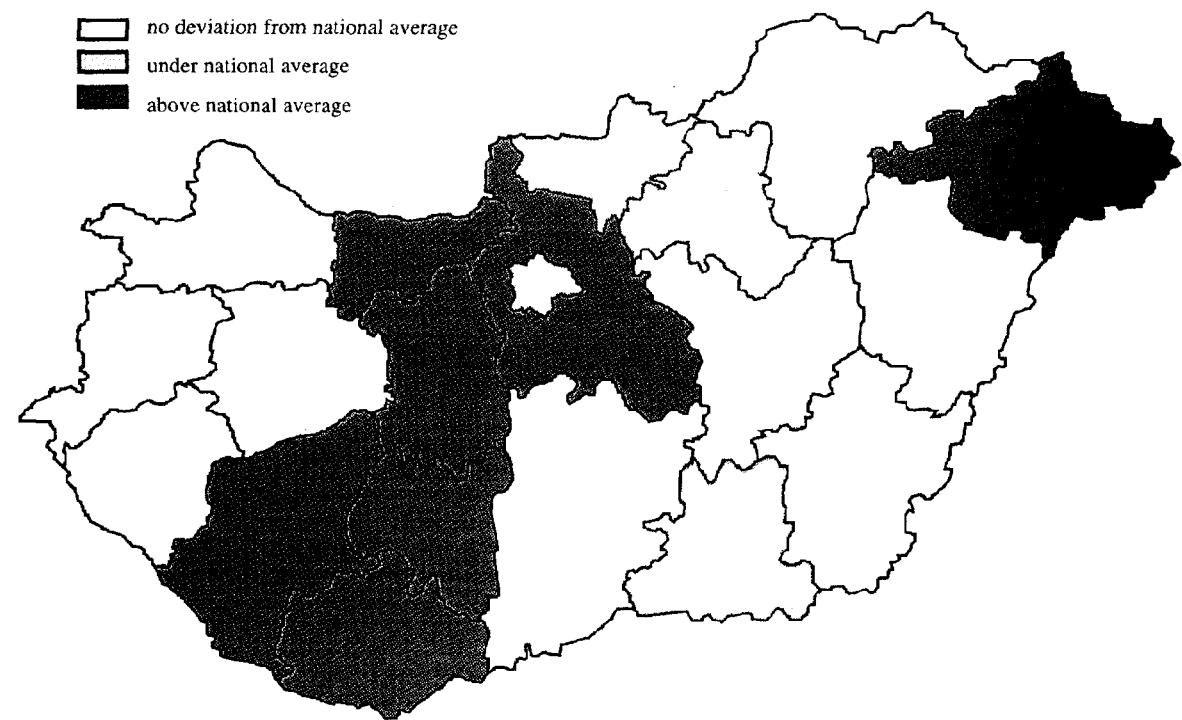
A close relationship can be observed between the gross national product and a better health status in the countries of the developing world, which was also true of the richer countries during the first half of the twentieth century. However, this correlation has been increasingly less valid since the 1960s. Similarly, there is no clear relationship between the GDP and the rise of life expectancy. In the 1970s the mortality rate in Hungary and the neighbouring countries was better than for instance, in Great-Britain or Austria. However, this trend turned around during the 1980s and now the rate in Hungary is among the worst in Europe, along with Russia, the Ukraine and Latvia. This change can certainly not be attributable to a deterioration of the financial conditions up to 1988, as the GDP rose by 208% between 1960 and 1988.

Richard Wilkinson from Great-Britain and later G. A. Kaplan et. al. from the United States have shown that in mortality rates developed countries do not correlate with the GDP but with inequalities within society. The greater the difference between the rich and the poor, the higher the morbidity and mortality rates. Therefore, the best indicators of health status are the economic differences within society, not the absolute measure of the economy.

Map No. 4 Total male mortality by counties, 1991-1994.

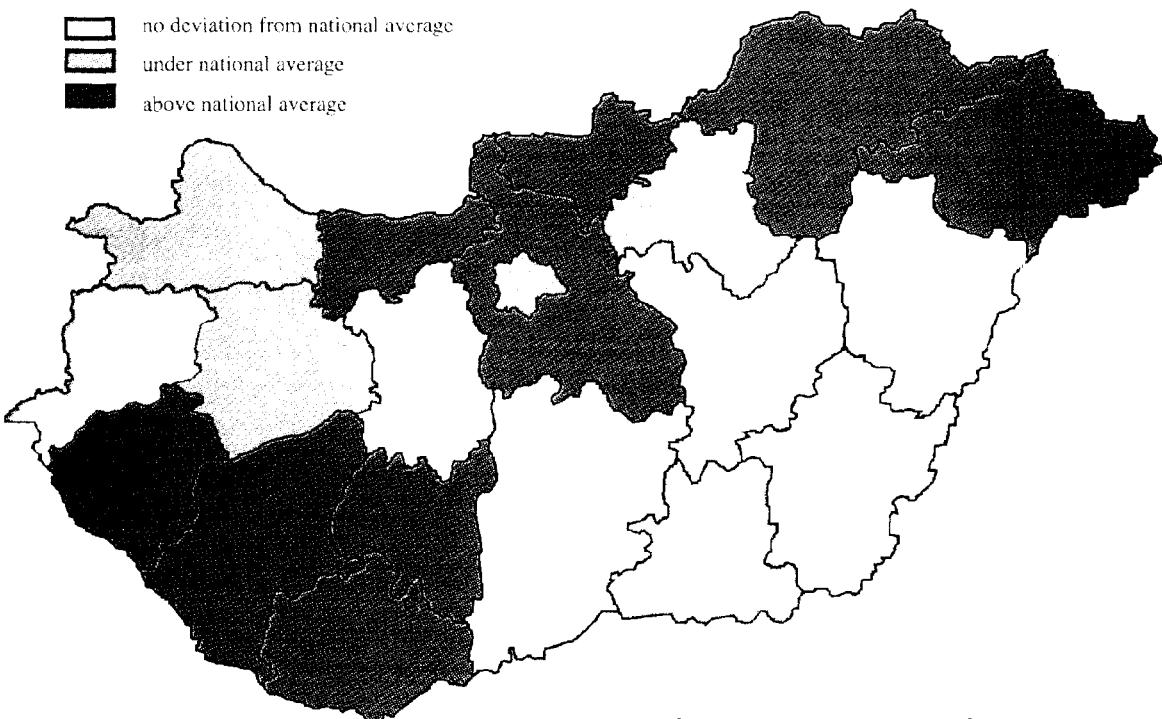


Map No. 5 Total female mortality by counties, 1981-1984.



Source: Hungarian Academy of Sciences

Map No. 6 Total female mortality by counties, 1991-1994.



Source: Hungarian Academy of Sciences

Inequalities between counties can be characterised not only by an inferior health status, but also by higher unemployment, greater crime rate, a higher rate of unemployability, low-weight infants, as well as the lower number of university graduates and smaller amounts of money spent on education. The strong correlation between health status and a relatively lower socio-economic status prevails even if the data is aggregated according to traditional risk factors, such as smoking, overweight and a lifestyle lacking in physical exercise.²¹

The number of children among Romas in Hungary is greater than that of the total population, but their number and rate of deaths are much higher, accordingly, life expectancy is much shorter. Under the scope of an investigation conducted in the late 1980s in a village in Pest County, Katalin Pik established that Roma men lived 12.5 years and Roma women 11.5 years less than the non-Roma inhabitants of the village.²² The proportion of children under 15 is twice the rate of the total population, that is, 38% compared to 19%. On the other hand, the proportion of people over 59 in the total population is more than four times the rate of Romas, that is, 19% compared to 4.5%.

²¹ The results of Wilkinson, Kaplan and Putnam are quoted by Mária Kopp—Árpád Skrabski—Sáncor Szedmák: The importance of social cohesion in the development of morbidity and mortality in Hungary. = Public health, physician, society. Editor Ferenc Glatz. Hungarian Academy of Sciences, Bp. 1998. 15-37.

²² Katalin Pik: The correlation between work and health status. Survey among old age Gypsy and same age non-Gypsy residents in a Pest County village. Cigánylet. Ed. by Ágnes Utasi and Ágnes Mészáros. MTI PTI, 1991. p. 162. See also: Death does not pick and choose. Phralipe, 1992. 7.

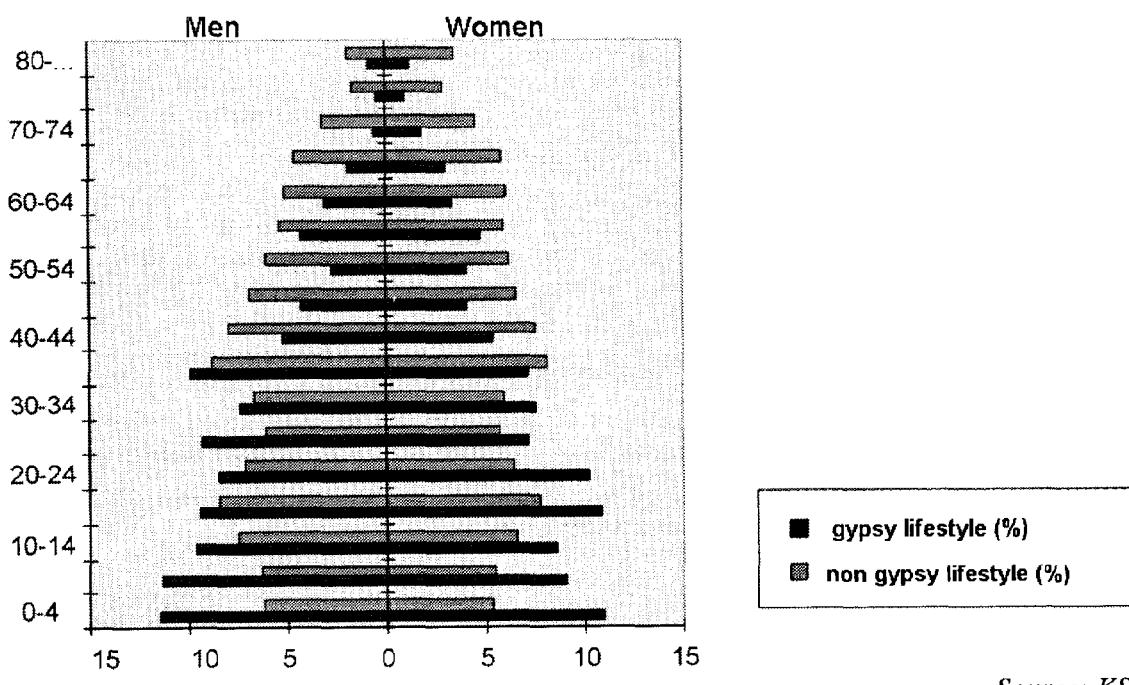
Table No. 3 Generation breakdown of Roma and the total Hungarian population in 1993.

Age group	Romas	Total population
0-14	37.8	19.0
15-29	27.9	21.5
30-39	15.5	14.6
40-59	14.3	25.6
60-	4.5	19.3

Source: Kemény-Havas and KSH

As evidenced, the number of children is higher in the case of Romas, but the number and rate of mortality is also much higher; accordingly, life expectancy is much lower. While the age pyramid of the overall population in Hungary is most similar to that of developing countries, the age pyramid of Romas resembles that of Brazil.²³

Figure No. 1 The population of Roma lifestyle and non-Roma lifestyle by gender and age groups.



Source: KSH

The KSH report is optimistic about the future life prospects of Romas: "In view of the fact these days that health care provides the same opportunities to Romas as non-Romas by and large at birth and subsequently, the proportion of elderly is expected to rise in a few decades, and if high fertility rates prevail, a significant increase in the Roma population can also be expected."²⁴ Other researchers are not so optimistic. Disregarding the second part of the assertion in the KSH report,

²³ Lajos Puporka: The age pyramid of Romas is not that high. Népszabadság, 8 July 1997

²⁴ The position and circumstances of Romas 1993. KSH, Bp., 1994. 14.

which more than likely is expected to prove true, for the time being it is difficult to substantiate that Romas get *by and large* similar opportunities in health care, nor has the proportion of elderly increased among the Roma population in recent years. The chances for Roma infants are still much worse in life than that of their non-Roma counterparts and they expectedly die at least ten years earlier than non-Romas.

Table No. 4 *The ten leading causes of death in Hungary and in Szabolcs-Szatmár County in 1978.*

Hungary			Szabolcs-Szatmár County		
Rank	Causes of Death	Rate (%)	Rank	Causes of Death	Rate (%)
1 st	Heart disease	39.9	1 st	Heart disease	41.9
2 nd	Tumours	25.2	2 nd -3 rd	Cerebrovascular disease	20.8
3 rd	Cerebrovascular disease	18.8	2 nd -3 rd	Tumours	18.0
4 th	Accident	6.9	4 th	Accident	6.3
5 th	Bronchitis, emphysema, asthma	4.6	5 th	Suicide	4.8
6 th	Suicide	4.3	6 th	Bronchitis, emphysema, asthma	3.9
7 th	Atrophy of the liver	2.3	7 th	Flu and pulmonary inflammation	3.5
8 th	Perinatal mortality causes	2.2	8 th	Perinatal mortality causes	3.1
9 th	Flu and pulmonary inflammation	2.1	9 th	Atrophy of the liver	1.9
10 th	Diabetes	1.7	10 th -11 th	Diabetes	1.3
			10 th -11 th	Birth defect	1.3

Table No. 4/a *Leading causes of death for Romas in Szabolcs-Szatmár County in 1978.*

Rank	Causes of Death	Rate (%)
1 st	Heart disease	22.1
2 nd -3 rd	Cerebrovascular disease	6.3
2 nd -3 rd	Perinatal mortality Causes	6.3
4 th	Flu and pulmonary inflammation	5.3
5 th	Tumours	4.7
6 th	Accident	4.2
7 th -8 th	Bronchitis, emphysema, asthma	2.6
7 th -8 th	Suicide	2.6
9 th	Nephritis and nephrosis	1.6
10 th -11 th	Colitis and other diarrhoea	1.0
10 th -11 th	Birth defect	1.0

In the absence of reliable and current data it would be difficult to take a position on the question whether the leading causes of death for Romas differ significantly from those of non-Romas.

Here, as in many other cases, we must be content with the published and formulated opinions expounded by experts. According to a publication that discusses the distribution of the causes of death among Romas who died in 1978 in Szabolcs-Szatmár County, not only the age distribution,²⁵ but also the characteristic causes of death differ significantly from that of the County's majority population.

It is clear from the table that in the case of Romas who lived in Szabolcs-Szatmár County in 1978, perinatal mortality was three times more frequent than in the country as a whole, and twice as frequent as in the County (the County data including the data on Romas as well). Deaths caused by tumour diseases, which mostly threaten the elderly, suicide, and accidents were placed in a lower order. On the other hand, flu and pulmonary inflammation as well as nephritis and nephrosis held a high place. Colitis and other diseases involving diarrhea—which has disappeared from the national list in the 1950s—were still found among the ten leading causes of death, while atrophy of the liver and diabetes were not included.²⁶

We are aware of the fact that after twenty years a survey of a very small sample tells very little, but let us compare it with one more current, covering several years. Zoltán Szirtes, district physician of Roma origin, published a small volume on the health status of a Roma settlement in Szeged-Kiskundorozsma that belonged to his district. Examinations conducted in the ghetto of one hundred and sixty inhabitants confirmed that the mortality of the population is highest at age thirty to fifty, and that most people die of a heart attack. The mortality rate and number of diseases of women are much higher than for men. Kidney and respiratory diseases are more frequent among women, while coronary and kidney diseases lead the list in the cause of death for men.

