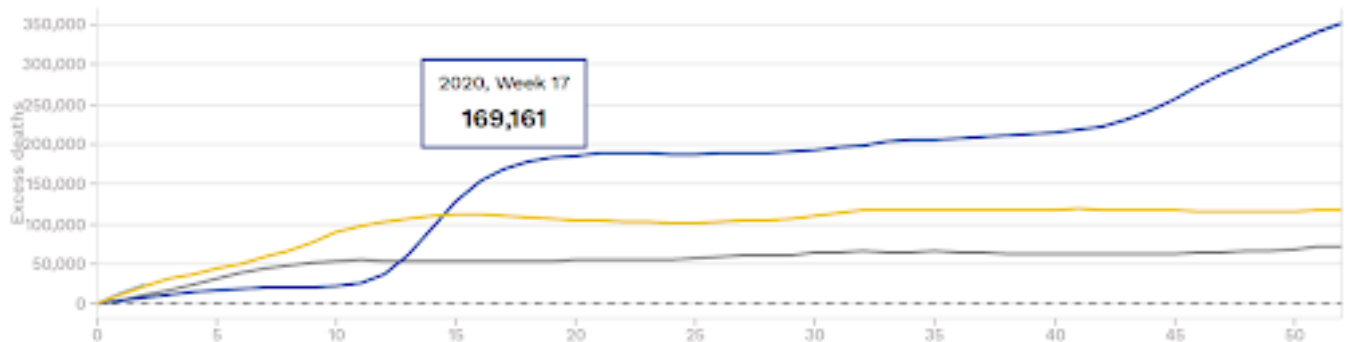


**SHOULD  
GOVERNMENTS  
CONSIDER ROMA A  
PRIORITY IN THEIR  
COVID-19  
VACCINATION  
ROLL-OUT PLANS?**

The emergence of the novel coronavirus SARS-CoV-2 infection and its related disease COVID19 has caused a global public health emergency. COVID19 has taken a drastic toll on lives. In Europe, 27 countries reported a total threefold increase in excess deaths for 2020 compared with 2018 and a fivefold increase over 2019 due to the COVID19 outbreak.

----- Baseline — 2019 — 2020 — 2021 — 2018

### All ages



*EuroMOMO, excess mortality, All ages*

With the approval of the first vaccines by the European Medicines Agency (EMA), European governments have been rushing to introduce vaccination roll-out plans. Under various national circumstances (often in a competition with political, cultural, and sport elites), risk groups, such as essential health workers, elderly, and people with co-morbidities including chronic lung diseases, heart diseases, severe obesity (body mass index 40 or higher), and diabetes have been granted priority in their plans.

Soon after COVID19 reached Europe it was clear the response to tackling the pandemic would heighten rather than lessen existing divides caused by existing socio-economic status, race and ethnicity (race and ethnicity was not reported as risk factors during the initial outbreak in China). The increasing scientific evidence demonstrates that the virus exerted a disproportionate burden on racialized and ethnic minorities living under detrimental social, economic, political, and environmental conditions in Europe and the United States. They share a higher burden of the infection, are of younger age and are dying in larger numbers.

As COVID19 has exploited existing discrimination structures embedded in our public institutions, one form of ethnic discrimination has hardly been mentioned, even by those arguing for a special attention for racial and ethnic minorities. Antigypsyism remains the most apologetic and blatant form of racial and ethnic discrimination in Europe (meaning that people with minimal prejudices against migrants and other ethnic minorities remain prejudicial towards Roma). The European Roma Rights Centre has documented some of the ways in which Roma have been severely impacted both by the virus itself and repressive responses from governments.

Roma are the largest ethnic minority group in Europe. Their substandard housing conditions (even in comparison with other excluded ethnic minorities) in segregated neighbourhoods makes it impossible to follow essential protective public health measures on hygiene and physical distance. These are crucial COVID19 vulnerability factors, according to the science. Yet, there is hardly any data on the number of infections, hospitalizations, ICU admissions, and mortality among Roma. They are also not mentioned in national vaccination roll-out plans and only a few advocates make a case for their priority for vaccination. We argue that this is a contra-factual development, due to conventional antigypsyism and concerns over sparking and spiralling new waves of anti-Roma racism across Europe.

