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Submitted to A.U.K. as part of requirement for graduation

Keywords: Antenatal, Kosovo, Roma, Health, Services

Access to Antenatal Health Services Among Roma, Ashkali, and Egyptian (RAE) Women in Kosovo

An Honors Society Project

Presented to

The Academic Faculty

By

Jete Aliu

In Partial Fulfillment

of the Requirements for Membership in the

Honors Society of the American University in Kosovo

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ABBREVIATIONS

DOW – Doctors of the World

KFOS – Kosovo Foundation for Open Society

MH – Ministry of Health

NGO – Non-governmental Organization

NRAEWOK – Network of Roma, Ashkali, and Egyptian Women's Organizations in Kosovo

RAE – Roma, Ashkali, and Egyptian

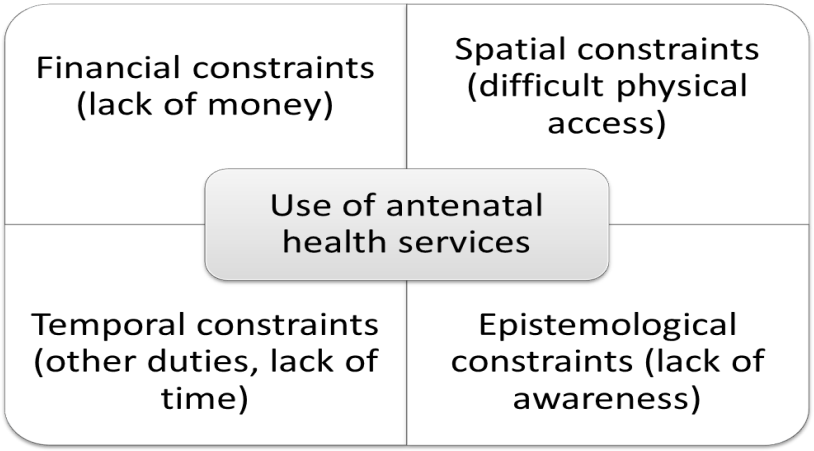
UCCK – University Clinical Centre in Kosova

WHO – World Health Organization

EXECUTIVE SUMMARY

The purpose of this project was to investigate the issue of the lack of access of RAE women in Kosovo to antenatal health care services. The study which included 30 research participants from RAE community in Fushe Kosova and Prizren and interviews with Ministry of Helath, two NGOs, and a gynecologist from Universal Clinical Center in Kosovo, has examined the reasons of the problem and the work done so far by relevant stakeholders regarding the lack of access to antenatal health care among RAE women. Some of the main findings suggest that the factors that cause this problem are multiple and interlinked. These factors include lack of awareness regarding the importance of health, socioeconomic and spatial constraints as summarized in Figure 1.0.

Figure 1.0: Explaining the inadequate use of antenatal health services among the RAE women



Epistemological constraints, particularly the low level of education is perceived to be the main source of the problem which triggers the other factors. The level of education influences the decision of women not to take care of their health during pregnancy. Since they lack education, majority of women are unemployed. Therefore, they do not have sufficient financial means to afford the health services. Even though the basic services are provided for free in public hospitals, they are usually required to do additional examinations in private hospitals and purchase drugs. These examinations, along with the drugs have to be paid by patients themselves. These costs impede the RAE women from using antenatal health services as much as they should.

One of the recommendations provided in order to improve the situation of antenatal health among women of RAE community is to address the epistemological constraints. This includes awareness raising lectures and trainings regarding the importance of health to these women. These education awareness trainings would help RAE women understand the importance of a better antenatal health. Through these lectures RAE women could be taught about the benefits of having good nutrition, adequate rest, family planning, and good hygiene. The second recommendation given is to address the spatial constrains by improving the access to health care services in the remote localities. This would include providing mobile clinics to the remote localities with high RAE concentrations. The examination of women regarding antenatal health would be very much facilitated by these clinics. This would help overcoming many barriers that impede their access to antenatal health services including financial and transportation barriers. Additionally, mobile clinics would make the medical examination a habit among the RAE community women, improving this way their antenatal health.

PROBLEM STATEMENT

This project will be addressing the problem of Roma, Ashkali, and Egyptian (RAE) women in Kosovo and their lack of access to antenatal health services. Regrettably in Kosovo RAE community are very much marginalized and face many difficulties in various areas of life. Amongst many obstacles, RAE women specially confront challenges in healthcare being as such deprived from accessing to health services and benefits, particularly during their pregnancy. Hence, the main question remains in what factors contribute to the underuse of antenatal health services among the Roma, Ashkali and Egyptian women? The scarcity of data available regarding this problem precludes the representation of the existent reproductive health status of RAE women in Kosovo. However, the studies conducted mostly by local and international non-governmental organizations (NGO) in this regard concluded that the reasons for RAE women having lack of access to health care are various starting from the lack of documentation, birth of children outside the hospitals, lack of information about the health services, illiteracy, and so on.

Nonetheless, not so much has been done so far as to improve the reproductive health situation of RAE women. The living style of RAE community is often traditional one i.e. women tend to get married at a very young age. Often parents arrange their marriages at the age 15 or 16. This results in young women giving birth to children before even reaching the adulthood. Therefore, RAE women reproductive health is most of the time endangered and as such they would most of the time need antenatal care. Yet, they usually lack the necessary information how and where to seek this help. Considering the fact that RAE women play a key role in their families and communities, providing access to public healthcare is an essential aspect for advancement RAE families and community in general. Hence, putting this problem as a priority and ensuring that RAE community women no longer face obstacles in accessing and using the antenatal health services as much as they should is of utmost importance.

The goals of this research are to identify the reasons of the lack of access of RAE women to antenatal health services in Kosovo and provide recommendations for the government institutions and the NGOs for improving the current situation. This study would serve to law and policy makers in Kosovo to better understand the situation of RAE women and their access to

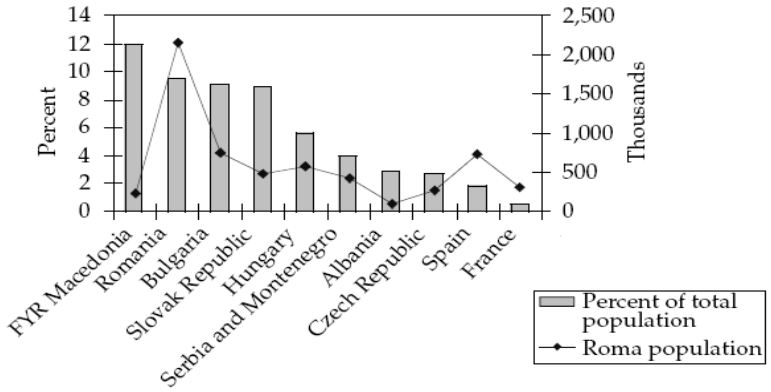
antenatal care and assist them in improving the design and enactment of policies, programs, and strategies that might contribute positively in the current situation of RAE community women and their access to antenatal health services.

1.0 LITERATURE REVIEW: Roma Community Worldwide

1.1 History and Demographic Patterns

Historical facts demonstrate that the Roma communities have been present in Europe for practically a thousand years, although Roma originally came from northern India (Mladovsky, 2007). According to the historical records Roma were exposed to discrimination even a thousand years ago. They suffered enslavement, prohibition, and segregations. The main injustice that history proves to have been done to Roma was the extermination of less than one million of Roma in the death camps of Nazi. The life conditions of Roma groups started to improve only slightly in housing and education after the period of World War II. Generally speaking Roma still live in very poor conditions regardless of the country they are concentrated in (Mladovsky, 2007). The name 'Roma' has derived from the Romani language. However, this term is best understood as a political replacement for the general term 'Gypsy'. Historians, anthropologists, and sociologists contest the idea of Roma 'race' because it is unclear how different Roma groups have a common indigenous origin. In fact the name 'Roma' includes a broad variety of groups differentiated by language, history, traditions, and socio-economic situation sedentary throughout Europe (Kovats, 2004). It is difficult to give a straightforward answer to the question of the number of Roma living throughout Europe. Figure 1.1 shows the estimates compiled by the "Minority Rights Group regarding the number of Roma" population in different European countries during early 1990s.

Figure 1.1: Estimated Roma populations in selected European countries



Source: Wheeler (1999); Liégeois (1995); total population data: World Bank Atlas (1995). Reproduced from Ringold et al.(2005)

When the Roma settled in the European soil they were immediately regarded as a threat to their territory. They were perceived to be untrustworthy, uneducated, lazy, and essentially thieves who are engaged in illegal activities to secure their living. Such mentality towards Roma is unfortunately still present among European people. Because this perception has prevailed for generations it is very hard to change it (Oprean, 2011). Roma were a nomadic group who dressed, spoke, and behaved differently from the European population. They were first welcomed by European people into their society; however, this did not last long because soon they left a negative impression to the state, church, and merchants. This impression was nurtured from three main reasons. First, Roma were wandering group who did not have a permanent home. This contradicted the goal of the state to have people settled in permanent addresses and as such pay taxes to the state. Second, Roma were mostly fortune tellers, a habit which was considered as a threat by the church. Finally, merchants perceived Roma as threat from the economic point of view since they were afraid that the newcomers would destabilize their prices (Oprean, 2011). Whereas, in today's time the European society animosity against Roma exists on the basis of their dark skin color which is regarded as a sign of weakness and evil (Oprean, 2011).

As explained above the Roma community has struggled through unique challenges throughout time. Their history is filled with discrimination, oppression, and exclusion. However, the Roma community is estimated to be the largest minority group in European Union. The parts of Europe in which Roma are concentrated mostly are Central and Southeast Europe (Fesus, 2012). Though generally data regarding their number lack, it is assessed that the number of Roma community in the world is 10 million. This number is continually increasing because of high number of births within this community. Majority of population is under the age of 20 which is the result of high births and low longevity. Even though most of the Roma community is concentrated in Europe, there is a trend of increasing number of Roma migrating outside Europe in a pursuit of a better life. Roma community people have suffered for many decades from discrimination. This discrimination has been nurtured based on several attributes such as, skin color, tradition, and culture (Fesus, 2012). Therefore, throughout time they had to fight to achieve equality with other nationalities regarding the freedom to live without oppression and discrimination. The injustices Roma suffered on the early years of their life by Europeans are hitherto far away from being over.

Commonly the problems faced by Roma minorities are related to poor economic conditions, unemployment, lack of documentation, illiteracy, and poor living conditions (Fesus, 2012). These problems then trigger other obstacles which make the life of Roma community really challenging. Health is one amongst many challenges faced by this minority group.

1.2 Health Status

According to the definition of WHO, health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity," (Shojikj, 2011). The right to enjoy the utmost possible standard of health is amongst fundamental human rights, integrated in legislations of the states and protected by several signed international instruments (Shojikj, 2011). Nevertheless, there are ethnic minorities groups throughout Europe e.g. Roma community, who are facing challenges in accessing health care. Due to the lack of documentation, information, and education, Roma community access to health is limited. In all the countries where Roma community is concentrated, the inequalities regarding access to health care between Roma and non-Roma are present. The health status of Roma is generally very poor. Data available suggest that Roma minorities experience poorer health compared to the majority of population. Moreover, the life expectancy between Roma and non-Roma population is remarkably different suggesting as such that Roma are more vulnerable in getting various diseases which may be fatal for them (Fesus, 2012). Especially Roma girls are disadvantaged in this regard because of the high rates of pregnancies among teenagers. Roma women are caregivers in their families and throughout their life take over the role of housewives. Because they spend more time at home than their husbands, they are more prone in getting various diseases which may be spread due to very poor living conditions (Council of Europe, 2003). As such, they are the ones to be in a more need of utilizing health services. The Roma community generally has little knowledge regarding the appropriate nutrition and also lacking incomes to secure it. Many Roma women do not know they need to change their eating habits and lifestyle during their pregnancy. Poor nutrition is reflected with the high number of children being born with various health problems. Moreover, the abortion rates among Roma women are high resulting from the lack of natal care and absence of access to family planning (Council of Europe, 2003).

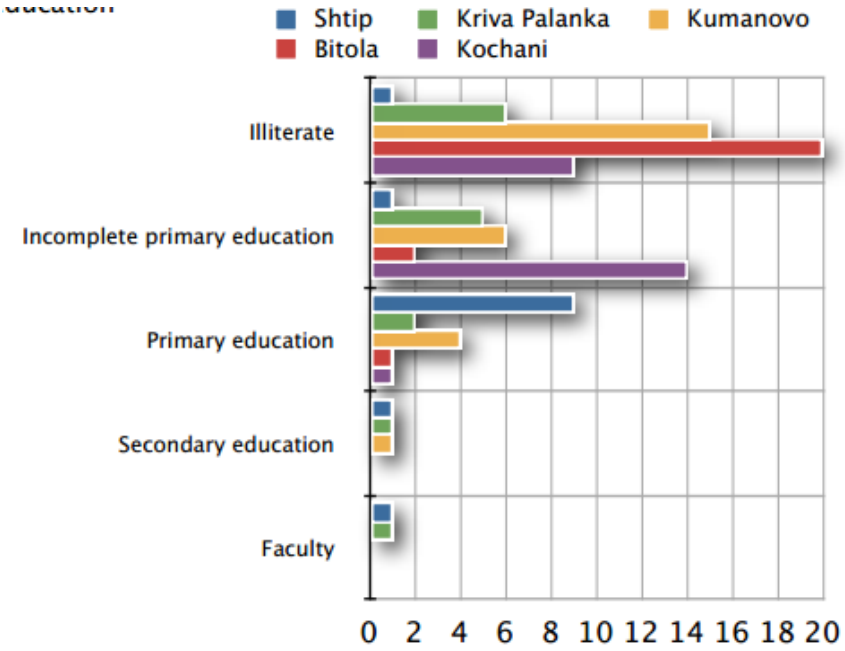
In almost every country, Roma are concentrated in the regions that are economically and socially deprived. Most of the time they live in segregated and congested neighborhoods with adverse environmental surroundings lacking access to basic services such as education, health, and other social services. Many studies have been conducted to determine the causes of the poor health among Roma and many of them concluded that social and economic factors play a significant role in this regard (Fesus, 2012). For example, a research done in Czech Republic concluded that the factors that are responsible for this situation of health among Roma community are socio-economic factors. The same conclusions were as well supported by other studies conducted in Slovakia, Hungary, Romania, and Bulgaria. Poor health among Roma can be attributed to cultural factor also since Roma were found to have high rates of alcohol consumption, smoking, and drug abuse, habits that often start at a very young age. This is exactly what the research done in Hungary concluded (Fesus, 2012).

The inequalities in health between Roma and majority of population can also be as a result of the lack of identification documentations which are necessary for eligibility to be covered by the insurance schemes. Because many of them do not have health insurances, the costs of accessing health care are high making health care often unaffordable for low-income families among Roma community (Fesus, 2012). Another problem that places a barrier to Roma community for accessing health care is transportation to health care facilities. Considering the fact that the majority of Roma live in remote localities, it is sometimes financially and physically impossible for them to commute to healthcare facilities (Fesus, 2012). Moreover, the dominant Roma lifestyle is still under strong cultural and traditional influence. There are yet some prevailing beliefs with regard to efficacy of alternative methods for treatment. For instance, traditionally Roma believe that in case a Roma woman is sterile, she should eat leaves taken from the grave of a woman who died after giving birth to a child. This as in their belief will help the woman to be cured from infertility (Council of Europe, 2003). These kind of traditional beliefs to a certain degree discourage Roma women to perform regular visits to doctors for medical treatments. There are diverse intertwined variables that cause the poor health among Roma such as education, employment, and living conditions. The sections below provide the situation of Roma regarding the abovementioned variables and how they influence antenatal health of Roma women.

1.3 Education Status

Generally speaking Roma women are not yet aware regarding the importance of their health especially during pregnancy. This lack of attention on health is attributed to lack of education among Roma women. These minorities continue to maintain their culture and tradition in various aspects of their life. Their traditional lifestyle especially prevails in the family planning and the role of women and men in the society. Commonly, Roma women are married at young age, and since then, they take over the role of taking care of the family (Oprean, 2011). The decision of marriage is most of the time made by the parents who arrange the marriages between children. Parents usually arrange marriages to use as a tool for creating bonds with important families as to increase the prestige of their own family (Council of Europe, 2003). Since children have no decision making power regarding the life they want to pursue, they will accept the decisions of their parents for marriage. This confines the decision of young girls to pursue their education. Once the parents decide about their marriages, they are forced to drop out of schools sometimes without even finishing the mandatory education. Moreover, parents themselves are not highly involved in education of their children because they do not acknowledge the importance of education. Due to the poor economic conditions many parents force their children to work at young age or in case of Roma girls stay home to take care for younger siblings (Council of Europe, 2003). According to a research conducted in Macedonia, the number of illiterate women is enormous (Shojikj, 2011). Data on Figure 1.2 show the level of education in Bitola and Kumanovo. As depicted by the graph the number of participants of the research that were illiterate was quite high in both cities whereas neither of them respondent to have finished faculty.

