HEALTH-RELATED EFFECTS AT THE OUTBREAK OF COVID-19 PANDEMIC IN VULNERABLE COMMUNITIES OF ROMANIA[1]

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This paper reports on health-related effects of the Covid-19 pandemic impact on vulnerable populations from Romania's vulnerable communities, Roma and non-Roma. Transmission in the most marginalized communities has been expected to be particularly high as self-isolation and social distancing are difficult to pursue as a result of crammed living conditions, limited access to basic services and infrastructure. The study reports research results from a qualitative survey based on expert interviews in communities.

The sample includes a total number of 34 communities, out of which 10 Roma vulnerable rural communities, 10 vulnerable rural localities and a counterfactual of 10 resilient communes. In addition, four small urban areas with large Roma neighborhoods complete the sample. Data collection has been organized in four rounds, during the period May−July, 2020.

Since the lockdown, a large number of interviewees declared non-compliance with the hygiene measures for preventing Covid-19 transmission to be a problem. While in the resilient communes this problem was not reported, it appeared to be widespread in the selected vulnerable communes. The non-compliant behavior of poor and Roma people is considered an aggregated effect of a lack of access to relevant infrastructure, particularly water, and lack of finances for the necessary sanitary products. According to opinions expressed by local institutional representatives, between Round 1 and Round 3 of research (May−June 2020), a large part of the population either has never observed the hygiene rules or has relaxed after the lockdown was lifted. Constant positive evolution was reported in the resilient communes and the vulnerable non-Roma ones.

This study adds knowledge on social and economic health-related effects of the Covid-19 at the level of the most vulnerable segments of

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Romanian society. The results underline the fact that short-term effects of the pandemic are borne unequally.

Keywords: *Covid-19; health equity; health services access; health behavior; social distancing; Roma; vulnerable; Romania.*

BACKGROUND

This study is focused on the health-related effects of the Covid-19 pandemic in Roma vulnerable communities of Romania. It looks at access to health services and basic sanitary products, as well as to population's compliance with the physical distance rules. In doing so, the study is aligned with surveying and analyzing the social determinants of health, while revealing a pandemic of health inequity (Ramirez-Valles *et al*. 2020; Banati *et al*. 2020; Buffel *et al*. 2020; Shadmi *et al*. 2020; Shaw *et al*. 2021; Marsh 2020; Mishra *et al*. 2021; Bach-Mortensen, Degli Esposti 2021; Davies *et al*. 2021; Dearinger 2020; Krzysztofik *et al*. 2020).

Not only for Romania, but in the entire Europe, the OECD policy brief shows that the mostly exposed population groups in relation to pandemic effects refer to children, youth, women and old people (OECD 2020). Furthermore, the crisis affects not only individuals and households, but also communities, particularly those underdeveloped. The main challenges for rural and small urban areas will relate to the age structure of the population, needs for high-speed broadband Internet connection, together with larger opportunities for remoteness and greater social distancing offered in the rural areas (ibid.).

In the national context, the first monitoring report of the Covid-19 crisis has been issued by UNICEF Romania (UNICEF, 2020a). UNICEF report is focused on assessing the situation of children and families during four rounds of qualitative research, each one within a timeframe of ten days. Amongst the categories most affected by Covid-19 pandemic in Romania, the first monitoring report identifies the following: children from families living in poverty, Roma children, children with parents left abroad for work, and children with disabilities. The study identifies several challenges in delivering adequate health, educational and social services. It provides, among others, overarching recommendations related to the development of the institutional capacity of the public sector in delivering social services, improving access and quality of online educational services, better community involvement of family doctors, improved complementary telemedicine services and a better joint effort between health professionals, social workers and other public administration professionals (UNICEF, 2020a). Additionally, the qualitative study conducted in the second round, in the selected communities reinforces the results related to the key categories affected by the pandemic − children from families living in poverty and Roma children. Another group is represented by children from families with a high risk of violence, as the number of respondents mentioning this problem was almost double in the second round of

assessment. Furthermore, obstacles related to the access to services are mentioned, in relation to health and educational services. Problems related to the access to vaccines refer to restrictions in the activity of family doctors throughout this period (UNICEF 2020b).

