20. Spain: Health Promotion among Navarre Ethnic Minorities programme

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Summary

In the 1980s, before the commencement of the Health Promotion among Navarre Ethnic Minorities programme, the Roma population in Spain and in the autonomous community of Navarre experienced poverty and social exclusion, unhealthy housing and environmental conditions, insufficient access to public services, prejudice, and discrimination. As a result, they incurred higher mortality, morbidity and the prevalence of unhealthy behaviour. These health consequences had more to do with lack of equity in life opportunities, access and use of resources than with genetic factors intrinsic to the Roma minority.

In response to the health and social inequities described above, the Health Promotion among Navarre Ethnic Minorities programme began in 1987. It was initiated by a nongovernmental organization, the Saint Lucia Foundation Patronage, which initially coordinated it while requesting that it be incorporated into public services. The Health Department of Navarre honoured the request and placed the programme's management first in the Directorate for Primary Health Care and later in the Health Promotion Service of the Public Health Institute of Navarre. In 1987, the programme was implemented in four basic health zones. By 2005, it had expanded to 15 zones and had direct contact with more than half of the 6000–7000 Roma living in Navarre. It is implemented in the health zones with the largest Roma populations.

The programme's objective is to reduce health inequities by improving the health of the Roma community. The activities and work strategies include: (a) health mediation, using Roma mediators; (b) coordination and collaboration with local and central authorities; (c) peer education; (d) empowerment and participation of the Roma community; and (e) exhaustive training of Roma mediators. The programme has three main partners at the central level of coordination: the Public Health Institute, Gaz Kaló (a Roma association that brings together Roma associations of Navarre), and central health, social and education services. In each implementation zone, the programme is represented by an Intersectoral Commission. This local Commission analyses the community situation, records Roma requests and needs, monitors local activities and objectives, and evaluates the programme.

Evaluations have provided evidence that the programme has had an impact on the health of the Roma community in Navarre. The programme has contributed to higher levels of primary health care coverage, strengthened the reproductive health of women and improved child health. It has increased the participation of the Roma community in health education and in chronic disease and other prevention programmes. It has also increased school attendance of Roma children younger than 12 years to 90%.

The Health Promotion among Navarre Ethnic Minorities programme began at a time in Spain when there was no other specific programme for the Roma population and when the concept of inequitable access to health services by the Roma population was not acknowledged. The programme has thus played a pioneering role in sharing lessons learned and in orienting the National Strategy for Health Equity for the Roma Population.

Socioeconomic and policy context

In Navarre

In the 1980s, before the commencement of the Health Promotion among Navarre Ethnic Minorities programme, the Roma population in Spain and in the autonomous community of Navarre experienced poverty and social exclusion, unhealthy housing and environmental conditions, insufficient access to public services, prejudice, and discrimination. As a result, they incurred higher mortality, morbidity and the prevalence of unhealthy behaviour. These health consequences had more to do with lack of equity in life opportunities, access and use of resources than with genetic factors intrinsic to the Roma minority.

Table 20.1 shows the characteristics of the Navarre and Roma communities when the programme was in its early stages.

Since the beginning of the programme and continuing through to today, data on Roma health has been scarce in Spain and in Navarre. However, the literature available has shown that the Roma population generally has worse health outcomes and behaviour than the general population. To start, infant mortality is 1.4 times higher than the national average, and life expectancy for the Roma population is between 8 and 9 years below the average (Montoya, 1994). Next, there is a higher incidence of infectious disease (Fos et al., 1987; Cabedo García et al., 2000), mainly hepatitis B and C, with frequently observed mother-to-child transmission (Delgado Sánchez, 1990). A higher incidence of HIV is also observed, mainly among intravenous drug users. In addition, vaccinations for children are deficient (Regional Government of Andalusia, 1996), and

