KEY CONSIDERATIONS: TACKLING STRUCTURAL DISCRIMINATION AND COVID-19 VACCINE BARRIERS FOR ROMA COMMUNITIES IN ITALY

SSHAP
Social Science in Humanitarian Action Platform

This brief highlights how structural discrimination and social exclusion shape attitudes to COVID-19 vaccines among Roma communities in Italy, and the role trusted communal and public authorities can play in supporting vaccine uptake and tackling broader exclusions.[1] Contradictions in the Italian state's response to COVID-19, alongside ongoing forms of exclusion can increase Roma mistrust in state initiatives and prevent vaccine participation.[2] This brief aims to aid and inform local government and public health authorities in Italy that serve populations inclusive of Roma communities.

This brief is based on research conducted in-person and remotely from November 2021 to January 2022 with Roma and Sinti communities in Milan, Rome and Catania, Italy, which have distinct historical, linguistic, geographical, religious, and other forms of identification. Similarities in how the different Roma communities experience the COVID-19 pandemic, and in their vaccine decisions were identified. This brief was developed for SSHAP by Iliana Sarafian (LSE) with contributions and reviews from Elizabeth Storer (LSE), Tabitha Hrynick (IDS), Dr Marco Solimene (University of Iceland), Dijana Pavlovic (*Upre Roma*) and Olivia Tulloch (Anthrologica). The research was funded through the British Academy COVID-19 Recovery: G7 Fund (COVG7210058) and was based at the Firoz Lalji Institute for Africa, London School of Economics. The brief is the responsibility of SSHAP.

KEY CONSIDERATIONS

- **Consider the entanglements of pre-existing structural and social inequalities** with new forms of marginalisation created by the COVID-19 pandemic as a starting point for engaging and redressing exclusions faced by Roma communities.
- **Raise awareness among public health professionals** about health, structural and social barriers, fear of side effects and the impact of new forms of vulnerability created by the pandemic for Roma communities. Information and communication strategies must consider wider socio-economic determinants of health to address resistance to vaccination.
- **Avoid 'mass' and arbitrary quarantines** as these exacerbate pre-existing vulnerabilities of Roma groups including economic precarity, and lack of access to education and healthcare.
- **Provide access to public services** if 'state of emergency' policies and quarantines are necessary. These should include access to healthcare, education and social benefits to counter economic marginality, social stigma and political exclusion of Roma communities.
- **Create vaccination services at convenient locations and times** for Roma communities and their families, including outreach and mobile vaccination sites and accessible transportation.
- **Offer free COVID-19 testing** to prevent further negative economic impact on populations facing poverty, and alleviate sanctions associated with vaccine mandates which result in resistance to vaccination and mistrust.
- **Ensure vaccination is confidential and personal information is protected** to mitigate fears of eviction and impacts on settlement and citizenship status among Roma. Research participants experienced the pandemic as a threat to their citizenship and security.
- **Make vaccination available and independent of residency and health records** to accommodate the needs and concerns of informal workers and migrants who may fear potential legal repercussions. Our research informants sought health assistance only in cases of critical illness, and from private health providers where vaccination was not available.

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- **Support continuity of vital family and community relationships of trust and solidarity.** Fears of eviction and deportation among respondents were closely linked to fears of separation from family and community.
- **Build on established Roma community relationships with trusted medical personnel**, particularly general practitioners, who are more likely to be viewed as credible messengers if they have an established relationship with Roma patients.
- **Include, employ, and engage Roma community members** in design and implementation of vaccination campaigns, communications, policy and public health initiatives to tackle social inequalities and increase Roma representation to support vaccine participation.
- **Support Roma-led outreach by engaging trusted community individuals** such as Roma community champions, health mediators, elders and religious leaders who can foster wider inclusive changes to strengthen collaboration between community members and local authorities. Support Roma community organisations (e.g., non-profit and faith-based) with direct access to resources, including training and funding to respond to diverse needs.
- **Increase messages on social media platforms used by Roma communities** (e.g., Facebook, WhatsApp and others), including materials featuring and shared by Roma community members, to contravene online misinformation about vaccination.
- **Do research to generate data and support long-term solutions** by involving Roma in the design and implementation of research studies. Research addressing the barriers in Roma health access and provision can aid pandemic preparedness and the tackling of longstanding health inequalities.

