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PARTIAL RIGHTS WITHIN AN OCCUPATIONAL SELECTIVE SYSTEM: THE ROMANIAN CASE

by Angela Genova, Valentin Burada, George Radulescu

Several factors influence the health of Romani women: poverty, lack of health insurance, the discriminationatory practice of medical staff, and lack of trust in the public health system. These factors are multiple and interrelated, and as a result Romani women can experience multiple barriers to service access. This study analyses the health inequalities of Romani women living in Romania, and focuses on the barriers they face in accessing health services within its occupational health system, their health needs, health outcomes, and the main policies aimed at reducing these inequalities. The study highlights that when attempting to tackle health inequalities for Romani women, the regulative framework should be redesigned. Any changes aimed at supporting women's empowerment should also promote integrated policies, that is, equitable access to health insurance, health services, and welfare and labour market policies.

Diversi fattori influenzano le condizioni di salute delle donne Rom: povertà, mancanza di assicurazione sanitaria, discriminazioni da parte del personale sanitario, mancanza di fiducia nel sistema sanitario pubblico. Questi elementi sono strettamente legati tra loro, determinando una condizione per le donne Rom di discriminazione multipla e intersezionale. Lo studio analizza le disuguaglianze di salute delle donne Rom in Romania focalizzando l'attenzione sulle barriere nell'accesso ai servizi sanitari all'interno del sistema sanitario occupazionale, i loro bisogni, e le principali politiche di contrasto a queste barriere. Per superare le disuguaglianze che limitano il diritto alla salute delle donne Rom, è necessario rivedere il contesto regolativo, ma anche realizzare politiche di welfare integrate che sostengano il loro *empowerment*.

About 10% of Romania's population is represented by minorities. The main minorities are Hungarians and Roma people. The study focuses on Romani women in Romania due to the conditions of social exclusion characterizing Roma[1] communities. In this country, as in most of the other EU Member States, Roma are characterized by discrimination, intolerance from the majority citizens, marginalization due to poverty, lack of qualification

Angela Genova, University of Urbin Carlo Bo, Giacomo Brodolini Foundation.
Valentin Burada, Civil Society Development Foundation.
George Radulescu, Civil Society Development Foundation.

[1] «In the Romani language, rom is a masculine noun, meaning "man, husband", the plural is roma. Romani is the feminine adjective, while romano is the masculine adjective. The term Roma is used as a noun for the whole community while Romani as an adjective. At the European Union level, policy-makers have chosen to use the term Roma to encompass different related groups throughout Europe (Roma, Sinti, Manouches, Kalés, Kaalés, Romanichels, Boyash, Ashkalis, Égyptiens, Yéniches, Travellers, Doms, Loms, etc...), nevertheless taking into account cultural diversity and lifestyles. When referring to EU policies the same distinction is kept» (European Women's Lobby Position Paper, 2012, p. 3).

and social exclusion (Council of Europe, 2012). Data show also higher rates of poor health and mortality among Roma than in society at large (Ringold *et al.*, 2003): life expectancy of the Roma population in Eastern Europe is about 10 years less than that of the overall population.

Romani women's health in Romania is affected by pervasive poverty, geographic isolation, direct discrimination by healthcare providers, direct and indirect discrimination in governmental policies, lack of citizenship and personal documents, communication barriers between Roma and healthcare providers (Council of Europe – EUMC, 2003). Moreover the strongly differentiated gender roles within the Roma communities bring about a condition of subordination of Roma women to men, exposing Romani women to discrimination also within their own communities.

This study analyses health inequalities concerning Romani women in Romania, focusing on the barriers they face in accessing health services within the occupational health system, their health needs and outcomes, and the main policies implemented to tackle Romani women's health inequalities.

1. The ethnic minority context

According to the Council of Europe, Roma in Romania are about 1.850.000 (Staff Working Document, 2012). Detailed data on age and gender distribution of Roma population are not available, but there is evidence of their socio-economic conditions. Roma are four times more poor than the remaining part of the population. Despite the increasing attention at national and European level, up to now the implemented policies have not substantially improved the Roma conditions that are embedded in vicious circles: illiteracy rate and incomplete elementary and/or secondary education lead to low qualifications with which to access the labour market, reducing their chances to improve their economical conditions. Most of the Roma work as unskilled workers in constructions, hygiene service, agriculture, and heavy industry. Hence, the cycle is taken over almost invariably and, apparently, without perspectives to escape from the spiral (Radulescu, 2009).

The economical difficulties and changes suffered by the Romanian state (economical crises, privatizations, and the closure of factories) led to the pronounced deterioration of the life conditions of the entire population, mainly amongst vulnerable categories such as women and children. Interethnic conflicts in schools generated massive school abandonment amongst the Roma children. The phenomenon is aggravated by the material deprivation of the families they come from (writing materials, clothes, footwear), but also by the lack of conditions to improve their social and economical perspectives. As part of this background, one has to note that the migration of a workforce intensely supplied by the Roma towards Western countries, represents a consequence of the inequality of chances in Romanian society.

Most of the Roma settlements are affected by the lack of water sources with dramatic consequences on individual and community health (Fleck, Rughinis, 2008). Moreover, the Roma continue to have a traditional lifestyle: Roma would rather live within extended families, marry at early ages and have many children. Early marriage of Roma girls and birth at early ages put an end to their school participation, contributing to the maintenance of a low education level. Regarding the marriage of Roma women, the data show that they marry, on an average, four years earlier than women belonging to the majority population

(*ibid.*, p. 257). Precocious fertility, for young women aged between 15 and 19 years, is 5.5 times higher than that of the remaining population, and for women 20-24 years, it is 3 times higher (*ibid.*, p. 262).

There are more Roma women with no qualifications than Roma men (37% compared to 15% respectively). This financial dependence on men is also the partial explanation for the marginal role of Romani women in traditional communities. The rate of poverty in the case of the Roma is estimated at being much over the national mean (UNDP, 2002), and a significant part of the Roma do not hold identity documents, their official access to work being limited from the very beginning (Stoian, 2010).

With the economical decline registered after 1989 the weak socio-economic conditions of the Roma population have even worsened. These are associated with worse health conditions. Poverty and illness are indeed interrelated. The alteration of the health condition compromises the income of the family, reducing the work capacity and productivity, affects the quality of life, determining or perpetuating poverty. At the same time, poor persons are more exposed to individual and environmental risk factors, are more poorly fed, less informed and with more limited access to health services, being therefore more exposed to disease and incapacity risk. Therefore, a poor health condition is both a cause and consequence of poverty.

The status of social-economical "transition" registered in Romania after 1989 negatively affected the health and welfare of the population of the country, that has been amongst the poorer countries in Europe. The Roma population is known as one of the most exposed to poverty risk and, as an unavoidable consequence, to a poor health condition, with women generally being more underprivileged compared to men. Promoting better health is thus crucial to prevent, or offer a way to escape poverty.

2. Occupational health system: the regulatory framework

The healthcare system in Romania is a social insurance system aiming at providing fair and non-discriminatory access to a package of basic services for the insured. The basic model of this system was adapted according to the German model, but many adaptations and alterations were brought.

The social insurance system assumes the collection of all contributions in a unique fund, especially destined to healthcare related expenses. The system is based on the principle of solidarity, where all pay and the needy consume, when needed. The payment obligation is usually divided between the employee and the employer, in a percentage different from one system to another (Eclemea, 2010). The payment of contributions is compulsory by law, the system being based on the withholding from the gross salary and transfer to the fund by the employer.