According to the study, heart and vascular system diseases account primarily for early mortality among Romas. Among the vascular diseases, cerebral aneurysm with the consequence of a stroke and infarction resulting from the narrowing of the coronary artery are the leading causes of death, unhealthy nutrition and hereditary characteristics also playing a significant role in the occurrence of disease.²⁷

III. Morbidity in general

The greatest problem in Hungarian health statistics is that while we have relatively relevant information on the causes of death, we have no reliable data concerning morbidity. This is particularly so as regards the morbidity indicators for Romas. Consequently, we are forced to

²⁵ In the county the 0-14-year-old generation of Romas accounted for 22.7% of deaths and the generation over 60 for 46.4%; for non-Romas these rates were 6.1% for the generation of 0-14 and 72.4% for those over 60.

²⁶ Lóránt Bodnár: Leading causes of death among Romas. Public Health, 1984. 279-283.

²⁷ Zoltán Szirtesi: The health status of Romas. Agroinform Publishing House, Bp., 1998. 18-24.

quote a study published in 1985 in order to present a picture of what characterises (once characterised) the morbidity of Romas.

The results of a survey conducted among Romas living in the Ormánság in Baranya County mostly represent dilemmas to which exact scientific answers have not yet been given in full. The unfavourable proportion of active wage earners, the under-employment of women, low family incomes and educational levels constituted jointly the framework on the basis of which Romas were considered a disadvantaged population group. The primary concern of the survey was how the disadvantaged position of Romas manifested in their health status. This required first of all, knowing the proportion of ill to healthy individuals. People were considered healthy if no medical documentation was issued about them the year of the survey and no diseases were registered through either screening or follow up. According to the above, in 1978 in the Ormánság 19% of the non-Roma population did not consult a doctor, that is, "they were healthy;" this rate for Romas was 21.4%. Clarification of the data base favourable to Romas however brought a different result. In theory it is conceivable that the health status of the Roma population by virtue of their younger age composition lends a starting advantage. However, if we unify the age composition, the advantage of 2.4% diminishes to 0.5%. Furthermore, as the researches articulated self-critically, it is not certain that the physician-patient encounters measured health, but rather a demand for health care services. It is possible, as among others, the examinations of György Gyukits also confirm, that latent morbidity is high among Romas. However, the study did not attempt to analyse this supposition in depth. It did establish that the latent morbidity of Romas is also proven by the fact that the rate of disease detected through follow up and screening is half that of non-Romas for men and two-thirds for women.

Examining the number of sick days per thousand inhabitants, the condition of Romas also seemed more favourable compared to 5007 days for non-Romas (4122 for men and 5872 for women); they spent only 4406 days on sick leave (3478 for men and 5291 for women). However, with the advance of age, the extent of total diseases among the Roma population increased. The increase is less monotonous for non-Romas. It seems to be important that while for the age groups 0 to 4, 5 to 9, and 20 to 39 the values for Romas are lower, in all the other groups they are higher.

The authors of the study compare the diseases registered for one thousand Roma and non-Roma inhabitants by so-called BNO categories.

Table No. 5 *Leading causes of death for Romas living in Baranya County in 1978.*

Disease groups	Disease per thousand persons for Romas	Rank for Romas	Disease per thousand persons for non-Romas	Rank for non-Romas
I. Infectious diseases and diseases caused by parasites	262	3 rd	183	5 th
II. Tumours	13	15 th	16	15 th
III. Endocrine, nutritional and metabolic diseases	29	14 th	26	12 th
IV. Diseases of the blood and hematopoietic organs	31	12 th	21	13 th
V. Mental disorders	90	11 th	108	10 th
VI. Diseases of the nervous system and the sensory organs	119	9 th	133	8 th
VII. Diseases of the circulatory system	164	6 th	265	3 rd
VIII. Diseases of the respiratory system	800	1 st	606	1 st
IX. Diseases of the digestive system	345	2 nd	328	2 nd
X. Diseases of the genital-urinary system	117	10 th	94	11 th
XI. Complications of pregnancy, birth and confinement	30	13 th	17	14 th
XII. Diseases of the skin and subcutaneous tissues	130	8 th	113	8 th
XIII. Diseases of the skeletal and muscular system and conjunctive tissues	161	7 th	196	4 th
XIV. Birth defects	8	16 th	10	16 th
XV. Particular causes of perinatal morbidity and mortality	1	17 th	3	17 th
XVI. Symptoms and misdiagnosed conditions	178	4 th	140	7 th
XVII. Accidents, poisoning, violence	166	5 th	151	6 th

Source: POTE

Respiratory and digestive diseases are in the first two places in the morbidity structure for both population groups. A fundamental difference is that infectious diseases and diseases caused by parasites are the third most frequent cause of morbidity for Romas, while for non-Romas circulatory diseases stand in this place. The order of magnitude of the various classes differs also. Morbidity is considerably greater in classes I. and VIII. and lower in class VII.

The conclusion of the study is that Romas constitute a special population group not only on the basis of their social status, but they also differ from the non-Roma population in terms of health status.²⁸

Naturally, just as the mortality structure of Romas changes so does that of non-Romas, however, we do not have reliable, up-to-date and comprehensive data. The Roma morbidity structure in the 1970s shows a surprising similarity to the total population data of 20 to 30 years earlier. Therefore, the proportion of contagious diseases and diseases of the digestive organs was higher than in the total population, while perinatal mortality was exceptionally outstanding. While all previous publications present that heart, vascular diseases and diabetes are much lower in number and have a smaller share of all morbidity than the national average, in recent years this has probably changed among Romas as well. Zoltán Szirtesi describes coronary diseases among Roma men in Kiskundorozsma and respiratory and kidney diseases among women as quite general.²⁹ At the end of the 1980s Katalin Pik indicated asthma as the most frequent disease among the men of a Pest County village, while heart, vascular, kidney diseases, and respiratory disorders were the most characteristic among women.³⁰

IV. School Education

By now it has become a cliché of health sociology that the health of a country and a group of people is not primarily determined by the level of health care delivery, but by the quality of life, that is, education, employment and living conditions, civilisation, cultural standards and norms, etc. The health status of people living under adverse social conditions is also worse. Education therefore, has an increased role in health protection and risk reduction. A person with a higher education degree will have a chance for life which can be several decades longer than that of an illiterate person. (The difference may be about twenty years in Hungary.) In addition to a more favourable labour market position, higher income, better conditions of hygiene and a lesser physical burden, the fact that an educated person has easier access to health protection information and has a higher awareness of a so called health plan and health behaviour can also play a part. The recognition that with time

²⁸ Mária Komlósi-Edina Knáb-Erika Szikszay-Jenő Tényi: The health status of the Gypsy population I. and II. Népegészségügy. 1985. 305-307.. 339-341.

²⁹ Zoltán Szirtesi: The health status of Romas. Agroinform Publishing House, Bp., 1998. 22.

³⁰ Katalin Pik: The correlation between work and the health status.= Cigánylet. Ed. Ágnes Utasi and Ágnes Mészáros. MTI PTI, 1991. 174-176.

passing by, impairment is not a necessity, health can be maintained, diseases can be prevented, is an achievement of civilisation that is more readily accessed by those who have a higher level of education. Later, we shall see direct and indirect components of the effects of education on health. We would briefly describe the education data of Romas in Hungary which deviate significantly from the national average. At the time of a representative survey of Romas in 1971, about three quarters of Romas in their twenties were practically almost completely illiterate, while two decades later, three quarters of them completed primary school education. The 1993 survey determined that even though the education level of the Roma population increased substantially during the intervening years, its distance from that of the majority society continued to grow. The reason for this is to be found primarily in secondary school enrolment: of Romas over the age of 25 only 1% to 2% completed secondary education. Although greater progress is made in vocational training institutions, even here only a minority of Roma youth were able to graduate.

Table No. 6 Breakdown of age groups of Roma population by level of school education in 1993 (%)

Age	Grade 0	Grades 1-7	Grade 8	Vocational training or technical school	Vocational high school or grammar school	College or university
14-19	1.5	32.3	55.2	10.4	0.4	-
20-24	1.1	22.2	59.7	15.6	1.5	-
25-29	2.5	22.5	59.4	13.2	2.0	-
30-34	3.2	26.4	50.0	17.2	2.7	0.4
35-39	6.3	39.1	44.4	7.4	2.3	0.2
40-44	8.3	36.4	44.7	8.5	1.5	0.4
45-49	12.9	44.2	34.8	5.6	1.3	0.9
50-54	24.0	47.1	24.8	2.1	1.2	0.4
55-59	41.5	35.9	14.9	5.6	1.5	-
60-64	46.1	44.2	7.87	0.6	-	0.6
65-69	31.5	59.2	4.6	3.8	-	-
70-X	50.0	39.4	7.7	1.0	0.8	1.9
Total	9.4	32.8	45.5	10.4	1.5	0.3

Source: Kemény-Havas

Regarding the correlation of school education and unemployment, the two major watersheds are secondary and higher education qualifications. According to KSH (Central Statistical Office) data, a quarter of university graduates and four times more people without primary school education are out of work than the national average.

The data relating to Romas in Budapest differ significantly from those of Romas living in the country: they are much more favourable. The proportion of those without primary school education

is 15.5% in Budapest, 23.7% in country towns, and 27.3% in villages. In the same age group, the proportion of people with secondary school qualifications is 9.9% in the capital city, 2.8% in country towns and 1.8% in villages. The differences are even greater by mother tongue. The proportion of people with less than eight grades of primary school is 22.9% for the Romungro (Hungarian mother tongue), 41.6% for the Bayash (Rumanian mother tongue) and 48.2% for the Wallach Roma (Roma mother tongue). The elimination of Roma settlements has undoubtedly contributed to the spread of graduation from primary school: the proportion of apartments in such settlements was 56% in 1971 and 14% in 1994.

Table No. 7 *The distribution of non-Roma men and women by school education in 1993 (%)*

School education	Men	Women	Total
Grade 0	0.23	0.33	0.28
Grades 1-7	8.21	13.84	11.17
Grade 8	32.80	38.66	35.88
Vocational school	27.02	12.54	19.42
Secondary school	21.42	25.98	23.81
Higher education	10.32	8.65	9.45
Total	100.00	100.00	100.00

Source: Kemény-Havas

Table No. 7a *The distribution of Roma men and women by school education in 1993 (%)*

School education	Men	Women	Total
Grade 0	5.94	12.09	9.08
Grades 1-7	28.06	36.96	32.61
Grade 8	48.24	43.39	45.77
Vocational school	15.61	5.97	10.68
Secondary school	1.86	1.39	1.61
Higher education	0.28	0.19	0.24
Total	100.00	100.00	100.00

Source: Kemény-Havas

Kemény and his associates have established that the chance of further education for those with delayed completion of primary school education diminishes at a highly increased rate. The reason for this lies not only in frequent repeated years but also that the majority of Roma children start school at the age of seven only. "It must be pointed out that the greater portion of six-year old Roma children is in fact immature for school in terms of growth and intellectual development, and it is better that they start going to school at the age of seven only. It is not an early start, but the successful completion of primary school and further education that are necessary," formulate Havas and Kemény.³¹ This is how handicaps of health care, as well as way of life and civilisation impact, and reinforce one another already at school age.

³¹ István Kemény-Gábor Havas: Being Gypsy. = Társadalmi Riport 1996. Századvég - Tárki, Budapest, 1996. p. 360.

V. Employment

At the time of the representative Roma survey in 1971 the employment situation of working age Roma and non-Roma men hardly differed from each other: at a rate of 87.7% and 85.2%, respectively. Beginning in the mid 1980s, the major part of Romas were excluded from the labour market. By 1993, unemployment reached its national peak by the way, but the changes among Romas were even more dramatic than the national average. In 1993 the proportion of employed amounted to 64% for the 15 to 59 year old male population nationally and to only 28.6% among Romas. Even if changes are not as spectacular for women, their exclusion from the labour market is also evident: at the end of 1993, 66% of women at the age of 15 to 54 were employed in Hungary, while only 15.1% of Roma women.

Table No. 8 *The distribution of male population at the age of 15 to 74 years by employment in 1993 (%)*

	Non-Romas	Romas
Employed	54.8	28.7
Unemployed	9.0	28.8
Inactive	36.2	42.5
Total	100.00	100.00

Source: KSH, and Kemény-Havas

Table No. 8/a *The distribution of female population at the age of 15 to 74 years by employment in 1993 (%)*

	Non-Romas	Romas
Employed	42.6	15.3
Unemployed	5.4	14.6
Inactive	52.0	70.4
Total	100.00	100.00

Source: KSH, and Kemény-Havas

The labour market chances for Romas and non-Romas are largely influenced by regional circumstances. It is widely known that it is much more difficult to find work in the eastern and northern parts of the country than in Transdanubia [west of the Danube River] or in the capital city and its vicinity. It is an astonishing fact that while the proportion of non-Roma employed in the eastern region is 44%, and in the Budapest industrial area it approximates 51%, differences for Romas are far greater: in the East only 12.3% and in Budapest almost 30% of Romas are in employment. The employment problems of the eastern and northern regions increasingly impact Romas, since these are the two areas where 44% of Romas in Hungary live. We know that the country is being divided from all aspects: into an eastern part burdened with lasting recession, and a more lively, competitive western part with access to greater capital and more advantageous infrastructure. We cannot ignore the fact that 56% of Romas live in the eastern part while 73% of non-Romas reside in the western area, also reinforced by Budapest.

Of all the factors, it is naturally school education that influences chances in the labour market strongest. It seems to apply especially to Romas.

Table No. 9 *The distribution of non-Romas with various school education by employment and unemployment in 1993 (%)*

School education	Employed	Unemployed	Inactive
Grade 0	3.53	3.41	93.06
Grades 1-7	7.04	2.11	90.85
Grade 8	32.97	7.00	60.02
Vocational school	70.18	12.92	16.91
Secondary school	62.79	6.90	30.31
Higher education	76.11	2.30	21.59
Total	48.40	7.13	44.48

Source: KSH

Table No. 9/a *The distribution of Romas with various school education by employment and unemployment in 1993 (%)*

School education	Employed	Unemployed	Inactive
Grade 0	4.5	13.0	82.4
Grades 1-7	13.9	18.1	68.0
Grade 8	25.9	24.6	49.5
Vocational school	41.7	28.0	30.3
Secondary school	53.7	20.7	25.6
Total	21.8	21.6	56.5

Source: Kenény-Havas

The rate of the employed, unemployed and inactive for Romas who have only completed eight grades roughly follows the average characteristic for Romas, while for Romas with higher school education it is much greater than the average, but still does not reach the employment level of non-Romas.³²

VI. Housing

Housing conditions fundamentally influence the health status of the population. It is especially true for an ethnic community whose majority relocated from their traditionally considered settlements only in the past 30-40 years. Given the fact that the Roma population lives under extremely difficult economic and social conditions, it is almost self-explanatory that it is Romas who live in the majority of the worst of housing. The government programme adopted last year, aimed at improving the circumstances and living conditions of Romas, indicated as one of its most important objectives to improve the housing conditions of Romas. To this end, the government instructed the Ministry of Environmental Protection and Regional Development to prepare a survey of settlement-like housing environments. The deadline for completing the work was set for 1998 28 February, yet the complete survey has not been concluded to date.

³² Ibid. 363-371

Analysing the data received, one can establish even at this point that approximately sixty thousand Romas live in settlement-like environments (every eighth Roma in Hungary). This essentially corresponds to the results of the survey conducted by István Kemény and his associates, which stated that the proportion of settlement apartments amounted to 14% in 1994 (still 66% in 1971). The conditions relating to infrastructure in the settlements are disastrous in some places, often with access to water supply more than five hundred meters away and no sewage system. In a number of cases no electric power is supplied, and gas supply is tantamount to a luxury service. It is quite frequent that with no roads other than dirt roads leading to the settlements, ambulances cannot find access to the residents living there. In winter or adverse weather conditions, the settlements are practically cut off from the outside world. The social policy housing construction benefit, currently in effect, is difficult for Romas to access because often they are unable to meet its basic requirement: they do not have their share, thirty-five percent, of construction costs at their disposal. In consequence, potential for abuse and fraud have understandably proliferated. There were only a total of three applicants bidding for the tender issued by the Public Works Council [Közmunkatanács] in 1998 that aimed at improving the infrastructure conditions of the settlements. The reason for the low turnout was the lack of the required expertise in drafting proposals and the indifference displayed by local governments. In the aftermath of the change in government, the fate of the mid-term government programme adopted by the previous government to improve the situation of Romas has become uncertain by today, such that the faint ray of hope for an eventual survey and restructuring of Roma settlements in the country has also been extinguished.