ROMA AND THE COVID-19 PANDEMIC

This brief sets out to understand the diversity of responses to COVID-19 vaccines with the vital aim to convey understandings within the frames of the lived experience of Roma people themselves. Estimates suggest there are up to 12 million Roma in Europe.[3] Roma communities are diverse while also recognised as Europe's largest and youngest ethnic minority for whom the COVID-19 pandemic has been particularly detrimental.[1,4] Official state and public health reports have recognised that the pandemic would disproportionately impact vulnerable groups. Yet, there is no official data on rates of COVID-19 infections, hospitalisations, deaths or vaccine uptake among European Roma groups.[4] Roma communities have suffered higher rates of poverty, deprivation, and marginalisation than their non-Roma counterparts.[5] Already in precarious positions, the enormity of the COVID-19 crisis has brought further economic deprivation and structural violence to the daily lives of many Roma.[6,7]

For Roma people, the impact of the pandemic has been primarily narrated in terms of their assumed reluctance to adhere to emergency regulations or their lack of 'self-governance'.[8,9] As a consequence, pandemic policymaking has been characterised by measures to contain and control Roma settlements.[10] Policies, justified through a narrative of protection from COVID-19, were in practice disciplinary measures, driven by fear that COVID-19 would spread among Roma who could then in turn, bring contagion to the wider society. In Italy, lockdowns often involved increased military presence in Roma communities to control the spreading of the virus by Roma camp dwellers and eviction orders were served on Roma throughout the pandemic.[10] This social 'bordering'[9] and confinement of entire Roma settlements during the pandemic intensified social-economic inequalities.

Overcrowded accommodation[10] and limited scope for maintaining physical distance have been among the main drivers of the highly unequal effects of the pandemic on Roma. Many Roma dwell in poor sanitary conditions with no running water or electricity, in excluded settlements without basic amenities. The lack of masks and hygiene supplies during the pandemic, alongside widespread and longstanding chronic illnesses, placed them among the most disproportionally affected populations in Italy.[1,11] While state policy-making measures framed as solidarity and social support for the most vulnerable became available, these were largely restricted to people in the formal economy.[7] Roma

individuals reliant on informal work, short-term contracts, and seasonal forms of employment not available during lockdowns, were unable to access unemployment benefits and health insurance.

Public health research, policy and practice with Roma communities must consider the entanglements of pre-existing structural and social inequalities with new forms of marginalisation created by the COVID-19 pandemic as a starting point for engagement and redressing exclusions. While numerous state and non-state efforts have sought to mitigate the spread of COVID-19, little research and policy has focused on Roma community views and concerns throughout the pandemic.

Pre-existing histories of inequalities

Box 1. Who are the Roma?

In European Union policy, the umbrella-term 'Roma' encompasses diverse groups, including Roma, Sinti, Kale, Romanichels, Boyash/ Rudari, Ashkali, Egyptians, Yenish, Dom, Lom, Rom, as well as Traveller populations (gens du voyage, Gypsies, Camminanti, etc.).

Vaccine uptake among Roma cannot be understood without reference to previous historic and pervasive social inequalities and discrimination. There are between 140,000 and 160,000 Roma in Italy.[3] However, Roma are not a single homogeneous community group (see Box 1), nor are they recognised as an Italian minority in policy and national statistics. Roma are largely viewed as 'nomads' and 'outsiders' despite having lived in Italy for centuries.[12] Often referred to by the derogatory term '*zingari*', some Roma live in 'nomad camps' (*campi nomadi*, also called villages) or shanty towns, usually on the outskirts of cities.[13,14] The camps are the legacy of local and regional authority regulations from 1984 to 1992 when such settlements were offered by local authorities as temporary housing solutions for Italian Roma and Sinti who allegedly practiced a nomadic lifestyle.[12,15] Nevertheless, it was mostly non-Italian Roma facing poverty, and particularly those escaping war in the Balkans, who settled in the camps.[16] The temporary nature of the intervention acquired an indefinite character as generations of Roma were born and grew up in the settlements, both formal and informal. The settlements became largely characterised by poverty, unemployment and precarious work in the informal economy, and inadequate access to healthcare and education.