There are categories of persons who benefit from insurance without paying their contribution, such categories including pregnant women and postpartum women, if they have no income or benefit from incomes below the minimum gross basic salary. Another category of persons benefitting from insurance without paying their contribution includes persons which are part of families with rights to social security benefits (according to Law no. 416/2001, regarding the minimum guaranteed income, including subsequent amendments and additions). The individuals who do not pay their contributions cannot benefit from the gratuity of medical services and will have to pay their health contributions according to law, containing the related amounts and penalties.

There are categories of the population disadvantaged by this system such as individuals working without a legal labour agreement who should pay the insurance, but because of the lack of information such persons remained uninsured, and in the moment they access health services, they need to pay an amount of money that in most cases they cannot afford.

3. Health needs and outcomes of Roma women

The mortality and incidence of diseases amongst the Roma are sensitively higher than amongst the remaining population: the incidence of TB, HIV/AIDS cases and viral hepatitis is disproportionally high amongst the Roma in Romania, as it is in Central and Eastern Europe (Dev A., Zhuri G., Pana B., Tripathi V., 2004).

Data related to the health status of Roma women are not officially available. The existing data arise most of the times from various reports and researches performed by the NGOs active in the field of heath and vulnerable groups.

According to the Roma Inclusion Barometer survey, 55% of the Roma are satisfied of their health (Bădescu *et al.*, 2007). The assessment report on "Roma Access to Public Healthcare Services", performed by the Association Roma Centre for health Policies (SASTIPEN, 2010) brings to light that four out of ten Roma (39%) consider their health condition as good and very good, and three out of ten as neither good nor bad (30%), and a bad and very bad health condition is declared by (30%)[2]. Men report a better health condition than women and women, in a higher proportion than men, consider that their health condition is neither good nor bad: a third of the women (32%) compared to a quarter of the men (27%) chose the neutral variant of answer.

In the survey Open Society Foundation (2006), on the status of Romani women in Romania, the percentage of Romani women evaluating their health as poor was higher compared to non-Romani women. Most Romani women from the sample (88%) are aware of contraceptive methods, but almost one third (36%) say they have never used any. In the sample, abortion is the main contraceptive method for 78% of Romani women. The life expectancy of Roma women is 10-12 times lower than amongst the majority population. Maternal mortality rate within Roma women is 2 times higher than within non-Roma women (*ibid.*), and according to UNICEF Romania (2006), the rate of abortion is considerably higher amongst Roma women than amongst non-Roma women.

The Roma NGOs at national level, acting in the field of Roma health (e.g., SASTIPEN – Roma Centre for Public Health Policies; Romani CRISS – Roma Centre for Social Intervention and Studies; AFRR – Association of Roma Women in Romania), as well as the nongovernmental organisations acting at regional/local level (Association of Roma Women for Our Children, Timisoara; Roma Alliance Galati; Association of Inter-Active Community Development-Botosani; Alliance for Roma Unity, Braila, etc.) refer in their annual reports to the poor health condition of Roma, and in women in particular. The health condition generally depends on the living conditions, the life style, social-economic condition and education level. The nourishment is in most cases lacking in quality and quantity, as a consequence of the low income of this population. The basic food is legumes (potatoes, beans etc.), the dairy and

[2] The report was drafted in 2010 within the project "Assessment of Roma Access to Public Healthcare Services", financed by the governments of Iceland, Liechtenstein and Norway by the European Economical Area Financial Mechanism, available on the website www.sastipen.ro/publicatii.

meat consumption being limited, and that of fresh fruit and vegetables is almost non-existent. Food deficits have serious consequences which can lead to vitaminosis, malnutrition, anaemia, dystrophy, and rickets. Another important category of infections is coloenteritis which arise due to the consumption of tainted food preserved in improper conditions. As well, food poisoning was identified as a consequence of the consumption of expired food products or of inedible products.

The accessibility of drinkable water is another cause of health problems. Additionaly, low water quality enables the appearance of intoxications and contagious diseases. Hygiene, both personal and that of the habitation, is poor, due to the low accessibility to water resources, and to the absence, in most of the cases, of a bathroom.

These vulnerable health statuses are associated with scarce access to services. Romani women face barriers in accessing health services: 71% of Romani women have declared experiences of ethnic discrimination from medical staff. The data supplied by the Roma Inclusion Barometer show that the Roma feel the strongest discriminated in their relationship with the employees of city halls, of the police and those in the sanitary system (Bădescu *et al.*, 2007). The Roma face the highest levels of discrimination amongst all groups (and 11% of the respondents reported as discrimination their contact with the staff of medical-sanitary assistance units, this field being 2nd place after the discrimination within private services, reported by 14%) (FRA/UNDP, 2012). Moreover, one of the main obstacles is the lack of identity documents (Vlădescu *et al.*, 2008) and health insurance.

Civic social organisations (CSOs) estimated that the population not recorded in the registers of a family physician was mainly represented by categories of vulnerable populations, mainly Roma individuals – they consider that there are counties where approximately half of the Roma ethnic population is not socially insured (CEEN, 2006).

Romani women without insurance can only benefit from medical services in the following cases: medical-surgical emergencies, diseases with endemic-epidemic potential, monitoring the evolution of the pregnancy and of the postpartum, family planning services. Due to Roma women being largely uninsured persons, their access to healthcare services is limited, which makes them refer too late to a physician and not to the family physician, but to the emergency services.

Most of the Roma (86%) considered that money/lack of money is the main reason for issues they presently face, the place of work/lack of a job represents the second cause which generates problems. 72% of Roma claim that their current situation is related to the place of work, while the health related issues take third place. 68% of the respondents claim that their current issues are related to their health conditions (SASTIPEN, 2010). Regarding the failure to access the services of the family physician in cases of need, a proportion of 28.7% of the Roma respondents (females) answered that they did not refer to the family physician during the last year, amongst the main reasons – the lack of money, the medical office being too far away from the habitation of the respondent and the behaviour of the physician.

Difficulties in accessibility to health services is also stressed in another research involving 36 communities (Fleck, Rughinis, 2008) that brought to light that there were no medical offices or medical centres in the areas were Roma were living; moreover, health services were far away from Roma's houses, and the poor status of the roads and the lack of transportation means were barriers in accessing them.

In the report "Roma Access to Public Healthcare Services" (SASTIPEN, 2010), a percentage of approximately 14% of the women declare that they are not registered to a family physician, the main reason being that they do not benefit from health insurance. The

women invoked in a higher proportion the lack of medical insurances as an impediment in having access to primary medical services (42%), related to a second reason – lack of money (15%), followed by the lack of a workplace (12%). In case of less serious health issue, Roma women would rather treat themselves by using traditional methods (28%) or drugs bought from the pharmacy (30%) (*ibid.*).

4. Policies: is there equity in access to health services for Roma women?

Since 2001, specific policies targeted at Roma were drawn up: the Governmental Strategy to Improve the Roma Condition (Government of Romania, 2001), National Programme for Antipoverty and Promotion of Social Inclusion (PNAinc)[3], and Joint Memorandum for Social Inclusion (Government of Romania, 2005a) promoting a cohesive and inclusive society. They were all related to the National Development Plan 2007-2013 (Government of Romania, 2005b) and funded by the agency of structural and cohesion funds[4].