The COVID-19 pandemic is a dire situation for everyone, but we were struck by the lack of urgency, even resignation with which European governments and public health authorities are responding to the spread of infection among excluded Roma communities. Among the EU27, Slovakia is the only one explicitly recognizing Roma – the so-called “marginalized Roma communities” as a risk group in their vaccination plan, although some other countries – Romania and Bulgaria – have considered including priority for Roma health mediators as essential health workers.

Protective non-medical measures such as social distancing and the use of disinfectants and face masks play a crucial role in mitigating the spread of COVID19. However, other non-medical reasons – such as socio-economic and ideological/religious (racism, elitism, and anti-vaccination) factors - have also decisively compounded the effects of this pandemic. These latter factors also impact health and social workers’ practices when it comes to treatment of Roma. The hesitation over the Roma vaccination priority stems from these ideological factors also determining the COVID19 impact. Therefore, we set out below the arguments, two sides of the same coin, in support of the vaccination priority for Roma in Europe.

## PRECARIOUS HOUSING AND POLLUTION

A rapid assessment of the impact of COVID-19 on Roma communities in Spain revealed that there was “approximately 47,000 people who right now lack the necessary food or basic supplies necessary for survival [...] and who do not already rely on any kind of state-provided economic support”. They are pushed into going out to the frontlines of the pandemic every day. Unemployment, poverty, food insecurity, and inability to purchase disinfectant are the immediate consequences of the pandemic confinement on large numbers of Roma. Besides disrupted income and no savings to rely on, disrupted and inaccessible digital education, the response by many Roma to COVID19 is impacted by their substandard housing, public infrastructure, and environmental conditions.

These conditions also mean that the prevalence of so-called “lifestyle” cardiovascular diseases, hypertension, and diabetes is higher among racialized and ethnic minority groups. New research on 400 COVID19 patients in Queen Elizabeth Hospital, in Birmingham (UK) found that ethnic minority patients were twice as likely as white patients to live in areas of environmental and housing deprivation, and that people from these areas were twice as likely to arrive at hospital with more severe COVID19 symptoms and to be admitted to intensive care units. It concluded that ethnic minority patients are more likely to be admitted from regions with the highest levels of air pollution, housing quality and household overcrowding deprivation.

When it comes to the specific health status of Roma, they are collectively worse off due to the negative impact of the social and environmental determinants of health. For large numbers of Roma, living in substandard and over-crowded housing in segregated neighborhoods, following public health recommendations in times of pandemic outbreak is an arduous effort. Clean water supplies, sanitation, energy, disinfectants, and space for self-isolation are essential for mitigating COVID19 but frequently not available in Roma neighborhoods. Even in Spain, the country often given as a good practice example of Roma inclusion, “60 percent of Gitanos live in multi-family households—with two or more related nuclear families living together.”

Often relegated to reside on contaminated land, near to landfills, in river flooding zones, or former industrial and mining zones, many Roma households use makeshift stoves and solid fuels for heating and cooking, which further pollutes their air and contributes to the excessive prevalence of respiratory and cardiovascular diseases. According to the European Commission report on Roma Health: “Roma communities appear to suffer higher rates of chronic disease (i.e. asthma, diabetes, cardiovascular disease, and hypertension) and the associated disability and limitations on daily activities.”

While short-term pollution may irritate the lungs and increase the risk of infection, long-term air pollution may worsen the impact of COVID19 on patients. The link between air pollution and the prevalence of coronaviruses was confirmed during the SARS outbreak in China in 2003.

# RACE, ETHNICITY AND HEALTH INEQUALITIES

There is no doubt that it also exacerbates the impact of COVID19, as this study on the [link between air pollution, respiratory and heart diseases and number and severity of a COVID19 infection](#) shows. Patients with a severe course of COVID19 disease [are twice as likely](#) to have had pre-existing respiratory diseases and three times as likely to have had cardiovascular problems. [Harvard University research](#) demonstrated that a single unit increase in pollution exposure increased the COVID19 death rate by up to 8%.