Figure 1.2: Level of education among Roma women



Source: Shojikj (2011)

In addition, poor economic conditions constitute significant obstacles for Roma to access education. Due to the high poverty, Roma families cannot pay for the basic materials for education. Also, the poor living conditions in which Roma children live are not appropriate for them to finish their homework and usually, they do not get assistance from their parents who may as well be illiterate. The lack of education triggers afterwards the problem of lacking access to health care among women of this community. Because they are illiterate they lack the critical thinking as to reflect on the importance of their health, the rights they have to access health care, as well as lack information about the benefits they can enjoy with regard to health care (Council of Europe, 2003).

1.4 Employment and Economic Situation

The challenges Roma face in securing employment are most of the time related with their low level of education. Nevertheless, even if they succeed in securing good employment, they are among the first employees to be laid off in the scenario of an economic crisis. Still, there are Roma who have managed to find a good job position and secure good living standards for themselves.

Roma community are significantly less educated as data show that in primary education Roma enrollment does not even exceed 50%. Low level of school enrollment among Roma impacts afterwards their employment. Data show that the number of Roma who are employed and are paid is below than one-third (Bejenariu and Mitru, 2014). Regrettably, according to the Oprean more than 60% of Roma concentrated in Romania live on or close to poverty line (2011) while Bejenariu and Mitru state that compared to non-Roma, about 90% of Roma minority in Europe live below poverty lines (2014). The economic discrepancy between Roma and non-Roma arises not only as a result of inequalities in access to employment, but also as a result of differences in salaries available. For instance, the data published in a report of the "Romanian Institute of National Statistics" show that Romanian women are paid on average 250 Euros per month, while Roma women receive a monthly salary of below 120 Euros. Generally speaking, Roma women or men are often times discriminated against with regard to salaries they receive as they are paid less than non-Roma counterparts for the same work (Oprean, 2011). The poverty in which Roma community live most of the time imposes a barrier for Roma to access healthcare since health service are generally unaffordable for them.

1.5 Living Conditions

Roma community individuals are also socially discriminated. They are commonly forced to live in the remote areas which are considered usually the worst parts to live in. For example, in Timisoara, a city in Romania, Roma families are forced to build their houses alongside a river which risks overflowing time to time, while Romanians choose to live in other parts of the city, away from the river and its potential flooding. The problem with Roma living in separate neighborhoods isolates them from the rest of the society. Therefore, they are more likely to face problems like worsening of living conditions, problems with infrastructure, cleanliness, transportation, and other service provision as the investments done in those neighborhood are inadequate. The most severe consequence as a result of such isolation is the decline of opportunities for young Roma people to be prepared for the formal job market. That is why Roma minority face challenges and difficulties in finding good jobs. Moreover, when it comes to Roma families buying building land, they face challenges as landowners are often hesitant to sell the land

to them (European Commission, 2012). This results in imposing Roma to live away from areas of the middle class groups.

Also, majority of Roma live socially isolated from the rest of the society. Since Roma are often times perceived as spreader of different diseases, the rest of the society choose not to live close to them. This is especially present in the relation between Roma and non-Roma children. For example, Romanian children are not allowed by their parents to play with Roma children because they are believed to be unhealthy and dirty (Orstad, 2013). The report written by UNDP suggests that in 2012 life expectancy of Roma on average was ten years lower than that of European citizens (UNDP, 2012). This happens mainly because Roma minority is more susceptible to suffer serious diseases as a result of poor living conditions (Bejenariu and Mitru, 2014). The houses of Roma lack the most essential means for having a proper lifestyle. Lack of water supply, bathrooms, waste collection, telephone services are only few issues with which Roma deal every day in their dwellings. In Bulgaria for instance, data show that only 9% of Roma have access to hot water, indoor toilets and bathrooms (Chapkanski, 2011; Ringold et al., 2002). Physical distance from health facilities provides an issue for Roma women to visit doctors when they need to. In Romania, in a rural area named Balta Arsa, the location in which Roma dwellings are settled, lack many doctors and nurses. Therefore, women most of the time are not able to visit gynecological centers or family planning centers since they cannot pay for the transportation in the nearby town where these services are available (Council of Europe, 2003). Hence, location and transportation create barriers for Roma women to access healthcare.

1.6 Civil Registration

In almost every country, the legal status and documentations are prerequisite for having access to health care and public services. Unfortunately, in many countries a large number of Roma do not own documentation of legal status. There are different causes behind this ranging from lack of information on how to attain legal documentation, lack of understanding the procedure, problems in proving nationality, administrative fees, and any combination of abovementioned factors. Birth certificates are prerequisite to receive identity documents. Most of the Roma individuals lack birth certificates either because they were born at home and are not

registered by their parents, or because they lack funds or information about the importance of registering the children. There are also cases when state authorities do not recognize their places of dwellings therefore it is hard for Roma to receive legal status. For instance, Roma living in Italy were precluded from acquiring citizenship because the state authorities did not provide residence papers to localities settled in unauthorized Roma camp (Council of Europe, 2003). In other cases the financial means create a barrier for Roma to attain legal status. In Macedonia for example, it has been found that Roma community find it difficult to acquire the necessary documentations due to the high administrative fees. Since Roma minority lack some of the basic documentations like Identity Cards or Social Security cards, it is very less likely for them to enjoy social benefits or receive humanitarian aid (Council of Europe, 2003).

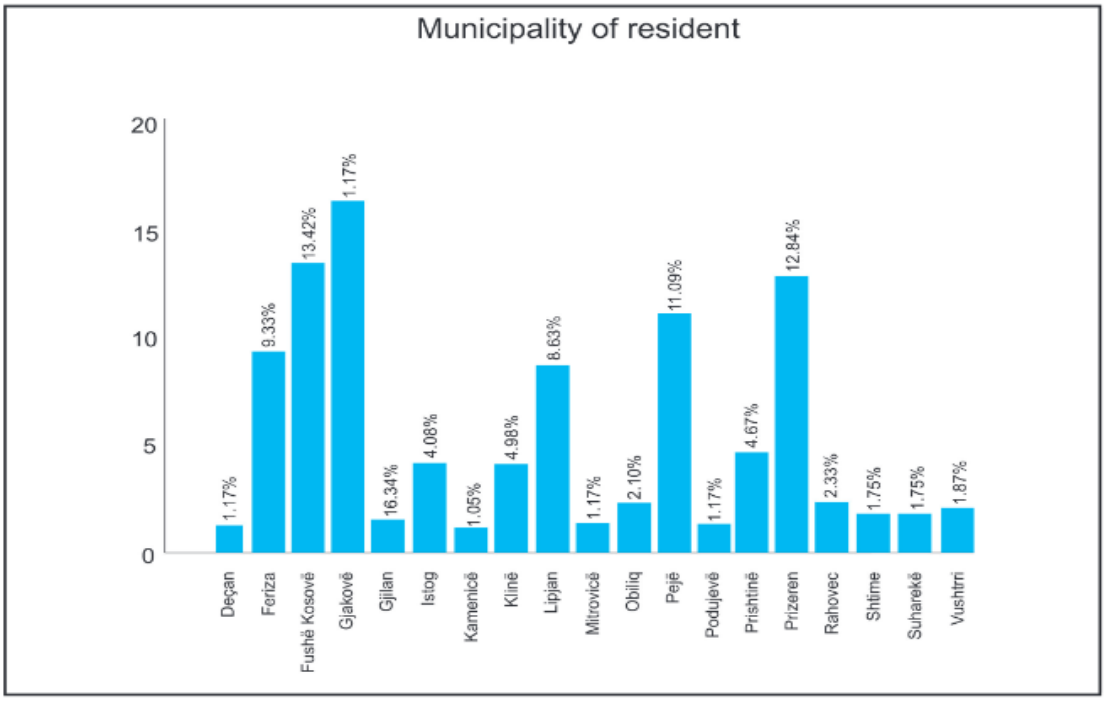
2.0 LITERATURE REVIEW: RAE Community in Kosovo

In Kosovo, Roma, Ashkali and Egyptians identify themselves as belonging to three distinguished communities. They are recognized as such by Kosovo's legal framework, institutions, and local and international organizations. However, because they experience similar social and economic conditions are usually addressed together. Therefore, this project will address the issue of health care for the three communities, Roma, Ashkali, and Egyptians referring to them as the RAE community.

2.1 History and Demographic Patterns of RAE community in Kosovo

RAE community have been living in Kosovo for many years. However, because of the conflicts that happened in Kosovo throughout history, especially during the conflict of 1999, many members of RAE community migrated outside Kosovo in pursuit of a better life. As a result of this population movement and since many of RAE community members are not registered it is hard to estimate how many of them reside in Kosovo. Nevertheless, the estimation of UNHCR denote that there are around 34,000 persons of RAE community residing in Kosovo (2006). According to the survey done by KFOS the majority of them are concentrated in the municipality of Gjakova with around 16%, Fushe Kosova around 13%, Prizren with 13%, Ferizaj around 9% and Peja around 11%. Other municipalities have lower percentage of RAE community living there (Vrenezi and Thaci, 2009). Figure 2.1 shows the concentration of RAE community throughout Kosovo's municipalities.

Figure 2.1: Concentration of RAE community in Kosovo's municipalities



Source: Vrenezi and Thaci (2009)

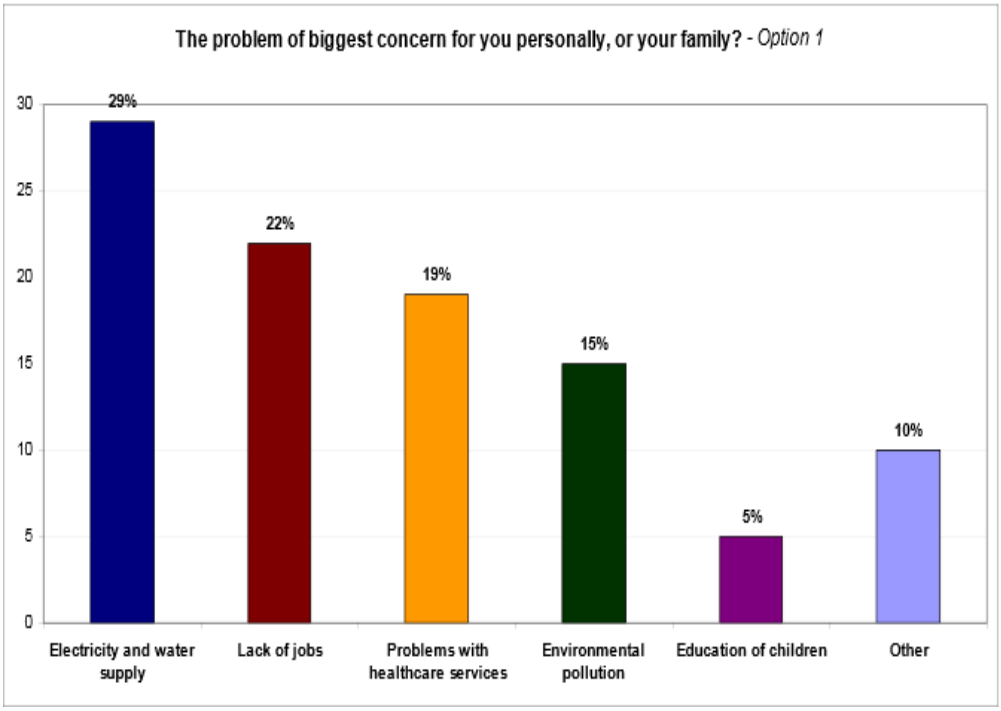
The Roma communities are known to live in Kosovo for a long time. It is believed that they stepped in Kosovo's soil in the middle of 14th century. They claim Romani to be their mother-tongue but in Kosovo most of them can also speak Albanian, Serbian, or both. The majority of them embrace Islam religion; however, there are some Roma who are Christian Orthodox (OSCE, 2010). Currently Roma reside in different parts of Kosovo; nevertheless, according to the survey conducted by KFOS Roma communities live mostly in Prizren municipality (Vrenezi and Thaci, 2009). The Ashkali communities have been living in Kosovo for a long time; yet, the census of 1981 and 1991 did not give data regarding this community. Hence, the official data representing the total number of Ashkali currently living in Kosovo are not available. Nevertheless, the estimations suggest that the number of Ashkali residing in Kosovo is approximately 12,000. The conflict that took place in Kosovo in 1999 forced many Ashkali to emigrate to Western Europe in a pursuit of a better life. Since then only a few returned to Kosovo. Ashkali communities have their own culture and tradition that distinguish them from other ethnic groups. In general they claim Albanian to be their mother tounge and Islam their religion (OSCE, 2010). The majority of them live in Fushe Kosova and Ferizaj (Vrenezi and Thaci, 2009). The Egyptian communities have also

been living in Kosovo traditionally. In 1970s they started to claim their ancestry in ancient Egypt and thus since then declared themselves to be identified as Egyptians. They recognize Albania as their native language and majority of them are Muslims (OSCE, 2010). Most of Egyptians are concentrated in Dukagjini region, specifically in Peja and Gjakova (Vrenezi and Thaci, 2009).

2.2 Health Status

In general, the RAE community access to health care in Kosovo is impeded by several factors. Many of the members of these communities are excluded from social assistance scheme because they do not fulfill the criteria set by law or because they lack necessary documentations. According to the report of the OSCE, the well-being of members of RAE community is being negatively affected by the lack of awareness on the importance of health and hygiene (2012). In order to increase the awareness about the importance of health, different local and international organizations have organized trainings and lectures. The increase of awareness among RAE community has been identified as necessary since RAE women are often times found having poor health. According to a study done by "Kosovar Center for Gender Studies", the conditions in which RAE community live are extremely substandard, which constitute a threat to the public in general. Since RAE women are housekeepers, they spend more time in home than RAE men; therefore, this makes them more vulnerable to health risks caused by poor living conditions. Figure 2.2 below shows that when asked about the list of problems RAE women face 19% of respondents identified the problem of access to health services (Demolli, 2008).

Figure 2.2: List of problems RAE Women face



Source: Demolli (2008)

Furthermore, during this study RAE women were asked in general about their health and many of them criticized the poor health services, and inadequate access to antenatal healthcare and family planning services. Frequent births along with the lack of nutrition threaten their reproductive health, particularly among young women (Demolli, 2008). Moreover, RAE families tend to make a lot of children as they will get 50 euros state benefits for each child under 5 years old. This amount is even higher for those living in the areas under parallel Serbian system (for example the Gracanica municipality or parts of Fushe Kosova and Obilic) (OSCE, 2010). Even though data suggest that home-births are declining in number, they are still common within RAE community. Usually women who deliver their children at home are not given medical support, which increases the risk of birth-related complications (OSCE, 2010). The findings from the research done in 2001 by Doctors of the World (DOW) show that 56% of RAE mothers surveyed in "Internally Displaced Persons (IDP) Camp" in Plemetina, delivered their children at home ("Strategy for the Integration of Roma, Ashkali and Egyptian Communities", 2008).

Moreover, lack of information regarding the usage of modern contraceptives results in a high number of abortions. RAE women face higher health risks compared to non-RAE women due to early and frequent pregnancies, multiple abortions, and heavy workload as housewives which might endanger their pregnancy (Demolli, 2008). Therefore, it is important for them to perform frequent visits to doctors so that they could take care of their health. However, some of the barriers they face in this regard most of the times discourage them to do so. For example, data show that Ashkali women are entitled to access family planning and antenatal healthcare free of cost. However, in the areas where they live such services are not available; thus, they often have to travel to the location of these facilities. Ashkali residing in Mitrovica region have to travel either to Prishtina or to southern Mitrovica hospital for medical checks. There those who fulfill the criteria for social welfare can access to health care services for free but the cost for medicines still creates a crucial barrier (OSCE, 2010). Another problem preventing access to healthcare is bribery. According to a study in many cases, patients have to pay for "free" healthcare because the doctors demand bribes, which the poor cannot afford (Uka, 2014). Nonetheless, generally speaking, the RAE women do not frequently consult with doctors. For instance, a study conducted by the UNICEF shows that more than 60% of women coming from RAE community have never consulted a gynecologist during their pregnancy (UNICEF, 2002).