In 2005 the framework of "Roma Decade 2005-2015" has been introduced as an initiative involving nine states in the Central and South-East Europe, to improve the socio-economic status and social inclusion of the Roma in the region, representing the first multinational project in Europe aiming at actively improving the condition of the Roma. One of the main innovative aspects of the Roma Decade has been the introduction of Roma expertise – the National Roma Agency – in the structures of the central public administration, uncovered by the Governmental Strategy, JIM or PNAinc.

The National Roma Agency has been in charge of drafting, implementing and monitoring the programmes/policies for the Roma. Amongst the fundamental initiative regarding the Decade, each participating state drafted its own National Action Plan which provides the objectives and indicators to be fulfilled in the fields of intervention. The National Action Plans (NAPs) were built on the grounds of the National Strategy for Improving the Condition of Roma in Romania.

The NAP proposals in the field of health refer to the extension of the sanitary mediator network, to the development of preventive care programmes and sanitary education in the Roma communities and anti-discrimination measures regarding the assurance of the equal access to high quality health services for the Roma. However, because of the lack of concrete results and successful projects which become models of good practice, it is impossible to measure if such objectives defined by NAP proposals have been or can be implemented in order to improve the health condition of the Roma communities in Romania. In the last years, to improve access to health services for Roma, government, with the support of EU funds, has focused on health mediator (Open Society Institute, 2005). However, as emerged by the interviews, the implementation of sanitary mediators at local level has faced several difficulties because of the lack of resources.

[3] Conceived by the Governmental Commission for Antipoverty and Promotion of Social Inclusion – CASPIS – is established in a complex document which proposes the following «a social construction programme directed towards an European society» having a full chapter – chapter 14 – destined to the reduction of the Roma poverty and social exclusion. The plan was adopted by Governmental Decision 892/2002, being conceived according to the model established by the European Council in 2000 for the national plans of the member states and updated in 2006 for the period 2006-08, in the perspective of the adhesion to the EU. The improvement of the life conditions of the Roma are provided for in the eight targets of the PNAinc, focused on the following fields: health, education, economic, habitation, property purchase and legal regulation of the property and citizenship, fighting against discrimination and continuing to prepare Roma human resources

[4] Especially by the European Social Fund – ESF and by the European Regional Development Fund of the EU/ERDF.

Presently, the monitoring and assessment reports (Moisă *et al.*, 2013) – even those recent – do not supply data regarding the improvement of Roma women's access to public healthcare services. As emerged also by the interviews with CSOs stakeholders, the locally implemented research projects show that the Roma keep on facing barriers regarding the equal access to public healthcare services due to the refusal of the registration of Roma patients on the lists of the family physicians, differentiated treatment applied to the Roma within emergency services of the hospitals, segregation of Roma women in maternities, as well as the limitation occurring because of the lack of ID Cards (*ibid.*).

The regulative framework concerning the minimum guaranteed income[5] foreseen the medical insurance[6] for those who do not have income, however Roma women face barriers in accessing support of the local authority for assistance. One of the obstacles is the lack of formal residence because of the precarious housing conditions and the direct and indirect discrimination the Roma face in applying for formal residence.

The only initiative which supported the uninsured individuals was the community medical assistance programme; it proposed the creation of a professional category, the community medical assistant, with the aim of increasing the access to healthcare services for categories of the vulnerable populations. After the assessment of the pilot project, this initiative was taken over at national level, but once the healthcare services were decentralized, the importance of the programme was diminished due to the lack of regulation in the new legislative background (*ibid.*).

The "Strategy of the government of Romania for the inclusion of the Romanian citizens belonging to Roma minority for the period 2012-2020"[7] intends to promote health mediators working with the public social assistance services organized by the local public administration authorities, with a focus on mothers and children (Government of Romania, 2012). Moreover actions are envisaged to raise awareness and informing the members of Roma communities on certain health issues: preventive campaigns carried out al local level, intended especially for women and children, as well as creating and implementing programmes for health information, medical counseling and family planning focusing on mother and child protection (Government of Romania, 2012, p. 19). Specific attention is dedicated to the implementation of information campaigns among Roma women concerning the risks associated to early marriage, preventing and fighting against domestic violence and trafficking in persons (*ibid.*, p. 21).

The importance of health information and promotion to reduce risk factors, as enlighted in the governmental documents and actions, has also emerged from the interviews to stakeholders. These interviews have also served to identify examples of good practice. One of them is the SASTIPEN medical social assistance centre.

The project was implemented in one of the most disadvantaged areas of Bucharest, Ferentari, and started in march 2009 and finished in February 2011. The project SASTIPEN Medical Social Assistance Center aimed at increasing the access to the health services offering social and medical intervention within the Ferentari community through the Centre of Medical and Social Assistance, established in a modular container, which was set in the community. The implemented activities of the project contributed to increasing access to basic medical and social services of assistance for the people exposed to risk situations, and

[5] Lege nr. 416/2001, privind venitul minim garantat, consolidata 2009 (law no. 416/2001 on the Minimum Income Guarantee consolidated in 2009), http://www. dreptonline.ro/legislative/legea_venitului_minim_garantat.php.

[6] Lege nr. 95 din 14 aprilie 2006, privind reforma în domeniul sănătăţii legea (law no. 95/2006 on Healthcare Reform – Title XVII), http://www. cdep.ro/pls/legis/legis_pck.htp_act_text?idt=72105.

[7] Available at http://ec.europa.eu/justice/discrimination/files/roma_romania_strategy_en.pdf.

also improving the knowledge level and reducing the risk of being infected with HIV/SIDA/ITIS among the drug consumers: Roma people (including Roma women), young people (including Roma girls), but also for the general public of this community.

This Centre provided primary medical care and social assistance, services focused on first aid and primary consultations; directing the beneficiaries towards specialized services; activities providing the beneficiaries with information, education and raising awareness of the importance of health care; identifying mobilizing and counseling of the beneficiaries in need; distribution of sanitary materials for preventing sexually transmitted diseases, and harm reduction actions for drug users.

The project contributed particularly to increasing the access rate of community members to the primary health services but also to the decrease of HIV infection impact or other sexually or blood transmitted diseases. Approximately 6000 people benefited from the services provided by the Centre, 4000 basic medical consultations were given, and 2000 people were redirected to specialized medical or social services.

5. Conclusions

Despite two decades of research (Moisă *et al.*, 2013), strategies, inclusion policies, programmes and project implementations which have mobilized important intellectual and material resources, the minority of the Roma keep on getting deeper and deeper in a vicious circle of social exclusion (Jaroka, 2013a). Bad health is part of this circle.

Several factors influence health conditions of Romani women: poverty, lack of health insurance, discriminations by the medical staff, and lack of trust in the public health system. The elements are multiple and tightly related to each other, leading Romani women in a condition of multiple and intersectional discrimination, due to being Roma and women. This study confirms that a significant number of Roma women, like the large majority of the Roma population, face formal legal barriers in accessing health services due to several conditions: unemployment and therefore the lack of health insurance; discrimination and barriers they face in applying for identity documents and legal residence as the first step to have access to social assistance and to health insurance for people without income.