Table 20.1. Navarre and Roma characteristics

Navarre characteristics	Roma ethnic minority characteristics
Overall population characteristics	Settled during the 15th century
519 277 inhabitants (53.5 inhabitants/km^2)	6000–7000 people (1% of total population) in 1300 families (700 in Pamplona)
2 municipalities with > 20 000 inhabitants	Young population: 24% less than 12 years old
Pamplona and Comarca: 55% of total population	Birth rate: five times higher than that of the general population
Health expectancy: 74.6 years for men; 81.0 years for women (77.7 and 85.0 years, respectively, in 2004)	Fertility rate: 6.7 times higher than that of the general population
Main morbidity/mortality from chronic and degenerative diseases	Deficient vaccinations for children
High levels of well-being indicators	Health-damaging nutritional habits (too rich in lipids)
Low birth rate	Tobacco and coffee used excessively, starting in early childhood
Health services	Abuse of medicine
Primary care: 51 health zones (55 zones in 2008).	High indices of domestic and work accidents
Specialist care	Preventive measures scarcely taken
Social services	Primary care services scarcely used
Municipal social services: health zones	Emergency health services and private providers of health services used often
Educational services	
Schools (for 3–12- and 12–18-year-olds)	

Source: compiled from Montoya (1994); Regional Government of Andalusia (1996); Dueñas Herrera et al. (1997); Viñes (1997); Mora Léon & Martinez Olmos (2000); Sastre Gussoni et al. (2000); Navarre Institute for Statistics (2007); FSG (2008).

follow-ups of prevention programmes are generally inadequate, especially in areas with a low socioeconomic level (Sastre Gussoni et al., 2000; Sánchez Serrnao et al., 2002). Moreover, there are health-damaging eating habits and nutrition (excessive consumption of sugar, coffee and fats), which also affect dental health in the case of children (Mora Léon & Martínez Olmos, 2000). Added to these examples are the improper use of medications and a higher incidence of accidents and unintentional injury (Sánchez Serrano et al., 2002), such as burns, falls, pedestrian traffic accidents, bone fractures and cuts. Furthermore, the Roma are a high-risk group for congenital malformations. The studies consulted make reference to genetic and cultural factors (endogamy) (Martínez-Frías, 1998; Martínez-Frías et al., 1998).

Although the socioeconomic conditions in which the Roma population live have improved in recent years, social inequalities persist. A large percentage of Roma do not perceive health as a priority: housing, finances or employment come before health. They perceive health to be the absence of disease and perceive disease to be an incapacitating phenomenon linked to death. This perspective leads to immediateness in seeking help, with transport by the family and infrequent use of ambulance services. It also leads to excessive use of emergency room services, lack of strict compliance with treatment (suspending it when symptoms disappear) and the partial use of health services, where appointments are seldom made for consultations with doctors. Also, health services have difficulty in clearly differentiating between the cultural and socioeconomic aspects of the Roma health situation. Moreover, health services are occasionally inflexible when confronting *differences*; for example, within the Roma community, the concepts of health and disease transcend the individual and extend to the group and community, leading to lack of comprehension by the medical establishment of the importance of relatives and their possible involvement. Furthermore, health services may face communication barriers when it comes to Roma. These barriers include the vocabulary used by professionals, written communication of professionals versus oral communication of Roma, different criteria for quality assessment of treatment (for Roma: length of time, empathy, concern), and mutual prejudice.

Roma women also experience an increased incidence of certain diseases or risk factors. These are related to the traditional role assigned to mothers and wives. For example, they have a high fertility rate, with pregnancies starting at a very young age and continuing into middle age (Dueñas Herrera et al., 1997). Also, information on family planning is scarce, so that some birth control methods are not used, because they are unknown or because of the persistence of myths and faulty ideas (Reig Majoral et al., 1999). Moreover, there is very little prevention of gynaecological diseases (Dueñas Herrera et al., 1997). Roma women also experience premature ageing, with an incidence of diseases atypical for the age groups affected, such as diabetes, bone ailments and cardiovascular problems. Among Roma women, the burdensome role of caretaker and the excessive degree of responsibility – both in and out of the home – causes symptoms of depression, anguish and anxiety in some cases.

