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Migration, Public Health, and Low-Threshold Health Services in Italy: A Culturally-Oriented Approach for Roma Communities

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ABSTRACT

Public health authorities and healthcare providers are often unable to overcome their rigid bureaucratic limits and offer low-threshold health services to vulnerable ethnic minorities, such as the Roma communities. Roma people frequently face institutional, juridical, social, economic, and cultural obstacles in the course of their access to appropriate, effective, and high-quality healthcare. In Italy, Roma people experience difficulties such as cultural constraints and discrimination while accessing health services. For this reason, in recent years, public healthcare institutions have been experimenting with innovative approaches aimed at overcoming inequalities and discriminations associated with the access to health care through cooperation between private and public health and the active involvement of the Roma communities. The implementation of low-threshold services have specific requirements such as; a strong commitment toward public health at the national, regional, and local levels; joint local networks of well-trained healthcare professionals, non-medical personnel, and civil society organizations; tailor-made projects addressing Roma with respect to the public health facilities; monitoring the access to the healthcare facilities of Roma; promoting direct interaction between healthcare providers and Roma; cultural mediation; actively involving Roma communities in overcoming the mistrust of and prejudice toward healthcare providers and medical facilities; promoting a healthy lifestyle in Roma households by fostering routine screenings, immunization, and medical appointments and respecting medical pharmacological therapies. To improve the Roma communities' health in Italy, we have proposed a culturally-oriented model that offers a methodological approach beyond prejudice to improve access to healthcare.

Keywords: Emigrants and immigrants, health services, Roma, social problems

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INTRODUCTION

In several European countries, Roma communities face institutional, juridical, social, economic, and cultural obstacles in the course of their access to appropriate, effective, and high-quality healthcare. In their migration from Eastern to Western European countries, Roma migrants experience these obstacles on a daily basis, which are exacerbated by a lack of attention to their specific social and cultural background that prevents the enhancement or improvement of their health. In Italy, the Romas' poor health status is strongly connected to the community's lower levels of education and literacy, limited socio-economic opportunities, and inadequate living conditions in marginalized and isolated urban areas. These drivers, together with strong prejudice and generalized mistrust against the Roma communities foster the discrimination that the Roma people face while accessing health services. Although access to healthcare is universal in Italy, not all Roma communities can access health services to the same extent as the rest of the population.

The health inequalities that they experience should be reduced through a comprehensive approach involving all the interlinked social determinants of health; from housing, education, and literacy to the access to employment opportunities and services, which will promote correct lifestyles among the people. In the recent years, public healthcare institutions have been experimenting with innovative approaches to help the Roma population and other vulnerable groups overcome inequalities and discriminations in the access to healthcare, irrespective of their juridical citizenship or their status as undocumented foreigners.

This strategy is the result of strong cooperation between private and public health, with the active participation of a large network of stakeholders and the direct involvement of the Roma communities. This outcome has not been easily reached. For years, the cooperation between civil society organizations and local health services played a relevant role in terms of expertise, knowledge, and practices for the better collective health of the Roma communities. Their daily duties permitted the reflection of the strengths and weaknesses of the methodologies carried out at the local level, the adaptation of the healthcare models, and the use of operational tools in different social and cultural contexts according to the various cultural peculiarities of the Roma communities. A mixed and informal private-public network for the promotion of the health of these communities was built and implemented for fifteen years in the marginal suburbs, and it has proved a propulsive tool that is able to increase the efficiency of public health services for Roma people. Hundreds of projects, financed by national and regional funding, have been carried out in the framework of the goals of national prevention plans, situated within the framework of the constitutional universal right to health and regulated by the immigration acts. The national strategy for social inclusion of Roma 2012–2020 formalized this method of a common public-private approach of intervention, the efficiency of which was the result of tested cooperation among state and regional governments, healthcare agencies and units, and private sector and civil society organizations.

This universal approach is producing promising results in the area of health prevention, which can benefit not only Roma people but also other low-income patients and migrants. Healthcare in Italy is based on a universal approach (the right to health for all), which in general terms cannot incorporate dedicated measures to help ethnic minorities, such as Roma people. The Italian strategy for the inclusion of Romas has been to combine this general universal approach with special measures that are able to increase the marginalized Roma communities' access to health, with an integrated approach and culturally-oriented guidelines for public health practitioners, municipalities, civil society organizations, general practitioners, and Roma communities.

