SURVEY INTO THE HEALTH-CONSCIOUS BEHAVIOUR OF ROMA WOMEN IN BORSOD-ABAÚJ-ZEMPLÉN COUNTY

CLOSING RESEARCH REPORT

for

the

OFFICE OF THE CHIEF MEDICAL OFFICER

within the framework of the project „improving the working conditions of health visitors working in Roma communities", under ID number HU12-0001-PP1-2016, financed by the Norway Grants

made by

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Introduction

The purpose of the research

In the first quarter of 2017, Psyma Hungary Public Opinion Research Ltd. conducted research – upon request by the Office of the Chief Medical Officer - into the health conditions, the health awareness and the health behaviour of Roma women. The research was financed by the Norwegian Fund, within the framework of the project entitled „Improving the working conditions of health visitors working in Roma communities", under ID number HU12-0001-PP1-2016.

The research surveyed the health awareness and the health behaviour of Roma women from various aspects and in several cross-sections. One of the major objectives of the project was to improve the special, preventive and health educational tasks of health visitors, with special attention to effectively influencing the health behaviour.

The research touched upon several topics within the factors that determine the health condition (lifestyle, risk factors, using the healthcare system etc.), and we tried to survey these topics in order to be able to provide feedback to the health visitors who (also) work in Roma areas.

An important part of the survey is covered by the screenings controlled and supervised by the Office of the Chief Medical Officer (mammography and cervical screenings): checking the frequency and intensity of attending such screenings, mapping the possible reasons for attendance or failure to attend etc. Based on these results, we tried to draw conclusions on how the willingness of Roma women to attend public health screenings could be

improved. We also attempt to provide professional recommendations through our own tools.

These conclusions often affect the area of communication as well, i.e. how the screening-related communication could be enhanced. Upon the start of the research, we presumed that specific means of communication may be required in presenting the patterns of health-conscious behaviour to disadvantaged social strata.

It is an evident objective of the survey to significantly improve the health culture and the attitude of Roma women as well as to enhance their rate of participation in health development and disease prevention programmes.

Research tools

The research consisted of two parts: a quantitative and a qualitative part:

In the quantitative research phase we conducted a questionnaire-based survey among adult (18+) Roma women living in Borsod-Abaúj-Zemplén county. The sample covered 1000 persons. The research was carried out through the PAPI technique, i.e. the interviewers used traditional, printed questionnaires. Then the questionnaires were processed by computer, and after the logical check of the raw data file we produced the empirical database that was applied through the analysis.

The research itself was conducted through quota-based sampling combined with random elements. In this case, quota-based sampling means that the Principal pre-determined the internal sample structure upon the start of the research. It was the Principal's request that the Roma population should be surveyed at settlements of different sizes (level of development and

infrastructure). The survey focused on four settlement types: Miskolc, the county seat town, two towns with more than 20,000 residents (Ózd and Kazincbarcika), settlements with 3000-19,999 residents as well as settlements with fewer than 3000 residents. The quota was set up with the same population in the four territorial sub-groups.

Another main dimension of selecting the respondents was age. Here, a threefold breakdown of age was specified. The quota paid special attention to the 18-29 age group, mainly because the work of health visitors is especially focused on women who belong to this age group. (The characteristic features of the surveyed population, for example, having children at an early age – for this reason health visitors are in also contact with pregnant women aged 15-16 – would also have justified to involve an even younger age group in the sample, but we only interviewed adult-age persons with a view to data protection.) In addition to the younger generation, the 30-55 age group also has a dominant role in the quota, while the elderly group (aged 56+) carries a lower weight. The latter group has fewer participants not only because health visitors evidently maintain fewer contacts with them but also because the rate of the elderly is very low within the Roma (female) population due to the characteristic age tree. Below we give details on the distribution of the sample framework prescribed in the research.

Sample distribution according to the requested quotas (persons)

	women aged 18-29	women aged 30-55	56+	total
county seat town	100	100	50	250
20,000-150,000	100	100	50	250
3000-19,999	100	100	50	250
fewer than 3000	100	100	50	250
total	400	400	200	1000

31 out of the 358 settlements of the county were involved in the research. (The list of the surveyed settlements can be found in annex 1.) The selection was clear and evident at the large settlements (Miskolc, Ózd, Kazincbarcika). According to the census data, 29 settlements belong to the third settlement category. 14 settlements were covered by the survey from here. Selection was made at random, but we made sure upon the selection that settlements of various sizes should be included in the sample, and from as many small regions as possible, so that the largest possible area of the county should be covered.

The fourth settlement category covers 326 settlements. Those settlements were first selected into this sub-category where there is a dominant number of Roma population (at least 200 persons under the census data). From this, we selected the 14 surveyed settlements. Again, the objective was to include settlements of various sizes within the settlement category.

Within the given settlements, we selected streets as well as residential zones or segregated areas where a large number of Roma people live. At the selected interview spots the participants were selected by the interviewers through the random walking method, with the proviso that

- only one woman can be asked at the selected household, and
- at least a two-door jump is obligatory between addresses/households, i.e. next door families, neighbours etc. cannot be asked.

As can be seen, the method of selection cannot be regarded as totally random, and the initial sample framework does not fully represent the expected distribution of the Roma population either. Setting up the quota was meant to provide sub-groups with a statistically analyzable element number in very many sub-groups (e.g. young Roma women in Miskolc,

young Roma women in small towns etc.). Therefore, the 12 social-demographic sub-groups specified by the quota consist of at least 50-100 persons. Upon the analysis, this 12-cell basic table will be used as a very important variable, and basically we will present all data in this breakdown. (These tables are available as an annex to the study. In the analysis itself, we only highlight the most important basic distributions or breakdowns in a table format.)

However, we subsequently adjusted (weighted) the sample to the expected breakdowns of the total universe – based on the census figures of the Central Statistical Office in 2011 – in order to give a general picture of Roma women living in Borsod county, so that the answers of the members of the sample framework represent the total surveyed population more or less accurately. Thus, through the weighting, the internal sample composition projects the internal structure of Roma women living in the county based on age and settlement size. After the weighting, our basic table shows the following breakdown.

Internal distribution of the "weighted" sample (persons) [1]

	women aged 18-29	women aged 30-55	56+	total
county seat town	34	54	10	99
20,000-150,000	30	42	10	83
3000-19,999	90	131	29	250
fewer than 3000	205	295	68	568
total	359	522	117	1000

Comparing the internal cell values of the original and the weighted samples goes to show that the age distribution of the quota worked out mechanically upon the start is very close to the real figures. The census data (also)

[1] source: We take this opportunity to thank for the help by Marcell Kovács (CSO, Census Department) for providing us with the CSO 2011 census data.

illustrate very clearly the young age composition of the Roma (female) population: almost every fourth adult Roma woman belongs to the 18-29 age group. (Although we will often use the term of female Roma population throughout the analysis, we find it important to highlight that these figures come from a county survey, therefore the results can only be related to Borsod-Abaúj-Zemplén county.)

The internal cell values of the original and weighted samples also show that the differences are already bigger according to settlement types. The purpose of the initial quota was to provide statistically relevant information in connection with each settlement type, therefore the settlement categories were worked out in equal proportions. Thus, after completing the field work, one-fourth of the respondents were residents of Miskolc and one-fourth of Ózd or Kazincbarcika, as prescribed by the Principal, therefore, all in all, every second respondent "came" from these three settlements. According to the census data, "only" 18% of the adult Roma women live in the three largest towns of the county. In reality, the female Roma population is related to small settlements at a much higher rate. According to the census data, 57% of the adult Roma women live at settlements with fewer than 3000 residents. This means that the figures relevant to Roma women living at small settlements will have a more powerful effect when publishing summarized, weighted county figures.

Our purpose is to always disclose the summarized, weighted data in the study, and generally as a part of the above-mentioned 12-cell basic table (the total lines of the tables will in each case contain the weighted data). Moreover, where possible and where we have relevant data, we will also highlight in the report what is shown by the summarized, nationwide figures (relevant to women) in the surveyed topic. Namely because the questionnaire was worked out by (also) applying strings of questions that

are included as basic questions in the European Residential Health Survey of the Central Statistical Office, therefore, these nationwide figures can also be handled as reference data.

It is a sensitive point of the research – just like in the case of any empirical research focusing on the Roma population – how to decide: whether the respondent is of Roma origin or not. The survey was based on self-declaration/self-classification: do the potential respondents regard themselves as Roma (origin, nationality). A drawback of this method is that it underestimates the size and the occurrence of the real Roma population because – for some reason - many Romas do not admit their ethnic origin. This is why the census data of the CSO also indicate a lower Roma population than the reality. According to the estimates, there is a threefold difference between the number of those claiming to be Roma upon the census and the Roma population estimated by various questionnaire-based surveys. This fact makes the reliability of our weighted data somewhat relative – when we make a general and summarized statement about the total, female Roma population of the county – as the weighted data are based on these census figures. Although we are aware of this "distorting" effect, unfortunately, no data source is currently available that would be more reliable than the census.

It is a question – though it is also a problem with all empirical surveys – how well the respondents understand the questions, and how the researchers can find the language that is easy to understand for the participants. Of course, we made an attempt to achieve this, but it has to be taken into account that this was not successful in each case. Naturally, it should also be kept in mind when evaluating the answers that in the course of the research the respondents evidently have a compulsion to conform (they feel that they must come up to the expectations). It can

happen that they do not always answer sincerely in a research covering such sensitive questions (e.g. topics like using drugs, drinking alcohol etc.).

The qualitative phase of the research ran parallel with the survey. Within the framework of the qualitative research, 50 in-depth interviews were made with Roma women, health visitors, social workers, Roma interest representation leaders etc. It was the Principal's request that in-depth interviews should be conducted at all settlement types, and this condition was fulfilled in the course of the survey (Annex 2 shows the territorial distribution of the in-depth interviews).

The aim of the qualitative research was to make the quantitative research data more detailed and more lively. Therefore, we generally covered topics that also served as a basis for quantitative research. However, there were also topics that can mostly be grabbed through qualitative tools (e.g. the world of communication and information on health).

The report will simultaneously disclose the data of both surveys as well as the conclusions drawn. When disclosing percentage rates, those figures always come from quantitative research, while conclusions from the qualitative research will always be reflected in the textual analyses.

2. Demographic situation, social background

In the course of the survey, we would basically like to focus on the subjective circumstances that influence the health conditions – i.e. which can also be changed by the individuals with more or less ease or difficulty – and, through this, the subjective factors that determine the health behaviour and the health awareness: we intend to survey how much more the individuals themselves can do in order to improve their health, and how the individual, subjective factors can be influenced and supported from "outside", in an institutional form. We do not do this because we would like to forget about the objective, definite aspects (which, in fact, often fully and rightfully exempt the individuals from what they can do in order to improve their health condition) but because - in most cases – the Office of the Chief Medical Officer can in no way influence these objective facilities (low employment rate, low educational level, deep poverty etc.). These are evidently macro-economic, social and socio-cultural problems, and their solution is indispensable for making favourable changes in the health conditions of the Roma population.

Primarily, the survey made an attempt to explore how, and to what extent the Office of the Chief Medical Officer and the health visitor society can, or could influence the subjective, health-related factors through their own tools. Namely because the health visitor movement takes a distinguished place in the process of health education and healthcare. Health visitors maintain close and intensive daily contacts with the Roma women who live in their district. This is also due to the fact that they regularly attend the settlements or the segregated areas personally. (This is less true of the actors of primary healthcare. In the in-depth interviews, the participants mentioned – as a recurring problem – the missing GP/paediatrician practices, the large number of substituting doctors and the almost total

absence of specialist medical care at small settlements etc.). The relationship with the health visitors is also for a longer run as the health visitors are in contact with the mothers and pregnant women at Roma settlements for a very long time due to the early pregnancy and more frequent birth rate (unless the health visitors change districts). They also maintain a close relationship with Roma women who belong to the elderly age group as several generations often live together in the Roma families, and in some cases the health visitors even took care of the grandmother when she was expecting a baby.

2.1. The social and economic situation of Roma women

Unfortunately, there is nothing surprising about the fact that the social and economic situation of the Roma community reached by the health visitors and the surveyed Roma women in general – which can be regarded as an objective starting position – is very bad. And these unfavourable circumstances determine the health conditions already in themselves.

The educational level of the surveyed female Roma population is extremely low. 79% of the respondents have maximum primary education (older women often received even lower education), and only 2% of them passed at least the secondary final exam (table 2.1.1.). According to the census data, 53% of the adult women have a secondary school final exam nationwide, so the gap is huge.[2]

[2]http://www.ksh.hu/nepszamlalas/tablak_iskolazottsag

Table 2.1.1.: Highest educational level of Roma women living in the county according to age groups, %

	18-29	30-55	56+	total
less than 4 years in primary school	0,3	2,1	23,1	3,9
4-7 years in primary school	14,1	22,5	37,3	21,2
8 years in primary school	57,8	55,7	35,6	54,1
vocational school certificate	22,3	16,8	3,3	17,2
finished secondary school (general, specialized) without final exam	2,7	1,5	0,0	1,8
secondary school final exam giving qualifications	0,9	0,6	0,4	0,7
general final exam at secondary school (general, specialized)	0,7	0,1	0,2	0,3
certificate of special qualifications received in training after final exam at secondary school	0,8	0,5	0,0	0,6
certificate received in tertiary education, university or college degree	0,3	0,2	0,2	0,3
total	100	100	100	100

Theoretically, the educational level influences the trend in the health condition in two directions. On the one hand, it strongly influences the level of health awareness and culture, and, on the other hand, it determines who and where has the chance to enter the labour market, and thus what material-financial position they can gain, and what financial resources they can use in order to improve their health and general mood.

All in all, we can see that the majority of Roma women get stuck at the level of basic education. It is very rare for them to go to study in a secondary educational institution after finishing the primary education, and they only have a chance to receive vocational training. The breakdown of the data according to age groups shows that mainly the 18-29 age group was able to reach a higher than primary educational level (28%), and in this regard the lowest rate is scored by the elderly generation (4%). At the same time,

there is a bigger chance of advance in the school system if someone lives in a large town (27-33%) (annex 3).

As was mentioned, the educational level largely determines the labour market chances of Roma women, but also the fact that having children at an early age scores a high rate in the surveyed group (within the total sample, 37% of the mothers had their baby at the age of 17 or younger). The planned or unplanned children strongly influence Roma women's chances and opportunities in the labour market as many of them hardly enter the labour market but they drop out very soon and stay outside for some time. If young Roma women have a baby, they leave the educational system sooner and they will not get back to school any more. They also get far from the labour market as they typically have several children and stay at home with them. There are numerous factors behind having children at an early age: traditions, parental pattern, lack of knowledge about protection etc. (Issues related to having children will be covered in details in the next chapter.) Of course, it is difficult to fully and accurately map the cause-effect relations behind dropping out of school. Having children at an early age also plays a role here. However, the interviews also go to show that some young girls do not stay in the educational system even if they do not become pregnant or do not become mothers. Some fulfill the obligation to go to school until the age of 16 only formally (e.g. because the kids switch into a private student status either upon the parents' request or upon pressure by the school).

Our data show that only 24% of the 18-24 age group works, and 10% are unemployed. Most respondents are at home and receive child care benefit (54%). In the 25-29 age group, a higher 44% goes to work and 42% receive child care benefit. The number of workers is more dominant from

the age of 30 – around 60% - and the unemployment rate also increases with the older generations (Annexes 3-4).

This higher rate of employment is clearly due to the public work programme as about three-fourths of the workers do public work. Within the economically active respondents, this form of employment is especially dominant in small settlements and among middle-aged and older women. Employment over and above public work is mainly available in large towns (annexes 3-4).

The interviews show that the public work programme brings many positive results. The survey is not focused on the detailed employment policy analysis of the public work programme, but it is for certain that it provides the households with higher income than the unemployment benefits, it takes public workers back to the world of work in some form as well as brings some system and regularity into their everyday life. The programme started with difficulties at many places and the participants did not know what to expect, but currently the Roma population is showing significant interest in this form of employment.

Our research shows that Roma families are coping with serious financial problems. When asked about their financial situation, only 1% claimed to make a proper living, and 14% said they can more or less manage to make a living. 38% have difficulty to make ends with from their monthly income. The rest – 47% of the interviewees – already have serious financial problems. 36% has serious financial problems from month to month, and 10% definitely live in privation. Financial problems were especially reported by the members of the elderly age group (annex 3).

Although the surveyed Roma households are relatively well-equipped with basic electronic-entertainment articles (e.g. 98% have a coloured TV, 75% have a mobile phone) but their financial/income position is well shown by the fact that a car – a more valuable item – is only possessed by 14% (annex 3).

The survey figures show that the direct neighbourhood of the Roma families is very poor. 75% of the Roma women living in the region reside in a definitely miserable, run-down environment. According to the classification by the interviewers, 54% live in houses that are in a bad condition and require repairs, and 52% live in a simple peasant house or farm-style building, or in shacks. Only 57% of the flats/houses have a bathroom, 55% have pipe water and 52% have a flush toilet (table 2.1.2.).

Of course, these figures are significantly influenced by the fact that the interviews were basically conducted in an area that is populated by Roma people (often a segregated area). Those Roma families are accessed less by this research who managed to step out of this circle for some reason, and they live elsewhere, even under better circumstances. It is true though that – unfortunately – their number is probably not very high.

The housing conditions of the Roma families living at the surveyed settlements are very different, depending on whether the slums and the segregated areas had been rehabilitated or are being pulled down, and also depending on the type of settlement section (house with garden, block of flats, housing estate etc.). From this point of view, settlements with more than 20,000 residents are in a special situation. (In fact, at this point of the survey, we divided this settlement category.) Our data go to show that the Roma respondents in Ózd and Kazincbarcika live under much more urban-like conditions than the others. For example, the interviewers indicated that

those in Ózd clearly live in properties of higher than average quality and standards, while the respondents in Kazincbarcika live in parts of the town that represent not very good quality but their infrastructure is better than the average (there is pipe water, a separate bathroom etc.).

This urban character is less observed in Miskolc, which is due to the fact that many Romas live in the Miskolc environs, basically in a poor, village-like areas, but these belong to Miskolc in administrative terms. The interviewers reported that the housing conditions of the Roma interviewees are worse at settlements with 3000-20,000 residents than at settlements with fewer than 3000 residents, and there is also less pipe water supply at these settlements.

Table 2.1.2.: Residential and housing conditions of Roma women living at the surveyed settlements, %

	poor neigh-bourhood	building in bad condition	simple peasant house, farm	no bath-room	no pipe-water	no toilet
Miskolc	86,8	70,9	63,8	43,2	34,5	39,5
Ózd	65,1	32,2	13,7	27,9	28,6	36,2
Kazincbarcika	90,3	58,3	44,9	11,2	13,7	22,9
3000-19999	85,5	70,6	48,6	49,6	52,8	56,8
fewer than 3000	68,8	45,5	54,8	42,5	46,7	48,0
total	75,1	53,8	51,5	42,7	45,2	48,1

It is already reflected by these social-demographic data that we cannot talk about a homogenous Roma society in general. This community seems to be homogenous along certain factors (e.g. educational level, economic activity etc.), but some other factors show strong differences and heterogeneity within the Roma society: for example, according to financial situation (varied housing circumstances, different income potentials), family size, the

number of children or according to the cultural and ethnic identity ("oláh", "beás", Hungarian Gypsy etc.).

With regard to the topic, we will primarily concentrate on the respondents' age and residence as a background variable in our analysis, and will process the data accordingly. (These are the variables that we handled as basic variables upon the sampling.)