Women's health tends to come last, and the following situations may arise. Women usually find it very difficult to have outpatient home-based care, because their gender role is incompatible (to a certain extent) with the one of *patient* at home. Also, in the case of mental health, women tend to abandon treatment prematurely.

It is important, however, to also underscore the strengths of the Roma community. This allows the programme to also use an asset approach to improve Roma health. Such assets include the following.

- Community support and cohesion, particularly through the extended family, can provide a sense of security and can aid in protecting individuals. Strong Roma cultural identity is also an entry point for social cohesion and associative movements.
- Some norms of behaviour, customs and habits of the Roma population can benefit health. For example, despite difficult environmental conditions, Roma adhere to a number of hygienic practices, such as the widespread use of bleach as a disinfectant and clear differentiation of unclean objects or areas from clean ones.
- The role women play, as caretakers and transmitters of knowledge, gives them leadership when it comes to health.
- Respect for the elderly has an influence on youth.

In Spain

The Health Promotion among Navarre Ethnic Minorities programme began at a time in Spain when there was no other specific programme for the Roma population and when the concept of inequitable access to health services by the Roma population was not acknowledged. The programme has thus played a pioneering role in sharing lessons learned and in orienting the National Strategy for Health Equity for the Roma Population (FSG & Ministry of Health and Consumer Affairs, 2005).

The Roma population in Spain is between 650 000 and 700 000 people (Ministry of Health and Consumer Affairs & FSG, 2006), accounting for an estimated 1.6% of the country's total population (44 million). The Roma population arrived in Spain during pilgrimages to Santiago de Compostela. There is evidence of their residing in Spain since 1425. There is also evidence of legal procedures for social confinement of the Roma population dated as early as 1499, and these procedures can be documented until 1943 (Gomez Alfaro, 1993).

The Spanish Constitution of 1978 prohibits discrimination on the basis of race, sex, beliefs/opinions or religion. In 1985, the First Plan for Roma Development (Primer Plan de Desarrollo Gitano) was approved. The Plan has received €3 million annually since 1989 and is managed by the autonomous communities and the town councils. Also in 1989, an initiative began to provide financial support to nongovernmental groups through projects that focus on life opportunities and social inclusion of the Roma population. This initiative receives an annual budget of an additional €3 million, and social service administrations manage both streams of funding of the Plan for Roma Development. Even though health is often among the issues addressed by financed projects, it is usually not the main objective. One exception, however, is the Health Promotion among Navarre Ethnic Minorities programme.

In 2003, the evidence available showed that there were disparities between the health system usage of the Roma population and that of the population as a whole. In response, the National Strategy for Health Equity for the Roma Population was launched. The Ministry of Health and Consumer Affairs (Directorate-General for Public Health, Health Promotion Area) and FSG, a nongovernmental organization that has been operating since the 1960s, have put together a project of joint collaboration aimed at promoting health care equity for the Roma population in Spain. Within the framework of the collaboration agreement, the Ministry of Health and FSG have worked together on such measures as the following.

- The Experts Working Group on Health and the Roma Community was created to assess, mediate and build capacity for Roma health issues. It targets health professionals and administrators, as well as representatives of civil society.
- Training and awareness-raising of hundreds of health professionals throughout the country has occurred. To facilitate this process, the *Handbook for action in the area of health services with the Roma Community* (Ministry of Health and Consumer Affairs & FSG, 2006) was created.
- Several national seminars on health services and the Roma community have taken place.
- The National Survey on the Health of the Roma Population was carried out and will be compared with the National Health Survey for the general population; the data are forthcoming.

The Strategy has been endorsed and adapted by some of the autonomous communities, which have expanded its scope and increased its effectiveness. In the same vein, FSG is now coordinating a European-wide project inspired by the National Strategy for Health Equity for the Roma Population. It involves eight countries (SASTIPEN, 2007).