The access to antenatal health service among Albanian majority communities is better compared to RAE community. Statistics show that access to health care during pregnancy is moderately high with 98% of birth happening under the assistance of health personnel. The doctors' visits during pregnancy are more frequent among women of Albanian majority communities. According to a study done by UNICEF 98.5% of women claimed to have visited a gynecologist during their pregnancy (2009). As depicted in Table 2.1 over 60% of women begin using the antenatal services in the fourth month whereas 32.7% start with visits to health professionals in the periods of beginning of pregnancy (UNICEF, 2009). These numbers are higher compared to the number of visits among RAE community women.

Table 2.1: Healthcare professional consulted/visited during pregnancy

	Gynecologist / obstetrician		Family doctor		Nurse		Midwife		Traditional person[1]		Healthcare worker in the community	
Region	N	%	N	%	N	%	N	%	N	%	N	%
Prishtina / Priština	310	99.4	6	1.9	12	3.8	6	1.9	8	2.6	0	.0
Mitrovicë / Mitrovica	107	95.5	0	.0	3	2.7	14	12.5	4	3.6	2	1.8
Prizren / Prizren	124	96.9	3	2.3	2	1.6	2	1.6	1	.8	2	1.6
Gjakova / Đakovica	111	99.1	3	2.7	1	.9	2	1.8	2	1.8	1	.9
Gjilan / Gnjilane	94	97.9	3	3.1	19	19.8	4	4.2	6	6.2	1	1.0
Peja / Peć	127	99.2	11	8.6	49	38.3	13	10.2	0	.0	0	.0
Ferizaj / Uroševac	112	100.0	1	.9	5	4.5	3	2.7	0	.0	2	1.8
Total	985	98.5	27	2.7	91	9.1	44	4.4	21	2.1	8	.8

Source: UNICEF (2009)

Nevertheless, out of all health care institutions, private institutions have proven to be institutions that are visited frequently by women for antenatal services. As depicted in Figure 2.3 71.3% of visits are done in private institutions while only 28.7% of women seek antenatal services in public institutions. This could explain the discrepancy in the usage of antenatal services between women of RAE community and Albanian majority community. Since the latter group usually enjoys higher family income, they can afford the antenatal services offered in private institutions. In contrast, RAE community women have more difficulties in receiving such services in private institutions.

Figure 2.3: Institutions visited more often for antenatal services

Source: UNICEF (2009)

2.3 Education Status

The situation of RAE community in Kosovo with regard to education is characterized with high level of illiteracy. This is generally a result of high drop-out rates form mandatory education. As stated in the education section of the "Strategy for the integration of Roma, Ashkali, and Egyptian Communities in the Republic of Kosovo,"

> "An analysis of the situation of Roma, Ashkali and Egyptians in the education system in Kosovo paints a very bleak picture. The situation is characterized by a low level of general attendance in compulsory education, a very small amount of Roma, Ashkali and Egyptians attending higher education or university education, very few teachers of Romani, Ashkali or Egyptian origin and a high drop-out rate, in particular of girls" (2008).

According to the data in the Table. 2.2 published by the Ministry for Education, Science and Technology, the education level of RAE communities is a concerning issue ("Strategy for the Integration of Roma, Ashkali and Egyptian Communities," 2008). Thus abrupt actions are

necessary to improve this situation since the illiteracy is afterward affecting the well-being of the three communities.

Table 2.2: MEST data for RAE communitiy education level

Ministry of Education (MEST) education-related data for Roma, Ashkali & Egyptians in Kosovo[17]
Roma, Ashkali and Egyptians enrolled in pre-primary education: **176**
Roma, Ashkali and Egyptians enrolled in primary education: **4.153**
Roma, Ashkali and Egyptians enrolled in secondary education: **204**

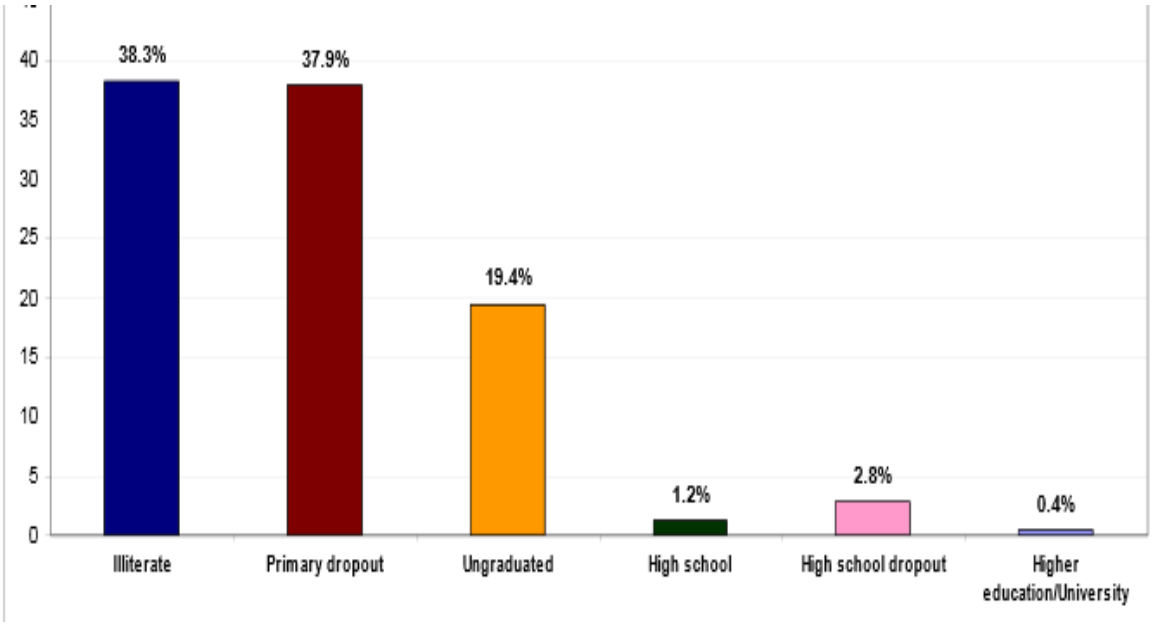
Source: Strategy for the integration of Roma, Ashkali, and Egyptian Communities in the Republic of Kosovo (2008)

"Balkan Sunflowers Kosova" organization conducted an education survey in RAE communities in 9 municipalities of Kosovo. The results generated show that only 34.9% who were born in the year 1986 finished 8 or more years of education; whereas, 36% are not educated at all. This fact is certainly concerning not only for the communities but also for the society in general because that generation is today's labor force and parents of current and future children (see Appendix 1) ("Schools Out," 2012). The high level of illiteracy is also supported by the results of the survey conducted by KFOS in which 19.93% of the participants responded not to have completed one year of formal education (Vrenezi and Thaci, 2009). The high poverty rate, early marriages, child labor, inadequate living conditions, and duty call to perform domestic work are few factors that are named as causes of this high illiteracy amongst the communities. Due to lack of educational scholarships, only a few RAE pupils afford to finish compulsory education, whereas even fewer afford to pursue into higher education. Data available suggest that very few Roma children attend school. According to data of 2010 in the region of Gjilan only 34 Roma pupils were enrolled in secondary education and only 6 Roma in tertiary education, among whom only one was a female. Physical distance provides a constraint to access education for Roma living in southern Mitrovica, in the Roma Mahalla, where 64 children need to travel every day to schools located in the north and the transportation is not offered by the municipality (OSCE, 2010). Because almost all RAE minorities speak Albanian the language does not impose an obstacle for children to enroll to Albanian schools and interact with children of other communities.

Furthermore, findings suggest that in the regions that have Serbian elementary schools, such as Gracanica, Kamenica, and some parts of Fushë Kosova and Obilic, parents choose to send their children to Serbian schools. The reason behind this is that if a child goes to a Serbian school, they will be provided many benefits from Serbian institutions, including the health insurance card. Nevertheless, the participation of children in education is still really low. For example, in Klina out of 200 Ashkali children, only eight are enrolled in primary school, while none of them is registered in higher education. Also, in Prishtina, none of the Ashkali children are registered in pre-schools due to the financial constraints and lack of interest from their parents (OSCE, 2010). Being aware on the importance of education, a few RAE youth have started to attend professional skills trainings which are organized by various international and local NGOs in Prishtina e.g. "Don Bosko" and "Vocational Training Centre" (OSCE, 2010). Moreover, an example of a program to improve health education amongst three communities is "Minority of Health Education Project" initiated by the DOW. This program aimed to train members of RAE community as Peer Health Educators (PHE). To make this program successful, DOW had requested meetings for the trainings of PHE. In those meeting members who came from different communities were enabled to share their experience and take part in activities together. This program stimulated the creation of a mixed but cohesive group of educators who afterwards proceeded to educate more than 1,300 members of their corresponding communities regarding hygiene, nutrition, and problems of basic reproductive health (Schaaf, 2009).

The discrepancy in the level of education between genders is an evident phenomenon amongst the three communities, with women suffering from even stronger disadvantage in this regard. The data show that 11.2% of men are illiterate, while this percentage amongst RAE women is 30.2% or three times greater than that of men (Vrenezi and Thaci 2009). In general, the percentage of illiterate women among RAE community is enormously high. The research conducted by Kosovar Center for Gender studies confirmed this disquieting situation as results show that 38.3% of RAE women and girls are illiterate. Also, as the Figure 2.4 shows the rate of drop-out from compulsory education is significantly high (Demolli, 2008).

Figure 2.4: Level of education among RAE women and girls



Source: Demolli (2008)

2.4 Employment and Socio-economic Situation

The socio-economic situation among RAE community in Kosovo remains precarious. High level of unemployment and social exclusion prevent them to live a comfortable life in Kosovo. The unemployment level is usually linked with low levels of education within these communities. Nonetheless, many RAE individuals are self-employed as to secure their living whilst the rest rely on social assistance. The social assistance provided to them is not enough to ensure dignified living conditions. RAE women are the most disadvantaged groups since they face double discrimination – being minority and women. Forced to marry at a young age and engage in domestic role within their communities, RAE women are obligated to drop out of school at an early age. Therefore, they face even greater barriers than RAE men when it comes to access formal labor market. Among the Roma community women only two are identified to be formally employed. One is employed in Mitrovica municipality and the other one in a NGO (OSCE, 2010). According to the data provided by OSCE, in the region of Gjilan, 30-40% of Ashkali have informal jobs e.g. collecting cans, while around 255 families are relying on state social assistance

and support from relatives living outside Kosovo. In Ferizaj however, seven Ashkali are employed in civil service of municipality and in Klina only one Ashkali works as a police officer. In Prishtina, a large number of Ashkalis rely solely on social assistance schemes or generate income performing informal jobs. Even though low in number there are still some Ashkali who have managed to attain good working positions in private and public sector such as teachers, technical assistants at local hospitals, or police officers. Also, in Vushtrri few have been employed by local and international organizations (OSCE, 2010). Egyptians too have secured good jobs in different municipalities. In Gjakova and Klina, five Egyptian women work as teachers; two Egyptian doctors work in the main health care center in Gjakova and one in the hospital of Klina. There are as well others who are employed as blacksmiths, in clothing shops, or own small farms (OSCE, 2010).

Nevertheless, the RAE members remain in an unfavorable situation compared to other nationalities living in Kosovo. A study conducted by UNDP indicates that young RAE are very much disadvantaged with regard to employment opportunities compared to Kosovar youth. As the Table 2.3 below shows the employment ratio* for RAE youth is 6-12 percentage points below the employment ratio of young Kosovar and Serbs respectively (UNDP, 2012).

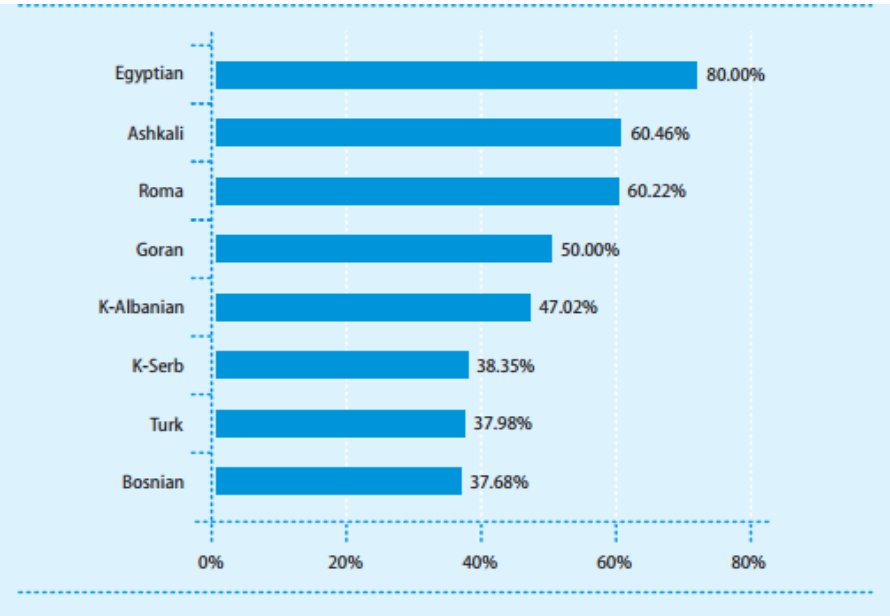
Table 2.3: Youth employment ratio by ethnicity

	Employment ratio (%)
All	28
K-Albanians	29
K-Serbs	23
RAE	17

Source: UNDP (2012)

***** Employment ratio is the ratio of total working age currently employed over total working age population of a country.

Figure 2.5: Unemployment rate by ethnicity



Source UNDP (2012)

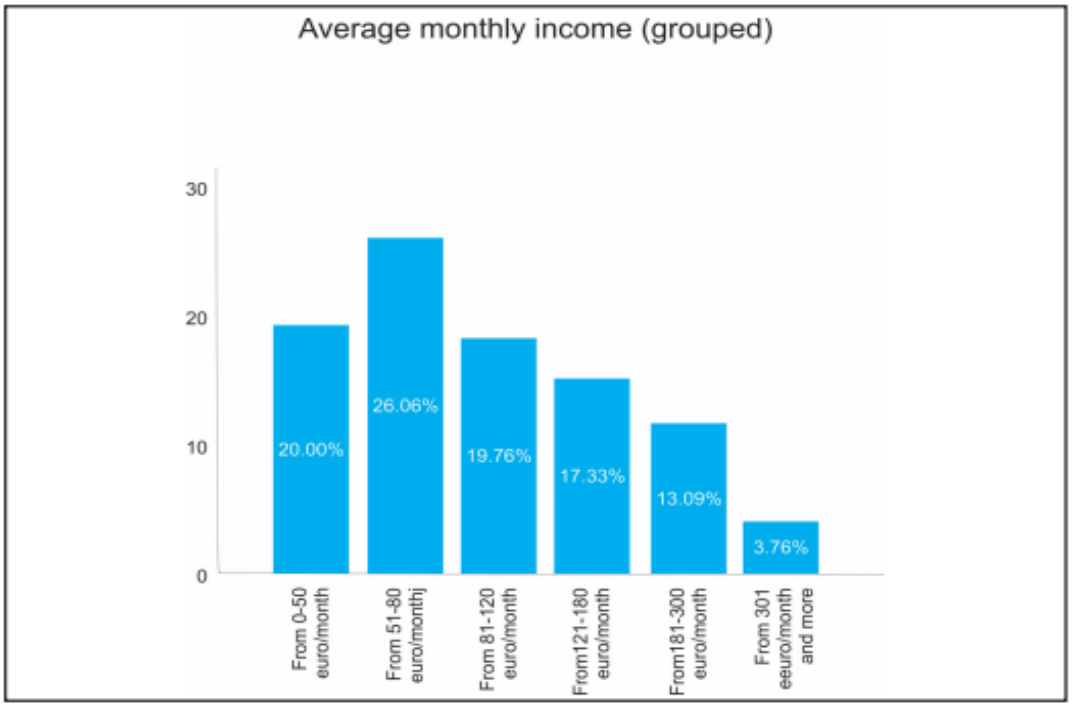
Moreover, as depicted in the Figure 2.5 above, RAE community face the highest percentage of unemployment from all other nationalities living in Kosovo (UNDP, 2012). Some of the reasons causing this high unemployment could potentially be low level of education, discrimination based on ethnicity, and lack of information regarding job opportunities.