During the wars of the 1990s, waves of Roma from the former Yugoslavia migrated and sought refuge in Italy.[17,18] Roma also arrived following the collapse of communism in Eastern Europe and later, in the wake of the European Union enlargement. During this latter period, they came mostly from Romania and Bulgaria, often in search of economic opportunities. Although Italy has among the lowest shares of Roma and Sinti populations in Europe, the more recent Roma migratory waves to the country have made them highly visible and demonised in public discourse.[18,19] In 2008, the Italian government declared a 'state of emergency' following an alleged 'nomad invasion'. The so-called 'nomads', a heterogeneous collective of long-established Italian Roma, Sinti and Camminanti (as referred to in the 2012 National Strategy), Roma from ex-Yugoslavian countries and Roma from new EU member states, became the target of the government's so called 'Nomad Emergency' strategy to tackle 'nomad criminality.'14,15,20

Box 2. Anti-Gypsyism

The European Commission against Racism and Intolerance (ECRI) at the Council of Europe defines anti-Gypsyism as 'a specific form of racism, an ideology founded on racial superiority, a form of dehumanisation and institutional racism nurtured by historical discrimination, which is expressed, among others, by violence, hate speech, exploitation, stigmatisation and the most blatant kind of discrimination' (ECRI – General Policy Recommendation No. 13 on combating anti-Gypsyism and discrimination against Roma, June 2011).

Nevertheless, Roma and Sinti in Italy have been mostly sedentary for generations, as is the case across many European countries. Yet, the legacies of 'nomadisation' and Romaphobia[21] in state policies continue, even despite the 'nomad state of emergency' having been declared unconstitutional in 2011.[22] Xenophobia, anti-Gypsyism (see Box 2) and discrimination, including the targeting of Roma in racially motivated attacks and countless evictions, have been directly linked to the public abjection to Roma mobility.[23] In policies, nomadism is regarded not just as a lifestyle, but

as an inherent socially-deviant Roma trait.[13,21] This meaning and use of 'nomads' in policy language has strongly contributed to the implementation of policies that perpetuate notions of Roma as suspicious non-citizens, transitory and unsettled, and in need of being contained and immobilised.[24]

With the onset of the COVID-19 pandemic, Roma groups in Italy and elsewhere found themselves in another predicament of containment.[6,8] Histories of anti-Gypsyism, continued isolation, exclusion and confinement to city outskirts and specific neighbourhoods[25] and forceful relocations[15] collided with new vulnerabilities. Roma dwellings located in areas with air pollution, poor sanitation, lack of access to medical care and education, and with sub-optimal housing, all contribute to higher morbidity in Roma communities.[26,27] Yet, these have been neglected by public health initiatives and policymakers due to the extreme marginalisation of Roma populations.

COVID-19 lockdowns and securitisation

Roma spaces and livelihoods are consistently presented by state authorities, neighbourhood planners and policy makers as temporary and transitional, meaning they are rarely provided with the same services other neighbourhoods receive.[24,28] The punitive character of these long-standing policies focusing on the temporariness of Roma dwellings and livelihoods reinforces stigmatising notions of them as undeserving 'outsiders'.[13,19,26] In pre-pandemic times, formal and informal Roma settlements were seen as threats to the majority society and its values. Their perceived illegality and (in)formality led to frequent police visits to control the social and physical boundaries between camp dwellers and the rest of the population.[15] This 'biopolitical control' and its normalisation reinforced views of Roma as a public health threat during the pandemic.[8,26] Another aspect of public imagery was added to the perceived illegality of Roma lives, where the physical characteristics of contagiousness intermeshed with long-standing prejudice against them.[9]