Similarly, [the study of the COVID19 outbreak in the Netherlands](#) indicated that a single-unit increase in people's long-term exposure to pollution particles – due to living in the proximity of the livestock farms in this case - raises infections and admissions by 10% and deaths by 15%. It was also pointed out that [dirty air might be a factor](#) explaining the disproportionate impact of COVID19 on ethnic minorities. Thus there does seem to be a [correlation between social and economic exclusion, precarious housing and population density, and air pollution](#). These combined factors produce [underlying health conditions for ethnic minorities](#), as was confirmed by the previously mentioned UK study of 400 COVID19 patients in Birmingham.

Focusing solely on medical arguments, however, can distract from why the spread and impact of on Roma communities are disproportionately severe. Accepting the impact of social and environmental determinants of health on the prevalence and severity of COVID19 and adopting targeted measures for places with poor air quality, limited access to water and sanitation, and substandard housing could make a real difference, among others also for Roma.

The COVID19 path from empirical observations and statistics to scientific correlations is straightforward. Race and ethnicity also came under scrutiny as an important risk factor for infection, severe disease and death, soon confirmed by [authoritative research findings](#). Several studies from the [US](#), [UK](#), and [Sweden](#) have placed race and ethnicity at the centre of discussion around the risk factors for COVID19, establishing that the spread of COVID19 was exploited and exacerbated by pre-existing health inequalities maintained by structural racism and ethnic discrimination.

As previously mentioned, racial and ethnic groups have been harder hit as they are over-represented when it comes to COVID19 hospitalization, ICU admission, and mortality. Taking into account that patients from ethnic minorities tend to be younger – a study in the UK found that the hospitalised patients from ethnic minorities were on average [10 years younger](#) than white patients - the morbidity and mortality gaps become even more unsettling. Furthermore, half of [pregnant women](#) hospitalised with COVID19 in the UK by June 2020, a risk group itself, were from ethnic minorities. Black British women were more than 8 times as likely as white British women to be hospitalised with COVID19 during pregnancy.

[Public Health England](#) confirmed that while being younger (12 years on average) and less obese, people of [south Asian background](#) were at most risk of dying after being admitted to hospital with COVID19, with Bangladeshi people around twice the risk of death. People of Chinese, Indian, Pakistani, other Asian, Caribbean and other black ethnicity had also between 10% and 50% higher risk of death when compared to white British. COVID19 reversed the pattern of mortality among these groups. In previous years, mortality rates were lower in Asian and black than in white communities. Furthermore, compared with previous years, the review found a particularly high increase in all-cause deaths among those born outside the UK and Ireland.

In the US, black people are twice as likely to become infected with COVID19 compared to white people. The evidence shows that people of Hispanic and native-Americans origin are also more vulnerable, although no peer-review article has yet been published. In Sweden, (often considered as a more egalitarian country and a global leader in digital health), the Public Health Agency expressed particular concern regarding the impact of COVID-19 on ethnic minorities as the data showed that compared to the same months over the period of 2016–2020, an excess mortality of 220% was found among people born in Somalia, Iraq and Syria both in the age range of 40–65 and aged 65 years or older. Conversely, among people born in high-income countries (Sweden, Scandinavia and North America), a slight decreased mortality, 1%, was found among persons aged 40–65 years, and an excess mortality of 19% of those aged 65 and above." By October 2020, the incidence of COVID19 cases among migrants was 4-5-times higher than among those born in Sweden. The median ages of the deceased between the Somalian and Swedish-born people were 68 and 85 years old.

Potential explanations include biomedical arguments based on health comorbidities. According to a study published in the Lancet in June 2020, "[T]he ethnic minorities have higher burden of comorbidities like diabetes, cardiovascular disease and morbid obesity", and that "increased prevalence of vitamin D deficiency, increased inflammatory burdens, could increase the risk of COVID-19 disease severity in those populations." Public Health England also found that people of Bangladeshi and Pakistani backgrounds have higher rates of cardiovascular disease, and people of black Caribbean and black African ethnicity had higher rates of hypertension compared with other ethnic groups. Black, Asian, and minority ethnic communities also have a higher prevalence of diabetes. By May 2020, it became clear that diabetes is a significant risk factor as one in four people who died in English hospitals with COVID19 had diabetes.