Also Romani women with ID cards, paying contributions to the health insurance fund, face other barriers in accessing public health services. The causes determining such a situation are:

Stereotypes and Prejudices of the medical staff regarding Roma patients. The health insurance system allows access to medical treatment to the patients benefitting from social security benefits or to other groups of persons in need. Despite all this, many Roma patients had no access to healthcare due to direct or indirect discrimination. Some medical employees discriminate directly against Roma patients refusing to offer them services or making them suffer from oral abuse or degrading treatment. Most of the medical staff, which have Roma on their lists of patients, accuse the Roma's lack of personal hygiene and indiscipline, for their failure to come for vaccination when called or their lack of patience to wait for their turn when coming for a consultation.

Segregation in hospital units is a phenomenon which started to magnify in Romania. Unfortunately, it is very difficult to identify such cases and to bring them in front of the competent authorities in order to be sanctioned. This practice is a custom in the maternity type hospital, in pediatric units or in the infectious diseases sections.

Lack of health services and family planning offices (lack of physicians trained in the field of family planning) in the Roma communities or close to them. Most of the Roma communities are placed at the periphery of localities or even outside them.

To tackle health inequalities for Romani women actions should be implemented with regard to the regulative framework to contrast barriers in accessing health insurance and health services that limit the right to health for Romani women.

Moreover, socio-economic conditions of Romani women represent the strongest and most consistent predictors of poor health. Poverty and social exclusion are the main elements affecting their health. Thus, to reduce health inequalities, policies with an integrated approach have to be drawn up, aiming to combine action in the four key policy areas identified in the framework of the European Roma Inclusion Strategy: housing conditions, education, employment and health.

The analysis of the National Strategy for Roma inclusion 2012-20 shows attention given to specifically targeted measures to improve Romani women's health, nevertheless all the envisaged actions considers Romani women as beneficiaries of services, without involving them in the process of drawing up and implementing services. Policies combing top down and bottom up approaches are necessary to improve Romani women health conditions with the support of Romani women CSOs to foster Romani women's empowerment and participation in policy making processes (Jaroka, 2013b).

REFERENCES

ABOUD F. (2009), *Editorial Virtual Special Issue: Health Behaviour Change*, "Social Science & Medicine", http://www. elsevier.com/social-sciences/editorial-virtual-special-issue-health-behaviour-change

ADANU R. M., JOHNSON T. R. (2009), *Migration and Women's Health*, "International Journal of Gynaecology and Obstetrics", 106, pp. 179-81.

ALLMARK P., BRITAIN G. (2010), *Ethnic Minority Customers of the Pension, Disability and Carers Service: An Evidence Synthesis*, Leeds, Department of Work and Pensions.

APRE – AGENZIA PER LA PROMOZIONE DELLA RICERCA EUROPEA (2011), *Worskshop Migrazione e Genere. Esperienze e conoscenze a confronto*, disponibile all'indirizzo http://www.unisi.it/dl2/20110218110059832/genderemigrazioni.pdf.

ASPINALL P. J., JACOBSEN B. (2004), *Ethnic Disparities in Health and Health Care: A Focused Review of the Evidence and Selected Examples of Good Practice: Executive Summary*, London, London Health Observatory.

ASPINALL P. J., WATTERS C. (2010), *Refugees and Asylum Seekers: A Review from an Equality and Human Rights Perspective*, Equality and Human Rights Commission. Research Report, n. 52.

ASTIN F., ATKIN K. (2010), *Ethnicity and Coronary Heart Disease: Making Sense of Risk and Improving Care*, London, Race Equality Foundation. Better health briefing paper, n. 16.

ATKIN K., CHATTOO S. (2007), *The Dilemmas of Providing Welfare is an Ethnically Diverse State: Seeking Reconciliation in the Role of a "Reflexive Practitioner"*, "Policy & Politics", 35, 3, pp. 377-93.

BALAAM M.-C., AKERJORDET K., LYBERG A., KAISER B., SCHOENING E., FREDRIKSEN A.-M., ENSEL A., GOUNI O., SEVERINSSON E. (2013), *A Qualitative Review of Migrant Women's Perceptions of their Needs and Experiences Related to Pregnancy and Childbirth*, "Journal of Advanced Nursing", 69, 9, pp. 1919-30.

BARALDI C., BARBIERI V., GIARELLI G. (a cura di) (2008), *Immigrazione, mediazione culturale e salute*, Franco Angeli, Milano.

BARBAGLI – MINISTERO DELL'INTERNO (2007), *Primo rapporto sugli immigrati in Italia*, disponibile all'indirizzo http://www.interno.it/mininterno/export/sites/default/it/assets/files/15/0673_Rapporto_immigrazione_BARBAGLI.pdf, p. 101-6.

BARTOLI C. (2012), *Razzisti per Legge. L'Italia che discrimina*, Laterza, Roma-Bari.

BELL L., CASEBOURNE J. (2008), *Increasing Employment for Ethnic Minorities: A Summary of Findings*, National Audit Office, London.

BETHEL H., LEWIN R., DALAL H. (2009), *Cardiac Rehabilitation in the United Kingdom*, "Heart", 95, 4, p. 271.

BHARJ K. K., SALWAY S. M. (2008), *addressing Ethnic Inequalities in Maternity Service Experiences and Outcomes: Responding to Women's Needs and Preferences*, Better Healt Briefing 11. A Race Equality Foundation Briefing Paper, Race Equality Foundation, London.

BISCHOFF A. (2003), *Caring for Migrant and Minority Patients in European Hospitals. A Review of Effective Interventions*, A study commissioned by the Ludwig Boltzmann Institute for the Sociology of Health and Medicine, MFH – Migrant Friendly Hospitals, a European initiative to promote health and health literacy for migrants and ethnic minorities, Wien.

BLANGIARDO G. C. (2009), *La presenza straniera in Italia*, in *XV e XVI Rapporto sulle migrazioni, 2009 e 2010*, ISMU, Milano, disponibile all'indirizzo http://www.ismu.org/?page=490#.

BLOCH A., SCHUSTER L. (2005), *Asylum Policy under New Labour*, "Benefits", 13, 2, pp. 115-8.

BLOOD L., BAMFORD S.-M. (2010), *Equality and Diversity and Older People with High Support Needs*, UK International Longevity Centre,London.

BOLDRINI R., DI CESARE M. (2011), *Certificati di assistenza al parto (CEDAP). Analisi dell'evento nascita*, Anno 2008, Ministero della Salute.

BOLLINI P., PAMPALLONA S., WANNER P., KUPELNICK B. (2009), *Pregnancy Outcome of Migrant Women and Integration Policy: A Systematic Review of the International Literature*, "Social Science & Medicine", 68, pp. 452-61.

BONIZZONI P. (2009), *Famiglie globali. Le frontiere della maternità*, UTET, Torino.

CAPONIO T., COLOMBO A. (2011), *Migrazione, separazione coniugale e ruoli di genere: il caso delle lavoratrici domestiche in Italia*, "Polis", 3, pp. 419-48.

CARCHEDI F., TOLA V. (a cura di) (2008), *All'aperto e al chiuso: prostituzione e tratta. I nuovi dati del fenomeno, i servizi sociali, le normative di riferimento*, Roma, EDIESSE.

CARITAS-MIGRANTES (2011), *Dossier Statistico Immigrazione 2011, 21° Rapporto*, Caritas-Migrantes, Roma.

