A critical discourse analysis of a Serbian Roma social inclusion strategy, its construction of Roma people, health and the implications for Roma people's access to health and healthcare in Serbia

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Abstract

Roma communities often face vast social and health inequalities and inequities in Europe, including Serbia, and this could be due to several possible multi-level factors. Recent national, regional and international initiatives have sought to reduce these disparities by developing or amending policies, with limited success across countries. Past research on such Roma inclusion policies points to the need to consider the discourses in these texts. In this mixed-methods study, I explored how Roma health policy discursively constructs Roma people and health issues in Serbia and consider the social implications of such constructions for health justice for Roma. I used Fairclough's critical discourse analysis (CDA) to critically analyse the current Serbian Roma social inclusion (health) strategy and the interview talk of those who have developed and implemented such policy. The strategy analysis found three dominant discourses of health: (1) neoliberal discourse, (2) neoliberal human rights discourse, (3) holistic human rights discourse. The discourses associated with neoliberalism contained the assumptions that raising awareness and providing information on health and health-related rights and economic integration into the labour market would enable better health access and health for Roma. These discourse types worked to individualise Roma health issues, placing most of the responsibility for achieving health on Roma people themselves. In comparison, the holistic human rights discourse worked with broader social determinants of health framework, which framed health and associated health-related resources as fundamental human rights and called for more government accountability. The interview participants' talk analysis revealed that while a neoliberal discourse on health information dissemination was evident, there was also a significant emphasis on the macro-social constraints impeding access to health, namely poor infrastructure, discrimination and cultural bias. Findings thus indicate multiple, at times contesting, ways of constructing Roma people and Roma health issues within the policy circle. Such diverse constructions can have important implications for Roma health. Overall, findings

extend discourse literature on European Roma health and inclusion policy, supporting and challenging dominant constructions of Roma health problems and solutions, and point to the need for more nuanced analyses of different countries' Roma policy and the talk of key stakeholders.

Acknowledgements

"To tackle health inequities, it is necessary for health systems not only to improve the services available to migrants and ethnic minorities, but also to address the social determinants of health across many sectors. A wide range of policies and practices need to be critically examined in the light of their consequences for the health and well-being of migrants and ethnic minorities." (WHO, p. vi)

"We live in a world in which poverty and inequalities in wealth and access to resources are the major causes of ill-health." (Campbell & Murray, 2004, p. 194)

"We live in a world in which we need to share responsibility. It's easy to say "It's not my child, not my community, not my world, not my problem." Then there are those who see the need and respond. I consider those people my heroes." - Fred Rogers, Children's Educator/Entertainer

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The quotes above speak to this thesis, and as I carried out my research on Roma health policy and advocacy in Serbia, I was repeatedly reminded that achieving social justice is no easy feat. I am in awe of the dedication and tireless efforts of many who work to better Roma's situation, and I am grateful for their passion.

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Chapter 1 - Overview

This thesis focused on the plight of Roma and their associated health issues in the Republic of Serbia through a critical discourse analysis of the Serbian government document, 'The Strategy of Social Inclusion of Roma for the 2015-2025 Period' (the Strategy), which was designed to better Roma health in Serbia, and which is located within a wider set of policy practices related to Serbian succession with the EU. How official policy documents and stakeholders construct key issues can enable and limit access to health in certain ways. Health policy has the potential to address many different factors that contribute to health inequalities and health inequities. Indeed, policy shapes and is shaped by broader social practices. Therefore, this study analysed how health and Roma people are constructed in the Strategy, arguing that how Roma and Roma's access to health is discursively framed can have real-life consequences for Roma's access to health and thus their health outcomes. In particular, the barriers and the solutions (mechanisms) proposed are pertinent for social and health justice.

To conduct an analysis of such discourses and their social implications, this thesis applied critical discourse analysis informed by the work of Fairclough (2015) to two data sets. First, the Strategy, an official strategy aimed at bettering Roma health in Serbia, and second interviews with key professional people who held important roles in the development and implementation of this policy document. The thesis shows that this novel, mixed methods design enabled a rich and insightful analysis of this important health document making a novel and significant contribution to existing research on how European Union health policy documents employ limited constructions of health and Roma that makes these policy documents unlikely to meet their success objectives. In the literature review below, I have outlined previous relevant research. I start with how health inequalities are conceptualised, locating these in wider debates of citizenship and health, and discuss what researchers know so

far about Roma and health inequalities, both in wider Europe and specifically in Serbia. This will be followed by a consideration of health policy research, describing what it entails, its value and previous findings; and an outline of the health policy documents relevant for Roma health in Serbia, and lastly the introduction of the Strategy in question in the Central Eastern European context, including Serbia, and the critical research findings on such documents thus far. This outline allowed me to justify the aims of this thesis, which are located in a social justice framework that seeks to better understand why health policies have consistently failed to support the health of Roma people.

1.1 Understanding health inequalities

Health inequalities is a term used in a variety of ways, and in this section, I discuss how we might understand health inequalities by exploring a number of issues, how health inequalities are defined and how they are made sense of within different models, including the social determinants of health model. In so doing this section provides the backdrop against which Roma health policy is both developed and critiqued.

1.1.1 Health inequalities, how they are measured and defined

Researchers have worked hard to define them and develop measures in order to assess health inequalities and develop policy and planning to address these disparities. Health inequalities are usually measured by comparing health indicators for different groups based on ethnicity, gender, age, socioeconomic position (or class) and geographical location, among others. Key health indicators include statistical health data on mortality (incidence and life expectancy) and morbidity rates (Albert-Ballestar & Garcia-Altés, 2021; Mackenbach, 2019).

Mirroring what Sen and Bonita (2000) asserted more than two decades ago, recent meta-analysis findings support the strong inverse link between low socioeconomic status (SES)

and premature mortality (Sen & Bonita, 2000; Stringhini et al., 2017). Indeed, there is growing and overwhelming empirical evidence suggesting that low SES is among the strongest predictors of both mortality *and* morbidity globally, over purely biological (genetic) explanations for ill health independent of such contextual factors (Evans et al., 2021; Sen & Bonita, 2000; Stringhini et al., 2017). The robust link between socioeconomic status, commonly measured by income, educational attainment level, and occupation ranking in the occupational hierarchy, is observed globally (Glymour et al., 2014). Extensive evidence suggests that those of lower SES tend to fare far worse in health outcomes than those with high socioeconomic positions, a phenomenon of health being worse for those facing absolute poverty (Braveman & Gottlieb, 2014; Hempel et al., 2021; Lyons & Chamberlain, 2006). However, health inequalities to do with relative deprivation also exist, with the middle class having generally inferior health compared to those with high SES (Lyons & Chamberlain, 2006). Growing epidemiological evidence suggests that those in more egalitarian societies, where income inequality is lower, have better health than those in less egalitarian societies when looking at the 'same absolute level of material wealth' (Stephens, 2008, p. 51). In other words, socioeconomic inequalities appear to be linked to preventable deaths and illnesses and thus is a significant cause of concern for social justice and health equity.

1.1.2 Social determinants of health frameworks

A common understanding of health inequalities is that they result from multiple determinants at multiple levels of different social and biological domains, from the biological (genetic) to the upstream structural factors, such as economic and social policy (Palmer et al., 2019). A focus on the social inequalities and their link to health disparities is known collectively as the Social Determinants of Health (SDH). In general, SDH represents interrelated social factors that appear to intersect to impact the health of individuals and

populations. Key determinants include income, housing and environment, employment opportunities and conditions, social protection and benefits, social connection, and education (Alderwick & Gottlieb, 2019; Lyons & Chamberlain, 2006; Stephens, 2008). The World Health Organisation (WHO) defines SDH as the '.... conditions in which people are born, grow, live, work and age, and also includes the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. Social determinants of health are mostly responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.' (WHO, 2021). Attention to the SDH highlights the responsibility towards those with power over these determinants, such as governments, contrasting with individualistic understandings of health determinants. This framework also points to the importance of attending to broader structural issues.

1.1.3 Wider structural issues

Different determinants can also intersect to affect health. It appears that those with low-socioeconomic status who also belong to certain minority ethnic groups have the worst health experiences and outcomes (Lyons & Chamberlain, 2006; Mackenbach, 2019). These quantifiable measures are considered as evidence to justify minority group health policies, where improvements in health and health outcomes are measured by the closing of these gaps. Terms like 'socioeconomic integration' and 'health justice' are commonly used in such policy, but what these mean in practice and the mechanisms to get there can vary greatly between policies. Of course, minority health policies lie in a broader context of other social and economic policies that can dramatically impact what is enabled and limited, leading health scholars to look at macro-level structural factors that can influence health disparities. It appears that specific socioeconomic and political structural changes lessen the chance that minority

groups' health and social inequalities will be abolished, as they obstruct the equitable distribution of social resources, such as healthcare, income, adequate housing and non-precarious employment, negatively impacting on health (Barnett & Bagshaw, 2020; van Baar, 2012). Thus, it is crucial to consider these broader factors and how they can influence health inequalities, specifically health *inequities.* Central to these contexts is neoliberalism, an ideology which proposes a reduction of the (welfare) state to instead have societies governed according to free market values and ideas (Navarro, 2007). Neoliberalism is a dominant ideology with worldwide reach, but one that works by interconnecting with local values (Ong, 2006; Morača & Stubbs, 2020). Thus, neoliberalism in practice can vary across diverse contexts too, however, there are commonalities in expression across societies, as discussed just below.

In the last four decades many states have shifted their economic policy towards neoliberalism. This transition has involved a reduction in social expenditure on public services, such as health, with the privatisation of such sectors occurring with support by fiscal policies in response to changing power structures in society (Navarro, 2009). These changes are related to what is often termed as 'neoliberal policies' and have seen an emphasis on market values, a different way of controlling state spending, assuming that this would lead to economic growth and improve quality of life and health for all (Fairclough, 2015). However, these desired outcomes have not materialised as the implementation of such policies, in most countries, has seen an increase in social inequalities, including those to do with accessing health and health outcomes (Lyons & Chamberlain, 2009; Navarro, 2009; Sakellariou & Rotarou, 2017). The WHO (2008) Commission on Social Determinants of Health Report asserts that '[a]spects of globalisation, such as trade liberalisation and market integration between countries, have brought major shifts in countries' national productive and distributive policies. "Structural

adjustment"—a core global programmatic and policy influence from the 1970s onwards—framed the emergence of a dominant (sometimes referred to as "neoliberal") orthodoxy in global institutions. Designed to reduce inflation in indebted developing countries, decrease public spending, and promote growth—all strongly oriented towards supporting debt repayment—adjustment policies promoted trade liberalisation, privatisation, and a reduced role for the public sector. This had a severe adverse impact on key social determinants of health—including health care and education—across most participating countries. Many countries, without doubt, stood to benefit from reducing runaway inflation and improving fiscal management. But it is not clear that the harsh degree and policy straitjacket that structural adjustment imposed produced the anticipated benefits, much less whether the health and social costs were warranted.' (WHO, 2008, p.166). However, at the same time, Mooney (2012) asserts that the commission has made no concerted efforts to address neoliberalism's effects on global health, i.e. no structural analysis of neoliberal policy.

Although WHO has not engaged in structural analysis of neoliberal policy, there has been substantial academic research critically investigating such policies worldwide and their links to social and health inequalities. There is growing evidence to suggest that those with more neoliberal policies and politics in place have more significant, more pronounced health inequalities (Collins et al., 2015; Mooney, 2012; Navarro, 2005). Through such research came the observation that neoliberal policies can and often do seem to affect the poorer classes the worst, and along with benefiting some classes over others; they have also benefited some ethnic groups, genders and nations at the expense of others (Navarro, 2005; Stephens, 2008). Lyons and Chamberlain (2006) discuss the adverse effects on global health: stating that '[t]he economic development, market and trade policies under globalisation are seen by many as promoting inequality and poverty in many regions of the world, with substantially negative

effects on health' (Lyons & Chamberlain, 2006, p.355). Although the stepwise negative gradient link between SES and health has been apparent throughout history, evidence suggests that the gap between the rich and poor has been growing in recent decades, albeit with different rates across the globe (Alvaredo et al., 2018). These disparities in socioeconomic position, and thus health, vary between countries, and they are also evident within the same country. Indeed, many countries in the Global North and South have had growing socioeconomic gaps in recent decades alongside growing health inequities.

Chapman (2016) asserts that '[b]oth the values neoliberalism espouses and the policies it advocates constitute an impediment to the goal of securing better health for all' (Chapman, 2016, p.107). As a result, many academics, organisations, and individual activists raise awareness of today's neoliberal policies and their effects on the disenfranchised and encourage further study investigating how social and economic policy may ultimately lead to health disparities (Fairclough, 2015; Palmer et al., 2019; Thomson et al., 2017). One area of study already given considerable attention is the discursive tendencies in neoliberal documents to individualise health in how they construct health citizenship, which are likely to justify and reinforce health inequalities. Such a discursive construction thus fails to include the broader socioeconomic and political factors that are largely outside of the individual's control; instead framing 'health behaviour' as an individual's choice, and thus can produce or merely reinforce a moral climate that blames people for being of ill-health and limits the potential for fundamental social change in the form of health equity. Neoliberal discourses assume that individuals are free-thinking, autonomous 'agents' who are responsible for their own health, minimising the role of the state in protecting people's health; therefore, placing a disproportionate burden for care on these self-responsible 'health citizens' (Marks et al., 2021).

At the same time, these discourses ignore wider socio-structural determinants, which as discussed above can have serious consequences on people's health.

Neoliberal discourse in healthcare corresponds to the commodification of health and health systems in society, where 'patient empowerment' and 'patient choice' are central ideas. Health policies that cater to the dominant neoliberal rationale promote an idea of individualisation of health whereby individual responsibility is key for enacting 'good' health citizenship. This type of citizenship thus positions the ideal citizen as individual 'self-governing' instead of the State taking social care of its citizens (Ong, 2006). Rose and Novas (2005) assert that when this self-responsibility for health becomes the norm, people who do not succeed in managing one's health become "new types of problematic persons" (Andrejic, 2019; Rose & Novas, 2005, p. 451). The section below discusses how evidence suggests that many people have become such problematised persons, including Roma.

Chapter 2 – Literature Review

2.1 Roma and health inequity

Because there are clear health inequality measures for Roma people and policy documents aimed at Roma (also referred to as Romani) people, this thesis uses the terminology and categorisation of Roma people. However, the ethnic classification 'Roma' (or 'Romani') is contentious, as Roma are not a homogenous group and vary in language, religion, culture, cultural customs, socioeconomic status, level of integration and even geographical origin (Marushiakova & Popov, 2002; Čvorović, 2019). Nevertheless, to keep the terminology of this thesis consistent with other research on Roma social inclusion in Europe, I decided to use the term 'Roma' while recognising the heterogeneity within which this term refers (Marushiakova & Popov, 2018).

To understand contemporary health issues for Roma people in Europe, it is necessary to give a brief historical background. People identified as 'Roma' are believed to have started migrating to Europe around a thousand years ago. Today, Roma make up the largest minority group in the continent, representing approximately ten to twelve million people (European Commission, 2020; Open Society Foundations, 2019). Roma are also considered the largest marginalised group (Parekh & Rose, 2011). Since their arrival, Roma people have faced social exclusion, at times persecution and genocide, and a general lack of "tolerance" in mainstream European society (Sigona & Trehan, 2009). Indeed, Roma are often considered the most disadvantaged and discriminated against people in Europe and have social inequalities compared to non-Roma in many areas, including health (Open Society Foundations, 2019).

2.1.1 Roma and health inequality in Europe

The general findings across European nations are that the ethnic group 'Roma' face poorer access to health than non-Roma groups and therefore, both their morbidity and mortality fare much worse (Parekh & Rose, 2011). Indeed, there is extensive and growing evidence to suggest that Roma face, at times severe, health disparities across Europe (Orton et al., 2019). Accounting for the heterogeneity of Roma's living situations, Roma fare worse in terms of higher rates in both communicable and non-communicable diseases and in mortality rates compared to non-Roma (Parekh & Rose, 2011). These health disparities seem to exist even for those in the same geographical regions and socioeconomic position (Alexiadou, 2018; Orton et al., 2019). Roma's life expectancy is ten to fifteen years lower than non-Roma, whereas child mortality (under the age of five) is reported to be around two to three times higher for Roma.

Many upstream and downstream factors may contribute to Roma's lack of access to health and poorer health outcomes, including the social determinants of health. However, a mainstream conceptualisation among many academics, policy developers and health workers frame Roma health disparities as mainly due to lack of health knowledge, and *cultural* or *lifestyle* factors (Rostas, 2019; Sigona & Trehan, 2009). For example, the tradition of earlier motherhood among Roma women has shown to have (mostly negative) health implications for both mothers and their children (Sigona & Trehan, 2009; UNICEF Serbia, 2017). At the same time, however, this social practice may serve as a protective factor against certain diseases such as breast cancer and sexually-transmitted infections; but these potentially positive health outcomes are generally ignored or side-lined because of embedded ideologies of Roma as deficit, which appear to structure many official analyses of Romani health (Coe & Čvorović, 2017; Popoviciu & Tileagă, 2020; Rostas, 2019).

In contrast to the deficit and cultural factors discourse, scholars assert that discrimination against Roma as an ethnic group alongside low socioeconomic status presents

a double threat against accessing healthcare and health for Roma (Janević et al., 2011). Roma people fare considerably worse than non-Roma in terms of socioeconomic status, when it comes to measures such as income, education attainment and occupation; and many studies show a relationship between their low SES and ill health (Kolarcik et al., 2009; Bjegovic et al., 2019). There is also extensive evidence showing that Roma people face ongoing widespread discrimination and social exclusion daily in the European countries they reside in or are currently seeking asylum (Escobar-Ballesta et al., 2018a; Janević et al., 2011; Clarke, 2020; Olesen & Karlsson, 2018). Even though the conditions of livelihoods of Romani communities can vary between European countries, in general, the finding is that many Roma still face discrimination and covert, as well as overt, racism across the continent and within their respective countries today (Escobar-Ballesta et al., 2018b; Olesen & Karlsson, 2018). Discrimination and social exclusion, often regarded as social determinants of health (SDH), can work as barriers towards accessing healthcare and health; and they are critical factors that can help explain why there are such vast health inequalities for Roma people compared to the majority population (Janević et al., 2011; Olesen & Karlsson, 2018; Parekh & Rose, 2011; Matrix, 2014).

Much research on Roma health is conducted in Central Eastern European (CEE) countries and to a lesser extent, South Eastern European (SEE) countries, i.e. the Balkan region. These groups of countries are where Roma populations are largely concentrated (Orton et al., 2019). Findings suggest that Roma health inequality has grown since the transition into the market economy of both CEE and SEE countries, due to a range of factors (Janević et al., 2011; Sigona & Trehan, 2009). Overall, health research has found that health disparities and other social inequalities between Roma and non-Roma are common within numerous European nations; and as I discuss below, this pattern of health inequalities for Roma is the same in Serbia

in general, but with particular intensity based on the history of this country (Janević et al., 2011).

2.2 Serbia

The focus of this study is on the Serbian document, 'The strategy of social inclusion of Roma for the period from 2016 to 2025', and as such, a broader socio-historical context is necessary to understand Roma's social position in Serbia today (Sardelić, 2016).

Researchers believe that Roma first migrated to the Balkans region around six hundred to one thousand years ago, and since their arrival, they have faced discrimination and socioeconomic marginalisation compared to other ethnic groups (MRGI, 2015). With this assertion in mind, it can be posited that Roma social inequalities and marginalisation is not a new phenomenon in what is now considered Serbia. Albeit, Romani peoples' position and the State's approach to their inclusion into society varied along the lines of different empires (Habsburg or Ottoman), periods of peace or conflict (wartime), and other significant social circumstances (such as industrialisation, State Socialism); with the recent social changes and situations, outlined just below, being most pertinent to this thesis (Marushiakova et al., 2001; Barany, 2002). Although historical, as I will share in this section, these epochs produced their own discourses regarding Roma and citizenship that echo through into contemporary health policy.

2.2.1 State Socialism

Around thirty years ago, Serbia was part of Self-governing Socialist Yugoslavia, or Socialist Federal Republic of Yugoslavia (SFRY) led by Josip Tito (Barany, 2002). This Socialist State evolved shortly after the Second World War, after a short-lived communism

(1945-1950), with frequent changes in its system that resulted in a rather different approach to Socialism than other respective Socialist countries at the time (Perić, 2020). Shortly after its conception, SFRY was no longer part of Cominform, nor was it ever part of the Soviet Union or the Warsaw Pact; and while an in-depth description of the SFRY system is beyond the scope of this paper, it may be stated that Yugoslavia rejected the Soviet model for a unique, new Yugoslav one, with its principle of decentralisation, a relative openness to the world market, and what they termed as "social" ownership (Perić, 2020). This latter social practice is described as “general people’s” ownership of the means of production, as opposed to private or State ownership. In other words, enterprises were collectively owned, with their operation under management by the workers. Like in Capitalism, these businesses were required to run at a profit (for a full description see Bockman, 2011; Medjad, 2004).

What is more relevant to the thesis is that this State model had central to its principle *equality* between citizens, however it employed this differently to other Socialist countries of the same period (Sardelić, 2016). More specifically, within Yugoslavia, Roma inequality and thus social inclusion was addressed primarily in terms of recognising them as an ethnic group rather than improving their socioeconomic position by assimilating, or forcing, them into the working class as was the focus for the other Socialist states of the same period (Barany, 2002; Sardelić, 2016). Such an approach may thus reflect in the official employment statistics of the Roma during the Yugoslav state's existence never having exceeded fifty per cent, while neighbouring countries (such as Bulgaria and Hungary) could reach over eighty-five (Sardelić, 2015). At the same time, however, unofficial or informal employment of Romani peoples was largely tolerated in Yugoslavia, for example, in 'traditional' craft making of troughs (Sardelić, 2015). Meanwhile, land reforms saw the Roma being distributed land, particularly in Serbia; making many Roma become owners of small-scale farms (Barany, 2002; Thompson, 1993). This approach to Roma integration may have reflected the apparent promotion of ethnic

harmony in an ethnically-heterogeneous and multinational state (Barany, 2002). During the last decade of Tito's rule, Roma's political representation increased, and they were given relative autonomy from state control for a number of social and cultural organisations (Barany, 2002).

Although the 'Socialist' period is considered the most favourable time for Roma in terms of social equality and progression, these efforts were not effective in equalising Roma people in social status; with their educational attainments, living conditions being particularly lower than non-Roma (Barany, 2000; Barany, 2002; Sardelić, 2016). Scholars assert that social stratification and thus inequalities existed and even grew in this period, in particular along socioeconomic and national/regional lines (including urban versus rural zones); as well as socioeconomic and ethnic lines, and here Roma fared worse (Archer et al., 2016; Barany, 2002; Sardelić, 2016).