Research Institute for Quality of Life (RIQL), part of the Romanian Academy of Sciences, also issued four social reports dealing with social impacts under the new context of Covid-19 pandemics, dealing with the pandemic and the standard of living, quality of life in times of pandemics, emergency state for population's consumption, Covid-19 pandemics from a demographic perspective. All four reports are based on secondary data analysis, and provide several policy recommendations for counter-balancing the social and economic impact of the pandemics at population level (Arpinte *et al*. 2020; Stanciu *et al*. 2020; Voicu *et al*. 2020; Zamfir *et al*. 2020). In particular, one of the RIQL reports draws attention of the need to reconsider social policy response, in the light of the new context, which results in new vulnerable groups, such as: (i) individuals who lost their source of income, yet they do not receive technical unemployment subsidy, as is the case of persons who have been 'forced' to have a period of unpaid leave; (ii) individuals losing source of income, yet not eligible for unemployment subsidy, as they are not part of the unemployment insurance system; (iii) long-term unemployment – no longer part of the unemployment insurance system, and who are low employable, especially in recession circumstances; (iv) poor individuals who are not eligible for receiving minimum income guarantee or emergency support, most likely from rural area, with a low level of education, and with a low employability level; (v) Romanian citizens returning from abroad, losing their income source, and who don't have enough savings to support themselves more than a few weeks, as these individuals are not part of the unemployment insurance system, either in Romania, or in the migration country (Arpinte *et al*. 2020).

Under this background, the present study captures the pandemic impact in the first months since the outbreak, in several selected communities of Romania, Roma and non-Roma, vulnerable and non-vulnerable. Whereas the whole study grasps impact on various transmission channels, this article is focused on health-related effects. Concerning this topic, the article looks at whether there are any changes between rounds of monitoring, and whether there is any support received for vulnerable communities (corresponding to the final monitoring round – in June 2020).

METHODS

The study is based on qualitative methods that capture the early "signs" of the impact of Covid-19 pandemic on vulnerable communities and groups. The study reports research results from a qualitative survey based on expert interviews in communities. To this aim, the study focuses on four channels of impact

transmission associated with the measures to prevent the spread of Covid-19. The considered channels of impact transmission are: (1) lack of access to basic infrastructure, including potable water, connection to wastewater systems or sanitation services, and poor housing conditions; (2) the disproportionate risk of illness of certain groups of the population, especially in the conditions of basic medical services missing or overloaded; (3) the lack of access to correct and relevant information on the prevention of the disease and of the measures imposed on the population through the state of emergency; (4) reducing the demand for labor, in both the formal and informal sectors of the economy, both at home and abroad, as well as closing schools and disrupting social services in communities.

The selection of rural communities followed a two-step process. In the first step, the team elaborated a typology using available data from previous researches for all (2861) communes of Romania. Thus, the population of rural communities (communes) was classified into three categories based on the following six criteria: (1) poverty/development – (i) human local development index (Sandu 2013), at the commune level; (ii) communes with or without marginalized area (one or more areas, Roma or non-Roma), determined based on census 2011 data (Swinkels *et al*. 2014; Teșliuc *et al*. 2016); (2) access to services – (i) the commune is far from the county seat (at the top 40% of the number of kilometers distribution), and it contains at least a village far (32+ km) from any city, and (ii) lack of medical services (HM, HCW, HM), and of a professional social worker (SW) in the commune, and (3) at-risk groups – (i) proportion of the older people in the total common population on 1 January 2020 (NIS data), and (ii) proportion of migrants abroad in the total population, aggregated index constructed by professor Dumitru Sandu using data from the 2002 and 2011 censuses, plus 2005 survey data.

Using the abovementioned criteria, a summative index was determined by interpreting the selection criteria as (1) risk factors given the negative aspects (poverty, lack of access to services, over-representation of groups at risk in total population) and, alternatively, as (2) sources of resilience, given the positive aspects (development, access to services, under-representation of risk groups). Theoretically, the summative index built based on these risk factors can take values from 0 to 6. In reality, the communes in Romania have accumulated between 0 and five risk factors, of which 68 communes characterized by four factors and 10 communes by five risk factors. However, there are also communes where risk factors abound, in the absence of sources of resilience. As well, some communes benefit from many resources of resilience, without being exposed to the risk factors considered. Consequently, the typology includes the following three categories of communes: (i) vulnerable communes (a total of 78 in the country): communes most likely to suffer from a short-term negative impact (cumulating four or five risk factors, and having insufficient or no resources for recovery); (ii) resilient communes (a total of 67 in the country): communes with the lowest chances of negative impact in the short term (cumulating four or five sources of resilience; the

only accepted risk factor is related to relatively intense migration abroad); (iii) the other communes in the country.