This article is the result of personal desk research and semi-structured interviews with stakeholders, carried out by the author between 2012 and 2013 and in 2018 as the senior expert of the National Office against Racial Discrimination (UNAR) and as the expert of the Equi-health program of the Migration Health Division of the Regional Office for Europe of the International Organization for Migration (IOM) in 2014. The term "Roma" refers to Roma, Sinti, Kale, travelers, and related population groups in Europe, as defined by the Council of Europe, and encompasses a wide range of concerned groups, including those which identify themselves as "Gypsies" and those which are referred to as "Traveler communities".[1] In this paper, the author will not address the controversial aspects of ethnic labels and categorizations connected with the exclusionary or ethnic claim of the term "Roma," which has already been debated in other studies.[2] However, the "Roma" label will also include the Sinti people, living mainly in central and northern Italy.

THE HEALTH OF ROMA

Roma communities have been living in Italy since the 1400s with strongly increased migratory flows since the latter half of 1800.[3] This created a complex mix of cultures and social and legal statuses that had a deep and diversified impact on politics, in terms of the inclusion of Roma people in the society.[4] In fact, some Roma nationals are Italian citizens (whose ancestries go back several generations or centuries) and are used to living in regular houses and enjoying the same rights and access to healthcare as non-Roma Italians. Their social and health-related conditions cannot be compared to stateless Roma and foreign-born Roma people, or to those Roma nationals who have migrated in the last 30 years and who are, sometimes, still undocumented and often found to be living in precarious settlements known as "Roma camps."

The Italian strategy for the social inclusion of Roma people mentioned an estimated number of about 120,000–180,000 Roma people currently living in Italy, half of whom are Italian and the other half are migrants who have started living permanently in Italy. Roma represent around 0.23% of the Italian population and most of them are children and youngsters of Italian nationality. According to Strati,[5] the percentage of the Roma children under the age of 16 (45%) is three times higher than the national average (15%) in the same age group. On the other hand, the percentage

of Roma people over 60 (0.3%) is equivalent to one-tenth of the national average for the same age group (25%). In 2015, the National Association of Municipalities and Cittalia made an estimation of authorized and spontaneous Roma settlements in municipalities with over 15,000 inhabitants. According to the survey[6] performed on 606 municipalities, 206 reported the presence of Roma communities and 163 contained 516 Roma settlements. Approximately 78.2% of these settlements (398 out of 516) are classified as stable or permanent. Only 15.6% of the spontaneous settlements are officially authorized, while 48.2% of them are unauthorized and only 36.2% are equipped camps.[6] In this paper, we consider Roma people living in camps as our main subject, irrespective of their nationality or migrant background.

The health of Roma people living in camps is more precarious than the health of the migrant population in Italy as a whole, which is largely due to the Roma peoples' low socioeconomic status and critical living conditions.[7] The persistence of stereotypes, misconceptions, and communication barriers increases the gap between the migrant Roma people and the healthcare services that are supposed to cater to their medical needs. Moreover, the limited available data demonstrate that the Roma people who live in camps have a lower life expectancy and higher infant mortality as compared to the general population. Roma children are more frequently born underweight than non-Roma babies, they become sick from respiratory diseases more often than their Italian peers, and suffer more often from poisoning, burns, and accidents at home. Besides, health problems in the Roma population are also the result of alcohol and drug abuse, diseases and/or discomfort due to degradation, and "diseases of poverty" such as tuberculosis, scabies, and lice. Some viral, fungal, and venereal infections occur more frequently among the Roma people. All these aspects worsen among the people living in unauthorized and precarious Roma settlements which are found to be lacking in water, heating, electricity, and hygiene facilities.[8]

Unfortunately, in Roma health surveys, there is a prevalence of qualitative research which is territorially based on small urban settlements that shows a shortage of epidemiological information and disaggregated data with regard to ethnicity and nationality.[9] At the national level, the collected data seems even more insufficient due to the absence of a national statistical data-collection system on the Roma's health status and the limited mention of their access to healthcare in hospitals.