One might ask what are the links between these findings on specific racial and ethnic minorities in the UK (black and south Asian Britons), the US (blacks, south Asians, and Latinos), and Sweden (people born outside Sweden) and Roma? First, when it comes to health comorbidities, equally to other ethnic minorities, large numbers of Roma are burdened by cardiovascular and respiratory diseases, diabetes, hypertension, and obesity, as we argued above.

However, the relationship between race, ethnicity and health is complex and it is determined by a variety of factors. A large(r) community of scientists emphasize the non-medical factors determining the health gaps among ethnic majorities and minorities. According to the US Centre for Disease Control and Prevention (CDC), "Long-standing systemic health and social inequities have put many people from racial and ethnic minority groups at increased risk of getting sick and dying from COVID-19. [...] Discrimination, which includes racism, can lead to chronic and toxic stress and shapes social and economic factors that put some people from racial and ethnic minority groups at increased risk for COVID-19." Racialized and ethnic minority groups are suffering by chronic diseases and dying more from how our societies are structurally organised. Roma are considered the largest and most discriminated ethnic group in Europe. Hence, it both makes sense and it is of highest urgency to review the impact of COVID19 in their communities.

Why ethnic minority communities experience health inequalities has little to do with having a different genetic makeup. Genetics are also not a cause why more racial and ethnic minorities die of COVID19. Any biological and genetic susceptibility that may predispose a person to a disease is also heavily influenced by social and environmental factors. It is the experience of racism and discrimination that has made them more vulnerable, according to Public Health England. More people of black, Latin and south Asian origin are dying of COVID19, but the science emphasizes that there are no genes responsible for the reaction of our immune systems to viral infections. Even the Lancet authors quoted above concluded that the disproportionate effects of the COVID19 morbidity and mortality on ethnic minorities is predominantly due to social factors such as housing, poverty, and the results of certain political and economic policies which are making them less protected. Health comorbidities are also a result of the above factors, not biological differences. Instead of a genetic predisposition, health conditions of racialized and ethnic minorities is largely determined by where they live, what they can afford to eat, how much green space they have, how much exercise they are able to take, and the stresses and strains in their lives. Factoring of the COVID19 outbreak among racialized and ethnic minorities by structural racism and social and environmental determinants of health is important as it does not conveniently allow governments to abdicate their responsibilities, which is what tends to happen when it comes to genetics framing.

# THE IMPACT OF THE FIRST COVID19 WAVE ON ROMA COMMUNITIES IN EUROPE

From the first moment of the COVID19 outbreak in Europe in March 2020, Roma civil society organizations warned that Roma communities are going to be largely affected. We know that during the first COVID19 wave, Roma were among the first affected in [France](#), [Spain](#), [Greece](#), and [Romania](#). In [Czechia](#), the very first hospitalized COVID19 patient who received an experimental treatment of Remdesivir was a Roma man, who recovered. A number of popular Roma activists from North Macedonia, [Slovakia](#), [Hungary](#), and Moldova fell victim to COVID19 and died. Some communities in [Slovakia](#), [Bulgaria](#), [Romania](#), [Spain](#), [Italy](#), and [Greece](#) were collectively cordoned off and prevented from leaving by the police and army, while infected individuals were not promptly isolated from the rest of the community. In many instances, collective quarantine was enforced after the media and public authorities created a discourse of Roma as a '[hygienic bomb](#)' and [carriers of disease](#), and blaming [Roma returning from abroad](#) for the main source of infection. None of these claims were supported by evidence.

While collectively quarantined, the supply of food, primary health care, and essential medicine in Roma communities was severely restricted or entirely interrupted – with Romani elderly suffering by chronic diseases and pregnant women being the most severely affected. The supply of water, detergents, and disinfectants was temporarily provided at the entry points to the communities, or sprayed by planes as in [Yambol, Bulgaria](#). They were mostly discontinued after the emergency quarantine was called off. These collective quarantines were often [discriminatory and in breach of](#) official COVID19 government policies.