2.2. Child birth, family planning

The issue of having children can also affect the topic of health awareness in addition to the demographic aspect. The early child birth and the higher birth rate – which is typical of Roma women – definitely affect the health condition of women having children. Pregnancy can outwear the body of a very young mother, and also too little time passing between two pregnancies if the body does not have enough time to regenerate. The interviewees reported several such negative cases and stories upon the in-depth interviews.

The research data show that in most cases Roma women have children at an early age (at the age of 17 or even earlier). However, it should also be kept in mind that there is a significant number of Roma women – also within the young age group – that do not have children (yet). Of course, the exact rates related to minor age girls – i.e. how many of those aged 14-17 have children – is not known as our survey did not cover this topic.

We can provide retrospective figures, which go to show that 32% of those aged 18-29 had their first baby before the age of 18. 26% have no babies at all, and 42% had their first baby at, or after the age of 18.

On the basis of the survey, we would not draw far-stretching conclusions from the age-related data (e.g. the sample is not representative at all within the elderly age groups due to the relatively low life expectancy, and no deductions can be made back to the initial figures due to the high death rate). However, it can be declared in the light of the data that the rate of having children at a young age is not increasing. 38% of the surveyed elderly Roma women had their babies at a young age, while this rate is 32% in the 30-55 age group and the identical 32% in the 18-29 age group (annex 5).

According to the survey, having children at a young age is frequent also today, which is due to numerous reasons. We are highlighting the most important ones based on the findings of the in-depth interviews.

The impact of the Roma culture

Having children carries a symbolic importance in the Roma culture, and this is how a woman becomes a full member of the Roma community. It also offers young girls the chance to move from their parents, although this does not bring total independence at small settlements as they mainly move to the boy's/husband's family.

Anti-abortion attitude

It was frequently mentioned upon the interviews that Roma girls keep their babies even if the pregnancy was not planned, and they choose abortion very rarely. The rejection of abortion is also strengthened by the clearly perceivable affection of children and the child-centered attitude, in addition to beliefs and superstitions.

Priority of the traditional family model

The traditional family model is very strong within the surveyed population, where raising children is defined as a basic task for women. Women deal with home and household tasks and they ensure the emotional integrity of family life. They can get help only from other women, who also stay/stayed at home in the multi-generation families (grandmothers).

Serious ignorance of young people about ways of protection

The interviews highlight that young people know very little about protection. (Boys are even less informed than girls. Protection against pregnancy is primarily a task for women, also at an older age, men do not deal with it. For example, condoms are used very rarely.) The home environment does not help with information either because female topics are often handled as taboo even between mothers and daughters. Many tasks would have to be undertaken by the school, and it seems that much more information would have to be provided about this topic than currently. The ways of protection, family planning, male-female relationships etc. would have to be covered not just at a meeting with the form master or with the health visitor but it should be better integrated in the school curriculum. Throughout the survey, 44% of the Roma women who have babies reported using some contraception method in their life in order to prevent pregnancy. However, only 23% claimed to do this on a regular basis. As can be seen, three-fourths of the respondents did not use any protection method at all, or only occasionally.

The weak retaining power of the educational system

The educational system has difficulties with integrating young Roma people aged 14-18, and they often drop out of school. It is also due to the lack of educational and training opportunities that some Roma girls become mothers already at a young age. The retaining power of the educational system would definitely have to be strengthened because this would shift the start of family life over time, and the educational level of the Roma population could increase significantly.

Another general opinion about the birth rate is that Roma women have many children. Indeed, our figures show a high rate. However, at this point it is difficult to accurately interpret our survey results as most respondents are at a fertile age, so the current conditions do not yet reflect the final situation at all.

For example, 39% of those who have children at the age of 18-29 only have one child (right now), but if we look at the sampled 40-59 age group, those with one child only score 5%, 14% have two children, 25% have three children, 19% have four and 39% have five or more. This – let us call it – reference age group has a very high average child number (4.76). Of course, this does not lead to a clear forecast on how many children the younger generations will have. (Upon the in-depth interviews the respondents mentioned several times that nowadays Roma mothers more and more seem to be willing to stop after two or three kids.)

In fact, only very few respondents make plans about having a big family. If it was totally up to them, almost 90% of the interviewees would have at most three kids, and this is what Roma women regard as ideal in a family today. Within this, most women would prefer two children (41%) and 36%

would like to have three (therefore, many respondents even find three children too many).

It is worth checking what is regarded as ideal today by the above-mentioned reference age group, which has 4.76 kids on average. The data show that they would also plan 2-3 kids (ideal number of children: 2.53). The age of the respondents also affects the number of kids regarded as ideal: the younger someone is, the more probably they regard a lower number of children as ideal (average of ideal child number – 18-29: 2.36, 30-55 age group: 2.48, 56+ age group: 2,62). The settlement type also influences the answers: Roma women living in large towns prefer two children, while residents of smaller settlements regard it possible to have three children (average of ideal child number - Miskolc: 2.25, Ózd, Kazincbarcika: 2.26, settlements with 3-20.000 residents: 2.50, settlements with fewer than 3000 residents: 2.50).

Once again, no direct comparison can be made about these two data lines – how many children the respondents have and how many children they find as ideal – because many respondents are still at a fertile age. Still it can be established with certainty that these two figures are not synchronous with each other. While the problem at an all-society level is that women cannot have as many children as they want or plan, the situation is just the opposite among Roma women, as they have much more children than what they find as ideal.

If we intend to check the possible explanations for this, we need to highlight the following reasons based on the experience gained through the interviews:

Roma customs and traditions

Traditions do not only mean having children at an early age but they also carry the need for a big family. Even if not planned, children are regarded as a blessing, and they often decide to have the baby, they rarely choose abortion, and even if they do, mainly at an older age.

Lack of conscious family planning

Conscious family planning is often totally absent from the life of Roma families. Naturally, this is the mutual responsibility of the partners who live together, involving not only women but also the male family members.

Lack of contraception

Young girls have very little information about protection. Among adult women (and among those who already have children) the problem is not primarily ignorance. Although there are deficiencies in conscious family planning, the lack of protection is many times due to financial reasons. Many people simply cannot afford contraception. From among the possible ways of protection, Roma women very rarely use expensive solutions (e.g. pills). If it comes to protection at all, they usually get the cheaper injection. The intrauterine device is relatively popular as well, and its placement is financially supported by several municipalities for women who have several children but decide to find a temporary or final solution against unwanted pregnancy. Under this programme, the municipality covers the cost of buying the IUD, the travel to the gynaecologist etc., thus Roma women have no expenses at all. In the future it would be worth extending such types of programmes and to promote them more and more among Roma women.

Financial reasons

Some of the respondents believe that in certain cases financial considerations also play a role in having more children. In the lack of work opportunities and break-out points, this can result in more benefits and material support.

Although health behaviour and health awareness will be covered in details in the next chapter, it is worth mentioning that in the surveyed circle giving birth to children and raising them plays a significant role in taking up and leading a healthier lifestyle despite the many work- and money-related difficulties at home: even if pregnant women do not stop smoking, in many cases they somewhat reduce it, they start taking vitamins etc. Later, however, more health conscious lifestyle mainly means that women pay attention to their children's health, they take the kids to the doctor sooner, they pay attention to children's nutrition etc.

3. Health behaviour, health awareness

3.1. The theoretical model of health behaviour

In the case of people mainly living in deep poverty it is very difficult to evaluate and qualify what health behaviour means for them, to define the intention and the practice of health preservation as well as to characterize the readiness and the abilities to make sacrifice. Leading a healthy lifestyle often means setting up certain prohibitions and various restrictions. Certain rules must be observed: what to eat, what not to eat, what to do and what not to do. Therefore, we need to make sacrifice in order to preserve our health. The question is whether this type of sacrifice can be expected from impoverished people, who are disadvantaged in so many ways, and whether they are able to live with more and more "prohibition signs" as their circumstances and income position already imply enough restrictions.

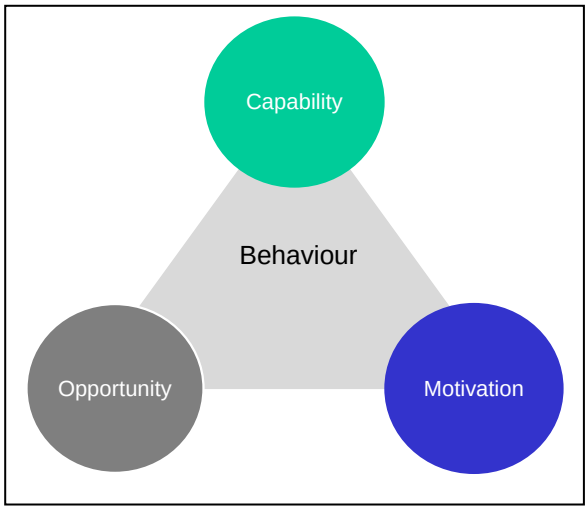
The in-depth interviews show that the conscious health behaviour of the respondents often comes with a disease, therefore they can/will mainly step on the road of health awareness only in the final case. Leading a healthy lifestyle does not mean avoiding and delaying illnesses but preventing the already arising diseases from becoming more serious.

The interviews go to show – and it can also be seen in the later chapters and according to the data of empirical research – that the respondents do not see the doctor for prevention. Roma women – especially the elderly - turn to the doctor in many cases only if they have a bad pain and very clear symptoms.

As can also be seen in the last chapter of the analysis, the rate of attending preventive screenings is also very low among Roma women.

The process that encourages people to follow a healthy, healthier lifestyle can be described as a complex impact of numerous factors. These days, the COM-B theoretical model is often used in health-sociology research in order to define and to influence health behaviour. In the interpretation of the model, there are three main components in the background to health behaviour: capability, opportunity and motivation. According to the model, these three influencing factors – that also affect each other – will develop and modify the individuals' health behaviour[3].

The COM-B model: the system of behaviour



The "capability" element covers the most important (health-related) knowledge as well as the physical and mental skills required for implementing the behaviour. To put it in another way, these elements provide the internal, subjective basis for further construction: the individuals know (theoretically) what to do, they know the rules and the background etc. of the given area and also possess the skills that help them to take the required actions.

[3]Source: Health Report 2015, National Institute for Health Development

"Motivation", the second behaviour-influencing factor is made up of the conscious decisions and intentions that launch the action as well as the automatically given answers and habits. These are the components that trigger the individuals to reach their objectives, and give the reason for using the available information and activating the already available skills. These factors actually give the answer to the "why", why is it necessary to take the given step, and what do I want to achieve with it.

"Opportunity" is the third set of factors that determine the implementation of the actions. This covers our physical, social and cultural environment. These are often external conditions, independent from the individuals, that cannot really be influenced by the individuals and often have to be accepted as something given.

3.2. The main elements of the theoretical model of health behaviour

The development of health conscious behaviour within the Roma population is made difficult by the fact that most components work counter-actively instead of driving people towards the right direction. This was explored on the basis of the in-depth interviews as well as the empirical research data.

Perhaps the deficiencies emerge the least with regard to the basic knowledge. Statistics show that stress and tension, the lack of exercise, unhealthy diet, smoking and alcoholism as risk factors – added with some other risk factors – significantly increase the chance of becoming sick. Our respondents are fully aware of these basic relationships, or to put it with some exaggeration, these are clear theses also for them. Through the survey, 80-90% of the interviewees claimed that these lifestyle elements

largely influence the health condition (table 3.2.1.). Such fully evident elements are for them: stress, alcohol consumption, smoking, diet, obesity and lack of exercise.

Table 3.2.1.: The rate of those who believe that the following aspects (significantly) affect the human health conditions, %

nervousness, stress, tension	89,6
alcohol consumption	89,3
smoking	88,2
nutrition	88,0
obesity	86,1
doing exercises	79,6
inherited genetic attributes	74,3
work environment, type of work done	57,4
type of dwelling environment, condition of the flat/house	57,2

From among the health-influencing factors covered by the survey, the Roma women basically failed to mention only those that do not really belong to the capabilities but rather to the opportunities, which are outside the individuals' control (genetic and environmental elements).

Still, reality shows – which will also be supported with accurate figures in the later chapters - that many Roma women are smokers (also while they are pregnant), many of them are overweight, they are not very health-conscious in their diet etc. According to the above described model, this kind of inconsistence is in many cases mainly due to the lack of capabilities (e.g. persistence to give up smoking) or motivations or opportunity: the given circumstances, facilities. A good example of the latter is – with regard to smoking - that almost everybody is a smoker in most families, newer and newer generations are born into this, and this is the generally accepted form of behaviour. It works, for example, against motivation that the respondent's mother and grandmother also used to smoke, also when they were pregnant, so they perceive the damaging effect of smoking less (or

they can see more benefits than drawbacks), they could also give birth to their babies etc.

3.3. The manifestations of health behaviour

In this chapter we present what the respondents do in possession of the available knowledge, skills, opportunities etc. What is the output as a result of the operation of the above-mentioned model, in what form is their health behaviour manifested and in what area it appears.

Health conscious behaviour can be measured in a relatively narrow circle compared to the principled levels and opportunities; the two levels are separated from each other very distinctly. Only 20% claim to do/to have done a lot for their health, and this kind of health awareness can be perceived less, or not at all in the case of other respondents. All in all, 44% of the interviewees think that in principle they could also do (a lot) for their health. However, 49% are very sceptical and closed in this regard, as if they were feeling that they hardly have any chance to significantly influence their health conditions (table 3.3.1.).

Table 3.3.1.: How much the respondents think they can do, and actually do for their health, %

	could do	actually do
very much	6,9	1,5
much	37,5	18,1
little	40,3	56,1
nothing	8,6	18,6
don’t know	6,8	5,6
total	100,0	100,0

The differences are very significant also if we compare these data to the nationwide figures. At a national level, 81% of adult women agreed that the key to preserving health is if we also do something about it in addition to the genetic and biological factors, i.e. health conscious lifestyle.[4] The low figures among Roma women (44%) are not because they are basically not aware of the importance of doing exercise, balanced diet, screenings etc., but mainly that they many times under-appreciate their own role in this process (either with or without a reason).

The willingness and the ability to do something strongly depends on the age and the settlement type: more people want and try to live in a more health conscious way in the younger age group, and the same goes for Roma women living in large towns (annex 6).

One of the possible causes for the separation of the principled and the practical levels is well shown by the fact that when asked in the questionnaire what they can do to improve their health condition, the respondents very often mentioned the lack of money spontaneously, although we expected doing beneficial exercises: that the respondents do not have enough money to buy healthier and better products and services and cannot afford food, medicine, vitamins etc.

If we look at the specific directions of action, the answers clearly highlight one factor being the target area of health behaviour, and this is nutrition. The Roma women living in the surveyed area try to lay large emphasis on this aspect. Within this, the following was mentioned: healthier diet, more frequent consumption of fruits and vegetables, taking vitamins (this probably also came up due to the large number of pregnant women and

[4] https://www.ksh.hu/docs/hun/xftp/stattukor/elef14.pdf

mothers with babies), being on a special diet etc. (Table 3.3.2.). In many cases, focusing on nutrition takes up the strength and the energy of housewives from other areas.

Table 3.3.2.: What respondents think they do for their health, % (N=those answering the question in the merits, „those who do a lot")

exercise, gymnastics, sports	28,2
eating in general: paying attention to meals, foods, nutrition, cooking and diet	22,4
eating fruits	22,1
vitamins	21,8
giving up smoking, I don't smoke	20,6
eating vegetables	17,6
general answer: taking care of, paying attention to myself etc.	17,1
taking medicines (regularly)	12,4
diet in general, actions against obesity	10,5
drinking, alcohol (drinks little, does not drink alcohol)	9,0
seeing the doctor, attending check-ups in general	6,4
attending screenings	5,6
other concrete actions related to nutrition	3,8
seeing the doctor if I feel ill or unwell	2,6
observing the doctor's instructions	2,1
walking	1,7
relaxation	1,7
less tension and stress	1,1
giving up drugs	0,4
less sweets	0,3
biking	0,2

Relatively few people mentioned screenings spontaneously. From this we would conclude that attending screening tests is not really a part of active health preservation, perhaps it many times means just ticking off an obligatory task.

Since smoking is very widespread within the Roma population, we would have been happier to hear practices about reducing/cutting the rate of smoking. The respondents seem to be more immune and more tolerant towards smoking, as against, e.g. nutrition.

We also touched upon this topic many times in the in-depth interviews, and the answers imply that Roma women do not consider the issue of smoking as healthy or not healthy. Although they know at a basic level that smoking is harmful to health, it carries so many meanings and messages to them that this dimension is only placed further down the list of priorities (many times they only cut the number of cigarettes when they are pregnant). Upon the in-depth interviews, the respondents mentioned many types of motivation and meaning content about smoking.

Smoking as a general form of behaviour

Many people smoke in the Roma communities, it has a tradition, and young people also start smoking very soon (smoke penetrates clothes, bed linen etc. in the flats).

Addiction

We can talk about express addiction to nicotine in the case of many Roma women, and serious withdrawal symptoms can be expected if they manage to give up smoking. In the course of the interviews there were also comments on whether some kind of addiction may evolve already in the embryo status, or later among babies as a result of passive smoking.)

Stimulant

It can be perceived in many cases that Roma mothers can relieve stress and tension only in this manner, and there are many similar situations. Some get totally worked up about everyday cases, but very serious

problems also emerge: lack of money, unemployment, dealing with many children, a lot of housework etc.

A way of escape for women

The time spent with smoking offers people a break from the monotony of daily work, cooking etc. at home (husbands very rarely take a share in these tasks) or at the workplace.

It will decrease hunger

Smoking can also have practical aspects. Smoking makes many people eat less, and they can go with an empty stomach for a long time during the day (by also drinking coffee with the cigarette). In this manner, other family members, e.g. children, can have more of the food available at home.

Status symbol

For many people, the opportunity of smoking means a message to the external world saying that they are above a certain level, and they can afford it.

By highlighting all these motivations (there are probably some more) we intended to give an idea of how many aspects a smoker needs to fulfill in order to make their way towards a more health conscious behaviour. Knowledge and abilities are not enough if they do not go together with appropriate motivation and the opportunities are not available, and in this case one cannot give up smoking.

4. Sources of health information (communication)

4.1. Communication channels

Many kinds of information can be collected from many places about health and healthy lifestyle. The survey tried to explore what Roma women do if they want to gather information about how they can live healthily or more healthily: where they turn to, and what tools they use. (On the one hand, we asked them to tell which is the most important communication channel for them, and, on the whole, which three are the most important.) By standardizing the information sources, we can perhaps pinpoint the communication sources through which the Roma population could be addressed most effectively in the topic of health.

The survey outlines basically two types of communication spaces that are used in a wide circle. One is the communication network running within the Roma community (family, friends, acquaintances), and the other one is the communication space basically operating under medical-professional control.

In the communication process, most respondents emphasise the role of doctors (GPs, specialists) or the nearby family members, friends, acquaintances (table 4.1.1.).

The top of the most important information sources is taken by doctors (mentioned by 42% first and by 65% in the list of the first three most important information sources). In our opinion, emphasizing the professional medium is also some kind of advanced confidence, because the in-depth interviews show that this professional communication channel many times works only formally. As can be seen later, many Roma women

go to see the doctor, e.g. GP, gynaecologist, although serious inequalities are coded in the healthcare system. However, contacts are many times made only for formal reasons, e.g. sick pay papers are filled in (which is quite frequent since the public work programme was introduced) or medicines are prescribed. They talk only rarely about the reasons for diseases, about the treatment to be followed or about forms of health-conscious behaviour. The weaknesses of patient information can especially be perceived at the level of specialists. We heard about several cases where the examination was completed, the findings were issued and the patients received no information about the test results. It often happens that they learn about the final result of the examination when they go back to the village and consult with the health visitor or the GP.