A situation requiring a resolution prevails in Kiskundorozsma also, where the major portion of residential apartments under settlement conditions cannot be heated in winter; this will result in further health deterioration in the opinion of the district doctor for this part of the community.³³ In one Roma settlement in Ózd there is practically a one hundred percent unemployment rate. People here live off the dregs of big industrial production, collecting metal refuse in the waste dumpsites. Families manage to scavenge iron worth of 500-800 HUF with 12 hours of hard labour a day. This sort of “mining” from the collapsing dump pits has already demanded fatal casualties. It is characteristic for the conditions that the local government has not had the frozen sewage pipes repaired wherefore, human excrement flows into the streets, while children, in the absence of any better, play on the factory grounds full of chemical contaminants.

The elimination of the former Roma settlements, so it seemed from the political peaks, was finally completed at the turn of the 1970s and 1980s. In contrast however, new settlements have in fact been established. In addition to others, they were set up in the settlements constituted by the former “Cs” apartments and houses (reduced level of amenities). The re-settlement process was pointed out to the

decision makers quite early by sociologists,³⁴ but local authorities did not want to heed this word of warning and sabotaged the changes, thereby contributing to the re-settlement process themselves. “Housing lots are very small....In contrast to the usual size of gardens in the village, about 300 square fathoms, about 50 square fathoms are allotted to one parcel, at the outskirts of the village, in an open field....Crowding is excessive....At present 50% of Romas do not consider their apartment healthy....Many families have accumulated substantial debts, the local council therefore, has not maintained the area for some time; has not repaired the houses; or siphoned off the community cesspool.” “Thus, the difference between the quality of the old and new apartments for Romas is much smaller in fact than the statistical indicators,” reports a sociologist on the process at the end of the 1980s.³⁵

By now the process of re-settlement is a matter of fact. It is not a completed but an ever growing fact, which can even be called ghettoization or the segregation of Romas, but the process is schematic: ethnically and socially homogeneous residential zones are forming that have a much lower level of public utilities than other neighbourhoods, with a steadily declining state of disrepair, unstoppably devalued residential housing is being established, inhabited by “communities” without cohesion, where deviant behaviour is becoming the norm.

The housing conditions of Romas are however, bad not only in the settlements.

According to a survey of the Ministry of Welfare (MW), 78% of Romas live in houses they own. The majority, almost 90% in the countryside, live in apartments they own, while in major cities rented apartments prevail (79% in Debrecen). In the villages, 15%-20% of families live in parts of the house only. A generally used although a bit obsolete indicator for the perception of housing conditions is the construction method, the quality of walling. In this regard, serious positive changes can be detected: 47% of country houses inhabited by Romas are built from bricks and 18% are adobe built on foundations. Regional differences are however, major: of the five counties in eastern Hungary for instance, the proportion of adobe houses without foundations is 28% in Jász-Nagykun-Szolnok County while the rate of other walling (pounded wall, cast wall, pounded earth) is 27%. The best condition is in Pest County with three quarters of the families living in brick buildings.

A more sensitive set of indicators of housing conditions are the factors of amenities/utilities. Unfortunately, regional differences are so extreme in the MW survey that it is hopeless to draw any conclusions of national value on its basis. In any case, Szabolcs-Szatmár-Bereg County is the area with the least amenities; almost half of the families have electricity only, piped water is connected to

³³ Zoltán Szirtesi: The health status of Romas. Agroinform Publishing House, Bp. 1998. 24.

³⁴ István Kemény notes summarizing the lessons learned from the national representative survey of 1971: “despite central plans and ideas, local practices result in many places in the formation of new Gypsy settlements.” Report on the Research of Romas in Hungary in 1971. Report by the Sociology Research Institute of MTA. Budapest, 1976.

³⁵ Katalin Pik: The correlation between work and health status. Survey among old age Gypsy and same age non-Gypsy residents in a County Pest village. Cigánylet. Ed. by Ágnes Utasi and Ágnes Mészáros. MTI PTI, 1991. pp. 171-172.

one in every five families only, and about the same proportion applies to the use of bottled liquefied gas. The rate of canalisation is disastrously low everywhere, not even approaching a national average rate of 50%, which is also considered too low, hardly reaching an average of 10% (with a total of 1% in Jász-Nagykun-Szolnok County).

Modern, individual ways of heating can scarcely be found with the village Romas (oil, gas or electric heating). Furthermore, 7% use stoves for heating, but in the absence of chimneys, smoke is conducted through a gap cut in the door or window.

In the 674-household sample in the survey, 26% of the apartments were rated modern (concrete blocks or brick, well equipped with utilities and up-to-date heating facilities), 52% less modern (founded adobe, moderately equipped with utilities, individual heating with chimney) and 22% obsolete (adobe or other, few utilities, stoves without chimneys).

The 1991 and 1992 survey by MW provided the residential density of apartments by indicating the living area per one resident. Intolerable residential density of under 5 m²/resident was found in 14.1% of households; very tight, with 5-10 m²/resident in 33.4%; 11-15 m²/resident in 25.7%; 16-20 m²/resident in 16.0%; and over 21 m²/resident in 10.8%. "This level of crowdedness, even in the warmest of family environments, is unacceptable and unhealthy, both in physical and mental terms. Resting is rendered impossible for adults; children are obviously unable to learn with the appropriate attention, which will later diminish their opportunities in life," says Pál Bánlaky in summarising the data.³⁶

In cities they live almost exclusively in low market value apartments and residential neighbourhoods and move into such. In Budapest they live mostly in local government owned small size apartments, in derelict houses with poor amenities in districts VI, VII, VIII and IX. In Miskolc, in addition to the two Roma settlements, most live in prefabricated block housing where maintenance has become unrealistically expensive after the changes in the political system, especially for those who have lost their job. Arrears in payment of charges is difficult to bear not only as a psychological condition but the utility service providers can shut off electricity, gas, or even the water supply to debtors, terminate the supply of heat, and transportation of household waste. As a result, the lasting deterioration of amenities can mean serious health risks. In Sátoraljaújhely for instance, the local government-owned water works shut off the water to a complete block of flats, and in a few weeks' time an epidemic of Hepatitis-A erupted and ceased only after ÁNTSZ [National Medical Officer's Service] exercised pressure to open the water supply.

It is a remarkable fact that the majority of conflicts between Romas and local governments were concerned or occurred with respect to housing (Székesfehérvár, Zámoly, Sátoraljaújhely,

³⁶ Pál Bánlaky: Survey of Gypsy Families. Family Protection Department, Family, Child and Youth Policy Directorate, Ministry of Welfare, [Bp.], 1993. pp. 28-42.

Kecskemét, Miskolc, Szeged, etc.). Undoubtedly, the local authorities were left too much on their own in the new public administration and social system (meaning both the lack of control and the absence of support) as regards the provision of housing as well, but local decision makers mostly avert any efforts or attempts to make changes "for the benefit of Romas." In this regard, not only anti-Roma prejudiced thinking is projected, but also the recognition that "helping Romas" will generate counter-sentiments among the constituents, and thus it does not pay off politically.³⁷

In recent times, the most spectacular undertaking to improve the housing conditions of Romas has been offered by a social policy benefit to acquire a first home. It is not our task to pass judgement on the current or especially on the set of conditions a few years ago; we can merely state that the anomalies surrounding the socio-political housing construction have not promoted a real and lasting solution for the socially dependent housing of Romas. In those places where homes were indeed completed and to a fair quality, buildings were erected that for the most part did not conform to real needs, and whose operations and maintenance is impossible for their residents despite their every effort.

With respect to housing, the situation of Romas in cities is probably more favourable than that of their village counterparts. Urban living, moving to a city brings Roma families closer to the majority society, at least in terms of the formal indicators of family and housing conditions. It seems that polarisation is also strong regarding housing conditions not only along the city-village demarcation line but elsewhere. There is a 10%-20% segment, differing in size by area, which has risen above the average conditions of Romas and lives at the level of the majority population. At the same time however, the large majority lives well below the housing conditions of the society in general.³⁸

VII. Pregnancy, Birth Control and Child Delivery

Pregnancy, birth control and child delivery are perhaps the most researched area on the health status of Romas. Already at the turn of the century researchers, especially ethnographers, were intrigued by the customs and superstitions of Romas relating to pregnancy and child delivery. After the Second World War, in relation to Romas, besides epidemiology, this health area was perhaps given the greatest emphasis. Alongside well-meaning philanthropy, it is not difficult to recognise the fear in the majority society, primarily from the 1970s on, in its regard of the "prolific" Romas. In addition to the "world of hovels," and "idleness," perhaps one of the most scorned "Roma characteristics," one of the major causes for their backwardness, was fecundity, irresponsible acceptance of child birth, lack of family planning, a licentious sexual life, and promiscuity. A great deal more prejudice,

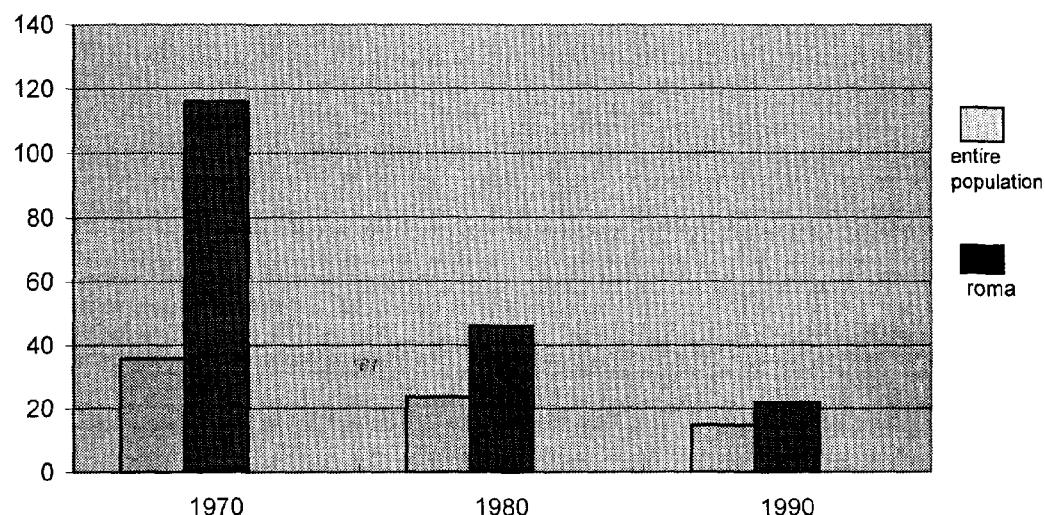
³⁷ Guidebook for the Local Development of Social Policy. Edited by Zsolt Zádori, DHV, Budapest, 1998. pp. 97-100.

³⁸ Pál Bánkay: Survey of Gypsy Families. Family Protection Department, Family, Child and Youth Policy Directorate, Ministry of Welfare, [Bp.], 1993. pp. 34-35.

misinformation and folklorist details were attached to the real facts than could be sorted out by the specialists working in the field.³⁹

Anna Aszmann, acting director general of the National Family and Child Protection Institute (OCSGYI) considers the high infant mortality rate prevailing among the Roma population to be the gravest problem. Despite decline in this rate at the beginning of the 1980s, the perinatal mortality indicator of the Roma population is especially high (we refer to mortality up to the age of six days of new-born babies as perinatal mortality).

Figure No. 2 Changes in total infant mortality, within this context, Roma infant mortality per mille in Hungary, 1970-1990



Source: OCSGYI

Smoking during pregnancy or the extremely low age of mothers can play an important role in the cases of mortality. Actually, infant mortality also expresses the social welfare of the population: the lower the mortality rate, the higher the standard of living in a given community. The child mortality rate of Hungary is worse than that of its neighbouring countries, but the mortality among the Roma population is almost double the Hungarian average. The directress thinks resolution of the problem lies in education, in addition to raising the standard of living. According to surveys, child mortality rate declines in direct proportion with school education.⁴⁰

The observations made by the director general are also in line with research on pregnant Roma women conducted in the 1980s, which made the chances for survival for Roma embryos and infants

³⁹ See more details on the issue in Mária Neményi: Gypsy Mothers in Health Care. NEKH, [Bp.], 1998. pp. 28-59.

⁴⁰ The same subject is addressed by Kálmán Joubert: Socio-demographic Relations of the Development of Newborn Babies. Statisztikai Szemle, 1990. 11. pp. 857-868.

measurable in exact figures, and established they were worse than those of the majority society.⁴¹ From the aspect of the foetus, one of the most serious risk factors is a negative obstetric pathological history: dead birth, artificial and spontaneous abortions. A survey conducted in Szabolcs-Szatmár County determined that despite a significant reduction at the beginning of the 1980s,⁴² obstetric pathological history can be observed in pregnant Roma women twice as often as non-Romas. Among previous pregnancies of Roma women, premature and late mortalities, "premature deliveries" (<2500 g), as well as induced abortions occurred significantly more often than in the latter group. Among the children of endangered Roma mothers, the proportion of new-born babies with low weight approached 30% (this rate amounted to 17.2% with the non-endangered group). Within the continuously declining negative obstetric pathological histories, the rate of abortion of first pregnancies rose steadily. In 1980, the proportion of younger than 19-year old Roma women carrying out induced abortions reached 18.4%, while it was 10% for the non-Romas.⁴³

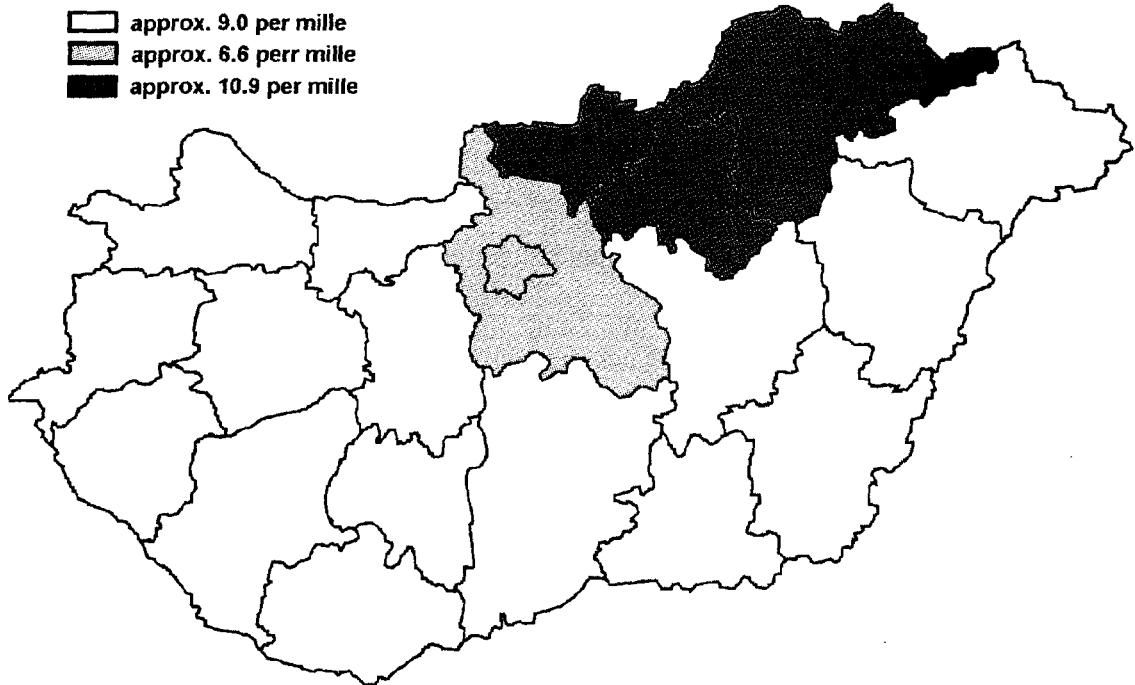
We have also learned from the survey of the Executive Commission of the Szabolcs-Szatmár County Council's Health Department that at the beginning of the 1980s the weight of Roma women giving birth was 3.3 kg lower than non-Romas. The difference in weight was 4 kg. with mothers who smoked. The importance of living conditions is also demonstrated by the fact that the weight of women living on settlement lots was an additional 2.1 kg. less than Roma women not living on such. The weight of an expectant mother is an especially important factor since significant correlation can be shown between increase in a mother's weight and the weight of new-borns at birth. Mothers with low weight often give birth to low weight, shorter new-born babies with small head circumference. In the sample, 20% of Roma women over 52 kg. gave birth to low-weight children, whereas with women of low weight it was 26.7%.