2.5 Poverty and Living Conditions

The living conditions among RAE community are remarkably low compared to the other nationalities living in Kosovo. The poor social, political and economic conditions of the three communities have negatively impacted their well-being throughout years. Due to the low levels of education, lack of professional trainings and proficiency to integrate in the formal labor market, the life of RAE community is very challenging. The difficulties RAE members face in securing a good working position causes them to live in poverty. In fact, poverty is a plain phenomenon of the life of RAE community (Vrenezi and Thaci, 2009). The level of monthly income for households of these communities is exceptionally low as to not allow most RAE families live in suitable conditions. The income they receive can be either from working informal jobs, assistance form

relatives living abroad, pensions, social assistance, and so on. As shown in the Figure 2.6 below, the survey conducted by KFOS shows that 20% of RAE families live with an average €50/month, 20.06% receive monthly income from €50-80/month, 17.33% receive monthly €120-180, 13.9% are able to secure monthly incomes from €181-300, and only 3.76% claimed to have incomes higher than €300/month (Vrenezi and Thaci, 2009).

Figure 2.6: Average monthly income of RAE families



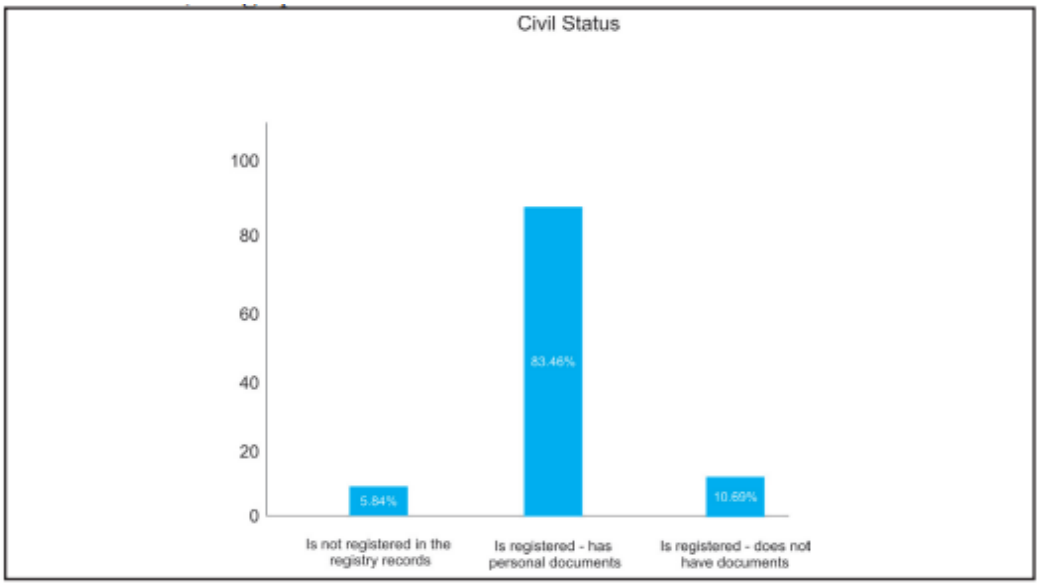
Source: Vrenezi and Thaci (2009)

The low level of incomes RAE families receive monthly does not allow them to afford proper housing. Their dwellings are usually characterized with minimal hygienic conditions which negatively impact the health of individuals and communities as a whole. Lack of possession of various house equipment such as electronic ovens, TVs, refrigerators, and boilers, indicate that the living conditions of RAE community are really humble (Vrenezi and Thaci, 2009).

2.6 Civil Registration

One of the major problems in Kosovo is the problem of civil registration. For a long time there has not been a census of population. The last one which is considered legitimate was done in 1981. Nevertheless, since then Kosovo has experienced massive population movements, especially during the conflict of 1999. The major movement of population has led many minority groups be excluded from the records of civil registry, particularly RAE members who left during or after the war and have been forcibly returned from Germany and Austria (Vrenezi and Thaci, 2009). Due to this problem they subsequently face other negative consequences such as exclusion from the social welfare programs, employment opportunities, healthcare services, education, and so on. The only health and other services available for the paperless people are those provided by the NGOs or international organizations such as the UNICEF. However, according to the KFOS survey the situation of RAE community in this regard is generally satisfactory based on the responses of the participants with 83.46% of responders being registered and possessing identification document 5.83% of the responders addressed the issue of not registering and not possessing identification documents, and 10.6% claimed to be registered but not having identification documents (Figure 2.7) (Vrenezi and Thaci, 2009).

Figure 2.7: Civil status of RAE community members



Source: Vrenezi and Thaci (2009)

Another concern in this regard is the lack of documentation among RAE children age 0-6. Data show that 14.7% of them fail to get registered in birth registers and this is mainly as a result of home births. Children of this age are more vulnerable in getting various epidemic diseases and hence, will need medical help more often than adults. However, lack of registration imposes an obstacle to access health care system (Vrenezi and Thaci, 2009). This is why it is very important for RAE women to give birth in hospitals.

Taking into consideration the poor situation of RAE women in various field that affect their health care, as indicated above, this project will tackle the issue of the lack of access of RAE women to antenatal care. What are the sources of this problem, role of the government in designing and implementing policies, as well as the role of the civil society actors in improving the access to the antenatal services among the Roma, Ashkali and Egyptian women? These are the inquiries the project will address which would afterwards help in providing recommendations to assist policy makers in drafting or initiating programs and strategies that would stimulate the improvement of the current situation.

3.0 Methodology and Results

The purpose of this project is to tackle the issue of the lack of access of RAE women to antenatal health care. The goals of this study are to identify the reasons of the lack of access of RAE women in antenatal health services in Kosovo and provide recommendations for the government institutions and the NGOs for improving the current situation. This research would serve to law and policy makers in Kosovo to better understand the situation of RAE women and their access to antenatal care and assist them in improving the design and enactment of policies, programs, and strategies that might contribute positively in the current situation of RAE community women and their access to antenatal health services.

The problem has been examined through a research using primary and secondary data. The secondary data was used for a better understanding of the current situation regarding the underuse of antenatal health services among RAE community. Analysis on the secondary data assisted in designing the surveys and interview questions. For the primary research, a combination of quantitative and qualitative data inquires have been gathered. Qualitative data was gathered for the purpose of identifying the factors of the lack of access to antenatal health services and the role of NGOs, government institutions and civil society in improving the current situation. Interviews were conducted with the representatives of the Ministry of Health (MH), two local NGOs - Network of Roma, Ashkali and Egyptian Women's Organizations in Kosovo (NRAEWOK) and Kosovo Foundation for Open Society (KFOS), and Gynecology and Obstetrics Clinic in University Clinical Center of Kosovo (UCCK). The qualitative questions were designed to understand the problem from the perspective of respondents and examine the role and actions of their respective institutions made so far in regard to the improvement of the current situation (*see Appendix 2 for interview questions*).

For the purpose of understanding the problem from the perspective of RAE women themselves, 30 RAE women were surveyed. In Kosovo, Roma, Ashkali and Egyptians identify themselves as belonging to three distinguished communities. They are recognized as such by Kosovo's legal framework, institutions, and local and international organizations. However, because they experience similar social and economic conditions are usually addressed together. Therefore, the 30 women were surveyed as representatives of all the three communities. 20

participants of the research were from Fushe Kosova municipality and 10 participants from Prizren municipality. The questions in the survey were designed as to investigate the factors that affect the lack of access to antenatal health services (s*ee Appendix 3 for survey questions*). The main factors that have been investigated in the surveys are divided in these categories:

(1) Demographic information;
(2) Education and Economic Status;
(3) Antenatal Health.

The criteria for selecting the participants of the research were: (1) the research participant should be a woman; (2) the research participant should be a member of either Roma, Ashkali, or Egyptian community; and (3) the research participant should have been or should currently be pregnant. The selection of municipalities of Fushe Kosova and Prizren as places of drawing the participants was based on the convenience and possibility of completing the surveys there. The strategy of selecting the research participants was completely random sampling. The surveys were conducted by going door-to-door in the neighborhoods where these communities live in Fushe Kosova and Prizren. This selection strategy was considered to be appropriate to have an unbiased sample to analyze the issue at hand. The data obtained from the questions of the surveys are quantified to draw the results presented in this chapter.

3.1 Problems and Difficulties

The process of conducting this research comprised in itself some difficulties. One of the main challenges encountered was finding the respondents for both the interview and the surveys. In order to conduct the interview with the representative from the UCCK, permission was needed because no information was allowed to be provided without permission from the director of the clinic. The consent for conducting the interview was provided to me two weeks after submitting the request. Also, another difficulty faced while doing the research was regarding the arrangement of meetings with research participants from NGOs and MH. Because of their busy schedule the participants had to be contacted several times until agreed for a convenient meeting time. Whereas, regarding the surveys the main challenge was gaining the trust of respondents to be part of the

research. Members of these communities had difficulties in trusting someone outside their community. Therefore, at first some of the participants were hesitant in accepting to answer the questions. Also, some of them had difficulties in understanding the purpose of the research and the issue at hand. Some of the respondents had problems in understanding the questions of the questionnaire which was mainly as a result of their lack of education. Hence, many of the questions had to be explained in a simpler way to be easier understood by them. Financial and time constraints were another problem while conducting this research. Such constraints limited the possibility of expanding the selection of research participants in other municipalities of Kosovo as well.

3.2 Strengths and Weaknesses

Ethical consideration was an important part of this research. Therefore, an informed consent was provided to the research participants to ensure confidentiality that the data collected would be used only for the purpose of this project (*see Appendix 4 for informed consent*). Ethical consideration is considered to be strength of this research because after being ensured on the confidentiality of the data, research participants were more collaborative in providing honest answers. Therefore, the results obtained from the qualitative interviews and the surveys are reliable and helpful to reach the objectives of the study. They are credible to be used for reaching into conclusions and providing recommendations aiming to improve the current situation of RAE women and antenatal health care.

Also, the research participants were representatives of different institutions that have an important role on the issue at hand. Thus, the problem was tackled from different perspectives making the results gathered as such strong enough to be used in drawing conclusions for the problem discussed in this research. However, the study encountered some limitations. Due to financial and time constraints the sample size was relatively small compared to the number of total population of the RAE community members. Moreover, lack of time and money limited the conduct of the research in only two municipalities, that of Fushe Kosova and Prizren.

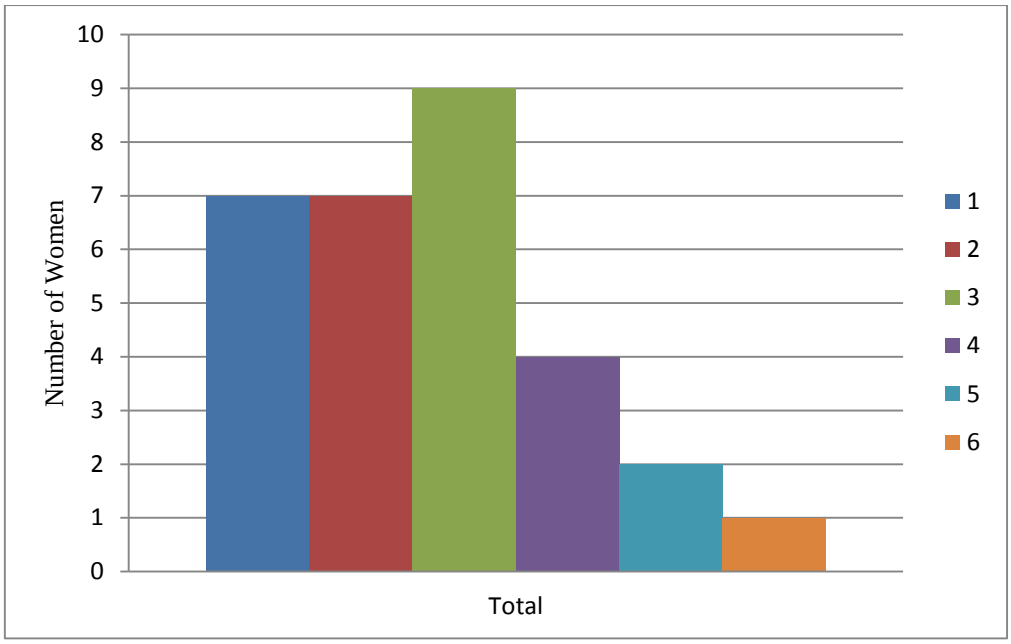
3.3 Results

The results gathered from the qualitative interviews and surveys support the hypothesis that there is a lack of access to antenatal health service among RAE women in Kosovo. The interviews with representatives of institutions relevant to the issue at hand suggest that there is a difference in the use of antenatal health services between RAE community women and Albanian majority communities. For better understanding of the problem discussed the results gathered while conducting the study are categorized as following:

3.3.1. Education and Economic Status

Many of the existing sources suggest strong correlation between education levels and health awareness. Hence, it is important to provide evidence about the low education levels of the RAE women. The research study analyzed the education level of participants as well. Figure 3.1 provides an illustration of the low education levels of RAE women. 23 out of 30 respondents have completed less than four years of formal education. Seven out of 30 respondents were illiterate, and another seven were literate but have never completed a year of formal education. This means that 46% of the respondents were with no education. Only two respondents had nine to twelve years of education and only one more than thirteen years. Furthermore, none of the respondents, neither in Fushe Kosova nor Prizren, were aware of any programs to support education and literacy.

Figure 3.1: Education levels of the RAE women (1=no education, illiterate; 2=no education, literate; 3=1-4 years, 4=5-8 years; 5=9-12 years; 6=13 years or more)

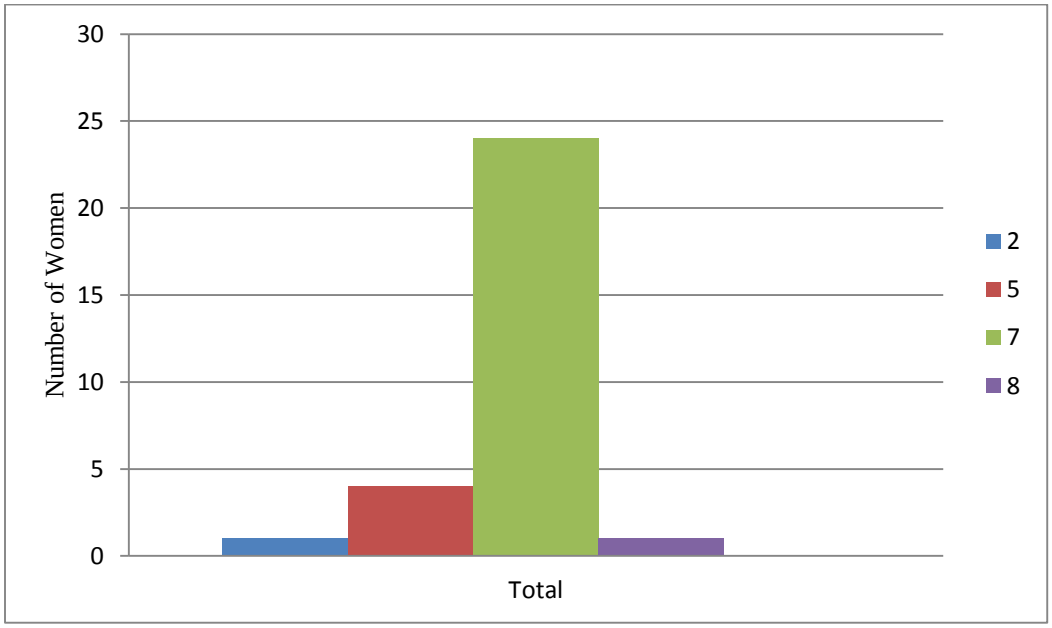


Low level of education among these communities is identified as a concern also from the responses of the interviewees. All of the interviewees mentioned low level of education as the source of the problem. As the representative from MH said, "I believe that low level of education is amongst the main factor which causes the lack of usage of antenatal health services among RAE women," (MH, Personal Communication, 2014). The results from qualitative interviews suggest that due to the low level of education, RAE women lack awareness regarding the precaution on antenatal health. According to the respondents the number of women who adequately take care of their health is quite low. However, the interviewees claimed that the situation has started to improve in the recent years. The interviewee from the NGO "KFOS" said that with their mediators and doctor visits in the RAE families they have managed to increase the awareness of many RAE women regarding antenatal health care. Nonetheless, according to him there is still need for awareness among women of these communities (KFOS, Personal Communication, 2014).

