



Review article

Health literacy in the Roma population

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Abstract

This article examines health literacy in the Roma population. The goal of the authors was to analyze, through a literature review, which aspects of health literacy of the Roma have been studied by researchers. The research was carried out as an analysis of original scientific papers examining “health literacy in the Roma” found via the EBSCO Discovery Service, PubMed and Scopus databases, based on a keyword search for “health literacy” and “Roma”. Based on the analysis described above, the following topics were included: (1) perception of one’s own health – subjective and objective criteria, subjective perception of one’s own health; (2) the Roma concept of a “healthy person”; (3) objectively perceived health status of the Roma population; (4) health literacy; (5) education as a fundamental aspect of health literacy; (6) knowledge about health (also an aspect of health literacy) and preventive behaviors; (7) health care for Roma; (8) the experiences of Roma relative to healthcare and social care systems. The analysis of published papers showed that there are certain aspects of health literacy among Roma, which can be reorganized into fewer, but more inclusive, categories, i.e., (1) perception of one’s own health (objective and subjective); (2) health literacy education; (3) knowledge about health and preventative behavior; (4) health care. It is obvious that the weakest link in health literacy among Roma is health literacy education, which is also the key to improving health literacy.

Keywords: Health care; Health literacy; Knowledge about health; Knowledge of preventive behavior; Roma

Quote:

“Ethnic and racial minorities have existed since the very beginning of mankind. There are linguistic minorities in basically every European state; small states and nations are minorities among bigger states, and even the largest states and nations are, after all, minorities in comparison with the human world. Therefore, proper handling of minority policies are a prerequisite for a better and more advanced organization of the world.”

Tomáš Garrigue Masaryk

Introduction

Health and social services are socially determined issues and their quality mirrors the current state of a society. Health is a dynamic process dependent on interactions between health potential and external components that determine health. It is also a phenomenon that does not apply to an existing individual, but is connected with the social environment (Bártlová, 2005; 2018). Today’s postmodern and highly technological society should lead to greater health awareness since the infor-

mation needed for health awareness is freely available (Hekelová, 2012). The importance of the above-mentioned availability is underlined by the establishment of an action plan, whose primary focus is increasing health literacy, which has become an important instrument in realizing the Health 2020 program in the Czech Republic. It is also the starting point for the National Plan of the Czech Republic for improving Health Literacy. The aim of this long-term and goal-oriented plan is to document the current health literacy situation in all target groups through clear and measurable data (Zdraví 2020, 2015). The low level of health literacy in the Czech population is apparent not only by their lifestyle but also by the level and distribution of healthcare (Holčík, 2010). In addition, recent reports show that the Czech Republic is below the average of other EU countries in relation to health literacy (Zdraví 2020, 2015).

There is no single definition of health literacy, and this is primarily due to the multidimensional view of the subject. Příbová and Votinský (2008) say that health literacy is above all “the ability to be active when in contact with medical staff, thus becoming a partner and not a patient”. Holčík (2010) perceives health literacy as “the ability to act, on the basis of health information, to improve health”. Despite health literacy

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being an important factor influencing health, and one which affects the quality of life of everyone, health literacy is not accessible to all (Nielsen-Bohlman et al., 2004). Low health literacy leads to worse overall health of the whole society, which in turn leads to higher health care costs (Zarcadoolas et al., 2006). In every democratic society, health literacy is an indispensable tool for achieving better health and peaceful co-existence (Parnell, 2015).

Many foreign studies have focused on the evaluation of health literacy levels and showed that higher levels of health literacy are a clear benefit to society, while lower levels are risk factors for poor health and lead to higher health care costs. Furthermore, these studies showed that health literacy, which is considered to be a lifelong process, is closely linked with one's economic and social situation, and cultural heritage. It is clear that health literate citizens are a necessary precondition (Janura, 2018). Health education is especially important in childhood as it builds healthy attitudes and behaviours to one's own health that last into adulthood. (Machová and Brabcová, 2018). It is also demonstrated that health literacy was related to the social gradient (scale), i.e., the lower on the social gradient, the greater the health inequality gap (WHO, 2013). Equally indisputable is that people with higher health literacy are healthier, which establishes a link between health literacy and a higher quality of life. People with lower health literacy often underestimate the importance of health care, which further limits their full use of the latest advances in healthcare as well as access to various social services. It also distances them from healthcare workers trying to improve the health and health literacy of the society (Zdraví 2020, 2015).