According to a national survey on the condition of Roma communities in Italy[10] based on interviews with 1,600 Roma people, precarious housing within camps increases the risk of illnesses and social vulnerabilities. In addition, two-thirds of their inhabitants do not have health insurance cards, which are owned by Roma nationals and Roma people with proper documents. For this reason, the correlation between precarious and illegal housing and the right to healthcare access should be taken into account. Moreover, the survey shows that the Roma people, having lived in Italy for a long time, are more likely to have documents and free access to public healthcare in Italy than the Eastern European newcomers. The level of knowledge of interviewees regarding the different services also varied. The interviewees were aware of healthcare services, for which nine out of ten respondents expressed a positive opinion. In their access to services, it was found that the most widely used ones were; healthcare (82%), followed by education (schooling) (66%), specific services for Roma and Sinti people (43%), and social services (42%).[10]

To analyze the socio-economic and health status of Roma people in Milan's unauthorized settlements, a volunteer healthcare NGO (Non-Governmental Organizations) for Roma and migrant people called Naga has spoken about the difficult situation of Roma people living in irregular settlements. During medical visits in the field, Naga monitors the health situation of its patients. For this reason, it has collected data during two years of activity (2009–2010) on 1,142 Roma people living in 14 Milan settlements (only one of which was authorized).[11] The number of children per family was 2.8 and the average length of formal education was 4.9 years. Out of 803 people over the age of 13, 129 were employed (16%). In 56% of the total population of Roma people, people over the age of 12 were smokers (of which 53% were females vs 59% males). The most frequently reported diseases were; respiratory diseases (21% of total diagnoses), orthopedic-rheumatologic-traumatology disorders (13%), gastroenterological diseases (10%), and dental problems (8%). An overwhelming majority (94%) of residents had no healthcare coverage. Almost all settlements (except the authorized one) were overcrowded and lacked sanitary facilities and garbage collection systems.[12]

In a survey by the Caritas health department of Rome, carried out between 1999 and 2001, doctors provided services to Roma people using a specially-equipped camper van in 686 clinical visits made to two camps in Rome. During this period, they identified a prevalence of breathing diseases, cardiologic and circulatory illnesses, hypertension, osteoarticular diseases, and digestive and skin diseases, all of which were related to the lack of access to health services and specialized medical treatments.[13] This situation does not seem to have improved over the years.[14] Another cross-sectional survey was carried out in five settlements

of Khorakané Romá (known as gypsies in Muslim culture) in Italy to study the living conditions and health status, among other factors, of children under five years of age.[15] This study was part of a general survey covering 137 households and a total of 737 people, out of whom 167 were children aged 0–5 years. In addition, the team held five focus group meetings (one per camp) with the children's mothers. The study showed that Roma children living in camps were at high risk for asthma, one-third of them suffered diarrhea within a period of 15 days prior to the interview (32%; 53 out of 165), and a strong relationship existed between years of residence in the camp and the occurrence of diarrhea. Children living for more than two years in the camp were found to have a higher risk of suffering from diarrhea episodes. Cough was common among Roma children living in camps (55%; 90 out of 165). The lack of a toilet with a shower and hot water, presence of stagnant water, overcrowding, use of wood-burning stoves for heating, humidity and dampness in the houses, and rat allergens were factors that increased the risk of cough, respiratory difficulties, and wheezing.[15]

CULTURALLY-ORIENTED LOW-THRESHOLD HEALTH SERVICES

The marked separation between the Roma people and the general population is not only the result of the prejudices and discrimination that they face, but also an outcome of policies that segregate housing in the legal camps and the Romas' attitude of self-segregation in the unauthorized settlements (which ultimately prevents social integration and affects the proper use of healthcare services). These aspects concern the migrant and undocumented Roma people and also many foreign-born Roma communities who live in precarious housing conditions and have completed the steps of obtaining legal residence in Italy but still do not exercise their right to a primary care physician. Research on their healthcare practices has shown that cultural aspects affect the correct use of healthcare facilities and medicines. Roma patients' medication is often interrupted at the disappearance of disease symptoms and in many cases the extended family is directly involved in the administration of care, thus creating tensions between themselves and the medical staff that administers the treatment. At the same time, healthcare professionals often report difficulties in establishing a trust relationship with Roma patients, often due to their own lack of knowledge of Roma cultural interpretations of the symptoms or a lack of awareness among the patients about how individual health problems can impact their families.[16]

According to national law and within the framework of constitutional principles, even foreign citizens who do not comply with the entry and residence provisions even under force are guaranteed urgent and essential outpatient and hospital care within the scope of healthcare facilities. Moreover, the regular residence permit entitles one to healthcare services provided by the National Healthcare Service (NHS) for all the family members of the permit holder, irrespective of his/her ethnic or national background. In addition, the standardization of regional healthcare laws extends healthcare rights to EU and non-EU nationals. NHS registration further entitles one to choose his/her own general practitioner and pediatrician. Regrettably, the lack of health education and the mistrust felt toward the healthcare system have led to the improper and incomplete use of public healthcare by Romas. Furthermore, more often than not, the first interaction between migrant Roma patients and the National Health Service is in the emergency room.