Taking into consideration that the level of education generally predicts employability, the study gathered information about employment status of the research participants. The results obtained suggest that the unemployment level among the RAE women is high. As seen in the

Figure 3.2 80%, or 24 out of 30 women surveyed were housewives. Out of 30 women surveyed only one of them was employed in the private sector. Four of the respondents claimed to be self-employed while one was a pensioner. This suggests that the incomes of these women are quite low and thus, it is presumably difficult for them to cover the expenses related to health care.

Figure 3.2: Employment Status of RAE Women (1= employed in public sector; 2 =employed in private sector; 3=employed in a NGO; 4=unemployed; 5=self-employed; 6= looking for a job; 7=housewife; 8=pensioner)



Another important issue to mention is the correlation between wealth and health status. Generally, higher income is associated with higher self-perceived and externally evaluated health situation. Therefore, this study focused also on the household income level of the respondents.

Figure 3.3: Monthly income levels of the RAE families (1=0-50 euros; 2=50-80 euros; 3=81-120 euros; 4=181-300 euros; 5=more than 300 euros)

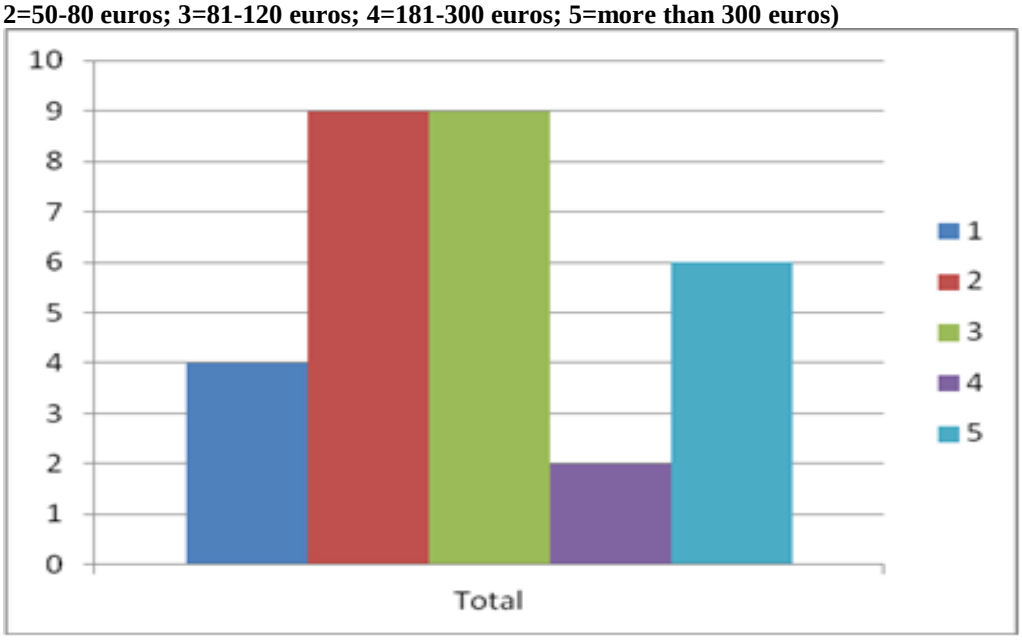


Figure 3.3 demonstrates that 22 out of 30 women had a monthly family income of less than 120 euros. Four families had an income of 50 euros or less. These figures are far behind from the average Kosovo family income of 443 euros.

Table 3.1: Receive of social assistance for RAE women and cover of health expenses

Social assistance		Cover of health expenses	
Receive	19	Cover	0
Do not Receive	11	Doesn't cover	19
Grand Total	**30**		**19**

Moreover, 19 out of 30 families were receiving social assistance. None of these families agreed that the social assistance is enough to cover the health care costs. The struggle to afford the expenses related to the use of antenatal health services is evident. 19 out of 30 respondents have chosen "Doesn't cover" as a response for health expense coverage through social assistance.

Therefore, this suggests why there is an underuse of antenatal health services among the RAE women (Table 3.1).

In addition to the social assistance, other sources of income for RAE families could be from other non-government institutions e.g. local or international NGOs or relatives living abroad. In the question about the assistance from other institutions all the participants answered that they do not receive such assistance. Meanwhile, with regards to the assistance from relatives abroad, 13 out of 30 (43%) received this kind of assistance. The remaining 17 claimed not to receive it. From those 13 who received assistance from relative living abroad, 5 of them said that they rely a lot on it and 8 said that rely little on such assistance (Table 3.2).

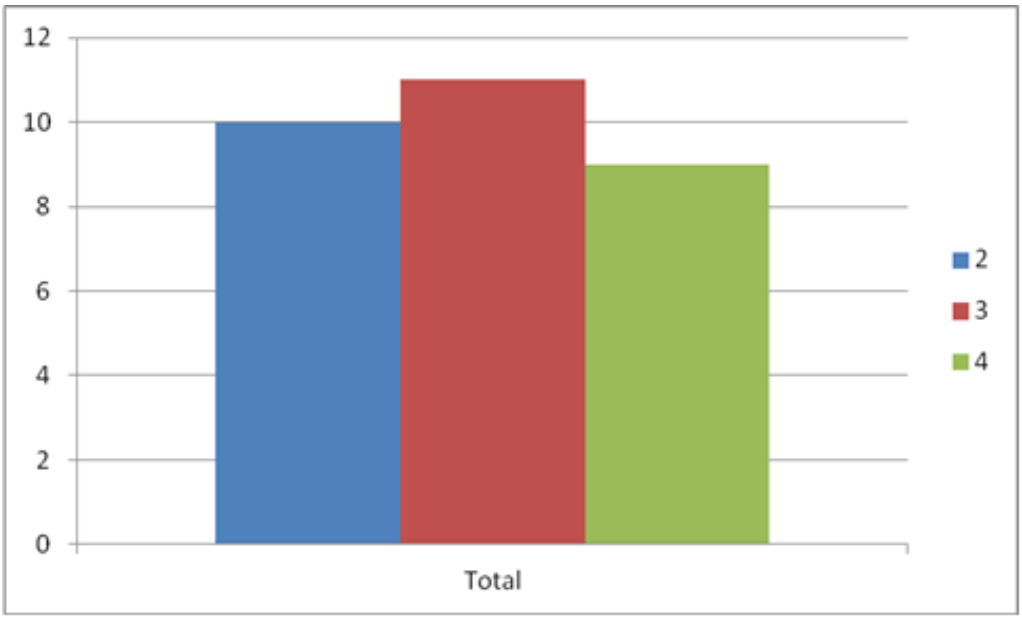
Table 3.2: Assistance from relatives living abroad of RAE women and reliance on the assistance

	Assistance from relatives abroad		**Reliance on the assistance**
Receive	13	A lot	**5**
Do not Receive	17	Little	8
Total	**30**	**Total**	**13**

3.3.2 Antenatal health

For better understanding of the issue from the perspective of RAE women, the respondents were asked to assess the antenatal health. As illustrated by Figure 3.4, 10 of the 30 respondents assessed RAE women's antenatal health as good, 11 as average, and 9 as poor.

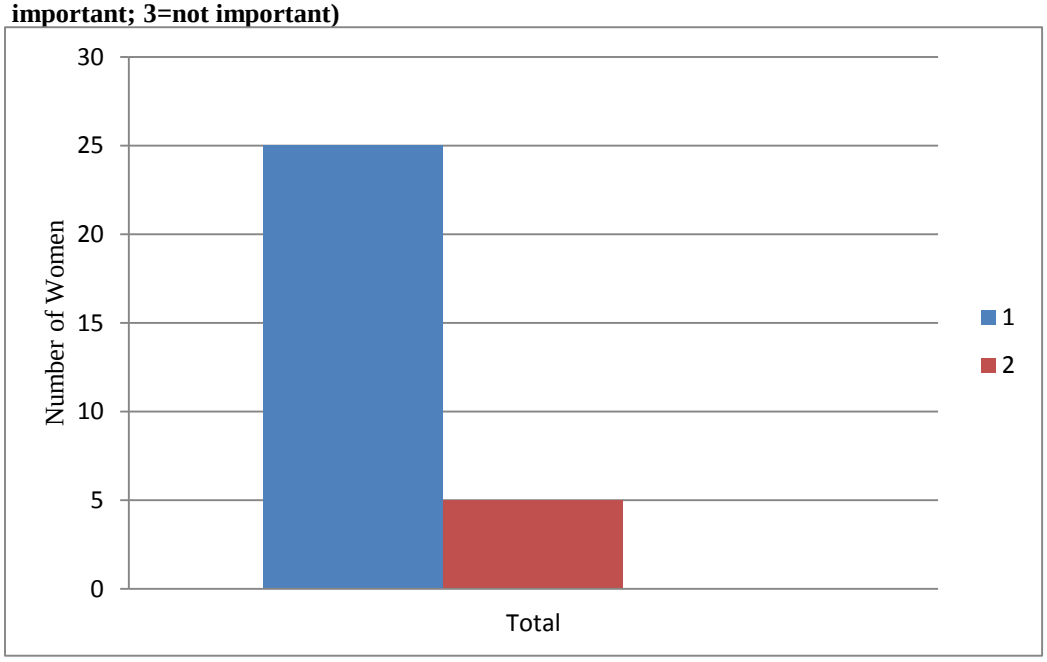
Figure 3.4: Self-assessment of RAE women's antenatal health (1=very good; 2=good; 3=average; 4=poor; 5=very poor; 6=I don't know)



From the interview with the representative from the UCCK it was found that generally the health of RAE women is poor. The reasons behind that, as mentioned by the interviewee include: firstly, RAE women do not care much about their health, secondly, they live in poor living conditions, and finally they are overloaded with housework even during their pregnancy (UCCK, Personal Communication, 2014).

Meanwhile, all survey respondents agreed that health during the pregnancy is very important or somewhat important for them. This is reflected in Figure 3.5 which shows that 25 out of 30 or 83% of respondents perceived health during pregnancy as very important; whereas for 5 out of 30 or 17% of them health during pregnancy was somewhat important. This suggests that health is important for RAE women; however, due to various reasons they do not use antenatal health services as much as they should.

Figure 3.5: Importance of health for RAE women (1=very important; 2=somewhat important; 3=not important)



Regarding the use of health services during the pregnancy, the research participants were asked whether they have consulted with a medical professional during their last pregnancy. Table 3.3 shows that out of 30 women, 19 said they have consulted someone during their last pregnancy while 11 out of 30 claimed to have never consulted someone during their last pregnancy. Furthermore, 11 out of 19 women listed the gynecologist as the person whom they have consulted; the remaining claimed to have been consulted with the family doctor. Table 3.3 represents also the place where the women delivered their children during the last pregnancy. 19 out of 30 women who visited the doctor delivered their children in hospital while 11 out of 30 said to deliver their children at home.

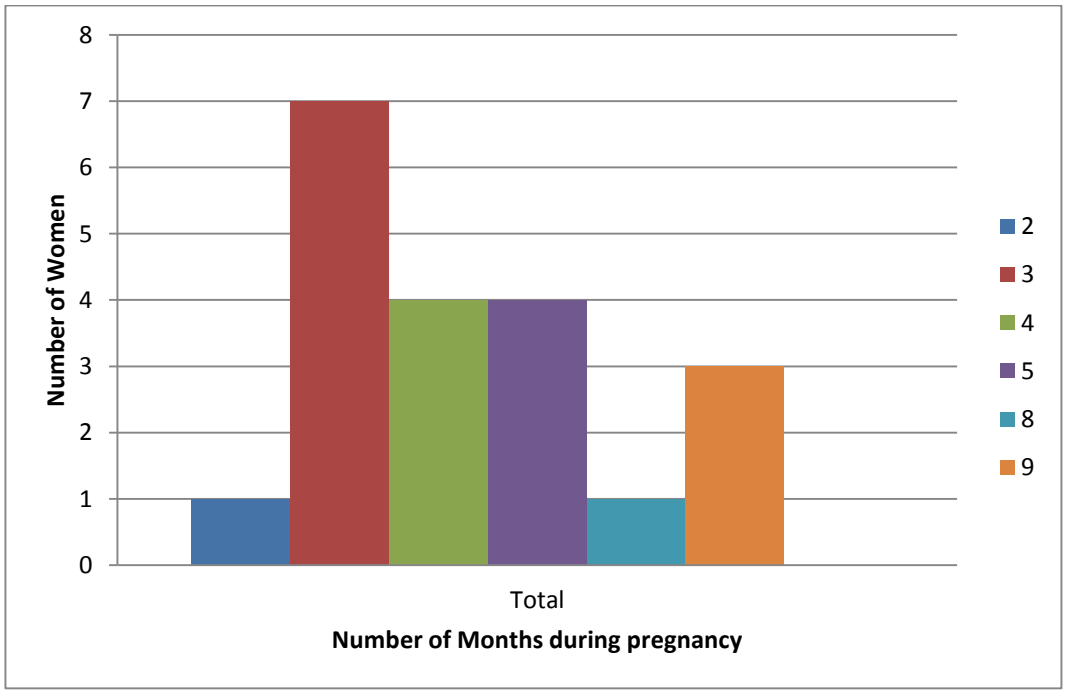
Table 3.3: Consultation during last pregnancy for RAE women and delivery place during last pregnancy

Consultation during the last pregnancy				**Place of delivery during the last pregnancy**	
Yes	19	Gynecologist	11	Home	11
No	11	Family Doctor	8	Hospital	19
Total	**30**	**Total**	**19**	**Total**	**30**

There are no statistics available from the UCCK regarding the number of RAE women who give birth at the Gynecology Ward. From the interview conducted with the representative of the UCCK it was fond out that when registering in UCCK the registration form contained the section of selecting the ethnicity the patient comes from. However, that part was not filled out by the UCCK staff. Therefore, the UCCK could not provide with the exact number of RAE women registering at the Gynecology Ward and giving birth there.

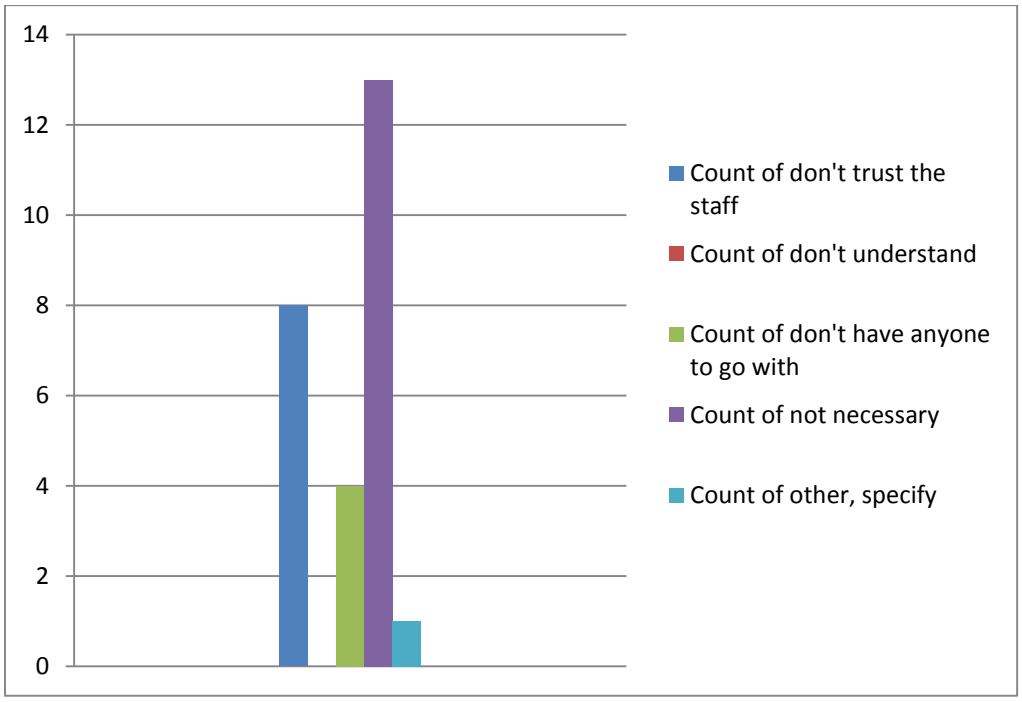
Furthermore, Figure 3.6 illustrates the months of pregnancy in which RAE women visited a doctor for the first time during their last pregnancy. The majority of them went to a doctor during the third month. 7 out of 19 visited a doctor in the third month, 4 out of 19 answered to see a doctor in the four month and 4 others in the fifth month. The results show that only 1 of 19 women surveyed consulted a doctor at the beginning of the pregnancy in the second month, while none of them went to a doctor when first learning about their pregnancy. 3 out of 19 have visited a doctor only during the delivery period i.e. in their ninth month.