Health literacy in minority populations is a very topical issue due to recent objective research findings. Some studies have explored possible underlying mechanisms that could explain the association between ethnicity and health care use (van der Gaag et al., 2017). The relationship between ethnicity and health can also be explained by selected parameters – such as education, language skills or access to care (see e.g., Ackermann et al., 2014; Maxwell et al., 2010). Roma are among the most numerous minorities living in many European countries, and they show evidence of worsening health – such as higher child mortality rates, shorter life expectancy or higher incidence of various diseases (Sepkowitz, 2006; Zeman et al., 2003).

The Roma form a large and unique minority group in the Czech Republic (Tóthová et al., 2012). Compared to the non-Roma majority, Roma have significantly worse health. This is demonstrated by lower life expectancy, twice as high infant mortality, significantly lower vaccination coverage, higher incidences of infectious diseases, higher rates of accidents and injuries, higher fertility, lower age of first-time mothers, and a greater tendency to neglect preventative measures – which is associated with the philosophy of the Roma ethnicity (Davidová 1995; 2010). Roma have also been shown to have low health literacy – as many as 62.2% of Roma have insufficient or problematic health literacy (see Rolantová et al., 2019).

The Roma population is characterized by a lower standard of living and below par living conditions. The homes of Roma with lower socio-economic status often lack sanitation and running water, and in many cases are not connected to the infrastructure of major cities (Laverack, 2015). Additionally, the Roma have lower levels of education compared to the majority population, which leads to increased unemployment. This then results in an increased dependency on social benefits (Marcincin and Marcincinova, 2009). Jarcuska et al. (2013) re-

ported that 80% of the Roma had only a primary education as their highest level of education.

The aim of this article was to analyze original scientific papers on “health literacy in Roma”, and determine which aspects of health literacy in Roma have already been critically examined by researchers. Another goal was to conduct a SWOT analysis based on various aspects of health literacy to define the strengths, weaknesses, opportunities and threats related to health literacy in the Roma population. A third goal was to propose areas that would be appropriate to include in a research paper as part of a development of science and research grant entitled “Health Literacy in Selected Groups of the Population in the South Bohemian Region” (lead by doc. Sylva Bártlová in 2016–18), which is currently being conducted by the Faculty of Health and Social Sciences, University of South Bohemia, České Budějovice.

Material and methods

A content analysis of studies found via the EBSCO Discovery Service, PubMed and Scopus databases was used for the purposes of this article. The databases were searched for the keywords “health literacy” and “Roma”. The search was conducted in the following order: (1) EBSCO, (2) PubMed, and (3) Scopus. Due to the large number of articles, a Boolean “AND” operator was used (i.e., Health Literacy “AND” Roma). In the next phase of the search, the number of studies was reduced based on a pre-established time criterion, i.e., only studies published from 2000–19 were selected. All sources were academic periodicals (Table 1).

Selected studies were fully translated and subsequently categorized in order to map the published aspects of health literacy in the Roma population. Marginal phenomena were excluded in an effort to maintain the highest quality of this paper (e.g., mostly the health of Roma people used without the term literacy). Additional information was sought through an analysis of domestic and foreign professional monographs on health literacy in the Roma population.

Areas that were closely related to health literacy in the Roma and formed part of the phenomenon were described based on the results of the analysis, which included: perception of one's own health (subjective and objective criteria), education in Roma communities, knowledge of health and preventive behaviors, experiences of Roma relative to healthcare and social care systems, and “examples of good practice” concerning health literacy of Roma people.

Results

Perception of one's own health – subjective and objective criteria

Researchers examining the perception of one's own health tended to choose two fundamentally different research strategies: (1) measurement of the subjective perception of one's own health (on a five-point Likert scale) and (2) measurement of the objective perception of health based on selected characteristics, e.g., the occurrence of a subjectively declared disease or an assessment of one's health, by a doctor, and based on objective medical documentation (Table 2).