CARLETTI P. (a cura di) (2009), *La salute della popolazione immigrate: metodologia di analisi*, Ancona, Osservatorio Diseguaglianze Regione Marche, disponibile all'indirizzo http://www.ars.marche.it/osservatorio_dis/doc/pubb_SaluteImmigrati2009.pdf.

CEEN (2006), *Assessment of the Health* Status *of Roma and the Related Health Care Need*, CEEN Economic Project & Policy, Consulting GMBH.

CHAUHAN U., BAKER D., LESTER H., EDWARDS R. (2010), *Exploring Uptake of Cardiac Rehabilitation in a Minority Ethnic Population in England: A Qualitative Study*, "European Journal of Cardiovascular Nursing", 9, 1, pp. 68-74.

COOK J., MALTBY T., WARREN L. (2010), *A Participatory Approach to Older Women's Quality of Life*, in A. Walker, C. Hagan Hennessy (eds.), *Growing Older: Quality of Life in Old Age*, Open University Press, Maidenhead, pp. 149-66.

CORETTA P. (2011), *Institutional Racism and Ethnic Inequalities: An Expanded Multilevel Framework*, "Journal of Social Policy", 40, pp. 173-92.

COUNCIL OF EUROPE (2012), *Human Rights of Roma and Travellers in Europe*, Council of Europe Publications, Strasbourg.

COUNCIL OF EUROPE – EUMC (2003), *Breaking the Barriers: Romani Women and Access to Public Health Care*, available at http://fra.europa.eu/fraWebsite/attachments/ROMA-HC-EN.pdf.

CRAIG G., GAUS A., WILKINSON M., SKRIVANKOVA K., MCQUADE A. (2007), *Contemporary Slavery in the UK: Overview and Key Issues*, The Joseph Rowntree Foundation, York.

CRAWLEY H., HEMMINGS J., PRICE N. (2011), *Coping with Destitution: Survival and Livelihood Strategies of Refused Asylum Seekers Living in the* UK, Oxfam, London.

DAVIES M., ELWYN G., PAPADOPOULOS I., FLEMING L., WILLIAMS G. (2009), *Can Promoting Patient Decision Making be Exclusionary? Moral Expectations and Cultural Differences in the Narratives of* UK *Maternity Clinicians*, "Communication & Medicine", 6, 1, pp. 39-48.

DEV A., ZHURI G., PANA B., TRIPHATI V. (2004), *Tuberculusis Partnership Project-Romania. Doctors at the World_*USA, http://pdf.usaid.gov/pdf_docs/pdaca983.pdf.

DIREZIONE GENERALE DIRITTO ALLA SALUTE E POLITICHE DI SOLIDARIETÀ (2012), *Coordinamento Interregionale in Sanità. Tavolo interregionale "Immigrati e Servizi Sanitari"*, Ancona, Osservatorio sulle Disuguaglianze nella Salute. Indicazioni per la corretta applicazione della normativa per l'assistenza sanitaria alla popolazione straniera da parte delle Regioni e Province Autonome italiane. Giugno 2011, disponibile all'indirizzo http://www.immigrazioneoggi.it/rubriche/salute/docs/sanita_regioni_autonome.pdf.

DITSCHEID C. (2004), *Older Refugee Women*, "Refugee Women's News", 26, January and February.

DWYER P., PAPADIMITRIOU D. (2006), *The Social Security Rights of Older International Migrants in the European Union*, "Journal of Ethnic and Migration Studies", 32, 8, pp. 1301-19.

ECLEMEA I. (2010), *Management Financiar în sănătate – secţiune de formare realizată în cadrul proiectului Competenţe în administrare şi gestiune pentru sectorul de sănătate publica*.

EGGSI (2010), *Ethnic Minority and Roma Women in Europe: A case for gender equality?* available at http://ec.europa.eu/social/main.jsp?catId=738&langId=en&pubId=492&type=2&furtherPubs=no.

EKBLAD S., LINDENCRONA F., SHAHNAVAZ S. (2009), *Promoting Mental Health and Preventing Mental Disorder among Refugees in Western Countries*, "International Journal of Mental Health Promotion", 11, pp. 33-44.

EKÉUS C., CNATTINGIUS S., ESSÉN B., HJERN A. (2011), *Stillbirth among Foreign-born Women in Sweden*, "European Journal of Public Health", 21, pp. 788-92.

ERIKSSON C., JÄRLIDEN E., LARSSON A., SANDBERG S. (2010), *Partnerskap för hållbar välfärdsutveckling – Utveckling och forskning under sex år i fyra städer (Partnership for Sustainable Welfare Development – Research and Development for Six Years in four Cities)*, "Studier i folkhälsovetenskap", 2, Örebro universitet.

ESSCHER A., HAGLUND B., HÖGBERG U., ESSÉN B. (2013), *Excess Mortality in Women of Reproductive Age from Low-income Countries: A Swedish National Register Study*, "European Journal of Public Health", 23, 2, pp. 274-9.

ESSEN B., BÖDKER B., SJÖBERG N. O., LANGHOFF-ROOS J., GREISEN G., GUDMUNDSSON S., OSTERGREN P. O. (2002), *Are Some Perinatal Deaths in Immigrant Groups Linked to Suboptimal Perinatal Care Services?*, "BJOG", 109, pp. 677-82.

ESSEN B., BÖDKER B., SJÖBERG N. O., GUDMUNDSSON S., OSTERGREN P. O., LANGHOFF-ROOS J. (2002), *Is there an Association between Female Circumcision and Perinatal Death?*, "Bulletin of World Health Organisation", 80, 8, pp. 629-32.

EUROPEAN COMMISSION (2007a), *Opinion on the Gender Dimension of the Inclusion of the Ethnic Minorities*, DG Employment, Social Affairs and Equal Opportunities, Advisory Committee on Equal Opportunities for women and men, Luxembourg.

ID. (2007b), *Ethnic Minorities in the Labour Market: An Urgent Call for Better Social Inclusion*, December, Luxembourg.

EUROPEAN WOMEN'S LOBBY POSITION PAPER (2012), *Tackling Multiple Discrimination of Romani and Traveller Women – A Crucial Factor for the Successful Implementation of the National Roma Integration Strategies*, available at http://www.womenlobby.org/spip.php?article4454&lang=en.

FEDYUK O. (2012), *Images of Transnational Motherhood: The Role of Photographs in Measuring Time and Maintaining Connections between Ukraine and Italy*, "Journal of Ethnic and Migration Studies", February, pp. 279-300.

FLECK G., RUGHINIȘ C. (eds.) (2008), *Vino mai aproape – incluziunea și excluziunea romilor în societatea românească de azi*, Human Dynamics, http://www.academia.edu/285917/Vino_Mai_Aproape_Incluziunea_si_Excluziunea_Romilorì_in_Societatea_Românească_De_Azi

FRA – EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS (2013), *Inequalities and Multiple Discrimination in Access to and Quality of Health Care*, available at http://fra.europa.eu/sites/default/files/inequalities-discrimination-healthcare_en.pdf.

FRA – EUROPEAN UNION AGENCY FOR FUNDAMENTAL RIGHTS, UNDP – UNITED NATIONS DEVELOPMENT PROGRAMME (2012), *The Situation of Roma in 11 EU Member States: Survey Results at a Glance*, available at http://fra.europa.eu/sites/default/files/fra_uploads/2099-FRA-2012-Roma-at-a-glance_EN.pdf.