⁴¹ Inter alia: Népegészségügy, 1984. I. pp. 20-22; 1984. 5. pp. 279-283; 1985. I. pp. 7-9; pp. 28-31; Orvosi Hetilap, 1984. 23. pp. 1387-1390; Statisztikai Szemle, 1990, II. pp. 857-868.

⁴² Magyar Nőorvosok Lapja, 1983. p. 340.

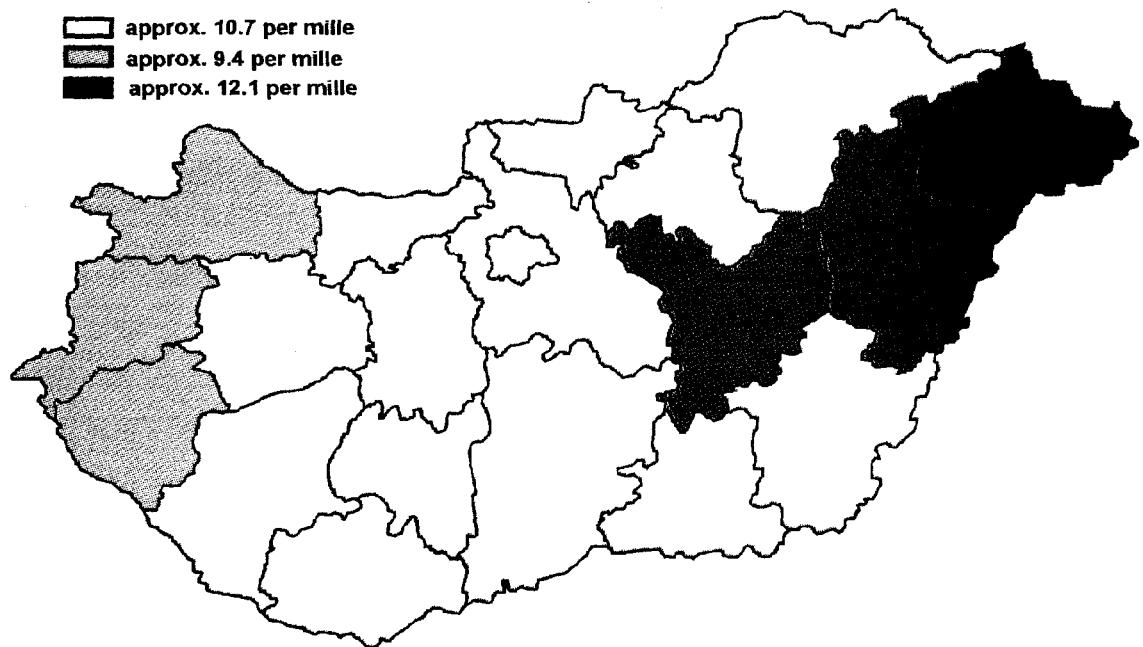
⁴³ Lóránt Bodnár: Negative obstetric pathologic history of Gypsy pregnant women. Népegészségügy, 1984. pp. 20-22.

Map No. 7 Perinatal mortality (between day 0-6) in 1995



Source: OCSGYI

Map No. 8 Infant mortality (between day 7-365) in 1995



Source: OCSGYI

Already in 1972 data were published that lower weight (and height) for Roma women in Hungary imply higher risks for the new-born baby. As the average weight of Roma youth in the 1970s was substantially lower than that of non-Romas (this was verified at conscription⁴⁴), it could be suggested that the lower average weight of Roma women and their children could be explained by ethno-genetic origin and was directly responsible for a part of endogenous effects. This, however, was not fully substantiated by a survey of Roma pregnant women in Szabolcs County. Researchers found the causes, first of all, in lifestyles. Among others, 63% of pregnant women were smokers, and 48% lived in low hygiene level settlements or "settlement-like" conditions. (The weight of embryos of non-smoking and/or non-settlement resident Roma women was more favourable in all maternal weight groups.) In the view of researchers on the subject, malnutrition during the childhood of socially disadvantaged mothers is a further reason for their growth and developmental backwardness, as well as weaker reproductive capability. The consequences affect generations. An unfavourable environment of pregnant women with weights lower than average can further reduce the weight of the foetus. Children of underweight mothers are usually born with low weight.⁴⁵

Almost all the publications with which we are familiar about events occurring during the pregnancy of Roma mothers conclude that the results achieved can be traced back decisively to the living conditions and care of Roma pregnant women. The improvement of living conditions is, of course, not a responsibility for health care delivery, but even at present no beneficial changes were seen which would alleviate the situation of expectant Roma women and their families. Health care is still to develop a care scheme tailored to the specific needs of a high number of Roma pregnant women, who constitute an ever increasing proportion of women giving birth in Hungary, that would be able to improve the current unendurable situation. "A significant contribution to solving the problem would be if university and college curricula included teaching information about Roma culture," suggests Anna Aszmann. Roma customs are unknown to beginning specialists working in the field. In Hungary, Romas like to wrap different objects into the baby's swaddling clothes: forks, spoons, blessed pictures of St. Mary, etc. It is also a custom to circumvent bewitching by binding coloured ribbons on the baby's wrist, or putting a piece of garlic in their hand. Beginning paediatricians are seriously perplexed by the Roma tradition that a baby must not look into a mirror. These customs, however, are vanishing folklore elements for the majority of Romas; in fact, it is not these customs that make Roma pregnant women unique, but the prosaic sociological facts mentioned above.

The study written by Mária Neményi investigating the relationship between Roma and others and health care workers points out that both parties represent worlds of their own. Narratives referring to the same events seem as if they were not even talking about the same thing.

⁴⁴ Honvédorvos, 1982, 17.

⁴⁵ Népegészségügy, 1984, pp. 279-283.

According to the image formed by health care workers about Romas, they stand on a different level of civilisation somewhere half way between a primitive people, the savage and cultured man. Health care professionals often complain about the Romas' lack of information, ignorance and unsuitability for family planning. Research has, however, found that Romas surveyed were no different from the majority society of the same level of education or social situation. Greater child increase is, however, not attributable to their unsuitability for family planning but is a result of following traditions that continue to play a significant role for Romas. According to the research findings, the prejudices prevailing in health care in many cases constitute an obstacle to the curative and care-giving nature of the work. Another lesson learned is that one cannot talk about a homogenous group on either side. It is another important finding that based on experience, if a health care worker has few encounters with Roma patients their image about them and the relationship tends to be much more prejudiced. The findings of the study suggest that the best relationship with Roma patients was established by their welfare representatives in permanent contact with them.⁴⁶

VIII. Infections and epidemics

It is generally held that Romas are the ones who spread epidemics and in today's Hungary the group most exposed to infections. Ilona Straub, director of the Johan Béla National Epidemiological Centre said that due to the provisions of data protection there are no exact statistics available as to how many Roma patients suffered infections. When epidemics are reported, it is mentioned, however, if an exceptionally high proportion of the infected are Roma. Most recently a serious epidemic caused by the hepatitis-A virus broke out in Tiszabura, where, as reported by the medical officer concerned, all the patients were of Roma ancestry.⁴⁷ Nonetheless, it cannot be by accident that from an epidemiological point of view, Szabolcs-Szatmár-Bereg County, which is densely populated by Romas, is the most infected area.

Among Romas, epidemic diseases are most frequently caused by the hepatitis-A virus, with a mild course. The disease is spread by droplet infection because of unsatisfactory hygienic conditions. The majority of infections attack children; the disease is often of such mild course that it is not even observed. After its passing, children become, however, immune to the disease. Frequently, the infection is communicated from Romas to others and may bring about a serious epidemic.

Among Romas, dysentery (flux) is a frequent communicable disease, also spread by droplet infection, and develops as a result of inadequate hygienic conditions. A virus called *Shigella Enteritis* (Latin, *Shigella Flexneri*) causing more acute dysentery is, however, much more frequent

⁴⁶ Mária Neményi: Gypsy Mothers in Health Care. NEKH, [Bp.], 1998.

⁴⁷ Népszabadság, 9 September 1998.

in the Roma population than in the majority society. These diseases generally occur in poorer social classes all over the world, where hygienic conditions are not appropriate.

The infection hepatitis-B is a contagious disease much more dangerous and more prevalent among Romas. The disease is spread by blood or body fluids. The most frequent modes of communication are from mother to child, by sexual transmission, by medical malpractice (by breaking hygienic regulations). The disease is extremely malignant and long lasting and can have an incubation period of decades. Owing to the long incubation period without any symptoms, the infected persons can endanger the whole of society without their knowing it. In the final stage of the disease it causes cirrhosis and cancer of the liver. The screening of pregnant mothers for hepatitis-B has been in progress for years now, and according to results half percent tested positive. *Almost all of the mothers infected were of Roma descent.* The reasons for this were, in addition to living in tight spaces and inadequate hygienic conditions (the infection can be facilitated by the use of common razor blades, easier communication of body fluids because of the tight living arrangements), sexual life begun at an early age, as well as frequent change of partners (promiscuity). As a result of screening pregnant mothers, the new-born babies are vaccinated and thereby become immune to the virus causing the disease.

Experts are of the view that due to the role Roma women played in prostitution, it is of concern that exposure to AIDS will be substantial among Romas. Of the 700 HIV infected people registered in Hungary since 1985, only one man was Roma. At present, surveys are conducted among pregnant women every three years to check to what extent the HIV virus spreads to heterosexuals. Fortunately, no infected persons have been found among the mothers tested to date; it suggests that AIDS has been restricted to homosexuals in Hungary for the time being.

A study conducted by György Gyukits among Romas living in Miskolc revealed a high degree of lack of information among Romas regarding the spread of, and protection against the HIV virus and the characteristics of the AIDS disease. Although everybody had heard about this condition, their understanding was rather fragmented and confused. An extreme but typical example is that a male respondent thought that AIDS was spread by condoms. It was the impression of the researchers that information about AIDS was more uncertain the worse the conditions were under which the interviewed families lived. It is very likely that knowledge about AIDS is primarily related to the level of school education. The only positive experience gained about AIDS in the study was that the younger generations' knowledge in this field seemed to be more reliable than their elders.⁴⁸

Food poisoning is not more common among the Roma population than the majority society. The majority of food infections is caused by salmonella in Hungary, which can arise among Romas because they do not own refrigerators or freezers. It is quite common that the same dishes are used

⁴⁸ Information provided by courtesy of György Gyukits.

for storing meat and prepared meals without washing up because of inappropriate kitchen equipment and the absence of water. A child died recently of serious salmonella infection because a dish in which previously chicken had been stored and had not been washed contained gnocchi noodles and this is how the prepared meal became infected. The poorest, most destitute Romas in the countryside are forced to eat carcasses in many places; however, although it is extremely dangerous, relatively few infections result because of this. It is actually well-known through tradition that carrión should be cooked longer (this having a germ killing effect, because cooking will practically destroy bacteria). In 1997 a six-year old boy died in the village of Mikekarácsonyfa (County Zala) because his family was forced to eat carrión, but the meat had not been cooked enough.

Measles are not a disease typical for the majority society--on account of vaccinations--nevertheless, a serious wave of infections swept through the Roma population in Debrecen this year. The infection causing the disease was very likely to have been transported by Romas from Transylvania to our country. The rate of vaccination of children is 99.8% in Hungary, but it is estimated that there is a high number of Romas among the children not covered. "A lot depends on the specialists working in the settlements," suggested the director, because if they strike an appropriate tone with Roma mothers and build on their love of children, the mothers can easily be convinced of the necessity of vaccinations.

The attractive statistics relating to the vaccination rate of children is questioned by the findings made at a Roma settlement in Hétes in the town of Ózd. Abukamar Ata, a consulting obstetrician at the local hospital, and the Roma minority self-government of the town organised a vaccination campaign for the children in Hétes because a large number of these children did not get the mandatory vaccinations in time. The reason for this delay is in part accounted for by the illiteracy of the parents (they cannot read the notices sent for vaccinations); and on the other, for the immeasurable poverty, whereby the parents were unable to buy the bus tickets and take their children adequately dressed up to the doctor. As a result of this joint action, every child was given the omitted vaccination, accompanied by a bar of Sport chocolate. An application for a grant, drafted in 1997, to continue the programme for the vaccination of children of other Roma settlements in the neighbourhood of Ózd was rejected by the Ministry of Welfare.⁴⁹

The allegation often made by sociologists that scabies is becoming increasingly more frequent in Roma settlements is refuted by Gyula Erdős, chief physician of the Disinfection and Deratization Department of the Johan Béla National Epidemiological Centre. In Hungary 500 cases of scabies are registered every year, but the rate of incidence is not higher among Romas. The infection tends to occur in nursing homes, workers lodgings, hospitals and only sporadically in families. The last epidemic of scabies occurred in 1972 and is usually repeated every twenty five years. Last year,

⁴⁹ Information provided by courtesy of Abukamar Ata.

Romas in Tiszavasvári were accused of their children being scabby, but this was refuted by subsequent examinations.

Among Romas a much more common problem is lice (see table No. 10). Since 1961 various efforts have been made to establish various action plans to eliminate lice at Roma settlements. Serious results, however, have not been achieved to date. It is impossible to make everybody free of lice at the same time. If only one person remains a carrier of lice, they can easily infect an entire population. Resistance by the population and the lack of equipment also pose additional problems in practice. The spread of lice starts as a result of the lack of personal hygiene. In the 1970s a grave lice epidemic was raging in the country, and interestingly enough it occurred most frequently in Rózsadomb [translator's note: posh neighbourhood in the Buda hills of the capital]. Head lice do not spread any disease; they create a problem when the scalp, as a result of constant scratching because of itching, becomes scraped and gets infected from dirty hands. The same relatively mild symptoms can be found with fleas and bedbugs.

Body-lice are a much more dangerous parasite, the single carrier to spread spotted typhus, which is an extremely malignant disease. At present it can be detected among the homeless, and it is not typical even for Roma settlements. The last incidence of spotted typhus occurred in 1971. In a period of 8-10 years different programmes managed to rid Romas of body-lice. It is saddening that body-lice and lousiness appear in urban ghettos twice as frequent as in village Roma settlements. The menace of lousiness has shifted threateningly from Roma settlements to the cities (see table No. 10).

Table No. 10 Data for lousiness from 1997 (%)

	Roma settlement	Infected living places
Number of people at risk	30,533	23,608
Number of people with head lice	754	1,748
Number of people with body lice	--	5
Rate of head lousiness (%)	1.6	3.0
Rate of body lousiness (%)	--	0.02

Source: Johan Béla National Epidemiological Centre.