Although the Roma communities fully accept doctors, this is primarily based on emotional rather than on professional factors. When keeping contacts with doctors, Roma women are characterised by a high level of sensitivity. On top of that, they have to try to overcome very strong fear of certain medical treatments (e.g. dentist, gynaecologist). If the patients feel that they get adequate attention and care from the doctor, it can build some emotional ties, so the patients can basically accept everything from their doctor (advice and information). If, however, there are no such ties, Roma women may drop out of the healthcare system for a long time: they will not find and see another doctor.

However, this required emotional basis is many times built in vain due to the problems with the doctor-patient relationship, which is generally also true of healthcare in general: there are too many patients, there is little time for one patient – the information flow does not always work with proper efficiency (and the patients may not always understand the received information). In our opinion, this great emphasis on the medical com space

is mainly due to the acceptance of the importance of doctors and not due to the quantity and quality of the information actually received and collected. It would be very good if this professional-medical com form could work more effectively in the future.

The other, widely used com space actually works within the Roma communities. All in all, 28% of the respondents mentioned the family as the primary information source (and 8% mentioned friends and acquaintances). Looking at the first three main information sources, we can see that 67% mentioned the family. This is the highest figure in this regard. To say nothing of the fact that friends and acquaintances also take one of the first three places at a 42% rate. (It would be good to compare these results and see how many people would choose these com forms within a non-Roma community, but, unfortunately, no such data are available to us.)

Table 4.1.1.: Communication channels on health: A: most important / B: included in the first three places, %
(rounded figures)

age group	18-29 A/B	30-55 A/B	56+ A/B	total A/B
parent, family member	32 / 76	24 / 62	28 / 66	28 / 67
doctor (GP, specialist)	33 / 61	46 / 68	45 / 63	42 / 65
friend, acquaintance	7 / 40	8 / 41	9 / 43	8 / 41
health visitor	5 / 36	4 / 25	0 / 14	4 / 28
TV, radio	9 / 25	8 / 27	10 / 34	8 / 27
internet	11 / 21	5 / 13	0 / 1	6 / 14
newspaper, magazine	1 / 6	1 / 6	0 / 2	1 / 6
other	0 / 0	1 / 3	0 / 0	1 / 1

This internal com form often works on a generational basis. In multi-generation families the final decision is made by the oldest parent, the grandmother, mainly due to the experience gained over the years. (In fact, this is also the basis for the surviving Roma customs and beliefs related to baby and child care.) In this internal com space an important role is played by the Roma opinion leaders, whose opinion is also accepted by many. As the families come together often, the family members and the neighbours are many times in a big company so the information can spread very quickly among them. If an important and relevant piece of information enters this com space, it can run through the system very fast.

Workplaces can also appear as a community scene of information flow. Roma women work together at places where many of them are together (e.g. public work programmes), so they can discuss their problems and can exchange their experience.

This system is more or less closed, and the information flows within the system (many times also items of information that are not acceptable from e.g. a medical-professional viewpoint). Evidently, external information must somehow reach this more or less closed community. This closed, internal chain can be accessed best if one finds the opinion-leaders and grandmothers whose opinion is important, and they can be involved in the com process. In the course of the interviews, many positive examples were given about the efficient use of local com forms (e.g. Roma mentors, training and involving Roma health guards).

With a view to the research topic, it is worth checking separately what data we obtained about the health visitors, and what place they take in this communication system. The figures show that health visitors represent an important information source within the younger age group (18-29).

Although 5% mention them at first place, but as many as 36% at some of the first three places.

Based on the in-depth interviews we can say that the health visitor information received on the professional side is much more informative than the information received from doctors. This has many reasons: apart from the health visitor's personality, the com process is also affected positively by the fact that on this instance women talk to each other, for the most part they do not meet at the surgery but in the mothers' home, there is time to ask several questions etc. If we wish to very briefly characterise the professional health information channels, we can state the following:

- health visitors: there is a large number of encounters with the Roma women who need this service, and the information flow regarding health and diseases is more intensive and profound
- GPs: there are frequent encounters with Roma women, but the meetings are often formal, and the health-related information is often delivered in a too official manner
- specialists (mainly gynaecologists): the encounters with Roma women are rarer, the delivery of information flow regarding health and diseases is very restricted and deficient

It is worth mentioning that the internet as health information source is relatively popular among young people. Quite a lot of young respondents (11%) mentioned this com source at the first place, and it was mentioned by 21% on the whole. (The internet is also worth mentioning separately because it is evidently a decisive factor whether families have an internet connection at home at all. Our survey shows that 31% of the households have a home internet, so the above 21% score is especially impressive in the light of this. Within the internet usage, Facebook scores a dominant rate among young people.)

From among the traditional electronic and written press, electronic press has some role in "health" communication – mainly on TV and primarily among the elderly – while the written press does not carry too much significance. The members of the surveyed population rarely read newspapers.

4.2. Health visitors as information source

In the section related to health visitors, we are initially going to cover only the respondents where there is at least one, maximum 7-year-old child in the family. They can personally see the work of health visitors also currently. (This is a relatively wide respondent circle, 47% of the surveyed universe.)

Prior to checking the health visitors' responsibility to provide information, it is worth briefly mentioning the general tasks of health visitors. The survey shows that the basic expectation of the interviewed Roma women is that health visitors should not only deal with the health and care of embryos/children but they should do more, so they should also pay attention to the health condition of mothers and pregnant women (by giving advice on lifestyle, answering questions about medical examinations etc.). On the whole, this opinion was voiced by 77%, and only 17% said that health visitors should mainly focus on the children. Although the protection of women/mothers as a health visitor task is generally emphasized in all respondent groups, it can be observed that these needs are even stronger among those living in small settlements. In larger towns, somewhat fewer interviewed women said that the health visitors should also deal with their health (table 4.2.1.).

Table 4.2.1.: Opinions about the health visitor tasks in a breakdown by settlements, %
(N = households with child/ren aged 0-7)

settlement size	county seat town	20,000 - 150,000	3000-19,999	fewer than 3000	total
health visitors should mainly deal with the health of embryos/children and should provide related consulting	26,4	29,3	9,2	16,6	16,7
in addition to this, it is also an important task of health visitors to deal with the mothers' health condition	68,9	64,1	83,6	78,3	77,7
don't know, no reply	4,6	6,5	7,2	5,0	5,7
total	100,0	100,0	100,0	100,0	100,0

These expectations are in conformity with what health visitors also think about their profession. Health visitors also define their work as a complex, comprehensive set of tasks. Although the interviewees also highlighted opinions claiming that these tasks are sometimes a bit too complex (e.g. the health visitor society is divided about the planned introduction of the cervical screening task). However, the real problem is caused to the health visitors by the extreme amount of administration that comes from complexity, and it is often found to be superfluous. They feel that the administration burden has increased, and it takes the time and space from real work and family visits.

Some say that - as a result of the extended tasks – they can get to a phase where health visitors with special skills and training will be required and they will focus on specialized fields. For example, upon the introduction of

cervical screening by health visitors, there could be a specialist health visitor who is primarily responsible for the protection of women and mothers, even in several districts (cervical screening, contraception, other screenings etc.).

The continuously extending tasks also lead to proposals on employing health visitor assistants who would mainly deal with administrative and organizing tasks in order to cope with the extreme administration work.

As can be seen, health visitors carry out many types of tasks and their competence covers many fields beyond their basic assignment. This also includes the obligation of providing various types of information. The interviewed Roma women also find this information source very important. Whatever area we look at (social issues, screenings, healthy lifestyle, health protection programmes), about 80-90% of the respondents claim that information given by the health visitors is very important (table 4.2.2.).

However, the residents living in settlements of various sizes have very different opinion about the health visitors' obligation to provide information. Those living in small or medium sized settlements regard this information source as "very important", and those living in large towns regard this as a less important health visitor task (about 50-60%).

The data show that this also works in practice, at least on the level of information delivery. 70-80% of the respondents claimed to have received help and information from the health visitor in the surveyed areas. At this point, there are fewer differences between various settlement types. The concurrence of the data implies that the health visitors fulfill this obligation more or less to a similar proportion.

Table 4.2.2.: Information by the health visitors: A: How important is it that health visitors provide information to mothers? / B: Did the health visitor give information in addition to child care, %
(rounded off figures, N = households with child/ren aged 0-7)

settlement size	county seat town A/B	20,000-150000 A/B	3000-19,999 A/B	fewer than 3000 A/B	total A/B
family support options: social benefits / supports / aids e.g. child care allowance, maternity benefit	65/74	68/79	93/82	89/91	86/87
adult health screenings	50/79	48/79	89/80	88/80	82/79
women's health, how they could live more healthily	46/68	56/66	88/73	84/77	80/75
health protection and development programs (e.g. baby-mother club, child birth preparatory sessions etc.)	47/51	56/69	89/70	82/73	79/70

If we compare what expectations the respondents have about gathering information and how much of this is realized in practice, we can say that the two levels are synchronized with each other at small settlements, what's more, a little lack is perceived as the health visitors do not always fulfill the demands. A contrary trend is observed in large towns, where the health visitors actually over-achieve as they fulfil their obligations at a higher rate than required. This is especially true of calls for screening tests. The health visitors notify the population as prescribed, although this is not so much expected by the respondents.

Looking at the evaluation of the health visitors' tasks on a territorial basis, it can be clearly seen that a different health visitor role, help and information is expected at small settlements and in large towns (Miskolc, Ózd, Kazincbarcika). At small settlements it is much more expected that the

health visitors' task should cover basically everything. The interviewees mentioned a lot of personal cases and stories: if necessary, they help filling in the aid request forms, or they fill them in themselves, if mothers go for consulting, they drop in to measure their weight etc. In larger towns, mothers do not expect such "multi-functional" health visitors, they rather require the performance of the basic tasks.

This large difference between the expectations clearly shows that health visitors fill up a significant blank space at small settlements. Partly because these settlements are less covered by institutions (there are fewer offices, there are more deficiencies in the supply system, official personal contacts are rare or missing etc.) But it is also true that the information basis of the respondents living in small and more secluded settlements is poorer in most issues, and they require more help.

It is eye-catching that most respondents point out the importance of providing information about social and family support topics and, on the whole, information on health education and healthy lifestyle takes the second place, although health visitors should basically check the health status of kids and their mothers. This also means that the health visitors' health-professional work at small settlements could be largely promoted with more institutional help and support in these fields by competent authorities and co-organisations (social workers, municipality employees, family supporters etc.).

It is important to note that that these information data are only quantitative indicators, only showing in what cases the information is delivered. It is another question how open the recipient side is to accept this information, whether they understand the received information and whether they are able to integrate it into their everyday life.

The health visitors have doubts and negative experiences in this regard. The health visitors often feel that they have difficulty with breaking through the "walls" that exist due to the different cultural customs and socialisation processes. They need a lot of patience, empathy and acceptance to make sure that this information really hits home and makes an influence. Based on the interviews with the health visitors, the following aspects should be considered if they intend to pass on the information effectively:

Differentiated communication

Confident appearance and com is needed upon the personal meetings, but at the same time it must be kept in mind that the recipient side may react sensitively to what has been said. There are situations where strict, "official-style" com is more beneficial, but basically one has to try to set up a confidence-based partnership.

Usage of terms

Upon the com it is definitely expedient to use simple terms and explanations that work in the simple Roma environment, and it must be ensured that the information goes through and is understood.

Tolerance, readiness to accept

One definitely has to tolerate and accept e.g. the baby care or child rearing customs that come from the Roma culture, provided that those do not have any harmful effects on health.

Showing personal examples

Com should not only work on a theoretical level, and it is important that concrete and personal examples should also be mentioned: how others do this, what happened to X.Y. in this regard, etc. Showing personal examples has a very important orienting role in the Roma communities. Both positive (e.g. X.Y. had nice teeth made while she was pregnant) and negative examples (cow milk caused bad rashes on the baby) can have very strong impacts.

Involving the opinion leaders of families

Passing on information and persuasion can be helped a lot if the advice given by the opinion leader of the family, e.g. grandmother, is in harmony with that of the health visitor. The participation of opinion leaders can help in the information flow and in verification. (At the same time it can happen that involving opinion leaders may lead to conflicts because e.g. in the given case the grandmother's opinion does not conform with the advice given by the health visitor.)

Using aids

When passing on information, the health visitors should use several auxiliary materials that they can also leave with the families. It also seems important that these aids should (also) have pictorial elements. The information many times works and gets imprinted better visually than in a textual form, in writing.

4.3. Health development and health protection programmes

It can be seen clearly that – despite the good intention and the efforts – information by the health visitors is not enough in itself to change the health awareness and health behaviour of people with low education and living in deep poverty as in many cases the fundamental items (abilities, information) are missing.

A lot more than that is required, which can be provided through various health development and health protection programs where the health visitors themselves are also involved directly (baby-mother clubs, baby massage sessions, health clubs, mother milk days, health visitor sessions at school) as it is a part of their jobs. However, they also participate in several other programs either as consultants or only as organizers (e.g. health days, blood donor days etc.).

The target group of these events is obviously made up by adult women with children, who have already left the educational system. Still, it is worth briefly mentioning training at school as the (school) health visitors are also present at schools. It would be very important to launch these health development and health protection programs already at school, in some preliminary form. Here, perhaps some more is needed than the thematic sessions held by health visitors, which are often too formal despite the health visitors' efforts. Since some of the girls finally leave the educational system in 1-2 years after finishing primary school, intensive sessions could be organized in the 7th and 8th grades of the primary school on basic topics like pregnancy, child care, household management, money matters etc. There are good examples of this, e.g. health visitors organize extracurricular sessions or training courses. This line could be further strengthened in some form. These practical skills should be better

integrated into primary school education (household, cooking, baby care etc.) in a manner that the children do not only cover these important topics just for an hour. Several professionals should be involved in these sessions, of course, also including the health visitors. It would be important to work out a training curriculum with lesson plans and educational aids that could be permanently used within the framework of school education.

These training schemes are also important for the elderly (perhaps a "Women's School" or an "Adults' School" could be launched). As has been mentioned, numerous health development and health protection programs and initiatives are already in progress in the region. The organizers try to run the programs from various grants or foundation support, but some are sponsored by large business associations. The picture is also colourful on the organizer and implementation side: there are various NGOs, foundations, the Hungarian Charity Service of the Order of Malta, the Red Cross etc., and of course the health visitors are also there.

The experience is very diverse about the operation of these programs: there are some very successful programs, some are less successful, some are attended by a lot of local (Roma) people, and some are not attended despite the mothers' promises. Below we try to sum up on the basis of the interviews what could be the guarantee for success of such types of programs.

Instructions for organising programs

Personalisation of organization and persuasion

It is not enough to place posters of a program or event at a settlement, it will not reach the Roma population: they might not even see it, or if they

do, they will not read these messages. a successful program definitely needs personal contacts and convincing (introducing details of the program, why is it important to attend, what are/will be the palpable results and consequences of participating).

Involving Roma mediators, opinion leaders and mentors

It seems indispensable that the organizing work and the persuasion process should come from above. The persons who are accepted in the Roma communities and whose opinion is decisive must be found and involved in the organizing process. It is much more motivating if they do the recruiting for these programs, especially if they also attend the program.

Organising and participation in groups

It can also be important upon organizing that several people are simultaneously tried to be persuaded to attend (e.g. in the family or in the neighbourhood). People are more willing to attend events if they do not come alone but with friends and relatives.

Providing enough time for preparation

It is not only true of health protection programs but also all other programs that enough time should be provided for planning and preparation, e.g. the participants should not be recruited one day before the event.

Selecting a venue as close as possible

The location is also of key importance as people can easily miss the events drop out of programs if it is difficult to get there, a lot of travel is involved

etc., even if they eventually show interest. If, for example, an event is organized in the centre of the settlement, smaller is the chance that people will attend it from the Roma settlement that is 2 km away from the centre. It would be definitely good to find a place for the Roma communities near their home (e.g. by renewing, transforming an empty house) that can solve the problem of distance and the local people can regard it as their own.

Taking care of children

It is also said frequently that Roma mothers cannot attend programs due to the lack of time. They have no one to take care of the children left at home. This also needs some solution. When organizing health days, this can be easily solved as the larger organiser team can help by setting up play houses, kit watch spots and animators, so mothers can also take their children. Upon minor events this would also be important (e.g. in cooperation with the *Biztos Kezdet Ház* (Sure Start House), which could provide for temporary stay and supervision for the children).

Support by the employer

If the mothers work (e.g. in the public work program) and the even is organized during work time, the employer's help would be very useful (e.g. by providing a day off).

Financial motivation

An organized program cannot be successful if it does not offer any financial compensation or gift. The participants must feel that their attendance is appreciated by the organizers in some form (this has to be rather symbolic,

it is not the value that counts, it would be enough to give away some food or cleaning material etc.)

Informality, interactivity

The sessions should not be organized in form of an official, boring presentation (this will not guarantee continuous participation). The sessions should be based on experience and interactivity, the participants should be involved as well as encouraged to speak and act (e.g. healthy lifestyle can be introduced by cooking together with the pps, or a cooking contest can be organized – we have heard of many good examples of this – instead of introducing healthy nutrition in a direct form).

Talking about personal experience

It would be very important to have presenters also coming from the Roma community or people who are well known locally. Accepting the contents of the lectures and putting them into practice can be helped better if the pps hear about concrete, personal examples and cases (e.g. if it comes to a cervical screening lecture, a locally known Roma woman should be invited – of course, only if she is willing to do it – who already had that disease, so her personal experience can be heard first hand). A form of passing on personal experience can be if elderly Roma women tell about their own personal experience in the given topic, how it happened in the past, what should be preserved or discarded from the earlier practice etc.

Regularity

It is essential that the lectures and sessions of the programs are organised regularly, as far as it is feasible financially. They should not be organized

on an ad hoc basis, but there should be standard dates (if it is a monthly program, it should be organized e.g. on the first Friday of every month, if it is annual, it should be organized every year etc.).

Long term

Once a program is running, it should be a long-term, monitored program for several years, also supported with impact studies. No matter how successful a current pr is, it will not produce the required result if it is only for a short term. This is, of course, also a question of money. As these prs currently run on the basis of applications for grants and the deadline of the grants is usually not too long, a bigger role of the state in long-term financing would be definitely important.

The homogenous composition of the pps:

Many say that it is worth forming "clean" groups among the pr pps, and this partition line does not always have to be drawn between Roma and non-Roma people. Due to the differences within the Roma society, maybe "beás" Romas do not want to be together with non-"beás" Romas, or Romas who consider themselves as wealthy with Romas who are poorer, etc. However, some opinions claim that accepting each other is only possible if these people are together, e.g. they cook together so that they can learn about each other and they can accept each other.

5. Health condition

The state of health of the Hungarian population is much worse than what could be expected by the experience in countries at a similar development level. The survey used several indicators to evaluate the health condition of Roma women.

The first indicator in the chapter is the presumed health, based on the individuals' self-evaluation, i.e. what they think about their own health status. It is not closely related to the actual, medically verified diagnosis, the related opinion is not influenced by the individuals' social, economic or cultural position (e.g. educational level, job, income, residence etc.), at the same time, it has been proved to be a realistic indicator of the health condition, therefore, it is an accepted and regularly applied tool in the international practice for surveying public health.

Furthermore, the existing health problem or disease is an absolute indicator of the health status, and tells whether these problems restrict the individual in any way in their everyday activities.

On the other hand, learning about mental health is indispensable for surveying the individuals' health status because these days mental health has become just as important as physical health.

The body mass parameters give further information as eventual underweight or overweight or obesity can cause numerous diseases, so it is very important to know what BMI index category the surveyed population can be classified into.

5.1. Presumed health

The survey results show that slightly more than half (55%) of the Roma women in Borsod-Abaúj-Zemplén county think that their health is good or very good. Based on the figures of the European Health Interview Survey in 2014[5], 58% of women find their health to be good or very good, so in this regard no significant difference can be measured between the total population and the residents of the surveyed county, and this slight difference perhaps suggests that the Roma origin does not significantly influence the value of the subjective health perception and general mood indicator.