2.2.2 The dismantling of Yugoslavia

Although the Socialist period was problematic for Roma equity, the consensus among researchers and economic experts is that after the death of Tito in 1980, the economic crisis in the late 80s and the subsequent often-violent dismantling of the Socialist State, Roma social disparities became significantly more pronounced. Indeed, it is important to mention that what is now considered the Republic of Serbia underwent significant political changes and social disruption in the last three decades or so; including civil war, corresponding economic sanctions and war expenses, corruption, savage privatisation, and a rise in Nationalism (Kleut & Drašković, 2020; Perić, 2020, p. 94; Vidojević & Perišić, 2015). This economic and political disarray has forced people to flee their homes (becoming internally displaced persons (IDPs) and refugees, created social divides (including ethnically-motivated hate crime) and

interlinkingly has slowed down health gains and, in some cases, negatively affected the health status for many within Serbian society, including Roma (Navarro, 2005).

Roma's position dramatically worsened after 1991 during the disintegration of Yugoslavia in particular (Đorđević et al., 2004; Sardelić, 2016; Vidojević & Perišić, 2015). The wars among the former republics, a political and humanitarian disaster, was a period of massive social upheaval that saw very many human rights abuses, and severely negatively affected the social and economic situation of all Republics, including the one now-known as Serbia (Medjad, 2004). The Kosovo War of Independence of the late nineties saw an estimated 50,000 Kosovo Roma forced out as internally displaced persons into the region then known as Serbia and Montenegro; and post-conflict selective back-and-forth policies saw their migrant status precarious, with many Roma losing legal status (Human Rights Watch, 2003). A lack of regulated status alongside the threat of persecution, placed many barriers to integrating in these areas or returning to their former homes in Kosovo (Human Rights Watch, 2003; Sardelić, 2016). Research on Roma in the post-Yugoslav space observe there are many displaced Roma who still struggle to access social justice due to such issues as structural and everyday discrimination against Roma and refugees; lack of identity and citizenship documentation, making them 'legally invisible', and thus having poor access to social services; inability to speak the majority language (Serbian) or the local Romani dialect, among others (Sardelić, 2015; Vidojević & Perišić, 2015).

During and in post-conflict periods an increase in violence was observed as social and legal protection measures weakened. Thus, this era was also marked by an uprising of nationalism and direct violence towards ethnic groups. Social distancing and hate crimes towards minority groups, particularly Roma, increased; where the latter activity commonly went unreported due

to fear of retaliation or when reported, it was effectively ignored by law enforcement authorities and judicial bodies (Basic, 2021; Cierco, 2017).

The political and social turmoil also saw that social and economic resources diminished due to economic sanctions and war expenses, inflation and savage privatisation that caused widening social disparities (Vidojević & Perišić, 2015). Kleut and Drašković (2020) also argue that the State's former strong commitment to the social cause was overwhelmed (Kleut & Drašković, 2020).

2.2.3 Contemporary times

After the year 2000, in the fall of Milosevic's power, Serbia had its first democratically-elected elections in over fifty years, which opened up the possibility for a pluralistic society and (re)-decentralisation of power; however, this was a 'messy and uneven process' (Perić, 2000, p.94). At this time, the slow transition into free market began, and this meant aligning the economic, social welfare and other systems to more market-oriented models (Kleut & Drašković, 2020). Supported by international institutions such as the International Monetary Fund (IMF), the World Bank (WB) and the European Union (EU), were neoliberal reforms and thus the implementation of new policies (Mooney, 2012). Many companies formerly 'socially' or 'state' owned became fully privatised, resulting in significant numbers of employees losing work. The large industrial complexes that did not sell were kept running through State subsidies but with minimal wages for workers. Practices of liberalisation and deregulation saw a further increase in wage flexibility, the suspension of minimum wage, and a decrease in those employed in the public sector (Kleut & Drašković, 2020). The cumulative effect of such a process was the creation of many virtually unprepared for this type of precarious economic

citizenship, pushing many into low-paid informal jobs or unemployment, including a large proportion of Roma.

2.2.4 Social inequalities in Serbia

According to recent Economic Reform Programmes (ERP) findings (2017 -2019 and 2018 - 2020), income inequality is high in Serbia, with the most affluent twenty percent of the population having close to ten times higher income than the poorest twenty percent (UNDP, 2018). Related, at least indirectly, to income inequalities are other social disparities such as education level, housing and living locations, access to healthcare, and employment opportunities (Parekh & Rose, 2011; Stephens, 2008). Such social inequalities, widely known as the socioeconomic determinants of health (SDH), are found across Serbian society and are more prevalent among some groups than others.

There are various arguments for why such social disparities exist. Veselinovic (2019) asserts that 'The specificity of Serbia lies in the fact that the population paid a high social price even before the serious transition to the transition process. The social consequences, everything that happened in the nineties of the twentieth century, are very similar to the social consequences of market transformation that have emerged in other former socialist countries. These consequences include impoverishment of the population, decline in employment, unemployment, lowering the level of public services, social exclusion, deterioration of population health, etc.' (Veselinović et al., 2019, p.303).

Meanwhile, Cvetičanin et al. (2021) propose that the current social disparities in Serbia can be understood by considering Serbia's sociohistorical context as a 'hybrid' society. Hybridity here results from carry-over aspects of socialist Yugoslavia and the last three decades of neoliberalisation or 'intensive neoliberal transformation' (Cvetičanin et al., 2021, p.947). The

authors underpin their analysis with a reconceptualisation of previous works of the late French sociologist Pierre Bourdieu. In particular, Bourdieu's notions of different forms of capital, including social, political, cultural and economic capital, which can be considered as resources, often interlinked, which are possessed in different global quantities (total volume of capital) and ratios among different types of capital between people and thus can determine people's social position in various societies. Cvetičanin et al. (2021) assert and offer evidence to suggest that two main mechanisms are deemed responsible for social inequalities in Serbia: exploitative market pathways (based on economic capital), new ways associated with the introduction of neoliberal practices; and various forms of social closure mechanisms (based on political and social capital), inherited from Serbia's socialist past. The first mechanism was facilitated mainly by the privatisation of the economy and the opportunities brought about by the consistent reduction of worker's rights and entitlements and the reduction of the enactment of these new limited sets of rights; which can significantly negatively affect their economic resources (capital). Indeed, such changes have seen a great number of people employed in precarious and part-time work, sometimes even unpaid work. As well as reduced access to entitlements, including healthcare-, social- and pension- insurance contributions, especially for those working in the 'informal' or 'grey' economy (Cvetičanin et al., 2021). It appears that these types of exploitative processes mainly affect industrial and service sector workers, as well as those employed in temporary and casual work across a variety of fields. However, as the authors succinctly put, in the Serbian context, '...for exploitative market mechanisms to begin operating, for any job—either high end or low end—one usually has to first pass through social closure filters.' (Cvetičanin et al., 2021, p.959).

Within a context such as Serbia, social closure mechanisms are based on different memberships or 'connections', both informal and formal; such as those in public institutions, as well as those

based on ethnicity, kinship/geographic origins/informal interest groups, political party affiliations and (formal) membership in professional associations. Social closure mechanisms work to monopolise ‘scarce resources for one’s own group, thereby excluding others from using them’ (Cvetičanin et al., 2021, p.950). Cvetičanin et al.'s (2021) case study in Serbia suggests that here ‘[s]ocial closure mechanisms have a wider application: they play a key gatekeeping role in all levels and in all fields. Through them, it is decided who gets a job and gets a promotion in Serbia, how one gets tenders for public contracts, state subsidies, and favourable business loans, down to who gets expensive medical services and scholarships’ (Cvetičanin et al., 2021, p.958). Thus, with such political and social capital, some people have more access to societal resources than others; and such a filter works across public institutions, including education and healthcare (Cvetičanin et al., 2021; Cvetičanin & Popescu, 2011).

There is strong evidence to suggest that peoples identified as 'Roma' are more likely to face hardships in these areas, due to lack of multiple forms of capital; social, political and economic, negatively affecting their health status and lowering their access to healthcare within the nation (Vidojević & Perišić, 2015). For example, although highly reliable data are not available, multiple academic sources suggest that there is a disproportionate number of Roma employed in the informal sector within Serbia, especially those living in segregated areas, and link this observation to lack of personal connections and discriminatory and marginalisation practices based on ethnic grouping (Lebedinski, 2020; Blazevski et al., 2018). Indeed, a recent study by Blazevski et al. (2018) indicates that the difference between Roma and non-Roma in informal employment is the highest in the Western Balkan region, at fifty-five percent. This data shows that seventy-one percent of Roma are employed in this sector compared to seventeen percent of non-Roma (Blazevski et al., 2018). The research suggests that alongside a lack of education and skills, discriminatory attitudes towards Roma limit their employment options, especially

for formal work, pushing many Roma into informal work instead (Blazevski et al., 2018). As mentioned above, academic literature finds that people employed in the informal market are often poorly paid (lower incomes), and lack legal work contracts and thus have more precarious but worse working conditions and do not have access to social entitlements (Cvetičanin et al., 2021; Lebedinski, 2020; Blazevski et al., 2018). Lebedinski (2020) states that 'the absence of social benefits such as health insurance, pension insurance, unemployment insurance makes it very difficult for this ethnic minority to escape the poverty trap.' (Lebedinski, 2020, p.131). This lack of security, alongside both short and long-term health hazards encountered in such jobs, can negatively affect Roma health outcomes (Blazevski et al., 2018). Before discussing health inequalities within Serbia, in regard to both the wider population and then Roma, it is important to outline some of the changes to the Serbian health system and restructuring of health services in general.

2.2.5 The health system and health inequalities in Serbia

The former Socialistic Republic of Yugoslavia healthcare system can be characterised as a universal health coverage (UHC) system, based on the Bismarck mode, which included free access for citizens in treatment, medicine and prosthetic interventions financed by a social insurance system. This social insurance scheme entailed employed persons to make compulsory contributions in order for themselves and their families to be covered, while those unemployed were insured through the state budget (Arsenijevic et al., 2014). Socialist Yugoslavia thus had a form of free health care which according to some scholars functioned relatively equitably in regard to accessibility and quality.

Since the collapse of Socialist Yugoslavia, Serbia has somewhat upheld the infrastructure and traditions of this former socialist period. The state provides a comprehensive and UHC system

based on compulsory health insurance network that by law should be able to be accessed by both the employed and unemployed, internally displaced persons and asylum seekers, along with vulnerable groups (such as Roma) without payment (Bjegovic-Mikanovic et al., 2020). At the same time, it's slow transition into a market economy has meant the reshaping of the health system to align with market-oriented models of health provision (Jakovljevic et al., 2016). Indeed, severe cost-effective, or simply cost-cutting, policy interventions introduced new limits to public health services coverage and resources to be used in the public sector (Jakovljevic et al., 2016). Although the official rhetoric was that these measures were not meant to decrease quality of care or maintenance, a recent study reported that health practitioners in Serbia tend to view the public health sector as having indeed decreased in quality since the restrictive policies were implemented (Jakovljevic et al., 2016).

The first post-war health system reforms in Serbia began in 2002 and can be divided into having two main objectives: to renew the medical equipment, infrastructure and staff upskilling; and financial mechanism changes (Arsenijevic et al., 2014). While the Ministry of Health (MOH) focused on the first set of goals, the Institute for Health Insurance in Serbia (IHIS) attended to the financial restructuring, among these was the reforms of official fees. Although the current-day Serbian healthcare system is still largely financed by employee contributions to the National Health Insurance Fund (NHIF), the 2002 health reforms brought changes to the health insurance funding system too with the introduction of patient fees for inpatient and outpatient health services (Arsenijevic et al., 2014). This additional source of financing from out-of-pocket payments sees that co-payments for GP and specialist visits, diagnostic testing procedures and drugs are now compulsory for all patients, except for some exempted groups. Indeed, The Health Insurance law provides an exemption mechanism whereby public health care services are accessed by both the employed and unemployed, internally displaced persons and asylum seekers, along with other vulnerable groups (such as

Roma) without payment (Bjegovic-Mikanovic et al., 2020). In other words, such groups should not at all be charged for the use of health services in Serbia. However, numerous studies (Arsenijevic et al., 2014; Bjegovic-Mikanovic et al., 2020) suggest that such exempted groups still pay for health care, and thus the equity promotion mechanism may be ineffective in enabling equal access to healthcare in Serbia. Indeed, there are still inequities between certain groups (such as the socially and economically disadvantaged and those more advantaged and Roma compared to non-Roma) in accessing primary care and in health outcomes (Arsenijevic et al., 2014; Bjegovic-Mijanovic et al., 2019; Janković et al., 2010).

Due to various reasons mentioned above, including the break-up of the socialist Yugoslav republic, civil war and associated social and economic sanctions, hyperinflation, political changes of 2000, the most recent financial crisis, and multi-sector reforms, the last few decades have seen significant changes to the health system in terms of scoping, financing, organisation and management of health services (Jankovic et al., 2010). On a broader level, the changes that have been brought on from the transition period onwards have benefited some whilst negatively impacting others; and this has reflected in the health and wider social inequalities observed in society today.

Research on the relationship between population factors such as socioeconomic status and morbidity and mortality rates conducted in Serbia is relatively scarce as compared to other European countries. Indeed, there continues to be a deficit in disaggregated administrative data which would help identify health inequalities linked to factors such as ethnic group, disability, gender or geographical location (Bjegovic-Mikanovic et al., 2019). Nevertheless, there is growing academic literature researching such issues, mostly using self-reported health as health status indicators, a commonly used method endorsed by WHO (Radevic et al., 2016). Several of such studies (Jankovic et al., 2011; Jankovic et al., 2012; Jankovic & Simić, 2012; Simović

et al., 2018; Vukovic et al., 2008) indicate that socioeconomic status (mainly measured by income level, occupational status and educational attainment) is the best predictor of health inequalities in Serbia. For example, Simović et al. (2018) study observed a direct relationship between SES, as measured by employment status, educational level and income, and self-perceived health; where those with lower SES were more likely to report poor health, in particular, those with lower educational and employment status. Adding to this, Radevic et al. (2016) found that older people, females, people with lower educational attainment, unemployed persons and those with SES (categorised as lower or middle class versus rich class), were more likely to report their health as poor. Meanwhile, research by Janević et al. (2012) showed that Roma were more than twice as likely to report ill health.

The current health system of the Republic of Serbia can be described as a health system in transition. The transition here mainly refers to the internationally sponsored health sector reforms that started in the new millennium, related to the other public sector reforms, and the large-scale growth of the private sector (Bjegovic-Mikanovic et al., 2019; Morača & Stubbs, 2016). Despite the objectives of such reforms to deliver health in an equitable way, there are nevertheless growing health inequalities towards access to health and health outcomes seen in modern-day Serbia (Janević et al., 2012). Most of the health inequalities research in modern-day Serbia looks at the inequalities in health service utilisation or access, linking these to health disparities. Indeed, access to health services is of course a critical determinant in relation to health outcomes and thus will be discussed below, in the context of the Serbian health system. Veselinovic (2019) argues that factors such as cost-cutting to health services, the closure of health clinics (especially in low-population areas and outpatient facilities in rural areas), reductions in working hours and the number of health workers have all impeded access to healthcare. The main barriers to the health services observed will now be discussed.

2.2.6 Healthcare barriers in Serbia

Popovic et al. (2017) assert that '[r]egardless of the fact that the health care system in Serbia is based on the principles of accessibility (physical, geographical, economic and cultural) health care and the principle of equity, the differences are evident in health status, accessibility and use of health care services, the level of satisfaction with the services provided and out-of-pocket payments for the services received among vulnerable social groups and the majority population' (Popovic et al., 2017, p.4). Indeed, there appear to be several factors limiting access to health in Serbia, including financial, geographical, organisational, administrative and informational barriers; which I outlined below in relation to the Serbian context.

Financial barriers. Popovic et al. (2017) found that financial costs were the most frequent reasons for unmet health needs in Serbia. This finding was mirrored in a 2018 statistical analysis conducted by the European Union's statistical office 'EuroStat'. In this report by Eurostat (as cited in Bjegovic-Mikanovic et al., 2020), financial reasons (cost) were the main barrier restricting accessing medical services, accounting for 3.1% for unmet needs; people most likely to report this constraint were those who were poorer and with lower educational attainment. Again, this percentage was higher than surrounding countries and the EU average (1%) (Bjegovic-Mikanovic et al., 2020). Such financial constraints are proposed to contribute to health inequalities in Serbia, whereby those who can belong to higher SES groups are able to access healthcare and thus health more so than those in lower SES groups.

Meanwhile, despite internationally-funded reforms that aimed to modernise the health system, in particular the technology and equipment in Serbian healthcare institutions, public health institutions have limited resources and are lacking in quality of existing resources (such as a lack of hospital beds, diagnostic equipment, etc.) and long waiting lists as compared to

private; and thus pushing some to take up private health services funded primarily for OOP, as such health provision is not covered by the mandatory health insurance scheme mentioned above (Bjegovic-Mikanovic, 2020; Muzik & Karajičić, 2014). However, private doctors and dentists are visited less by those belonging to disadvantaged socioeconomic groups, a finding that is believed to be related to financial constraints (Jankovic et al., 2010).

Geographical barriers. Geographical or travel distance is another factor constraining access to health care within Serbia. Indeed, the same EuroStat (2018) data mentioned above found that travel distance was the second most common barrier that people in Serbia reported as being the reason for unmet health needs (Bjegovic-Mikanovic et al., 2020). Several recent studies (Bjegovic-Mikanovic et al., 2019; Simović et al., 2018) found that utilisation of health services differed according to geographical location, most notably by different settlements (urban versus rural). It appears that those living in deprived and rural areas, as opposed to affluent and urban zones, have less access to health resources and facilities (Simović et al., 2018). A number of recent studies (Bjegovic-Mikanovic et al., 2019; Grustam et al., 2020; WHO, 2010) report that the geographical distribution of health workers across the country is unequal, especially in relation to specialist care.

Organisational barriers. As mentioned, long-waiting lists are another factor impeding access to health care in Serbia. Indeed, the same Eurostat report (2018) mentioned above suggests that this may be a key barrier. One way to circumvent this health access constraint seems to be bribery, most commonly through informal payments. A study conducted by the United Nations Office of Drug and Crime (UNODC) (2011) found that one in five Serbian citizens take part in any type of bribery in order to speed up access to services. Indeed, several recent studies (UNODC, 2011; suggest that bribery (operationalised as ‘giving, receiving, or offering goods or services to influence the actions of an official’; most commonly in informal payments) are

common practices to accessing healthcare in Serbia; with a number of studies reporting that Serbian citizens perceive the healthcare sector to be the most corrupt sector in the country (International Federation for Human Rights, 2005; TNS Medium Gallup, 2011).

Administrative issues. Access to healthcare is even more restricted for those with internally-displaced or refugee (IDR) status. Even though the current laws state that such persons have equal access to health insurance as they are exempt from payment, due to the difficulty of registering a place of residence they are prevented from obtaining legal documents necessary to access free health care. Again, even though there are appropriate laws and policy that enable IDR persons to obtain such documents (registering residence in one's local centre for social work), these mechanisms are often not fully implemented and thus IDR persons are forced to either pay or not access health services; and due to their often-low socioeconomic positions, the latter most commonly occurs.

Informational barriers. There is also the issue of lack of awareness or information on health insurance coverage schemes among the poorer and vulnerable groups in Serbia. In other words, such persons are not privy to what they are entitled, legally, and thus make unnecessary payments (Arsenijevic et al., 2013).

In conclusion, there are many possible contributing factors responsible for the health inequalities observed in Serbia. Thus, even though the State offers free health care to its citizens, access to health services and health seems to be restricted nonetheless. This finding is likely to be reflected in the sometimes-severe health inequalities that exist in current-day Serbia; where some groups lack access to healthcare and have poorer health outcomes (morbidity and mortality rates) than others. However, no "group" fares worse than that labelled as Romani, and this trend continues regardless of the recent amendments to health insurance policies and Acts which grant Roma exemption from payment for healthcare

services as a recognised vulnerable and thus protected group (Arsenijevic et al., 2013). Before discussing Roma health inequalities and inequities in Serbia, it is necessary to provide some more socio historical context specific to the Roma people.

2.2.7 Roma in contemporary Serbia

According to the figures obtained by the 2011 Serbian census, there were 147, 604 people declared as belonging to the Roma national minority group in Serbia (Basic, 2021). However, highly accurate census data on Roma population figures is hard to come by as many Roma do not want to disclose themselves as Roma in fear of discrimination. Research findings from a study conducted by Basic and Jakšić (2005) observed that there were 247,591 Roma living in Serbia, with 46, 238 of these people being internally displaced persons (IDPs) from Kosovo. The study saw 593 Roma settlements dispersed around the country around towns and cities, with many Roma settlements around the capital city Belgrade. Such settlements had one hundred or more peoples or fifteen families residing in them (Basic & Jakšić, 2005). Meanwhile, the Council of Europe (COE) estimates there are approximately 400,000 to 800,000 Romani people in Serbia, making Roma the one of the largest minority groups in the country (Majumdar & Woodhouse, 2019).

Lebedinski (2020) asserts that most Roma in Serbia are sedentary, as opposed to nomadic, and therefore their settlements are permanent. Although the Roma people residing in modern-day Serbia can be thought of as very diverse in terms of religion, first language, legal and social status, Roma as a "group" are officially recognised as vulnerable and socially excluded in Serbia; with those seeking asylum or internally displaced being the most disadvantaged (Janević et al., 2011; Kleut & Drašković, 2020; Vidojević & Perišić, 2015).

Many academics and historical experts agree that Roma socioeconomic inequalities have never been more significant until now, as following civil wars, transition into the free market and other social changes, such as the 2008 economic recession, marginalisation and poverty among Roma worsened (Sardelić, 2016; Vidojević & Perišić, 2015). While the transition from socialism to privatisation saw Roma in Serbia go from working in state-owned institutions to precarious and occasional work; the aftermath of the global economic crisis of 2008 saw that neoliberal reforms, particularly austerity measures, produced growing social inequities; affecting some groups more than others (Bingulac, 2017; Mikuš, 2018; Pešić & Petrović, 2020). Roma are often cited as the 'biggest losers' of neoliberalism because many were and still are suitably unskilled for the current labour markets (Pešić & Petrović, 2020; Vidojević & Perišić, 2015). In other words, Roma are often lacking the qualifications and skills and training necessary to be flexible and effectively 'survive' in such a precarious market-driven environment. Neoliberalisation of the Republic is a hotly debated topic, with many critics pointing to adverse effects on the whole society; it is widely considered that Roma, as the most socioeconomically disadvantaged segment of society, will continue to suffer from the breakdown of a welfare state (Pešić & Petrović, 2020). It is perhaps unsurprising then that key minority rights and critical policy scholars argue that it is primarily the country's ongoing transition from self-governing socialism to neoliberal capitalism that has increased the barriers for vulnerable groups' access to resources, including health (Escobar-Ballesta et al., 2018b; Mikuš, 2016; Pešić & Petrović, 2020; Sigona & Trehan, 2009; Vidojević & Perišić, 2015).