In the second step, the team selected the sample of communes to be assessed. To this end, the typology presented in the previous section was crossed with two sampling criteria, namely: (i) geography – development region, county, rural or small urban and (ii) ethnicity − proportion of self-identified Roma in the total population of the commune, at the 2011 census (most recent census data available).

In the next step, a sample of 30 communes was randomly selected, as follows: (i) 10 Roma vulnerable communes, out of the total 21 in the country with a high share of self-identified Roma (5−80% of the population), (ii) 10 vulnerable communes, out of the total 33 in the country without self-identified Roma, and (iii) a counterfactual of 10 resilient communes, out of which four communes without self-identified Roma, four communes with a high share of self-identified Roma, and two communes with an average share of Roma population.

Additionally, four small urban areas with large Roma neighborhoods completed the sample. Thus, the sample includes a total number of 34 communities, out of which 30 rural and four small urban, vulnerable and resilient, both Roma and non-Roma.The sample of communities was presented and agreed with the National Agency for Roma (NAR), Roma Sounding Board (RSB), and the World Bank (WB).

The study is based on qualitative methods, interviewing the following categories of experts: (i) representatives of Roma NGOs (list of respondents provided by the National Agency of Roma and contacts provided by the Roma Sounding Board); (ii) Roma experts employed in the county or local public institution, such as County Offices for Roma, County School Inspectorates, Prefecture (list of respondents provided by the National Agency for Roma, and contacts provided by the Roma Sounding Board), and (iii) representatives of the selected communities (Roma and non-Roma), namely: mayor, deputy mayor, locality secretary, representatives of public social services (social worker or person with social assistance responsibilities), mayoralty specialists and other local institutions, such as school, family doctor, the priest, other members of the Community Consultative Structure, as well as the community nurse, the school mediator or the Roma mediator, local businesses, groups of local volunteers, NGOs acting locally, if any. For this last selected group of representatives, respondents were identified by the research team through the snowball technique, and selected according to availability. Besides the interview by phone, the research team sent by e-mail an electronic version of the interview guide at the respondents' request. The guide was accompanied by official letters signed by the President of the National Agency for Roma and the representative of the World Bank Country Office in Romania. The whole methodological approach, including ethical considerations, has been approved by the representatives of NAR, RSB and WB.

The study was based on qualitative data collected through semi-structured interviews by phone. Nonetheless, in the qualitative framework, the analysis is quasi-statistical and comparative. This means that collected qualitative data have been analysed to produce counts, and test whether discrepancies are reported/ perceived, in relation to the following set of variables: (i) vulnerable versus resilient communes; (ii) area of residence (rural versus small urban); (iii) share of self-identified Roma population within the total population of the locality (Roma − with shares of 5% or more versus non-Roma − no self-identified Roma); (iv) whether the commune includes or not marginalized areas, including if the marginalized areas are predominantly inhabited by Roma, non-Roma or mixed (Teșliuc et al. 2020); regarding the selected small urban areas, all four of them include Roma marginalized areas (Swinkels et al., 2014); (v) share of older population in the total population of the locality; (vi) gender differences, and (v) type of respondent (community representatives, Roma experts/ councilors, and Roma NGOs).

Data collection has been organized in four rounds, during the period May−July, 2020. The state of emergency has been enacted in Romania in March 2020. This article presents information collected during the final monitoring round (July 6 and July 17, 2020). Data gathered in the previous rounds of research, especially those from Round 1 (May 8−22), Round 3 (second half of June), are used for comparisons. First round also collected information about the period of lockdown (March – April 2020).

The study is based on a longitudinal design, and panel data was collected. In Round 1 of data collection, the sample included 33 communities both vulnerable and resilient, Roma and non-Roma[2], rural and small urban. In Round 2, the sample was completed with six more rural communities (out of those that were not available in Round 1). Subsequently, in Rounds 3 and 4, some communities refused participation. Consequently, in Round 4, the sample remained with 34 localities. Panel data represent 77% of the total sample of persons interviewed in Round 1.