Comparing the age groups we can see that this rate is much higher among young people, i.e. 83% of them think they are healthy or very healthy, and this rate is only 11% in the oldest age group, which means that age largely influences the value of this indicator.

However, no territorial differences can be registered, so the type of residence all in all does not affect the presumed health (table 5.1.1.).

Table 5.1.1.: Rate of respondents finding their health good or very good, according to age and settlement, %

age settlement	18-29	30-55	56+	Total
county seat town	66,0	45,0	26,0	50,3
20,000-150,000	83,0	41,0	14,0	50,3
3000-19,999	76,0	50,0	12,0	53,2
fewer than 3000	89,0	44,0	8,0	50,3
total	83,0	45,4	11,1	54,8

[5] Statisztikai Tükör – 30 April 2015 – EHIS flash report - Central Statistical Office

5.2. Restrictions

25% of the Roma women living in the surveyed county have some lasting disease or a health problem. The settlement types do not show any significant differences in chronic diseases, the highest frequency was measured in small villages at 27%. However, the age group survey shows that the rate of those suffering from some disease or health problem increases together with the higher age, This rate is 6% in the youngest age group and 73% in the oldest age group (table 5.2.1.).

Table 5.2.1.: Rate of those having some chronic disease or health problem that lasts for 6 months and will probably last for 6 months, according to age group and settlement type, %

age settlement	18-29	30-55	56+	Total
county seat town	6,0	25,0	50,0	21,0
20,000-150,000	9,8	36,1	66,7	22,4
3000-19,999	5,0	24,0	70,0	20,2
fewer than 3000	6,0	27,3	79,2	27,2
total	6,0	26,9	73,1	24,8

However, the admitted health problem or disease does not always restrict the individuals, 23% of the Roma women living in the county claimed to be restricted or seriously restricted by their disease or health problem. The rate of restriction also increases with age: 6% was measured in the youngest age group and 65% in the oldest age group. There is no significant deviation according to settlement types either, the highest rate was once again measured in small villages (25%) (table 5.2.2.).

Table 5.2.2.: Rate of those restricted or seriously restricted by their chronic disease or health problem, according to age group and settlement type, %

age / settlement	18-29	30-55	56+	Total
county seat town	5,0	21,0	58,0	19,3
20,000-150,000	6,0	30,0	52,0	20,9
3000-19,999	8,0	23,0	70,0	18,0
fewer than 3000	6,0	24,0	66,0	24,5
total	6,4	23,9	65,1	22,5

5.3. Mental health

Only a low percentage of the Hungarian society has anxiety or mood disturbances at such a serious level that it can be regarded as clinical disease. However, research shows that the consequences of a depressive status at a sub-clinical level can also be dangerous in several aspects.

Even slight depressive symptoms may adversely affect everyday life management and life quality, they can forecast clinical depression and cardiovascular diseases and they increase the risk of self-damaging behaviour.

Upon the mental health survey, when asked whether they had felt sad, depressed and hopeless over the past 2 weeks, 25% of the Roma women living in the county claimed to have that feeling at least in half of the past period.

Such feelings increase parallel with the advance of age: this rate is 45% in the oldest group and 10% in the youngest age group. As for settlements, the highest rate of sadness and depression was measured among village

residents, as 27% claimed to be sad and depressed at least in half of the past 2 weeks (table 5.3.1.).

15% of those who felt sad or depressed went to see a psychologist or psychiatrist over the past one year, therefore, they found their mental problems so deep that they felt necessary to turn to a doctor.

The in-depth interviews also revealed that the mental problems are serious. The respondents have difficulty in coping with the problems related to finances, their environment etc. The problems overgrow them and sometimes they cannot find any efficient solution. It is difficult to process the problems mentally, and they often expect help from other people. Although no accurate statistics are available, the respondents take prescribed medicines quite intensively in order to improve their mental conditions (Frontin, Rivotril etc.), and taking these medicines sometimes exceeds the level of healthy medication and reaches the level of drug use.

Table 5.3.1.: Rate of those who felt sad, depressed or hopeless in more than half of the past 2 weeks or every day, according to age group and settlement type, %

age settlement	18-29	30-55	56+	Total
county seat town	9,0	29,0	44,0	23,6
20,000-150,000	10,0	26,0	48,0	21,6
3000-19,999	9,0	27,0	50,0	15,5
fewer than 3000	10,0	32,0	42,0	27,1
total	9,6	30,0	44,7	24,4

5.4. Overweight/obesity

Obesity is one of the biggest public health problems of the 21st century. Since 1980, its frequency increased threefold in the European region of the

WHO, and the number of people concerned keeps growing sharply[6]. 14% of the health loss of the Hungarian adult population is due to overweight and obesity (HUF 656 bn). Overweight and obesity play a role mainly in the diseases of the circulation system, but they also affect – to a more or less similar proportion – diabetes, tumour and locomotor disorders[7].

As overweight and obesity also represent a risk factor for several diseases, the knowledge of this indicator can help to highlight the health status of Roma women in more details.

53% of the Roma women living in Borsod-Abaúj-Zemplén county are overweight or obese, and 4% are underweight. The differences according to age groups show that the rate of overweight and obese people increases with age, while most underweight people were registered in the youngest age group (annex 7).

Compared to the EHIS 2014 results, which say that 55% of adult women are overweight or obese, the 53% score among Roma women does not show any major difference compared to the nationwide data[3].

One of the main reasons for obesity is unhealthy diet and insufficient physical activity. Looking at the rate of overweight and obese people from this aspect, we can see that Roma women do not show any significant difference in eating habits and physical activities on the basis of the BMI categories. However, it can be regarded as a limit on the survey that a question was posed only about the regularity of eating but not about the quality and the quantity of the doses, therefore further survey is required

[6] WHO/Europe. http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/obesity; Accessed: 2017.03.17.
[7] National Institute for Health Development Health Report 2015

in order to establish the actual reasons for overweight and obesity (table 5.4.1.).

Table 5.4.1.: The rate of those belonging to various BMI categories who are characterized by the following aspects, %

	underweight	normal	overweight / obese
eating vegetables and fruits every day	38,1	45,2	43,3
consuming sugary drinks every day	33,0	44,0	41,0
eating meat every day	55,5	38,0	39,2
doing exercises at least 3 times a week	13,0	13,3	13,8

6. Risky health behaviour

High death-rate diseases like tumour or problems with the circulation system are due to the individual health behaviour, like smoking, alcohol, inadequate nutrition or insufficient physical activity. In 2015, the large majority (almost 80%) of health loss in Hungary that can be explained with risk factors is related to behaviour[2].

6.1. Smoking

Smoking is a worldwide death cause that could be prevented in the easiest manner, still about 6 million people die of smoking worldwide every year, and it causes an economic damage of over USD 500 billion.[8,9] 50% of smokers die early, on average 14 years earlier than non-smokers.

Smoking is a serious public health and national economic problem in Hungary. In 2015, 22,496 people died of smoking, and we lost more than 500,00 years of life spent in health.

The smoking-related death rate is close to the European trend, i.e. the number of deaths is decreasing among men and does not change significantly among women. Several estimates have been made about the smoking-related economic burdens: accordingly, the smoking-related domestic loss was between HUF 450 and 1000 billion in 2010.

60% of the Roma women in the surveyed county are currently smokers, 7% stopped smoking and 33% never smoked (table 6.1.1.). The rate of

[8]Source: http://www.who.int/mediacentre/factsheets/fs339/en/

[9] WHO Report on the Global Tobacco Epidemic; 2013; WHO; Source: http://apps.who.int/iris/bitstream/10665/85380/1/9789241505871_eng.pdf?ua=1 (available: 2017.01.27.)

current smokers does not show too much difference according to age groups and settlement types, except for the county seat town, where 49% are smokers in the youngest age group, 69% in the oldest age group, and current smokers score 68% (annex 8).

Our figures show a significant difference from the EHIS2014 results. At a national level, less than one-fourth of women smoke currently[3], and the rate of regular smokers is 60% among Roma women.

Table 6.1.1.: Rate of current smokers, according to age groups and settlement types %

age settlement	18-29	30-55	56+	Total
county seat town	49,0	69,0	68,0	61,9
20,000-150,000	59,2	59,0	48,0	58,9
3000-19,999	56,6	64,6	48,0	62,3
fewer than 3000	65,0	58,0	58,0	63,8
total	60,9	60,9	55,6	60,3

Many people believe also currently that the effects of passive smoking are not so harmful as the consequences of active smoking, however, continuous passive smoking is almost as dangerous as active smoking. The exposure not only to active but also to passive smoking is rather high among Roma women, as 73% of them live in the same household together with someone who is a smoker currently (table 6.1.2.).

Table 6.1.2.: Rate of those who have smokers in their household, according to age groups and settlement types %

age settlement	18-29	30-55	56+	Total
county seat town	68,7	68,4	68,2	68,5
20,000-150,000	73,7	62,8	65,8	64,0
3000-19,999	70,0	77,3	76,3	74,2
fewer than 3000	78,1	70,1	80,0	76,1
total	74,8	71,2	76,5	73,0

When jointly surveying the rate of Roma women living in a smoky environment because they smoke or because they live with someone who regularly smokes, we can see that 79% of Roma women are exposed to the harms of smoking.

Those Roma women who smoke or used to smoke started smoking at the age of 17 on average. Looking at the age groups: the younger someone is, the earlier they try smoking. The average age when smoking is started does not differ too much according to settlement types (table 6.1.3.).

Table 6.1.3.: Average age of those who smoke or used to smoke, according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	15,6	17,3	16,8	16,8
20,000-150,000	15,8	16,8	17,3	16,5
3000-19,999	15,6	17,4	17,7	17,1
fewer than 3000	16,1	16,8	17,2	16,7
total	15,9	17,0	17,3	16,7

It is common knowledge that smoking during pregnancy is harmful and can cause – among other things – a low birth weight[10]. 60% of the Roma women (who smoke and are at a fertile age) living in the surveyed county used to smoke at a certain frequency during their pregnancy. The survey of age groups shows that this rate rises with the increase of age, scoring 56% among young people and 68% in the oldest age group. This difference is due to the fact that more and more knowledge and information is collected over the years about the harmful effects of smoking during pregnancy, therefore, a smaller rate of young mothers smoked during their pregnancy, although this attitude still covers more than half of them (table 6.1.4.).

Table 6.1.4.: Rate of those who smoked during their pregnancy, according to age groups and settlement types %
(N=those who smoke/used to smoke and had child/ren)

age settlement	18-29	30-55	56+	Total
county seat town	74,3	41,6	56,1	49,9
20,000-150,000	60,4	66,2	58,6	60,1
3000-19,999	62,0	70,2	73,1	60,6
fewer than 3000	50,9	58,7	69,7	60,1
total	55,9	60,2	67,9	59,8

27% of those who smoked during their pregnancy had a premature baby, and 22% had a child with a small birth weight (although not premature). This ratio is 11 and 10% among non-smokers. This leads us to conclude that smoking during pregnancy can have an effect on the birth weight and on eventual premature birth.

[10]CDC- Tobacco Use and Pregnancy
https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy

Due to the high rate of smoking, it is further on important to extend knowledge about risky behaviours, with special regard to the harmful effects of smoking and, within this, smoking during pregnancy. It would be also important to point out the harmful effects caused by passive smoking so that such health-damaging effects can be reduced.

However, passing on knowledge is not enough, but motivation and a suitable environment are also indispensable for a real behaviour change.

6.2. Alcohol consumption

These days, alcohol is one of the most harmful factors of physical and mental health mainly in the developed countries, but also in some developing countries. It plays an important part in most of the early deaths and deaths that could be prevented.

Based on the survey results, more than two-thirds of the Roma women living in the county did not drink any alcohol at all over the past one year. Daily alcohol consumption cannot be measured in statistical terms (annex 9).

The in-depth interviews go to show that the respondents did not find this problem too serious among women, either. (Some Roma cultures (men) do not expect (also) women to drink.) Extreme alcohol consumption is mainly a health-damaging behaviour among men.

The results of the EHIS 2014 survey highlighted similar problems, as men scored a ten times higher rate among drinkers than women, so too much alcohol consumption mainly affects men and not women.

The opinions about alcohol consumption are a bit different from the respondents' own point of view as 8% of the Roma women living in the county said that they consume alcohol more often or more than necessary. The rate of alcohol consumption often or more than necessary according to the respondents' own point of view increases with age: 4% in the youngest age group and 25% in the oldest age group, therefore, this type of behaviour is mainly typical of the older respondents, and primarily at small settlements. As for breakdown by settlements, especially high consumption can be registered in settlements with 3000 – 20,000 residents, as 28% of them claim to consume more alcohol, or more often than necessary (table 6.2.1.).

Table 6.2.1.: Rate of those who think they consume more alcohol, or more often than necessary, according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	0	3,3	8,7	2,7
20,000-150,000	11,5	15,4	0	5,1
3000-19,999	5,7	13,2	33,3	28,2
fewer than 3000	3,2	6,9	30,0	9,0
total	4,4	8,7	25,3	8,4

6.3. Drug consumption

Drug consumption and its consequences in Hungary can be summed up as follows: over the past 10 years, 20-30 overdosage-related deaths took place every year. In 2014, 23 drug-related overdosage deaths and 42 indirectly related death cases were reported. In about half of the cases, the joint usage of some opiate and other drugs led to poisoning. The other half of the cases were related to some stimulant, amphetamine, methamphetamine or designer stimulant.

The research conducted in 2015 on adult drug usage[11] shows that every tenth person in the 18-64 population (9.9%) and almost every fifth person in the 18-34 young adult population (17.7%) have used some illegal drug in their life. Most adults tried marijuana or hashish (7.4%), and the life prevalence value of ecstasy is about half this figure (4%), still high compared to other drugs. The two most popular drugs are followed by synthetic cannabinoids (1.9%), amphetamine (1.7%) and designer stimulants (1.3%).

Drug usage is insignificant among the Roma women living in the county: those who used cannabis, cocaine, amphetamines, extasy or other drugs over the past 1 year do not even score 1% in any age group or settlement type. However, most surveys show – similarly to this research - that the questions on drug usage based on self-assessment do not reflect reality, but its measuring needs a special survey.

The in-depth interviews show that drug consumption must be much higher in the region, and the respondents mentioned many types of drugs used (from inhaling organic solvents (*szipuzás)* to designer drugs, from home-made drugs to extreme amount of medicine combined with alcohol). It is true though that this drug usage is mainly typical of the teenager age group that is not affected by the empirical survey, and affects young adults only secondarily. Drugs are not only consumed by boys/men but also by girls/women.

[11] Paksi B., Magi A., Felvinczi K., Demetrovics Zs. (2015): Drug consumption by the adult Hungarian population – the initial results of „National Data Collection from the Population on Addictological Problems" in 2015 (OLAAP 2015). The 10th National Congress of the Hungarian Addictological Society, 26-28 November 2015, Siófok, Supplementum volume.

7. Lifestyle

Our health, diseases and recuperation largely depend on what lifestyle we follow. There are some health-damaging forms of behaviour like smoking, too much alcohol and drugs (already covered by this survey) but there are also some habits that help maintain or improve health, e.g. regular physical activity or healthy diet.

Public health interventions that promote healthy lifestyle could prevent one-fourth of all deaths and more than half of early deaths in Hungary. The detailed analysis of the health risks shows that 80% of the Hungarian health loss is due to behavioural risks.

Besides the high risk factors like dietary risks, smoking, alcohol and drugs, individual health behaviour plays an important role in high systolic blood pressure, BMI, total cholesterol and blood sugar level on empty stomach, and within this the quality of nutrition in most of the listed risks.

7.1. Workout

Regular exercise is an important element of health behaviour, it plays a dominant part in the prevention and the intervention of numerous chronic diseases. It improves physical and mental health, psycho-social well-being, the ability to cope with stress[12], as well as has a preventive and therapeutic influence on numerous diseases and statuses.
Reducing physical inactivity provably enhances the public health conditions, which increases productivity and reduces the health-related social expenditures. Physical activity helps to achieve the major objectives set

[12]Gémes K. (2008): Sports as a chance. In.:Kopp M. (ed.) The Hungarian state of mind 2008, Semmelweis Publisher, Budapest, pp. 529-537.

forth in the Europe 2020 strategy, namely in the field of growth, productivity and health.[13]

Therefore, the benefits of regular physical activity are well-known regardless of age and gender, however, the survey results show that only 14% of the Roma women living in the county do any physical activity at least 3 times a week in their free time. Regular physical activity is mainly characteristic of young people, though this rate is only 15%, and the oldest age group scores only 9%.

The EHIS 2014 reported that 9% of women do physical activity according to the WHO recommendation, but the questions of the surveys on ph are different, therefore no comparison can be made, however, the rate of physical activity measured in the two surveys show that the rate of those doing regular physical activity must be increased without delay (table 7.1.1.).

Table no. 7.1.1.: Rate of those who do physical activity at least 3 times a week in their free time, according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	12,0	9,0	4,0	9,5
20,000-150,000	2,0	7,0	4,0	6,9
3000-19,999	9,0	8,0	4,0	5,2
fewer than 3000	20,0	18,0	12,0	18,9
total	14,9	13,7	8,6	13,5

These relatively unfavourable data are somewhat improved by the fact that many people do some workout at home, in their household or at their

[13]COUNCIL RECOMMENDATION on promoting health-enhancing physical activity across sector (2013/C 354/01), 26 November 2013.

workplace, even if not in their free time. Upon the in-depth interviews many Roma women mentioned this (e.g. those doing public work do a lot of physical activity, but working at home with 3, 4, 5 kids is also a serious task for mothers). It can also be regarded as physical activity that many people walk or bike large distances because either there is no mass transport within the settlement or they cannot afford to buy tickets.

7.2. Nutrition

Healthy eating is important at all ages, from birth until old age, for optimal growth, for physical and mental health and capacity and for staying healthy as long as possible, and the lack of health carries numerous risks[14].

It is especially important to inform the population with recommendations on foods and food groups, about the guidelines of healthy nutrition, furthermore to propagate modern, easy-to-understand, food-based recommendations as well as to provide a healthy range of foods and to make them constantly available.[15,16]

This information is perhaps even more important than the average with regard to the surveyed Roma population. On the one hand, because the respondents are relatively susceptible to these issues. As could be seen earlier, the signs of health-conscious behaviour were mainly spotted in this area. On the other hand, because the proposals that are to be elaborated should also focus on the basic facilities that are typical of the surveyed Roma households.

[14] WHO: Global Health Observatory Data, NCD Morbidity and Mortality, http://www.who.int/gho/ncd/mortality_morbidity/en/
[15] https://health.gov/dietaryguidelines/2015/guidelines/
[16] http://mdosz.hu/uj-taplalkozasi-ajanlasok-okos-tanyer/

Based on the in-depth interviews, we have to start out from the fact that a large portion must be made upon the everyday cooking in Roma families (families are big, with several generations, no separate meal is cooked for everyone) and there is often just one main meal. It is worth considering foods that can be prepared relatively quickly and simply, and the restricted financial opportunities of households should also be kept in mind. No wonder that pasta-based foods are popular when it comes to hot meals (a large portion can be made, it is quick and relatively cheap). Roma households traditionally like greasy and spicy foods. Major changes would probably not be welcome – especially by the elderly age group – so perhaps attempt should be made to reform the traditional foods.

Eating fruits and vegetables

Fruits and vegetables play an important nutritional and physiological role in the proper body functioning. They are low in energy, fats and carbohydrates and rich in vitamins, minerals and antioxidants, thus they reduce the risk of numerous diseases. Furthermore, they positively influence the body's fat and carbohydrate metabolism and regulate the fluid balance of the body. Daily consumed vegetables and/or fruits are one of the most frequently used indicators of healthy diet.