2.2.8 Roma health inequalities in Serbia

Serbian Roma health disparities relative to non-Roma have been noted in previous health studies with the use of various health status indicators, including mainstream (quantitative) health measures (see Statistical Office of the Republic of Serbia and UNICEF, 2019); self-reported health status studies (see Čvorović, 2019; Janević et al., 2011); and ethnographic and other qualitative studies which look at daily health practices of local Roma communities (see UNICEF Serbia, 2017). A recent study by Bjegovic-Mikanovic et al. (2020) found that within Serbia people identified as Roma were more than twice as likely to rate their health as poor as compared to non-Roma. Indeed, there is compelling evidence that Roma face higher mortality rates and morbidity rates. In 2018, infant and under-five mortality rates in Roma settlements were twice as high than the national average (Bjegovic-Mikanovic et al., 2020; Bogdanović & Jovanović, 2007; Janević et al., 2011). Roma people have a life expectancy of at least ten years below the national average (Bogdanović and Jovanović, 2007; Janević et al., 2011).

There are many proposed causes for such health disparities, among them seems to be the links to other social disparities, namely socioeconomic ones (income) and living conditions. Indeed, Roma are eight times more likely to live in absolute poverty (nearly 60% of Roma live under the World Bank's absolute poverty line) and many live in substandard settlements (65% without access to safe drinking water; 77% without sewage systems; and 26% without access to electricity (Bingulac, 2017; Izerda et al., 2011). There are many other existing barriers to accessing health care that Roma disproportionately faces, including regional differences in availability and quality of services, meaning that those living in the periphery must pay transport costs to access appropriate health service (Bjegovic-Mijanovic et al., 2019). Because Roma who live in isolated settlements are often amongst the poorest of Roma, these costs may

prove to be yet another factor impeding health access. Discrimination and racism in society at large and discriminatory practices within the healthcare system are other barriers that limit access to adequate health services for some in modern-day Serbia. Discrimination can negatively affect Roma health in multiple ways; from the most visible, like access to health services, to indirect psychosocial pathways such as, stress-illness mechanisms (Bingulac, 2017; Janević et al., 2011).

It appears that Roma women may be particularly discriminated against and marginalised (Basic, 2021; Janević et al., 2011). In other words, gender and racial discrimination are intersecting issues that can affect access to healthcare and health status (Perić, 2005). Additionally, other factors that directly or indirectly contribute to Roma's unequal access to healthcare and health include lower educational attainment, poor access to healthcare (rural, isolated/marginalised villages without running water and electricity, let alone public transportation systems nearby), lesser employment opportunities (also related to discrimination and racist attitudes/behaviours from non-Roma employers or society at large), among others (Bjegovic-Mikanovic et al., 2019; Idzerda et al., 2011).

As discussed above, there are administrative barriers to accessing healthcare in Serbia, and these are intensified for Roma as many are without the legal documentation and thus the health documentation necessary to access free healthcare. There are many Roma who are IDR, particularly those from Kosovo; who struggle to access even the most basic of healthcare due to not having birth certificates and other forms of ID. What is more is that under two health laws, those who identify as Roma in Nationality are exempt from even needing a health insurance card to instead be able to receive health care regardless of this documentation. However, in practice, such provision is not applied and thus presents another case where laws

or policies exist but are not implemented consistently, where Roma people are obstructed from their rights to healthcare.

On the individual lifestyle and cultural level, there appears to be risk factors linked to traditional practices, such as early marriage and traditional methods of contraception; practices which increase the likelihood for sexually transmitted diseases and maternal mortality as well as being linked to higher child malnutrition and mortality rates (Hotchkiss et al., 2016; WHO, 2015).

In summary, there is extensive evidence suggesting that a great number of Roma face multiple obstacles towards accessing health services and health and that these impede on their health (Bjegovic-Mikanovic et al., 2019). There are structural access barriers such as the costs of medical services and registration issues, especially for IDP Roma, as described above. However, there are many other determinants at multiple levels (micro, meso, macro) that may affect the health of Roma residing in today's republic. Outcome of such findings is the general consensus that there are multiple pathways to improve Roma health in Serbia and thus a range of policies designed to do so. Health policy research can shed light onto the ways in which such policy can enable or limit health equity for Roma.

2.3 Health policy research

Health policy research can be described in several ways. In general, it is a study seeking to understand how societies are structured to achieve their health objectives, providing data and recommendations which can contribute to better health (Sutter Health, 2021). While Walt et al. (2008) describe health policy analysis as '...a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process.'

(Walt et al., 2008, p.138). This field draws upon the research of many disciplines, including anthropology, sociology, economics, critical policy studies, public health among others.

What is most pertinent to this thesis however is that health policy has the potential to address many different factors that contribute to health inequalities as well as health inequities. Indeed, policy shapes and is shaped by broader social practices. Critical health policy research enables consideration and insight into what health policies open up and/or limit in terms of health and social justice; which can potentially influence current and future policy development and practice.

Past studies have proposed that ideologies of the self-regulating, self-responsible health citizen mirror what is considered to be the constructs of the ideal 'health citizen' according to the neoliberalism health citizenship framework, mentioned above, and such discourses are often promoted through policy among other texts. Coupled with the effects of neoliberal discourses of health on attitudes and perspectives in society, is the very real issue of health experiences and outcomes. Critical health research can work as a commentary to challenge such views. It is also a form of advocacy on behalf of those people who are targeted by such strategic documents; by considering power dynamics and who participates and who is left out of the policy processes. By considering alternative perspectives and ways of framing health issues and solutions, a more inclusive and considered discussion may develop; instead of imposing dominant frameworks which may not have the power to challenge the status-quo, thereby reducing the chance for real social change.

2.3.1 *Policy documents relevant for Roma health in Serbia*

The Republic of Serbia has many laws and policy documents relevant to Roma health in Serbia. Several national policies set out to ensure equal access to healthcare and thus health, including the Strategy for Public Health (2009) which recognises that the most common diseases are directly linked to socioeconomic determinants (Government of the Republic of Serbia, 2016). Meanwhile, the Constitution of The Republic of Serbia (2006) stipulates that "[e]veryone shall have the right to protection of their mental and physical health.' while the Law on Health Care (2019) guarantees '[s]ocial care for health, under equal conditions, shall be exercised in the territory of the Republic by providing healthcare to the groups of population that are exposed to increased risk of contracting diseases, health care of persons related to prevention, control, early detection, and treatment of diseases of major social and medical importance, as well as by health care of the socially vulnerable population.' (Constitution of the Republic of Serbia, 2006; Law on Health Care, 2019, p.4). This Law on Health Care (2019) and the Law on Health Insurance already discussed above both exempt Roma and those in the poorest brackets of society from making compulsory payments for public health services within Serbia (Bjegovic-Mijanovic et al., 2019).

The country has also ratified several international and regional human rights treaties guaranteeing equal rights to health and other health-related rights to all people (Petrović & Pokuševski, 2015; Bjegovic-Mikanovic et al., 2019). Instruments include the 'Universal Declaration of Human Rights' (UDHR), the International Covenant on Economic, Social and Cultural Rights with Protocols thereto and the Revised European Social Charter in 2009 (Petrović & Pokuševski, 2015). In the context of joining the European Union (EU), Serbia has harmonised many laws in accordance with those of the EU; among such legal frameworks are

specific human and minority rights and protection laws, which stipulate providing healthcare access to minorities without discrimination (Cierco, 2017)

Despite such initiatives, there are still inequities between certain groups, including Roma compared to non-Roma, in accessing health care, including primary care, and in health outcomes (Bjegovic-Mijanovic et al., 2019; Janković et al., 2010). Perhaps the most concerted effort is the current 'Strategy of Social Inclusion of Roma for the period of 2016 - 2025', addressing several social determinants of health. This initiative will be discussed below.

2.3.2 *Serbia in the Central-Eastern European context*

Like Serbia, many other countries in Central-Eastern Europe (CEE) which transitioned from Communism/Socialism to the market economy saw a rise in Roma's poverty and unemployment levels, as well as an increase in nationalism, racism and discrimination against them both in public media and general society; all factors which have negatively affected Roma's health (Janević al., 2011; Vermeersch & van Baar, 2017). Condemned internationally for Roma's treatment and disadvantaged situation, CEE governments adopted national programmes aligned to what the European Commission (EC) regards as Roma's 'social inclusion' (Rostas, 2020). Within this context, Roma are seen in need of socioeconomic integration, protection from discrimination and equal access to certain rights (European Commission, 2020). Perhaps the most significant effort so far has been put forward by what is collectively known as the 'Decade of Roma Inclusion' (DRI) (Brüggemann & Friedman, 2017).

Along with various Roma organisations, both international and national, the founding international partner organisations of the DRI initiative included the World Bank, the Open Society Institute (OSI), the United Nations Development Programme (UNDP), the Council of

Europe, and the Organisation for Security and Cooperation in Europe (OSCE). The Decade was also heavily supported by the European Commission, which is a member of the International Steering Committee (ISC), a committee made up of the DRI's "highest decision-making and coordinating body" (Kirova, 2013). After research conducted by the UNDP (2002) found that human rights as inextricably linked to "development opportunities", the ISC identified the four priority areas to focus on: health, housing, education, and employment, along with the intersecting issues of discrimination, poverty and gender (Kirova, 2013).

In the context of European Union (EU) enlargement, where minority protection and recognition were criteria for joining as a current European Union Accession candidate country, Serbia responded to the EU recommendation to address discrimination and other social disparities Roma face in society, including health disparities (Rostas, 2020). On the 2 February 2005 in Sofia, Bulgaria, the prime minister of Serbia, along with other European prime ministers, signed the DRI Declaration, with its four priority areas, signifying a commitment to combat discrimination towards Roma and to close the socioeconomic gaps between Roma and the rest of the general population in their respective societies (Kirova, 2013). The countries involved showed their varying levels of commitment to the strategy by developing or amending multi-sectoral policies and implementing them and the DRI ran from 2005 to 2015, intending to eradicate discrimination and inequities but unfortunately with generally limited success (Bogdanović et al., 2007; Janević et al., 2011; Majumdar & Woodhouse, 2019).

Serbia's DRI strategy was developed to be implemented over nine years, 2005 to 2015. According to the study prepared by a coalition of Serbian civil society organisations (namely Roma and minority rights organisations) both the strategy and its implementation was done in a piecemeal fashion, where sectors worked independently instead of collaboratively and thus without the practical appreciation of the intersectionality of all social sectors/determinants

(priority areas) (Vidojević & Perišić, 2015). Along with several other oversights, the limitations mentioned proved the success of such implementation to be limited (Vidojević & Perišić, 2015).

However, there exists a general consensus among such institutions that there is one area of success of the Strategy, and that is the work of the Roma Health Mediators (RHM). RHM are Roma women from local communities who are employed on short term contracts to work with Roma communities on health concerns (Bingulac, 2017). As gatekeepers between Roma communities and the health system, RHM have enabled better trust and communication between these two parties. Their activities have also seen many Roma gain improved access to identity documents required to access the public health services in Serbia and education as well as education and training on personal hygiene, substance abuse and other health-related issues (Bingulac, 2017).

Based on the problems and successes of the previous document, a new national Roma integration strategy (NRIS), *'The Strategy of Social Inclusion of Roma for the Period of 2016 – 2025*', was developed, representing a continued commitment by the Serbian government to promote Roma social inclusion. This new document proposes a more integrated, multi-sectoral approach at the local and national government levels. Along with four key priority areas (education, employment, health, housing), this NRIS also has one additional strategic area, social security, which looks to improve social security services and financial aid access. In March 2016, the Republic of Serbia's government signed this second, amended version, representing its adoption of another nine years. The document was developed based on several national, international legal and strategic frameworks; among them: United Nations Human Rights; The Council of Europe's (CoE) document, The *Convention on Protection of Human*

Rights and Fundamental Freedoms (1951), as well as the *EU Framework for National Roma Integration Strategies up to 2020* (Government of the Republic of Serbia, 2016).

Along with autonomous provinces and local self-governments, the national government allocated funding from their budgets towards implementing the strategy activities in cooperation with international financial experts. Much of the funding comes from international financial organisations, such as The World Bank, The International Monetary Fund (IMF), and The European Commission (EC). The IMF has imposed structural adjustment plans (SAPs) in Serbia, where fiscal and austerity measures impact the most vulnerable in the country, among them Roma, and thus its involvement may seem paradoxical to some critical researchers (Mooney, 2012).

As mentioned above, Serbia's NRIS is heavily influenced by the EU's framework for National Roma Integration Strategies. The framework itself sets out the agenda, such as for different NRISs to be aligned with EU objectives (for integrating Roma), the General Basic Principles of Roma inclusion, and most importantly, the "Europe 2020" Strategy and the country's national development and reform programmes. The latter two are considered to be 'severe' in terms of reductions in public spending and thus having potential adverse effects on the most socioeconomically disadvantaged people residing in Serbia, where social safety nets, financial and otherwise, are proposed to protect Roma from such fiscal policies (Government of the Republic of Serbia, 2016). Several analyses on other countries' NRIS documents have found a very limited framing of 'socioeconomic inclusion' for Roma and have related this to these associated documents and social practices (Goodwin & Buijs, 2013; Popova, 2019).

2.3.3 Critiques of Roma social inclusion discourse

With the nearing of the second decade of national-level Roma strategies, or NRIS, closing in, there is indeed a growing research base investigating such documents and their impact. A large portion of these studies have taken a discourse analytical approach, assuming that discourses in such documents interact with and influence broader social practices (Olesen & Karlsson, 2018). Many observe relatively stable patterns of discourse and thus social practice across the strategies (Sigona & Trehan, 2009; van Baar & Kóczé, 2020).

The health policy literature to date has provided some, often contentious, debates regarding the appropriate ways of framing the issues and the remedial mechanisms towards improving the social and health conditions for Roma. The standpoint of such research is that the way in which these documents discursively frame the problem and solution of the Roma situation can have significant consequences for what happens in practice for Roma social and health inclusion. Among key debates in such research is the question of whether Roma social inclusion policies need to focus on rights related to redistribution (predominantly socioeconomic) or rights of recognition; with some academics asserting that the best approach would be a balance of the two (Mikuš, 2018; Sigona, 2009; Vermeersch & van Baar, 2017). While an approach prioritising the first set of rights is less common, a focus on recognition, with its emphasis on civil and political rights is a trend that permeates many NRIS (Sigona & Trehan, 2009). What such a rights-based framework asserts are that Roma need more political representation (recognition) as an ethnic and minority group and one that is European and thus 'non-alien' to the continent (van Baar, 2012, p.287). Such identity politics lend themselves to anti-discrimination policies and affirmative-action strategies based on ethnic minority identity and are proposed to enable better access to human rights (such as health) and combat Roma social exclusion. Paradoxically, however, critics of such an approach deem it as potentially

contributing and maintaining the 'othering' of Roma from mainstream society due to the discursive statements positioning Roma as a distinct group from non-Roma; therefore, highlighting their difference or otherness (Vermeersch & van Baar, 2017).

Because such a human rights framework often side-lines socioeconomic rights, a number of scholars argue that this framing is problematic as it ignores the urgent structural and material needs requiring a redistribution of socioeconomic resources; limiting possible actions towards socio economic justice (Trehan, 2009). A great deal of social research (Kováts, 2016; Sigona & Trehan, 2009, among others) has found such a discursive trend towards civil rights in the national policies of post-socialist, Central-Eastern European (CEE) countries; and is worth noting that this region is not only one where significant Roma minority populations reside, but where there have been relatively recent transitions into free-market economies and accompanying Neoliberal welfare reforms (Sigona & Trehan, 2009; Trehan & Kóczé, 2009). Critical researchers argue that such a neoliberal version of human rights discourse with its primacy on political and civil rights is indicative, at least discursively, of these transitions (Sigona & Trehan, 2009). Sigona and Trehan (2009) mark this discourse as being typical in such transitional contexts as it poses little threat to the new neoliberal order, which is likely to increase inequalities rather than equalities, compared to say social welfare discourses that support egalitarian redistributions of resources, framed as social goods. Meanwhile, political theorist Huub van Baar (2015) asserts that a structural analysis of EU Roma initiatives is necessary, suggesting that Roma's social position in this contemporary space is 'structurally and inherently related to the European institutional, political, governmental and socioeconomic architectures and infrastructures and that they affect Roma, as well as several other groups in Europe and at its fringes.' (van Baar, 2015, p.7).

There are other reasons why scholars argue neoliberal discourses may not be efficacious in reducing Roma social inequities (van Baar, 2012). This includes the observation that such a dominant discourse has seen principles of collective responsibility and solidarity replaced by ones of individual and community responsibility; thus, radically decreasing the ability for combatting the poverty and social inequalities Roma face (Roy, 2017; Stephens, 2008; van Baar, 2012).

The discourses of 'active participation', 'empowerment' and 'responsibilisation' of Roma are prolific in many NRIS (van Baar, 2012). They are seen as traces of neoliberal political logic, which centre around the idea that citizens should be active, autonomous, and self-managing, and thus 'deserving', to access human rights and social inclusion. By shifting responsibility, and ignoring effects of power imbalances of health, structural determinants of health are obfuscated from sight. This frame also makes it easier to "blame the victim", a phenomenon where people's ill health status and poorer access to health is blamed on them. Indeed, researchers analysing various European NRIS have noted such a limited capacity for change and social justice because of the same underlying neoliberal perspectives that blame Roma for their poor health, thus potentially increasing, or at least maintaining the stigma towards the Roma group (Kóczé, 2018).

Even when socioeconomic rights are discussed in Roma inclusion policies, it is commonly considered achievable only by specific mechanisms, namely, through inclusion in the increasingly precarious neoliberal labour markets (Morača & Stubbs, 2020). Through the assumption that the 'good citizen' is one that is 'activated' mainly in terms of formal labour market participation, many NRIS assert that Roma needs to 'improve' their social capital by upskilling, training, education and thus are positioned as currently lacking (Rostas, 2019; van Baar, 2012; Vermeersch & van Baar, 2017). Indeed, a trend of 'civilising or 'disciplining' Roma

to mirror neoliberal citizenship through the discourse involved in social inclusion 'development' programmes have been findings across European countries, and such social practice frames inclusion (for example, accessing health) as a benefit that must be earned by enacting the obligations of the 'good citizen' (Kühlbrandt, 2019). Ryder and Taba (2017) assert that '[a]t times, at the EU and national level, narrow notions of development have been evident for Roma communities which constitute a form of control, which normalises neoliberal and assimilative policy agendas, and 'responsibilisation', which individualises and pathologises the victims rather than the structural agents of exclusion' (Ryder & Taba, 2017, p.5). Ryder and Taba (2017) propose that more economic intervention and redistribution may be more effective in combating Roma poverty.

Activating Roma, via education and employment, as ways out of poverty and social exclusion implies that Roma must be included through a specific channel also seem to work with discourses that position Roma as either an at-risk or risk group to be measured against a norm group (non-Roma). Thus, by centring on a deficit-thinking basis instead of 'asset-based development', discourses of Roma diversity and alternative systems are obscured from view (Fairclough, 2006; Marjanović, 2012; Trehan, 2009; Vermeersch & van Baar, 2017, p.126). Some academics assert that this thinking effectively promotes discrimination against- rather than social inclusion of- Roma by effectively stating the Roma not only need to earn their rights through fulfilling the obligation of being a good citizen, versus having unconditional human rights, but are lacking in desirable traits. Thus, these discourses can work to "justify" the (current) discrimination that the Roma face due to a lack of this 'active' citizenship.

Some researchers urge the move beyond the recognition-redistribution binary dilemma to look at how policy frameworks encapsulate the notion of diversity and 'authentic' participation that acknowledges, or simply makes room for, the different views of health and

Roma needs that come directly from Roma peoples themselves (Vermeersch & van Baar, 2017). This recommendation is made with the observation that although Roma participation in their local social inclusion activities is stressed throughout many NRIS documents, there is critique as to how and which Roma contribute to the designing activity of such strategic measure (Sigona, 2009; Sigona & Trehan, 2009; Vermeersch & van Baar, 2017; Vidojević & Perišić, 2015). In particular, the question of whose interests and needs are mirrored in these documents remains a central as the Roma who do contribute to the development of the strategies have usually been 'technocrats' or elites whose agenda may or may not be adequate representations of the diversity the Roma communities' needs (Trehan, 2009; Vermeersch & van Baar, 2017). In other words, Roma "representatives" contributing to these documents, may be a very specific group of Roma community representation, with the outcome of silencing other voices and perspectives that may be more in line with broader Roma views; as such, 'authentic Roma community' representation is questioned by many scholars and practitioners alike (Sigona & Trehan, 2009; Vermeersch & van Baar, 2017). This is perhaps best illustrated by the finding that many strategies supposed to *cater to Roma needs* are not written in a language they can read (Olesen & Karlsson, 2018; Sigona & Trehan, 2009).

The failure to genuinely incorporate Roma participation is particularly evident in health perspective matters: when looking at whose way of doing health, and life, is privileged in most cases, it does not appear to be Roma (Miranda et al., 2019; Orton et al., 2019). Indeed, Orton et al. (2019) argue that across European Roma health policy there appears to be a "generic representation of Roma health" that is not representative of the heterogeneity of Roma communities and experiences and that this may limit the possibility of improving health for Roma (Orton et al., 2019, p.2). Such a focus thus is intersecting with other structural issues that influence Roma's health, such as political and general power in society. At the same time, however, Roma are expected to participate as partners in enacting the strategy, to achieve the

goals and priorities set out by adhering to the mechanisms for achieving them. Orton et al. (2019) recommend working in collaboration with Roma communities to ascertain their perception of problems in health, i.e. their health experiences, and not further to marginalise Roma.

2.4 Research aims

As the above section has shown, studying policy is important because it carefully considers what discursive constructions are used and what these open up and limit in terms of social justice practice. Research on Roma inclusion policy has shown limited potential thus far for such instruments to produce real social change, as it supports and therefore sustains the existing power relations in society, effectively blaming Roma for their health inequities and putting the onus on accessing health on those with the least power. The above discussion has shown that research at present suggests that EU Roma policies in CEE in particular evoke certain discourses, which work to effectively blame and problematise and thus further stigmatise Roma, minimising the role of the state (Sigona & Trehan, 2005; Slepickova & Bobakova, 2020). While at the same time, structural barriers that can impact Roma social inclusion are obfuscated from sight. Critical researchers explain this trend as reflective of the transition process into a neoliberal market structuring of society. However, the gaps in research conducted in the Serbian Roma policy space remain, particularly in the area of health justice for Roma.