While the most effective public health strategies are based on mutual trust between the government, public health authorities and citizens, these collective repressive measures and directive top-down communications against Roma had a largely opposite effect and created an atmosphere of mistrust. This gap in trust towards their governments provided fertile soil for anti-vaccination conspiracies among Roma. While language and cultural barriers make their access to official information even more limited, Roma tend to rely on social media for advice on COVID19 prevention and mitigation. This advice is often, and sometimes intentionally, erroneous.

In June 2020, Sastipen, the Roma Centre for Health Policies in Romania, with the support of National Roma Agency, identified 690 Roma vulnerable communities of some 450,000 people. Some 61,000 people were over 65 years and almost 54,000 were burdened by chronic diseases. The organization made an address to the Prime Minister requesting the activation of a national emergency programme addressing the needs of vulnerable communities at higher risk of COVID19 such as Roma. The Government responded with formalistic assurances that every citizen of Romania will be treated equally.



# CONCLUSION

The COVID-19 outbreak poses immense challenges and demands the rapid reduction of health inequities. **Preventable health inequalities are the ultimate manifestations of systemic injustice built into the institutions of our societies.** The avoidable but persistent gaps in life expectancy and child mortality rates between the rich and the poor and between ethnic majorities and minorities are perhaps the starkest examples of endemic injustice in the world. These are politically arbitrary decisions ensuring that people with different social, economic, cultural and residential circumstances continue to experience a larger burden of preventable diseases.

While some experts argue that the effects of COVID19 has extended beyond health care, having serious social, economic, and cultural consequences, we argued that this health crisis demonstrates the **centrality of social and environmental determinants of health – i.e. standards of our communal, residential, environmental, and political surroundings - for our individual health status.** Racial and ethnic minority groups are suffering and dying more from how these determinants are structurally organised. Every new public health crisis is burdening these groups disproportionately.

In April 2018, [the Swedish Parliament](#) committed to eliminate “health gaps among ethnic groups within a generation through an active and strengthened public health policy”. The above-analyzed hard impact COVID19 had among ethnic minorities in Sweden is a reminder **that health inequalities are deep structural problems which require a concentrated effort going beyond political declarations.** As the [Lancet](#) authors emphasize, “Understanding the relationship between ethnicity and COVID-19 is an urgent research priority, in order to reduce the disproportionate burden of disease in Black, Asian and other minority ethnic groups.”

Although the scientific evidence on race and ethnicity as the COVID19 risk factors is unequivocal and increasing, there is an embarrassing silence from governments, public health experts, and the scientific community on the situation of the “largest ethnic minority group in Europe”, the [Roma](#). The evidence points out that COVID19 thrives because of pre-existing health gaps determined by racial and ethnic inequality, but governments have so far refused to act when it comes to Roma. **They should be publicly held to account for not introducing a more diverse vaccination strategy which includes deprived Roma.**

We should urgently collect Roma-specific data in hospitals and in their communities. The data on the infection, tracing, hospitalizations, ITU admissions, and deaths among Roma are so far only signalled through anecdotal civil society and media reports. The fact that when it comes to Roma the governments do not commit to a simple review of existing medical data, is itself a form of serious neglect of their legal obligations under the public health emergency. You cannot adopt effective measures without the data.

Considering the measures adopted to tackle COVID19 in Roma communities so far, we doubt that without public scrutiny and evidence collection, governments would consider taking the situation of Roma seriously when it comes to vaccination rollout or the introduction of digital health technologies. It is thus important to advocate that governments and public health authorities focus on scientific data and put forward targeted measures for their Roma minorities. Therefore, as the single advocacy priority, civil society organizations should aim to ensure that **Roma inclusion policies are a substantive part of any [COVID19 recovery strategies at national and European level.](#)** Without more effort in collecting reliable data and supporting Roma communities to hold public authorities accountable, governments will be able to easily continue to abstain from mitigating the unequal burden of COVID19 and other diseases on Roma.

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The Roma Health project is implemented by the European Public Health Alliance and aims to address social determinants of health resulting in health disparities between Roma and the general population. One of its main initiatives is the Roma Health Network - a public health community striving to close the gap in health by encouraging cooperation beyond the health sector, promoting sustainable initiatives at European, national and local levels and creating space for dialogue and cross-sectorial civil society cooperation.