In the last fifteen years, public health institutions, NGOs and health providers have tried to find an answer to these complex issues. Several interventions have been carried out in order to promote the right to health and the availability of health care services for Roma people. Information and awareness campaigns have been carried out in Roma and Sinti settlements and systematic measurements of the health of children and the adolescent Roma population have been done. Public health institutions have been pressurized to raise immunization campaigns; promote the inclusion of Roma in the National Health Service, with their choice of pediatrician and family doctor; inform in Romani language about local health services and healthy lifestyles at the national level via targeted information materials; provide information on motherhood and the use of drugs; produce training materials on Roma peoples' health needs for public health and social services. Still, in the last few years, NGOs and public health services have implemented special health protection programs for Roma minors involved in criminal proceedings.

Policy developments and case studies at the local and municipal level show strengths and weaknesses, effective approaches, and interesting outcomes, even if they largely adopt a project-based approach and temporary objectives that lack a global view and long-term strategy. The measures aimed at the promotion of health for Roma communities vary based on region and municipality, with some of them including innovative local approaches and solutions. It is virtually impossible to grasp the diversity and complexity of interventions that are developed at the local level in Italy. The overview of some of these experiences provided below provides an idea of possible solutions to the prob-

lems being discussed.

The cities of Udine (Friuli Venezia Giulia Region, north-eastern Italy) and Bologna were the first principal cities which made a local Action Plan for the inclusion of Roma people, devoting a specific part of the plan to healthcare. From 1990 onwards, the municipality of Milan made specific agreements with grassroots associations for the social inclusion and health support of Roma people. NGOs and public health services in Naples have been involved for several years in vaccination campaigns and health facilities in both formal and unauthorized settlements, with the added use of mobile units. All these organizations provide preventive medical services with a particular focus on exposing Roma children to dental services, supporting reproductive health with maternal and childcare, facilitating pregnancy and post-pregnancy visits, promoting healthy diet behaviors, and educating mothers and children on behavioral factors that favor the onset of caries and informing them about the public healthcare services that are available for the treatment of specific diseases.

The Health Center of Immigrants and Nomads of the Local Health Agency (AUSL 6) of Palermo is an outpatient facility that is specifically focused on the healthcare of foreigners and Roma people. In addition to maintaining a clinic for migrants to issue them temporary health cards (STP/ENI) codes and performing general medical examinations, a vaccination center and a gynecological clinic are also present here. The high presence of Roma patients is the result of the work done by health professionals in the last twenty years, in an effort to reduce Roma peoples' excessive use of the emergency facilities even in cases of minor illnesses. In fact, Roma people living in the Palermo's park of La Favorita used to consider the emergency room as the only point of reference for healthcare before they were informed otherwise. For many years, the health team of the AUSL 6 makes guaranteed bi-weekly visits to the camp in order to promote the members' trust in public health facilities and make the families aware of the local healthcare centers. The AUSL approach was initially meant to bring doctors into the Roma settlements, who entered the camps with an attitude of openness, curiosity, and receptivity to Roma patients, a behavior that has allowed them to gradually decrease the cultural distance between the public services and the Roma community, thereby building a relationship based on trust. Doctors guaranteed the continuity of the visits to the settlement as per the established schedule and were responsible, in all weather conditions, for ensuring assistance for Romas. Later, the medical staff began to encourage Roma population to independently access the public outpatient service. Nowadays, for illnesses, vaccinations, or drugs all the Roma residents of La Favorita visit the nearest public health center on a regular basis. After 20 years, the doctors of Ausl 6 still remain a harmoniously working team. Their experience with the Romas of La Favorita permitted the creation of a strong network of public and private health providers used by Roma families and served as a point of healthcare reference for the country's populace, namely Italian citizens, asylum seekers, refugees, or other Roma people.