In March 2020, seeking to halt the spread of the pandemic, the Italian prime minister Giuseppe Conte signed a decree implementing a strict lockdown across Italy. Seen as spaces of contagion, police securitisation of Roma camps intensified to ensure physical distancing and to curb mobility beyond the camps.[11,29] As in other European countries,[6,7] lockdowns for Roma included state securitisation on a neighbourhood and community basis, as opposed to individual circumstances.[21,24] The curtailment of movement disproportionately affected people in informal employment or in manual and essential jobs outside Roma settlements. Roma experienced negative socio-economic impacts largely related to their employment in various low-paid, informal, temporary, and precarious work. Roma in Milan and Rome were forced into debt and deeper poverty due to loss of access to work in flea markets and restrictions to scrap collection. Roma in both formal and informal settlements found themselves struggling even more to access food, medication, education, and general services. When a Bulgarian Roma woman in Catania working as an informal carer for the elderly fell sick, she resorted to a high-interest loan to cover the incurred out-of-pocket hospital costs due to her restricted access to medical care and income security. Reliance on family support and community solidarity increased, although these forms of internal communal support also became less prominent over time as household resources depleted, further exacerbating vulnerability and poverty.

Education for Roma children, however sporadic in pre-pandemic times, became inaccessible due to lack of technology and internet access, school supplies and general amenities in Roma settlements under lockdown. While local authorities across Italy provided food vouchers for disadvantaged communities, this measure did not include Roma living in informal settlements because they were not enrolled in municipal civil registers.[7] Moreover, emergency COVID-19 rules and policies for isolation were predicated on the assumption that all individuals had access to basic sanitary conditions such as drinking water, electricity and adequate accommodation. Public health messages urging social distancing and sanitation had no relevance for occupants of overcrowded Roma camps which lacked basic amenities.

Despite the ease of access to vaccination for the general Italian population, at the time of the research, Roma populations living in camps had not been reached by public health vaccination initiatives. The vaccination initiatives had not catered for Roma living far from public health services, to provide vaccination in spaces accessible for them. Moreover, vaccine campaigns intersected with memories of punitive public measures towards Roma, including the recent lockdowns implemented at

the scale of entire settlements, rather than individual households.[6,8] This lockdown securitisation of entire Roma settlements in Italy was understood by many Roma as part of a continued state legacy of discrimination. Past experiences of exclusion, present hardships, and communal strategies for survival shaped Roma responses to COVID-19 vaccination as it became available. Roma expressed mistrust towards state initiatives for vaccination due to the historic, structural, and recent inequalities, of living in precariousness. Top-down approaches to state-led vaccination and communication campaigns have not incorporated the concerns of Roma communities leading to vaccine mistrust.[30]

VACCINE HESITANCY AMONG ROMA COMMUNITIES

Box 3. Vaccine Hesitancy

According to the SAGE Working Group on Vaccine Hesitancy, 'Vaccine hesitancy refers to delay in acceptance or refusal of vaccination despite availability of vaccination services. Vaccine hesitancy is complex and context specific, varying across time, place and vaccines. It is influenced by factors such as complacency, convenience, and confidence'.[31]

The term 'vaccine hesitancy' (see Box 3) refers to an individual or group who is hesitant to be vaccinated. However, the concept fails to denote the role of public health authorities in reaching out, informing, and gaining the trust of those viewed as hesitant. Moreover, this framing does not consider various non-linear factors, including structural discrimination and barriers, that lead to lower vaccination uptake. Our research considered complex realities that require shifts from 'one size fits all' approaches,[32] to solutions which account for social relationships, and histories of inequality, discrimination and poverty – the effects of which have been compounded by pandemic policy.