Table 1. Selection criteria for literature review

| | |
|-----------------------|---|
| 1. Searching criteria | <ul style="list-style-type: none"> • Databases and services: EBSCO, SCOPUS, PUBMED • Key words (Boolean operators): Health literacy, Roma (AND) • Time period: 2010–2019 • Selected criteria (type of publications (sources)/languages): academic periodicals (EBSCO, SCOPUS, PUBMED) • Total number of sources: EBSCO (2572); SCOPUS (16), PUBMED (21) |
| 2. Excluded topics | <ul style="list-style-type: none"> • Duplicate texts: 8 • Excluded topics: nonfiction, gross domestic product, emigration and immigration, foreign investment; quality of life, immunisation, dental health services, reproductive health, pregnancy, and other topics where the goal was not to examine selected parameters of Roma Health Literacy • Total number of sources: EBSCO (95), SCOPUS (8), PUBMED (6) |
| 3. Full texts | <ul style="list-style-type: none"> • Selected criteria: Roma, Romani • Excluded criteria: access to health services and other topics where the goal was not to examine selected parameters of Roma Health Literacy • Total number of sources: EBSCO (12), SCOPUS (4), PUBMED (2) |

Subjective perception of one's own health

Research entitled “Romská populace a zdraví; Česká republika – Národní zpráva 2009” (The Roma Population and Health; Czech Republic – National Report 2009) (led by Nesvadbová et al., 2009), focused on the subjective perception of health in the Roma population. Respondents rated their current health (over the previous twelve months) on a point scale that ranged from very good to very bad. The results were relatively positive; almost two-thirds of Roma (64%) consider their health to be good or very good, while a quarter rated their health as changeable (i.e., sometimes good, sometimes bad; see Vacková and Velemínský, 2010b). Approximately one tenth of respondents perceived their health negatively, i.e., they stated having bad or very bad health (Nesvadbová et al., 2009).

Vacková and Velemínský (2010b) also described the subjective perception of health in selected Roma respondents. Subjectively perceived health versus health described by a doctor showed that even those who suffered from polymorbidity, perceive their health over a wide range, from very good health to a feeling of bad health. It is thus clear that a disease does not necessarily predict subjective feelings of health. Therefore, it cannot be claimed that those who suffer from, for example, non-specific back pain syndromes (VAS) will always subjectively report that they feel very bad; even respondents suffering from severe cardiovascular disease (e.g., coronary artery disease) do not always report feeling very bad. It can therefore be assumed that subjective feelings of health are affected by more than just the incidence of a disease. Subjective feelings of health are therefore a complex phenomenon and are affected by multiple (and highly individual) factors.

Larger comparative research studies conducted in the Czech Republic have one unifying feature: most Roma subjectively report feeling well or very well: (RCZ: Romská populace a zdraví – Národní zpráva za ČR (2008–09) (The Roma Population and Health – Czech National Report for 2008–09); REV: Romská populace a zdraví – mezinárodní srovnávací výzkum – Bulharsko, Česká republika, Portugalsko, Rumunsko, Řecko, Slovensko, Španělsko (2008–09) [The Roma Population and Health – International Comparative Research – Bulgaria,

Czech Republic, Portugal, Romania, Greece, Slovakia, Spain (2008–09)]; IGA: Determinanty zdraví romské populace v ČR (1991–01) [Components Determining Health in the Roma population in the Czech Republic (1991–01)]; HIS: Výběrové šetření o zdravotním stavu české populace (ÚZIS, 2002) [Sample Survey on Health of the Czech Population (ÚZIS, 2002)]; GAČR: Kvalita života, střední a zdravé délky života z aspektu determinant zdraví u romského obyvatelstva v České a Slovenské republice) (Quality of Life, Life Expectancy in terms of Components Determining Health in the Roma Population).

The Roma concept of a “healthy person”

The Roma concept of a healthy person is built around someone being young, sporty, pursuing a healthy lifestyle, unstressed, free of medications, and free of the need to visit doctors (Jarcuska et al., 2013). This also corresponds to the findings of Vacková and Velemínský (2010b), who reported that the subjective perception of health (SPH) was dependent on whether a person was taking medications (which statistically significantly worsened the subjective feeling of health) and whether they had a full disability allowance (in which case the SPH was also significantly lower).