The danger of flies poses a serious problem in Roma settlement. Flies play an important part in spreading first of all salmonella, hepatitis-A and typhus. In Roma settlements a similar grave problem arises because of rats: this animal's flea spreads the plague, which has fortunately disappeared from Hungary. The worm *Trichinella* (bladder-worm) is usually transferred from rats to pigs, and so humans can also be infected by consuming pork. Rats' excrement and urine pass a pathogen called *Leptospira* into drinking water, and this may effect jaundice in humans. There are

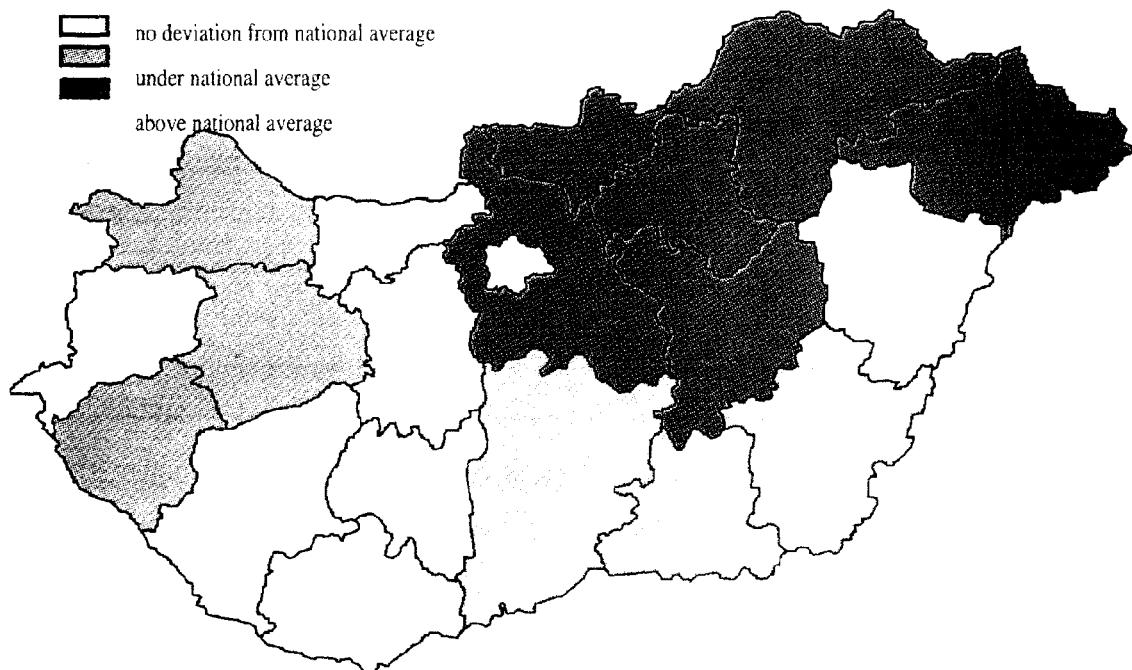
no data, however, that Romas would be affected by the diseases mentioned more often than other people.

Tuberculosis shows a rising tendency all over the world; a 20% increase was registered in Hungary between 1990-1995. According to the information given by Dezsô Kozma, chief physician, Deputy Director General of the National Korányi Tuberculosis and Pulmonary Institute, WHO consultant, there are no special data available now on the incidence of tuberculosis diseases among Romas. There are groups at very high risk of the disease, so first of all people under poor social conditions and the homeless. The last, informal survey in this regard was completed for a professional conference about fifteen years ago. The difference was not significant in terms of the rate of infection: only a few percentages higher rate of infection was found among Roma communities surveyed. These patients were, nonetheless, in a much graver and neglected condition. There are forty tuberculosis patients per 100,000 people in the Hungarian population; these data should not be much higher for Romas either. In the doctor's experience there were no more Roma patients than non Romas. Among Roma patients, however, there is a higher number of women than men. This may emanate from the fact that the plight of women is perhaps much more difficult in Roma families than that of men.

To this day, the condition of Roma patients when seeing a doctor is more neglected, with frequent bilateral infections among them. It is probable that Romas do not go for screening tests. Although the chief physician indicated that there are targeted screenings among the population, such as undertaken among the homeless, no such attempts at screening have been made for Romas to date due to legal and moral concerns. But if the Roma minority were to express a need for the screening at the settlements, they would be pleased to participate and interesting conclusions could be drawn from the data. Since the full treatment of the disease after discharge from the hospital could take another six months, and a great majority of Romas cannot afford to wait this long for financial reasons, the patients treated may include many who have recovered only partially.

György Gyukits found in his study conducted with Romas in Miskolc that the understanding of Romas about tuberculosis is disastrous. Many have not even heard about it, and the ones who have, have no idea what tuberculosis is about. The results made by Gyukits confirm Dr. Kozma's suspicions that the majority of Romas in Miskolc have not attended screening tests in years. After the political changes, no one can be mandated to attend lung screening, and for the time being (with no money and ideas) incentive methods are also missing. The traditional attitude typical for Romas can in this way predominate, namely, that one only goes to the doctor when one has some pains.

Map No. 9 Mortality for men caused by all tumours, 1991-1994



Source: Hungarian Academy Of Science

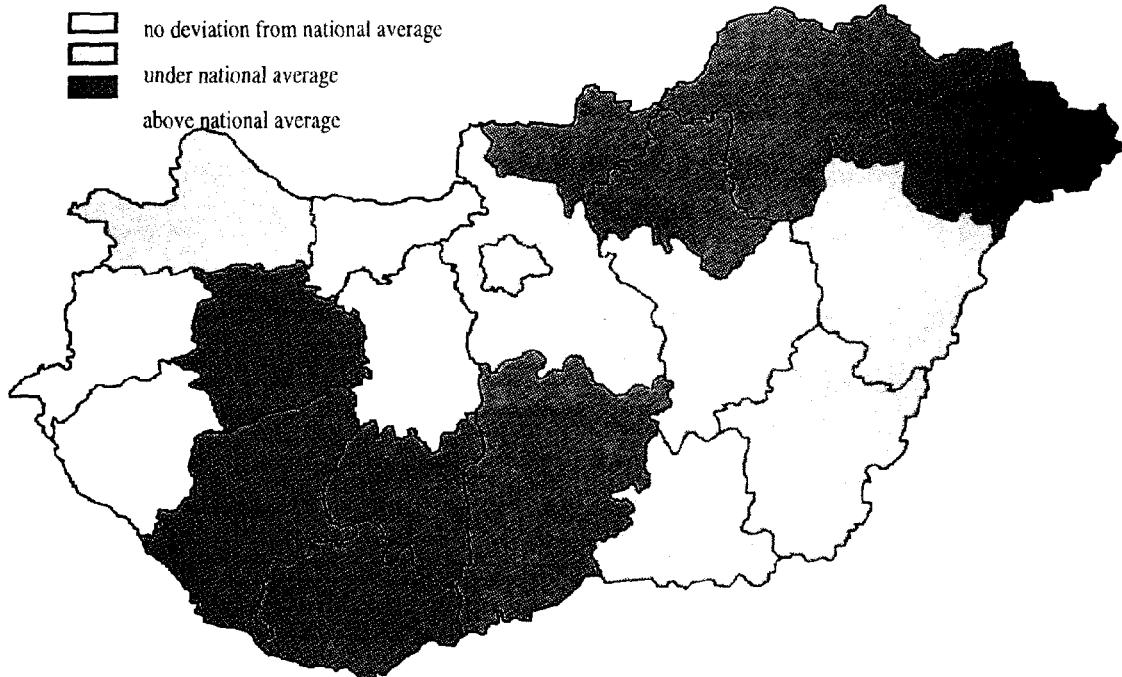
IX. Cancer and respiratory diseases

In Dr. Kozma's opinion the most prevalent respiratory diseases among Romas are emphysema and chronic bronchitis, which are primarily the consequences of very heavy smoking. It is frequent that patients have to be put on respiration machines and unfortunately deaths also occur as a result of the disease. In one form of emphysema, cystic fibrosis, genetic inclinations may also play a part, but in the case of tuberculosis it is out of the question. "Because genetic examinations are a sensitive area, we would rather talk about family genetics in relation to the examinations than the genetics of Romas as an ethnic group," says Dr. Kozma.

In the course of an empirical sociological study conducted at the end of the 1980s, it was concluded that Roma men tend to suffer from asthma and other respiratory diseases accompanied by difficulty in breathing to a greater extent than non Roma men or Roma women.⁵⁰

⁵⁰ Katalin Pik: The Correlation of Work and Health Condition. Survey conducted in a Pest County village among old age Romas and non Romas of similar age. Cigánylet. Ágnes Utasi and Ágnes Mészáros. MTI PTI. 1991. p. 172.

Map No. 10 Mortality caused by chronic, aspecific respiratory diseases, 1991-1994

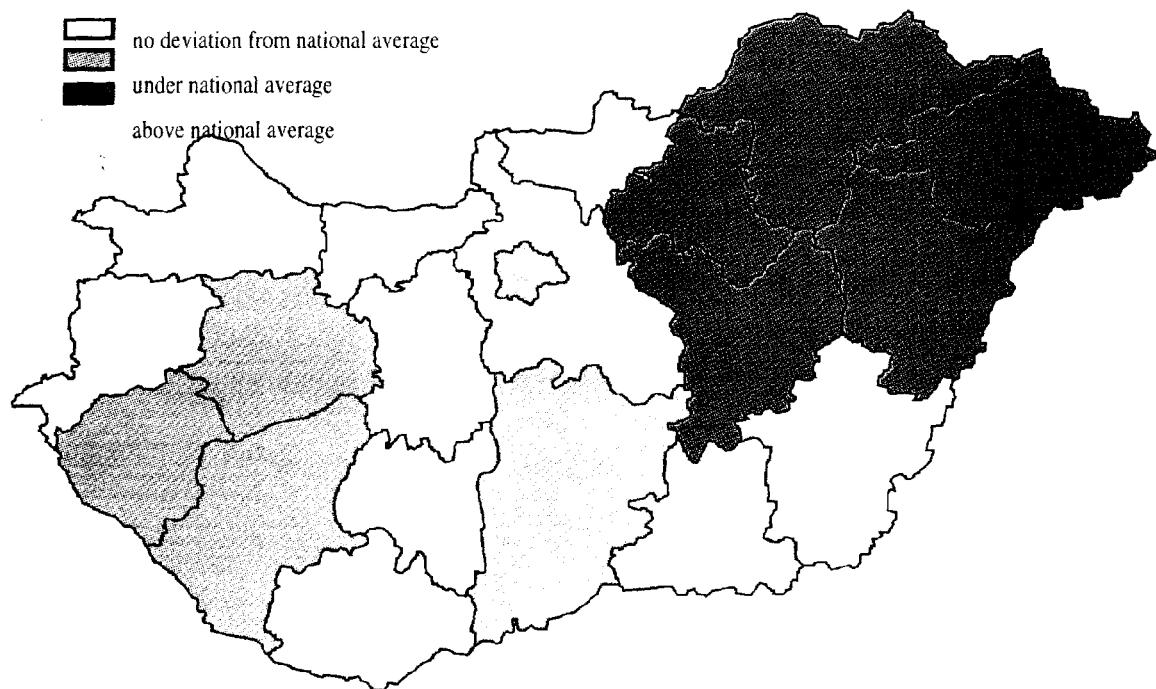


Source: Hungarian Academy Of Science

It is impossible to even hazard a guess in the area of malignant diseases. It is, however, a fact that there are Roma patients currently hospitalised and being treated for lung cancer. Potential screening tests, as referred to earlier, could also examine this. (See Map No. 9).

No higher occurrence could be discovered in other morbidities among the Roma population. It is possible that because of smoking the morbidity rate of Romas is also much higher in the area of vascular and heart diseases. Over-representation is also presumable in this area because of the consumption of low priced foods high in fat content, which is much more characteristic of this population.

Map No. 11 Mortality of men caused by lung cancer, 1991-1994



Source: Hungarian Academy Of Science

X. Nutrition

Nutrition is a fundamental factor in lifestyles, with a decisive effect on health. In the civilised world at the end of the 20th century, it is of course not the quantity of food (obtaining it is no longer a problem) but the quality, which is decisive: the distribution of fats-vitamins-carbohydrates-minerals, as well as the proportion of vegetable fibres, proteins from animal sources, and the number of meals. This does not, however, apply to the whole of Romas in Hungary. No reliable estimates are available as to the number of Romas starving in Hungary, the proportion of undernourished, and the areas where most of these people live. A number of news stories appeared in the media about Roma children fainting at their school desks, women cooking carrion, hedgehog and ground squirrel or men scavenging at dumpsites, nevertheless, we can only work with indirect data even if we want to merely illustrate the extent of starvation.

We referred to two studies earlier, which showed on the one hand that Roma men at conscription, and on the other that pregnant Roma women weighed less than non Romas. Both surveys found that this is not due primarily to the below average height of Romas but mainly to their deficient and one-sided nutrition. According to the study conducted by György Gyukits among Romas in Miskolc, for the majority of Romas procuring their daily meal is a serious life struggle. A rights protection

agency, the National and Ethnic Minority Office, undertook a survey with respect to a crime that fell in the category of the so-called crimes committed for subsistence (where the potato store of a co-operative was burglarised and the produce stolen), and found that in a community in north-eastern Hungary the per capita income was 54 Ft [about 50¢—Eng. Editor] a day in 1995.⁵¹ A health report from Kiskundorozsma revealed that the nutrition of the entire unemployed population was inadequate, with both parents and children undernourished.⁵² According to the survey made by the Ministry of Welfare in 1991-1992, seven percent of a sample of 774 north – east Hungary Roma households indicated a per capita income of under 1000 Ft; 90% of the families surveyed was below the subsistence minimum in effect at the time.⁵³

Consequently, the relationship of Romas to food, eating, and body weight is also significantly different from middle class non-Romas. With respect to nutrition, it can be established that even though they are generally familiar with the principles of a healthy diet, they do not follow these very principles. György Gyukits, in addition to destitute Romas being outside the mainstream also experienced another variation of this. Families "better off," not struggling with subsistence on a daily basis, also consumed a lot of fat, sugar, etc. because this is what they have become accustomed to. Paradoxically, they consider fat and sugar unhealthy, yet they envision a healthy person as fat. He quotes one of the respondents as saying, *"A healthy man? Shall I say it straight? Fat as a pig. He would probably not be like I am. Because before my ulcers renewed and I didn't go below eighty one kilos, I used to be ninety one, ninety two, ninety three. I fluctuated between ninety five and eighty five. True, I had the height to go with it, but I felt in good shape."* These families, however, at least eat fresh vegetables and fruit and frozen foods. Therefore, better off families tend to be endangered by over-nutrition.

In 1992 a survey was made of Roma children vacationing in a summer camp at Lake Balaton and it was found that they had extremely bad teeth. Statistics for dental hygiene are pitiful in Hungary anyway, but the situation was much worse for Roma children. Within the framework of the participants examined, there was an unusually high proportion of obese children. The reason is not that they lived under too good circumstances; just the opposite, they were not provided with the food requirements for their age, they ate inexpensive unhealthy foods high in fat and carbohydrate content.⁵⁴

Ethnographer Péter Szuhay thinks that obesity among some Romas is not only due to nutrition and health reasons but socio-psychological and cultural as well. In the majority of traditional cultures

⁵¹ White Book, 1997, 89.

⁵² Zoltán Szirtesi: The health status of Romas. Agroinform Publishing House, Budapest, 1998. p. 24.

⁵³ Pál Bánkay: Survey of Gypsy Families. Family Protection Department, Family, Child and Youth Policy Directorate, Ministry of Welfare, [Bp.], 1993. p. 51.

⁵⁴ Information provided by courtesy of Márta Váczi.

excessive eating and a corpulent body indicate potency, wealth, prosperity, and high social status.⁵⁵ Sociologist Katalin Pík pointed out to us that among those freed from the nightmare of starvation just one or two generations ago--such as Romas-- it is quite natural "to try to make up for centuries of backwardness as quickly as possible."⁵⁶

XI. Addictions

József Csorba, psychiatrist and addiction specialist, deputy chief physician at the Drug Prevention Methodological Center and Ambulance of the National Alcohol and Addiction Institute, has found that drug, nicotine and alcohol addiction is possibly in greater proportion among the Roma population than other segments of the population. There are no exact data but in his opinion over 20% of the patients treated in the clinic are of Roma origin. The two characteristic forms of drug consumption are sniffing, typical for children between the ages of nine and twelve; and from the age of nineteen, the use of very hard drugs (heroin, cocaine, speed, LSD, etc.) is more characteristic. It is interesting that drug dependency develops much faster among Romas than non-Romas.