Roma health policy analysis can provide findings that may be able to ascertain why the NRIS has currently had some but yet limited efficacy for Roma health; and also extend the current research on policy discourse which often focuses solely on policy without considering actor constructions. Such study is also important to undertake because the Serbian context is

unique in terms of its history and current EU succession plan; there is a significant Roma population within the space, officially defined as vulnerable in health matters; and as each European country has designed NRIS differently and so these texts need to be studied separately and specifically. This thesis thus furthers research by focusing on critical discourse analysis of the NRIS and the understandings and discourses used by the people who develop and implement this policy, which may offer further understanding of the different ways that stakeholders can construct Roma health. To achieve this aim, an in-depth analysis was conducted on the Serbian NRIS, including both the document and also an analysis of the accounts of key stakeholders related to the production and implementation of the Strategy. The research questions were as follows:

1. How is health constructed in this policy document?
2. How are Roma people and their health positioned within these discourses of health?
3. Are these discourses also evident in key stakeholders' accounts of this policy?
4. What are the implications of these discourses for Roma people's access to healthcare and health?
5. What can be learnt from bringing the analysis of the stakeholders' accounts into dialogue with the policy analysis?

Chapter 3 – Method

3.1 Research design overview

A critical discourse analysis (CDA) was performed on two sets of data, one official policy document, 'The Strategy of Social Inclusion of Roma for the period from 2016 to 2025', and five stakeholder interviews, and then brought these together to consider implications for Roma health. The CDA design was informed by Fairclough (2001; 2015), and the application of his CDA to documents in Danish healthcare documents by Jørgensen and Praestegaard (2018), and had a focus on three dimensions of text - (1) the textual level, describing textual features, (2) the discursive practice level, interpreting discourse; and (3) the social practice level, explaining the sociohistorical context of the discourse and its relation to the text and interaction. (described in more detail below).

3.2 Participants

The Strategy document, 'Strategy for social Inclusion of Roma 2015-2025' (referred to as 'the Strategy'), is an official strategy document based in Serbia, which was endorsed by the Serbian Government in the year 2015 (see http://socijalnoukljucivanje.gov.rs/en/roma-inclusion-strategy-adopted/).

Five stakeholders involved with the Strategy or Roma issues were interviewed. These participants were three female and two male professionals based in Serbia and working in the field of Roma inclusion in various ways. The participants included an international staff member involved in Roma inclusion, an NGO professional, a policy expert, an academic who specialises in Roma matters, and a professional working for the government on Roma

inclusion. Due to ethical reasons related to anonymity, more specific details as to the professionals' occupations cannot be given.

3.3 Methodological theory

I chose to use Fairclough's CDA as a model for analysing the Strategy and interview text, as this method has been developed specifically for policy analysis among other types of text, while being flexible to analyse virtually any text. Moreover, this version of CDA has been successfully applied to such contexts as healthcare and minority policies, including those of European countries undergoing social transition (Fairclough, 2005; Jørgensen & Præstegaard, 2018; Olesen & Karlsson, 2018).

Fairclough's CDA is a trans-disciplinary research method that combines social theories with a critical investigation into texts. This version of CDA has a basis in Fairclough's Critical language theory (CLS) and is used to explore the links between language, power and ideology. Namely, it identifies and critiques discourse and explains how it relates and contributes to the other social elements of the existing social reality, such as power relations, ideologies, and political strategies. The method is very useful in revealing both dominant and alternative discourses, and to consider the social reasons and broader implications of such discursive constructions (Fairclough, 2015). Fairclough's theory posits that discourses are particular ways of representing the social world and the people in it that enable and limit certain understandings of social issues. and that some discourses are more dominant and 'naturalised' in society; and thus, discourses are linked to social purposes and power. Indeed, within this framework, discourse is more than just language, it is language as a social practice which is determined and constrained by the structures and powers of social institutions (Fairclough, 2015).

In Fairclough's work, discourse applies in three different ways. Firstly, as a social practice that is internally and dialectically related to other social elements: it is both constituted by and constitutive of social structures. Indeed, discourse is a form of power that contributes to constructing social identities, social relations (including power relations), and knowledge and meaning systems. At the same time, discourse is determined by or reflective of other social practices and social structures (Fairclough, 2015; Jørgensen & Phillips, 2018; Jørgensen & Phillips, 2020). Discourse is also a type of language used within a particular social domain, for example, scientific discourse or political discourse. And lastly, the most concrete sense, as a count noun (discourse, the discourses) which refers to a way of speaking which gives meaning to experiences from a particular perspective' (Jørgensen & Phillips, 2020, p. 7). The last concept is thus referring to specific discourses, such as Neoliberal discourse or Marxist discourse; those discourses can differentiate from one another. Pertinent to this study is Fairclough's general view that discourses are particular ways of representing and making sense of the social world and the people in it (i.e., the third definition above); and as social practices they are related to other social elements (first definition). As such, different discourses enable and limit certain understandings of social issues; because discourses help to make up social identities (an identity function), social relations (a relational function), and knowledge and meaning systems (ideational function) (Fairclough, 2015; Jorgensen & Præstegaard, 2018). They thus have social implications and are important to study in the context of Roma health equity.

The specific research method this respective study uses mainly draws on the work of Fairclough's *Language and Power*, which the critical linguist calls 'a radical view of CDA' (Fairclough, 2015, p.3); although a range of has work was drawn upon to develop the method for this study (including his books 'Critical Discourse Analysis: the critical study of language',

2010, ‘Analysing discourse’, 2003, and his collaborative work with Lilie Chouliaraki in ‘Discourse in Late Modernity’, 1999). Fairclough (2015) sees his work in this main body as radical insofar that the focus is not only on the power in discourse but the power *behind* discourse; the latter looks at how powerful agents shape orders of discourse (discourse types and the way they are structured) as well as orders of society more broadly (Fairclough, 2015). Part of investigating the power behind discourse is to reveal implicit ideologies and their workings within discursive conventions. Fairclough sees ideology as a way to make meaning of the world's aspects that contribute to producing, maintaining or transforming power and dominance relations (Dahl, 2017; Fairclough, 2015; Jørgensen & Phillips, 2020). Within his argument, ideology is the key vehicle for manufacturing consent, which in contemporary societies is the increasingly practised vehicle for social control as an alternative to rule by coercion. In other words, ideology is the primary mode to 'exercise of power', (Fairclough, 2001, p.2). Meanwhile, he views discourse as the preferred vehicle for delivering or sustaining ideology, and thus, discourse is a crucial player in obtaining social control or enabling change. In other words, discourses are linked to social purposes and power. His theory posits that some discourses are more dominant and ‘naturalised’ in society; and this is a crucial consideration as according to Fairclough, ideology is only 'truly effective' when disguised as common sense (Fairclough, 2015, p.107). By illuminating what is 'backgrounded', assumed or taken for granted in texts, researchers can raise awareness of how such particular features of commonsensical ideologies that underlie discourse sustain social inequalities and thus work to resist and challenge such effects. At the same time, these dominant discourses can be resisted or opposed by alternative discourses. In this way, researchers can contribute to enabling conscious awareness and social change

Fairclough's methodological theory sees discourse as part of broader social reality, and within this methodological framework, discourse is more than just language. Rather, discourse is language as a social practice which is determined and constrained by the structures and powers of social institutions (Fairclough, 2015). To reveal such processes, he proposes a three-dimensional model that looks at texts at the (1) the textual level, (2) the discursive practice level; and (3) the social practice level. I discuss each of these in detail below.

Text level

The first stage, 'text level', considers the formal features of a text. Important here are particular word choices, grammatical features, cohesion and text structure and seeing whether certain key words and themes stand out. Here, one can find what ideologies the text communicates; what is taken for granted and what is made explicit in the text. This is what Fairclough (2015) declares as finding out ``how ideological differences between texts in their representations of the world are coded in their vocabulary" (Fairclough, 2015, p.131). For example, is there over-wording, which refers to an 'unusually high degree of wording' indicating a 'preoccupation with some aspect of reality' (Fairclough, 2015, p.133). Overall, this stage is effective for exploring how certain words and grammatical features can naturalise common sense statements within discourses.

Discursive level

The discursive level is the interpretation stage, which assumes that to understand a text people need to understand the discursive context in which that text is embedded; in other words, people understand texts only when given reference to a certain discourse. This level is the one which Fairclough (2015) considers a mediating stage between the relationship of text and social structure; as such, it helps to answer whether a discourse does this and how does this discourse

maintain or challenge the hegemony, or status quo. To achieve this, the researcher considers which discourses are articulated in the texts and how the texts do this by paying attention to intertextuality and interdiscursivity. Intertextuality is where texts draw upon other texts in various ways, either explicitly naming them (as with manifest intertextuality) or by subtly cuing them; with the effect of sustaining, appropriating, or contradicting these texts, among other possibilities. Interdiscursivity refers to looking at what various discourse types are drawn upon and how.

Social practice level

In theory, changes in language should reflect changes in society; and thus, sociohistorical considerations are pertinent for analysis and this is where social and political theory comes in. The last stage, social practice, considers this. Namely, the social practice stage, or the explanation stage, allows the researcher to explore how social practices in their socio historical context relate as well as help constitute and are constituted by such discourses. Fairclough's CDA focuses on how discourse can play a part in sustaining or changing power relations in modern society with the underlying assumption that social change is in part marked by discursive changes. It is thus a very useful method for investigating how language reflects and is part of transitions. Indeed, Fairclough's CDA model has successfully applied to such contexts as healthcare and minority policies, including those of European countries undergoing social transition (Fairclough, 2005; Jørgensen & Præstegaard, 2018; Olesen & Karlsson, 2018). After using the three-dimensional model on a Danish NRIS, Olesen and Karlsson (2018) found that Roma were positioned as a weak group who were outside or not full members of mainstream society; lacking in attributes to be able to contribute. After critiquing and explaining how this discourse interacts with other social practices in the Danish context, the

authors provided recommendations for improvising such strategies, drawing on findings from effective work in Sweden (Olesen & Karlsson, 2018).

As touched upon above, the relationship between discourse and social structures is dialectic, meaning that discourses can also be constitutive of wider social practice and thus potentially contribute to the continuity and change in society. Dominant discourses on a particular social concern can be naturalised by seeming like common-sense, and thus are linked to power relations in social institutions; at the same time, these dominant discourses can be resisted or opposed by alternative discourses. Thus, discourses are both powerful and are linked to power. What is more is that Fairclough's work emphasises the importance of local context and sociohistorical specificity for understanding how and why discourses can be refashioned, or recontextualised in various ways.

Recontextualization of discourses, according to the critical scholar, is whereby elements or aspects of discourses and other social practices are moved from their original context into a new, different context; either through colonisation or appropriation (Fairclough, 2015, p.38). Such processes are particularly important to consider in transitional contexts such as Serbia. It is also vital to note that such strategies may not be linearly applied in real-life practice and do indeed interact with other policies and social practices, sometimes in unpredictable ways. Thus, discourses can be 'recontextualised' or 'translated' in various ways by those who implement such a policy (Fairclough, 2015; Kühlbrandt, 2019). Indeed, such discursive constructions can be resisted and counteracted by those doing the practice (enacting such strategies) (Fairclough, 2015). This is where such stakeholders' views are a crucial consideration. When such policy discourse has been analysed alongside key actor's perspectives, researchers can discover creative ways of how these documents are translated in local settings. Morača and Stubbs

(2019) study explored how a Roma inclusion project in Serbia, a programme focusing on Roma children's education, was put into practice; to find that the underlying policy's discourses were taken up in different, at times opposing, ways by those charged with implementation (Morača & Stubbs, 2019). In particular, there was a difference between how those employed by the State and those in NGOs 'understood' such policies, whereby the latter group tended to maintain the policy's dominant discourse, while those working in the public sector contested such discursive constructions (Morača & Stubbs, 2019). At the same time, the authors observe that the policies and their limitations for effectiveness need to be viewed both in this local context and the broader context of Serbia's neoliberal austerity policies and reforms (Morača & Stubbs, 2019).

The level also considers the social implications of such discourses for Roma regarding real social change, health justice. Fairclough (2015) proposes that after obtaining such an understanding and envisaging alternatives, it can contribute to critical social science and change social reality for the better, including reducing social inequalities and discrimination. Such a stage is thus action-oriented, insofar as it can provide suggestions and further considerations of the Strategy and its associated practices; to be used in praxis.

Overall, by analysing language and its associated social practices, the method is thus very useful in exploring both dominant and alternative discourses, and to consider the social reasons and broader implications of such discursive constructions for sustaining or challenging the status quo (Fairclough, 2015). Indeed, Fairclough's CDA carefully considers how every discourse enables and shuts down possibilities and as such, it is a highly suitable way to answer the thesis questions. This method also allowed me to consider the social implications of Serbia's NRIS discourses to understand better why it is failing in efficacy and provide

directions that might improve Roma policy and its implementation. Such critical analysis thus has the potential for its findings and recommendations to then be used to produce social change.

3.4 Method of data collection

The Strategy was accessed via an official Serbian government website (http://socijalnoukljucivanje.gov.rs) which was open to public access and available in Serbian and English. The Strategy was chosen because it is the current and most relevant strategy in Serbia that focuses specifically on health for the wider Roma population.

Key actors in the policy process were interviewed. This consisted of a broad range of stakeholders who worked with the policy in various ways. The inclusion of such actors was pertinent, as to quote Morača and Stubbs (2019), 'policies often mean one thing in the heads of those who make them and quite another on the ground' (Morača & Stubbs, 2019, p.35). To identify key stakeholders, I undertook some preliminary research into who was involved in the development and actualisation of the Strategy in various ways, with some of their emails accessed from their official work websites whilst others were passed on by colleagues. I then spent a lot of time negotiating interviews with a range of people, chosen based on their professional positions, and in the end, five agreed. The purposeful method was advantageous insofar that interviewees were highly relevant to the purpose of the study and the sample represented a broad range of key stakeholders; namely, an international civil servant (Zoran), a domestic civil servant (Daria), a policy expert (Milan), an academic whose research topics include Roma issues (Lenka), and a government professional (Brankica). Such a sample allowed for the possibility of accessing a range of discourses related to this policy.

The interviews were conducted using an interview guide that had a range of open-ended broad questions that touched on their experiences and perspectives on Roma inclusion strategy, especially the health objective (see Appendix A for an example of the interview schedule). The interviews were administered via Zoom, with the exception of the last interview which was completed in written format by the participant, by their choice. The Zoom-interviews took approximately ninety minutes per participant, and this allotted time allowed for the participant to draw on several different discourses. While the first interview (with Zoran, the international civil servant) was conducted in the English language, all others were conducted in Serbian. These latter interview texts were translated and transcribed by a professional transcriber/translator (the original transcriptions, in Serbian, can be found in Appendix C), whereas the first interview text was transcribed using the Otter.ai programme.

3.5 Procedure of data analysis

Each research project is unique, so researchers using CDA generally design the process with CDA analytics that best meets their research questions and aims (Fairclough, 2015). After reading Fairclough's work in an in-depth way, looking at how his ideas are developed over time, looking at how people had applied these ideas in a similar health research context; through this, I developed a multi-step strategy/procedure to apply for doing my CDA, which I describe below (see Table 1 for the further details). Such a data analysis used was one adapted from work by Fairclough (1992, 2001, 2003, 2010, 2015) and Jørgensen and Praestegaard (2018) who used a Fairclough-inspired CDA to analyse several official governmental strategies and patient records in the field of health in Denmark. The method is thus highly relevant for analysing a Strategy document, as well as talk of professionals.

The actual procedure of my analysis was not applied in the order as described above in this same chapter and in Table 1 (which for readability, started with the textual level), but rather

started with conducting a thorough literature review and then observing discourse. Indeed, the discursive practice level is a consideration of discursive practice features, including intertextuality and interdiscursivity, among others (Table 1). This stage of analysis was heavily informed by previous social research. Indeed, through a thorough literature review, I researched the background of the Strategy in question and this provided the sociohistorical and political context necessary to base the discursive-level and the social practice level of the analysis on. In particular, this activity provided the social context and what Fairclough (2015) refers to as the *members' resources* (MR) needed for the analysis of intertextuality and interdiscursivity (Fairclough, 2015). MR is the background information that interpreters of text use to make sense of the given text and include aspects such as common-sense assumptions and expectations based on ideologies, as well as the "knowledge of language, representations of the natural and social worlds they inhabit, values, beliefs…, and so on." (Fairclough, 2015, p.57). Such MR has social origins, as Fairclough (2015) states '[p]eople internalise what is socially produced and made available to them and use this internalised MR to engage in their social practice, including discourse' (Fairclough, 2015, p.57). To internalise these socially generated resources, for intertextuality, I needed to familiarise and read in-depth the texts both directly referred to in the Strategy text, as well as those implied, to internalise these socially generated (Fairclough, 2015). Such study included reading the said Strategy which included the index citations and any relevant documents mentioned in the policy. Whereas, interdiscursivity was informed mainly by my previous study on Roma inclusion strategies, and other social theory (particularly that from the field of Critical Health Psychology). Although I have Serbian heritage, I can speak Serbian and family in Serbia with whom I have contact which gives me some insight into contemporary issues, I am socially and geographically distanced from modern-day Serbian society; and thus it was highly necessary to investigate the dominant and competing discourses around key topics such as Roma social inclusion, poverty and social

welfare, neoliberal discourses and its actual practice, as well as other transdisciplinary topics that yield insight into possible influences on the strategy in question. The databases, such as 'Scopus', 'Academic Search Complete', 'Academic Search Premier', 'Ebsco', 'PubMed', were used, with key words and topics such as 'Roma', 'Serbia', 'health', 'social inclusion', 'discrimination', 'Europeanisation', 'socioeconomic', 'civil rights', 'political rights'.

The Strategy was the first piece of text analysed by this CDA method. This process began with an in-depth reading of the whole Strategy (all ninety-two pages), followed by particular parts, namely, the 'Health' section, which outlined the objectives and strategic measures, and the 'Introduction' section, which provided the principles and frameworks underlying the Strategy. After doing such an in-depth reading of the entire strategy document in question, the method procedure of analysing the text's discourse practices. This procedure was conducted on two health sections, followed by the document in full. These two specific sections were where the texts explicitly discussed Roma and health; section '4.4 Health' which describes the health problems as conceptualised by the text producers, providing data to suit; and section '5.4 Health' which outlined the operative objectives towards Roma health and the strategic measures proposed to achieve these. I did these health sections first, as once I understood the discourses of health, I could then go through the document and pick up where else these discourses might be or where other health-related discourses were embedded that were not in the health sections. After identifying two key discourses that conceptualised health and Roma in particular ways, I then applied the textual analysis (vocabulary, grammatical features and text structure) described below, followed by the social practice level of analysis.

When analysing the interviews, I applied the same procedure (starting with discourses of health and so on) as the one just above to each interview and then brought these interview

analyses together in dialogue to produce a separate analysis to the policy analysis of these first-person accounts. Treating these as two data sets allowed me to compare and understand any similarities and differences between the policy document and the accounts of stakeholders related to it. I discuss the implications of these similarities and differences for Roma health in chapters' 4 and 5.

The following is a description and explanation of each different stage of the analysis:

Discursive practice level

To analyse the texts in the *discursive practice stage*, one has to interpret the discourse types and text types that such a text draws upon and consider whether these are in harmony with one another, i.e. 'make sense'; or are opposing or contradictory, and thus saying different things within this same text sample. To be able to analyse at this stage, I had to rely on my MR which was largely informed by the literature review and social theories, which I engaged with thoroughly. For example, to interpret 'neoliberal discourse', I already had to familiarise myself with this construct in order to interpret it. It is at this point that the issue of subjectivity comes in (see section on reflexivity below); however, to ensure that I was allowing for objectivity in my analysis, I did two things. Firstly, I re-read these extracts, seeing whether I could find any other discourses and if so, if I could justify them as being the dominant one conceptualising Roma health. Secondly, my interpretative data was regularly discussed with my supervisor, in order to ascertain whether this was robust evidence of such a discourse.

Text level

For the text analysis, the text was read line by line and word by word, and then as a 'whole' body of text by seeing how extracts spoke to others in terms of internal coherence or contradictions.

1. The first step consisted of reading the text looking for vocabulary features such as key words, over-wording (which refers to 'an unusually high degree of wording' indicating a 'preoccupation with some aspect of reality'), what ways words collocate or co-occur (synonymy/antonyms and hyponyms), the use of pronouns/metaphors (Fairclough, 2001, p. 115). This phase consisted of looking at how vocabulary and wording help construct an understanding of actors, their duties and assignments in regard to Roma and health issues.

2. Then, the analysis moved on to looking at grammatical features, starting with transitivity of the text. Transitivity asks what process types were used, for example, representing an occurrence as an action with responsible agents (Fairclough, 2015, p.139), and whether nominalisations are apparent (processes turned into nouns, thus obscuring agency and accountability). In this sub-stage, the question of whether agency is unclear is important. For example, the researcher asks what process types were used, for example, representing an occurrence 'as an action with responsible agents', and what factors may account for this (Fairclough, 2015, p.139). Additionally, I looked at whether nominalisations were apparent (processes turned into nouns, thus obscuring agency and accountability). The transitivity stage also looks at where sentences are positive or negative and are in active or present tense. While present tense can

work to help make statements appear immediately logical and true; negative statements (or negation) can say what is not reality (Fairclough, 2001).

3. Modes of sentence analysis look at what modes are used, i.e. *declarative, grammatical question and imperative*, as such modes position subjects differently and thus are important for looking at power relations. For example, a typical declarative statement has the speaker/writer in the subject position of the giver of information and the addressee as the receiver; however, there are many other subject positions (Fairclough, 2015, p.141). Modes are important to consider *speech acts, i.e. what* the text producer is 'doing by virtue of producing it [the text]', but also need to work with taking into account the 'textual context of an utterance (what precedes and what follows in the text), the situational context and intertextual context, and elements of MR (Fairclough, 2015, p. 166 - 167). Meanwhile, modality looks at what modalities are frequent: What do these say about the authority of one participant in relation to others (relational modality)? For example, *may* can signal permission, while *must* obligation. The authority and power relations of the text producers are often not made explicit, but rather implied through the use of such modal auxiliaries (Fairclough, 2015). Meanwhile, expressive modality looks at what modalities express about truth, possibility or necessity. For example, the use of modal auxiliary verbs like may, might, should etc. signal possibility and necessity; while the use of categorical modality, such as using the verb *are*, supports the view of a transparent reality. It is important both to note the use of such modalities, and also where in the text they are used.