The research shows that 44% of the Roma women living in Borsod-Abaúj-Zemplén county eat fruits and/or vegetables on a daily basis. This rate decreases with the increase of age, scoring 50% among young people and 34% in the oldest age group. According to settlement types, we can see that the rate of those eating fruits and/or vegetables on a daily basis increases parallel with the decrease in the number of population. (table 7.2.1.)

This can be due to the fact that more fruits and vegetables are grown at small settlements, therefore, these foods form a bigger part of the everyday diet. The EHIS 2014 results show that the national rate of women is 72%, thus the difference can be considered as significant.

Table 7.2.1.: Rate of those who eat fruits and/or vegetables every day, according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	30,0	27,0	22,0	27,5
20,000-150,000	45,0	44,0	48,0	37,1
3000-19,999	44,0	43,0	22,0	45,3
fewer than 3000	57,0	44,0	38,0	50,5
total	50,2	42,0	33,5	43,9

Consuming sugary soft drinks

Soft drinks with high sugar content can be harmful to health and can lead to diabetes in the long run, therefore their consumption is not recommended on a daily basis[17]. However, the research shows that 42% of the Roma women living in the county consume sugary soft drinks on a daily basis. The young age group has the highest score, as more than half of them consume soft drinks with high sugar content, and the oldest age group scores the lowest 16%. As for settlement types, such soft drinks are consumed the most often – at least once a day - by villagers (table 7.2.2.).

[17]Dietary Guidelines 2015-2020 https://health.gov/dietaryguidelines/2015/guidelines

Table 7.2.2.: Rate of those consuming sugary soft drinks every day, according to age groups and settlement types %

age settlement	18-29	30-55	56+	Total
county seat town	39,0	37,0	10,0	34,8
20,000-150,000	43,0	31,0	8,0	33,7
3000-19,999	43,0	37,0	10,0	21,5
fewer than 3000	59,0	45,0	18,0	49,7
total	51,7	41,0	14,5	41,7

Meat consumption

Meat and similar products contain nutrients, vitamins B, valuable heme iron and zinc that are important for the human body, therefore, their consumption is a part of balanced, mixed diet, although only at a moderate extent.

39% of the Roma women living in the county eat meat every day. The rate of daily meat consumption decreases with the increase of age: 47% was measured in the youngest age group and 40% in the oldest age group. The differences according to settlement types show that daily meat consumption is most typical of villagers (45%). The reason is probably that animals are still kept at small settlements (table 7.2.3.).

Table 7.2.3.: Rate of those consuming meat every day, according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	37,0	35,0	30,0	35,1
20,000-150,000	46,0	41,5	34,0	34,2
3000-19,999	34,0	58,0	12,2	34,3
fewer than 3000	54,0	36,0	40,0	45,5
total	46,7	45,5	31,8	40,3

All in all, the lifestyle results show that it is important to significantly change the approach in this respect – as was also the case with smoking – namely that the traditional, domestic health development programs and health communication methods are not sufficient in themselves any longer. We need approaches which consider that health behaviour is also influenced by health-related attitudes and beliefs, practical skills and values in addition to information and knowledge.

7.3. Slimming diet

As against various beliefs, slimming diet is not a lifestyle change but a drastic modification to our dietary habits, which, unfortunately, cannot be maintained in the long run, or only with a lot of difficulties. However, learning the frequency of sliming diets helps to survey the nutrition-related attitudes.

11% of the Roma women living in the surveyed county tried a slimming diet at some frequency over the past 12 months. The rate of those on a slimming diet does not differ significantly according to age groups and settlement types (annex 10).

Looking at the slimming diet habits according to BMI categories we can survey what people think about their own body weight and, if necessary, whether they tried to make a change. From this viewpoint we registered that - from among the Roma women living in the county - 13% of overweight women and 18% of obese women tried a slimming diet at some frequency over the past 12 months. However, 6% of those with normal weight and 3% of those who are underweight also followed some slimming diet plan (table 7.3.1.).

Table 7.3.1.: The rate of those who were on a slimming diet over the past 12 months, breakdown by BMI, %

BMI categories	were on a slimming diet over the past 12 months
underweight	2,6
normal	6,4
overweight	12,6
obese	18,1
total	10,8

8. Healthcare services

It is important to learn the usage of healthcare services, within this meeting health workers and attending health screening tests, in order to research the health-related attitude of the surveyed population. Furthermore, the failure of eventual services for various reasons can serve as a good indicator for defining the quality of healthcare services.

8.1. Visiting the doctor

As can be seen later, a relatively large number of the respondents see the doctor at a certain frequency throughout the year, however, it is important to see when the patients enter the health system, and in what stage of the disease. Namely because the majority only use the health services if they have some complaints, and in most cases this does not necessarily mean that the patients see their doctor already in the initial phase of their illness. Waiting and postponing the visit is quite typical of Roma women: they only go to see the doctor when it is a must and they feel that they have no other choice.

4% of the respondents seem to be clearly foresightful when they need health treatment. (Whenever possible, they see the doctor as soon as possible to seek advice on their complaint, and sometimes they also get a medical check when they feel healthy.) 7% of he respondents enter the health system a bit later, but they see the doctor also if they feel slightly unwell, which does not disturb the performance of daily tasks. Those who need constant medical treatment and control (11%) also have a close relationship with the healthcare system, although in their case we have no accurate information on the date of entry. This permanent medical control can mainly be observed among the elderly.

Therefore, the overwhelming majority only see the doctor, if at all, only at a later stage of their disease. 30% generally turns to the doctor only if they feel so unwell that they cannot do their daily tasks, while 47% only if their problem is very big. (11% do not take any actions even if the problem is serious, and they seem to totally reject the use of any health service.)

In summary it can be stated that the respondents generally see the doctor if they feel sick, but the role of GPs keeps increasing also in the field of health preservation, therefore, it would be important to see the doctor not only when we perceive a symptom but the GP should be a partner through regular visits in order to preserve health. About half of the Roma women in the surveyed county typically go to see the doctor only if there is a big trouble, and only 4% see the GP also when they are healthy. (Annex 11)

8.2. Using health services

Visiting other health experts apart from the GP also reveals a lot about the attitude of Roma women in the surveyed county to health services and to their own health. The question posed in the survey tried to cover most health experts, like in-patient care, GPs, gynaecologists, dentists, other specialists, dietitians, physiotherapists, psychologists etc.

The survey shows – based on the figures of the past 12 months - that most respondents went to see their GP from among the above-listed health experts (73% - table 8.2.1.). The second place is taken by gynaecologists at 36%, so about one third of Roma women attend some gynaecological examination or screening at an annual frequency. Dentists come at the third place with a 25% visitor rate. These two specialists are relatively dominant because, on the whole, only 20% of the respondents went to see other

specialist doctors over the past one year. 15% were in-patients at hospitals over the past one year.

Table 8.2.1.: The rate of those who went to see a health expert over the past 12 months, %

GP (due to own health condition)	72,6
gynaecologist	36,1
dentist	24,7
other specialist (e.g. dermatologist, ophthalmologist)	19,9
hospital care (other than child birth)	15,2
psychologist, psychiatrist	5,3
physiotherapist	2,4
dietitian	0,9
homeopath	0,3

According to age groups, seeing the GP takes the first place in all the three age groups, but parallel with the increase of age more and more people visited the GP over the past 12 months: 66% of the youngest group and 93% of the oldest group saw the doctor over the past one year.

All in all, the second place is for the gynaecologist. According to age groups, its ranking is different: it is still second with the youngest group (43%) but only number-four with the oldest group (23%). This is most probably due to the fact that young people visit the gynaecologist more often due to child birth, and their knowledge about gynaecological screenings must also be higher than that of the older generations.

The dentist, taking the third place in the total ranking, becomes less visited parallel with the increase of age, and the rate of in-patient hospital treatment due to chronic diseases as well as visits to specialists significantly increase with the higher age (annex 12).

The results of the survey show that the health of Roma women in Borsod-Abaúj-Zemplén county requires the improvement of their relationship with healthcare services. Although the GP visitor rate is expressly high, 96% of the oldest generation saw their GP over the past 12 month, the rate of visiting other specialists is rather low.

The usage of gynaecological services should be increased because several public health screenings can also be connected to this service branch, and it would be important to ensure that these visits are not only induced by child birth but women also attend cervical screening every two years, and the elderly age group's confidence in gynaecologists could also enhance the frequency of attending mammography tests (these issues will be covered in details in the closing chapter).

However, visiting health experts is only one aspect of learning about the usage of health services as the meeting itself may not lead to an actual examination, it may only be a formal visit or the prescription of a medicine. For this reason the survey also tried to deal with specific examinations in order to shed more light on Roma women's participation in health services. The question about specific examinations covered blood pressure measuring and blood tests because these two general examinations can be a good indicator of such health visits.

Over the past one year, health workers measured the blood pressure of half the Roma women living in Borsod-Abaúj-Zemplén county, in 30% of the cases earlier than one year but still within 3 years, for 7% earlier than 3 years but within 5 years, and for another 7% earlier than 5 years. Only 1% claimed to have no such health examination in their life. Looking at age we can see that the rate of those who had a blood pressure test rises together with the increase of age, the youngest age group scored 48% and the oldest

age group scored 74% over the past 1 year (the test was done by a health worker). When surveying whether the residence has any impact on the attendance rate of health examinations we found that there is no major difference between settlement categories with regard to participation in such tests (annex 13).

The comparison with the national results shows that the 55% attendance rate of Roma women in blood pressure tests over the past one year is below the summarised nationwide figure (72%)[18].

Over the past one year, 35% of the Roma women living in the county had a blood test or some examination e.g. for blood sugar measuring, which is by 20% lower than the rate of those who had a blood pressure test over the past one year. This difference is also due to the fact that blood pressure test or a simple blood sugar test can also be done at a GP surgery, while a more complex blood sample test is only done within the framework of specialist health service and – as has already been mentioned – the rate of specialist visits is only a fraction of GP visits. In 31% of the cases earlier than one year but still within 3 years, for 11% earlier than 3 years but within 5 years, and for another 10% earlier than 5 years. 13% never had a blood test before, therefore they probably never got involved in healthcare services.

As for eventual differences according to age groups, it has been revealed that blood tests within one year were much more frequent in the oldest age group (55%) than in the youngest age group (scoring only 32%). According to settlement types, the highest rate of blood tests were taken at the county seat town and in villages over the past one year: 43 and 39% (annex 14).

[18] here no measuring data are available in a breakdown by gender, https://www.ksh.hu/docs/hun/xftp/stattukor/elef14.pdf

It is worth once again comparing the Roma women's blood test figures (35%) with the nationwide data. According to the EHIS 2014 survey, about 60% of adult women claimed to have attended such an examination over the past one year.[19]

8.3. Medication habits

As for medicines and medicinal products, prescription medicines are meant to treat current chronic diseases that were diagnosed by the doctor or to cure an infectious disease, while non-prescription medicinal products and vitamins are mainly a part of today's health-conscious lifestyle.

It is also important to survey them as certain aspects of healthcare and health awareness. Since the two types serve different objectives, the questionnaire that we used surveys the situation with two separate questions. (It is important to note that healthy and balanced diet is not replaced by any vitamin or dietary supplement, therefore the frequency of various vitamin supplements should be increased if healthy and balanced diet is ensured.)

The rate of those taking pre medicines increases with age, which is most probably related to the development of chronic diseases that come with ageing. 79% of the oldest age group and 16% of the youngest age group took pre medicines over the past 2 weeks. However, the settlement types show no difference in the rate of those taking pre medicines, therefore, the residential area does not influence the usage of medicines prescribed by the doctor. All in all it can be said on the basis of the survey that 36% of the

[19] Source: https://www.ksh.hu/docs/hun/xftp/stattukor/elef14.pdf

Roma women living in the surveyed county take some pre medicine (table 8.3.1.).

Table 8.3.1.: Rate of those who took prescribed medicine over the past two weeks according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	18,0	38,0	66,0	33,9
20,000-150,000	11,0	43,0	70,0	35,5
3000-19,999	13,0	43,0	80,0	36,8
fewer than 3000	17,0	39,0	82,0	36,5
total	15,6	40,2	79,1	36,0

Non-pre medicines like vitamins are taken only by 20% of the Roma women, which is half the rate of pre medicines. (This is probably due to the fact that these medicines always have to be paid for, and are not subsidized by the state.) On the other hand, the usage of these products is also motivated by a more health conscious approach.) As for age groups, the case is similar to pre medicines, i.e. the rate of taking such products rises with the increase of age: 15% was measured in the youngest age group and 25% in the oldest age group.

According to settlements, those living in the county seat town scored the highest rate (26%) in taking such products over the past 2 weeks (table 8.3.2.).

Table 8.3.2.: Rate of those who took non-prescription medicine, medicinal product or vitamins over the past two weeks according to age groups and settlement types, %

age settlement	18-29	30-55	56+	total
county seat town	26,0	26,5	26,5	26,3
20,000-150,000	21,0	34,0	28,0	14,5
3000-19,999	14,0	14,0	24,5	22,0
fewer than 3000	12,0	23,0	24,5	21,1
total	14,6	21,9	24,9	19,7

8.4. Unequal access to health services

The unequal distribution of access to health services within the society is one of the manifestation forms of health-related inequalities. According to an analysis made in 2015, the failure to use the necessary healthcare service was influenced in a statistically significant manner by the Roma ethnicity, the educational level and the equivalent household[20]. Furthermore, in 2014, 14% of the total death rate of the Hungarian population could have been avoided with suitable and timely healthcare services[21]. The low level of healthcare services can be due to several factors, e.g. the long waiting time for certain examinations.

It happened to about 20% of the Roma women living in the surveyed county that they received the required healthcare service late, or not at all, because the waiting time was too long. This took place at a higher rate in the oldest age group (30%) than among the youngest people (15%), but this is also due to the fact that the older age group needs health services more often.

[20] Performance Assessment Report of the Hungarian Health System, 2013-2015
[21] National Institute for Health Development, Health Report 2016

The frequency of failed services due to the long waiting time is not increased by the settlement type, as the failure of healthcare services failed for this reason stayed the similar in the surveyed categories (table 8.4.1.).

Table 8.4.1.: Rate of those who did not receive the required healthcare service, or received it late, due to the long waiting time, according to age groups and settlement types, %

	18-29	30-55	56+	Total
county seat town	13,0	21,0	24,0	18,5
20,000-150,000	12,2	26,0	23,4	19,5
3000-19,999	21,0	24,0	24,0	20,8
fewer than 3000	12,1	18,0	34,0	19,4
total	14,5	20,4	29,8	19,4

Another reason for not receiving the necessary healthcare services can be bad or cumbersome transport, which happened to 17% of the Roma women living in Borsod-Abaúj-Zemplén county. The differences registered according to age groups are similar to the rates explored for heath services failed due to long waiting: the highest 24% was measured with the oldest age group and only 13% with the youngest age group.

The expected ratios were registered with regard to settlement types: failed health services due to bad transport occurred the least at the county seat town and this problem mostly took place at small settlements that are more difficult to access (table 8.4.2.).

Table 8.4.2.: Rate of those who did not receive the required healthcare service, or received it late, due to difficult transport facilities, according to age groups and settlement types, %

age settlement	18-29	30-55	56+	Total
county seat town	7,0	4,0	10,0	5,6
20,000-150,000	6,1	18,0	22,9	17,1
3000-19,999	17,0	21,2	22,5	21,5
fewer than 3000	13,1	18,2	26,0	17,7
total	12,9	17,5	23,5	16,5

Health services can also be absent for financial reasons: the patient has no money for using the health service and to pay the extra costs of the health service (e.g. travel, gratuity etc.).

Health services fail for financial reasons for the most part because the family cannot afford to get the prescription medicine (indicated by 34% of the Roma women living in the county). The second reason is the failure of medical service for financial reasons, scoring 19%. This rate is 16% for dental care and 8% for mental health care.

The number of health services failed due to financial reasons grows together with the increase of age, regardless of the form of the surveyed health service. 32% of medical services failed for financial reasons in the oldest age group, and 18% in the youngest age group. In the case of dental care problems these rates were 26% and 11%, in the case of medicine purchase issues 48% and 25%, while in the case of mental health related problems 17% and 4%.

As for settlement types, the rate of services failed for financial reasons differs according to various service types. Medical and dental care fails mainly at settlements with 3000-20,000 residents, medicine purchase

problems are typical of urban residents, and the failure of mental healthcare is mainly registered with villagers (annex 15).

The survey goes to show that it should be a key task – also in the future – to reduce the number of failed health services by guaranteeing the external conditions and circumstances as much as possible (improving transport facilities, solving financial problems, increasing confidence in health services etc.).

9. Public health screenings

It is the task of the Office of the Chief Medical Officer to control public health screenings at a national level. From among female screenings, this covers mammography and cervical screening. These are "organized screenings", therefore personal invitations are mailed, and the "screened" persons are followed up. The persons to be invited are centrally registered, and it is also recorded who attended the screening and who did not.

9.1. Mammography

The survey shows that 25% of adult Roma women living in Borsod-Abaúj-Zemplén county have attended a mammography test some time in the past (8% during the past 12 months, 5% more than a year ago but within 2 years and another 5% within 3 years). This means that three out of four Roma women have never attended a mammography test in the region.

Organised, invitation-based mammography screening works in the 45-65 age group. They receive an invitation, and attendance is not obligatory though but recommended. The question is if these invitations always get to the addressees because, e.g. address-based registration is not always simple in the case of those who live in slums, sometimes there are no streets/house numbers, only zip codes or topographical lot numbers. Many women live in rented flats e.g. in Miskolc, Avas, and they are not registered at their new residence.

The figures are somewhat more favourable in the 45-65 target group, still, only 43% of them have ever attended a mammography test. (The nationwide reference value in this regard is 89%, i.e. women aged 45-65 who have attended a mammography test). As the test is organized every

two years for women aged 45-65, it is also worth checking how many of them attended the test within two years (as prescribed). The figures show that 26% of Roma women aged 45-65 attended such a test over the past 2 years, although in principle all of them got an invitation. If we draw a bit wider time limit (3 years), the rate of those tested in due course is 33%. (The nationwide reference value in this regard is 78%, i.e. women aged 45-65 who have attended a mammography test during the 3 years prior to the EHIS survey.)[22]

As mammography test can only be done in Miskolc as far as we know, we expected that the test rate will be very different in territorial terms and forecast the highest reach in Miskolc. This presumption was not 100% true. The figures show that those who attend the test as prescribed is the lowest in Miskolc in the 45-65 target group. Attendance as prescribed means that the invited person goes to take the test within the officially prescribed 2-year cycle. While this rate is only 12% in Miskolc, a 2.5 times higher rate was registered in the other three settlement types (26-29% - table 9.1.1.).

[22]source: https://www.ksh.hu/docs/hun/xftp/stattukor/elef14.pdf

Table 9.1.1.: Participation in mammography test according to the date of last mammography X-ray, in a breakdown by settlement type, % (N = the respondent is aged 45-65)

settlement size	county seat town	20,000-150,000	3000-19,999	fewer than 3000	total
over the past 12 months	5,3	11,4	10,3	21,5	16,7
more than 1 years ago but within 2 years	6,8	17,2	15,6	5,7	8,8
more than 2 years ago but within 3 years	8,7	2,9	8,4	6,5	6,8
more than 3 years ago	51,2	20,8	9,8	3,1	10,7
never	28,1	47,7	56,0	63,1	56,9

At the same time, the expected territorial rates are received if we look at how many women in the endangered age group have ever attended at least one mammography test. Most of the local residents of Miskolc attended a mammography test (72%). 52% of the target age group in Ózd and Kazincbarcika have ever attended a mammography test, while this rate is 44% among the Roma residents of settlements with 3000-20,000 people, and 37% of those living in even smaller settlements.