Objectively perceived health in the Roma population

Disease symptoms most often described by Roma were: pain, difficulty breathing, fever, redness of the face, weakness, and inability to work (Jarcuska et al., 2013). In terms of common diseases, Roma most commonly mentioned respiratory diseases and cardiovascular diseases (Zelko et al., 2015). Measurements of anthropometric parameters, specifically cholesterol, showed that 55.7% of Roma men and 75.4% of Roma women had normal levels of HDL, compared to non-Roma, in which only 23.2% of men and 39.4% of women had normal HDL levels (see further Babinska et al., 2013).

Nesvadbová et al. (2009) investigated diseases and health issues in the Roma. They looked at health as diagnoses established by a doctor. A total of 16 chronic diseases or health issues were examined. Based on responses, almost half of the

Table 2. SWOT analysis – aspects of health literacy

| Aspects of health literacy in the Roma | Strengths (S) | Weaknesses (W) | Opportunities (O) | Threats (T) |
|---|--|---|--|---|
| Subjective perception of one's own health (abbr. SPH) | Subjective assessment of one's own health in the Roma is good to very good (international result). | SPH is age-dependent. Those who show aspects of social exclusion statistically significantly more often declare SPH as worse. | Change in the Roma concept of "a healthy person" – from the instrumental approach to health (health as an absence of a disease) to a participatory approach. Orientation toward the 'at risk' Roma groups (older people, women, residents in socially excluded localities). SPH is not affected by the incidence of a disease – SPH as a comprehensively experienced phenomenon. | |
| Objective examination of health | | Prevalence of obesity in the Roma (in the Czech Republic). Prevalence of respiratory problems in the Roma. Prevalence of cardiovascular diseases in the Roma. | | Difference in the occurrence of a disease among men and women – "Roma women in danger" (Roma women assume the role of a man; women become the main source of income for the whole family; if a woman fails, the whole family ceases to function). |
| Education | "Maturia" (secondary education) is the key to overcoming the relationship between: low education (primary school) and low health literacy and low socioeconomic status. | Most Roma have only a primary education – there is a significant relationship to low health literacy. | It is necessary to increase the number of Roma with secondary educations. | Primary education as a risk factor for social exclusion – social exclusion results in a lack of options for using the health care system. |
| Knowledge about health and preventative behavior | Knowledge of the relationships between causes of diseases (smoking, poor diet – and the emergence of cardiovascular disease). Socio-cultural characteristics (moral standards, values and the resulting relationship to one's own health; a different way of life from the majority population; different nutritional habits and eating habits; a different relationship to disease and disease prevention. | Socio-cultural differences in relation to health (e.g., traditions, hygiene, eating, and use of funds to live on throughout the month – a period of abundance after 'payday' and then hardship. | Adjustment of prevention programs with respect to socio-cultural differences. | The absence of preventive behaviors in health ("most Roma do not engage in preventive healthcare"). They ignore preventative check-ups at the doctor. Cultural barrier between doctors and Roma patients (lack of socio-cultural knowledge on the part of the doctor which can lead to fatal misunderstandings). |
| Health care | | Limited financial resources. Language barriers. Negative experiences with doctors and other healthcare professionals. Distrust and fear of medical staff. | Examples of good practice from abroad – building confidence in medical personnel – as a measure of quality healthcare. Increase in the number of preventative programs aimed at raising health literacy – advocating a participatory approach to one's health. Preventative programs in socially excluded localities. | Difficult access to health care in socially excluded localities. Seeking medical care after it is too late. Health insurance – the issue of moving from one insurance company to another without being aware of the risks (Roma find themselves in a situation where they are not insured by any of the insurance companies). Discrimination against the Roma – in the doctor/patient relationship. |

respondents (46%) were free of the studied diseases. Fifteen percent of respondents (diagnosed by a doctor) had at least one of the studied diseases or health problems, and roughly a quarter (26%) had serious health issues (due to the presence of three or more diseases). In terms of morbidities and polymorbidity, men fared better than women (none or only one disease was seen in 64% of men and 59% of women, while three and more diseases was seen in 20% of men and 30% women).

According to Nesvadbová and Elichová (2010), all these findings have some type of methodological weakness that was related to the selection of respondents (and the representativeness of the studies), fragmentation and different methodologies, and tendencies to elicit and report certain answers over others. When preparing for this type of research, it is necessary to train interviewers thoroughly and educate them on how to avoid these methodological errors.