Social practice level

For the *social practice stage*, I had to know the broader social context that the types of discourses are interacting with; and thus, once again, the literature review findings were very important at this stage. Such literature was largely informed by work in a range of social theories, including critical policy studies, critical health psychology, and the like; and provided a large repertoire for explaining the social context that surrounds Roma social inclusion in general, as well as the Serbian health system and practices within this space. For example, Mikuš (2018) explored the discourses of minority policies in contemporary Serbia, contextualising these in both the current neoliberal reforming of the State *and* the legacies left behind from the Socialist era. The researcher found the 'Productivist' discourse of SFRY that promoted social cohesion through productive labour input worked in harmony with the more contemporary neoliberal discourse of economic participation. Such findings allowed me to consider such creative workings for when I conducted my analysis of the Strategy in question, and indeed I was able to map these onto my study by considering the intricacies or peculiarities of such individual discourses and how they work or didn't work together; these will be discussed in Chapter 4, the analysis section below.

3.6 Ethical considerations

There were several key ethical issues to consider, including autonomy, avoidance of harm and mutual respect; cultural considerations; potential benefits and justice; privacy and confidentiality; and safety of participants. These will be described in detail below.

3.6.1 Autonomy, avoidance of harm and mutual respect

Consent forms and information sheets were administered to and then read and signed (consent form) by interviewees in order to ensure that they were well informed about the interview procedure, their rights and obligations and consented to this. Each interviewee was

offered the right to edit their interview transcripts, and this to avoid potential harm and foster mutual respect; it also offered the participant's control (ongoing consent).

3.6.2 Cultural considerations

As the research focuses on the ethnic or social group Roma, I had to consider my position as a non-Roma woman and thus ensured that I would not make any claims that I understand Roma 'issues' from the stance of a Roma person (man or woman). However, the research contributes to the critical studies concerning how Roma are represented, i.e. constructed, in official policy and professional's talk; and thus, may be beneficial to the Roma community. The research group were not consulted per se, as the research is about people writing about Roma people and not the Roma people themselves. I am turning the critical lens on the policy discourse as an ethical act from my positionality as non-Roma. I will thus carefully consider my own discourses, to not be contributing to (potentially discriminatory) research on Roma by non-Roma. Moreover, as a non-minority group member, I can also use my relative position of power to hold to account those in power.

Prior to conducting the interviews with the participants in Serbia, I undertook careful considerations to ensure that I was culturally appropriate. For example, I spoke to relatives based in Serbia to understand what would be considered as appropriate in terms of questioning, framing and interview practice so that I could create a culturally safe interview space.

3.6.3 Potential benefits and justice

Participants were also sent a summary of the completed research which may be of benefit to them by presenting favourable findings for their own practice or by allowing for more knowledge on others' practice if they wish to learn more. It might give them a novel

insight into the policy documents which they are working with that they might find useful in their work. As mentioned, it appears that talk about Roma and health in health strategies and health practice is not consistent between European Nations. This research adds to the growing conversation about the necessity for developing inclusive strategies that decrease discrimination and stigma towards Roma and improve their access to health.

3.6.4 Privacy and confidentiality

In order to protect the confidentiality and privacy of participants and their data, the identities of the participants were held as confidential and only known by me, the researcher. Pseudonyms were given while data on the participants' specific professional positions was not given throughout the research process and the final report. My personal laptop is password protected and only known by me. It is virus-protected. The actual data is stored on a highly-secure drive, OneDrive and anonymised. The consent forms and all other forms with identifying information were stored in a locked folder, separate from other collected data.

3.6.5 Safety of participants

Participants signed informed consent forms after being given information that enabled them to make an informed decision. They were also given the right of withdrawal at any stage of the study (up to its being published) and were notified when the final write-up commenced. Initial discussions with the key stakeholders ensured that their potential research participation would not make them vulnerable within wider organisational and political structures in Serbia.

3.7 Reflexivity and validity

My outsider perspective has its strengths as well as its drawbacks in terms of its impact on the kind of data produced and the analysis. Being geographically far from the potential

participants and the Serbian society in general meant that I may have missed out on contextual information only available to 'locals. To account for this, I had to engage in rigorous and open-ended inquiry into Serbia's 'orders of discourse'; namely, the typical patterns of discourses found in certain institutional settings. Therefore, to give more contextual information, I not only investigated how Neoliberalism ideology sits within contemporary Serbian society, but also the history of Serbia, given its somewhat recent transition from a 'socialist' to a market economy, and also EU ideas (for example, integration, values, documents). Associated discourses also investigated included health, minority, Roma; through this study, I was able to observe how mainstream poverty discourse has also changed (Kleut & Drašković, 2021).

In reading such critical academic literature about relevant topics, I was able to gain a sense of what discourses predominated and thus I developed new ways of looking at the document to see what might be intertextual or interdiscursive (have social relevance).I took time to reflect on each go at her analyses of the main bodies of text (strategy and interview text) to consider other ways to interpret and thus 'see' the data. Other activities I undertook to achieve a more insider view including speaking to academics that studied minority rights in Serbia, in person or via telephone conversation. Discussions with academics in the field of Roma inclusion, healthcare, especially those based in Serbia, proved to be invaluable in allowing me to gain insight from an insider's perspective, and thus make more connections of the possible social influences on Roma inclusion practice in Serbia.

The outsider perspective was beneficial in terms of providing for a more distanced view from internal politics and thus possibly a less biased view (a *bird's eye view* of sorts). This is of course just a speculation. At the same time, because I grew up in, studied, worked and continue to be based in what is considered to be a 'very' Neoliberal country, New Zealand, I

was able to identify easily the types of discourses that correspond to the Neoliberal rationalities and in particular, of Neoliberal health citizen ideals. On the other hand, although I am an outsider in the sense of being a New Zealand citizen, I have Serbian heritage and can speak Serbian. This directed my research interests and also enabled me to conduct the study in the Serbian language, i.e. in the interviews. These different perspectives qualified me from having what Carling et al. (2014) term as a 'hybrid insider-outsider' position and thus not being firmly placed on either side of the insider-outsider divide; insofar that I share similar characteristics of those under study, the interviewees, whilst also living and having grown up in another (outside) country (Carling et al., 2014, p.51). This unique positioning enabled me to establish proximity and trust, whilst my distance ensured that the interviewees elaborated more thoroughly (in details and context) when they were given their responses (Carling et al., 2014).

In Fairclough's recent work (2016) he addresses some of the critiques of his work - including the questions of how discourse analysis is just discourse itself. He responds to such an apparent paradox by asserting that whilst this is true, it is indeed discourse itself, by being critical and reflective of one's own practice and ensuring that social theory is relevant for a given context, researchers can contribute to the critical study of language and place. These arguments resonated with my own desires to use the skills I have and the opportunity in the spaces to contribute to a social justice agenda.

In terms of validity, I ensured that I met the quality criteria for a good CDA. For in-depth engagement, I engaged with the Strategy text and the other policies related to this document. I made sure to carefully read through these texts, reading sections and then the whole texts. I re-read both the Strategy and the interview texts before conducting the analysis. The analysis itself was an iterative process, where my prescribed method was adhered to in order

to produce a careful and methodical reading; this allowed me to notice differences and similarities between sections and texts with relative ease. Most of the interviews conducted lasted ninety minutes, were in-depth; and this length of time, prior correspondence as well as my own field research on the participants prior to the interviews allowed me to establish rapport early on in this meeting with individual stakeholders.

Chapter 4 – Analysis

4.1 Analysis part one: Strategy document analysis

I applied the CDA which showed that while some of the discourses limit the efficacy of the policy by locating the blame on Roma, others open up possibilities for more comprehensive State and local government action, by placing more accountability on such constituencies. The analysis of the Strategy, 'The Strategy for Social Inclusion of Roma for the 2016-2025 Period', identified two *dominant* competing discourses: the more common and thus dominant neoliberal citizenship discourse, and the holistic "human rights" discourse. Neoliberal citizenship discourse centres on autonomy and responsibilisation, assuming that Roma people are individually responsible, or should be, for their achieving health, side-lining the State's responsibility. Its limited prevention approach articulates information, education and counselling as the mechanisms enabling health, obscuring broader structural constraints.
In contrast to the neoliberal discourse, holistic "human rights' ' discourse constructs Roma health as a broader human rights issue, tied to other 'inalienable' social determinants such as housing, education, employment, and other socioeconomic resources. The neoliberal discourse was supported through interdiscursivity by a sub discourse (less dominant discourse), productivist, a legacy of Yugoslav socialism with its core ideology of productivism. While other sub-discourses intersected with the holistic human rights discourse, these were paternalistic discourse and developmentalism discourse. At times, the neoliberal and human rights discourse come together in creative ways, as shown in the neoliberal human rights discourse section. The third and less common discourse, neoliberal human rights discourse, was found and provided an example of where two seemingly contesting discourses can work together in creative ways.

Below I describe and give text examples of two main and competing discourses, neoliberal citizenship discourse and holistic human rights discourse, and the neoliberal human rights discourse, that I identified in the analysis as structuring the document. To show where interdiscursivity was found, I also describe and show how the sub-discourses work with key discourses in creative ways.

4.1.1 Neoliberal discourse

The most common discourse constructing health and Roma observed in the Strategy is neoliberal discourse, which rests on the neoliberal premise of the ideal individual as being autonomous, self-responsible and self-regulating and therefore *choosing* health. This discourse obfuscates other more structural barriers towards access to healthcare and health by promoting the idea that individuals should manage their own lives and risks, thus practising self-care. Indeed, neoliberal discourse of health is to do with people accessing health for themselves, via information and individual rights and economic means, as a way to fit into what is considered an ideal or good autonomous health citizen. Health is more of a commodity (to be sold and bought by such citizens) than a social good or resource that people are entitled to, and thus it is also expected that one should be able to afford such expenses. Within this framing those who cannot meet these economic and health citizenry requirements are often problematised as being 'dependent' and/or 'inactive' and thus need to be empowered to be able to participate in this self-regulating and consumer culture of health. Such assumptions are all evident in the document.

Central to neoliberal discourse is the *shrinking state* is one central to neoliberal discourse and can also be seen in the Strategy text. In particular within the introduction, with the statement:

Extract 1. ***"Social inclusion of Roma is won in the local community. The exercise of the right to education, work, adequate housing, and health care, reflect the overall State of human rights and social equality (non-discrimination) in the local community and as such require the adoption of local community-specific measures if they are to achieve measurable, tangible progress. Implementation of the said measures from the national level, top-down, is carried out with a lot of difficulty: it is economically non-viable and requires additional human and material resources that the State does not have. A more rational approach would be to decentralise the activities related to the implementation of political inclusion of Roma women and men, and to delegate a greater part of tasks and responsibilities to local self-government."*** **(Section 2, Principles, p. 5).**

Thus, the shrinking state idea is not only purported but justified, and the Roma issue is argued to be a community issue', thus decentralising social practices and putting less accountability on the state by placing more responsibility on the smaller units, local government, rather than national. This extract "exercise of right to education [and] health" to the point where education on health takes precedence over direct socioeconomic support, as the right to social security as another key priority of the Strategy is omitted. Thus, when paired with the sentence above, the discourse on the State's lack of resources, this preference for the discourse, and social practice of 'health education' is seemingly justified.

Indeed, the key words 'empowerment', 'empower', 'empowering' are observed repetitively throughout the document and work to construct Roma's (lack of) inclusion as a lack of empowerment problem. The assumption here is that Roma people need to be 'activated' or 'empowered' to access their rights to health. Synonymous terms such as empower(ment),

activate, and social capital work together to create this construction and are what Fairclough (2015) calls *overwording*; they appear repeatedly at a throughout the Strategy, which he posits is an indication of a 'preoccupation with some aspect of reality', thus highlighting their ideological significance (Fairclough, 2015, p.133). This line of thinking is also prevalent in other sections of the document, where Neoliberal civil and political rights are stressed and ideas of the Market dictating social practices takes precedence; all working to justify the idea of 'economic' and 'education-based' empowerment to make Roma flexible, autonomous and self-regulating (health) citizens. This neoliberal discourse and rationality underlie two key discursive patterns (information enables health; economic citizenship is key to health) which work to sustain it, these are discussed in detail below.

Assumption 1: Information dissemination on health-related behaviours enables health for Roma. In particular, the neoliberal discourse on the 'good (health) citizen' is evident, that centres on the premise that individuals should manage their own health by choosing the correct health-related behaviours and managing risks to their health. To enable such choices, individuals need the correct information to be able to make informed decisions, seen for example in:

Extract 2. ***"...including programs for promotion, prevention, treatment and rehabilitation and education of Roma men and women with regard to the protection of patients' rights."*** **(5.4. Health, Outcomes by 2025, p. 81).**

Information provision is based on the Social Cognitive Model (SCM) of health behaviours which as discussed in the literature is simplistic and has little evidence base. This social-cognition model supports the posit that it is ultimately the good health citizen's self-responsibility for health, by educating individuals on the correct health-related beliefs and

behaviours (Short & Molborn, 2015). This linear social model of conceptualising health issues and their solutions is most apparent in the sections where health is discussed in its own terms; this includes section '4.4. Health' which explains and frames the Roma health problem within Serbia, and section '5.4. Health' which states which strategic measures will be put into place. Exemplar extracts are given below.

Extract 3. ***"Providing health care promotional activities and adequate promotional culturally-sensitive materials which warn about harmful effects of inadequate diet, smoking and alcoholism and other risk factors;"*** **(5.4. Health, Operational Objective 3c, p.80).**

Extract 4. ***"Providing access to and information on counselling related to non-contagious illnesses (primarily diabetes)."*** **(5.4. Health, Operational Objective 3d, p.80).**

Extract 5. ***"Health mediators and public health institutes shall make continuous made towards educating and teaching Roma in informal settlements and families about health issues; familiarising the Roma population with health risks and healthy lifestyles through lectures, workshops and promotional materials;"*** **(5.4. Health, Operational Objective 5a, p.80)**

Text level. At the word-level, the key words 'education', 'educating', and their near-synonyms 'teaching', '(providing) information', '(spreading) knowledge', 'warn' shows overwording, 'an unusually high degree of wording'; showing a preoccupation with the idea that information dissemination is health-enabling (Fairclough, 2015, p.133).

The Romani population are predominantly positioned as the object, inactive currently, that will be enacted upon, as they need risk management knowledge, techniques, and skills to manage and access their health. In other words, it places Roma as currently deficit and to-be

competent and self-responsible and 'active' citizens that will look after their health. Thus, such extracts articulate the logic of SCM: giving information will enable the rational person to then act on it. Extract 3, in which the text producers did not state that these promotional activities would enable an adequate diet, but instead are again promoting the assumption that awareness of the "harmful effects of inadequate diet" is conducive to allowing access to health. These constructions are of interest because we see here the idea that health outcomes and "access to health" are in Roma's hands. Thus, the texts locate the issue in Roma whilst ignoring the role of the structural barriers and more of an active role from the State to enable an adequate diet. While extract 5 ('familiarising the Roma population with health risks and healthy lifestyles') is a particularly clear example of the information giving model for promoting health; in particular, the logic that what these people need to know is information about how to avoid risks and thus have access to health.

Meanwhile, Roma health mediators are positioned as directly enabling such information and this being conducive to enabling health for Roma, as shown in the next two extracts:

Extract 6. ***"The activities of health mediators related to health education of Roma men and women have proven the most successful measure undertaken as part of public policies implemented following the adoption of the 2009 – 2015 Strategy for Improvement of the Roma Status."*** **(4.4. Health, p. 50).**

Extract 7. ***"It is beyond doubt that by spreading knowledge among the Roma, health mediators have made a considerable contribution not only to the availability of health care but also to the improvement of the status of health in this segment of the population."*** **(4.4.1 Analysis of public policies in health care, p. 50).**

When looking at modality that works to position statements as 'facts' or 'categorical truths' as Fairclough (2015) puts it, extracts 6 and 7 are of particular interest. Indeed, by using 'have' and 'is', the use of simple present tense not only positions the producer of the text as an authority or expert but represents a categorical commitment to this truth. Thus, extract 2 ('***it is beyond doubt that by spreading knowledge among the Roma, health mediators have made a considerable contribution')***, is particularly effective in conveying the idea that spreading knowledge is conducive to ('beyond doubt') bettering access to health and health outcomes for Roma. Thus, this answers the question of how is achieving Roma health articulated.

Discursive and social practice of information-dissemination. Although health mediators and the other body members are proposed to be involved in strategy implementation, the overpowering message is that it is ultimately Roma who need to do health in the 'correct way'. Indeed, the dominant Neoliberal rhetoric still depoliticises and moralises health behaviour to argue that Roma can achieve simply by being responsible, informed (and economically active) citizens and then choosing health; thus, side-lining issues of structural barriers and opening up the possibility for Roma's health problems to be blamed on the Roma themselves. In other words, while a paternalistic discourse supports these education activities as being necessary; the ultimate goal for health services (mainly health mediators) is to provide Roma with the appropriate knowledge and skills which enable them to make correct choices regarding their health and be autonomous citizens; speaking to a neoliberal ideal health citizen discourse as an autonomous citizen.

Such a discourse can be linked to the broader social context of recent forms, partly described in earlier sections. Such reforms aimed to reduce health expenditure and rates of

preventable diseases by placing more of an emphasis on primary care and preventative approaches as opposed to curative service (Bjegovic-Mikanovic, 2019).

What is absent in this sense making is the macro social barriers towards achieving health for many Roma. Indeed, increasing literature challenges the efficacy of individualistic social cognitive models for healthy lifestyle change. There is strong evidence that such narrow health promotion interventions aimed at lifestyle changes via information are often minimally effective, at times ineffectual, for improving health outcomes for disadvantaged groups; which suggests the appropriateness of this approach is questionable (Marks et al., 2021; Mielewczyk & Willig, 2007). Such prevention strategies may not be so efficacious if not paired with 'real' socio-economic changes, i.e. if Roma is to consume an adequate diet, then material needs also should be addressed. What is more, as mentioned above, is that if Roma do find it difficult to enact this new health knowledge, the potential for more victim-blaming through neoliberal ideology is heightened.

Assumption 2: Economic empowerment (via education) is health-enabling. The neoliberal discourse/health information discourse outlined above is intertextually related to subsequent sections of the same document, where core values and goals of economic 'activation' and 'empowerment' lie, and Roma are positioned as currently lacking and at risk, with education and employability as the key enablers to social, including health, inclusion. Interwoven throughout the Strategy text is the idea that economic empowerment is the key mechanism towards health, as people should be able to *afford* health. Thus, instead of being a social good, health is constructed as a commodity. Like the discursive framing discussed just above, this neoliberal construction in these sections treats Roma as passive recipients, of welfare rather than patients, by positioning them as the 'object' in declarative statements; whilst proposing

that their health should be improved by "empowering" Roma to be 'active' citizens and thereby manage risky behaviours (The Government of the Republic of Serbia, 2015, p.80). Thus, it is intertextually connecting the neoliberal logic and the deficit-thinking model as it positions in Roma as in need of improvement, change or assimilation to afford health whilst minimising the states' role in providing material and health sources directly. Again, such an assumption puts most of the onus of individuals themselves minimising the states' role.

Extract 8. "*Accountability of public authorities for the implementation of planned strategic goals and for raising social responsibility, solidarity and awareness about the fact that social exclusion represents a true loss in the country's social capital, and that the social empowerment of members of socially excluded groups means strengthening human security which will, in turn, lead to the overall economic growth and advancement of human rights."* (Section 2, Principles, p. 2).

Extract 9. *"Inclusive growth means empowering people by ensuring a high employment rate, investing in skills, fighting poverty and modernising labour markets, training, introducing social protection systems designed to help people anticipate and manage change and build social cohesion. Changes in the policies for education and employment, together with the creation of a healthy commercial and economic core, will create conditions for a successful implementation of the European platform for fight against poverty and social exclusion, which should result in a raised awareness and fulfilment of basic human rights for the poor and socially excluded, and allow them to live in dignity and take an active role in society."* (Section 2, Principles, p. 2).

Extract 10. ***"A person's professional profile is the profile of their fundamental economic and personal characteristics, because it usually determines the amount of earnings, and consequently the economic and social status of a person. The most common occupations among the Roma population reveal the existing professional and social inferiority of Roma, directly conditioned by their educational structure."*** **(Section 3, Description of Current Affairs, p. 18).**

Similar to the discursive constructions, key terms such as 'activate', 'skills', 'awareness', 'empowerment' and 'training' position Roma as currently lacking in the types of attributes necessary to be included into society, and ultimately enable health equality. However, as noted above, these particular texts position general education and employment (or employability) as the key factors to enabling such empowerment; arguing that a person's professional status is 'the' determinant of their economic and social status (extract 10). This type of economic discourse positions Roma as not only passive but what Popova (2019) terms an 'economically targeted audience' and argues is contradictory in terms of arguing for (primarily) universal human rights insofar that including Roma in society is positioned as an economic benefit to society over what could be a basic human right to health, healthcare, education and so on (Popova, 2019, p. 31).

For example, in extract 8 the word 'social' is present at an unusually high amount, and thus a preoccupation of Roma exclusion as a social issue; of particular significance too is that 'accountability of public authorities' and building 'social responsibility' and 'solidarity' are the first principles mentioned in the Strategy. However, these core values are positioned for more instrumental rather than social moral reasons. Indeed, the text producer uses 'social capital' as both a sociological term, and a kind of economic one (in its wider sense); positing

that these people have value because at some level they contribute, rather than the argument that they exist therefore they should be valued as humans who exist; this is only strengthened in the last section of the extract which gives an explicit economic argument for social inclusion, namely that ultimately social inclusion will "***lead to the overall economic growth and advancement of human rights."*** Indeed, it is interesting how economic advancement and human rights advancement are positioned as related gains in society with the use of the cohesive feature (the conjunction 'and'); however, the economic level seems to come before human rights.

Another example is in

Extract 11. ***"The Strategy's primary beneficiaries are the citizens of Roma ethnicity, but one should not ignore the fact that the strategic measures defined in it create room for a gradual yet safe and permanent elimination of social inequality and poverty as phenomena plaguing the political, economic, social and financial system."*** **(Section 2, Principles, p.3).**

In extract 11 above, I observed that the last simple sentence in this text expresses an action, where the social issues ('social inequality' and 'poverty') are positioned as the agent (or subject) which is acting upon ('plaguing') the patient ('the political, economic, social and financial system'). Although both the agent and patient are inanimate, it is implied that the social agent (social issues) represent people (Roma and the other poor segments of society) and thus Roma are positioned as responsible; instead of an alternative framing where the systems are responsible for, and indeed 'plaguing', Roma in terms of social inequalities and poverty. Taking this finding along with the argument that Roma should be better educated and be more employable found in the other extracts, further justifies the idea that it is Roma's lack of

desirable and compatible traits that. In other words, Roma of this economic citizenship framing are positioned as a burden on society.