Besides communities, the sample has also included Roma NGO partners of the NAR and Roma experts/councilors employed in public institutions from the county or local levels. Due to the unsatisfactory rate of response among the Roma NGOs (that has not improved in Round 2 and declined further in Rounds 3 and 4), the number of Roma experts from the local level was increased in Round 2, as compared with Round 1.[3] However, in Rounds 3 and 4 of data collection, a part of the Roma experts recruited for Round 2 was no longer available to participate in

[2] Based on the availability of data on Roma communities, the variables used for selection of communities refer to self-identified Roma communities.

[3] Roma experts from the local level are employed in mayoralties from cities or communes of other types than vulnerable or resilient, which however have large shares of Roma population (the reason for which they have hired a Roma expert).

the research. Besides the sample of 34 selected communes and towns, the Roma experts/councilors and the Roma NGOs provided information about the people and activities from other 54 rural and urban localities. Thus, 88 communities are covered by the study, out of which about 77% are rural and 23% are urban, mostly small towns, but also Roma neighborhoods from larger cities. These communities are located in all regions, respectively in 30 counties of the country, with an over-representation of the North-East, South-East and South-West regions, especially in Botoșani, Buzău, and Gorj, mainly due to the territorial distribution of the activities implemented by the interviewed NGOs.

Overall, 115 persons participated in the data collection process in Round 4. Some of them provided data across all topics, whereas others focused on their area of expertise. For example, school principals focused on education and children, general practitioners confined their answers to health status and medical services, mayors and deputy mayors answered mainly to institutional issues. However, all of them completed at least some themes of the interview guide.

The sample of interviewees is gender-balanced (50% female and 50% male), and includes representatives with various types of expertise. However, female respondents prevail among the interviewed community representatives (60%), while male respondents predominate among the Roma experts/ councilors and especially among the NGO representatives (about 80%). Representatives that self-identify as Roma are very few among the rural community representatives, and are present only in the Roma vulnerable communes. Their share among the interviewees increases to almost a third of the institutional representatives from small cities, and account for about 90% of the Roma experts, councilors, and NGOs.

The researchers recorded the collected data in an Excel database, coded the information, and then exported it into an SPSS database on which the quasi-statistical analysis has been conducted. In total, almost 250 variables correspond to all the questions included in the interview guide for Round 4, including codes for the open questions. The report uses quasi-statistics as the main method of data analysis. Correspondingly, the numbers just show the frequency of answers and underpin the comparative analysis between the various types of communities and vulnerable groups. The quotes included in the report are accompanied by the following sequence of information (gender − F/M, function/position, type of community, region).

RESULTS

This section presents the results as identified by respondents, grouped around the following key topics: (i) compliance with the hygiene preventive measures; (ii) access to basic sanitary products of the vulnerable groups; (iii) complying with the regulations within institutions; (iv) compliance with social distancing; (v) access to health services.

Compliance with the hygiene preventive measures

Since the lockdown (Round 1) a large number of interviewees declared non-compliance with the hygiene measures for preventing COVID-19 transmission to be a problem. While in the resilient communes this problem was not reported, it appeared to be widespread in the vulnerable communes either non-Roma with large shares of elderly or Roma.

According to the opinions provided by local institutional representatives, between Round 1 and Round 3 of research (May−June 2020), a large part of the population either has never observed the hygiene rules or has relaxed after the lockdown was lifted. Constant positive evolution was reported in the resilient communes and the vulnerable non-Roma ones. In contrast, a constant negative situation was signaled in Roma vulnerable communes and small towns with large Roma neighborhoods. More than half of the interviewees assessed that in July (Round 4), the situation remained similar to that from June (Round 3).

Nonetheless, the other interviewees have opposite views. For almost a quarter of the respondents, the population's hygienic behavior has further relaxed in July, particularly in the vulnerable non-Roma communes, so that "everything is like before the pandemic" (M, GP, Vulnerable rural community non-Roma, S-E). Changes are reported in relation to entering public institutions, where "they are compelled" to observe the protection rules – "They are protecting only if they are compelled to do it as for example when entering public institutions". (F, HCW, Roma vulnerable rural community, S).

"Almost no one wears now a face mask". (F, Roma NGO & Prefecture Office for Roma, N-E).