Much public health research and policy conceptualise vaccine hesitancy as the result of insufficient health literacy among vulnerable populations – an argument which dominates public policy conversations about resistance to COVID-19 vaccines. On account of their perceived reluctance to accept vaccines, Roma have been portrayed in public discourse as a threat to public health, which has reinforced prejudice against them.[21,27] As outlined above, non-inclusive COVID-19 policy responses, alongside histories of exclusion and social inequality, have diminished Roma trust in government initiatives, with implications for their participation in vaccination. Where vaccination coverage or uptake has been limited, it is important to consider the multiple social and structural inequalities preventing vaccination. Our respondents who wished to be vaccinated faced structural barriers such as lack of finances and access to transportation to vaccination centres; fear of how vaccine side effects could impact their often informal and irregular employment; and worries about how government access to personal data required for vaccination could endanger their migrant status and/or citizenship. Research and policy framing Roma as vaccine hesitant can feed into existing prejudices, including blaming them for spreading the virus and also for the challenges they face. Employing a sensitive lens, including considering the below listed aspects of structural discrimination and vaccine barriers, can aid vaccine participation, and contribute to greater equality.

Identifying and addressing vaccine barriers

Our research identified a variety of themes regarding barriers to vaccine uptake among Roma communities in Italy. Importantly, vaccine barriers were inextricably related to the social determinants of health, structural discrimination and complex ongoing experiences of disadvantage and communal striving for survival.

Respondents assessed **COVID-19 risk in relation to socio-economic precarity** including poverty, unemployment, insecure and informal jobs, lack of adequate housing and accommodation, and interrupted access to education for Roma children due to impending evictions. These everyday inequalities remained central to the lives and livelihoods of Roma for whom COVID-19 became just another life hurdle. To many, it was a marginal consideration in comparison to the need for socio-economic survival, often summarised as a choice between death from COVID-19, or death from hunger. Local and national authorities must account for the socio-economic needs of people facing poverty, informal and irregular employment who assess COVID-19 risk and vaccination in relation to these circumstances. Mitigation of the multiple negative effects of COVID-19 to protect Roma groups

is necessary. For instance, this can be done through policies that alleviate the economic impact on low-income earners, irregular and informal workers.

Roma experienced **the 'mass' nature of quarantine on entire communities and settlements as a continuation of discriminatory state interventions** to contain and control disease and perceived illegality. Social restrictions and isolation disrupted communal networks within and between Roma households, preventing them from meeting essential health and socio-economic needs. Moreover, the lockdowns were a reminder of historical events such as Roma extermination in Nazi camps and previous historical events of mistreatment of Roma and Sinti communities. Alternatives to 'mass', even arbitrary quarantine is crucial. If quarantine is necessary, access to amenities, services, aid, healthcare, education and employment must be supported.

Roma participants articulated **mistrust in government and health authorities due to historical and current 'state of emergency' policies** and discrimination which merged to form resistance against vaccination when it became available. In one camp, the vaccination campaign was taking place at the same time as evictions. As a result, camp dwellers saw the vaccination campaign as coercive, and as related to the displacement they had been experiencing. Also, the lack of formal enrolment in civil registries prevented some of our respondents in Rome and Milan from accessing grocery store credits made available by the government to help the most vulnerable obtain food during lockdowns. Despite advocacy and demonstrations of several non-governmental organisations across Italy, some cities did not change their access criteria for food store vouchers.[7]

The limited access to vaccination centres and the lack of state socio-economic support were barriers to vaccination for research respondents, even if they wanted to be vaccinated. Structural barriers also contributed to mistrust in the vaccination campaign. Mostly living on the outskirts of cities, many of our interlocutors relied on public transport to access services and employment. Not being able to earn during lockdowns (especially for informal workers), combined with a lack of affordable transportation options for travel to far away vaccination sites and perceived risks of increased viral contagion in public transport, prevented vaccination for many.