In 2005, the State Council of the Roma Community (Consejo Estatal del Pueblo Gitano) was created as a mechanism for consultation and assessment. The Council is composed of 40 members (50% from Roma associations and 50% from state-sector administrations, with representatives from employment, housing, health, education, culture and other sectors). Linked to the Council are working groups composed of representatives from Roma associations and state administrations, as well as other topic-specific experts. There is a working group on health (the Health Working Group of the State Council for the Roma Community: Grupo de Salud del Consejo Estatal del Pueblo Gitano), and it contributes to the National Strategy for Health Equity for the Roma Population, as well as undertakes complementary measures.

In this general context, in 2003 and in keeping with EU Directive 2000/43/CE (EC, 2000a) and Directive 2000/78/CE (EC, 2000b) related to the equal treatment of all people independent of their ethnic affiliation or race, the Council for Equal Treatment and against Discrimination (Consejo para la promoción de la Igualdad de trato y no discriminación de las personas por el origen racial o étnico) was created. In 2005, the Foundation Institute of Roma Culture (Fundación Instituto de Cultura Gitana) was inaugurated, to further an increased awareness of Roma issues and an appreciation of the Roma culture by the general population.

In 2008, a new document was published, *Roma community and health: conclusions, recommendations and proposals* (Ministry of Health and Consumer Affairs & FSG, 2008). This publication shows the first results of the Roma National Survey on Health; it also includes proposals and recommendations to improve areas where health inequities have been described. The analysis of the Roma National Survey on Health is nearly complete, and results and conclusions will be available in the near future.

Health Promotion among Navarre Ethnic Minorities programme

Background

Responding to the health and social inequities described above, the Health Promotion among Navarre Ethnic Minorities programme began in 1987. It was initiated by a nongovernmental organization, the Saint Lucia Foundation Patronage, which initially coordinated it while requesting that it be incorporated into public services. The Health Department of Navarre agreed to the request and placed its management first in the Directorate for Primary Health Care and later in the Health Promotion Service of the Public Health Institute of Navarre, under the direction of a social worker. Considered to be of great importance among health promotion professionals at this time, the principles of the Alma-Ata International Conference on Primary Health Care (WHO, 1978) largely inspired the development of the programme. As a consequence, the reform of primary health care taking place in Navarre was an opportunity to improve the Roma community's health service access.

In 1987, the programme was implemented in four basic health zones [1]. By 2005, it had expanded to 15 zones (including Barañain, Burlada, Huarte, Villava, Tafalla, Estella, Tudela, San Adrian, Lodosa, Peralta, Carcastillo, and four in Pamplona) and had direct contact with more than half of the 6000–7000 Roma living in Navarre. It is implemented in the health zones with the largest Roma populations.

Objective

The programme's objective is to reduce health inequities by improving the health of the Roma community. It considers the strengths of the Roma community and uses an assets approach to improve health outcomes, address the socioeconomic and environmental determinants of health, and increase access to health services. It does this by coordinating health, social and education services and by using trained Roma mediators.

Partners and funding

Currently, the programme has twelve Roma health mediators and a coordinator, in addition to a professional from the Health Promotion Section responsible for the management of the programme. All staff members work part time. Funding comes entirely from the Public Health Institute (Servicio Navarro de Salud/Osasunbidea), Government of Navarre. The budget is ensured through grants for health promotion that the Institute convenes annually. The programme budget in 2007 was €143 499. Most of it is destined to cover the salaries of the mediators.

The programme has three main partners, listed below, which represent the central level of coordination.

1. **Public Health Institute.** At the Department of Health Promotion, a social worker, along with other technicians in the Department: helps coordinate activities and provide technical support for social and health workers and Roma from implementation health zones; ensures selection and training of mediators – for example, ensures weekly contacts for training; assesses needs; and does general monitoring and evaluation. The Institute is also responsible for financing activities, and hiring and training mediators.