Discursive and social practice of this economic citizenship. The focus on economic benefits before social rights, or economic rights *as* social rights, can be intertextually linked to the 2011 EU Framework for National Roma Integration Strategies and the 'Europe 2020 Strategy'; indeed, both basis documents for the strategy in question (Goodwin & Buijs, 2013; Popova, 2019). The dominant discourse of this framework document sees economic and social progress as 'mutually sustaining', with economic goals appearing to be the primary basis for social inclusion; and asserts that education and training programs for Roma to be employable in the formal labour market are necessary to achieve a break from poverty (Goodwin & Buijs, 2013). In this sense, it supports the notion that it is Roma who must adapt to the new formal labour market conditions; ignoring other values and rights included in the Framework, such as cultural diversity (Goodwin & Buijs, 2013).

This economic targeting of Roma and rationale of Roma inclusion is intertextually linked to a number of other regional and international institutions, including the World Bank (WB). In relation to Serbia most notably is the paper 'Roma Inclusion: An Economic Opportunity for Bulgaria, the Czech Republic, Romania and Serbia' which includes an economic argument for Roma social inclusion (World Bank, 2010).

While the European social inclusion (or economic integration) discourse may seem like a relatively new social practice to the Serbian context, it also closely mirrors the 'productivist' discourse associated with Yugoslavia's Socialist regime. This productivist discourse is one whereby a human becomes a full "citizen" when they contribute to society via productive

labour; and as such, provides a rationale to measure a person's social worth based on their contribution to society, rather than stating they exist (as humans) and therefore should be valued as humans who exist ((Mikuš, 2018). Such ideas are alluded to in the introduction section, shown as 'Extract 8' above, where the statement '*that the social empowerment of members of socially excluded groups means*' the idea of 'social capital' and 'economic' input are positioned as heavily related and are among the most important principles. Whilst this positions the State as caring for its citizens and the message of Roma social issues being a common cause in society, it also stresses the economic benefits to society, thereby supporting that one's social worth and citizenship are measured in productive labour. The productivist discourse, being a more durable norm in Serbian society, is in harmony with the ideal EU (neoliberal) citizen discussed above. Namely that building a cohesive society is through citizens' inclusion in economic productivity (Mikuš, 2018). As stated earlier in the literature, neoliberalism works by connecting with existing local ideas, and the discursive constructions just mentioned might be an example of such interaction.

As stated above, where the rationale for improving Roma health is an economic one takes away from the idea Roma are universally entitled to the human rights of access to health and health; in essence, dehumanising them. Meanwhile, such talk is calling for economic integration on the basis of mainly educational attainment and skills training the discursive construction, ignoring other social determinants, such as the aforementioned social closure mechanisms that can obstruct access to the labour market.

Summary of findings from neoliberal discourse. Above I have outlined evidence for a neoliberal discourse running through the document, made up of description of a shrinking state, individual empowerment through information, locating responsibility in individuals and a

deficit model of Roma addressed through information, and citizenship constructed as economic citizenship; this was evidenced through found features in the text analysis such as overuse of words and phrases such as 'information', 'awareness' and 'economic empowerment', and the intertextuality of historical Serbian discourses and contemporary, such as EU and WB policy.

Social implications of neoliberal discourse. The discourses linked to the neoliberal discourse are important insofar that they are the dominant discourses constructing Roma and healthcare issues. They frame Roma health in a way that posits that Roma's lack of activation, in various forms, is the key problem to them not accessing healthcare and thus health outcomes; therefore, side-lining other non-voluntary barriers in their way.

Neoliberal discourses are thus found throughout the analysed Strategy document and are of particular importance in the health sections as discussed. Indeed, this particular construction dominates the health section of the Strategy, and thus, I consider this to be the key discourse constructing health and Roma issues in Serbia. Assumptions related to the SCM, that access to health-related beliefs and behaviours are effective in enabling health, takes precedence in the health section, 5.4 Health; where the Strategy proposes how health is to be achieved with reference to specific actions. This section and its objectives are thus significant because they operationalise relatively abstract concepts into measurable behaviours, and here text producers prioritise information dissemination. In effect, this prioritisation side-lines or is directing attention away from broader contextual factors such as constraints to accessing health. While this may enable the idea that Roma need to have access to more information, which should in theory be related to more information dissemination as a social practice, it also assumes that once they have this information that healthcare attainment and health is relatively straightforward; namely, once the targeted group obtains such information they should be able to enact these health behaviours. Therefore, as argued above, this discourse places most of the

responsibility and thus accountability on Roma to rationally choose health. As discussed in the literature review, much critical health research has shown this is not always the case, especially for minority groups, and thus not only may these measures be ineffective in addressing the health gap, but that if ineffective, Roma, as the responsible agent, will be blamed (Campbell, 2003; Marks et al., 2021; Stephens, 2008).

Where socioeconomic barriers are discussed, they are proposed to be due to a lack of education and therefore employability on part of the Roma, again positioning Roma as lacking; in this case lacking in economic activation. This again opens up the possibility for what is sometimes referred to as a 'moral underclass' discourse, where Roma (and the poor) are implicitly blamed for their deprivation insofar that they have personally failed to acquire the correct and desired traits and skills for employment and employability as key to social inclusion (Morača & Stubbs, 2019). Another rather paradoxical social implication may stem from looking at Roma as a targeted economic group, undermining their humanity.

Ultimately, neoliberal discourse articulates a certain rationality, perhaps best captured by Kováts (2016), "By promoting heavy individualism, it overstates the importance and responsibility of individual decisions on someone's social position within the existing unequal social structure, without problematizing the structural oppression within the system itself." (Kováts, 2016, p. 11). Applying this interpretation to the above analysis, neoliberal discourse in this policy document undermines the potential to make significant structural changes towards bettering Roma health.

4.1.2 Holistic human rights discourse

The more holistic human rights discourse is supported by the politics of redistribution and care from the State, UN Human Rights frameworks and the socioeconomic determinants

discourse. The holistic human rights discourse is evident in how Roma health is often framed as a holistic issue, interlinked with other inalienable rights such as adequate/safe housing, education, social security and employment opportunities. Indeed, this discourse sees health as intimately and bi-directionally tied to these other priority areas, thus seeing the broader structural determinants in Roma's way to accessing healthcare and bettering health outcomes. Within this model, Roma is still mainly positioned as the object in need of the subjects (for example, bodies consisting of authorities such as the State, the local government unit, NGOs) to act for them to access these resources. Indeed, the Strategy positions the Romani peoples as dependent on the active agents obliged to enact such policy measures to ultimately grant resources to the community.

The following extract located in the introductory 'Principles' section of the Strategy projects a relatively transparent view of reality, namely what human rights "are", with the lack of auxiliary markers to signal likelihood or severity. Indeed, the use of the verb are/is denoting an actual or real representation of the social world, and thus 'fact', for example:

Extract 12. **"*The Universal Declaration of Human Rights (1948) obliges the states to respect, protect and observe human rights. Article 22 of the Universal Declaration stipulates that: "Each person, as a member of society, has the right to social security and is entitled to exercise their economic, social and cultural rights indispensable for their dignity and free development of their personality, with the aid of the state and through international cooperation, in accordance with the organisational structure and resources of each State."* (Section 3, Legal and Strategic Basis, p. 6).**

Extract 13. **"*Article 25 guarantees that "Each person has the right to a standard of living that ensures their personal health and well-being and that of their family, including food, clothing, housing and medical care and necessary social services, and the right to security***

insurance in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond the control of that person." **(Section 3, Legal and Strategic Basis, p. 6).**

Extracts 12 and 13 both carry across the idea that the Republic of Serbia is 'obliged' to respect, protect and observe particular human rights and thus should (in theory) guarantee access to such human rights. The international human rights treaty is explicitly named an agent which acts upon (obliges) the State to adhere to this, in extract 12 of section 3 'Legal and Strategic basis: International legal basis'. Meanwhile, these human rights are aimed at the individual, and thus frame human rights as an individual-level versus a collective-level endeavour. Building on this is extract 14 below, which in the way of omitting auxiliary modal verbs and the use of is/are is thus denoting a sense of truth.

Extract 14. "Human rights are universal, indivisible, inalienable and interrelated. They belong to all human beings by sole virtue of them being human beings. States have the obligation to ensure, by means of their bodies, institutions and agencies, full respect, protection (including judicial protection) and exercise of human rights. There is no hierarchy among the human rights, and no human right exists that would be more or less important than the others. Thus, the right to life is subject to other human rights, including the right to living inadequate conditions, right to adequate housing, health care and others. In this context, the exercise of right to education, health and social security, adequate housing and work, which this Strategy particularly addresses, remains the condition sine qua non for the enjoyment of all other human rights guaranteed by law." **(Section 2, Principles, p.3)**

Extract 14 is also particularly interesting regarding the over-wording (explained above) of the word 'rights'. This repetition works to emphasise rights as an ideologically important

feature of the Strategy. Meanwhile, words such as 'universal' and 'condition sine qua non' frame health and related rights as universal and essential human rights.

The next extract in a subsequent section of the strategy, namely the 'Description of Current Affairs', describes not only the root cause of the problem, but a potential solution (by way of improvement). It clearly states the authority of the International community, legal discourse linked to human rights, as one that the State of Serbia has accepted via ratifying such pacts and conventions. Thus, this reproduces and, in some ways, justifies the power and authority of such an institutional body:

Extract 15. ***"The improvement of the position of Romani women and men is linked to their full access to human rights. Problems the Strategy deals with, touching on education, employment, health and social care, and housing, are essentially related to the access of Roma people to the human rights the content of which is defined by the international law on human rights through pacts and conventions ratified by the Republic of Serbia."*** **(Section 3, Description of current affairs, p. 20).**

At the same time, not only does the UN human rights frameworks support this holistic rights framework, and also the idea of redistribution is fair and effective for equal rights exercises; but the text's inclusion of such an International discourse reinforces and thus sustains the authority of such frameworks both as a basis for the document and wider social practices.

Text level. Extract 15's text use of the verb ('is') in its present simple tense form makes the link between improving Roma's position and their full access to human rights a given truth and thus again, the text explicitly frames the Roma social exclusion and thus the improvement of the Roma position as a holistic human rights problem, and once Roma persons have access to these rights, they should be able to move to higher social status as individuals and a group.

This second direct quote also clearly shows how Romani, in this case, women and men, are positioned as objects to be impacted upon by the Strategy. This is a typical pattern throughout the discourse of social determinants and works to justify the paternalistic and state-level approach of the Strategy. This thus contradicts the above neoliberal discourse of the shrinking state, and in particular the assertion that the State does not have the material resources and thus more local approaches are necessary.

Later on, in the document, the text producers seem to introduce an element of 'perspective' when referring to this previously simply 'existing' and 'universal' human rights. The following quote exemplify this:

Extract 16. ***"According to international human rights standards, the right to health is not limited solely to the human right to health care. It encompasses as well all the socio-economic factors which are necessary for a person to be able to lead a healthy life. Under the international law, those factors are viewed as socioeconomic determinants of health and comprise housing, access to nutritious foods, drinking water and adequate sanitation, occupational health and safety and living in an unpolluted environment. Therefore, in order to improve the health of Roma men and women, efforts must be made to improve these socioeconomic determinants as well, which is one of the Strategy's tasks."*** **(Section 4.4. Health, p. 47).**

Text level. The declarative statement "According to international human rights [IHR] standards..." provides a direct subject (IHR) to act as an authority on the subject. Because the "International legal basis" is the first collective "source" to be mentioned in the "Legal and strategic basis" section, located at the beginning of the strategy document, it thus prioritises such advisory bodies, speaking to a discourse of "higher authority" and the strong international basis, or governance, of the strategy.

Although not explicitly named, through intertextuality, the bodies in charge of implementing and monitoring the said Strategy have already been described and here they have been called upon as 'active agents' for change in order to "improve these socioeconomic determinants". Thus, unlike with the Neoliberal discourse mentioned above, this discourse is primarily calling upon accountability from higher structures, i.e. those with the power.

While the strategy clearly identifies the significance of such a human rights framework, at the same time, however, the paragraph above cues the reader to interpret this as only one perspective (Fairclough, 2015). Indeed, the first sentence offers a comparison of perspectives on what the right to health entails, through the use of negation (*"is not limited solely to"*); which makes it clear that there is a mainstream view of health rights that the text producer's challenge. Thus, by stating an explicit theory of what determines health, the text producers identify a sight of power/social struggle. More specifically, the text states that this narrower view of health rights (the right to health as being solely the right to health care) is a mainstream notion (ideology) is limiting, and that in this context the approach and view of health needs to be broader for a population such as Romani.

Discursive and social-practice level of holistic human rights discourse. In such a context as Serbia, a transition-country strongly influenced by the EU and international agencies, it is important to consider wider social practices such as the importing of international, or regional, discourses and policy norms into Serbia's national strategies; as well as highlighting how different international stakeholders' (such as the United Nations) perspective on human rights need to be honoured and indeed enacted upon in Serbian society.

This theme is prevalent in the supporting sections of the document, namely the 'International legal basis' section at the beginning of the Strategy, and indeed included somewhat in explaining the 'Health issues' that Roma face (Section '4.4. Health') as shown in

extract. In the later section where the text proposes the specific strategic measures in place for enabling better health outcomes (Section '5.4. Health'), such a holistic theme is not *as* apparent; opting instead for the neoliberalist discourse of risk-management and individualised behaviours that effectively place the responsibility (of health outcomes) on Roma themselves. However, there seems to be a few key exceptions in this latter section, see for example extract 17 below which makes as its primary objective "supportive environment".

Extract 17. ***"Operational objective 1: Creating a supportive environment for the development and health of Roma men and women."*** **(Section 5.4. Health, Operational objective 1, p. 78).**

Extract 18. "***Improving access to timely and comprehensive prenatal health care through the work of health mediators;"*** **(Section 5.4. Health, Operational objective 2, measure 2, p. 78)**

Extract 19. ***" Developing public health care activities to eliminate the conditions which have a specific impact on the health of Roma men and women (improving sanitary and epidemiological conditions in Roma settlements, increasing the coverage rate of mandatory immunization, improving reproductive health, preventing chronic non-contagious diseases, improving nutritional status of infants and small children in Roma settlements, decreasing addiction rates and reducing other risks."*** **(5.4. Health, Operational objective measure b, p. 78).**

Extract 20. ***"Activities of the public health care system and advocacy towards other systems in order to improve sanitary and epidemiological conditions (improving access to drinking water and sanitation, pest control, disinfestations and disinfection of the area where***

informal settlements are situated and arranging garbage removal, etc.);" **(5.4. Health, Operational objective 5, measure 2, p. 81).**

Text level. Extract 17, though not explicitly naming those responsible, positions Roma as the object in need of the provision of a health-enabling environment. While extract 18 is noteworthy as it is positioning the agent (health mediators) explicitly. Indeed, it is interesting to note that this is the first time an agent, other than the targeted (and often objectified) Roma, has been explicitly named in the Strategy document itself (not to be confused with the order of extracts in the thesis analysis). Thus, the text constructs the health mediators as active agents for change. In this way, the mediators are responsible and accountable for their work as "gatekeepers" to health (change) for Roma. Their position as one with such power is naturalised or assumed to be natural through the implication of power, versus the explicit formulation of such workers being able to do the tasks stated (for example, mediators "can" improve access… or have the ability to because of their position). Such an implicit assumption of power imbalance and the need to care for citizens thus has ideological confluence with the two discourses, paternalistic and developmentalism discourse.

Discursive-level and social practice-level of holistic human rights discourse. Indeed, these extracts support the overarching discourse of 'holistic human rights' as supported by the idea that Roma should be enabled to 'develop' with the provision of State healthcare and health mediators. Intertextually, these extracts work with the previous sections, such as those mentioned above, which posit that Roma should be given better (equal) access to priority areas such as housing and infrastructure to enable them to be better included (Extract 16 in particular). Specifically, too, the priority areas have stand-alone sections; for education, employment, housing and social security; which speak to this discourse, adhering to the conceptualisation of Roma health as a broader issue of human rights.

The above quote, declarative statement, and many subsequent statements within this section ('5.4. Health') of the document position Roma as the object to be enacted upon by the subject (mainly, the explicitly-named health mediators); and thus, the discourses of developmentalism and paternalism intersect and support this human rights discourse. Such particular interdiscursivity works to leave the issue of empowering Roma to the side, instead maintaining the power distance between health professionals and 'lay' persons in society. This mix of discourses brings up to the foreground the idea that it is the responsibility of the State, who employs such workers, to provide comprehensive care. This can be contrasted with the statements about capacity-building in Roma communities in the neoliberal discourse discussed above, which imply a more "empowerment" driven rhetoric; versus a comparatively more paternalistic one observed here.

Developmentalism discourse argues that Roma people need to develop their health status through mainstream measures outlined in the health objectives section ('5.4. Health'). Furthermore, this section states that the public health system needs to provide Roma men and women access to health-enabling environments throughout their lives, including *as* children, implying that Roma's current environments are putting them at risk of not achieving health equality. Such a discourse works with the holistic human rights discourse to frame Roma health issues as access to fundamental human rights or social determinants, i.e. housing, adequate sanitation, rights which are explicitly mentioned in Extract 16. Such a discursive construction is thus in opposition to neoliberal discourse framing where Roma health problems are mainly to do with the lack of individualised health information and behaviours.

Meanwhile, the paternalistic activities are most easily observed in Extracts 18 - 20, where Roma's lack of health behaviours (i.e. '[lower] coverage of mandatory immunisation'; 'reproductive health') are problematised as either putting them 'at risk' or being 'risky' themselves. Thus, the text purports a risk-management approach as essential to 'protecting'

Roma from essentially themselves. This type of thinking thus works hand-in-hand with that of paternalism discourse mentioned above and justifies paternalistic measures where the state takes responsibility for creating a context where Roma can flourish.

Embedded into this holistic human rights discourse is the social determinants of health (SDH) framework discussed above, which is a health model endorsed and adopted by many of the regional and international organisations cooperating with the strategy initiative, most notably United Nations Development Programme (UNDP). Additionally, this discourse is part of wider social practice in Serbia. For example, both the government of Serbia and WHO are part of the initiative 'Sustainable Work Management Initiative for a Healthier Tomorrow (SWIFT)', which looks to address social determinants in order to improve Roma health (WHO, 2022).

The holistic human rights discourse may also be reflective of the long-prevailing discourse of state responsibility inherited from Serbia's socialist past; when the state was expected to provide accessible healthcare and education as well stable jobs and salaries (Kleut & Drašković, 2021). Nonetheless, this discourse works in opposition to the neoliberal discourses discussed above, by placing more accountability on the state and more possibility for radical change enabling health equity for Roma.

Social implications of the holistic human rights discourse. The human rights discourse positions Roma as objects and thus relatively passive persons who are affected by a lack of access to their human rights, which by way of being human they are inherently entitled to. Meanwhile, health is a complex construct, one intimately tied with a number of social goods other than information, should be provided by the state and its stakeholders. Though this discourse and associated social practice does not open much possibility for the power-dynamics of Roma in Serbian society to be addressed, indeed its paternalistic approach positions them as

in need of management; it does enable that health to be improved through comprehensive measures. Addressing multiple social determinants of health for Roma is potentially more effective in achieving Roma health equity, than to only give them access to information (Marks et al., 2021).

4.1.3 Neoliberal human rights discourse

Occasionally, human rights discourse and neoliberal discourse are brought together in ways where human rights locate most of the responsibility (and blame) for Roma accessing health on Roma people themselves. As discussed in previous sections discussing discourse found in other NRIS texts, a neoliberal version of human rights frames human rights as predominantly civil and political rights (i.e. freedom from discrimination) instead of socioeconomic rights. Indeed, what I term neoliberal human rights discourse refers to a discourse of health whereby civil and political rights are positioned as health-enabling via the assumption that Roma will have access to health by enacting *these* rights. Like neoliberal discourse, such a discourse places most of the responsibility for accessing Roma health equality on Roma people themselves by stating that it is their responsibility to enact rights once they have been made aware of them.

Though the positioning of Roma as the subject of *civil and political rights* is not as dominant in the Strategy when it comes to framing health, where found, it justifies and indeed reproduces the idea that Roma must be empowered by education to be exercising the civil and political rights that ultimately enable them to enact their right to healthcare. The following extract, Roma are explicitly positioned as responsible '***The Roma do not take advantage of mechanisms available for demanding protection of their rights' this locates blame in those who do not demand protection.'***

Extract 21. ***"Issues related to Roma men and women's exercise of right to health care are the result of a number of causes. The Roma do not take advantage of mechanisms available for demanding protection of their rights – they do not make complaints to protectors of patients' rights, the Commissioner for Protection of Equality or the Protector of Citizens nor do they initiate proceedings before courts. Reasons behind this are a lack of knowledge among Roma men and women about the competences of the above-mentioned bodies and the fact that those bodies are not adequately present in Roma settlements; however, the main obstacle is posed by Roma people's distrust in the system's willingness to protect them from discrimination and other obstacles to their access to rights. In such circumstances, it would be necessary to take simultaneous steps and deal with the causes by empowering the Roma community and strengthening their capabilities, as well as by consistently applying the accountability principle to the institutions which are obligated to facilitate access to such rights."*** **(Health, 4.4., p. 50).**

Text level. Although here there is some focus on institutional responsibility (*'as well as by consistently applying the accountability principle to the institutions which are obligated to facilitate access to such rights'),* a significant part of extract 11 reproduces the language of awareness and knowledge of rights information as the mechanism for Roma health. Indeed, the overwording or overuse of certain near-synonyms such as 'knowledge', 'empowerment', 'empowering', 'awareness' and 'capabilities' puts most of the responsibility for changing access to health on Roma. Again, it is a lack of such empowerment that Roma do not have access to health, and Roma's lack of action is problematised rather authoritatively; through the lack of modal auxiliary verbs and the use of present tense in extract 10, making these declarative sentences above make them appear immediately logical and true.

By framing Roma health and the solution as ultimately up to them, extract 21 (‘***The Roma do not take advantage of mechanisms available for demanding protection of their rights – they do not make complaints to*** …’) from section '4.4. Health' clearly illustrates how Roma are now positioned as subjects, and thus the onus is on them (the responsibility for health). In this same regard, they are positioned as the problem, responsible for their own lack of healthcare access or the continuation of this situation. Indeed, by way of negation, i.e. The Roma do not take advantage…"; the blame flips from those discriminating against Roma (mentioned in the Strategy text in a paragraph just above extract 21) to the "victims". The negative statement implies that for Roma to have better access to health, they should be making complaints or initiating proceedings before courts; instead of saying that Roma face discrimination and a lack of power. Even when discrimination and ‘other obstacles’ are mentioned, assumed to sit outside Roma’s direct control, it is ultimately Roma who must do something about it. At the same time, Roma’s lack of exercising their right to health care is conceptualised as mainly an issue around a lack of trust (‘***the main obstacle is posed by Roma people’s distrust in the system’s willingness to protect them from discrimination and other obstacles to their access to rights’***); however, instead of contextualising this sociohistorically (the system lost the trust of Roma by systematically excluding them, or treating them differently from other sociohistorical or ethnic groups), it is depoliticised and positioned as the main barrier towards accessing rights. In other words, the locus of change is overwhelmingly put on Roma.