"Everything is now more relaxed. My personal opinion is that it's no good, people do not wear face masks anymore. It is a lot of stress because the law has to be applied, yet it's all too much." (M, Roma expert/councilor, Other types of rural communities with large Roma population, S).

"Roma people don't care about the pandemic". (M, Roma NGO, B-IF).

"There is this summer period now, people come for holidays, they don't think at the rules anymore". (F, SW, Mixed resilient rural community, S-E).

In the perception of the other interviewees, the situation improved due to fear, fines, or guidance and support offered by the relevant community specialists, such as the health community worker or school mediator. They also relate to the return of children from final grades to school, where representatives from educational units recount high compliance with rules.

"More people wear masks since the number of cases started to increase on TV". (F, HCW, Roma vulnerable rural community, N-W).

"They are wearing the mask because of the fines. Only by coercion, they have been convinced". (F, School principal, Roma vulnerable rural community, N-W).

"In localities where there is a health or school mediator, people listen to what they say and respect hygiene rules and wear masks". (F, Inspector for Roma education, County School Inspectorate, N-W).

"Children have been scared, they wore a face mask, they followed all the steps, they followed the set route from the entrance, they had no objections. We were pleasantly surprised by their attitude". (F, School principal, Small urban with large Roma neighborhood, S).

Access to basic sanitary products of the vulnerable groups

The non-compliant behavior of poor and Roma people is considered an aggregated effect of a lack of access to relevant infrastructure (particularly water) and lack of finances for the necessary sanitary products. This is the dominant approach among the local institutional representatives, Roma experts, and representatives of Roma NGOs.

"People cannot afford buying hygiene products". (M, Roma expert/councilor, Urban with large Roma neighborhood, S-W)

"One mask costs 2 lei, one family with four members should spend 8 lei/ day, they have 260 lei social aid, and they would need 300 lei each month for masks and gloves – this is not possible". (M, Roma NGO, Alba, Center).

In most of the selected communities, the number of households without basic sanitary products has either been low (only isolated cases) or has declined between May and June 2020. Nevertheless, this number has been significant or has increased during this period in some communities, especially the Roma vulnerable communes and in urban Roma neighborhoods.

Support for the vulnerable groups was also available in most communities, being financed from the Operational Program on Supporting Disadvantaged Persons (OPSDP), funded by EU funds. Generally, the aid consisted of packages with food and sanitary and cleaning products, for several hundreds of persons per community. Support through the OPSDP was provided to beneficiaries of social aid, pensioners with low incomes, persons with disabilities, and other vulnerable groups eligible for benefits. The group of poor not eligible for benefits, making a living in the informal sector, has not received support.

The support with OPSDP financed packages arrived in communities in two waves. The first wave was in May (Round 1), and covered 30 of the studied communities. The second wave was reported in June (Round 3) by local institutional representatives from 20 communities, out of which in 17 communities the support for vulnerable groups was also granted in the previous wave. After the two waves of aid, in June (Round 3), the need for support within the community was covered, however, in only 20 of 35 communities in the sample. The situations in which the need for support was only partially covered were reported significantly more by the local institutional representatives from Roma vulnerable communes (8 out of 12) and small urban with large Roma neighborhoods (3 out of 4), as compared with those from the resilient communes (none of the 10 included in the sample). The interviewed Roma experts and NGOs made similar assessments, namely that the need for support has only partially been covered in Roma communities from various other localities across the country.

In July 2020 (Round 4), the situation reported by interviewees was unchanged. The majority of the studied communities declared waiting lists, obtained the necessary approvals, and were expecting the sanitary and protective products for the vulnerable groups.

"On July 17 we expect the food aid to arrive, and around July 31 we hope for the sanitary products". (F, SW, Vulnerable rural community non-Roma, S-E)

"Nothing was distributed in the community, people managed by themselves". (M, Roma expert/councilor, Urban with large Roma neighborhood, S)

"Public Health Directorate writes Urgent on the requests – they sent the list, yet nothing received". (F, SW, Roma vulnerable rural community, Center)

Only in few communities, the interviewees reported some support for vulnerable groups offered in July 2020. Nearly all these cases referred to support financed from the local budget and distributed to the most in need. Consequently, generally these cases come from resilient communes, and not from the vulnerable ones.