Figure 3.6: Months of pregnancy in which RAE women visited the doctor for the first time during the last pregnancy(2= 2nd month; 3=3rd month; 4=4th month; 5=5th month; 8=8th month; 9=9th month)



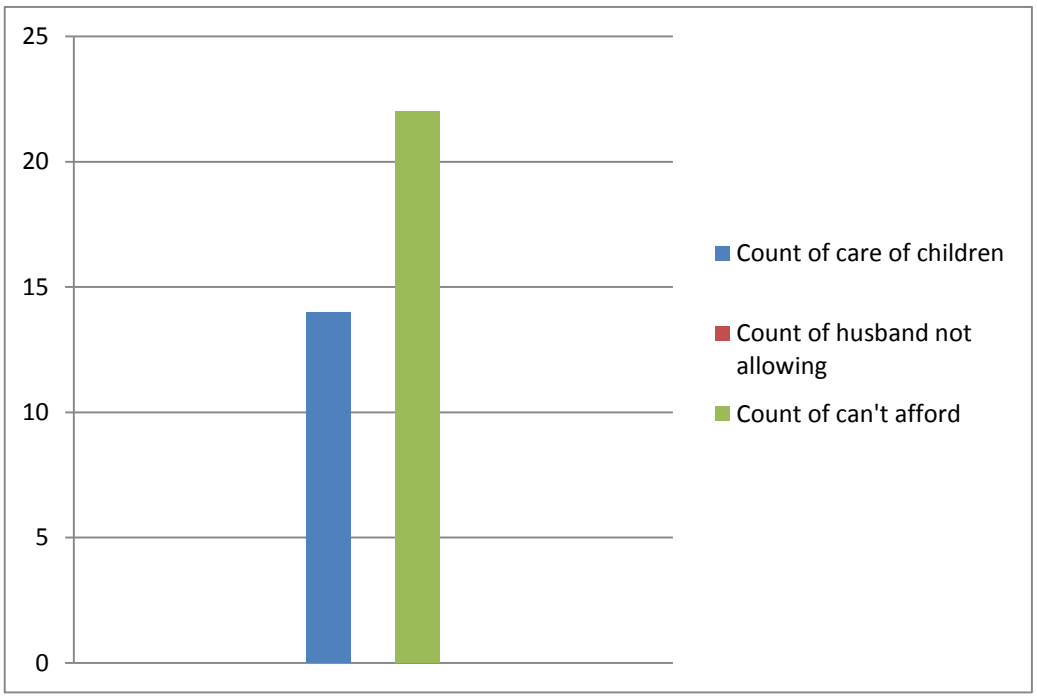
The results from the interviews demonstrate that there are various reasons behind the lack of access to antenatal health care service. In order to understand why RAE women do not use antenatal health services as much as they should, the survey respondents were asked about the reasons. Figure 3.7 provides an illustration for the personal reasons that prevent RAE women from using the antenatal health care. 13 out of 30 respondents said that they do not see antenatal health services as necessary. 8 out of the 30 answered women said that they do not trust the staff in the public hospitals. The lack of trust in the health service providers comes as a result of discrimination these women had faced because of their ethnicity. Discrimination based on ethnicity is identified as a reason preventing RAE women from using antenatal health services by the representatives of the two NGOs as well. The interviewees said they had witnessed and heard about many cases where RAE women were refused of services simply because of their ethnicity. Other reasons that prevented RAE women from using antenatal health services are not having anyone to go with or not possessing any means of transportation.

Figure 3.7: Personal reasons preventing RAE women from using antenatal health services



Also, 23 out of 30 women said they had one or more family-related reasons preventing them from using antenatal health services. The participants had the possibility to choose more than one of the listed options. As seen in the Figure 3.8, 22 of them listed the inability to afford healthcare expenses as one of the reasons; while 14 of the respondents were listing the care of children or other sick member in the family as the family reason as a barrier preventing them from using of antenatal health services.

Figure 3.8: Family reasons preventing RAE women from using antenatal health services



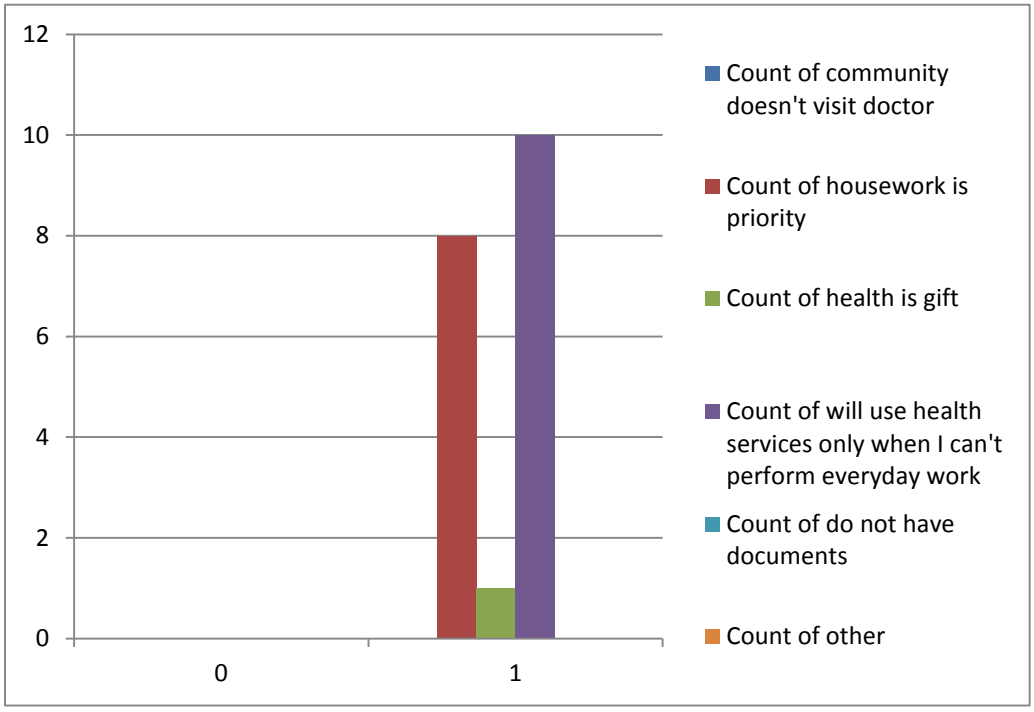
Low level of household income is also mentioned as a problem by the interviewees. All of them claimed that among the other barriers preventing RAE women from using antenatal health services are the financial constraints. When asked why these special challenges in the use of antenatal services exist among women of Roma, Ashkali and Egyptian communities, the interviewee from the NGO NRAEWOK stated that,

> "Socio-economic conditions are the reason why this problem exists. Even though the services are free and provided to all citizens, *further treatment, drugs, or test that are required to be done which are not provided in the public hospital, causes them not to continue with the necessary treatments.* This can also sometimes

> discourage women to even go to the doctor. They believe that the doctor will ask them to buy medicines or do additional test in private hospitals and *since they cannot financially afford it they decide not to visit the doctor at all* (NRAEWOK, Personal Communication, 2014)

Figure 3.9 illustrates the cultural reasons why RAE women are underusing antenatal health services. 10 out of 30 responded that they would use such services only when it is really necessary, for instance, when they cannot perform their daily works. Eight of the respondents set the housework as a priority, thus not paying much attention to their health whereas only one of them considered health as a gift believing that if she is lucky enough she will not need to visit the doctors.

Figure 3.9: Cultural reasons preventing RAE women from using antenatal health services

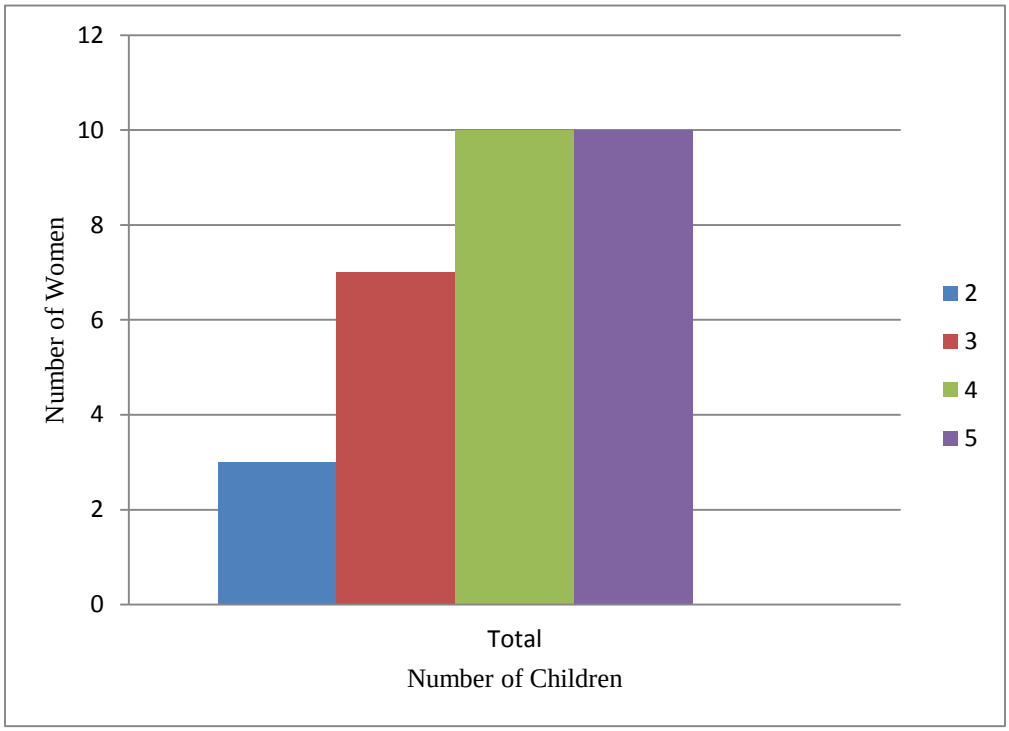


From the interview with the representative from the UCCK, the negligence of health care was emphasized also as the reason for RAE women not using enough antenatal health services. The interviewee mentioned that even when RAE women visit the gynecologist they do it when their delivery time is near. Very often they do not listen to the doctors' advice to stay in the hospital but request to leave the hospital as soon as they have their children born. They claim that they have to

take care for other members of the family and perform daily housework (UCCK, Personal Communication 2014).

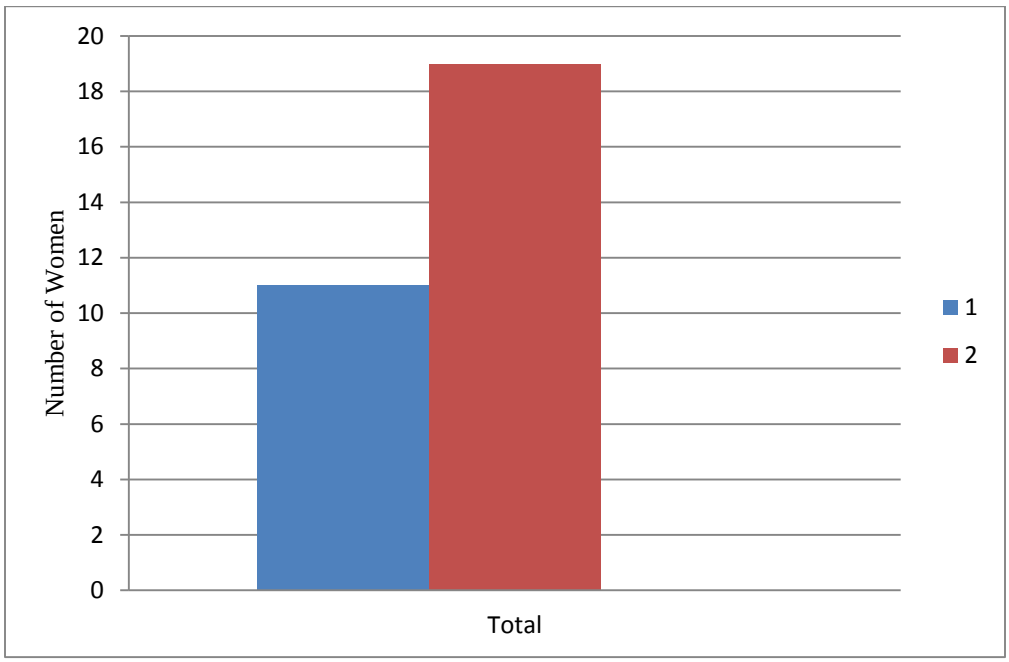
Furthermore, family planning is another issue which is related to antenatal health of RAE women. Usually RAE families consist of high number of children. This is supported by the survey results as well. As seen in the figure 3.10, 20 out of 30 women had 4 or more children. Out of them, 10 had 5 and more children.

Figure 3.10: Number of children of RAE women



Moreover, to understand the precaution of RAE women regarding their reproductive health, it is important to assess the family planning among the women from these communities. When asked whether they plan their pregnancies, 19 out of 30 said not to plan their pregnancy whereas the remaining 11 claimed to plan their pregnancies (Figure 3.11).

Figure 3.11: Family Planning among RAE women (1=yes; 2=no; 3=I don't know)

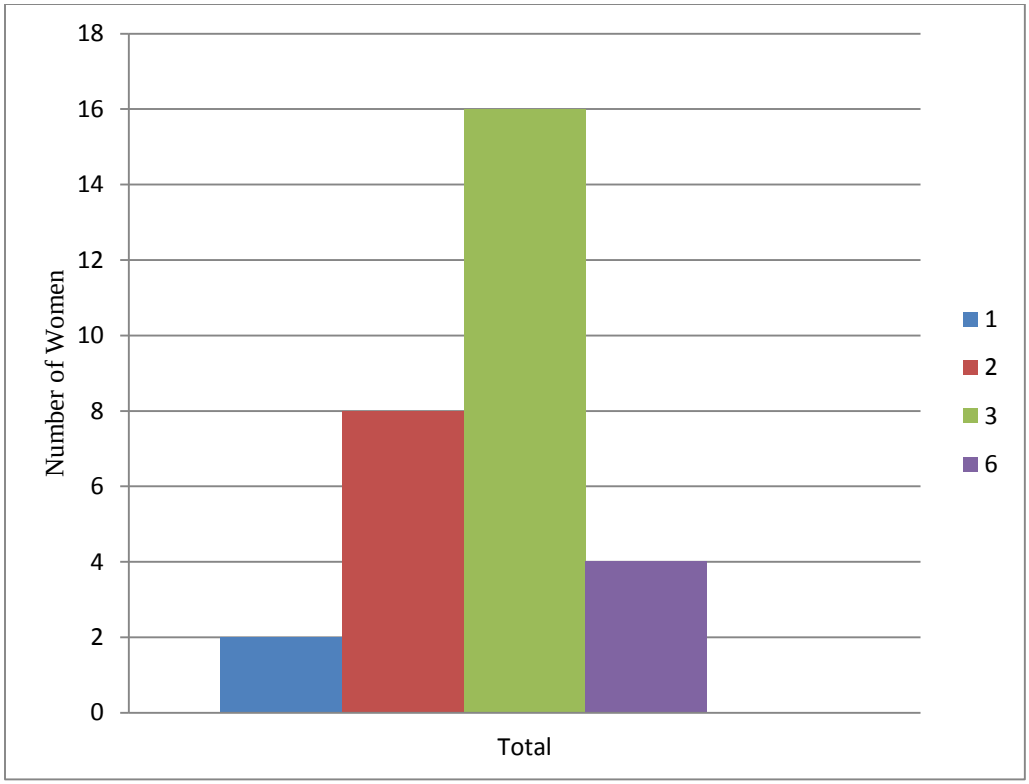


Results gathered from the qualitative interview support the view that family planning among RAE women is really low. All the interviewees said that only in few cases women are asked about the number of children they want to have. Most of the cases women get pregnant unintentionally due to low level of usage of protective means. "In most of the cases the husband decides about the number of children. *The number of women who are given the power to decide or take part in family planning is still really low*," said the representative from NRAEWOK during the interview (NRAEWOK, Personal Communication, 2014).