What do these figures mean? On the one hand that the territorial disproportions work strongly in the usage of services. At the same time, there is a chance to somewhat moderate these disproportions. The interviewees often mentioned that the municipalities support access to mammography tests at many places. This means that a group is taken to the venue by bus, the municipality pays the expenses and the health visitors organize the travel for women who have an invitation. This is done regularly if permitted by the financial resources (every year, every half year). In this manner there are women who are able to regularly attend the tests. In principle, free travel and test would be available at many places for much

more people compared to the number of women who actually use it. (The possible reasons for absence will be covered later.)

The attendance of tests is also supported by the initiatives where not the patients are taken to the test venue but the test venue is taken to the patients: mobile cancer screening stations are set up and run at the targeted settlements for a day.

There is no such centrally organised bus service for the residents of Miskolc as they live on the spot. The residents are less motivated in the lack of organization centrally or by the health visitors, and - despite the info by the health visitors – women do not attend the tests regularly, at the prescribed dates. Much more time passes between two mammography tests than 2 or 3 years.

Many in the target age group fail to regularly attend the test in spite of knowing that women at their age should attend mammography tests at least every 2-3 years (62%), what's more, many of them think that it should be done every year. Many of them cannot tell exactly how frequently this examination is recommended (27%), but they are certain that they should not go more rarely than 3 years (every 4, 5 etc. years) (11%).

9.2. Cervical screening[23]

70% of adult Roma women have attended cervical screening some time in the past, so much more than those taking a mammography test (26%

[23] When we generally write about cervical screening in the chapter, it can cover both screenings organised by the Office of the Chief Medical Officer as well as („non-organised") cervical screenings carried out by gynaecologists, within the framework of specialist examinations.

during the past 12 months, 13% more than a year ago but within 2 years and 8% within 3 years). This means that one out of three Roma women claimed to have never attended such a cervical screening in the region. (The nationwide data show that 84% of adult women have ever attended cervical screening.)[24]

As against breast cancer, cervical cancer endangers women at a much wider age scale: the 25-65 age group is involved in organized screening. A slightly higher screening figure is registered if we focus expressly on this target age group (75%).

As cervical screening is organized every 3 years for women aged 25-65, it is also worth checking how many of them attended the test within 3 years before the interview. The figures show that 48% of Roma women aged 25-65 attended such a test over the past 3 years.

The territorial breakdown of the data shows that the type and size of settlement once again determines the chance of access to screening as 82% have ever attended cervical screening in Miskolc and 92% in Ózd/Kazincbarcika. As against this, 74% was registered at the smallest settlements and 68% in medium-sized settlements (annex 16). Mainly similarities are dominant in the rate of those regularly attending cervical screening. In three of the surveyed four settlement categories, almost every second Roma woman attended cervical screening over the past 3 years (44-48%). As against these, the data taken in Ózd/Kazincbarcika can be regarded as exceedingly high (61%).

[24] https://www.ksh.hu/docs/hun/xftp/stattukor/elef14.pdf

Compared to mammography tests, fewer central, campaign-like organization attempts can be perceived with regard to cervical screening, which can make it easier for women to attend the test. (For example, we heard nothing about bus services at all.) The probable reason is that there are much more screening facilities in this area, and no big distances have to be covered. (It can be regarded as a central, campaign-like action when the municipalities/health visitors try to invite gynaecologists to small settlements. This used to be a frequent practice but not now due to financial reasons.)

Probably the invitation lists are not so long either as many women sometimes meet their gynaecologist, e.g. when they have a baby, so from time to time they undergo a screening (thus they are not included in the invitation list for organized screening).

The more detailed breakdown of the data by age shows that the breaking line with regard to regular attendance comes at around 45 years as the attendance rate is basically identical in all age groups until that time. About 50-60% of women aged 25-44 claimed to have attended screening over the past 3 years and about 20-30% claimed to have attended screening earlier than that. However, the attendance rate over the past 3 years was only 40-45% in the 45-55 age group and 24% of the 56-65 age group (table 9.2.1.).

Table 9.2.1.: Attendance of cervical screening according to the date of the last cytology test, according to age groups, %
(N = 25-65 age group)

age group	25-29	30-34	35-39	40-44	45-49	50-55	56-65	total
over the past 12 months	29,5	31,3	32,1	28,2	18,4	20,9	15,6	25,6
more than 1 years ago but within 2 years	16,7	17,8	9,6	12,0	16,9	10,4	2,9	12,5
more than 2 years ago but within 3 years	6,9	14,5	10,4	12,5	8,9	7,4	5,9	9,5
more than 3 years ago	11,8	12,6	31,9	26,9	25,5	37,9	49,8	27,3
never	35,1	23,7	16,0	20,4	30,4	23,4	25,7	25,1

As against mammography, cervical screening can be done at many places, basically anywhere where a gynaecologist is accessible. Although no exact data are available about how many women attend tests in the form of organized screening, the interviews show that this is not so much the reason for the definitely higher screening rate compared to mammography. Women at a fertile age are automatically entered into the healthcare system when they become pregnant, and they undergo the most important screenings parallel with the gynaecological tests, and its duration basically depends on how many children they have: the more children they have, the longer is this type of gynaecological screening control.

Thus, attending screenings does not necessarily depend exclusively on the individual's own decision or resolution. This also plays a role as women see the doctor immediately if they perceive some gynaecological problem, although they often do this only when they feel a bad pain, so they do not visit the doctor for prevention. (Women can perceive gynaelogical problems much more easily than e.g. breast problems, where the initial symptoms

are invisible and less painful.) It must be mentioned that "unorganized" screenings are more popular also because – contrary to organized screenings – pregnant women are more willing to go to tests, but not for themselves but for their yet-to-be-born baby. (This secondary own-health importance can also be observed when the babies are already born, the mothers primarily mind their children's health and illness and care less about their own health and illness.)

After the fertile period, Roma women tend to lose contact with the gynaecologists, they do not go to control checks, and sometimes they even miss out 10-15 years. This is why the rate of cervical screening sharply falls after the age of 45. It is hard to reach all age groups with organized screening, it is even more difficult to reach the middle-aged and older groups, and especially the 55-65 age group. This age group feels that they are nearing the end, so screenings have no big importance, and if they turned out to be sick, they would probably not get any treatment or operation. According to "Roma calculations", this age group is already regarded as very old. (Upon the interviews it was often said that a middle-aged or old Roma woman looks 10-15 years older than their true age.) Therefore, in principle, this is the most important target group for organized screening, so they should be mainly reached and convinced.

Organised screening regulates participation by sending invitation to cervical screening every three years. It is interesting that most women in the 25-65 age group think that that women should have cervical screening every year at their age (59%). 79% got to the 3-year cycle, and 10% believed that screenings should be done more rarely. 11% could not decide how often this screening is recommended.

9.3. Cervical screening by health visitors

The current cervical screening venues and facilities will be extended by gradually making the screening a part of the health visitor competence. The tasks of the health visitors to protect women – consulting on family planning, helping to prepare for maternity, organising targeted screenings for the population – will be added with cervical screening for public health purposes. This element is already a part of high-level health visitor training, and all practicing health visitors will have to attend this theoretical and practical training. The amendment to the ministerial decree no. 49/2014. (V.21.) ESzCsM on district health visitors that entered into effect from 1 October 2015 says that this is obligatory for all health visitors until 31 October 2018.

The acceptance of cervical screening by health visitors took a central place in our questionnaire-based research, and evidently this question was also asked in the qualitative interviews.

The health visitors interviewed upon the qualitative phase were reached in very different professional stages. Someone only finished theoretical training and was about to start practical training. Someone completed practical training and was already working in practice. Some are planning with this job in the long run, and some others believe that they would leave their career if this is made obligatory. Of course, a few interviews do not lead to exact conclusions on what health visitors think about its overall introduction (whether they find it necessary and would do it etc.). However, the experience gained upon the interviews shows the set of arguments worded on both sides.

If we try to collect the arguments and counter-arguments mentioned in the health visitor interviews, the following typical opinions can be highlighted:

Arguments, argument groups for cervical screening by health visitors	Arguments, argument groups against cervical screening by health visitors
the health visitors and the mothers in the district know each other well, and worked out strong confidence	this cannot substitute a more complex, multi-element gynaelogical examination
a higher screening rate can be expected as several people would see the health visitors who would not see the gynaecologist	this may generate tension and conflict between health visitors and gynaecologists (at large settlements)
there is more openness towards a female examiner (women will be less ashamed to take off their clothes)	the issue of responsibility, positive findings will be very difficult to communicate
an examination by the health visitor means less time input: it is closer, there is no waiting time	if the findings are not negative but a serious problem is revealed later that the health visitor's examination could not indicate, it will be difficult to communicate (it will result in confidence deficit) and the health visitor will be challenged for it
the health visitor is available locally and she is easier to contact (primarily at small settlements)	such service seems superfluous to introduce in a large town where there are several gynaecologists
the call-in system could work more effectively (the health visitors profoundly check the screening list, upon the personal meetings they could better motivate the women concerned)	the professional level of training is not always appropriate, the number of smears prescribed upon the training may not be enough
	gynaecologists know better about it, this is their professional area
	adult women refrain from such intimate tests (physical contact, hygiene issues etc.)

	cervical screening as an extra task is yet another burden on health visitors, who are busy anyway
	the financing of cervical screening by health visitors is not really solved
	the obligatory feature should be eased, it should rather be an option (if it is obligatory, a lot of health visitors may leave their career and it may also affect the efficiency of screenings)

Reading the positive arguments, the situation is relatively clear. Increasing the efficiency of screening and the number of screened women may depend basically on two factors. On the one hand that the health visitors and the (Roma) women living in their district have a very strong relationship: they know each other well, they built confidence. On the other hand, the health visitors are available on the spot: they are easy to contact, women would not have to travel, wait in the surgery etc.

Negative arguments, once worded, are much more diverse. This does not necessarily mean that there are more negative opinions, only that the approaches are much specific in this regard. Some of the negative opinions envisage that a group of health visitors would not like to do cervical screening, they refrain from it, they feel it is not their professional line, they are scared of unsuccessful tests, and that positive findings may erode the already built confidence. This may even make them leave their job after 2018. Another group of negative opinions imply that some health visitors would not reject this task if certain conditions were fulfilled (e.g. if the level of training were raised, if the financing issues were solved, if the already existing workload were eased etc.).

All in all, the opinions go to show that the health visitors do not take a uniform standpoint about this question, so it is definitely worth working out a consensus-based solution.

However, let us see the other side as well, namely that what the potential (Roma) subjects of screenings (by health visitors) think about this issue.

The data show that they still know little about the option of cervical screening by health visitors. This is not so surprising in itself as the health visitors will probably mention this in their district only if they already have the opportunity to carry out such a screening: an employment contract is available and a consulting room is equipped. On the whole, 24% of the Roma women claimed to have heard that health visitors can also do such a screening. This rate was a stable one fourth in almost each respondent group. Only the older respondents were less informed about this issue, but they are positioned "further away" from the health visitors (annex 17).

The respondents basically support this opportunity and find it useful to introduce cervical screening by health visitors. 71% of the interviewees claimed that it is very useful or quite useful. The territorial breakdown of the data shows that those living in small settlements support this option more than the average, while the residents of large towns find it less favourable than the average (annex 17).

It is also envisaged by the introduction of cervical screening by health visitors that the women concerned can get to the examination spot more easily, they do not have to travel, wait etc. This intention is based on realistic phenomena as two-thirds of those who have already attended such a screening said that they had to travel because the test could only be done at another settlement. And this does not even cover those who do not

attend screenings exactly because they do not want/cannot travel, as well as those who live in the same settlement but waiting would take a lot of time from them.

Currently, the residence of the respondents clearly determines who can have this test done locally.

94% of those living in settlements with fewer than 3000 residents cannot do it, and they had to travel to the last cervical screening. (Those who did not have to travel were maybe lucky and managed to visit a local or a "traveller" gynaecologist, or the test was already done by a health visitor. But it is also possible that the respondent had a different residence upon the last screening.)

In large towns (Miskolc, Ózd, Kazincbarcika), travel was necessary only in 5% of the cases, so the local screening is (was) clearly feasible. (Those who had to travel perhaps had a different residence upon the screening, or they had a complication and had to travel to e.g. Budapest for this reason. But it is also possible that the respondent travelled from a place that is in the agglomeration of the town and she interpreted it as another settlement despite the same public administrative unit, e.g. Miskolc-Lyukóvölgy.)

The picture is more divided at settlements with 3000-20,000 residents. Here, the participants in the screening had to travel to another settlement in every second case. The respondents in this settlement category answer this question according to whether a gynaecologist is available at the given settlement or not. If not, they have to travel.

The patients must spend some time on the screening, either due to the travel or the waiting time. The data suggest that travelling increases the

time spent on the screening with 2 hours on average, but this may even be 3 hours for those starting from the smallest settlements. While the "travellers" need an average of 4.5 hours for the test, those who attend "local screening" "only" need 2.5 hours (table 9.3.1.).

Table 9.3.1.: Time spent with travelling to, waiting for cervical screening, in a breakdown by settlement type, average hours
(N = those who have attended cervical screening, based on the last screening)

settlement type	county seat town	20,000 - 150,000	3000-19,999	fewer than 3000	total
screening was done locally	2,63	2,95	2,19	1,36	2,44
she had to travel to another settlement	1,63	4,41	3,68	4,54	4,36
total	2,59	3,06	2,92	4,33	3,66

Basically, the option of cervical screening by health visitors cannot really emerge in the screening statistics. Based on the last screening, 97% of cervical screenings are done by gynaecologists and 3% by health visitors in the county. Screenings by health visitors cannot be measured yet (0%) in large towns (Miskolc, Ózd, Kazincbarcika) statistically. And this figure is also insignificant (1%) at small settlements, which are considered as important from the viewpoint of screening by health visitors. Results are measured in the merits at settlements with 3000-20,000 residents (10%), which is probably due to the fact that these settlements have health visitors who find this issue very important and their screening activities are reflected in this relatively high figure (annex 17).

The respondents are very divided over who to select: a health visitor or a gynaecologist if cervical screening by health visitors were introduced everywhere.

As was seen earlier, the new system is also accepted by health visitors in various ways, and health visitors can see both the positive and negative impacts of the new system. However, the picture is also very diverse on the side of the patients.

Our survey shows that – in the case of an option - 44% of the interviewed Roma women would (continue to) turn to the gynaecologist and a similar 42% would see the health visitor. The smaller the settlement, the more likely it is that the respondent would go to a health visitor, but the differences are not so significant: 35-36% would opt for health visitors in large towns and 40-45% at small and medium sized settlements. (So it can be said that those living at small settlements – where there is no gynaecologist care – would like to change at a much higher rate.)

The preferences are also strongly influenced by age. The older age group – to be handled as a key target group from the viewpoint of organized screening – would clearly choose screening by a gynaecologist in large towns and medium-sized settlements, where the specialist can be reached easily. (Another reason for this is probably that they do not have so close contacts with the health visitors due to their age, and presumably there is a gynaecologist surgery that they visit frequently.) This relationship is not registered only at settlements with fewer than 3000 residents, where older women would choose the two experts in a more or less identical number (annex 18). The rate of health visitors is probably influenced at small settlements by the fact that more generations tend to live here together, so the elderly must know the health visitors better.

Screening by health visitors is supported at the highest rate by the members of the 18-29 age group, who have the most intense contact with the health visitors through their children. It is a paradox, however, that they are less likely to be really assigned to a health visitor within the framework of organized screening. Namely because health visitors can only screen women who are in the invitation list, but most members of the 18-29 age group will not be featured in these lists because those who had a baby are more or less under screening control. They may from time time undergo such screenings at the gynaecologist because of the child births.

The preferences are largely determined by who and how often goes to cervical screening: those who go frequently will probably do screening with the gynaecologist also in the future. The target group of cervical screening by health visitors can be primarily those who do not attend such screening. (This is one of the evident targets of introducing the service.) Our data show that this group can lay a real demand on screening by health visitors as they prefer health visitors to gynaecologists (table 9.3.2.). At the same time, this group has the largest uncertainty as well: they do not really know what to do, they do not really care, maybe they would not even go for a screening. Therefore, it will not be easy for the health visitors to reach and convince this group.

Table 9.3.2.: Preferences about who should do the cervical screening, according to who attended the last cervical screening and when, % (N = 26-65 age group)

who would you choose? when was it?	gynaecologist	health visitor	makes no difference	would not go	don't know
over the past 12 months	63,2	32,0	3,8	0,0	1,0
more than 1 years ago but within 2 years	45,3	45,7	0,5	0,0	8,5
more than 2 years ago but within 3 years	44,4	53,5	0,8	0,0	1,3
more than 3 years ago	43,0	48,2	0,9	1,9	6,1
never	27,8	40,3	3,8	2,9	25,1

If we look at the reasons why the respondents would choose the gynaecologist or the health visitor, the answers show a very different motivation picture.

Choosing a gynaecologist is clearly based on professional reasons: they are found to be better and more reliable professionally, this is their special field etc. In this regard, therefore, cervical screening is strongly defined as a special professional task, which even needs medical education as well. Of course, there are also further aspects: habits, former relationships etc., but basically everything is dominated by the professional element (table 9.3.3.).

Table 9.3.3.: If the respondents had an option, why do they find cervical screening by a gynaecologist a better solution? %
(N = those who prefer the gynaecologist and they can also justify this)

They know more professionally, this is their special area	42,7
I trust their work	41,0
Because they are doctors, this is their job	5,3
Generally out of habit	4,0
She has had a gynaecologist for years, and she would also see the doctor for other reasons	4,0
Personal acquaintance, I know him better	3,7
This is not the health visitor's job	3,1
He is generally good, better	2,8
He deals with a wider range of tasks	2,1
The doctor has more licences, he can send me to another doctor, can prescribe medicine, can see the results	2,0
Safe	1,5
Generally he pays more attention, he is more conscientious	0,5
He is close, he is here, not far away	0,5
He is quicker, will get the job done sooner	0,2
Because he is a man	0,2
This is generally more practical, simpler, more comfortable, more pleasant (it is not revealed why)	0,1
Other	1,2

The picture about the health visitors is different. Here, mainly practical reasons are mentioned, the time and space barriers are pulled down. The test can be done more easily as the health visitors are close, easier to reach, one does not have to travel and spend money on travel. Thus the test is quicker and no long waiting time is needed. There are other aspects as well, e.g. personal acquaintance, mothers are more willing to undress in front of a woman, but the answers basically reflect time-related and practical approaches (table 9.3.4.).

Table 9.3.4.: If the respondents had an option, why do they find cervical screening by a health visitor a better solution? %
(N = those who prefer the health visitor and they can also justify this)

No travel is needed	41,3
She is close, she is here, not far away	35,6
personal acquaintance, I know her better	15,7
She is quicker, will get the job done sooner	12,7
There are fewer people there, there is no waiting time	7,8
It's free, cheaper, no ticket is needed	7,7
I trust their work	7,1
Because the respondent is ashamed, bashful	7,1
Because she is a woman	6,2
She is nice, friendly	5,5
This is generally more practical, simpler, more comfortable, more pleasant (it is not revealed why)	3,9
She is generally good, better	1,9
They know more professionally, this is their special area	0,7
Generally she pays more attention, she is more conscientious	0,7
Safe	0,1
Other	1,9

Professional aspects with positive contents are not really mentioned about health visitors (although negative contents are not mentioned either). This kind of professionalism is attached by the respondents almost exclusively to doctors. In our opinion, the professionalism and the expertise of health visitors should be strengthened to make cervical screening by health visitors better accepted by Roma women, e.g. it should be pointed out what education and training they received about the screening, what examination tools they have etc.). Or the screening itself should be somewhat de-mystified and lowered from the medical level. It should not be introduced as a complicated professional issue but rather as a routine job, which does not actually need the presence of a doctor.