"Mayoralty bought masks and distributes to those who need and ask for them. Vulnerable groups are monitored – mayoralty continues to support them, against payment from their money". (F, Locality secretary, Resilient rural community non-Roma)

"At the school, we received more face masks than what we asked for or what we would need, so we keep them so we can use them in September. Those who come at school without a mask, receive one. In the commune, there are also companies and NGOs who made available face masks. I don't think some people would like to wear a face mask and don't find one. Now we also have more distribution points in the commune (including free face masks)". (F, School principal, Resilient rural community non-Roma)

Complying with the regulations within institutions

Both in June (Round 3) and July (Round 4), compliance with social distancing health guidelines was reported to be satisfactory within institutions. Office spaces were reorganized to allow physical distancing, spaces for relations with the public were redesigned with protection panels, spacing areas were marked, access is controlled, thermal scanners and hygiene measures were introduced. Regarding institutions, references have been made to the mayoralties (public institutions at local level), public services' office (like social assistance offices), county councils (public institutions at county level) and schools. Also, protection equipment for employees has been ensured in all communities, according to the interviewees. In general, more and more people now declare that, at institutions' level, they have what they need to comply with the regulations. Only 4 (out of 94 valid responses) claim that in July the situation deteriorated, but only regarding the compliance with the rules in open public spaces.

"We received masks from the Ministry of Education. Even in the shops people are not allowed in without masks. Before and during the state of emergency,

people entered without masks. Because of the fines, more people are now wearing a face mask". (F, School principal, Roma vulnerable rural community, N-W).

"At the mayoralty we go out in the yard to talk to the people, they enter the building only if it's strictly necessary. We give information in any way, someone in mayoralty's yard. At the entrance we have face masks and disinfectants for everyone entering". (M, Roma expert/councilor, Other types of rural communities with large Roma population, S).

"People enter the mayoralty one at a time, people receive face masks if they don't have one, but at the bars and terraces nobody takes into consideration this, it is an important problem". (M, Roma expert/councilor, Other types of rural communities with large Roma population, N-E).

Compliance with social distancing

For the entire period of May−June 2020, about 80 percent of the interviewees assessed that majority of the population complied with the social distancing requirements in their communities. More frequent negative assessments referred to the Roma communities. Regarding July 2020, the situation has somewhat deteriorated. Imediately after more restrictions were removed, the population relaxed, and fewer people complied with the social distancing and health guidelines, said about a third of the interviewees. Respondents talk about participation in events like weddings, funerals, baptisms, without compliance with the social distancing rules, especially in Roma communities. In contrast, a representative from the urban communities with large Roma neighborhoods stated that cases of deceased people registered in their neighborhood, acted as incentives to compliance with social distancing rules – "They keep the distance. They stay in the queue outside at a distance, they have no objections, they follow the routes. Some from the Roma people even died and they are afraid". (F, School principal, Small urban with large Roma neighborhood, S). Additionally, relaxation of rules is also associated with the upcoming local elections. Representatives of local communities are not willing any more to apply fines or rules which contradict "the local will", as they want to maximize the number of votes.

"People participated in funerals and weddings with 50−60 people. No one intervenes, things are only ticked in the agenda, they are not for real. Elections are coming and they don't want to risk not being voted because they impose restrictions or give fines". (M, Roma expert/councilor, Other types of rural communities with large Roma population, S-W).

"The situation now is out of control. Now. Before this, prevention was the key, and if the case occurred, immediate intervention. Now, no one complies to anything". (M, Roma expert/councilor, Other types of rural communities with large Roma population, S-W).

Moreover, an increase in the number of people uprising against social distancing measures or other imposed measures has been reported since June (Round 3), by a

part of the interviewees (about 20 percent), either from localities with Roma villages/neighborhoods or Roma representatives (experts, councilors or NGOs).