The low level of family planning is supported by the fact that most of the pregnancies of RAE women result in a child birth, and very few of them have artificial abortion. Figure 3.12 provides an illustration of high number of children born. 16 out of 30 women surveyed or 53% of them answered that their last pregnancy resulted in childbirth. Eight out of 30 had spontaneous abortion as a result of complications and health problems during pregnancy. 4 of surveyed women were pregnant; whereas only 2 out of 30 had artificial abortion. Moreover, none of the respondents, neither in Fushe Kosova nor Prizren are aware of any health educational program.

However, all of them expressed their willingness to participate if such programs would exist within their communities.

Figure 3.12: Ending of last pregnancy among RAE women (1= artificial abortion; 2= spontaneous abortion; 3= delivered living child born; 4= delivered dead child - before delivery / during delivery; 5=child died after the birth; 6=currently pregnant)



4.0 ANALYSIS AND DISCUSSION

The antenatal health status in Kosovo is considered to be the poorest compared to the neighboring countries. The services provided to the patients are not always of the highest quality. Due to the lack of necessary medications in public hospitals, patients are often required to visit private ones. As such, many of them choose not to visit the doctor in the first place unless they are left with no other choice. However, the situation regarding access to health care is even more a concerning issue amongst RAE community living in Kosovo. Since this study focuses on the access to antenatal health care among RAE women, the results gathered with this research exhibit the scope of the situation of the issue being discussed. The current situation shows that there is a difference in the use of antenatal services among RAE community women when compared to the Albanian majority communities. The goals of this study were to identify the reasons of the lack of access of RAE women in antenatal health services in Kosovo and provide recommendations for the government institutions and the NGOs for improving the current situation. The results suggest that there is indeed a lack of access to antenatal health care services among RAE women. Education and financial situation appear to be the main factors causing this problem. As depicted in Figure 3.1 the level of education among RAE women is quite low. 46% of the respondents claimed to be with no education. This situation is concerning because the low level of education triggers afterwards a chain of other problems e.g. low family income and low awareness regarding the importance of health during pregnancy. According to a study done by Council of Europe, the low level of education results in women of these communities lacking access to health care. The illiteracy rate prevents them to have the level of critical thinking as to reflect on the importance of their health, the rights they have to access health care, and also lack information on the benefits they can enjoy with regard to health care (2003).

Taking into consideration that traditionally women of these communities are caregivers in their families, they tend to get married at a very young age. Throughout their life they take over the role of housewives; therefore, they are obliged to drop out of schools as to take care of the family. The drop outs usually happen without even finishing the mandatory education. Hence, the level of illiteracy among women of RAE communities is high. Many of the existing sources suggest a strong correlation between level of education and health awareness. For example, according to

to Higgins et al., (2008) and Feinstein et al., (2006) education is strongly interrelated to health and determining factors of good health such as health care habits and preventative service use. The knowledge, personal, and social skills acquired through education can better prepare individuals to access and use information on improving their own and family's health. Since the level of education is low among women of these communities, the awareness regarding their health is also low. As a result of this RAE women tend to visit the doctors less frequently during their pregnancies. Low level of awareness regarding the importance of health causes them to think that if they are meant to be healthy they will remain as such without visiting a doctor. Moreover, as the level of education generally determines the employment, low level of education suggests that the unemployment level among RAE women would be high. In fact this is supported by the results of the study as demonstrated in Figure 3.2. 80% of RAE women participant in this study were housewives. Only one of them was employed in the public sector while four were self-employed. This suggests that traditionally women of RAE community take over the role of housewives while husbands are the breadwinners.

Nevertheless, even if these women would seek employment, the low level of education would limit their opportunities in having a well-paid job position. For instance, majority of RAE women who are employed are so in private sector working informal jobs. This situation of unemployment or employment in low-paid low level of incomes jobs means that the level of incomes of RAE women is quite low and thus it is presumably difficult for them to cover the expenses related to health care. Furthermore, RAE community families usually have as majority of members of these communities work unprofessional jobs. The results gathered in this study show that many of RAE families have really low level of family income. As depicted in Figure 3.3 majority of participants declared that their family income is less than 120 euros. Considering that the average Kosovo family income is 443 euros, it means that RAE families struggle in covering the most basic expenses. As a result of this, often times RAE women are discouraged to visit the doctors during their pregnancies as to avoid the incurring of costs related to doctors' examination. According to the interviewee from the NGO NRAEWOK the inability to afford health services often times discourage RAE community women to visit the doctors. As the interviewee stated, "even though the services are free and provided to all citizens, *further treatments, the use of*

medicines, or additional test that are required to be done which are not provided in the public hospitals, discourage RAE women to continue with the necessary treatments," (NRAEWOK, Personal Communication, 2014).

Another alternative for generating income is through social assistance. Based on the Social Assistance Scheme in Kosovo, the social assistance is provided to: Category one – "a family where all family members are dependents and where such dependents are not working" and Category two: "a family where there is a family member able to work and where there is at least one child under age of five and/or an orphan under the age of fifteen who is under their full-time care" (Law No.2003/15). RAE community families often times fall under the Category Two. Therefore, RAE community tend to have a lot of children and undergo frequent pregnancies so they could be eligible for social assistance when having a child under the age of five. However, the social assistance they receive is not sufficient to cover health expenses; thus, the struggle to afford the expenses related to the use of antenatal health services is evident. The results in Figure 3.10 depict the high number of children among RAE families. 67% of RAE women claimed to have 4 children while 33% had 5 children or more. These frequent births along with the lack of nutrition threaten their reproductive health, particularly to young women.

Also, the reason why RAE women tend to have high number of children is because of poor family planning. Their awareness regarding precautious measurements for pregnancy is quite low. As seen in Figure 3.11 majority of RAE women do not plan their pregnancy. The qualitative results of this study also demonstrate that in most of the cases RAE women get pregnant unintentionally due to low level of usage of protective means. Most of the pregnancies end up with child birth, meaning that the number of artificial abortion among RAE women is fairly low. Under the culture of RAE community artificial abortion is prohibited. Of the 30 RAE women participants in this study only 2 of them had experienced artificial abortion. And they had to undergo the abortion due to the life risk of having the child born. The only abortion accepted by communities is the natural one which often times is caused due to the poor health of the mother or the heavy workload at home during pregnancy.

It is important to note that RAE women are aware of the poor situation regarding their health. The lifestyle of RAE communities greatly affects the health of RAE women. Since their role in the society is mostly to perform housekeeping duties, they are often overloaded with housework during their pregnancy. Also, the low monthly income levels of RAE families do not allow them to afford proper housing. Their dwellings are usually characterized with minimal hygienic conditions which negatively impact the hygiene of families and individuals. The health of RAE women is especially endangered considering the fact that they spend more time at home in performing household obligations. The interviewee stakeholder from the UCCK also listed the poor living condition and overload with housework as the reasons behind the poor antenatal health among RAE community women (UCCK, Personal Interview, 2014).

Even though the antenatal health of RAE women is assessed to be poor, RAE women are at some extent aware of the importance of their health during pregnancy. Nevertheless, due to various reasons they do not use antenatal health services as much as they should. One reason as seen in Figure 3.7, is the lack of trust in the staff of the health services. Such lack of trust comes as a result of ethnically based discrimination these women had faced when visiting the doctor. Even though discrimination based on ethnicity has started to vanish in Kosovar society, it is still present in some cases. An example of discrimination is providing poorer services for those with low level of income. Because of the low socio-economic status of the RAE community, they are the worst affected because of such discrimination. The interviewees from NGOs identified discrimination as amongst reasons that prevent RAE women from using antenatal health services. They had witnessed and heard about many cases where RAE women were refused to be provided the services simply because of their ethnicity. As the interviewee from NGO NRAEWOK stated, “Recently there was a case in Shtime where the staff of the hospital refused to provide services to a patient of RAE community because of her ethnicity, color of the skin, and clothes. This is a case which shows that members of RAE community still face the problem of discrimination from the majority of population,” (NRAEWOK, Personal Communication, 2014).

Another reason for preventing RAE women using antenatal health services as much as they should includes not having anyone to go with. Men of the family are majority of the time outside their house working. RAE women, being much dependent on their husbands, cannot go to the doctor alone when they have to. Moreover, not possessing means of transportation is deliberated as one reason why RAE women do not use antenatal health services frequently. Usually RAE community live in remote neighborhoods thus they need to travel to parts of the city where services like health care are provided. Those living outside of the city centers often do not have a family medicine center near their neighborhoods. Depending on the situation sometimes they need to go to the main hospitals where there are more health services available. The transportation cost to the hospital usually cannot be covered by the family incomes of RAE women; hence, it is difficult for them to go to the doctor for examination while being pregnant. The Figure 3.8 depicts inability to afford healthcare, including here transportation cost as a reason preventing RAE women from using antenatal health services.

Moreover, RAE members usually live in large families in which women have to take care of children, parents, and other family members. Having so much responsibility put on them, RAE women place other responsibilities as priority over their antenatal health. As the results of this study suggest in Figure 3.8 most of RAE women put care of children or other sick members in the family above care of their own health. The interviewee from UCCK said that even when RAE women visit the gynecologist they do it when their delivery time is near. Very often they do not listen to the doctors' advice requesting to leave the hospital as soon as they have their children born. They claim that they have to take care for other members of the family and perform daily housework (UCCK, Personal Communication, 2014).

As mentioned earlier, due to low level of awareness regarding health care, the access of RAE women to antenatal health care services is low. It is not a habit for them to visit the doctor regularly as to follow their health conditions during pregnancy. RAE women tend to use such services only when they cannot perform everyday work and take care for other members of the family. This is why the results gathered during this study show that a high number of RAE women had visited the doctor less frequently and in the later months of their pregnancy. In fact, there are cases when RAE women visit the doctor for the first time only when the delivery period

approaches. Even worse, there are cases where RAE women had never consulted a health care professional during their pregnancy. As shown in Table 3.3, 36% of RAE women had never consulted a healthcare professional during their pregnancy. Even though data suggest that home-births are declining in number, they are still common within the RAE community. RAE women still give unassisted births to their children, outside of hospitals. Those women who never visited the doctor during their pregnancy claimed to have given birth at home with the help of a community's midwife. Usually women who deliver their children at home are not given medical support as such their health is put at risk even more.

Since the results of this study proved that the situation of RAE women with regard to access to antenatal health services is poor it is important to initiate actions to improve it. The main actors for achieving this are the government institutions. In order to ensure that RAE community are provided the same rights and living conditions as to Albanian majority communities, the Government of Kosovo, specifically Office of the Prime Minister, has drafted the "Strategy for Integration of Roma, Ashkali, and Egyptians in the Republic of Kosovo." According to this strategy the MH is to offer financial incentives for health service providers who work in mobile health institutions. This assistance would allow them to perform more frequent visits to the marginalized communities, with special focus on RAE community. In addition, the strategy anticipates for many awareness raising lectures regarding antenatal health care to be offered to these communities ("Strategy for the Integration of Roma, Ashkali and Egyptian Communities," 2008). The MH in collaboration with Red Cross and agencies like the United Nations Population Fund (UNPF) organize activities to raise awareness on the importance of health. Nevertheless, these strategies have not been implemented fully since there are still many RAE neighborhoods without any health education programs. Health sector still remains the sector in which much more should be done and where the specific needs of RAE community sometimes failed to be taken into account by relevant institutions. According to a report done by OSCE they are not aware of any specific activities aiming to support specifically the health of mother among RAE community (2012). However, some work has been undertaken regarding the commitments of the Action Plan to awareness raising among RAE community. OSCE has identified a few vaccinations and health campaigns initiated by MH targeting the three

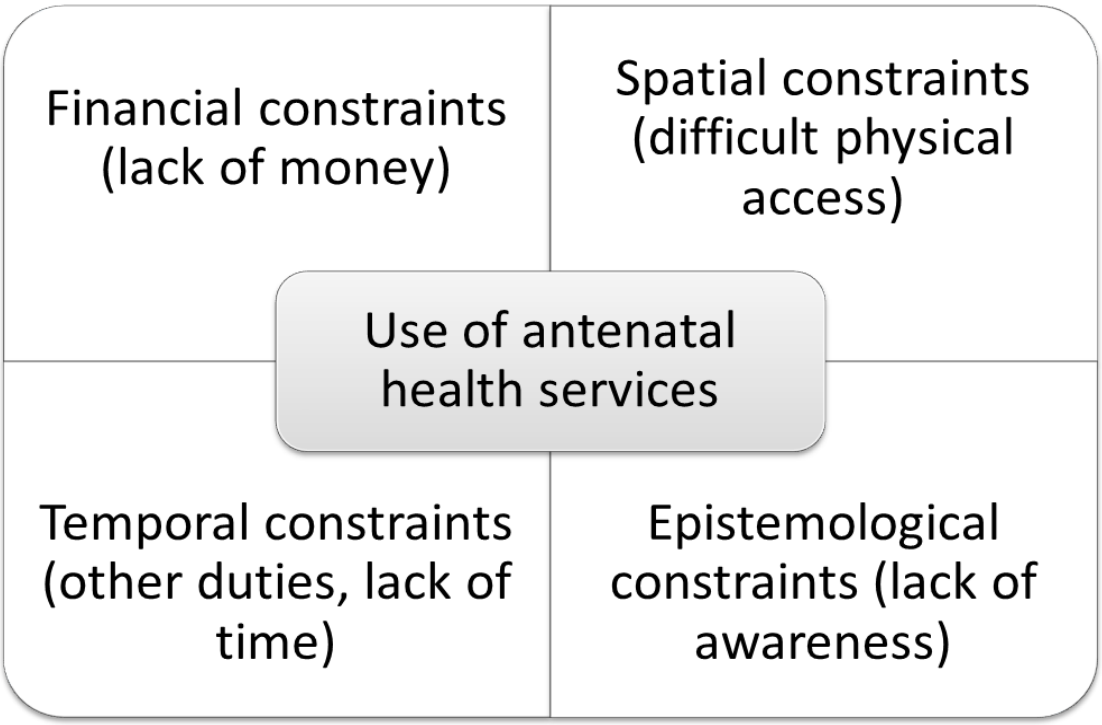
communities. These activities were organized in the municipal level; however, they are still not initiated across Kosovo. According to the report of OSCE, the MH stated that shortage of funds available hampered their ability to initiate awareness raising campaigns as foreseen in the Action Plan (OSCE, 2012).

There are as well many NGOs present in Kosovo whose main mission is to improve in general the life of RAE community in Kosovar society. Their work focuses also in the improvement of antenatal health among RAE women. Even though government institutions so far have failed to do much for the awareness regarding health among girls and women of RAE community, women NGOs have done and continue to do their best in initiating and implementing various activities concerning health such as awareness about family planning and the use of contraceptives ("Monitoring Report," 2012). These activities have proven to be successful managing to increase the awareness to at least some women of RAE community. As the interviewed stakeholder from the NGO KFOS stated, "In locations where we operate, at first women have been very little, if not at all, informed on the importance of health during pregnancy. However, with our mediators and doctors' visits in RAE families we have managed to increase the awareness to a large number among these women (KFOS, Personal Communication, 2014). Nevertheless, there is still much to be done so RAE women can overcome the barriers preventing them to use antenatal health services as much as they should and enjoy better antenatal health.

Figure 4.1 summarizes the identified barriers that impede the use of antenatal health services among RAE community women residing in Kosovo. Epistemological constraints, particularly the low level of education triggers the other factors. The level of education influences the decision of women not to take care of their health during pregnancy because they lack critical thinking to recognize the importance of antenatal health. Therefore, they give priorities to other family responsibilities above their health. Since they lack education, majority of RAE women face high level of unemployment. Therefore, they do not have sufficient financial means to maintain themselves and afford the health services. Even though the basic services are provided for free in public hospitals, they are usually required to do additional examinations in private hospitals and drugs. These examinations, along with the drugs have to be paid by patients themselves. In addition to this, RAE women who live in remote localities should often pay for the transportation

to the health care facilities. These costs hamper the RAE women from using antenatal health services as much as they should.