2. **Gaz Kaló.** As a Roma association that brings together Roma associations of Navarre, this partner shares responsibility for training and providing technical support for mediators.

3. **Central Health, Social, and Education Services.** This partner handles central health services, including the Foral Plan for Drug Dependency and the Directorate for Primary Health Care.

In each implementation health zone, an Intersectoral Commission represents the programme. This local Commission analyses the community situation, records Roma requests and needs, monitors local activities and objectives, and evaluates the programme. A local Commission normally includes representatives from at least the following entities:

- the Health Care Primary Centre (one social worker, responsible to the Commission and maintaining contacts with the central-level coordinator);

[1] Basic health zones are the smallest units of the organizational structure of the Spanish health care system. They are usually organized around a single primary care team (*Equipo de Atención Primaria*), which is also the main management unit of the zone, coordinating illness prevention, health promotion, treatment and community care activities (Durán, Lara & van Waveren, 2006).

- social services of the municipality (one technician);
- educational centres (one representative);
- a Roma association (one person); and
- the Roma mediator of the implementation zone.

Since 1987, an annual budget has been guaranteed, with the budget for 2007 being €143 499.90. Throughout these 20 years, the number of mediators recruited annually has varied, between 5 and 13.

Activities

The activities and work strategies of the programme include: (a) health mediation, using Roma mediators; (b) coordination and collaboration with local and central authorities; (c) peer education; (d) empowerment and participation of the Roma community; and (e) exhaustive training of Roma mediators.

The central actors are the mediators from the Roma community (one in each implementation zone). Their selection by the Public Health Institute is based on a test of their educational level, the respect and value their own community grant them, their adaptability, their commitment to promote health, their initiative, and their respect for confidentiality. Once they are selected, the Intersectoral Commission is created, and mediators are then trained by the Public Health Institute in collaboration with Gaz Kaló, which will also ensure their continuous training afterwards (once a week).

When starting, mediators follow an initial training course that focuses on the following areas:

- know-how and tools for their professional activity, such as guidance on how to write a report, manage group dynamics and conduct interviews;
- health needs of Roma people: chronic diseases, lifestyle, mental health, children's and women's health;
- aspects of personal empowerment, such as dealing with stress, managing workloads, and increasing awareness of socioeconomic conditions facing the Roma community and of Roma culture and health;
- functioning of other services used by the Roma community, such as social, education, housing and employment services, and work; and
- aspects of health education, such as vaccination, programmes and resources for health, family planning, healthy habits, and substance abuse.

The subsequent weekly training for mediators focuses on aspects of health education that correspond to the needs of their communities.

A model programme starts with a census, carried out by the mediator, of all families within the community, to assess their needs and requests. A so-called history of every family is created, and the mediator keeps this information confidential. The history focuses on family health: vaccination status, food habits and nutrition, family planning, and control of pregnancies. On the basis of this census, the mediator, together with the social and health services responsible for the implementation health zone where the Roma community lives, develops a work plan, which eventually involves the schools attended by the children from the community. During the first year, priority is given to vaccinating children and to training mediators: in the beginning, 50% of a mediator's time is dedicated to individual or group training. As the years go by, this part of the mediator's time is reduced to 20–30%. The workplan incorporates other activities, such as prevention programmes, breast cancer, chronic diseases, dental health and mental illness.

In these later years, the work of the mediator consists mainly of following the workplan, in conjunction with all necessary services. This is done through regular meetings with health services, to coordinate actions with the social worker and paediatrician, and through meetings with social services or school teachers, when mediation is necessary. In so doing, a mediator develops the important skills of mediation, coordination and health education.

The programme increases mediators' opportunities for education, emphasizes and gives importance to their skills and assets, and strengthens their leadership abilities. Choosing such an approach has led to establishing more intermediate objectives than originally proposed. It has also meant working at a slower pace than that set in other types of programmes that promote

health. This approach, however, is part of the technical and ethical criteria of this programme, and abandoning it would mean failure.