Health literacy

Education as a fundamental aspect of health literacy

The effect of education levels on health literacy is a frequent research subject both in domestic and foreign studies. Additionally, a Slovak study showed that both ethnicity and level of education can affect self-assessment of health. An interesting fact is that Roma, often with low levels of education (i.e., incomplete primary education or primary education only) have a 2.64 times higher chance of providing a poor self-assessment of their health compared to non-Roma, who generally have higher levels of education (i.e., secondary or tertiary education). A correlation can also be observed between Roma with an intermediate level of education (vocational certificate); they have a 2.04 times higher chance of providing a poor self-assessment of their health compared to non-Roma with higher levels of education (secondary or tertiary education – see Janura, 2018). According to Vacková (2010), Roma with secondary educations (“maturita”) are more often employed and have a higher socio-economic status. Thus, there is a statistically significant relationship between education levels and socioeconomic status (objectively measurable using selected parameters, such as work, income, housing type, etc.). The influence of education has also been demonstrated to affect the Roma mortality rate (Sudzinova et al., 2015). Janevic et al. (2012), who carried out a study of Serbian Roma and Serbian non-Roma, identified a relationship between education, unemployment, and reduced health literacy. According to the study, Serbian Roma are significantly discriminated against and socially excluded. A comparison of health literacy between the Serbian Roma vs. Serbian non-Roma found statistically significantly lower health literacy in the Roma population.

Knowledge of health (as an aspect of health literacy) and preventive behaviors

It is clear that Roma understand the severity of certain diseases, e.g. tuberculosis (Vukovic and Nagorni-Obradovic, 2011). They are also aware of the risk of smoking and obesity, and how lifestyle and diet can affect atherosclerosis (Babinska et al., 2013).

Vacková and Velemínský (2010a) reported that those suffering from chronic illnesses attended preventive health checkups. The study further revealed that the majority of Roma do not take adequate preventive measures to protect their health. One possible explanation is that Roma do not know what steps they should take to improve or protect their health; this, however, was not statistically validated.

According to Jarcuska et al. (2013), Roma often report that they rarely seek medical help immediately for a health problem, and when they do seek help, the problem is often more serious and difficult to treat.

Cook et al. (2013) maps factors affecting the depth of cognitive and social skills that determine the motivation and ability of individuals to obtain access to health information. It is evident from this research that increasing the number of intervention programs can significantly improve health literacy.

Additional factors, which according to Nesvadbová and Elichová (2010) are conditions for improving health literacy and greater use of preventive behaviors in Roma, are:

- Socio-cultural characteristics (moral standards, values, and the resulting relationship to one's own health).
- A different way of life compared to the majority population.
- Different eating habits consumption of traditional foods and cooking styles.
- Different relationships to disease and disease prevention.
- Influence of socio-professional ranking.
- Cultural barriers related to the doctor/patient relationship.

Health care of the Roma

In a study conducted with Romanian respondents, Roman et al. (2013) revealed that Roma people have a more difficult situation in accessing and receiving adequate health care. This issue was exacerbated by the fact that the Roma were exposed to more risk factors related to physical and mental health. The study showed that the main barriers to accessing health care for the Roma involved limited financial resources, lack of health insurance, lack of health literacy, language barriers, and failing to comply with the social norms.

According to Zelko et al. (2015), Romanian Roma often cannot afford health insurance and, therefore, face situations where they cannot use health and social services. The study also found that some Roma had sufficient incomes, but didn't want to pay for health insurance – which could be associated with the very low health literacy of the studied population. Also, a significant percentage of Roma did not have legal residence in the country, therefore, they could not receive social security benefits. Certain parallels with other studies were observed in the area of reduced socioeconomic status, which may also be an explanation for the worse health that was observed.

Fésüs et al. (2012) point out that the interconnectedness of the economy, the labour market and the financial resources for funding healthcare promote equal access to health education. Fésüs et al. (2012) also express concerns about the future of vulnerable groups (which undeniably includes the Roma), since the current economic problems go hand in hand with adverse health and social conditions. Bad situations are exacerbated by infrequent use of health services, which is often associated with the absence of important documents, low income, problems associated with the availability of healthcare, cultural barriers, or feelings of discrimination.