In July 2021, the Italian government introduced **the 'Green Pass'** as a prerequisite to accessing public services, employment and leisure.[33] Those who were not vaccinated were asked to prove a recent COVID-19 recovery or to provide a negative COVID-19 test to access jobs, services, and public venues. Breaking these rules warranted fines and restricted access to public facilities. While many of our vaccinated research participants were not necessarily in favour of vaccination, they made the choice to vaccinate only to access employment. Many felt coerced into vaccination and expressed post-vaccine fear and regret. For unvaccinated respondents who were unemployed or in low paid or informal work, the cost of COVID-19 testing had the effect of further exacerbating poverty. A Roma woman in Rome, who feared the side effects of vaccination due to suffering with heart disease, diabetes, and asthma, shared that she had to choose between going hungry and buying a test to keep her job. Accordingly, vaccine outreach campaigns must address the interface of wider, socio-economic determinants of health with risk of COVID-19 infection and vaccination.[34,35]

Vaccination was also resisted because of **fear of eviction or deportation** if one's status as a Roma migrant or informal worker became known to public health authorities. In addition, employment in the informal sector presented the need to be 'ready for work' whenever opportunities arose, and thus fear of vaccine side-effects that could prevent people's ability to work. While COVID-19 was primarily treated as a medical crisis by scientific experts and policymakers, communities in our research also experienced the pandemic as a threat to their citizenship, security, livelihoods and status. Public health strategies requiring personal information (including the "Green Pass") were perceived as coercive, and exacerbated fears of eviction, and mistrust of authorities.

Fear of eviction was also related to **fear of separation from family, livelihood and solidarity networks**. Households we encountered tended to be large and multigenerational, consisting of a high number of young children. In environments where employment, accommodation, and health access are restricted, these family and social structures and patterns of household formation represent key communal strategies for tackling poverty and ensuring socio-economic and cultural survival. There is a need for provision of and access to adequate accommodation, living conditions,

employment, education, and health that preserve vital communal relationships. Such policies would support greater Roma inclusion, and trust in the state and public health authorities and wider society.

The **fear of side effects** due to underlying chronic morbidities and wider socio-economic circumstances was a common theme in participants' narratives. Respondents expressed fear due to high levels of pre-existing illness among Roma communities and the perceived effects the vaccine might have on their long-term health conditions. On average, Roma in Italy are likely to die ten to fifteen years earlier than their non-Roma counterparts.[34] Living in socio-economically disadvantaged settlements, Roma have higher rates of underlying clinical risk factors that increase the severity and mortality of COVID-19.[36] It is vital that health information provision and communications strategies consider the wider socio-economic determinants of health which affect Roma disproportionately, to counter fears of side effects. Along with strategies for alleviating poverty, local and public health authorities must provide opportunities for open dialogue about vaccine benefits and side-effects through local outreach with trusted community actors.

To register in the Italian health system and to access a GP, a major access point to health, requires a **formal residence certificate and a National Insurance Number**. Some of the research participants lacked public health insurance and access to social support due to being informal workers or undocumented migrants, and were hence not eligible for health, social and employment aid. The lack of residence and health records also meant that access to public health services and to vaccination was limited. The fear of authorities, including public health officials, led our interlocutors to seek health assistance only in cases of critical illness, usually through costly private healthcare provision. Access to private healthcare, however, did not give them access to vaccination as COVID-19 vaccination was not available privately.

Roma who had **access to, and an established relationship with a GP**, were more likely to trust and view medical professionals as credible messengers regarding vaccination. It is important that there is greater involvement of GPs in vaccine campaigns to deliver consistent, relevant messages and boost outreach efforts among Roma communities. This includes the understanding of the needs, concerns, and inequalities that Roma face. Encouragingly, past instances of successful public health campaigns for Roma children in Italy and elsewhere have achieved higher rates of vaccination, and we urge learning from these examples.[37]