Monitoring and evaluation

Evaluations provide evidence that the programme has had an effect on the health of the Roma community in Navarre. During the past 20 years, the programme has been implemented in 23 of the 55 health zones in Navarre. It has contributed to higher levels of primary health care coverage, strengthened the reproductive health of women and improved child health. It has also increased participation of the Roma community in health education and chronic disease and other prevention programmes. Moreover, it has increased school attendance of Roma children younger than 12 years to 90%. In 2004, the programme was recognized by Eurohealthnet as a European good practice model on equity in health.

Programme results were achieved in the following diverse areas.

- **Primary health care.** Among Roma families: 90% are now covered; 80% of Roma have their clinical histories recorded; 80% of children are vaccinated and 70% of adolescents are vaccinated against hepatitis B; and 39.7% of children attend the dental prevention programme.
- **Women's health.** Among women of reproductive age: 62% attend family planning centres; 75% control their pregnancy in primary health care centres; 25% attend prebirth courses; and 72% go to the breast cancer prevention programme.
- **Health education.** In 85% of the 15 implementation health zones, group education projects were convened. These projects covered health topics identified through the assessment of community needs.
- **School attendance.** Among Roma children, 90% attend school until they are 12 years old (primary school), although only 33% continue to attend compulsory secondary education until 16 years. Also, high levels of absenteeism are recorded.

The qualitative results of the programme also deserve mention. The Health Promotion among Navarre Ethnic Minorities programme has succeeded in empowering Roma communities through their active participation and the control they gain over their health and its determinants. Health education in Roma communities has been increased. Intersectoral collaboration has benefited Roma communities and professionals in public services, having reduced mutual prejudices and increased mutual comprehension and acceptance.

The programme also aims to value and strengthen the role of Roma women, who are educators, caretakers of children and the elderly, and primarily responsible for passing on Roma cultural norms. Work that targets them has a multiplying effect, with repercussions on family members. With the participation of mediators from the programme, and in conjunction with the Centre for Attention to Women and Roma organizations, a study about whether the health of Roma women in Navarre is improving is underway. Information from this study will be used in the design and modification of interventions that aim to benefit the Roma community. Preliminary quantitative results, based on an analysis of data from 320 women, show that 80% of these women think it is important that their children study, 45% think that their daughters should marry after 20 years of age (67% of the surveyed women were married before 19 years of age), and 67% consider the ideal number of children to be between 1 and 4 (37% of those surveyed had had between 5 and 10 children). Of the women surveyed, 91.0% had the last birth in a hospital, 75.0% had access to gynecological check-ups, and 94.3% considered birth-control methods to be necessary and knew of services to access these (72% had used a birth-control method). In terms of qualitative results, women reported an evolution in how they see themselves within their own Roma culture, and they indicated that there is a need to maintain and improve their culture, paying equal attention to both.

A parallel process that analyses and considers the role of men is also fundamental. The programme therefore tries to work on men's responsibility for their health, on risk-taking attitudes (mainly traffic accidents and substances abuse) and on encouraging them to share domestic and family responsibilities.

Lessons learned

A complete evaluation of the programme (covering 1987–2006) was undertaken. Some conclusions about the programme follow.

Changes in health needs

The Health Promotion among Navarre Ethnic Minorities programme has been successful in creating a real concern about health in Roma communities. For example, in the beginning, actions were based more on children's and women's health. Now, however, a real request from the community does exist; for example, more and more educators work on absenteeism problems.

Since its beginning, the Health Promotion among Navarre Ethnic Minorities programme has focused mainly on women and children, for their benefit and an as entry point to the greater community. Recently, however, some other issues that need to be addressed have been discussed.