9.4. Factors preventing participation in public health screenings

We hope that the full introduction of screening by health visitors will increase the number of screenings of women, especially women who live under disadvantaged circumstances. It is for certain that the institutionalized screening by health visitors can significantly reduce the grave territorial disproportions in screening. (It could be seen that those living in settlements with fewer than 3000 residents have to travel to another settlement in almost all cases.)

It is true not only of cervical screening but also mammography tests and generally any kind of medical examinations that everybody should have the opportunity of access to the required examinations. Therefore, any initiative is welcome that reduces this territorial disproportion. This line covers cervical screening by health visitors and buses for mobile mammography tests, whereby the tools of mammography tests can be easier taken also to small and secluded settlements. As for gynaecological tests, a solution to the problem of territorial restrictions can also be mobility, e.g. health visitors visit the given settlement on a weekly basis. (If a test is too far territorially and is not accessible locally, it should be brought as close to the target group as possible.)

However, starting out from what was said in the in-depth interviews, these solutions only give a principled chance and framework. Unfortunately, this may not be filled with proper contents, i.e. it is not for certain that the persons concerned will actually attend these local examinations. The respondents reported many cases where the local residents could not be really mobilized. At the same time, many cases were also mentioned where mobilization was successful.

Bringing examinations to the spot solves numerous restrictions and problems (travel, time, finance etc.). In this chapter we try to outline what other restrictive factors can be explored in the background.

In the questionnaire-based survey the respondents were given 8 restrictive factors that we think can be relevant, and we asked them to tell whether those restrictive factors are relevant to them. (These must be realistic factors because 82% of the respondents selected at least one of them.)

The empirical research shows that there are four factor groups that can significantly hold back the respondents from attending the test, and these are basically irrespective of whether the given test is accessible locally or not. Therefore, the fact in itself that the territorial disproportions more less cease to exist does not necessarily mean that the level of screening will also increase considerably.

The main problem for every second respondent (48%) is that they have to undress in front of a stranger, especially in front of a man (table 9.4.1.). Appearing naked may not only disturb the women attending the test, but there are some sub-groups within the Roma society where it is expressly prohibited for Roma women to show up naked in front of a man. Although the interviews suggested that this is already a smaller problem for the younger generation, still, this was mentioned as a drawback by most respondents in the 18-29 age group.

Fear is another major issue for Roma women. The fear that something bad would be revealed, they will realize that they are sick and they would have to attend treatments. 46% of the respondents mentioned such fears, mainly members of the older age group. This is strongly related to the fact that the surveyed Roma women many times perceive health/sickness only if their

body produces some palpable symptom. And even here, there are certain stages and levels, they often take action only if there is a big problem and they can hardly move for the pain. It is less typical of them to use preventive solutions, e.g. screening examinations. Fear is also generated by the thought that these types of tests can be painful. 37% of the respondents mentioned this as a retaining argument, mainly members of the younger age group as some of them may not have attended any screening test yet due to their age.

The above mentioned retentive factors derive from the personality and the cultural habits of the respondents. The fourth most important argument that holds people back from screening is basically independent from the characteristic features of the surveyed population. It is much more an internal, work organization problem, attached to the technical parameters of organized screening: how up-to-date the databases are, how well the current moving to new addresses can be followed, how well the sent letters find the target persons of screening. 37% of the respondents claim that they do not attend screenings because they do not get an invitation.

Table 9.4.1.: Factors preventing participation in public health screenings (e.g. mammography test, cervical screening), according to age groups, %

	18-29	30-55	56+	total
I feel ashamed, I don't want to undress for medical examinations	52,4	46,9	40,6	48,1
I fear that they might find something at the screening	40,1	46,8	56,6	45,6
I fear that the examination is painful	45,9	33,1	28,7	37,1
I do not always get an invitation so I do not know if I have to attend the screening	36,0	35,5	43,8	36,6
If they find a problem at the screening I think they cannot help it any more, I have to live my life with that disease	24,5	28,6	36,1	28,0
I do not have to attend screening due to my age	36,7	16,9	20,3	24,4
I have no time for screenings	17,7	23,9	10,3	20,1
I think we have to pay for screenings these days	5,7	7,5	6,0	6,7

These obstacles must be pulled down somehow in order to ensure that screenings work more effectively in Roma communities. The question is whether the inhibitions and beliefs can be pulled down somehow. Screenings by health visitors can help in certain cases. For example, getting undressed in front of a woman can be a smaller problem. Maybe a health visitor can better relieve the fear of a presumed painful intervention by giving proper information. Once again, the problem can be solved by providing proper and detailed information and knowledge. It is true though that the basic problem deriving from the weakness/lack of preventive mentality is not solved by the mechanic delivery of information either. It is worth transplanting / entering all this information into the earlier mentioned COM-B model and check how this system works, where are the deficiencies and how intervention into the process should be made so that the expected behaviour (attending screenings) can develop.

Capability

This has to feature the basic knowledge, that patients should know as much as possible about the examination itself, its role, process, date etc. In our opinion, this kind of info basis is more or less available about screenings. We find it more problematic that the abilities required for attendance are missing (e.g. I cannot go because I have to undress, I fear that the examination will be painful, I feel ashamed because my clothes are dirty, I will not go because it turns out that I am ill etc.). In order to work out these abilities, it would be important to integrate into the communication process some information that would reduce the existing reservations and fears. It could be shown that the test is done by a woman, a female staff, so getting undressed would be no problem. (Although there are also women who rule out the possibility of getting such an intimate examination carried out by another woman.) Or it could be explained what type and intensity of pain one can expect. It could be highlighted what happens if a trouble is detected by the examination just in time and what happens if someone goes to the doctor too late.

Motivation

There are even more deficiencies with motivation for screening due to the weakness/lack of preventive mentality. Excluding an eventual future disease that has no clear symptoms yet carries very little motivation in itself. When providing info on future screening programs, it should be highlighted why the test is important and what it means for the individual and for the family (e.g. as was defined in an interview, a grandmother unwilling to attend the test could be persuaded to go by saying that - as a result - she will surely see her grandchild to grow up). The in-depth interviews concluded that Roma women should hear about as many

personal examples as possible. It is much easier for them to adopt these personal stories and in many cases they can identify themselves with the characters of the story. It can work even better if these examples – personal stories – come directly from their direct environment.

Opportunity

In this case, this covers the direct, physical accessibility of the screening and that attending the screening should not mean any cost for the women to be screened (e.g. travel costs). This condition can be fulfilled in the future at many places with screening by local health visitors and with providing many mobile buses. It would be important to plan and organize the screening programme (either by health visitors or on a mobile bus) in a manner that it is in conformity with the basic organizational principles of the health protection and health information programmes that were introduced and summarized in a former section of our analysis. Its key aspects are repeated now in headlines:

- personalisation of organization and persuasion
- involving Roma mediators, opinion leaders and mentors
- organising and participation in groups
- time factor: providing enough time for preparation
- selecting a venue as close as possible
- taking care of children
- support by the employer
- financial motivation
- talking about personal experience
- regularity
- long term

10. Management summary

Psyma Hungary Public Opinion Research Ltd. conducted research – upon request by the Office of the Chief Medical Officer - into the health awareness and the health behaviour of Roma women.

The most important findings of the research are as follows:

- The Roma respondents covered by the survey have very low education and are employed at a low level – although the public work programmes have produced favourable changes – they basically live in deep poverty.

- The direct neighbourhood of the Roma families is very poor. 75% of the Roma women living in the region reside in a definitely miserable, many times run-down environment: 54% live in houses that are in a bad condition and require repairs, 55% have pipe water and 52% have a flush toilet.

- The kind of sacrifice – e.g. demanded by a healthier lifestyle – to give up certain habits and restrict themselves in certain respects is hard to expect from a group of people that is disadvantaged in several ways, because the restriction set by their circumstances and income position is already a problem in itself.

- On the whole, the individual, conscious health behaviour is functioning weakly in the surveyed group. Only 20% of the interviewed Roma women think that they do/do a lot for their health. All in all, only 44% of the interviewees think that in principle they could do (a lot) for their health. Compared to this, 81% of adult

women nationwide agree to the opinion that individuals also have a great responsibility for preserving their health.

- The low figures on active health behaviour registered with Roma women are not due to the fact that they are theoretically not aware of the importance of workout, balanced diet, screening tests etc., because they possess this type of basic information.

- The problem is – apart from the objective factors (poverty, lack of education etc.) – that they have difficulty with activating the existing knowledge and they do not have enough skills to make a move towards conscious health behaviour.

- Furthermore, they have a weak motivation basis to find the objectives for adopting the more health conscious behaviour pattern.

- The current educational and health system as well as the related civil- or state-organized health protection and health info programs primarily aim at passing on the health info, but help to work out and deepen appropriate skills and motivation strategies only on the second line.

- Surveys show that Roma women often adopt a more health conscious behaviour only if they become sick. Roma women – especially the elderly - turn to the doctor in many cases if they already have a bad pain and very clear symptoms.

- Closely related to this: preventive screening tests are attended by very few Roma women. Excluding an eventual future disease that has no clear symptoms yet carries very little motivation for them in itself.

- The number of doctor-patient meetings or screening tests is not very high within the surveyed Roma population. 73% of the respondents visited the GP and 36% the gynaecologist over the past year. 26% of the Roma women aged 45-65 had a mammography test over the past 2 years, and 48% of Roma women aged 25-65 had a cervical screening over the past 3 years.

- Our survey shows that the GP visits are often formal (mainly related to sick pay, prescriptions etc.), and there is very little info on specialist levels. More active info flow in health com can mainly be observed between health visitors and Roma women.

- The basic expectation of the interviewed Roma women is that health visitors should not only deal with the health and care of children but they should do more, so they should also pay attention to the health condition of mothers. They should give advice on healthy health protection programs, screening tests etc.

11. Professional policy recommendation for the more active participation of roma women in public health screenings

The survey that serves as a basis for the professional policy recommendation consisted of two parts: questionnaire-based interview of a representative sample covering 1000 Roma women living in Borsod-Abaúj-Zemplén county – according to age and settlement size – as well as 50 in-depth interviews with Roma women and experts (health visitors, social workers, Roma interest representation leaders etc.) who know the condition and the life circumstances of Roma women.

The survey shows that few Roma women attend public health screenings. While the nationwide mammography attendance rate is 60% (those who had a test in their life) and 44% (those who had a test over the past 3 years), these rates are 25% and 18%, respectively among Roma women in Borsod-Abaúj-Zemplén county. If we look at the 45-65 age group defined as a target group, 89% of them attended mammography in their life and 78% over the past 3 years nationwide, while these rates are 43 and 33% among Roma women in Borsod-Abaúj-Zemplén county.

The cervical screening figures are somewhat more favourable. Cervical screening was attended by 70% of adult Roma women in their life, compared to the national reference value of 84%. These figures are 47% among Roma women and 59% nationwide over the past 3 years.

Based on the research, our pp recommendation is summarized in the following eight points in order to enhance the rate of screening attendance:

1. The principled opportunity of local screening must be provide for everybody

The lower screening data among Roma women are due to the territorial disproportions as many Roma women live at a settlement where screenings cannot be carried out. This is also underlined by the empirical data: the smaller the settlement where a Roma woman lives, the lower is the chance that she can/is willing to attend screening. The research figures also highlight that in the case of the last cervical screening 2/3 of the Roma women had to travel because the test could be done only at another settlement (the necessity of travel is almost totally general among those who live at small settlements). These figures are even higher for mammography as it can be tested only in the county seat town of Borsod-Abaúj-Zemplén county.

It should be regarded as a basic principle that if a test is too far territorially, it should be brought as close to the target group as possible. This problem could be solved with mobile test buses that could bring the mammography or gynaecological tools also to small and secluded settlements. This line could also be added with institutionalised cervical tests by health visitors, which would provide more local tests at small settlements.

2. Differentiated, consensus-based introduction of cervical tests by health visitors

The introduction of cervical tests by health visitors would definitely raise the attendance rate. However, a problem can be that the health visitors do not have consensus about the conditions and the implementation of this job. Many issues are not properly settled yet (quality insurance, liability insurance, labour and financing issues, the process, type, level of training etc.)

The survey results suggest that it can be expedient to introduce differentiated, optional cervical screening by health visitors. Looking at the issue from the viewpoint of Roma women, the potential screening subjects are divided about who to turn to if they had an option: 44% would (continue to) turn to the gynaecologist and a similar 42% would see the health visitor. It is a trend that the smaller the settlement and the younger is the Roma woman, the more likely she is to see the health visitor. The preferences are largely determined by who and how often goes to cervical screening.

The target group of cervical screening by health visitors can be primarily those who do not attend such screening. Among those who went to a screening within the past 3 years, 48% would choose health visitors and 43% gynaecologists. These figures are 40% and 28% among those who have never been to such a screening. Therefore, these groups support health visitors more, but this cannot be regarded as general. The reason is that cervical screening is defined in many cases as a medical-professional task, and the respondents mainly regard doctors as professionally competent in this field.

3. Financing the extra costs of screening

Many times, the members of the surveyed population cannot attend screenings due to their unfavourable financial position, as well as to the feeling and the awareness of poverty, e.g. because they cannot pay the screening-related costs (travel etc.). The current post-financing system of travel costs does not help in this regard. The opportunity of pre-financing should be worked out (e.g. invitation to screening on the planed day of the test with a free travel facility). It can also be regarded as direct financial support if the employer – if any – covers the eventual (travel) costs.

4. Rendering help in work organisation tasks at home

Many times, Roma women cannot be away from home permanently because of their home tasks (supervising children, keeping a large household etc.). Our survey shows that a cervical screening would need on average 4 hours for a Roma woman today. In order to reach the highest possible attendance rate, some kind of an institutional solution should also be found in this case (e.g. playhouse for children, child supervision, animators etc. on the day of screening).

5. Support by employers to screening attendance

In case of employment, the employer can give a paid holiday to those female employees or public workers who attend (organized) screening.

6. Terminating the subjective obstacles to participation in screening

Attendance is many times restricted by factors that are independent from accessibility or expenses. Theses subjective factors come from the Roma women's cultural habits, fears and reservations. For many of them (48%), e.g. the main problem is that they have to take off their clothes in front of strangers (e.g. a man). Another serious problem for them (46%) is the fear that something bad would be revealed, they will realize that they are sick and they would have to attend treatments. This is strongly related to the fact that the surveyed Roma women many times perceive health/sickness only if their body produces some palpable symptom. Fear is also generated by the thought that these types of tests can be painful (37%).

The subjective obstacles must be pulled down somehow in order to ensure that screenings work more effectively in Roma communities. The problem can be solved by providing proper and detailed information also in the

future. However, it would be important to integrate into the communication process some information that would reduce the existing reservations and fears. The programs and information regarding future screening tests should lay a bigger emphasis on telling Roma women why the screening is important for them and for their family by showing concrete, personal examples, life stories and fates.

7. Updating the registration system of planned screenings

The registration of persons to be invited to organised screening works with relatively many errors. The main reason for this is that the address records are not always accurate: they cannot follow the true demographic, territorial etc. changes. If possible, the system should be improved and updated.

8. Basic principles of organising public health screenings as well as screenings within the framework of health protection and health information programs

When organizing various health protection programs and screenings, it is very important that the following basic organizing principles should be present, and should be properly working upon the organizing process:

- personalisation of organization and persuasion
- involving Roma mediators, opinion leaders and mentors
- organising and participation in groups
- time factor: providing enough time for preparation
- selecting a venue as close as possible
- taking care of children
- support by the employer
- financial motivation
- talking about personal experience
- regularity
- long term.

12 Annexes

Annex 1: List of the surveyed settlements and number of respondents, persons

county seat town		fewer than 3000	
Miskolc	250	Farkaslyuk	20
20000-150000		Tiszakarád	20
Ózd	175	Köröm	20
Kazincbarcika	75	Taktaszada	20
total	250	Kesznyéten	20
3000-19999		Lak	20
Sátoraljaújhely	20	Csenyéte	20
Encs	20	Rudabánya	20
Arló	20	Tiszatarján	20
Taktaharkány	20	Szin	20
Felsőzsolca	20	Szomolya	20
Tiszalúc	10	Homrogd	10
Sajókaza	20	Makkoshotyka	10
Mezőkövesd	20	Boldogkőújfalu	10
Abaújszántó	20	total	250
Putnok	20		
Mezőcsát	20		
Szendrő	10		
Onga	10		
Szikszó	10		
total	250		

Annex 2: distribution of respondents according to settlement size, %

county seat town	17
20000-150000	5
3000-19999	13
fewer than 3000	15
total	50

Annex 3: Trend in some basic socio-economic background variables in the surveyed settlements and age groups, %

	rate of those with max. 8-year primary	rate of those who work currently	rate of public workers	rate of those who claim to have serious financial problems	those who have no cars
	women aged 18-29				
county seat town	69,0	30,6	15,3	37,0	82,0
20000-150000	62,2	38,3	10,6	34,0	73,0
3000-19999	70,0	26,3	17,2	46,0	84,0
fewer than 3000	75,0	33,7	27,6	42,0	83,5
total	72,1	31,9	22,4	41,9	82,6
	women aged 30-55				
county seat town	69,0	65,7	29,3	41,0	87,0
20000-150000	66,0	52,0	32,0	39,4	76,0
3000-19999	85,9	58,6	43,4	48,0	90,0
fewer than 3000	82,0	61,2	54,1	49,0	86,0
total	56 +				
	80,3	60,3	47,0	47,1	86,3
county seat town	94,0	20,0	10,0	48,0	92,0
20000-150000	88,0	27,1	18,8	40,0	88,0
3000-19999	100,0	16,0	16,0	60,0	98,0
fewer than 3000	95,8	25,0	25,0	66,0	92,0
total	total, weighted				
	96,0	22,4	20,8	60,7	93,1
county seat town	71,6	48,7	22,4	40,3	85,8
20000-150000	67,4	44,2	22,9	37,5	76,4
3000-19999	81,7	42,0	30,8	48,7	88,8
fewer than 3000	81,1	47,0	41,1	48,5	85,8
total	79,2	45,7	35,1	46,8	85,8

Annex 4: Economic activity of Roma women living in the county, according to age groups, %

age group	18-24	25-29	30-34	35-39	40-44	45-49	50-55	56-65	66-	total
works (e.g. public work)	24,4	43,9	63,0	63,1	57,8	60,3	57,7	29,8	0,0	45,7
unemployed	10,3	12,1	12,8	15,6	15,7	9,9	17,6	12,9	0,0	12,7
receives old-age / widow/er / early retirement pension	0,0	0,0	0,0	0,0	0,0	0,5	3,1	40,2	94,5	6,6
receives disability / rehabilitation provision	0,6	0,0	0,5	0,0	1,0	4,1	9,8	8,8	5,5	2,6
student / attends a course	5,9	0,7	2,0	0,4	0,3	0,6	0,0	0,0	0,0	1,7
receives child care allowance / benefit / aid etc.	54,1	41,8	21,0	16,4	11,7	13,5	0,0	0,2	0,0	24,2
homemaker	3,3	0,9	0,0	1,3	4,5	3,2	5,6	3,0	0,0	2,7
nursing aid	0,2	0,0	0,6	0,5	4,6	1,6	3,1	1,2	0,0	1,3
social benefit, aid	1,4	0,7	0,0	2,7	4,3	6,4	3,1	3,8	0,0	2,5