We cannot determine its cause, however, the fact of Romas' more active emotional life probably plays a part. Withdrawal symptoms also appear more intensely in their case than among non-Romas. They generate the financial means necessary for drug consumption from criminally acquired goods. It is interesting in the breakdown by gender among drug consumers that in the majority society there is one female drug consumer for four males while in the Roma population the proportion is much higher, it can be one to seven.

In the area of alcohol addiction, the proportion among Romas is also much higher than in the majority society. Adverse conditions, exclusion from society, and being different from others probably also contribute to this fact. It can also be observed here that alcohol consumption is less characteristic among women than men. In the area of alcohol dependency, social status determines primarily the type of alcoholic drink selected, the poorer the person the cheaper and more harmful spirits they drink.

Smoking is also more characteristic for Romas than for non-Romas. In this respect, however, Roma women are much heavier smokers than men. As mentioned earlier, in Szabolcs-Szatmár County at the turn of the 1970s and 1980s, 63% of all Roma women giving birth were smokers. There are no preventive programs launched against damaging addictions specially designed for Romas. Such programs would certainly be much more effective, but serious assessment work is

⁵⁵ Information provided by courtesy of Péter Szuhay.

⁵⁶ Information provided by courtesy of Katalin Pík. A moving account is given by Géza Csemér in the book *Habiszti. The Food and Life of Romas*.

required before its commencement. Several proposals for funding requests have been prepared for launching such a program but none have received any support.

Based on experience in the course of therapy, it is necessary to meet with Roma patients much more frequently, more aggressive outbursts are noted among them, and they also have a lower tolerance for withdrawal symptoms than youths in the majority. In the case of Romas the proportion of drug recoveries is 30% to 40%, which corresponds to the experience in the majority society. In the case of alcohol addiction, this figure is around 15%.

According to a survey of twenty pupils in the Kaji Jag Roma Nationality Vocational School, children first encounter cigarettes and alcohol in the family. In families where drugs are also present, the pupils have access to it also. Eighty-five percent of the pupils between ages 15 and 22 years have at least lit one cigarette in their lives and 45% of them became active smokers. Smokers generally finish a pack a day. Ninety five percent of the pupils tried alcohol and 40% of them had gotten drunk at least once. Coffee is found in every Roma family and is consumed regularly, it is an indispensable part of welcoming guests. Twenty-five percent of those interviewed had already tried drugs (ecstasy, speed, marihuana, hashish). In general, a very low percentage of children engage in regular physical exercise, although 25% frequently complain about neck, back or head aches. The eating habits of the pupils was typically that they ate when they got hungry. Characteristic of foods consumed is the excessive use of lard, fatty meats, organ meats, poultry fat and skin. Three quarters of the pupils spend 2-3 hours a day watching television.

XII. Environmental pollution and workplace damages

According to international investigations, a primary role among the leading causes of illnesses resulting in death are lifestyle habits, i.e. primarily smoking, excessive drinking, and eating habits, followed in sequence by unhealthy work environment, circumstances of life, infectious agents, social and psycho-social conditions, and environment pollution.

The economic policy of existing socialism, its forced industrialization as well as extensive agricultural development caused significant damage. A sound, healthy environment did not appear as a value, environmental protection considerations did not play a role, and industry, concentrating on qualitative indices, instead stood out as an environmental pollutant. Disproportional conditions developed in the communal infrastructure: for instance, the drinking water supply pipeline system covering 97% is coupled with a hardly 50% sewage system. The disposal of communal waste was not given appropriate emphasis, neutralizing and dumping of hazardous wastes did not keep up with the volume generated. The impact of illegal waste dumping on human health can hardly be assessed. According to data from a recent study in Békés

County on sources of soil pollution, there are 309 industrial or communal, etc. settlements that are potential sources of damages.

The consequence of the drop in industrial and agricultural production was naturally accompanied by improvement in part: industrial air pollution and waste decreased. At the same time, due to motorization the volume of volatile organic compounds (benzol, toluol, xylol) and carcinogenic poly-cyclic aromatic hydrocarbons in the air increased.⁵⁷ In addition, the collapse of large-scale industrial and factory-based agricultural production was coupled with re-cultivation activity without anyone at the helm, and management of the towering waste left behind in their wake represents a serious problem. The status of Hungarian environmental-health care is further deteriorated by worsening social conditions. Therefore, the chances for Romas to enjoy a healthier environment obviously worsened or at least did not improve. The majority of Romas currently live in areas that from an environmental-health aspect are dangerous. They live mostly in the eastern and north-eastern regions of Hungary where extensive industrialization caused the most damage.

In the 1960s and 1970s Romas moved in masses to highly industrialized areas and taking jobs in heavy industry; at the same time, industry also enthusiastically settled in areas densely populated by Romas, ensuring a cheap and large labor force. They worked as unskilled or semi-skilled laborers in jobs that were mostly dangerous from an environmental or occupational health perspective. We are not aware of any publication that would have analyzed with statistical tools the environmental and occupational damages that Romas were exposed to during the 1970s and 1980s. However, there are several sociological studies describing Romas who became disabled at work, exploited and then discarded.

According to Katalin Pik for instance, a palpable feature of the 1980s was the unskilled worker, poorly paid for physically demanding work, often far from his residence (commuting), and injurious to his health, required to change jobs frequently, wandering until at best he qualified for disability or died.⁵⁸

As can be seen from the above, the regional breakdown of respiratory diseases does not primarily reflect environmental pollution, the reasons are probably more complicated; however, polluted air is a very strong risk factor. The people who are more exposed to environmental damages are those who already live under adverse conditions or are struggling with some disease; in other words, Romas among others, and from among them, those who primarily live under settlement conditions.

⁵⁷ Alán Pintér - Mihály Csanády - Amanda Horváth Environmental-health care aspects of the regional inequalities In *Népegészség, orvos, társadalom* Ed: Ferenc Glatz, MTA, Bp. 1998, 156

⁵⁸ Katalin Pik: Interrelation between employment and health conditions. Study on elderly Romas and non-Romas of similar age in a village in Pest County = In *Cigányélet* (Gypsy life), Ed. Ágnes Utasi and Ágnes Mészáros, MTI PTI. 1991. 167.

The image of a Roma walking from his home in rows of settlement shacks next to dumpsites, open mines, or other facilities endangering health to abandoned industrial plants or dumpsites to scavenge, is now as much a part of the landscape as the sweep-pole well used to be once upon a time. Some of the Roma survival techniques that resurrected after the change in regime such as gathering, reuse of things abandoned by others, also represent serious health risks to health. It is sufficient here to refer to the recent years' infamous case in Gyöngyösoroszi where Romas making their living by illegally melting down batteries, polluted their environment so much that a small child died of lead-poisoning and complete re-cultivation of the soil will take decades and cost several ten million forints.

When studying the relationship between the workplace and the health condition of the employee, György Gyukits reached the conclusion that a Roma becoming ill in his workplace leads to a coercive situation from which it is very difficult extricate oneself. On the one hand, an employee falls ill due to unhealthy working conditions and loses his job as a result of this, or gets put on disability or is dismissed. On the other hand, the employee who lost his job due because of illness, falls into such a bad social situation consequently that his chances of recovery are greatly diminished. There is no advocacy organization to protect the interest of the (Roma) employee; for the most part do not eliminate the damaging working conditions that cause illness, and may dismiss employees absent from work because of illness.

In an ideal situation health status does not significantly impact the chances for mobility since serious illnesses generally appear in later years by which time most people have managed to accumulate some resources such that they are able to eliminate more easily, or at least diminish somewhat, the negative effects following such disease. However, in the case of Romas serious illnesses appear at a younger age, consequently the sick are not yet unable to moderate the negative social consequences. Due to the poverty of the social support system the scheme of social benefits is unable to stop their decline and impoverishment, and consequently these sick people sink to the bottom of the social hierarchy in a few years.⁵⁹

XIII. Social cohesion and anomoly

It has only been in the last few years that interest has increased in the sciences connected with the status of health in terms of what can be explained as intermediary factors linked to relative deprivation such as the examination of subjective, psychological and social relationships, and belonging to a cultural community.⁶⁰ In line with international findings, Hungarian researchers have also seemed to find a correlation between possibly our worst demographic trends in the

⁵⁹ Information provided by courtesy of György Gyukits

⁶⁰ Mária Kopp – Árpád Skrabski – Sándor Szedmák: Significance of social cohesion in the development of morbidity and mortality in Hungary

civilized world and the deterioration factors mentioned above. At the request of the Hungarian Academy of Sciences, a representative research was conducted in 1988 and later in 1994-1995, where health problems and the nature of visits to the doctor were examined in the population over the age of 16, as well as in this context, the characteristics of life style and welfare, economic, sociological and psychological factors. An important part of the study, which offered relevant lessons for the purpose of this investigation as well, was that in terms of the eminent factors from a social cohesion perspective—group support, hostile conditioning and altruistic attitude—they also analyzed their relationship and changes in, among others, the context of the quality of life. Although this study does not include data and assessments specifically on Romas, through it and the application of indirect critical methods we can derive cautious and we hope relevant results with respect to the Roma population in Hungary.⁶¹

First of all, however, we should clarify what we mean by social cohesion and anomaly. Both are sociological concepts. The concept of anomaly was introduced by Emile Durkheim in reference to the weakening of the common interests of society, the condition wherein an individual believes that they can only achieve appropriate circumstances in life through deviant means. The loss of trust in values, long range planning and public consent leads to an atomized society that destroys itself. The opposite of this condition is identification with society, cohesion, which is based on the acceptance of common values and the rich and organic net of social relationships. The consequences of the deterioration of the natural net of human relationships, acceptance of common values, the existence of life goals based on these, and identification with the society, are more frequent occurrences of deviance—suicide, alcoholism, crime, and other self-destructive behaviors—which, however, have a direct impact on the development of mortality and morbidity rates.⁶²

Some years ago Richard Wilkinson demonstrated in his works that the mortality rates of developed countries are related to inequalities within society and not to the GDP.⁶³ This was supported by the studies of Kaplan and his associates in America. In other words, the greater the difference between rich and the poor in a given country, the greater the morbidity and mortality ratios; i.e. the best indicator of health conditions is not the absolute measure of the wealth, but the economic differences within society.⁶⁴ The tight relationship between health conditions and lower socio-economic status will remain even if the data are consolidated according to traditional risk

⁶¹ Ibid. pp 23-35

⁶² Ibid. pp 19-20

⁶³ Wilkinson, R.G.: National Mortality Rates: The Impact of inequality? Am. J. Publ. Hlth, 1992, 82, 1082-1084

⁶⁴ Kaplan's studies are cited in Mária Kopp – Árpád Skrabski – Sándor Szemnák: Significance of social cohesion in the development of morbidity and mortality in Hungary = Népegészség, orvos, társadalom, Ed.: Ferenc Glatz, MTA Bp. 1998, 16-17. "E.g. the internal differences are bigger than average in Louisiana and Mississippi and the mortality rate in these states are 9.6 per thousand people, whilst in the less unequal states the rate is lower: 7.8 in New Hampshire, 7.1 in Utah. In Hungary this rate is 14.2. The inequality within the states can be characterized not only with the poorer health conditions, but also with higher rate of unemployment, murder and crime, invalidity and smaller weight of the newborn babies, and also smaller number of persons having academic degree and smaller amount dedicated to education"

factors, i.e. smoking, addiction or low physical activity life style. This is supported by the results of Marmot and Syme who analyzed the cardio-vascular disease of Japanese people living in the USA, since the rate of mortality from disease of such origin in middle-aged men living in Japan was ten times lower than that of American men of the same age.⁶⁵ In the course of their study the researchers considered two contingents most important as protective factors: lower cholesterol meals and, what is at least as important for us, identification with the Japanese culture and community. It is surprising that the American males of Japanese origin with similar eating habits but a different relationship to traditional culture produced different cardio-vascular disease rates. Among the “Americanized” Japanese males the number of illnesses of this origin in men under 45 years of age was five times higher, and in men above 45 years of age was three times higher than in those adhering to their traditional culture. Results consistent with this were obtained from similar studies of Greeks and Italians living in the USA.⁶⁶

The old axiom by sociologists and anthropologists that social mobility and the loss or change of culture, the dispersion of traditional communities is accompanied by numerous negative, deviant or anomolic phenomena, since the person or group participating in these processes are more vulnerable and defenseless and are therefore much more subject to illnesses, as has been evidenced by several public health studies. According to them, cultural and sociological identification, social cohesion, have became one of the most important protective factors in modern or modernizing societies. If this exists, the wealthier segment is even willing to make a sacrifice for the community, so those left behind do not feel that they have been abandoned in a hostile world. A high degree of social cohesion, the experience of belonging, is in and of itself a significant health protective factor.

Roma people of Hungary went through a radically rapid and mixed modernization period between 1950 and 1980: due to government intervention they lost their *traditional* areas of life (demolished Roma settlements); their trades, and place in the division of labor within society (marginalized to the lowest sector); their unique culture dispersed; and their existence, parallel to non-Roma Hungarian society, ceased to continue. Government guardianship, no matter how enlightened its leadership may have been, or merely as a result of government welfare’s indirect need for control, or as a result of the voracious appetite for labor by the extensive development of socialist heavy industry, destroyed the network of Roma society based on (large) family relationships, and upset the experience of belonging somewhere, which seemed secure once upon a time. Although it established the need in the Roma population, marginalized to the lowest working class, the need to separate from their culture and close themselves off from their

⁶⁵ Matsumoto, Y.S.: Social stress and coronary heart disease. Milbank Mem Fund, 1970, Q.48, 9-36

⁶⁶ Keys, A. (Ed.) Coronary heart disease in seven countries. Circulation 1970, 41, 42 (Suppl.1)

tradition, however, it offered do new identity in exchange, at least nothing that could provide security under the changed circumstances. The majority society, apart from a short period—was not at all to receptive to Romas changing their culture, furthermore, with increased existential problems of its own, its neutrality changed to a growing aversion and explicit or implicit hostility to Romas.

Perhaps the statement is over simplified, but in such a study of this kind it is difficult to avoid, there are serious signs of crisis with respect to Roma identity. And we mean not only the first or the second generation of the “successfully” assimilated, but the majority of groups of Roma origin (probably Romungro primarily).

There are two examples to validate the above: the 1990 census, like the previous ones, was based on self-declaration and thus 143 thousand persons were registered as belonging to the Roma nationality. Based, however, on the representative survey conducted by the Central Statistical Office three years later that covered 27 thousand households, the number of ethnic Romas reached or possibly exceeded the magnitude of 400 thousand.⁶⁷ This can hardly be interpreted other than a large segment of Romas concealing their origin or their belonging to an ethnic group before their environment, or suppressing it within themselves because of some “vested interest.” This is evidenced by the fact that although the number of Roma-speakers is growing from census to census, according to the 1980 census, during what was probably the most successful period from the aspect of Roma assimilation, altogether 6400 persons declared themselves as Roma nationality.⁶⁸

Following the socio-political transition, the identity and self-identification of Romas, considered to be the greatest victims of the changes, did not strengthen visibly. Although in terms of public law the majority society fulfilled its many centuries old obligation by recognizing Romas as a nationality or ethnic minority,⁶⁹ the *de facto* emancipation of Romas is still delayed. A spectacular indicator of this fact is that according a popular opinion survey conducted this year, the least favored ethnic group among Roma circles are Romas themselves, while the most favored by them, the one most different in many respect from theirs, is the German.⁷⁰ It is not surprising if we consider that within the Roma population, treated by the majority society as a single unit, among several ethnic groups with different origins and degrees of assimilation, there are in fact such great contradictions and even prejudices respect to each other, that they are

⁶⁷ Status and circumstances of Romas 1993, KSH, Bp. 1994. 5.