The text producer also asserts (it *would* be necessary to…) how to remedy these issues, namely empowering Roma and capacity-building, two solid neoliberal ideals; building on the assumption that the Roma 'should' be responsible for their own health, and indeed correlating to the neoliberal idea of the self-responsible health citizen.

Thus, this rationale supports the propositions made in subsequent extracts, extract 22 and in particular extract 23, which advocate empowerment activities; mainly through the activities (health education) undertaken by health mediators.

Extract 22. ***"Raised awareness of the Roma on healthcare sector opportunities."*** **(Health Section, 5.4., Objective 1, Outcomes by 2025, p.78).**

Extract 23. ***"Roma as bearers of rights that need to be empowered in such a way that they finally start demanding their rights, accessing them, and enjoying them."*** **(Section 4, Current State of Affairs, p. 20).**

Extract 23, from a subsequent section to the two prior extracts also constructs Roma as static objects that should be activated in order to access the existing health rights (services). While this extract proposes an emancipatory activity, where Roma can enjoy their rights, how they do it is by changing their behaviour not the governments. Therefore, once again, other structural factors are ignored, and Roma accountability is highlighted.

Discursive and social practice level of neoliberal human rights discourse. Intertextually, civil and political rights are stressed in the Strategy as a whole and support neoliberal discourse on individual's rights and obligation to access health as independent, autonomous citizens. Thus, here too are equal rights "bundled with autonomy" (Mikuš, 2018, p. 301). The civil and political rights that are further justifying and maintaining the construction of the ideal Roma as self-empowered and able to look after their own health needs simply by enacting such rights.

Emphasis on civil and political rights at the expense of socioeconomic rights is also observed in several international- and regional-level texts that Serbia has officially ratified or accepted. Perhaps most notably is the International Covenant on Civil and Political Rights

(1966), which is explicitly mentioned in the Strategy's Legal and Strategic Basis section (section 3); and European-level texts, in particular the legal documents that frame Roma issues as a civil and political rights issue; such as anti-discrimination text in the Revised European Social Charter (1999) and other Council of Europe anti-discrimination texts; again, explicitly mentioned in the Strategy's 'Legal and Strategic Basis' section.

The way in which seemingly holistic human rights discourse shifts to be a narrowly-defined set of rights well-aligned with neoliberal rationale is also harmonious interdiscursivity at play. Such interdiscursivity shows how human rights can be articulated in a way that minimises its more radical potential or implication for state action. This is an interesting example of where discourse samples undergo transformation, where the text producer uses seemingly opposing discourses, perhaps creatively, to provide coherence.

At the same time, this discourse reflects broader social practices across Europe, particularly contemporary CEE nations. As discussed in above sections, a neoliberal version of human rights discourse, which understands human rights as civil and political liberties as opposed to social and economic rights, has been observed in many NRIS of other CEE countries (Sigona & Trehan, 2005). Kováts (2016) explains that the introduction of such a human rights paradigm and a neoliberal structuring of the economy both came during the post-socialist European countries transition. According to critical researchers who analyse discourse (Kováts, 2016; Mikuš, 2018; Sigona & Trehan, 2009), neoliberal and neoliberal human rights reforms were implemented simultaneously, often by the same actors, but are not to be confused as being causal. At the same time, however, such an introduction made it extremely difficult to counter the structural barriers that neoliberal reforms imposed (Kováts, 2016).

Social implications of neoliberal human rights discourse. The above analysis demonstrates that, although the text producers also note that institutions should be held accountable ('as well as consistently applying the accountability principle to the *institutions which are obligated to facilitate access to such rights*'), and thus the responsibility is not solely on the Roma; it is only after Roma should take responsibility, so in terms of what gets prioritised it isn't the state doing things better. In other words, this is where human rights are articulated but at the same time are rearticulated by being connected to the neoliberal discourse. The implications of this is again, most of the blame being located on the Roma; justifying paternalistic measures to empower Roma. Such deficit-thinking thus further maintains the neoliberal discourse on the need to make Roma more autonomous and self-responsible, minimising the role of the state.

4.2 Analysis part two: Stakeholder interview analysis

The five stakeholders interviewed all held different relationships to the Strategy - four out of the five had been involved in its implementation, with the other focused on producing such texts. Yet despite being involved in the Strategy in various ways, those interviewed were not particularly optimistic about it bettering Roma health. This view was due to multiple reasons (vague measures, no measurable indicators, insufficient data to guide action plans, no budgeting/funding plan available and lack of political will). What is more, the key stakeholders not working for government, Zoran, Milan and Daria, all agreed that as well as lack of careful implementation, that the said document does not consider local issues and needs, but rather uses the same central strategy that might not necessarily be relevant to other local contexts. Within this local context argument, Daria took the time to stress the additional issues that many Roma refugees and internally displaced (IDP) face in terms of access to personal documents needed to access health services.

Nevertheless, Zoran, Daria, Milan, Lenka and Brankica framed Roma issues and health in much the same ways as the Strategy does, drawing on the same discourses to construct Roma and health in Serbia. This is of particular importance because it supports these discourses as social practice on its own as well as the non-discursive activities associated with them. Three discourses were shared across the participants (information and awareness, infrastructure and discrimination), however there were some alternative constructions (cultural capital and cultural sensitivity) from individual interviewees also identified. These alternative constructions highlight what was absent in the strategy. Each of these individual discourses are analysed below in turn. For easier readability, a text level analysis is given after each individual extract (exemplar of discourse), whilst the discursive- and social practice-level analyses and

the social implications for each discourse-type are given at the end of each individual discourse section.

4.2.1 Information and awareness discourse

The assumptions related to the Neoliberal health discourses discussed above were also part of the talk on Roma health issues by the participants Zoran, Daria and Milan. Indeed, one of the most prominent and dominant ways of bettering health discussed by these interviewees was giving out information and raising awareness about health-related issues and individual rights, based on the idea that Roma did not have access to such information but once they did, they could use it to access healthcare and better health. Zoran used the recent pandemic to illustrate a scenario where this need was illuminated. **Extract 24. *'So, number one, would definitely be the fact that there is a very low understanding of certain issues within the Roma community.'* - Zoran.**

While Milan explicitly positioned Roma's lack of education as the barrier towards accessing health in this case, thus further justifying education as a way out of ill health:

Extract 25. '*Roma who, let's say, who are integrated, who are educated, who have certain knowledge, information, that they do not have big problems in accessing health. There is a large number of Roma who are poor, who are uneducated and who have no information, and who are uneducated as to the way the health system works. That is the basis of that position, it is about poor people who live in really extremely difficult conditions. You will see children who are barefoot at minus 5 or 6 degrees, with inadequate clothing. Then you will see Roma who are overfed, who essentially eat poor quality food and whose health is endangered in that way. There are Roma women who do not take care of their reproductive*

***health or their health after motherhood. The third problem is that of underage marriages where there are premature pregnancies or premature abortions. These are all things that can be prevented through education and timely information, through a certain degree of socialisation.'* - Milan.**

Text level. At the text level, the amount of positive assertions that position these statements as truths are high. The first two sentences are particularly strong assertions as evidenced by the use of categorical or 'truth' modality; by using the verb ('are') in its simple present tense form, making the statements seem immediately logical and true (Fairclough, 2015).

Once again, the idea of Roma heterogeneity, different groups of Roma, is brought into light, as suggested by the different categorisations of Roma in the first two sentences. These two sentences work to contrast Roma in terms of binary traits using antonymy, namely educated or uneducated Roma; showing the meaning relations between those two terms as having what Fairclough (2015) terms as 'meaning incompatibly'. Milan clearly identifies the group of Roma targeted by the Strategy, based on socioeconomic position, which thus compliments the Neoliberal discursive framings found in the Strategy.

Later sentences in the same extract use modal auxiliary verbs, such as 'will', a marker of relational modality, which denotes Milan's authority relative to the probability of an observation (i.e. seeing children barefoot in minus 5 degrees). While the pronoun 'you' denotes a sense of solidarity between the speaker and the audience (Fairclough, 2015).

The process types that predominate this extract are attribution and events, where Roma (the participant) is given some sort of attribute (*Roma who are overfed*) or are doing something (*Romani women who do not take into account*...). Unlike actions, which provide for a clear responsible agent or agents, these statements denote some ambiguity about who is to be held accountable. However, when taken with the first two sentences as well as the last sentence

regarding access to education and information, what these sentences convey is the assumption that once given such knowledge and information, Roma people will be able to enact health behaviours.

The extracts above mainly locate lack of health information as a community-based problem as supported by deficit-thinking around traditional values and customs and thus endorsement for the activities of Roma health mediators. Indeed, the above paragraphs predominant use of certain process types (namely, events and attributions; versus actions) and participants (subjects/objects – Roma) over others offer some ambiguity for more structural reasons as to how or why information does not quite "reach" Roma. In other words, it does not offer a causal human agent or agency to pinpoint this lack of top-down action.

The text's large-scale structure, the ordering of the elements, makes information-dissemination, or lack thereof, a key barrier preventing Roma health; and even though structural barriers are implied (particularly the clause 'it is about poor people who live in really extremely difficult conditions'), the most significant ideological perspective evoked in this extract is likely to be one of Roma doing health via information. Such declarative statements, in turn, justify the use of information-dissemination techniques that are later proposed to be ideal measures for solving the Roma health question. Thus, this small part of a text 'speaks' to other parts, which further reinforce the information discourse and social practice as being vital to protecting Roma health. Daria largely attributed the progress thus far of the Strategy to health information distribution:

Extract 26. '*The progress in the health and health care system is also huge, the percentage of those who do not have a health card is now immensely smaller than it was and, what is very important, the Roma know now that they have the right to health and they know roughly what this right entails.'* - Daria.

Text level. Considering Daria's extract above at *text level,* apart from denoting the progress and the evidence for it as a given truth by using the verb (is) in its simple present tense form, Daria is explicitly positioning Roma's access to information, and some understanding (on the right to health), as a 'very important' agent in enabling such progress.

Another obstacle obstructing Roma's access to information, is socialisation; which in the above extract's case, is likely to relate to their marginalisation from mainstream society. Zoran's talk further supports such thinking as shown in the next extract:

Extract 27. '*There is no, there is limited access to information related to various diseases to various protection of diseases. And on top of this you do have also certain traditional values within the Roma communities, which tells you that somehow the topic of discussion related to health is not necessarily something that should be on a daily basis. So Roma people are somehow always distanced to talk about their health issues, which somehow even more puts them on the margins of having a healthy lifestyle. So this would be the type of measures that would really need to be somehow insured in the new Strategy.'* - Zoran.

Text level. The first sentence in the paragraph above shows that the need for information is foregrounded as a central issue; with the verb (is) in the simple present tense form, the statement denotes Zoran's categorical commitment to the truth of his proposition. Without pronouns, however, it is unclear what the barriers to the information are (albeit, later on, we find that the problem lies with a lack of infrastructure and appropriate health campaigns reaching Roma communities).

The next sentence then moves onto locating the problem in traditional values of Roma. By the end of the above paragraph, what is constructed is a twofold problem: information does not reach Roma, but even if it does – it doesn't circulate within the community appropriately because they do not like to talk about it.

While information dissemination is constructed as essential in the above extract, no specific routes (strategic measures) are given for how to achieve this, as evidenced instead by the modal adverb 'somehow', which creates vagueness and ambiguity around who is responsible for dealing with it. However, as stated above, Zoran goes to give further support for the information and awareness-raising activities carried out by the Roma health mediators (RHM), positioning the mediators as critical stakeholders in Roma health. Meanwhile, this idea of health mediators' work and the associated underlying paternalistic activity as key to the success of Roma health measures was evident in all of the stakeholder's talk. Milan went on to propose that their activities enabled for spreading not only awareness, but allowing Roma communities, in particular Roma women, to develop their health culture and health citizenship. In answering the question, 'what is your perspective on the Roma view of health?', Milan took the opportunity to note the changes largely attributable to the mediator work:

Extract 28. ***'It is a very broad and complex question to answer now, but it seems to me that gradually there has been a growing sense of responsibility and a greater degree of health culture among Roma people than there had been before, especially among Roma women. And that is, it seems to me, the achievement of health mediators and women's NGOs in large part, especially those that included Roma women or that Roma women founded and developed. They simply talked to their compatriots about what was bothering them and provided not only help that could be concrete, in money, in some, I don't know, necessities, but also gave them advice, talked to them, taught them. I think that it has contributed to the reduction of some diseases, so that the situation regarding this is somewhat better, looking at percentages.'*** **- Milan.**

While acknowledging both the broadness and complexity of such a question, Milan gives his perspective on the views Roma have on health, insofar that there is greater

responsibility and a greater degree of *that* health culture compared to before, particularly among Roma women; which assumed to be positive towards Roma health and an indicator of the Strategy's success. In the second sentence, this assumption is reinforced by the clause 'the merit of health mediators and a large part of women's NGOs'.

The second part of sentence two credits this success to two specific strategic methods: material resources and education and awareness raising activity, but these two methods are divided into relatively important and relatively unimportant parts. Namely, the text positions money (for necessities) as the subordinate clause 'not only help that could be concrete, in some money, in some, I don't know, necessities' and not asserted, but rather assumed with only some certainty ('I don't know') and is thus less informationally prominent. In contrast, the main clause asserts that advice and education is effective in contributing to reducing diseases and developing a certain health culture; only further supported by the directly following sentence which communicates the participant's opinion that this latter practice contributed to bettering Roma's situation (reducing some diseases).

As implied above, at the same time, this passage shows another somewhat competing discourse to the simple information dissemination one, one that centres on the need for economic resources for necessities; thus, implying that Roma may not even have the basic means for achieving health. This may be evidence of the remnants of past Roma policy discourse, which centred on human rights versus the socio-economic benefits of inclusion (Popova, 2019).

Discursive and social practice level of information and awareness discourse. The information discourse observed in Zoran, Daria and Milan's interview text further supports Neoliberal health citizenship discourse by framing health as achievable by raising individuals' education and awareness, thus giving them a choice to enact such 'good' citizenship. At the

same time, as discussed below in detail, the social practices conducted by the mediators are framed as (ideally) being the responsibility of the State. Therefore, the information discourse also speaks to paternalistic discourses by drawing on multiple responsibilities (Roma individuals and communities, as well as Roma health mediators) for Roma taking up health-related behaviours.

However, the idea that the individual 'chooses' health was contested by another discourse that positioned Roma in the social context, namely culture and tradition. In other words, the idea of additional barriers, cultural traditions and customs, challenges the neoliberal ideal of Roma individuals' idea as autonomous and independently-choosing agents. Here, the individualised Roma did not "make sense" due to the family hierarchies and community traditions of Roma culture.

Social Implications of information and awareness discourse. Such text conveys the taken-for-granted assumption that access to health information is an ideal strategy for bettering health. However, Roma's traditional values and customs can challenge even such effective measures. Thus, as the Roma individual is effectively positioned as responsible for taking up health information but that their culture may be inherently problematic; and thus, Roma culture may impede this strategic measure. As such, this discursive framing puts most of the onus of the measure's success (and failure) on the Roma and Roma community. In particular were the barriers towards women's health issues framed around culture, namely patriarchal, values and customs. Thus, Roma culture and health ‘culture’ were seen as somewhat exclusive. One social implication of such talk is that it fits within a deficit-thinking model which can work to justify assimilative practices that effectively ‘change’ Roma culture by way of health education and adopting a specific health culture.

Ultimately, like the Strategy in question, these stakeholder's talk showed the dominant discourses that positioned health information (or lack thereof) as the main obstacle to Roma's access to and health in general. Meanwhile, traditional lifestyles and values were also constructed as key barriers towards Roma accessing healthcare and health in Serbia. Thus, such constructions position Roma's lack of access to health (and therefore poor health outcomes) as mainly a community-level problem, mediated by the support of the State in providing health-related information and skills. These constructions justify Roma health mediators and health dissemination within the community as the primary mechanism towards bettering Roma health. Indeed, they support the Strategy's emphasis in using SCM models to guide strategic measures and the underlying SCM conceptualisation of health behaviours mostly stemming from individual choice via information and awareness about health and health norms. In the context of the Covid-19 pandemic, this made particular sense to the respondent, Zoran.

4.2.2 Infrastructure discourse

While the above discourse positioned lack of awareness and access to information as the main barrier to Roma health, mediated by traditional values; the following constructions of infrastructure discourse point to a more complex picture of Roma health and one interrelated with other basic human rights.

Brankica emphasised the importance of holistic human rights paradigms which stress how multiple social determinants of health cannot be separated but indeed work together to form a complex picture of why Roma health inequalities exist. She stressed in particular the idea of Roma substandard settlements limiting Roma health due to lack of electricity, water, adequate nutrition and sanitation:

Extract 29. *'The key problem is living conditions, then when you improve the living conditions and when these people have electricity, water, infrastructure in the settlement and the possibility of personal hygiene and a healthy diet, especially when we talk about children, then the health picture of the Roma population will actually improve. So, you can provide these people with health insurance cards and vaccinate, of course, the children, which is very important, but they will return to the settlement where they lack basic living conditions and it will again affect their quality of life and Roma men and women will still have a much shorter life expectancy. Thus, the problem of living conditions in Roma settlements needs to be solved in parallel with the approach to health.'* **- Brankica.**

Text level. Enabling health insurance (in the form of health cards or 'books') and essential prevention services such as children's vaccinations is positioned as the sub-clause, and thus according to Fairclough (2015) is a taken for granted assumption that needs no strong assertion. Meanwhile, the main clause is the direct assertion that living conditions, substandard settlements, are indeed limiting towards Roma health; and unless this is remedied the health inequalities will persist. More specifically, everyday living conditions that many Roma face are brought into light and argued to affect their quality and length of life.

In answering the question of what he sees as the key barrier in accessing health for Roma, Zoran states ***'I think that the main barrier here is that there are limited facilities that are in close proximity to Roma'*** **(Extract 30).** Indeed, the following sections of Zoran's interview also alludes to a discourse of holistic human rights which clearly identifies a lack of infrastructure as central to this information problem.

Extract 31. *'Things are even more challenging, because I think that the COVID 19 pandemic really showed us how bad the situation with the Roma communities is. You might remember that a year ago when this whole pandemic started, there were many campaigns*

on social media and traditional media on how people should protect themselves from the pandemic, with self-isolation, with regularly washing their hands, with many many many recommendations on how people should should protect themselves from the pandemic. Unfortunately, more than half of these recommendations could not be applied to Roma. You have to take into consideration that many Roma still live in overcrowded spaces. So, unfortunately when only one of the members gets the COVID virus, chances for self-isolation in a very small household are very minimal. Then we also have to take into consideration that unfortunately many Roma's still live in very big informal settlements, which means that there is very limited, ah the communal infrastructure is not up to the standards, it should be. There is lack of water, there is lack of electricity, which are the necessary preconditions again for a healthy lifestyle. And most importantly, there are not necessarily, these Roma communities are not necessarily very close to health facilities. So, if there is a need for Roma to receive some health services, they really, really have to go long distances to find an appropriate health facility. So the distance and accessibility of health services for Roma is very limited…' **- Zoran.**

Extract 32. ***'The State has to ensure that based on appropriate urban planning, there are enough health facilities in the close proximity of the communities where Roma live, and the State knows where the Roma communities are based.'*** **- Zoran.**

Text level. Line three in extract 31, 'You have to take into consideration…', in the first of Zoran's paragraphs uses pronoun ('you') and relational modality of necessity and obligation (as expressed by the semi-modal auxiliary 'have to'). As such, this statement calls upon the audience to see the social determinants of health that stand as barriers to Roma achieving health services. He then lists the conditions that Roma live in, which through the use of verbs (are, is) in their simple present tense forms stand as categorical truths.

Zoran's text (extract 32) positions the State as the agent responsible, obliging the party to know where the Roma communities reside; to then calls upon (*has to*) this agent, the State, to provide 'enough' health facilities in the proximity of the communities where Roma live. Thus, instead of laying most of the responsibility for such health equalisation on Roma individuals, the above sentence clearly and explicitly outlines the State as a responsible agent and the corresponding duties for this party as responsible for achieving Roma health. Although Zoran is vague about what enough is (he does not offer a specific definition of enough), he is by implication stating there are not enough facilities currently.

Discursive and social practice level of infrastructure discourse. Zoran's extract above (extract 31) is a speech act which works to authoritatively declare a statement regarding the complexity of health protection for Roma and contest a competing discourse on Roma health protection. By explicitly naming the media as purporting what he implicitly frames as a short-sighted or de-contextualised perspective, he effectively contests, or at least challenges, the media discourse. Indeed, by way of using negation ('more than half of these measures *could not* be applied to Roma') Zoran is stating that such measures are not effective Roma in reality, taking issue with the media's social protection discourse.

The discourse that Zoran draws upon is a more holistic human rights paradigm, in particular the right to quality housing and infrastructure. Thus, this discourse challenges the simplification of the information dissemination discourses and social practice where the mainstream assumption is that information dissemination is all that is required to better Roma health. In other words, such a discourse challenges the relative-narrowness of the previous education/information discourse by placing Roma in everyday living conditions. Information access and health behaviours can only be enabled by attending to preconditions such as infrastructure (lack of water, lack of electricity, which are the necessary preconditions again

for a healthy lifestyle). What is constructed is a hierarchy or checklist of conditions, contextualising Roma health problems further; which shifts responsibility for predominantly Roma to the State.

Thus, this discourse explains why Roma people do not hold understandings of health beyond the argument of traditional values. It also offers a rhetorical understanding that contests the information-processing discourse – that even if Roma have the information, they may not be able to enact such 'healthy lifestyles' because of structural barriers, i.e. lack of infrastructure. Such statements (extracts 30 - 32), therefore, position infrastructure, namely nearby health facilities, as *the* most significant barrier towards Roma health.

Meanwhile, the focus on housing as a particular problem/solution framing of health issues for Roma may correspond to another document, the Poznan Declaration (2019), in which the Serbian government has agreed that housing is one of the highest priorities for Roma integration measures (Regional Cooperation Council, 2019). Therefore, it is perhaps no surprise that housing infrastructure is prioritised as a critical barrier.

Meanwhile, Daria positions these conditions as having negative implications for Roma health and development.