Jarcuska et al. (2013) carried out a study in Slovakia, comparing the approach to health and health services in the Roma and the non-Roma population. The total number of respondents in the sample was 452 Roma (average age of 34.7 years; SD 9.14; men accounted for 35.2%), and 403 non-Roma (average age of 33.5 years; SD 7.4; men accounted for 45.9%). Respondents answered questions regarding health and health services through self-assessment questionnaires. The results

indicated that women assessed their own health as being worse statistically more often than men (measured as subjective perceptions of health on a scale). In the area of personal health care, respondents stressed the importance of prevention, healthy lifestyles, and good communication with medical staff.

Roma living in smaller towns or villages also indicated greater difficulty paying for prescribed medications, as well as greater difficulty traveling to distant medical facilities. The lower average incomes of Roma families was closely related to their inability to cover even small costs for medical services, which made their overall attitude toward health care more negative. This may explain the widespread use of cultural/traditional remedies among the Roma (Jarcuska et al., 2013).

Parekh and Rose (2011) describe the Roma as a community characterized by the importance of support in the area of health needs. They also reported that Roma had reduced access to health care, education, and employment compared to the majority population. Many present-day diseases are associated with poor social and economic conditions, which are often common in Roma communities.

Experience of the Roma with health and social care systems

Zelko et al. (2015) examined the Roma minority in Slovenia. Based on interviews, the following categories were created relative to health literacy: experience with the health care system, personal health care, perception of health and disease, suggestions for improvements, common illnesses from the Roma point of view, poverty and socioeconomic status, discrimination, and steps to better health literacy. Most respondents stated that they had very good experiences with the health care system and the services provided. Vukovic et al. (2011) puts confidence in medical staff among the top characteristics of high-quality health care. A group of authors from the United States identified many variables that have a causal relationship to assessed experiences with health and social care systems; they agree that it is necessary to continually address this issue, because, as demonstrated by this study, increasing the number of intervention programs can improve health literacy (Cook et al., 2013).

Bad healthcare experiences can be a reflection of distrust. Unlike the non-Roma population, the Roma often indicate bad experiences, i.e., fear or lack of confidence in the healthcare system (Jarcuska et al., 2013) – contrary to the previous statement made by Zelko et al. (2015). So it is necessary to conduct further research on Roma satisfaction with the health care system and see what has to be done in this area.

Satisfaction with medical care is also described by Vacková and Velemínský (2010a). Their research failed to show that Roma living in villages were less satisfied with medical care than those living in towns or cities. The results also indicated that the majority of Roma were satisfied with the medical care they received. However, when comparing statements made regarding doctor/patient cooperation, a mismatch was identified (i.e., doctors were more positive about the degree of cooperation, while Roma were more negative). This indicates that there may be communication barriers which are leading to misunderstandings.

Some Roma respondents mentioned examples of discrimination. This was illustrated by the statement of one Roma woman: “A ‘gádžo’ (understood to mean ‘a non-Roma’ individual) spends 10 to 15 minutes with the doctor, while a Gypsy gets less than 2 minutes” (Vacková and Velemínský, 2010a).

SWOT analysis – aspects of health literacy

The SWOT analysis focuses on the aspects of health literacy categorized above, and as reported in Czech and foreign research. Categorization into strengths and weaknesses, and opportunities and threats was used in order to get an overview of the issue examined in terms of the research focus, proposals for intervention programs, and preparation of documents for forthcoming research – as part of the “Health Literacy in Selected Population Groups Living in South Bohemia” project.

Discussion

Our analysis of previously published research papers showed there are aspects of health literacy in Roma that can be organized into fewer – although, more general – categories, such as: perception of one’s own health (objective and subjective), education, knowledge of health and preventive behaviors, and health care (Table 2).

It is obvious that, in relation to Roma health literacy, the weakest link involves education; reciprocally, education is key to improving health literacy. To address this issue, two important questions must be answered:

- (1) What options are available for increasing health literacy education in the Roma community?
- (2) Why have we failed so far to successfully achieve this goal in our society?