Access to health services

This part looks at the changes in access to a hospital or other health services for sick persons with other diseases than Covid-19 (including pregnant women and women who are about to give birth). Since the lockdown (Round 1), the interviewees have reported problems linked to delays in periodic treatments or interventions (like dialysis, radio or chemical therapy, surgery interventions, births) for people with diseases/ health needs other than Covid-19, from various communities. Data from late June 2020 (Round 3) showed that the access to hospitals and emergency units for people with such health problems has remained a problem even after the lockdown was lifted. In July (Round 4), almost 90 percent of the interviewees declared that the situation has remained the same. On the one hand, people are afraid of going to hospitals because of to the rise in the number of infected cases, and on the other hand, more hospitals have become Covid-19 exclusively, and only emergencies are treated. Only six interviewed persons (of the 94 valid responses) evaluated that in July the situation has improved and 'hospitals are now open for everybody' (F, SW, Resilient rural community non-Roma, N-E). Hospitals nearby transformed into Covid-19 support hospital are no longer used by pregnant women. Instead, they choose to go to private practices in cities with a significantly better offer of health infrastructure, like Bucharest (capital city). In addition, ambulance services are reported to be delayed. Other difficulties include lack of access to day hospitalization as the hospital became a Covid-19 support one, even though "there is no Covid case hospitalized in there" (M, Roma NGO, Ialomița, S).

"Because people died for other reasons but they were registered as being infected with Covid, people with chronic diseases are scared, they think they will go being sick of something and coming back with Covid, and are afraid of going at the hospital because it's compulsory they are tested when entering the hospital. In addition, tests can also have errors. "If I go there, I will come back in a nylon bag, they say [...]. Due to the stress, some even broke down, they have phobias or mental diseases because of that. For those who have problems with medicines, they are resolved by the mayoralty individually... Face-masks received from UNICEF are hard to be worn ... Disinfectants contain something that can give stomach ache … And so on". (F, HCW, Resilient rural community non-Roma, N-E).

DISCUSSION AND CONCLUSIONS

This study reinforces findings related to amplified health inequity in times of Covid-19, for vulnerable groups, as reported by the interviewed stakeholders. Findings on the inequalities in access to health services are in line with the

evidence provided in correspondent studies (Epps *et al*. 2021; Germain *et al*. 2020; Mishra *et al*. 2021; Shadmi *et al*. 2020; Shaw *et al*. 2020; Singh *et al*. 2021). Specific issues are reported by this paper, common to on-the-topic previous research. These refer to canceled or delayed medical healthcare (van Ballegooijen *et al*. 2021), reduced access to scheduled medical appointments (Nshimyiryo *et al*. 2021), or decline in the utilization of health services for fear of Covid-19 infection (Nshimyiryo *et al*. 2021). Structural inequalities in observing the rules of the quarantine in Roma communities complement the findings in other studies (Berescu *et al*. 2021).

Simultaneously, the study adds knowledge on several issues which have been continuously promoted as preventive measures against the spread of Covid-19 pandemic. These are represented by access to basic sanitary products and complying with several rules – like physical distancing regulations inside public institutions, or hygiene preventive measures. Adherence to preventive measures is differentiated across types of studied communities, and it also depends on access to sanitary products. Institutional support for provision of food and sanitary products was reported as not sufficiently covering the needs in vulnerable communities. Simultaneously, the periodic monitoring conducted in the same communities showed no changes in several communities. Therefore, this study is more nuanced against health inequities driven by social inequities (Ramirez-Valles *et al*. 2020). It contrasts with other analyses bringing a spotlight on household composition, reporting a direct influence on adopting prevention measures (Gutierrez-Velasco *et al*. 2021).

This study has several strengths and limitations. Firstly, there are inherent limitations in the data used for constructing the typology of rural communities in Romania, relevant for the study purpose. Secondly, reported information is based on a qualitative study, with all the limitations inherent in qualitative research. Therefore, the presented findings, although relevant, cannot be seen as representative either for the Roma population in Romania, or for other types of vulnerable groups. Also, data collection was limited to a very short time limit, in a period with strong dynamics, amid of a global health crisis. The interviewees are institutional representatives from the public or non-profit environment, but not the directly affected population. Therefore, the interviewees' discriminatory attitudes, their lack of knowledge (or solid information), as well as interviews completed by phone, could have seriously influenced the research results. Despite these limitations, the information collected in real-time can and must be understood within the general objective of the research, that of identifying the early "signs" of the social and economic impact of the COVID-19 pandemic and the adaptation strategies developed at the level of the most vulnerable segments of the Romanian society.