⁶⁸ Ibid. pp 9-10

⁶⁹ Act LXXVII of 1993 on the rights of the national and ethnic minorities, promulgated on 22 July 1993, in paragraph (2) of Article 1 determined Roma people as one of the thirteen national and ethnic groups that are indigenous in Hungary, which differs from other Hungarian citizens and from the population by its own language and traditions, and meanwhile “evidenced such collective conscience that is directed to the safeguarding of the above and expression of the interests of the historically developed community.”

⁷⁰ Népszava, July 26, 1998

stronger than those articulated by the majority. The most reliable indicator of the aversion existing among groups is the development of the willingness to marry. Marriage between the young people from the three main Roma groups in Hungary (Romungro, Wallach, Bayash) is far more rare than between members of the majority society and Romas.⁷¹

Recent research in behavioral science and psycho-physiology made it conclusive that from the standpoint of our own condition of health it is fundamental how we evaluate and assess our own status.⁷² Belonging somewhere is undoubtedly a reduces stress on the central nervous system and is a prerequisite for a psychological state characterized by a general sense of security and an attitude of confidence. Its absence can be accompanied by a judgment of interpersonal relationships as dangerous, and biological vulnerability, e.g. decreased immune competency. The unfulfilled need to belong (in general, to a community) that leads to a depressive and aimless state of mind can also be considered fundamental in the development of addictions, frequently experienced in Roma circles in Hungary (alcohol and drug consumption, even smoking). Sarason and others concluded with respect to the interaction of social support and health status that social support increases the ability of the individual for conflict management and mitigates the loss-of-controlled state of mind, and as a result supports both the physical and psychological welfare.⁷³

A fundamental conclusion of a representative study of the Hungarian Academy of Science conducted between 1988 and 1995, is that within the Hungarian population, socio-economic differences through the intermediary of a depression syndrome lead to an increased number of sick-days, that is, to a detectable deterioration of health status. This is so very true that the role of the intermediating depressive syndrome is more important than direct and primary socio-economic facts, except for education. The depression syndrome in the scope of the active population under the age of 60 shows the tightest connection with days of illness due primarily to cardiovascular, and locomotive, stomach, intestinal and infectious illnesses.

In comparing the 1988 and 1994 average values based on education and the numerical points for depression, as well as that of the groups of unemployed in 1994, it is obvious that the average value of those who finished less than eight elementary grades in 1994 was higher than the 18 points, considered the boundary for medium seriously depressed. At the same time, the depression score among the unemployed is conspicuously high at the lowest and highest educated groups.

Both a low degree of perceived social support and a stronger attitude of hostility are more frequent among the lower educated groups. The value of these indicators as well as physical and

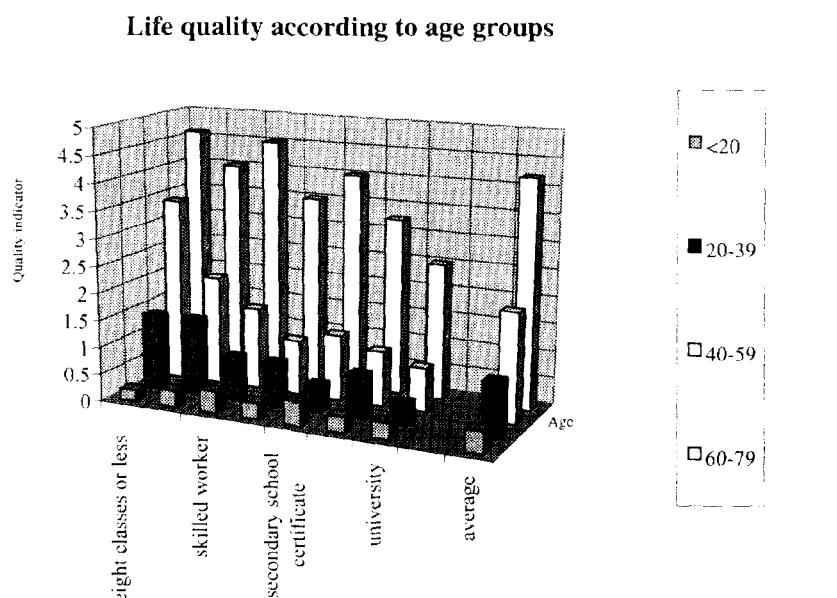
⁷¹ Péter Szuhay: Gypsy culture. On the cultural integration of the Gypsy ethnic groups in Hungary and the creation of the national culture. BUKSZ, 1995.3.

⁷² Lazarus, R.S. Folkman, S.: Stress, appraisal and coping. Springer, New York, 1984. Bandura, A.: Self-efficacy mechanism in human agency. American Psychologist, 1982, 37, 122-147.

psychological status improve in parallel with the level of education. In the lowest educated segment, the quality of life deteriorates significantly already in the 20-39 year age group. Today, the school has become the most important area of socialization after the family, where in addition to the norms of collective behavior and co-operative skills the bases of health protection behavior can also be learnt indirectly. It is no wonder therefore, that all the surveys found tight correlation between the level of education and health status.⁷⁴

(See Figure No. 3)

Figure No. 3 Life quality indicator (0-5) in the Hungarian population over the age of 16, broken down according to age and education, in 1995 (best score: 0, worst score: 5)



Source:
Hungarian Academy of Science

It is public knowledge that within the Roma population the proportion of under-educated and unemployed is much greater than the national average. When presenting the results of a representative survey of the Roma population in 1993-1994, István Kemény stated that 22.3%, 24.9%, 29.6%, 45.4%, 44.7%, 57.1%, 71.1% and 77.4% of the age group of Romas between 20 and 24; 25 and 29; 30 and 34; 35 and 39; 40 and 44; 45 and 49; 50 and 54; and 55 and 59 respectively, that is, 42.2% of the Roma population over the age of 14 did not finish the eight grades of the elementary education.

According to the Central Statistical Office data the unemployment rate of the "population leading a Roma life style" is three times higher (35.8%) than that of the non-Roma population (11.2%).

⁷³ Sarason, B.R., Sarason I.G., Pierce G.R. (Eds): Social support: An interactive view, New York, Wiley, 1990

⁷⁴ Mária Kopp – Árpád Skrabski – Sándor Szedmák: Significance of social cohesion in the development of morbidity and mortality in Hungary = Népegészség, orvos, társadalom, Ed.: Ferenc Glatz. MTA Bp. 1998. 34

Meanwhile, the low rate of economic activity shows that a significant proportion of Roma people of active age do not even appear on the labor force market.⁷⁵ (As for the relationship between education and unemployment Kemény believes that the elderly Romas, primarily those over the age of 50 became unemployed mostly because they did not even finish the eight grades of elementary school. The young on the other hand, cannot find jobs because on the current labor market, eight grades or the trade schools are not enough for finding employment.)⁷⁶

Therefore, if we accept the results of the above studies, supported by several experiential facts, the Roma population of Hungary is more exposed to the illnesses of depressive origin than the majority population. Consequently, common stereotypical statements, namely, that the loss of employment does not really bother Romas, or that their lower education does not directly impact them, cannot be justified. This belief is not true even if the preliminary results of a research by health sociologist György Gyukits conducted in a settlement in Borsod-Abaúj-Zemplén County suggest that the mass unemployment and impoverization following the economic transition impacted the non-Roma population more seriously and that their health conditions deteriorated more noticeably.⁷⁷ It is understandable, since the end of a relatively solid life style and the collapse of a life-plan based on continuous enrichment entails a greater stress than changes for those who essentially take continual poverty into account, who only wish to survive. One must not forget that one of the characteristics, or even the sole continuous characteristic of Roma culture, spanning over centuries, is that it is a so-called culture of poverty, with its assigned survival techniques and attitudes. This, however, does not mean that this culture was left unmarked by the decades of socialism. One of the characteristics of the culture of poverty, among others, the high degree of family and community solidarity, cannot today be considered tight enough to counterbalance the dramatic burst of anomalic development in the anomalized majority society as well. Anomaly threatens the (health) conditions of the low prestige and status groups of the society foremost.

Depression syndrome, that is, the absence of life objectives and a feeling of emptiness is seemingly always coupled with a hostile attitude. This mostly does not mean the hostility of an individual towards the environment, but rather the feeling that the world, or people in general are hostile.

⁷⁵ Status and life conditions of Roma population 1993, KSH, Bp., 1994, 8

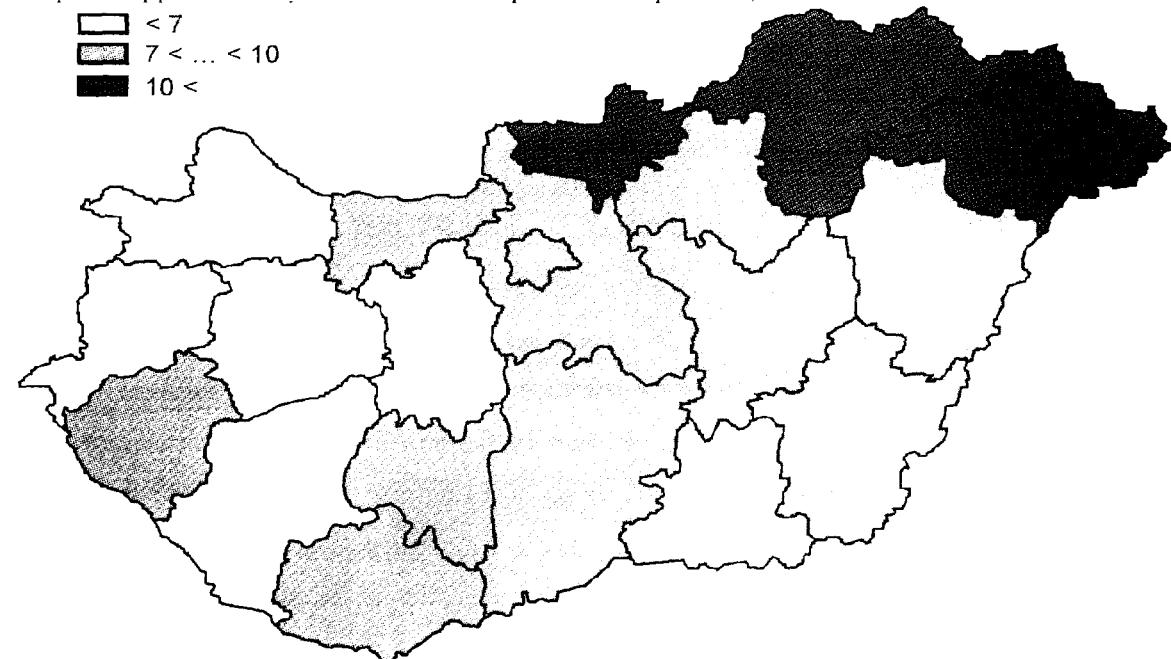
⁷⁶ István Kemény: Romas and the school = School and Society, Ed.: Mihály Andor WJLF – Új Mandátum, Bp. 1998. 438-439

⁷⁷ Information provided by courtesy of György Gyukits (SOTE)

A survey by the Hungarian Academy of Science concluded that people in Hungary today feel significantly more left to themselves than they did in 1988.⁷⁸ This is obviously no different for the Hungarian Roma population.

The survey states that the most important components of the depression syndrome that lies in the background of the health deterioration of the Hungarian population are a lack of confidence, and the motivation for achievement, which increased dramatically after the political transition, and with which the uneducated and/or unemployed Romas are least able to cope.

Map No. 12 Average depression score according to counties in 1995. (The average of the entire sample is approximately 8.14. N. The sample: 12,477 persons)



Source: Hungarian Academy of Science

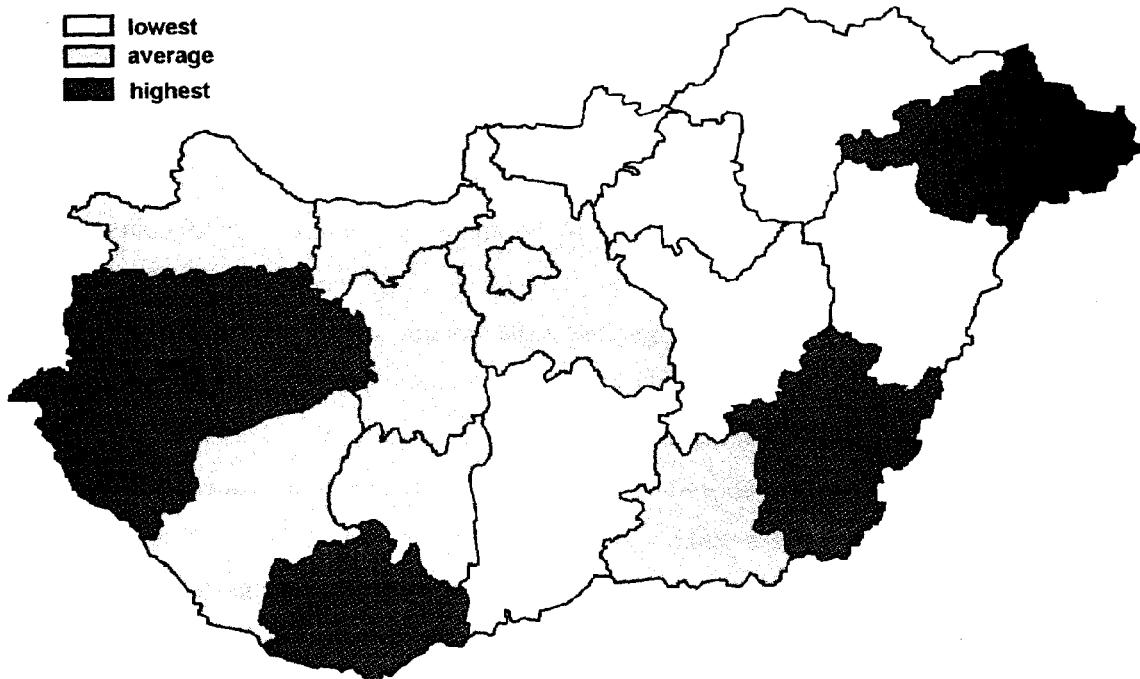
In the north-eastern section of Hungary (deemed to be a crisis-region), the depression score, average mortality rate, death due to tumors, and chronic aspecific illnesses of the respiratory organs greatly correlate with the number and proportion of the Roma population there. In Szabolcs-Szatmár-Bereg, Borsod-Abaúj-Zemplén and Nógrád counties where, according to Central Statistical Office data, almost one third of the Hungarian Roma population lives (32.3%), in addition to being on the edge of the average score for depression syndrome (first three placements), total male mortality (first, fifth and seventh placements), total number of male deaths caused by tumor (second, third and fourth places), male death caused by lung cancer

⁷⁸ Mária Kopp – Árpád Skrabski – Sándor Szedmák: Significance of social cohesion in the development of morbidity and mortality in Hungary = Népegészség, orvos, társadalom, Ed.: Ferenc Glatz. MTA Bp. 1998. 32

(second, fifth and seventh places), as well as death caused by chronic, aspecific respiratory illnesses (first three placements), in almost all these causes of death during the last 15 years a strongly significant increase can be experienced.⁷⁹ (Compare maps 4, 6, 9, 10, 11, 12.)