The work of GrIS (Group immigration and health) Lazio is worth a special mention. GrIS has been working since 1995 in the city of Rome and is composed of health workers of public services (currently, all regional health agencies), social workers, and associations working on the health protection of migrants and the Roma population. The group, after a few years, extended their interventions to all of Italy through a partnership with many health institutions in other regions. Since 1995, with their years of experience combined with their project-by-project methodology, they have developed an approach that has served as the model of a networking approach involving Roma communities, grassroots organizations, the third sector, territorial health care centers, regional health institutions, and the Ministry of Health. This approach has been used and enhanced on the occasion of the delineation of the first National Plan of Action for Health of Roma in 2014. The first implementation of the Plan in 2014–2015 by the National Institute for Health, Migration, and Poverty (NIHMP), was meant to overcome cases of measles, mumps and rubella (MMR) in Roma settlements. They achieved high MMR vaccination coverage and provided better access to preventive services in the framework of a national comprehensive strategy, which will be re-launched in 2019.

THE NEED FOR A LONG-TERM STRATEGY

In 2012, the national strategy regarding the social inclusion of Roma population introduced a formalized multi-stakeholder approach based on common aims and actions, to be implemented by a cooperative network of ministries, regional governments' technical working groups, civil society organizations, health agencies and units, and experts and medical practitioners with a long-term multi-sectoral approach. The national strategy respected the bottom-up approach for the improvement of Roma health that had been positively tested in the previous years by the common work of private as well as public health service organizations. The effective involvement of all the stakeholders in the works of the National strategy was centered around three specific objectives: (1) "Promoting the analysis and methods of access to quality social services for RSC com-

munities, with a specific focus on women, children, adolescents, the elderly, and the disabled"; (2) "Promoting access to preventive health services, with specific regard to reproductive health and maternal-child health"; (3) "Involving trained Roma and Sinti people in social services and medical care programs such as cultural mediation."

In 2013, the health authorities, coordinated by the National Institute for Health, Migration, and Poverty (NIHMP), launched a series of informal consultations with the representatives of Roma communities, at both national and local levels. The aim of the consultations was the recognition of the health needs as perceived by the Roma people themselves, in order to produce a shared platform for organic proposals to define policies on health protection. Roma associations argued that healthcare must be guaranteed to Romas in clinics, hospitals, and public health facilities. Roma representatives reported the utility of awareness campaigns regarding prevention and health interventions in Roma camps (e.g., talking to mothers for the protection of maternal and child health, holding workshops on women's health, sexuality, and family planning). They considered the presence of health mediators having Roma origin as a useful trait. Even with the experience gained by the health mediators, they opined that Roma mediators should be recruited in the health facilities in order to facilitate more visits/exams with physicians. Roma mediators should also be recruited in the emergency department, which is often misused by the Roma people in relation to chronic illnesses and rehabilitation. Since 2014, NIHMP and the Directorate-General for health prevention and health promotion of the Ministry of Health have both been working with the National Round Table to write and coordinate the National Roma Health Plan. In order to maintain a common integrated approach to Roma healthcare at the local level as well, the main authority of the Ministry promoted the direct involvement in the writing of the national plan of all the local stakeholders, such as municipalities, civil society organizations, general practitioners, and Roma communities.

The Plan of Action for Roma Health implies a reorientation of existing services. This doesn't refer to creating new services but rather talks about making the existing ones friendlier for the entire population, with particular attention being paid to those who are subjected to conditions of greater vulnerability due to social, economic, cultural, legal, and institutional discrimination. The reorientation will start from those who are territorially based in marginal areas and permit easier access to services such as women's health and child welfare, the territorial departments of mental health services, and the local units of health prevention. Health facilities will be able to communicate and network well inside the health centers and with other institutions, but they will especially ensure the same with those parts of civil society which may be interested in the health services. The prevention activities outlined in the health plan for Roma will be carried out with the direct involvement of Roma communities and will mainly promote healthy lifestyles and living environments and educate the people on correct maternal care and childcare during pregnancy and vaccinations. Priority interventions of the prevention will target women and school children and will be implemented not only in the area of maternal-child health but also on activities such as smoking, drinking, and maintaining a healthy diet and good behavioral habits that affect the entire population.

Concerning diagnosis and treatment, it is crucial to improve the advocacy of policies in order to stabilize the Roma population and overcome emergency interventions. The goal is to place Roma population on the path to normal, periodic, and preventive medical care by way of ensuring regular visits to the general practitioner and pediatrician and building a relationship based on mutual trust that avoids the inappropriate use of emergency services. However, considering the different legal statuses of Roma people in Italy, the situation throughout the country remains uneven, with diverse healthcare access in each region. Moreover, many local authorities still consider the Roma as nomadic, an issue that has been largely overcome in the national strategy. For instance, the Rome Municipality Office for Nomads has been recently renamed as the Office for Roma, Sinti, and Caminiti people. Using the ethnonym Roma, some administrative units have entered into a new era of structural policies, overcoming any emergency approach that was used in the past. Another issue concerns health policies targeting the Roma people in Italy, which are based on the occasional faulty assumptions that they are Italian citizens while not taking into account the current variety of legal statuses among them, i.e., Italian citizens, citizens of other EU member states, third-country nationals, foreigners who have been granted asylum or subsidiary protection, and stateless people. Public and/or private institutions, as well as grassroots associations, must take into account these different ethnic and juridical backgrounds among Roma people of the same municipalities or regions and use distinct politics and unique approaches in their social interventions.