GERACI S., BONCIANI M., MARTINELLI B. (2010), *La tutela della salute degli immigrati*, Roma, Caritas, disponibile all'indirizzo http://www.stranieriinitalia.it/briguglio/immigrazione-e-asilo/2010/luglio/rapp-caritas-salute-2010-1.pdf.

GILL A., BANGA B. (2008), *The Reality and Impact of Domestic Violence, Crime and Victims Act 2004 on BMER Women Experiencing Gender-based Violence. Safe*, "Journal of Domestic Abuse", 25, Spring.

GLICK SCHILLER N., BASH L., SZANTON-BLANC C. (1992), *Towards a Transnational Perspective on Migration*, New York, New York Academy of Sciences.

GOVERNMENT OF ROMANIA (2001), *Governmental Strategy for Improve the Rome Condition*, printed in the official gazette no. 252, May 16.

ID. (2005a), *Joint Memorandum on Social Inclusion of Romania*, Brussels.

ID. (2005b), *2007-2013 National Development Plan*, available at http://erawatch.jrc.ec.europa.eu/erawatch/opencms/information/country_pages/ro/policydocument/policydoc_0009, Brussels.

ID. (2012), *Strategy of the Government of Romania for the Inclusion at the Romanian Citizens belonging to Roma Minority for the Period 2012-2020*, http://ec.europe.eu/justice/discrimination/files/rome_romania_strategy_en.pdf, Brussels.

GRIGORAȘ V., RUGHINIȘ C., VOICU M., VOICU O. (2007), *Barometrul Incluziunii Romilor Roma Inclusion Barometer*, Open Society Foundation, Bucharest.

HAWTHORNE K., ROBLES Y., CANNINGS-JOHN R., EDWARDS E. G. K. (2008), *Culturally Appropriate Health Education for Type 2 Diabetes Mellitus in Ethnic Minority Groups*, "Cochrane database of systematic reviews", 3.

HEALTH PROTECTION AGENCY (2011), available at http://www.hpa.org.uk/webc/hpawebfile/hpaweb_c/1317131998682

HEDLUND E., LANGE A., HAMMAR N. (2007), *Acute Myocardial Infarction Incidence in Immigrants to Sweden. Country of Birth, Time since Immigration, and Time Trends over 20 Years*, "European Journal Epidemiology", 22, pp. 493-503.

HJERN A., HAGLUND B., PERSSON G., ROSÉN M. (2001), *Is there Equity in Access to Health Services for Ethnic Minorities in Sweden?*, "European Journal of Public Health", 11, 2, pp. 147-52.

HOME OFFICE (2011), *Control of Immigration: Quarterly Statistical Summary*, United Kingdom, Quarter 4 (October-December), Home Office, February.

HONDAGNEU-SOTELO P., AVILA E. (1997), *I'm Here, but I'm There: The Meaning of Latina Transnational Motherhood*, "Gender & Society", 11, pp. 548-71.

INGLEBY D., CHIMIENTI M., ORMOND M., DE FREITAS C. (2005), *The Role of Health in Integration*, in M. L. Fonseca, J. Malheiros (eds.), *Social Integration and Mobility: Education, Housing and Health*, IMISCOE Cluster B5 State of the art report, Estudos para o Planeamento Regional e Urbano n. 67, Centro de Estudos Geográficos, Lisbon, pp. 88-119.

ISTAT – ISTITUTO NAZIONALE DI STATISTICA (2002), *Flussi migratori e popolazione straniera, Anni 1990-1998*, ISTAT, Roma.

ID. (2010), *La popolazione straniera residente in Italia al 1 gennaio 2010*, disponibile all'indirizzo http://www.istat.it/salastampa/comunicati/non_calendario/20101012_00/testointegrale20101012.pdf.

ID. (2011), *La popolazione straniera residente in Italia: 1 gennaio 2011*, disponibile all'indirizzo http://www.istat.it/it/archivio/39726.

JAROKA L. (2013a), *Working Document on Gender Aspects of the European Framework of National Roma Inclusions Strategies Committee on Women's Rights and Gender Equality*, Committe on Women's Rights and Gender Equality, European Parliament, Brussels, http://www.europarl_europa.eu/sides/getDoc.do?pubRef=_%2FEP%2FNONSGML%2BCOMPARL%2BPE-516.873%2B01%2BDOC%2BPDF%2BV0%2F%2FEN

ID. (2013b), *Draft Report on Gender Aspects of the European Framework of National Roma Inclusion Strategies (2013/2066 [INI])*, Committee on Women's Rights and Gender Equality, European Parliament, http://www.europarl_europa.eu/sides/getDoc.do?pubRef=_%2F%FEP%2F%2FNONSGML%2BCOMPARL%2BPE-516.873%2B01%2BDOC%BPDF%2BVO%2F%2FEN

JAYAWEERA H., QUIGLEY M. A. (2010), *Health Status, Health Behaviour and Healthcare Use Among Migrants in the UK: Evidence from Mothers in the Millennium Cohort Study*, "Social Science & Medicine", 71, pp. 1002-10.

JIMÉNEZ-RUBIO D., HERNÁNDEZ-QUEVEDO C. (2011), *Inequalities in the Use of Health Services between Immigrants and the Native Population in Spain: What is Driving the Differences?*, "The European Journal Health Economics", February, 12, 1, pp. 17-28.

JOHNSON M. R. D. (2003), *Asylum Seekers in Dispersal*, Healthcare issues, Home Office online Report 13/03, Home Office, London.

ID. (2007), *Researching the Health of Ethnic Minority Groups*, "Researching health: Qualitative, quantitative and mixed methods".

KARLSEN S., NAZROO J. Y. (2002), *Agency and Structure: The Impact of Ethnic Identity and Racism on the Health of Ethnic Minority People*, "Sociology of Health and Illness", 24, pp. 1-20.

KELLY R., MORRELL G., SRISKANDARAJAH D. (2005), *Migration and Health in the UK*, an IPPR FactFile.

KOFMAN E. (2004), *Family-Related Migration: A Critical Review of European Studies*, "Journal of Ethnic and Migration Studies", 30, pp. 243-62.

KOFMAN E., RAGHURMA P. (2012), *Genere, migrazione e lavoro di cura nel Sud globale*, in F. Piperno, M. Tognetti Bordogna (a cura di), *Welfare transnazionale. La frontiera esterna delle politiche sociali*, EDIESSE, Roma.

LAURIA L., ANDREOZZI S. (a cura di) (2009), *Percorsi nascita e Immigrazione in Italia. Le indagini del 2009*, ISTISAN, Roma.

LEWIS G. (2007), *The Confidential Enquiry into Maternal and Child Health (CEMACH) Saving Mothers' Lives: Reviewing Maternal Deaths to Make Motherhood Safer-2003-2005*, CEMACH, London.

MAHLER S. J. (2001), *Transnational Relationships: The Struggle to Communicate across Borders*, "Identities: Global Studies in Culture and Power", 7, pp. 83-619.

MALMUSI D., BORRELL C., BENACH J. (2010), *Migration-related Health Inequalities: Showing the Complex Interactions between Gender, Social Class and Place of Origin*, "Social Science & Medicine", 71, 9, pp. 1610-9.