In terms of policy implications, the study's findings reiterate the need to address the specific needs of vulnerable groups, aligned with a rather 'person-

centered', instead of a "disease-centered approach", with a view of closing the gap on knowledge (Lee *et al*. 2021; Guglielmi *et al*. 2020), but also that of access to key public utilities, like running water provision. At national level, more than half of the population below 60% of median equivalized income neither has a bath, nor a shower, nor indoor flushing toilet in their household (56.6% in Romania, 2020, 5.7% in the EU, 2019).[4] Consequently, this article makes a plea aligned with the three key pillars to formulate adequate policy responses in relation to the Covid-19 impact, namely: (i) protecting people and places left behind; (ii) supporting small businesses and vulnerable workers; and (iii) responsive and coordinated governance (OECD 2020). A person-centered approach can also prove to be relevant for exploring acceptability of vaccines, as only one potential further research topic in vulnerable communities.

This study adds knowledge on social and economic impact of the COVID-19 at the level of the most vulnerable segments of Romanian society. The study documents a differentiated health related impact of the pandemic in vulnerable communities, Roma and non-Roma, against resilient communities. The results underline the fact that short-term effects of the pandemic are borne unequally. As the global pandemic is still unfolding and the vaccination campaigns are still on-going processes, this research can provide useful insights for future policy interventions in similar contexts.

List of abbreviations

EU – European Union; F – female; GP – General Practitioner; HM – Health Mediator; HCW − Health Community Worker; LHDI – Local Human Development Index; M – male; NAR – National Agency for Roma; N-E – North-East; NGO – non-governmental organization; NIS – National Institute of Statistics; N-W – North-West; OPSDP – Operational Program on Supporting Disadvantaged Persons; RSB – Roma Sounding Board; S – South; S-E – South-East; SW – Social Worker; WB – World Bank.

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[4] Source: Eurostat database, indicator code: [ILC_MDHO05].

Ethics approval and consent to participate

This study received approval from the National Agency of Roma, Roma Sounding Board committee and World Bank Romania. It was conducted under UNEG rules and standards of conduct. Before starting an interview, the representatives were informed about the context and topics of the discussion, as well as about the purpose of the discussion, and how their opinion will be processed, ensuring confidentiality. Informed verbal consent was obtained from all participants in the study. One of the researchers supporting data collection speaks fluently the Romani language.

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Articolul prezintă efectele legate de starea de sănătate ale pandemiei Covid-19, asupra populației vulnerabile, din comunitățile vulnerabile cu și fără romi, din România. În comunitățile marginalizate, se aștepta ca transmisia virusului să fie mare, ca urmare a dificultății de a respecta măsurile de auto-izolare și distanțare socială, în contextul unui nivel scăzut al condițiilor de viață și al accesului limitat la servicii de bază și infrastructură. Studiul include rezultatele unei cercetări calitative realizată prin interviuri cu experți din comunități.

Eșantionul include un număr total de 34 de comunități, dintre care 10 sunt comunități vulnerabile cu romi din mediul rural, 10 sunt comune vulnerabile, alături de un set contrafactual de 10 comune reziliente. În plus, sunt incluse și 4 orașe mici cu zone extinse de romi. Culegerea datelor a fost organizată în patru runde, în perioada mai-iulie 2020.

Începând cu perioada de izolare din starea de urgență, un număr ridicat de intervievați a identificat ca problematic gradul scăzut de respectare a măsurilor de igienă pentru prevenirea trasmiterii Covid-19. În timp ce în comunele reziliente această problemă nu a fost menționată, ea a apărut ca fiind extinsă în comunitățile rurale vulnerabile. Comportamentul neconform al populației sărace și de etnie romă este considerat a fi un efect agregat al lipsei de acces la infrastructura relevantă, în special apă, alături de lipsa resurselor financiare necesare pentru produsele sanitare. În opinia reprezentanților instituționali locali intervievați, între prima și a treia rundă a cercetării (mai−iunie 2020), o mare parte a populației fie nu a respectat regulile de igienă, fie acestea au fost relaxate, după ce izolarea din starea de urgență a fost ridicată. O evoluție constant pozitivă a fost raportată în comunele reziliente și în cele vulnerabile fără romi.

Studiul contribuie la extinderea cunoașterii asupra efectelor sociale și economice legate de starea de sănătate ale pandemiei Covid-19 asupra celor mai vulnerabile segmente ale societății din România. Rezultatele subliniază că efectele pe termen scurt ale pandemiei sunt inegal distribuite.

Cuvinte-cheie: *Covid-19; echitate în sănătate; accesul la servicii de sănătate; comportamente în sănătate; distanțare socială; romi; vulnerabile; România.*

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