Figure 4.1: Explaining the inadequate use of antenatal health services among the RAE women



5.0 RECOMMENDATIONS AND CONCLUSION

Taking into consideration that there is under usage of antenatal health services among women of RAE community compared to Albanian majority communities, it means something has to be done for improving this situation. There are many influential factors that can undertake actions to positively improve the current situation. Such factors exist inside and outside the responsibility of health care sector. Government institutions e.g. MH being an inside factor of health care sector should be responsible in providing the infrastructure for the access of RAE women to antenatal health care. Policies and practices about health are vital in this regard. Nevertheless, the non-health sector actors e.g. NGOs and RAE women themselves are significant actors in ensuring that the strategies and policies designed are successfully being implemented and that it is being worked toward creating a better access to health care. Therefore, strategies and policies aiming to improve the antenatal health among RAE women, must involve the community to be a complement of any facility-based component. The reasons identified in this study for the existence of the problem discussed include: financial, spatial, temporal, and epistemological constraints. Based on this conclusion from the study, the following recommendations could be drawn aiming to improve the current situation:

- *MH and NGOs should provide health education awareness lectures and trainings to remote neighborhoods of RAE communities*

Education regarding the importance of health is essential not only for RAE women but rather the entire community. Health education enables RAE women to improve their health by altering their lifestyles during pregnancy. The importance of education awareness lies in the fact that they help in the promotion and establishment of good health among mothers of RAE community before childbirth. When they enjoy better antenatal health the likelihood of giving birth to a healthy child increases significantly. As such, it is crucial for healthcare providers and RAE women to discuss about the important topics which affect the pregnancy of women. Some cultures promote healthy diets and rest for pregnant women. However, in the culture of RAE community pregnancy is not acknowledged. During antenatal period, RAE women continue to work hard and lack the essential nutrition.

Therefore, if done well, these education awareness trainings would help RAE women understand the importance of a better antenatal health. Through these lectures RAE women could be taught about the benefits of having good nutrition, family planning, good hygiene and adequate rest. The better women are informed on these issues, the better decisions they will make concerning their health and pregnancy. As such their lifestyle would change in terms that women would give priorities to their health rather than other things e.g. housework duties. Also, training would include information regarding their rights and responsibilities, role of government institutions, and health services that are and should be provided to them. Awareness raising activities would as well help regarding matters of anti-discrimination and the rights entitled to RAE women as citizens of the Republic of Kosovo.

- *UCCK should provide mobile clinics to the remote neighborhoods of RAE community*

Antenatal care includes a number of 'routine' visits for examination during pregnancy to healthcare professionals. These visits happen on a regular basis throughout the period of pregnancy. RAE women who live in remote areas often time have difficulties in accessing the health care services due to the long distance. Therefore, providing mobile clinics to those neighborhoods would help them overcome such barrier. Mobile clinics would allow RAE women to connect with health care services. Nurse home visits included in these mobile clinics would promote healthy lifestyle and influence seeking care. It is exceptionally important for women to have their health in control during pregnancy because the on-going monitoring is associated with more favorable birth outcomes. Apart from physical distance the culture of RAE community also impedes the access of RAE women to antenatal health. Traditionally women of the three communities do not see it necessary to seek medical health to health service providers. Therefore, nurse home visits would contribute in making a habit to RAE women to perform regular visits during pregnancy. Nevertheless, in order to ensure that these visits are successful and beneficial RAE women themselves should also keep track of their state during pregnancy. They

should follow up appointments, ask questions regarding their antenatal health, and control their own pregnancy. Nonetheless, for RAE women to be able to their contribution in having a better antenatal health, they have to be educated on the importance of their health during pregnancy.

- *Improving access to education specifically to RAE women and young girls*

As many studies have confirmed, the level of education greatly affects the awareness of women on antenatal health care. The level of education among RAE community is exceptionally low. This situation is even more concerning especially for RAE women who are obliged to drop out of schools sometimes without even finishing the compulsory education. Traditionally they get married at young age and that is why they abandon schools. However, there are also financial difficulties that impede them to continue education since their families fail to cover transportation, basic materials, and other costs associated with education. Reasonable accommodations, along with measures to change practices that prevent RAE women's access to education must be adopted so women who abandoned school can go back as mothers or married women. Moreover, teachers, parents, and authorities should collaborate to encourage young girls to pursue education and be literate.

- *Improving financial support for rural RAE women who must travel for antenatal health care services*

Since inequalities regarding access to antenatal care remain in rural residents of RAE community, the government ought to take actions to improve financial support for these families. The social assistance RAE women receive is not sufficient to cover the most basic expenses, including here the expenses incurred with doctor's visits. Therefore, removing financial barriers is a vital component of any plan and strategy aiming to improve the access of RAE women to antenatal health services. RAE families who live in rural areas

bear a greater financial burden in accessing antenatal health services than their urban counterparts do, since they have to travel to facilities where antenatal health services are provided. Increase in financial support would help RAE women overcome the barrier that supposedly prevents them to commute to the local health centers for necessary visits with health care professionals.

In conclusion, the aim of this project was to investigate the lack of access of RAE women in Kosovo to antenatal health care services. Data show that there are discrepancies in the use of these services among RAE women and Albanian majority communities. Therefore, the study investigated the reasons behind this problem, role of the government in designing and implementing policies, as well as the role of the civil society actors in improving the issue discussed. The results gathered suggested that the main factors that hinder the use of antenatal health care services among RAE women are interlinked. Epistemological constraints, particularly the low level of education proved to be the main source of the problem triggering the other factors. The level of education influences the decision of women not to take care of their health during pregnancy. Since they lack education, majority of women are unemployed. Therefore, they do not have sufficient financial means to afford the health services. Even though the basic services are provided for free in public hospitals, they are usually required to do additional examinations in private hospitals .These examinations, along with the drugs have to be paid by patients themselves. These costs impede the RAE women from using antenatal health services as much as they should. As such, it is recommended that much should be done to assist RAE women overcome the barriers and enjoy a better antenatal health. Better health benefits not only them but rather the community as a whole.

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APPENDICES

Appendix 1: Data for school completion among RAE children

Years of school completed, compared by year of birth, 1986-1995

		Primary school								Secondary school				University				Total
Year	No school	I	II	III	IV	V	VI	VII	VIII	IX	X	XI	XII	I	II	III	IV	
1986	67	5	6	9	19	6	9		37	5	1	1	15	2	2	1	1	186
	36.0%	2.7%	3.2%	4.8%	10.2%	3.2%	4.8%		19.9%	2.7%	.5%	.5%	8.1%	1.1%	1.1%	.5%	.5%	100.0%
1987	50	2	3	7	22	12	3	5	33	10	1	2	6	4				160
	31.3%	1.3%	1.9%	4.4%	13.8%	7.5%	1.9%	3.1%	20.6%	6.3%	.6%	1.3%	3.8%	2.5%				100.0%
1988	49	4	10	10	15	12	7	7	32	10	6		12	6		2		182
	26.9%	2.2%	5.5%	5.5%	8.2%	6.6%	3.8%	3.8%	17.6%	5.5%	3.3%		6.6%	3.3%		1.1%		100.0%
1989	40	4	6	8	14	7	12	11	28	7	3	2	12	6			1	161
	24.8%	2.5%	3.7%	5%	8.7%	4.3%	7.5%	6.8%	17.4%	4.3%	1.9%	1.2%	7.5%	3.7%			.6%	100.0%
1990	52	1	9	9	18	12	12	9	23	16	7	3	17	10				198
	26.3%	.5%	4.5%	4.5%	9.1%	6.1%	6.1%	4.5%	11.6%	8.1%	3.5%	1.5%	8.6%	5.1%				100.0%
1991	54	2	4	8	13	18	16	16	36	18	4	4	9	9	1			212
	25.5%	.9%	1.9%	3.8%	6.1%	8.5%	7.5%	7.5%	17.0%	8.5%	1.9%	1.9%	4.2%	4.2%	.5%			100.0%
1992	38	4	6	6	16	15	17	13	24	21	2	4	3	4				173
	22.0%	2.3%	3.5%	3.5%	9.2%	8.7%	9.8%	7.5%	13.9%	12.1%	1.2%	2.3%	1.7%	2.3%				100.0%
1993	51	3	7	8	9	17	14	12	14	24	3	2	3					167
	30.5%	1.8%	4.2%	4.8%	5.4%	10.2%	8.4%	7.2%	8.4%	14.4%	1.8%	1.2%	1.8%					100.0%
1994	57	5	7	5	13	14	15	23	21	19	7		4					190
	30.0%	2.6%	3.7%	2.6%	6.8%	7.4%	7.9%	12.1%	11.1%	10.0%	3.7%		2.1%					100.0%
1995	49	6	8	7	15	16	16	12	13	18	1		1					162
	30.2%	3.7%	4.9%	4.3%	9.3%	9.9%	9.9%	7.4%	8.0%	11.1%	.6%		.6%					100.0%
Total	467	32	60	69	140	122	109	97	233	141	32	16	70	35	3	3	1	1630
	28.7%	2.0%	3.7%	4.2%	8.6%	7.5%	6.7%	6.0%	14.3%	8.7%	2.0%	1.0%	4.3%	2.1%	.2%	.2%	.1%	100.0%

Source: School's Out: An Education Survey in Ashkali, Egyptian and Roma Communities in 9 Kosovo Municipalities (2012)

Appendix 2: Interview Questions

1. Based on your personal observations, do you see any difference in the use of ante-natal services among the Roma, Ashkali and Egyptian communities when compared to the Albanian majority communities?

2. Why do you think these special challenges in the use of ante-natal services exist among the Roma, Ashkali and Egyptian communities?

3. From your experience, how informed are Roma, Ashkali, and Egyptian women regarding the importance of health during pregnancy?

4. From your experience, what should NGOs and women of Roma, Ashkali, and Egyptians communities do in order to improve the health of mother and children among the communities?

5. How would you evaluate your own work in terms of improving the health of Roma, Ashkali and Egyptian women and children?

6. From your experience in working with these communities, do you think the traditional lifestyle influences the decision of Roma, Ashkali and Egyptian women to use antenatal health services? Would Roma, Ashkali, or Egyptian women/girl visit a male gynecologist?

7. What are some of your recommendations in improving the current situation of access to ante-natal health service among Roma, Ashkali, and Egyptians women in Kosovo?

Appendix 3: Survey questions

DEMOGRAPHIC INFORMATION

1. Age_____

2 Marital Status

a) Single
b) Married
c) Divorced
d) Widow

3. How many children do you have?

a) 1
b) 2
c) 3
d) 4
e) 5 or more

4. What is your civil status?

a) Not registered in the cadaster
b) Registered – has personal documents
c) Registered – does not have personal documents

EDUCATION AND ECONOMIC STATUS

1. What is your level of education?

a) Not one year (illiterate)
b) Not one year (literate)
c) 1-4 years
d) 5-8 years
e) 9-12 years
f) 13 + years

2. Is there any comprehensive educational program in your community that aims to eradicate illiteracy and prevent school dropout?

a) Yes
b) No
c) I don’t know

3. If yes who supports this program?

a) Government
b) Local NGOs
c) International Organizations
d) I don't know

4. What is your Employment status?

a) Employed in Public Sector
b) Employed in Private Sector
c) Employed in a NGO
d) Unemployed
e) Self-employed
f) Looking for a job
g) Housewife
h) Pensioner

5. What are your average monthly household incomes?

a) 0 – 50 euros
b) 50 – 80 euros
c) 81-120 euros
d) 121-180 euros
e) 181 – 300 euros
f) 300 + euros

6. Does your family receive social assistance?

a) Yes
b) No

7. Does it cover health expenses?

a) Yes
b) No
c) I don’t know

8. Regardless of whether you receive social assistance, does your family receive assistance from any other organization or institution?

a) Yes
b) No

9. Does your family receive any assistance from your relatives abroad?

a) Yes
b) No

If yes

10. How much does your family depend on such assistance?

a) Totally
b) A lot
c) Little
d) d) Not at all

ANTENATAL HEALTH

1. In general, how would you assess RAE women's antenatal health?

a) Very good
b) Good
c) Average
d) Poor
e) Very poor
f) I don't know

2. How important is health during pregnancy for you?

a) Very important
b) Somewhat important
c) Not important

3. Where did you deliver your children during your last pregnancy?

a) Hospital
b) Home
c) No answer

4. Did you have complications during last delivery?

a) Yes
b) No
c) No answer

5. How many pregnancies did you have until now?_____

6. How did last pregnancy end?

a) Artificial abortion Go to #7

b) Spontaneous abortion Go to #7

c) Delivered living child born

d) Delivered dead child - before delivery / during delivery

e) Child died after the birth Go to #6

f) Currently pregnant

7. Have you been consulted/served by somebody during your last pregnancy?

IF YES: Who did you visit? *(Tick all that apply)*

a) Gynecologist / Obstetrician

b) Family doctor

c) Nurse

d) Midwife

e) Traditional person that follow ups the delivery

f) Healthcare professional in the community

g) Other (specify) _____

h) No. I have visited nobody

8. Where did you get those services? *(Tick all that apply)*

a) At your home

b) At somebody else's home

c) Public hospital

d) Family Medicine Centre / primary care

e) Private clinic

f) Other (specify) _____

9. In which month of last pregnancy you used for the first time antenatal care services?_____

10. During your last pregnancy approximately how many times did you use antenatal care services?_____

11. During visits have you been advised with oral advises or educational materials concerning your last pregnancy and delivery?

a) Yes
b) No
c) No answer

12. During these visits have you been advised verbally or with educational material concerning eating habits during pregnancy?

a) Yes
b) No
c) No answer

13. Is there any comprehensive educational program in your community that aims to increase education regarding antenatal health?

a) Yes -> Go to #14 &15
b) No -> Go to #16
c) I don't know Go to #17

14 Who supports this program?

a) Government
b) Local NGOs
c) International Organizations
d) I don't know

15. Do you attend the programs?

a) Always
b) Sometimes
c) Never

16. Would you be interested for such a program?

a) Yes
b) No
c) I don't know

17. What kind of food should use a pregnant woman?

a) Should stick to certain diet
b) Could eat any kind of food
c) Other (specify)_____
d) Don't know

18. Do you plan (want) the pregnancy?

a) Yes
b) No
c) No answer

19. How far is the health facility (hospital) from the house?

a) Less than 1 km from the house
b) 1-3 km from the house
c) More than 3 km from the house
d) Don't know

20. To what extent you can cope with the travel costs occurring in relation to use of antenatal care services?

a) Yes I can
b) Partially I can
c) I can't
d) Don't know/refuses

21. Who takes the decision to make the visits at the health care facility?

a) Your self
b) Spouse
c) Somebody else from the family of the spouse
d) Somebody else (specify) _____

22. Is there any personal reason that stops you from using antenatal services?

a) Yes
b) No
c) Don't remember

If yes tick all that apply

a) I do not trust the health care personnel
b) I do not understand the health care personnel and there is no interpretation available
c) I have no one to go with me
d) I do not see it necessary
e) Other

23. Is there any family reason that stops you from using antenatal services?

a) Yes
b) No
c) Don't remember

If yes tick all that apply

a) I have to look after my children/sick mother or other family member
b) My husband does not let me go
c) I cannot afford the cost of visits
d) Other

24. Is there any social/cultural reason that stops you from using antenatal services?

a) Yes
b) No
c) Don't remember

If yes tick all that apply

a) Our community never uses antenatal services
b) Household work are priority/we do not have time
c) Health is a gift. If I am lucky I will not need antenatal services
d) I will use antenatal service only when I am no longer capable of performing daily duties
d) I do not have necessary documentation to access health care system
e) Other

Appendix 4: Informed Consent

Access to antenatal health services among Roma, Ashkali, and Egyptian (RAE) women in Kosovo

Informed Consent

Name of Interviewer:_____

Name of Interviewee: _____

Staff Position: _____

I am Jeta Aliu. Enrolled as fourth year student in the American University in Kosovo (A.U.K.), I am finishing my senior capstone project. This project concerns the lack of access to antenatal health services among Roma, Ashkali, and Egyptian women in Kosovo. The aim of the research is to identify the sources of this problem, role of the government in designing and implementing policies, as well as the role of the civil society actors (NGOs) in improving the access to the ante-natal services among the Roma, Ashkali and Egyptian women. The results gathered would afterwards help in providing recommendations to assist policy and law makers in drafting programs, and strategies that would stimulate improvement of the current situation.

I need to do an interview with relevant people who can provide me with useful information. I insure that the data gathered from the interview, will remain confidential and be used only for the purpose of this research.

By signing this paper you confirm your participation in this research.

_____ _____

Interviewee's Signature Date