Ten methodological principles address the implementation of the Roma National Action Plan, which are the same principles elaborated by the mentioned non-profit, GrIS, under its 2009 "Health Without Exclusion" project:[16]

1. Always act on both reference populations, i.e., Roma and health workers.
2. Network with other institutions and enhance the integration of public and non-profit associations.
3. Design interventions and actions with a multi-professional approach (medical, social, anthropological, psychological, legal, etc.) that also includes the Roma peoples' presence.
4. Implement training with specific technical and operational content for medical practitioners, including topics on human rights and intercultural communication.
5. Encourage the involvement of the local Roma communities through sensitive and frank relationships and answer their health needs (particularly those of women and girls).
6. Encourage direct interaction between health workers and Roma people, by ensuring the former's presence in the camps, to create a mutual understanding and personalized contact, with special attention being paid to gender equality.
7. Ensure the availability of services in Roma and Sinti settlements, not only in terms of medical facilities and health workers but also with regards to information tools for health education. Nevertheless, in the short-term, accomplish work that steers the Roma people toward the public health facilities.
8. Revise health facilities with a view to make them accessible to socially vulnerable populations, in order to offer low-threshold services with a good relational capacity.
9. Identify flexible intervention models that are attentive to Roma people's needs.
10. Implement a reason with a "mediation system" approach, i.e., a process of organizational changes where the relationship and the communication with the patients are facilitated by specific professionals (mediators, interpreters, facilitators) and the networking of skilled stakeholders.

The implementation of the Roma health plan is possible only with a strong partnership among national authorities, health care providers, and Roma people. As outlined in the Roma national health plan, we could sum up our requirements, which would be useful for the implementation of low-threshold health services as follows: implementing local networks of trained healthcare professionals acting as contact persons for Roma people in medical facilities situated in the neighboring authorized and unauthorized settlements; developing and monitoring health-related projects' spontaneous implementation in Roma settlements; addressing Roma people toward making use of the public health facilities; organizing regular professional training on the social determinants of health, non-discrimination, and Roma people's issues regarding healthcare professionals, non-medical personnel, and civil society organizations; monitoring the access of Roma people to healthcare facilities; promoting direct interaction between healthcare providers and Roma people; developing of training and the recruitment of Roma cultural mediators in healthcare facilities that have a high density of Roma patients; actively involving the Roma population in each action that is developed for their health; instituting a permanent mechanism for the training and recruitment of Roma mediators for healthcare services having a high density of Roma patients; ensuring Roma people's active participation in decision-making processes regarding their health and taking their support in the design, implementation and monitoring of health-related projects; leading Roma people to actively attend health prevention training courses; ensuring Roma communities' pro-active approach toward health services and overcoming the mistrust and prejudice toward healthcare providers and medical facilities; promoting a healthy lifestyle in households with a long-term commitment by attending routine screenings, immunization drives, and medical appointments and respecting healthy eating habits; giving special attention to the health needs of children and women; and respecting the medical pharmacological therapies.

In conclusion, public health authorities and healthcare providers are often unable to overcome their rigid bureaucratic limits and offer low-threshold health services to vulnerable ethnic minorities. Policymakers and service providers should address and share a common and comprehensive strategy that is aimed at addressing all the social determinants of health with other institutions and with the involved community. With a standardized and coherent cultural and institutional approach that is able to fill the gap between Roma communities and healthcare services, by implementing a bottom-up and integrated approach based on common aims and ensuring the action-oriented involvement of all the stakeholders, it could be possible to achieve the appropriate, concrete, and measurable developments to give Roma people better access to healthcare. The proposed multidimensional and culturally-oriented model for the improvement of Roma people's health in Italy, garnering a concrete multi-ground private-public part-

nership and community involvement, may offer a methodological approach to overcome the prejudice and the structural obstacles against health.

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