Annex 5: The age when the Roma women living in the county had their first child, %

	has no child (yet)	had a child at 17 or earlier	had a child later
	women aged 18-29		
county seat town	32,7	29,6	37,8
20000-150000	23,7	24,7	51,5
3000-19999	25,3	39,4	35,4
fewer than 3000	25,0	31,0	44,0
total	25,7	32,4	41,9
	women aged 30-55		
county seat town	5,1	33,3	61,6
20000-150000	3,0	22,0	75,0
3000-19999	4,0	30,0	66,0
fewer than 3000	4,0	34,0	62,0
total	4,0	32,0	64,0
	56 +		
county seat town	0,0	36,0	64,0
20000-150000	6,1	18,4	75,5
3000-19999	6,0	32,0	62,0
fewer than 3000	0,0	44,0	56,0
total	2,0	38,1	59,8
	total, weighted		
county seat town	14,0	32,3	53,6
20000-150000	10,8	22,5	66,7
3000-19999	11,8	33,6	54,6
fewer than 3000	11,1	34,1	54,8
total	11,5	32,9	55,6

Annex 6: The rate of those who believe that they could do (a lot) for their health, and those who do (a lot), %

	could do (a lot)	does (a lot)
	women aged 18-29	
county seat town	56,0	38,0
20000-150000	71,0	31,0
3000-19999	65,0	18,0
fewer than 3000	50,0	24,0
total	56,1	24,4
	women aged 30-55	
county seat town	45,0	30,0
20000-150000	70,0	35,0
3000-19999	48,0	15,0
fewer than 3000	34,0	15,0
total	41,6	18,2
	56 +	
county seat town	14,0	10,0
20000-150000	54,0	30,0
3000-19999	20,0	8,0
fewer than 3000	18,0	10,0
total	21,2	11,2
	total, weighted	
county seat town	45,6	30,7
20000-150000	68,4	32,9
3000-19999	50,8	15,3
fewer than 3000	37,8	17,6
total	44,4	19,6

Annex 7: Breakdown of BMI categories according to age groups and settlement types, %

BMI categories	underweight	normal	overweight	obese
	women aged 18-29			
county seat town	2,0	50,0	33,0	15,0
20000-150000	9,2	52,0	26,5	12,2
3000-19999	9,0	54,0	22,0	15,0
fewer than 3000	4,0	54,0	28,0	14,0
total	5,5	53,5	26,9	14,2
	women aged 30-55			
county seat town	3,0	39,0	34,0	24,0
20000-150000	6,0	44,0	34,0	16,0
3000-19999	5,0	42,0	32,0	21,0
fewer than 3000	0,0	36,0	39,0	25,0
total	2,1	38,5	36,3	23,2
	56 +			
county seat town	2,0	10,0	38,0	50,0
20000-150000	4,0	32,0	36,0	28,0
3000-19999	4,0	22,0	42,0	32,0
fewer than 3000	4,0	40,0	32,0	24,0
total	3,8	32,2	35,4	28,6
	total, weighted			
county seat town	2,6	41,8	34,9	20,9
20000-150000	6,1	45,6	28,2	20,2
3000-19999	1,5	48,1	35,0	15,5
fewer than 3000	2,5	41,8	34,9	20,9
total	3,5	43,1	32,8	20,6

Annex 8: Breakdown of the frequency of smoking according to age groups and settlement types, %

frequency of smoking	smokes currently	stopped less than a year ago	stopped more than a year ago	never smoked
	women aged 18-29			
county seat town	49,0	3,0	6,0	42,0
20000-150000	59,2	2,0	4,1	34,7
3000-19999	56,6	2,0	3,0	38,4
fewer than 3000	65,0	1,0	4,0	30,0
total	60,9	1,5	4,0	33,6
	women aged 30-55			
county seat town	69,0	2,0	10,0	19,0
20000-150000	59,0	4,0	8,0	29,0
3000-19999	64,6	1,0	4,0	30,3
fewer than 3000	58,0	1,0	7,0	34,0
total	60,9	1,3	6,6	31,2
	56 +			
county seat town	68,0	0	16,0	16,0
20000-150000	48,0	0	16,0	36,0
3000-19999	48,0	0	6,0	46,0
fewer than 3000	58,0	2,0	6,0	34,0
total	55,6	1,2	7,8	35,5
	total, weighted			
county seat town	61,9	2,1	9,2	26,7
20000-150000	58,9	2,3	9,4	29,5
3000-19999	62,3	0	7,6	30,1
fewer than 3000	63,8	0,9	3,1	32,2
total	60,3	1,4	5,8	32,5

Annex 9: Breakdown of the frequency of alcohol consumption according to age groups and settlement types, %

frequency of alcohol consumption over the past 12 months	never	once a month or less	2-3 times a month	2-3 times a week	4-5 times a week	every day
	women aged 18-29					
county seat town	47,0	42,0	9,0	2,0	0	0
20000-150000	47,0	44,0	9,0	0	0	0
3000-19999	65,0	28,0	6,0	1,0	0	0
fewer than 3000	69,0	13,0	11,0	7,0	0	0
total	64,1	22,1	9,4	4,4	0	0
	women aged 30-55					
county seat town	39,0	45,0	13,0	3,0	0	0
20000-150000	60,0	30,0	8,0	2,0	0	0
3000-19999	62,0	24,0	11,0	2,0	1,0	0
fewer than 3000	71,0	13,0	8,0	7,0	1,0	0
total	64,5	20,5	9,3	4,9	0,8	0
	56 +					
county seat town	54,0	30,0	14,0	2,0	0	0
20000-150000	84,0	14,0	2,0	0	0	0
3000-19999	76,0	14,0	4,0	4,0	2,0	0
fewer than 3000	78,0	10,0	10,0	2,0	0	0
total	75,9	13,1	8,2	2,3	0,5	0
	Összesen					
county seat town	43,4	42,4	11,7	2,6	0	0
20000-150000	58,2	24,5	12,3	5,1	0	0
3000-19999	67,1	12,0	13,7	4,2	3,2	0
fewer than 3000	73,8	14,7	6,5	4,5	0,5	0
total	65,7	20,2	9,2	4,4	0,5	0

Annex 10: Breakdown of the frequency of sliming diets according to age groups and settlement types, %

are you on a slimming diet?	yes, regularly	yes, occasionally	no
	women aged 18-29		
county seat town	5,0	14,0	81,0
20000-150000	3,0	14,0	83,0
3000-19999	3,0	11,1	85,9
fewer than 3000	1,0	6,0	93,0
total	2,1	8,7	89,2
	women aged 30-55		
county seat town	3,0	16,2	80,8
20000-150000	0	4	96,0
3000-19999	1,0	8,1	90,9
fewer than 3000	4,0	7,1	88,9
total	3,1	8,4	88,5
	56 +		
county seat town	2,0	8,0	90,0
20000-150000	0	4,0	96
3000-19999	0	12,2	87,8
fewer than 3000	6,0	0	94,0
total	3,6	4,1	92,3
	Összesen		
county seat town	3,6	14,5	81,8
20000-150000	1,3	10,7	87,9
3000-19999	2,2	8,9	88,8
fewer than 3000	3,5	5,3	91,3
total	2,8	8,0	89,2

Annex 11: Distribution of the reason and frequency of visiting the doctor according to age groups and settlement types, %

frequency of doctor visit, reason	also visits doctor if there is no problem	due to feeling slightly unwell, which does not disturb daily activities	feeling sick, which disturbs daily activities	visits doctor only if there is a big problem	is under regular medical control due to disease	does not visit the doctor
	women aged 18-29					
county seat towr	6,1	24,5	43,9	24,5	0	1,0
20000-150000	2,0	11,2	37,8	41,8	0	7,1
3000-19999	7,0	5,0	43,0	41,0	2,0	2,0
fewer than 3000	3,0	2,0	35,4	56,6	3,0	0
total	4,2	5,6	38,3	48,4	2,2	1,2
	women aged 30-55					
county seat towr	2,0	20,0	39,0	27,0	11,0	1,0
20000-150000	8,0	7,0	31,0	44,0	8,0	2,0
3000-19999	6,1	11,1	28,3	43,4	6,1	4,0
fewer than 3000	3,0	5,0	22,0	55,0	14,0	1,0
total	4,1	8,3	26,3	48,3	11,2	1,8
	56 +					
county seat towr	8,3	8,3	31,3	16,7	35,4	0
20000-150000	12,0	10,0	28,0	30,0	18,0	2,0
3000-19999	8.0	6,0	30,0	32,0	24,0	0
fewer than 3000	4,0	6,0	12,0	36,0	42,0	0
total	6,1	6,5	19,5	32,8	34,9	0,2
	total, weighted					
county seat towr	4,0	20,4	39,9	25,1	9,7	0,9
20000-150000	3,4	5,6	34,4	46,4	6,7	3,4
3000-19999	11,8	13,0	30,9	41,2	3,2	0
fewer than 3000	4,1	4,9	25,3	51,1	14,1	0,5
total	4,4	7,2	29,8	46,5	10,8	1,4

Annex 12: Distribution of health expert visits according to age groups and settlement types, %

over the past 12 months…	(was in-patient at hospital (no child birth)	saw GP due to own health condition	saw gynaecologist due to own health condition	saw the dentist	saw any other specialist (e.g. dermatologist, ophthalmologist)	went to phsysiotherapist	went to psychologist or psychiatrist	went to dietitian	went to homeopath
	women aged 18-29								
county seat town	7,0	67,0	38,0	17,0	21,0	2,0	1,0	2,0	0
20000-150000	9,0	56,0	33,0	27,0	10,0	0	0	0	0
3000-19999	8,0	68,0	40,0	34,0	17,0	0	1,0	0	0
fewer than 3000	7,0	67,0	46,0	29,0	7,0	0	3,0	0	0
total	7,4	66,3	42,7	28,9	11,1	0,2	2,1	0,2	0
	women aged 30-55								
county seat town	12,0	77,0	28,0	20,0	34,0	5,0	2,0	3,0	0
20000-150000	26,0	74,0	39,0	25,0	26,0	8,0	6,0	0	0
3000-19999	15,0	79,0	34,0	25,0	26,0	3,0	8,0	1,0	0
fewer than 3000	16,0	68,0	35,0	23,0	17,0	1,0	6,0	1,0	1,0
total	16,2	72,2	34,4	23,4	21,8	2,5	6,1	1,1	0,5
	56 +								
county seat town	36,0	84,0	6,0	6,0	48,0	10,0	6,0	4,0	0
20000-150000	28,0	86,0	20,0	14,0	38,0	18,0	6,0	10,0	0
3000-19999	34,0	92,0	26,0	18,0	44,0	6,0	20,0	2,0	0
fewer than 3000	36,0	96,0	26,0	20,0	34,0	8,0	10,0	2,0	0
total	34,8	93,1	23,7	17,8	38,1	8,5	11,8	2,9	0
	total, weighted								
county seat town	12,8	74,3	29,2	17,5	31,0	4,5	2,1	2,8	0
20000-150000	17,1	70,7	31,3	23,9	17,9	2,6	3,5	0,5	0
3000-19999	9,7	70,3	31,6	32,4	35,3	3,2	6,3	2,2	0
fewer than 3000	15,2	73,5	40,5	25,6	17,2	1,8	6.8	0,8	0,5
total	15,2	72,6	36,1	24,7	19,9	2,4	5,3	0,9	0,3

Annex 13: Distribution of blood pressure tests according to their date, according to age groups and settlement types, %

date of last blood pressure check by health worker	over the past 12 months	1-3 years ago	3-5 years ago	more than 5 years ago	never measured it
	women aged 18-29				
county seat town	45,0	44,0	11,0	0	0
20000-150000	40,0	44,0	6,0	1,0	9,0
3000-19999	37,0	46,0	8,0	5,0	4,0
fewer than 3000	54,0	35,0	7,0	2,0	2,0
total	47,7	39,4	7,5	2,5	2,9
	women aged 30-55				
county seat town	60,0	32,0	5,0	3,0	0
20000-150000	61,6	33,4	3,0	1,0	1,0
3000-19999	47,5	32,3	8,1	12,1	0
fewer than 3000	58,0	20,0	8,0	13,0	1,0
total	55,9	25,4	7,3	10,8	0,6
	56 +				
county seat town	64,0	28,0	8,0	0	0
20000-150000	74,0	18,0	4,0	2,0	2,0
3000-19999	66,0	16,0	10,0	8,0	0
fewer than 3000	78,0	18,0	4,0	0	0
total	73,5	18,4	5,8	2,1	0,2
	total, weighted				
county seat town	55,2	35,8	7,4	1,6	0
20000-150000	46,8	40,3	5,4	5,6	2,0
3000-19999	37,6	39,6	12,0	9,3	1,5
fewer than 3000	61,5	21,5	7,7	8,1	1,3
total	55,0	29,6	7,2	6,8	1,4

Annex 14: Distribution according to the date of the last blood sample taking, according to age groups and settlement types, %

date of last blood sample taking	over the past 12 months	1-3 years ago	3-5 years ago	more than 5 years ago	never had it
	women aged 18-29				
county seat town	39,0	45,0	16,0	0	0
20000-150000	28,3	41,4	8,1	4,0	18,2
3000-19999	22,2	42,4	14,1	5,1	16,2
fewer than 3000	35,4	31,3	8,1	3,0	22,2
total	31,8	36,3	10,4	3,3	18,2
	women aged 30-55				
county seat town	43,0	35,0	12,0	7,0	3,0
20000-150000	41,4	32,3	15,2	6,1	5,1
3000-19999	29,6	30,6	7,1	18,4	14,3
fewer than 3000	31,0	26,0	13,0	17,0	13,0
total	32,7	28,6	11,6	15,4	11,6
	56 +				
county seat town	56,0	36,0	6,0	0	2,0
20000-150000	42,9	32,7	10,2	10,2	4,1
3000-19999	29,6	30,6	8,2	8,2	6,1
fewer than 3000	61,2	20,4	8,2	10,2	0
total	54,6	26,4	8,1	8,8	2,0
	total, weighted				
county seat town	43,0	38,6	12,8	3,8	1,9
20000-150000	26,3	34,7	11,0	10,6	17,4
3000-19999	27,1	32,8	6,0	11,9	22,2
fewer than 3000	39,1	27,6	10,8	11,2	11,4
total	35,0	31,1	10,8	10,3	12,9

Annex 15: Rate of those who could not use the listed healthcare services due to financial reasons, according to age group and settlement type, %

healthcare services	medical care	dental care	getting prescription medicine	mental health related care
	women aged 18-29			
county seat town	12,1	13,1	17,2	2,0
20000-150000	6,0	8,1	17,0	1,0
3000-19999	19,0	19,4	34,3	6,1
fewer than 3000	13,0	8,0	23,0	4,0
total	13,8	11,3	24,8	4,1
	women aged 30-55			
county seat town	14,1	25,3	29,3	5,1
20000-150000	21,0	10,0	29,0	6,1
3000-19999	24,2	20,2	43,4	9,1
fewer than 3000	17,0	16,0	36,0	8,0
total	18,8	17,5	36,6	7,8
	56 +			
county seat town	20,0	18,0	36,0	6,1
20000-150000	16,3	4,1	28,0	4,1
3000-19999	28,0	22,0	58,0	12,0
fewer than 3000	38,0	32,0	48,0	22,5
total	32,1	25,9	47,7	16,8
	total, weighted			
county seat town	14,1	20,3	25,8	4,1
20000-150000	18,0	13,9	37,9	6,4
3000-19999	20,5	22,5	29,0	6,5
fewer than 3000	19,7	16,2	33,3	8,9
total	18,6	16,3	33,6	7,5

Annex 16:
Date of attending cervical screening, %

	over the past 12 months	more than a year ago but within 2 years	more than 2 years ago but within 3 years	more than 3 years ago	never
	women aged 25-29				
county seat town	26,5	20,6	5,9	26,5	20,6
20000-150000	19,1	38,3	19,1	10,6	12,8
3000-19999	32,6	10,9	4,3	17,4	34,8
fewer than 3000	30,3	15,2	6,1	6,1	42,4
total	29,5	16,7	6,9	11,8	35,1
	women aged 30-55				
county seat town	25,0	13,0	6,0	40,0	16,0
20000-150000	26,0	21,0	15,0	33,0	5,0
3000-19999	22,0	19,0	8,0	18,0	33,0
fewer than 3000	28,6	9,2	12,2	28,6	21,4
total	26,3	13,0	10,7	27,4	22,5
	women aged 56-65				
county seat town	12,5	6,3	6,3	50,0	25,0
20000-150000	13,2	5,3	5,3	63,2	13,2
3000-19999	24,3	8,1	8,1	35,1	24,3
fewer than 3000	12,8	,0	5,1	53,8	28,2
total	15,6	2,9	5,9	49,8	25,7
	total, weighted				
county seat town	24,1	13,6	6,0	38,7	17,6
20000-150000	23,0	22,9	14,7	31,7	7,7
3000-19999	24,5	16,1	7,2	19,8	32,4
fewer than 3000	26,8	9,0	10,3	28,1	25,8
total	25,6	12,5	9,5	27,3	25,1

Annex 17: Basic data on the opinions about cervical screening by the health visitor, %

	heard about this opportunity	finds it useful	venue of last cervical screening was different than the place of residence	last cervical screening was done by the health visitor
	women aged 18-29			
county seat town	28,0	67,0	1,3	0,0
20000-150000	18,0	67,7	13,0	1,3
3000-19999	33,0	71,3	46,6	13,8
fewer than 3000	24,0	75,0	91,7	2,0
total	26,1	72,8	58,8	4,7
	women aged 30-55			
county seat town	26,0	62,9	4,8	0,0
20000-150000	17,0	56,3	5,4	0,0
3000-19999	22,0	70,1	50,7	9,0
fewer than 3000	28,0	71,7	94,7	0,0
total	25,4	69,1	65,8	2,0
	56 +			
county seat town	12,0	59,1	,0	0,0
20000-150000	20,0	54,2	2,3	0,0
3000-19999	18,0	70,5	58,3	8,3
fewer than 3000	12,0	73,3	94,3	0,0
total	14,2	69,6	66,9	2,0
	total, weighted			
county seat town	25,2	63,9	3,1	0,0
20000-150000	17,7	60,1	7,5	0,4
3000-19999	25,5	70,6	50,4	10,4
fewer than 3000	24,6	73,1	93,9	0,5
total	24,3	70,5	63,9	2,8

Annex 18: Preferences about the expert performing cervical screening „If you had the chance to select the person to perform cervical screening in the future, which of the following two persons would you select?", %

	gynaecologist	health visitor	makes no difference	would not have it	don't know
	women aged 18-29				
county seat town	48,0	41,0	1,0	0,0	10,0
20000-150000	47,0	43,0	0,0	0,0	10,0
3000-19999	46,0	40,0	4,0	1,0	9,0
fewer than 3000	43,0	45,0	1,0	,0	11,0
total	44,6	43,2	1,7	,2	10,3
	women aged 30-55				
county seat town	54,0	33,0	1,0	,0	12,0
20000-150000	56,0	35,0	2,0	1,0	6,0
3000-19999	43,0	41,0	5,0	3,0	8,0
fewer than 3000	42,0	47,0	1,0	1,0	9,0
total	44,6	43,1	2,1	1,4	8,8
	56 +				
county seat town	64,0	30,0	,0	,0	6,0
20000-150000	48,0	22,0	,0	10,0	20,0
3000-19999	52,0	34,0	2,0	,0	12,0
fewer than 3000	36,0	40,0	6,0	4,0	14,0
total	43,5	36,1	4,0	3,2	13,3
	total, weighted				
county seat town	53,0	35,5	0,9	0,0	10,7
20000-150000	51,8	36,3	1,0	1,7	9,2
3000-19999	45,1	39,8	4,3	1,9	8,8
fewer than 3000	41,6	45,4	1,6	1,0	10,3
total	44,5	42,3	2,2	1,2	9,9