MANFELLOTTO D. (2002), *Case Study 5: From Misinformation and Ignorance to Recognition and Care: Immigrants and Homeless in Rome, Italy*, in WHO – World Health Organisation, *Health Systems Confront Poverty*, World Health Organisation Regional Office for Europe, Geneva, pp. 69-78.

MCCRONE P. *et al* (2005), *Mental Health Needs, Service Use and Costs among Somali Refugees in the UK*, "Acta Psychiatrica Scandinavica", 111, pp. 351-7.

MCKAY S., CRAW M., CHOPRA D. (2006) *Migrant Workers in England and Wales: An Assessment of Migrant Workers Health and Safety Risks*, Health & Safety Executive, London.

MENJIVAR C. (2006), *Family Reorganization in a Context of Legal Uncertainty: Guatemalan and Salvadoran Immigrants in the United States*, "International Journal of Sociology of the Family", 32, pp. 223-45.

MIR G. (2008), *Effective Communication with Service Users*, "Ethnicity and Inequalities in Health and Social Care", 1, 1, pp. 71-8.

MIR G., SHEIKH A. (2010), *Fasting and Prayer don't Concern the Doctors... They don't even Know what it is': Communication, Decision Making and Perceived Social Relations of Pakistani Muslim Patients with Long-term Illnesses*, "Ethnicity & Health", advance access.

MLADOVSKY P. (2009), *A Framework for Analysing Migrant Health Policies in Europe*, "Health Policy", V, 93, 1, 55-63.

MOISĂ F., ROSTAS I. A., TARNOVSCHI D., STOIAN I., RĂDULESCU D., ANDERSEN T. S. (2013), *Civil Society Monitoring on the Implementation of the National Roma Integration Strategy and Decade Action Plan in 2012 in Romania*, available at http://www.romadecade.org/cms/upload/file/9270_file24_ro_civil-society-monitoring-report_en.pdf.

NAZROO J. Y., BAJEKAL M., BLANE D., GREWAL I. (2004), *Ethnic Inequalities*, in A. Walker, C. Hagan Hennessy (eds.), *Growing Older: Quality of Life in Old Age*, Open University Press, Maidenhead.

NAZROO J. Y., FALASCHETTI E., PIERCE M. PRIMATESTA P. (2009), *Ethnic Inequalities in Access to and Outcomes of Healthcare: Analysis of the Health Survey for England*, "Journal of Epidemiology and Community Health", 63, pp. 1022-7.

NILSSON L. (2013), *Samverkan och medborgardialog för en bättre hälsa – en satsning på bostadsområdet Varberga i Örebro kommun (Collaboration and Dialogue with Citizens for better Health – An Effort in the District Varberga in Örebro)*, Samhällsmedicinska enheten, Örebro läns landsting, Örebro.

OPEN SOCIETY FOUNDATION (2006), *Broadening the Agenda. The* Status *of Roma Women in Romania*, Open Society European Policy, Brussels.

OPEN SOCEITY INSTITUTE (2005), *Mediating Romani Health: Policy and Program Opportunities*, New York, Open Society Institute, available at http://www.opensocietyfoundations.org/sites/default/files/roma_health_mediators.pdf.

PARREÑAS R. (2001), *Servants of Globalization: Women, Migration and Domestic Work*, , Stanford University Press, Stanford (CA).

PARRY G., VAN CLEEMPUT P. (2004) *The Health Status of Gypsies and Travellers in England*, The University of Sheffield, Sheffield.

PASINI N. (2011), *Cittadinanza sanitaria in prospettiva comparata e multilivello*, Franco Angeli, Milano.

PFEFFER N. (2004), *Screening for Breast Cancer: Candidacy and Compliance*, "Social Science & Medicine" 58, 151-60.

PHILLIMORE J., GOODSON L. (2010), *Failing to Adapt: Institutional Barriers to ECOs Engagement in Transformation of Social Welfare*, "Social Policy & Society", 9, 181-92.

PIPERNO F., TOGNETTI BORDOGNA M. (a cura di) (2012), *Welfare transnazionale. La frontiera esterna delle politiche sociali*, EDIESSE, Roma.

PRIBILSKY J. (2004), *Aprendemos a convivir: Conjugal Relations, Co-Parenting and Family Life among Ecuadorian Trasnational Migrants in New York City and the Ecuadorian Andes*, "Global Networks: A Journal of Transnational Affairs", 4, pp. 313-34.

RADULESCU G. (2009), *Between Design and Failure*, available on the website http://georgeradulescu.blogspot.com.

RAPHAELY N., O'MOORE E. (2010), *Understanding the Health Needs of Migrants in the South East Region*, London, Health Protection Agency and Department of Health.

REDSHAW M., HEIKKILA K. (2010), *Delivered with Care: A National Survey of Women's Experience of Maternity Care*, National Perinatal Epidemiology Unit, University of Oxford, available at https://www.npeu.ox.ac.uk/files/downloads/reports/Maternity-Survey-Repor.

RINGOLD D., ORENSTEIN M. A., WILKENS E. (2003), *Roma in an Expanding Europe*, Breaking the Poverty Cycle-World Bank, Washington DC.

RUNNYMEDE, THE CENTRE FOR POLICY ON AGEING (2010), *The Future Ageing of the Ethnic Minority Population of England and Wales*, Older BME people and financial inclusion support, London.

SALANAVE B., BOUVIER-COLLE M. H. (1996), *The Likely Increase in Maternal Mortality Rates in the United Kingdom and in France until 2005*, "Paediatric Perinatal Epidemiology", 10, pp. 418-22.

SASTIPEN – CENTRUL ROMILOR PENTRU POLITICI DE SĂNĂTATE (2010), *Accesul romilor la serviciile de sănătate publică- studiu realizat în cadrul proiectului*, Evaluarea accesului romilor la serviciile de sănătate publică", finanţat de Guvernele Islandei, Principatului Liechtenstein şi Norvegiei prin Mecanismul Financiar al Spatiului Economic European, disponibil pe www.sastipen.ro/publicatii.

SAUNDERS E. (2004), *Elder Abuse*, "Refugee Women's News", issue 26, January & February 2004, http.//refugeewomen.org.UK/PDF/Elder_abuse_26.pdf.

SCANLON K., WOOD A. (2005), *Breast Cancer Awareness in Britain: Are the Differences Based on Ethnicity*? "Diversity in Health & Social Care", 2, pp. 211-21.

SEDDON D., FITZPATRICK P., CHATWIN M. (2002), *Migration and Social Security Handbook*, London, Child Poverty Action Group.

SEKHRI N., TIMMIS A., CHEN R., JUNGHANS C., WALSH N., ZAMAN J., ELDRIDGE S., HEMINGWAY H., FEDER G. (2008), *Inequality of Access to Investigation and Effect on Clinical Outcomes. Prognostic Study of Coronary Angiography for Suspected Stable Angina Pectoris*, "British Medical Journal", 336, pp. 1058-61.

SIMONAZZI A. (2008), *Care Regimes and National Employment Models*, "Cambridge Journal of Economics", 33, pp. 211-32.

SMART K. (2009), *The Second Destitution Tally*, Asylum Support Partnership, London.

SOSTA E., TOMASONI L. R., FRUSCA T., TRIGLIA M., PIRALI F., EL HAMAL I., CASTELLI F. (2008), *Preterm Delivery Risk in Migrants in Italy: An Observational Prospective Study*, "Journal of Travel Medicine", 15, pp. 243-7.