The following are key barriers to health literacy education in Roma:

- Experience of Roma parents with school and special schools. (1) There is little parental motivation to send children to primary schools and (2) when there are problems at school, there is a tendency to reclassify Roma children and place them into special schools (although they do not belong there in terms of their intellectual abilities).
- Language barriers facing Roma children in primary schools and its impact on relationships between the majority population and the Roma minority population. This issue was mentioned by Hübschmannová (1995), according to whom “communication in one’s own language and within one’s own culture is naturally advantageous and often blinds people to the difficulties others may be facing and leads to language barriers being seen as mistakes, or even as ‘provocations’”, which can lead to misunderstandings escalating into conflicts.
- Stratification within the Roma community: After gaining a specific socioeconomic status, Roma often do not affiliate themselves with members of their minority (e.g. Dvořáková, 2003).
- Lack of unity as a Roma national minority: This prevents unified collaboration among Roma from various cities and regions in the Czech Republic.
- Weakening of the “Roma identity” in terms of traditions and customs, historical consciousness, language, territory etc. (see also Davidová, 1995; Machalová, 2001; Šotolová, 2000).
- Discrimination, which includes social exclusion and living in socially-excluded localities as well as the associated poverty that comes with discrimination.

Conclusions

It is evident from research examining health of the Roma over the past two decades (i.e., examination of selected health characteristics), that we can assert the following related to health and health literacy among Roma:

- There are differences in health perception (that is, measuring the subjective feeling of health) between men and women.
- Subjective perception of health is complex, and appears not to be overtly affected by the presence of a particular disease. Multiple factors (not only the presence of disease) are involved in the perception of one's own health, i.e., the issue requires a deeper examination of the concept of "health" and access to health in Roma.
- Low levels of education have a statistically significant effect on the assessment of health literacy, i.e., those with lower levels of education (limited to primary education only) also have lower levels of health literacy. Health literacy is also related to socioeconomic status and unemployment.
- Socio-cultural differences can be significantly reflected in the level of health care as well as the doctor/patient relationship.
- The following are research questions that need to be answered by further research:
- How do Roma perceive their own health?

- What attitudes do Roma hold with regard to their own health?
- What is the overall health of Roma women, and what needs to be done to improve it?
- What are the socio-cultural differences that significantly impact the preparation and implementation of effective prevention programs focused on health literacy in Roma?
- What strategies need to be used to increase the level of health literacy education available to the Roma?
- How can the level of confidence the Roma feel toward medical personnel and health facilities be increased?

The above analysis of health literacy research helps to provide a useful evaluation of intervention (outreach) programs aimed at raising health literacy, and thus ultimately increasing overall health. Therefore, building and creating health literacy programs, which are drawn up with regard to socio-cultural needs, appears to be of critical importance in improving health literacy among the Roma.

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Conflict of interests

The authors have no conflict of interests to declare.

Zdravotní gramotnost romské populace

Souhrn

Tento článek zkoumá zdravotní gramotnost romské populace. Cílem autorů bylo zjistit prostřednictvím analýzy vybraných zdrojů v určitém časovém období zvolené aspekty zdravotní gramotnosti Romů. Analýza proběhla pomocí multivyhledávače EBSCO Discovery Service, dále v databázích PubMed a Scopus na základě klíčových slov „zdravotní gramotnost“ a „Romové“. Z výsledků vyplynulo 8 kategorií/oblastí zdravotní gramotnosti Romů, kterými se vybrané publikace zabývají: (1) vnímání vlastního zdraví – subjektivní a objektivní kritéria, subjektivní vnímání vlastního zdraví; (2) romský koncept „zdravého člověka“; (3) objektivně vnímaný zdravotní stav romské populace; (4) zdravotní gramotnost; (5) vzdělání jako základní aspekt zdravotní gramotnosti; (6) znalost zdraví (také aspekt zdravotní gramotnosti) a preventivního chování; (7) zdravotní péče o Romy; (8) zkušenosti Romů ve vztahu k systémům zdravotní a sociální péče. Analýza publikovaných článků ukázala, že existují určité aspekty zdravotní gramotnosti mezi Romy, kterou lze reorganizovat do obecnějších kategorií – tj. (1) vnímání vlastního zdraví; (2) výchova ke zdravotní gramotnosti; (3) znalosti o zdraví a preventivním chování; (4) zdravotní péče. Je zřejmé, že nejslabším článkem v oblasti zdravotní gramotnosti Romů je samotné vzdělávání v oblasti zdravotní gramotnosti, které je zároveň klíčem k jejímu zlepšení.

Klíčová slova: preventivní chování; Romové; zdravotní gramotnost; zdravotní péče; znalosti o zdraví

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