- **Lifestyle and prevention of disease.** Unhealthy nutrition, lack of proper physical activity, obesity and stress should receive emphasis, because these have proven to be among the more difficult health damaging patterns that need to be addressed within Roma communities.
- **Education.** Increasing school enrolment until the age of 16 years, especially among women, should be emphasized, to improve communication between families and school, to reduce absenteeism and drop-out rates, and to produce better coordination between health and scholarship programmes within the implementation health zones. Effectively, a parallel improvement of educational levels of the community has to accompany the efforts to improve Roma health.
- **Mental health.** Access to and adequate use of resources (such as understanding diagnosis and compliance to treatment) present great difficulties, but Roma also suffer from under-diagnosis, particularly of depression in women and self-medication.
- **Occupational health.** Despite the progressive inclusion of the Roma community in the primary-sector labour market, some high-risk economic activities persist, such as the use of inadequate tools or vehicles and the lack of security measures. Interventions to reduce such activities should be further developed and could easily find a place within the programme as an entry point for adult men.
- **Other health determinants.** Professionals within the programme are aware that they should take advantage of any opportunity to improve housing and employment conditions, as these are difficult (but fundamental) aspects that influence the health of the Roma.

Mediator's role

The role of mediator carries some rewards, but mediators report that changes are also needed. It is rewarding when they are recognized as professionals and as a referent person from the community and as a social and health professional in their area of work. It is also a great responsibility: after eight hours of work, they cannot close an office and leave their work problems and worries behind, because they live in the community with the people they help and are always available.

Mediators report difficulties, however, in being recognized as a professional by health professionals. Therefore, work should be done on this issue, as it is important to the success of adapting services to better serve the diversity of communities and cultures that characterize the places in which people live. At the beginning of the programme, health professionals were more involved in educational events about Roma culture. This should be promoted again, together with a wider approach to developing social and interpersonal skills for health professionals during their pre-service training and to improving cultural competencies.

Culturally appropriate approaches to prevention

Other programme challenges are related to preventing sickness among the Roma. It is important to focus on prevention in a way that incorporates how the Roma culture views health. The Roma concept of health, which emphasizes curative aspects, makes it particularly difficult for them to attend, for example, regular check-ups or cancer screenings.

Organization of the programme

With regard to improving organization, the Health Promotion among Navarre Ethnic Minorities programme could benefit from:

- making the monitoring system of all different implementation zones homogeneous and including information from health services, to better evaluate, compare and analyse health outcomes in light of their wider determinants;

- frequently reviewing and redefining evaluation indicators, to adapt the evaluation process to the changes of the Roma community; and
- strengthening and reviewing the relationship between the development of the programme and the services available from primary health care centres.

Evaluations conducted thus far show that four aspects of the programme are particularly relevant to improving the health of the Roma community. First, the programme respects the rhythm of Roma people, because it accompanies them in their community life.

Second, the programme began in a period when the principles of the Alma-Ata International Conference on Primary Health Care (WHO, 1978) were considered to be of great importance among health promotion professionals and, concurrently, when a reform of primary health care was taking place in Navarre. The structure of the programme is what makes it so adaptive to (and respectful of) Roma community needs. Therefore, a lesson worth retaining could be: it is very important not to loose an opportunity to embed the principles of health promotion within services when restructuring is planned, because this might have very important long-term effects.

Third, advances in equity in health for the Roma community are facilitated by policies that promote the community's involvement in civil society, social inclusion, and antidiscrimination measures. Thus, it is important to develop policies that result in improvement of the socioeconomic conditions that determine the health of the Roma population. Policies should include actions aimed at decreasing inequities in access (to opportunities) that face this population.

Fourth, health, as a resource for life, is fundamental to the social integration of the Roma population. Some key strategies to reach this goal are:

- to guarantee consistent and complete access to culturally sensitive services;
- to undertake capacity building among the Roma population, particularly in programmes that promote health and prevent sickness; and
- to ensure the participation of the Roma community in all phases of activities that reduce health inequities, from analysis to execution to evaluation.

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