SPADEA T., FOSSARELLO L., MONDO L., COSTA G. (2013), *Le condizioni di salute*, in C. Saraceno, N. Sartor, G. Sciortino, *Stranieri e disuguali. Le disuguaglianze nei diritti e nelle condizioni di vita degli immigrati*, il Mulino, Bologna.

STAFF WORKING DOCUMENT (2012), *Commission Staff Working Document Accompanying the Document Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions National Roma Integration Strategies: A First Step in the Implementation of the EU Framework [COM (2012) 226 final]*, available at http://ec.europa.eu/justice/discrimination/files/swd2012_133_en.pdf.

STOIAN I. (2010), *Decadewatch Romania Report*, Mid Term evaluation of the decade of Roma inclusion, available at http://www.acrr.ro/download/DecadeWatchRomaniaReport_2010_EN.pdf.

STRONKS K., UNIKEN VENEMA P., DAHHAN N., GUNNING-SCHEPERS L. (1999), '*Allochtoon, dus ongezond? Mogelijke verklaringen voor de samenhang tussen etniciteit en gezondheid geïntegreerd in een conceptueel model*, "TSG", 77, pp. 33-40.

SUNDQUIST J. (1995), *Ethnicity, Social Class and Health: A Population-based Study on the Influence of Social Factors on Self-reported Illness in 223 Latin American Refugees, 333 Finnish and 126 South European Labour Migrants and 841 Swedish Controls*, "Social Science & Medicine", 40, pp. 777-87.

SUNDQUIST J., BAYARD-BURFIELD L., JOHANSSON L. M., JOHANSSON S. E. (2000), *Impact of Ethnicity, Violence and Acculturation on Displaced Migrants: Psychological Distress and Psychosomatic Complaints among Refugees in Sweden*, "The Journal of Nervous and Mental Disease", 188, pp. 357-65.

SUNDQUIST J., JOHANSSON S. E. (1997), *Long-term Illness among Indigenous and Foreign-born People in Sweden*. "Social Science & Medicine", 44, pp. 189-98.

THOMAS V. N., SALEEM T., ABRAHAM R. (2005), *Barriers to Effective Uptake of Cancer Screening among Black and Minority Ethnic Groups*, "International Journal of Palliative Nursing", 11, pp. 562-71.

TOGNETTI BORDOGNA M. (2012), *Donne e percorsi migratori. Per una sociologia delle migrazioni*, Franco Angeli, Milano.

UNDP – UNITED NATIONS DEVELOPMENT PROGRAMME (2002), *Avoiding the Dependency Trap*, A Regional Human Development Report, The Roma in Central and Eastern Europe, Bratislava.

UNICEF, MINISTERUL SĂNĂTĂȚII PUBLICE (2006), *Evaluarea programului de asistenţă medicală comunitară*, Alpha, Buzău, http://unicef.ro/content/report-final-24-4-aprilie-2007-pdf.

VAN ROOSMALEN J., SCHUITEMAKER N. W., BRAND R., VAN DONGEN P. W., BENNEBROEK GRAVENHORST J. (2002), *Substandard Care in Immigrant versus Indigenous Maternal Deaths in The Netherlands*, "BJOG", 109, 2, February 2002, pp. 212-3.

VASILEVA K., (2011), *Population and Social Conditions. Eurostat Statistics in Focus 34/2011*, available at http://epp.eurostat.ec.europa.eu/cache/ity_offpub/ks-sf-11-034/en/ks-sf-11-034-en.pdf.

VIANELLO F. A. (2009), *Migrando sole: legami transnazionali tra Ucraina e Italia*, Franco Angeli, Milano.

VISSANDJEE B., HYMAN I., SPITZER D. L., APALE A., KAMRUN N. (2007), *Integration, Clarification, Substantiation: Sex, Gender, Ethnicity and Migration as Social Determinants of Women's Health.*, "Journal of International Women's Studies", 8, 4, pp. 32-48.

VLĂDESCU C., SCĂNTEE G., OLSAVSKY V. (2008), *Health System in Transition*, "Romania Health System Review", 10, 3, http://www.euro.who.int/_dota/assets/pdf_file/0008/95165/E91689.pdf.

WALLBY T., HJERN A. (2011), *Child Health Care Uptake among Low-income and Immigrant Families in a Sweden Count*, "Acta Paediatrica", 100, pp. 1495-1503.

WALLER J., ROBB K., STUBBINGS S., RAMIREZ A., MACLEOD U., AUSTOKER J., HIOM S., WARDLE J. (2009), *Awareness of Cancer Symptoms and Help Seeking among Ethnic Minority Groups in England*, "British Journal of Cancer", 101, 24-30.

WEBB R., RICHARDSON J., PICKLES A. (2004), *A Population Based Study of Primary Care Predictors of Non-attendance for Cervical Screening*, "Journal of Medical Screening", 11, pp. 135-40.

WEISHAAR H. B. (2008), *Consequences of International Migration: A Qualitative Study on Stress among Polish Migrant Workers in Scotland*, "Public Health", 122, pp. 1250-6.

WESTERLING R., ROSÉN M. (2002), *"Avoidable" Mortality among Immigrants in Sweden*, "European Journal of Public Health", 12, pp. 79-286.

WESTMAN J., JOHANSSON L. M., SUNDQUIST K. (2006), *Country of Birth and Hospital Admission Rates for Mental Disorders: A Cohort Study of 4.5 Million Men and Women in Sweden*, "European Psychiatry", 21, pp. 307-14.

WIKING E., JOHANSSON S. E., SUNDQUIST J. (2004), *Ethnicity, Acculturation, and Self-reported Health. A Population Based Study among Immigrants from Poland, Turkey, and Iran in Sweden*, "Journal of Epidemiology & Community Health", 58, pp. 574-82.

WILLIAMS D. R. (2002), *Racial/Ethnic in Women's Health: The Social Embeddedness of Health*, "American Journal of Public Health", 92, 4, pp. 588-97.

WOMEN'S RESOURCE CENTRE (2007), *Report for London Councils: Funding of London Women's Refuges*, Women's Resource Centre, London.

WORKING GROUP WITH THE VOLUNTARY SECTOR (2006), *Thirty-Second Report of the Working Group with the Voluntary Sector Government Office*, House of Commons Committee of Public Accounts, London.

WORTH A., IRSHAD T., BHOPAL R., BROWN D., LAWTON J., GRANT E., MURRAY S., KENDALL M., ADAM J., GARDEE R., SHEIKH A. (2009), *Vulnerability and Access to Care for South Asian Sikh and Muslim Patients with Life Limiting Illness in Scotland: Prospective Longitudinal Qualitative Study*, "British Medical Journal", 388, p. 183.

ZANCONATO G., IACOVELLA C., PARAZZINI F., BERGAMINI V., FRANCHI M. (2011), *Pregnancy Outcome of Migrant Women Delivering in a Public Institution in Northern Italy*, "Gynecologic and Obstetetric Investigation", 72, pp. 157-62.

ZLOTNIK H. (1995), *Migration and the Family: The Female Perspective*, "Asian and Pacific Migration Journal", 4, pp. 253-71.

ZONTINI E. (2010), *Transnational Families, Migration, and Gender: Moroccan and Filipino Women in Bologna and Barcelona*, Berghahn, New York.