In our opinion it cannot be stated on the basis of the results by the Hungarian Academy of Science, however, there is an unequivocal correlation between pauperization and support from the residential and working environment. While in Szabolcs-Szatmár-Bereg County, with an 8.9% Roma population, and in the more favorably situated Vas County with a small Roma population (1.5%), altruism exceeds the national average, the willingness to help in Borsod-Abaúj-Zemplén or Nograd County is below average. In spite of the high altruism value in Szabolcs-Szatmár-Bereg County, it can be seen that while people in the western part of the country are more inclined to help their neighbors or colleagues, the altruism indicator east of the Danube exceeds the average only in the southern counties of the Great Plain. (See map No. 13)

Map No. 13 *Can rely on help from neighbors or colleagues in difficult situations, in 1995*



Source: Hungarian Academy of Science

⁷⁹ Alán Pintér – Mihály Csanády – Amanda Horváth: Environment-health aspects of the regional inequalities = Népegészség, orvos, társadalom, Ed.: Ferenc Glatz. MTA Bp. 1998. 153-201

Lack of prospects, goals, loss of values and a psychological state of depletion, as well as the lack of confidence (cynicism) is the link between the weakening of the social cohesion that was once the foundation on which the Roma large family system rested, the insufficiency of altruistic practice shown by the majority society, and therefore by the State, the anomaly of the majority of Roma communities, and the deterioration of their individual health status. We are not claiming by this that as regards Roma's bad state of health, the anomaly of Roma communities and weak social cohesion have a more decisive impact on the Roma population than the "hard" health-care, hygienic and sociological disadvantages discussed earlier, however, they have an impacts by all means and further undermine the health and life options for people of Roma origin in Hungary.

XIV. Health attitudes

It is unnecessary to prove the close relationship between health attitudes and health conditions. In the course of going to see a doctor it is a decisive factor how the patient evaluates their symptoms: which should be immediately shown to a physician, which are not considered indicative of a serious illness and therefore do not require immediately going to a physician, and which do not indicate any illness.

György Gyukits, on the basis of the results of an empirical study conducted in Miskolc, believes that unequivocally fever and pain are the two symptoms that drive Roma to the doctor. It seems that all other symptoms are subordinate to the two symptoms above, therefore any illness that does not entail pain or fever are considered to be illnesses running a mild course or not considered symptomatic of an illness at all.

In evaluating the relationship between pain and seeing a doctor, it is evident that the patient also evaluates the intensity of the pain and the part of the body affected and decides on the seeing a doctor after considering these. Patients in general tend to postpone the encounter, that is, they only see a doctor when the pain is unbearable. In case of dental pain for instance, a dentist is seen only when nothing else is left but to pull the tooth.

The relationship between health attitudes and health conditions can probably be best shown in cases of dental problems. The status of teeth, obviously, cannot be considered as a simple aesthetic issue, since in the wake of dental disease a number of serious illnesses can emerge, wherefore in the evolution of bad health conditions among Roma people the bad state of their teeth also plays a part. The majority of the village population Roma do not pay enough attention to dental care nor do parents urge their children to brush regularly. Consequently, tooth and gum disease develop early. Roma, however, are afraid of dental treatment and postpone intervention. It is interesting that even among those Roma who otherwise can afford a filling and therefore their tooth could be saved, opt for pulling.

In general we can say that Romas apply prevention and health maintenance techniques only haphazardly.

In the case of women, it is typical that they do not have time to go to a physician when symptoms appear, since they are primarily responsible for the household activities of often a large family.

There is debate between health-sociologists and anthropologists as to how much Romas fear health care institutions. Michael Stewart, an English anthropologist in his excellent work about a Wallach Roma community in Hungary, says the following:

Although fear of the gazho (non-Roma) authorities is general, it still pre-eminently relates to certain points of the gazho world, namely the pub, the hospital, the prison and – to a lesser extent – the barracks. (...) The hospital is a dangerous place where Romas must unavoidably be separated from their beloved relations, however, they try to mitigate such separation. Visiting family members in the hospital is an integral part of the settlement's calendar and a large number of close relatives gather around the bed of the patient. During the official visiting hours the festive image of the Roma community can be seen, which is exhibited by the men and women lined up along opposite walls, the most ceremonial of greetings exchanged upon arrival and departure. As well as the quality of drinks brought with them. Romas know very well that drinks and pharmaceuticals exclude each other, but they also know that a drink is a very strong symbol of Roma brotherhood and that it also cleanses the body.⁸⁰

J.C. Salloway took a completely opposite position. When analyzing the medical encounter habits of an urban Roma community and the use of a health care provider system, he debates the common assumption that Romas are afraid of hospitals and this explains the scarcity of their use of in-patient services. He says that Romas simply have access to the worst quality services and this is why they do not like to use them.⁸¹

A newer research organized by the Office of National and Ethnic Minorities supports Stewart's theory. Leading researcher Mária Neményi says that health care and the world of Romas are so different from each other that there is no chance at present for successful and untroubled communication between them.⁸²

In communities that do not willingly turn to physician or do not recognize their significance, self-healing is a frequent phenomenon. In the Roma circle in Miskolc self-medicating is observed in illnesses considered to be less severe, such as a cold or headache. They frequently drink teas, especially for a cold, and ask for medicine from relatives, acquaintances and neighbors. This, however, is not different from the habits of the majority society. Application of healing methods considered traditional were not found at all, however, among Romas in Miskolc. This can be

⁸⁰ Michael Sinclair Stewart: Daltestvérök [Song brothers], T-Twins Publishing, Bp. 1993, 128-129

⁸¹ Jeffrey Colman Salloway: Medical Care Utilization – among urban Romas. Urban Anthropology Vol.2.(1) 1973

⁸² Mária Neményi: Roma mothers in the health care system NEKH, [Bp.], 1998, 145-149

explained by the fact that among the circle of the urban Romas traditions may have lost some of their power and consequently, parents and grandparents can no longer bequeath their natural holistic therapies to the new generations.⁸³

It is inexorably the task of future research to clarify whether Romas ever receive the health care necessary for their conditions. According to our experience, even if a health-conscious way of thinking has already developed among them, the present health care system, or its way of operation, aggravates access to the benefits.

Access to medical treatment in practice could have developed into a problem because the social medical insurance system only provides automatic health care benefits to those in possession of a social insurance identity card. Before starting to write this study we thought that acquiring the health insurance identity card may be very problematic for unemployed Romas. The validity of the social insurance card for someone unemployed expires and must be renewed. Those who fail to renew it are ineligible to receive health care benefits.

In the course of his research György Gyukits stated that in the case of the medical insurance card we did not experience that the unemployed or those in the process of becoming unemployed would fall out of the social insurance system; on the contrary, it can be determined that Romas have no social insurance card primarily because they do not recognize its importance; stated in other words, they fall out of the system. Because of the complexity of the health care provision system.

Most benefits are free of charge, however, there are certain health care services that require payment, such as for example, dental care. If patients were unable to buy the health care service, they remained untreated. Due to the poor financial status of Romas, it is characteristic that they are often unable to pay even a small amount of money, even some few hundred forints, and therefore they are not provided with the necessary care. In addition, as a result of the lack of medical intervention, illnesses of such severity can emerge that their treatment may cost the social insurance system several times more than the original treatment.

A patient's solvency may not be a impeding factor in receiving treatment only in the case of purchasing health care benefits but also in traveling from a patient's residence to the health care institution, that is, the cost thereof. In addition, the physicians' gratuity has become an integral part of our health care system, therefore Romas in a bad financial status cannot buy the most favorable conditions necessary for their recovery.

The studies of György Gyukits pointed out that there is extensive difference between the relationship of Romas and their family doctors, and hospital or specialized physicians. While a

⁸³ Information provided by courtesy of György Gyukits (SOTE)

cooperative relationship of necessity develops between the family doctor and Romas, whose majority live in small villages, after all they are forced to work together (the physician also becomes financially dependent on the patient --by financing playing at cards), the right of the patient to choose a physician does not prevail for practical reasons, in the area of hospital or specialist treatment conflicts between physician and patient are a daily event.

XV. Prejudice and discrimination

According to the Hungarian Constitution all people living on the territory of the Republic of Hungary are entitled to the highest possible level of physical and psychological health.⁸⁴ The fundamental law in addition to numerous other laws forbid any adverse discrimination of people based on race, color, gender, language, religion, political or other opinion, national or social origin, financial, birth or other condition.⁸⁵ This, however, does not mean that Romas are not subject to negative discrimination. The majority of this is committed by the authorities, public institutions or their staff.

Romas who are not native Hungarian speakers are in an undisputedly disadvantaged position compared to native Hungarian speakers already at the point establishing contact. The same disadvantages fall to Romas living in traditional communities or who are uneducated or illiterate. Despite these facts we are not aware of any attempts on the part of the Hungarian health care system to mitigate these disadvantages for instance, in the area of the patient information. This situation, of course, is related to the fact that current health care provision practice is not patient oriented at all. Perhaps the new law on the patients' rights can remedy the situation, but currently patients are subordinated to the institution serving them.

These problems, with some good intentions, cannot be evaluated as *conscious* discriminative practice. Those who know the situation well however, declare that as regards Romas, health care is not without open and conscious discrimination. According to Mária Neményi, one of the decisive elements of the relationship between the health care authority and the Roma client is the prejudice that serves as fertile soil for discrimination. Furthermore, most personnel on the part of the authority experience the demonstrated and verbalized antipathy of Romas in reaction [to this attitude] as an aggression against the majority society, and a false and exaggerated self-consciousness.⁸⁶

According to the opinion of academician György Ádám, Roma people are in a more disadvantaged situation than patients in society at large since without paying the legalized gratuity they may lose out on even the most minimally required treatment. Ádám disagrees with

⁸⁴ Act XX of 1949, paragraph (1) of Article 70/D

⁸⁵ Act XX of 1949, Article 70/A

⁸⁶ Mária Neményi: Roma mothers in the health care system NEKH. [Bp.], 1998, 147

the common view that Romas “complain more about their physicians” and would initiate more malpractice litigation against health care institutions, as such cases are cost-free. The reality is just the opposite. Romas hardly take the path of legal remedy to rectify the injuries; they incurred in the course of treatment.⁸⁷

György Gyukits believes that courtesy and even rudeness against Romas is a general fact. Often it stems from insensitivity towards the patient’s culture but its cause can also be a fundamentally prejudiced personality. We have no separate data concerning the prejudice of physicians and health care professionals, however, it hardly can be less than the data collected on the whole of society.⁸⁸

From a reliable source who requests anonymity, we have knowledge of an outrageous practice that entails consequences under criminal law, whereby in one of the counties with a high density of Roma population, medical interventions are performed in the obstetrics department on Roma women without their knowledge, such as implanting spiral intrauterine devices or sterilization. All this is done under the reference of merely wishing to help Romas who are incapable of family planning.

Despite all of the above, it is perhaps surprising that according to the case statistics of the minority ombudsman’s office, not a single complaint on the health care benefits, the same as on employment, was received in 1997.⁸⁹

⁸⁷ Information provided by courtesy of academician György Ádám

⁸⁸ Information provided by courtesy of György Gyukits

⁸⁹ Report on the activity of the Parliamentary Commissar of the national and minority rights, 1 January to 31 December 1997, OBH 1998, 102-107.

Summary statements: The health status of Roma people

1. The health status of Roma people is worse than that of non-Roma people.
2. The life expectancy of Roma people is very low; they live 10-15 years less than non-Romas. The Roma populations are younger, on average, than other groups.
3. As with other population groups, rates of prenatal death and premature birth are declining among Romas. However, these rates are still higher than those of the non-Roma population.
4. Romas are a minority group historically at risk of infections and epidemics. However, in the past 20 years the number of illnesses has decreased, and today Romas have no more illnesses than non-Romas of the same social status. Currently most infectious diseases among Romas result from unsatisfactory hygienic conditions. These diseases are especially prevalent among Romas living in Roma settlements, which often lack modern sanitary facilities.
5. Addictive illnesses--including alcoholism, smoking, and drug consumption--are widespread among Romas.
6. The most frequent respiratory diseases among Romas are emphysema and chronic bronchitis (primarily a consequence of very heavy smoking). Incidence of cancer is extremely high, although data are not available yet.
7. Many Roma people suffer from hunger and malnourishment—problems that may affect the health of future generations as well.
8. The health status of Romas is similar to that of other poor people living in the same (marginalized) social circumstances. Further research should investigate however, whether Roma people have any health characteristics not shared by other poor people in these social circumstances.

Causes of poor health among the Roma people

9. The poor health of Roma people stems predominantly from social and lifestyle factors rather than from genetic or cultural factors.
10. Education is one of the most important health protection factors. The gap in education between Romas and the wider population has increased.
11. The low employment rate of Romas is a health risk factor. Illness and unemployment are mutually correlated. Early onset of illness prevents Roma people from stabilizing their positions at the work place.
12. Roma people's living conditions are very poor, especially in villages in the crisis regions, where Romas live in overcrowded flats not served by public utilities. In urban areas, the

conditions of Romas are comparable to those of the poorest members of society. Segregation of Roma populations and often their resettlement to Roma neighborhoods further contribute to their poor living conditions.

13. Almost the entire Roma population suffers from poor nutrition. The poor, who make up the majority of Roma people, eat foods high in fat and carbohydrates.
14. Although heavy industry has essentially ceased to exist—driving masses of Romas out of their former workplaces—the majority of Romas still live in polluted environments and work in dangerous places.
15. Weakened social cohesion that was once the foundation of the Romas' large family system, the deterioration of the Roma people's health status, less than enough state support to improve their living conditions together lead to loss of values, psychological depletion, lack of confidence, and of prospects. The marginal nature of Roma communities further erodes their psychological and social strength, contributing to their poor general health.
16. The health attitudes of Romas are similar to those of other poor and marginal groups. Romas rarely visit doctors or practice preventive health strategies.
17. Health care systems discriminate against Romas. Romas receive lower-quality treatment due to their different origin, culture, and language, and because of their poor financial status. Roma people are further disadvantaged by the gratuity system. Romas often establish more cooperative relationships with their family doctors than they do at specialty clinics or hospitals.

List of charts, tables and maps

Figures

1. *Population of Roma lifestyle and non-Roma lifestyle by gender and age groups.*
2. *Changes in total infant mortality and within that Roma infant mortality per thousand in Hungary, 1970-1990*
3. *Quality of life indicator (0-5) in the Hungarian population over age 16, according to age and education, in 1995 (best score: 0; worst score: 5)*

Tables

- 1 *The number of Romas in Hungary by region according to the data of the 1971 and 1994 representative surveys of Romas.*
- 2 *The distribution of Romas among the different types of settlement.*
- 3 *Generational breakdown of Romas and the total Hungarian population in 1993.*
- 4 *The ten leading causes of death in Hungary and in Szabolcs-Szatmár County in 1978.*
- 4/a *Leading causes of death for Romas in Szabolcs-Szatmár County in 1978.*
- 5 *Leading causes of death for Romas living in Baranya County in 1978*
- 6 *Breakdown in age groups of Roma population by level of school education in 1993 (%)*
- 7 *The distribution of non-Roma men and women by school education in 1993*
- 7a *The distribution of Roma men and women by school education in 1993*
- 8 *The distribution of male population from ages 15 to 74 years by employment in 1993*
- 8/a *The distribution of female population from ages 15 to 74 years by employment in 1993*
- 9 *The distribution of non-Romas with various school education by employment and unemployment in 1993*
- 9/a *The distribution of Romas with various school education by employment and unemployment in 1993*
- 10 *Data for lice-infection from 1997*

Maps

1. *Regional distribution of Roma lifestyle people in 1993*
2. *Proportion of Roma lifestyle people in the population in 1993*
3. *Total male mortality by counties, 1981-1984*
4. *Total male mortality by counties, 1991-1994*
5. *Total female mortality by counties, 1981-1984*
6. *Total female mortality by counties, 1991-1994*
7. *Perinatal mortality (between day 0-6) in 1995*
8. *Infant mortality (between day 7-365) in 1995*
9. *Male mortality caused by all tumours, 1991-1994*
10. *Mortality caused by chronic, aspecific respiratory diseases, 1991-1994*
11. *Male mortality caused by lung cancer, 1991-1994*
12. *Average depression score in the counties in 1995 (average of the entire sample is approximately 8.14. N= 12,477)*
13. *In difficult situations, help from a neighbor or colleague can be expected, in 1995*