The vaccination process was seen as 'solely belonging to the non-Roma' due to the **lack of community participants in vaccine campaigns and policymaking**. The missing communication and engagement of public health professionals with Roma community members and support workers, leaders and community champions also correlated with mistrust towards health professionals and state initiatives. Bearing in mind the heterogeneity of Roma communities, approaches to addressing vaccine participation may require varying strategies of communal engagement. Instances in which there was communal involvement, resulted in increased vaccine uptake. For instance, the availability of a Roma health mediator, supported by an NGO in a settlement in Rome, resulted in higher vaccination rates in that community. Religious leaders and faith-based circles in Catania also played a part, as discussions in church and communal gatherings reflected on how religious beliefs intersected with vaccination. Community members in Milan respected Roma elders' authority, and the drive to protect the elderly increased vaccination uptake in Roma households.

Roma use social media more than mainstream media and government websites. Within Roma households, nearly all generations frequently accessed digital media (Facebook, WhatsApp, TikTok and Instagram platforms). All research participants had access to social media outlets, and some were exposed to **online misinformation** referring to the pandemic as a hoax or tool for population control by elites. Thus, it is important to design communication strategies which leverage social media. Better use of both social and mainstream media by vaccine campaign implementers, including materials featuring Roma community members, can contravene misinformation and distrust in vaccination. Indeed, many of our informants reported receiving information about the COVID-19 emergency, protection and prevention from social media, and being influenced by the protests and social media initiatives of the no-vax movement in Italy.

Importantly, as well as looking at the barriers to vaccine uptake among Roma populations, our research sought to identify relationships of trust within the communities, and their impact on vaccine uptake. We found that trust rested within family and communal relationships. It is vital that public health campaigns must include **Roma-led outreach by engaging trusted community individuals** such as Roma community champions, health mediators, elders and religious leaders who can foster wider inclusive changes to strengthen collaboration between community members and local authorities. Communication and socio-economic response and recovery plans must engage and co-create strategies to improve vaccine uptake together with Roma community organisations (e.g., non-profit and faith-based organisations) with direct access to resources, including training and funding to respond to the diverse needs of Roma communities.

Finally, it is important to pursue **research agendas that better reflect the needs of Roma** communities. Involvement of Roma people in the design and implementation of such research agendas will contribute to better understanding of their needs. Previous research on health inequalities experienced by European Roma communities has called for more data on Roma health due to higher instances of morbidity and gaps in access, provision and health practices interlinked with the social determinants of health.[34,38] The COVID-19 pandemic has highlighted the under-representation of Roma in health research and the lack of data on health disparities caused by structural barriers and discrimination. Research, both qualitative and quantitative, will not only help to ensure future pandemic preparedness is more effective, but will also support the identification of the multiple and intersecting factors underpinning health inequalities faced by Roma.

CONCLUSION

Among Roma communities, social inequality and its compounding effects directly impact vaccine participation. The focus on the COVID-19 crisis, although immediate and unprecedented, must not distract from ongoing inequalities. Yet, pre-existing disparities and structural harm have become normalised and rendered invisible in public discourses on COVID-19 vaccine uptake. This brief showed that poverty, discrimination, and socio-economic disparity have a direct link to vaccine uptake. The impact of COVID-19 has also exacerbated mistrust between Roma communities, public authorities and health providers. Equitable access to vaccination requires the re-thinking of linear state solutions and the tackling of underlying, long-standing everyday realities in the lives of Roma communities. Public health research, policy, and engagement with Roma communities – including the entanglements of pre-existing inequalities with new forms of disadvantage – are necessary to redress disproportions in vaccine outreach and mistrust.

Vaccination mandates are the consequence of the shortcomings of public health in reaching, communicating, reassuring, and engaging vulnerable groups. Narratives of vaccine hesitancy, in placing responsibility on individuals, should be reframed to include recognition of multiple vaccine barriers, including social and structural ones. Transparent public health engagement with Roma communities is crucial. Finally, and most importantly, Roma community participation and co-production of solutions, including the allocation of resources targeted at socio-economic and cultural interventions should be integral to efforts to increase vaccine uptake and equality.

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