Extract 33. '...*Roma settlements in Serbia are still in a very bad condition, not all of them, but they are in a very bad condition. To the extent that they do not have access to drinking water, that they do not have regulated sewerage, that they do not have real roads, but dusty, macadam rural roads that do not have asphalt and are difficult to use in winter. It is often the case that they don't have electricity and connect to the power network by themselves. They practically steal electricity and connect directly to the transmission lines, which often results in someone getting injured. But it is simply an unsafe environment, it is bare power wires, it is an unsafe environment for children who live there. There are settlements that are*

really, extremely in a bad way. I could specify some that are really in a catastrophic state. In the sense that they often face infectious diseases, scabies spreads easily, and I don't even know what other diseases as well. Growing up and developing in such an environment certainly has far-reaching consequences for the health of tomorrow's adult individual. I mean, it seriously disrupts all aspects of a child's health and development. So that's what is supposedly being worked on.' **- Daria.**

Text Practice. Daria's text, here, shows a clear negative evaluation of Roma settlements, and goes on to describe the living environment as a barrier framed because of many risks across one's lifespan. Indeed, the participant locates Roma health barriers in a more longer-term vision, one where one's ill- health and development are framed as consequences of poor living conditions, which distinguishes it from previous accounts; as it more strongly locates responsibility with the government and social determinants of health.

Discursive and social practice level of infrastructure discourse. Daria draws upon the same discourse as Zoran does above but does so concurrently with one associated with development discourse discussed in the Strategy analysis findings. Development discourse here sees Roma health as influenced by factors over the course of one's lifespan and development, opting instead for a life course approach that considers multiple barriers in the way of healthy development, starting ideally from one's birth.

Social Implications of infrastructure discourse. The social implications of infrastructure discourse make it harder to blame Roma for their vulnerable position in health matters, particularly spreadable (communicable) viruses such as the Covid-19. The discursive constructions effectively position Roma as victims of such circumstances and conditions. Explicitly naming the State as the responsible agent for enabling changes thus opens up the possibility for more top-down structural changes. At the same time, development discourse

sees health and development being affected by multiple factors across one's lifespan and thus challenges the view that ad-hoc approaches such as information-dissemination are effective.

4.2.3 Anti-discrimination discourse

The interviewees also added tackling other societal and systemic issues as key barriers towards Roma health, and indeed positioned some as central to Roma's predicament. All of the participants interviewed who were involved directly with the Strategy mentioned discrimination as a critically important factor negatively influencing Roma health. For example, Milan posited that

Extract 34. ***'The local self-government, each of them, could easily identify [Roma needs] and could easily direct certain measures…. It seems to me, to put it that way, that we have a problem that has existed for generations, we have a system that solves all those problems for all the other people, but not for them, and that makes me think it is a matter of systemic discrimination or at least negligence.'*** **- Milan.**

The participant went on to state that he thinks that discrimination towards Roma is not recognised as such:

Extract 35. ***'And now when you ask me what I think it is, I think it's simple that people, even when they discriminate against Roma, don't think it's discrimination. They just think "it's like that, it just exists, they live there, and they want to live like that". Well, I'm not quite sure that they want to live like that, but no one even asked them if they want to live like that.'*** **- Milan.**

Whilst Zoran framed success as tackling what he defined as the root cause of the issues Roma face - discrimination:

Extract 36. '*Well, I think that one thing that is somehow a cross-cutting issue throughout, that has somehow been overlooked in the past year, is that we do not place enough focus on the topic of discrimination that is very much present in the, here, ah in the region and beyond. Unfortunately. And we do have data, I can share them with you later. Each year, the Regional Cooperation Council is publishing a Balkanbarometer, which measures the public and business opinion of citizens throughout the Western Balkans, with regard to two very different issues, ongoing issues, including Roma inclusion. And there are also specific questions which measure the social distancing between Roma and non-Roma so there are questions such as, would you have Roma as a neighbour? Would you marry a Roma? Would you live? Would you be comfortable with your children sharing a classroom with Roma, etc, etc, and results are devastating. I mean, I will share them with you and it simply shows how much prejudice and discrimination and intolerance towards Roma communities is present here in the Western Balkans…' - Zoran.

Text level. Like the other participants already quoted, the participant positions discrimination towards Roma as something that simply exists, using categorical modality to mark this; namely, the verb (is) in its simple present tense form *(*'discrimination that <u>is</u> very much present in the, here, ah in the region and beyond'*).* Zoran makes a direct declarative statement that he and other stakeholders (as denoted by the pronoun 'we') do not emphasise what he considers central to the Roma question, discrimination, thus taking responsibility for this omission. However, at the same time, through modifying words such as 'somehow' ('[discrimination] has somehow been overlooked') produces some ambiguity as to why discrimination is unrecognized. Meanwhile, the interviewee identifies discrimination as a 'cross-cutting issue'; reducing this

intersectoral occurrence to a nominalisation (converting a process into a noun), and thus obscuring agency, causality, and accountability (Fairclough, 2015). However, by offering an example of evidence of discriminatory practice in Serbia and the wider Balkans region, it is inferable that it is general society that is practicing social distancing at a severe level ('and results are devastating'); and that these practices exemplify prejudice and discrimination.

Discourse and social practice level of anti-discrimination discourse. Discrimination based on Roma identity, is one of the central discourses that the Strategy and other National Roma Integration Strategies (NRIS) draw upon, as somewhat suggested by the EU Framework for National Roma Integration Strategies. However, as a specific form of discrimination, antigypsyism is increasingly recognised and stressed in Roma inequality measures adopted in EU policies. Recently, the European Commission's (EC) (2018) evaluation of the aforementioned EU framework pointed to the need for a stronger focus on antigypsyism and intersectoral antidiscrimination measures in NRIS. The new EU Roma Strategic Framework (2020) centres on discrimination 'on the grounds of racial or ethnic origin' which they position as persisting for Roma; and thus, fighting antigypsyism is the key goal (EC, 2020, p.1). Thus, it is perhaps of no surprise that this discourse is stressed by a professional such as Zoran who works on behalf of such intergovernmental organisations. Zoran further reinforces this focus on fighting discrimination towards Roma:

Extract 37. ***'So, one of the main issues that has not been challenged enough is tackling discrimination, tackling hate speech, prejudices against Roma*****;** ***especially because this, this leads towards intolerance and further leads towards hate speech, hate crimes, and most importantly, it limits the equal access to public services for Roma… public services including health services.'*** **- Zoran.**

Text level. The above declarative statements (in extract 37) have no modal auxiliary verbs but act as categorical truths using the verb 'is' in the simple present tense form. Such statements support the assumption that the cause of Roma inequality is primarily known and that it is indeed discrimination but not enacted upon enough to date by the strategies. It thus supports and legitimises the idea that such known truths can allow stakeholders to follow a relatively linear pattern of consequences for Roma.

Discourse and social practice level of anti-discrimination discourse. Extract 37 above effectively justifies certain social practices, such as the legal measures introduced in Serbia to tackle discrimination, recommendations set out by the EU. However, many civil society organisations, EU and EC reports see these measures as not well implemented nor taken up and thus may need to be 'stressed' by those dealing with the Strategy's enactment, such as Zoran.

Taken all of the above, it is perhaps no surprise that soon after, the same interviewee positioned discrimination as the base for the Strategy's success:

Extract 38. ***'[T]he strategy has to be based [on] the pillar; the central pillar of the new strategy has to be fighting discrimination and antigypsyism.'*** **- Zoran.**

Text level. Such a solid and direct assertion with the (semi-) modal auxiliary verb 'has to' thus conveys a sense of obligation based on the assumption referred to above - that discrimination is the central issue. The use of the semi-modal auxiliary verb "has to" in the same declarative statement also denotes a sense of the interviewee's (the text producer's) authority insofar that he states what is necessary for the Strategy to succeed. Such a solid matter-of-fact assertion thus again represents the assumption of known truth, the cause of Roma issues in Serbia. Again, this positions the Roma as victims, and thus their (ill) health and poor access to health services are affected by external, or upstream, causes.

The following statement further reinforces the stance of such linear thinking and extends it to explain why this assumption is made using a formulation:

Extract 39. ***'If there is no appropriate fighting, there is no getting into the cause of why Roma cannot access public services, why Roma are always marginalised, why certain policies are not working for Roma, we really have to go to the root cause, and after 15 years of continuous work in this field, the root cause, seems to be discrimination.'*** **- Zoran.**

Text level. Again, negation justifies the normative thinking around the consequences of discrimination and thus frames Roma issues in Serbia as essentially discrimination issues. The phrase 'after 15 years of continuous work in this field' works as a claim to expertise and strengthens Zoran's argument by assuming that such a length of time in a specific field would allow for the observation of the root cause of Roma's plight.

Social implications of anti-discrimination discourse. As discussed above regarding the discourse linked to holistic human rights (infrastructure), the anti-discrimination discourse also positions Roma as victims rather than responsible (and blame-worthy) agents in their plight. This enables a more systemic approach that focuses on broader societal issues instead of changing the local Roma community.

4.2.4 Complexity discourse

Throughout the interviews, all of the participants alluded to the conceptualisation of Roma health as complex. However, none did so with more clarity than Zoran. Indeed, this participant was the most articulate in the intricacies of Roma health; different ideas regarding how to be successful in terms of the health situation for Roma in Serbia were touched upon;

with the main three being information dissemination (intersecting with traditions), infrastructure and discrimination:

Extract 40. ***'So, this would be the type of measures that would really need to be somehow ensured in the new Strategy. Besides discrimination as I said, tackling discrimination in access to health services, access to information and access and campaigns related to having a healthy lifestyle, which is relevant for for many Roma communities.' - Zoran.***

Extract 41. ***'One thing that really deserves much more attention is the fact that we know there are available data that Roma lives definitely less in average than non Roma, and this differs from country to country, it is between 10 and 15 years in average and this is not a small number, I mean we really have to consider the fact that this is something worrisome, and it can, it really has a big impact not only on the, on the community but it also has a big impact on the economy, and most importantly, it really shows how mistreated, certain issues could be, and this deserves much more attention to see why, why is this happening, what are the causes. How could this be improved? And most importantly whether this is based on certain lifestyles, based on a combination of lifestyle and traditional values as I said, because health is not an issue to be discussed within the Roma communities, or is it a combination of traditional values, lack of information, bad health ah -bad lifestyle and discrimination and lack of access to health services.' -*** **Zoran.**

Text-level. The text of extract 40 above lists the different possible causes of Roma health disparities and thus solutions; and thus the list makes up a classification of what measures should be in the new Strategy.

As for the extract 41 above, the first sentence ('One thing that really deserves much attention is the fact that…') offers a declarative assertion with strong claims to knowledge; as

conveyed the term 'fact', and again, the use of the verb 'is' in simply present tense which denotes a categorical commitment to the truth.

Discursive and social practice level of complexity discourse. The interviewee Zoran gives three rationales of why Roma health disparities (mortality rates) are significant to consider: firstly, as a community issue, making it centrally an issue for the Roma community; secondly, economic-market discourse is alluded to by positioning Roma health issues as an economic issue; and lastly, what the respondent positions being 'most important' - an ethical or moral issue, as denoted by the word 'mistreated'. In this context, mistreatment is likely to refer to Roma's human rights abuses, but it also constructs the causes as unclear. Thus, Zoran, drawing upon the discourse of how complex the issue of Roma health inequalities could be, proposes the complexity of bettering Roma's situation when looking at the solutions to health inequalities. In effect, this paragraph represents an awareness of the possible mainstream discourses surrounding the Roma situation. Namely, the discourse that centres on individualised solutions via information and awareness and ultimately supports neoliberal good health citizenship discourse; and a more holistic human-rights discourse that includes more upstream factors. These frameworks were alluded to in the same sentence, and such discussion mirrors the current policy debates on including Roma in society. In terms of coherence, these intertextual and interdiscursive properties may open up for the point that there are complex, even contradictory framings of Roma health problems and solutions, stressing the need to look at issues from multiple angles.

Social Implications of complexity discourse. In relation to social implications, Zoran effectively reinforced and thus supported the Strategy's focus on individualised measures, such as health information dissemination and awareness programmes, by alluding the importance of such social-cognitive models for the success of Roma health. At the same time, however, the

professional also clarified that Roma health inequalities were a complex, multifactorial problem. Thus, several parties, at different levels, are responsible for enabling the betterment of Roma health. Such a multifaceted conceptualisation makes it harder to blame Roma solely for their predicament but instead calls for a collaborative effort in society. Indeed, not only was the current State called into question regarding responsibility and accountability but the sociohistorical conditions (discrimination, racism) that have affected Roma for across generations was brought into the light.

4.2.5 Alternative discourses: cultural capital and cultural sensitivity

Above we have seen the discourses in the document reproduced in the stakeholders' talk, but they were not the only discourses in their interviews. Below I discuss other new discourses identified in the interviews that shed light on how Roma health in Serbia might be understood.

(Existing) Cultural capital discourse. An alternative and indeed opposing understanding of Roma and health came from the fourth interviewee, Lenka, an academic who researches Roma issues. Lenka's interview answers put forward the idea that Roma women had their own cultural resources for navigating and achieving health; albeit ones that did not fit into the 'mainstream'. The idea of Roma folk medicine and health perspectives was positioned as a 'strength' of Roma culture and this contrasted with the common view of Roma not having health information, one that fits within a deficit-thinking framework. While Lenka stated that there are many barriers in the way to Roma inclusion, in particular health, the first barrier was the lack of recognition and use of Roma's health knowledge and traditions:

Extract 42. ***"There are many challenges: 1. Some solid foundations of folk medicine exist in the tradition of Roma people and they do use it, but the majority of the people do not recognize it as a treasure that they could also benefit from. Roma folk medicine is not utilised enough in health institutions. If it was, it might prove that there is some benefit to this manner of treatment. Instead of giving due attention to the folk medicine that the Roma people are familiar with (medicinal herbs, manner of treatment, etc.), it is declared irrelevant."*** **- Lenka.**

Text level. By way of strong positive assertions that imply that Roma medicine is beneficial for their health as well as negation (but the majority people do not recognise it as a treasure), the text suggests what mechanisms should be but are not currently utilised.

'There are', 'Roma folk medicine is not', 'it is declared irrelevant'- sees that Lenka uses no modal auxiliaries to suggest possibility, but rather verbs (are, is) in their simple present tense are thus positioning these assertions as given facts. Such statements support the following direct assertions that Roma knowledge and skills are not valued in mainstream society, and the implicit statement that such frameworks should be (included) and thus not used effectively; it is only implied that this will help better Roma health, as the observation that it is not utilised is positioned as a barrier to Roma health.

Discursive and social practice level of cultural capital discourse. Cultural capital discourse moves away from positioning Roma as lacking in knowledge and skills for achieving health by drawing attention to the idea that Roma health systems already exist. This contradicts assumptions of Roma's inability to access health without mainstream forms of education and that they are lacking in the 'correct' socialisation to access health; or at least it suggests a different way to do health and be healthy.

I consider this a 'strengths-based' discourse as it positions Roma culture and knowledge as having benefits for their health. As a social practice, including discursive practice, Lenka positions Roma's folk medicine as alternative but valuable; and argues that this presents a challenge to the success of the Roma (health) inclusion objective. Lenka's background in Roma-related academia, where researchers work using participatory action-oriented models with Roma communities, positions her differently from the other stakeholders. Perhaps this is why she draws on less dominant and more culturally-relevant frameworks for understanding and addressing Roma health, and the valuation of Roma culture is the focus of her talk. Indeed, during the correspondence with Lenka, I was given access to several studies conducted with participation of Roma (particularly Roma women) which allowed for Roma voice, knowledge and skills to be highlighted and used the same strengths-based approach and discourses to discuss the Roma.

Social Implications of cultural capital discourse. A more culturally inclusive and perhaps empowering approach could be to incorporate Roma ways of viewing and achieving health into the existing health system. This practice may not only benefit Roma health directly by making it easier to identify with health services, thereby encouraging buy-in, but by recognising and using their cultural resources, it opposes a deficit-thinking perspective. The idea that Roma have got strengths (their health knowledge and skills) is generally omitted from such policy documents, opting instead for a biomedical view of health and health practices which positions Roma as in need of, and therefore lacking, health information. Such discourses can thus, unfortunately, promote deficit-thinking and possibly even discrimination. Moving away from deficit thinking to cultural difference or dissonance discourses can help illuminate that there is no one way to do health and achieve health; and help realise that Roma has their own cultural knowledge and systems (Levinson & Hooley, 2014).

It is important to consider the ramifications of such a discourse as it opens up new possibilities in terms of Roma health equity. Indeed, it has the potential to give Roma more voice and identification in their health services, which in other contexts such as New Zealand has proven to be effective for bettering minority group health (Marks et al., 2021). At the same time, the observation that this is the *first* barrier or challenge towards achieving Roma health inclusion can serve as a reminder that there are alternative priorities and conceptualisations for Roma health that are omitted in the Strategy and by those key stakeholders involved with the document. This particular omission is significant as the idea of integration generally involves some sort of cultural exchange between parties, which this cultural capital discourse supports. Although the other interviewee mentioned the richness of Roma culture and their cultural resources, Lenka explicitly discusses the concept of a cultural enrichment of two (or more) communities positioning Roma as currently able to participate in such a process. As mentioned, the Strategy often positions Roma as deficient in either some knowledge or skills that enable health and socioeconomic integration; which fits in with the idea that they need to be socialised to be 'active' (neoliberal) citizens. Thus, this strengths-based discourse can oppose such positioning and constructions. Moreover, it challenges the current status-quo, where Roma are relatively disempowered and may also be potentially an antidote to discrimination by positioning them as equal and participating citizens.

Cultural sensitivity discourse. A second discourse that centred on cultural sensitivity came from Milan, a policy expert involved in such minority documents, when he discussed how the Strategy design's focus on the individual instead of being embedded firmly in the family unit was a problem for its success. Indeed, Milan explicitly pointed to the idea that Roma are essentially family members:

Extract 43. '*Due to the fact that this is not possible with the Roma, it [the Strategy] was turned towards his family. Roma live, at least in Serbia, in large families that are generationally connected, that have, I forgot what it's called...and that is the peculiarity of their culture, one of the peculiarities… However, …. the strategy [was turned] towards the individual, which is the human rights approach and that's all fine in general, but it's not doing the job now and it makes the strategy much less measurable, clear and applicable.' -* Milan.

Text level. The use of the verb (is) in its simple present form makes the first assertion particularly strong, indeed acting as a factual statement regarding Roma culture and appropriate strategy design.

Discursive and social practice level of cultural sensitivity discourse. Intertextuality and interdiscursivity: By explicitly linking the individualised focus to the human rights approach and making a judgement ('that's all fine in general'), Milan somewhat defends it from not being irrelevant, whilst at the same time deeming it inappropriate for the Roma in particular due to the 'peculiarities' of their culture. This cultural sensitivity discourse evokes the idea that different cultures can exist and should be considered for the efficaciousness of the Strategy, and that the strategy implies that the solution is homogenisation. By drawing on cultural sensitivity discourse, the participant opens up the possibility for Roma health issues to be looked upon as a collective issue and thus collective endeavour in this given context. This creative approach of mixing texts and discourses opens up the view that Roma health issues are indeed complex issues, and that ideas of catering to cultural sensitivity must be considered to effectively work in the given context. Such constructions effectively contest the individualised approach that the SCM and the neoliberal good citizenship discourses suggest as mechanisms for success of the Strategy.

Social Implications of these alternative discourses. Like Lenka's text above, this small use of cultural sensitivity discourse as shown in Milan's text (extract 43) challenges a 'one size fits all' approach that the Strategy and the rest of the analysis found as a dominant idea. Moreover, it may also oppose the idea that the strategic measures do not work because of Roma's inability to conform or adapt, but rather the Strategy's (or those behind it) unwillingness to adapt to the cultural needs and values of Roma communities. Thus, this too, challenges deficit-thinking, by accentuating diversity as a key value for consideration.

Chapter 5 – Discussion/Conclusions

My thesis was interested in exploring how Roma people and health are discursively constructed in an official Strategy text and in the talk of those involved with the document in various ways; as well as considering the social implications of such constructs enabling or limiting social justice for Roma. The exploratory project used Fairclough's Critical Discourse Analysis (CDA) to critically analyse the current Serbian "National Roma Social Inclusion" strategy (NRIS); the talk of key stakeholders involved in such policies for how they construct Roma people and health; and what such discourses open up and limit in terms of Roma accessing healthcare in Serbia as discourses interact with and affect broader social policy and practice. As most of my discussion has been in the analysis section above, below I discuss my key findings in relation to the research questions and discuss how my research has developed, supported and at times challenged existing research. Then I discuss the implications and limitations of my research, suggestions for future research, followed by a short summary of the key points from my findings.

5.1 Answering the research questions

5.1.1 How is health constructed in this policy document?

According to the Strategy, (physical) health can be affected by multiple social determinants across one's life and thus is a complex issue. Rather than drawing on a purely biomedical perspective, one that has an almost exclusive focus on (biological) pathological causes of illness; health was able to be promoted, and illness prevented or controlled by addressing a range of factors such as individualised lifestyle factors and inter-related social barriers such as education, employment and housing status. This understanding of health

opened up room for different discourses of health, related to neoliberalism and human rights. The neoliberal discourses evident were where highly individualised notions of health were produced; health was something to be achieved, consumed and regulated by managing risks based on having and enacting on the correct information. Whilst, a holistic human rights discourse saw health as embedded in the social structural context of people's lives; a social good that could be influenced by a range of more macro-level factors. Within such a human rights discourse, health was to be managed and protected by governments and those with relative power by providing for health-related resources and health-enabling environments.

5.1.2 How are Roma people's health and Roma people positioned within these discourses of health?

Three discourses of health were identified, namely neoliberal, neoliberal human rights and a holistic human rights discourse. When it came to how Roma people and their health was positioned within such Strategy discourses, their placing differed according to discourse type. In the holistic human rights discourse, Roma were positioned as relatively passive in relation to their health issues, as the conditions affecting their health were largely outside of their control; and the state was placed as accountable for the improvements in health access, by addressing several factors. However, in both the neoliberal and neoliberal human rights constructions, Roma were positioned as in-need of activation or empowerment to be self-responsible in taking care of their own health. Other than providing information, the state had a minimal role. Such a discourse of activation (in terms of employment, i.e. labour market inclusion) has been observed in many other NRIS, albeit in different ways. Rostas (2019) found that the central assumption of the EU Framework's social inclusion discourse is that activation into the labour market is the primary way towards social inclusion and combating poverty. The

author asserts that the EU framework for Roma carries across the common-sense idea that 'all the other problems Roma encounter will be solved once they have jobs.' (Rostas, 2019, p. 155).

5.1.3 *Are these discourses also evident in key stakeholders' accounts of this policy?*

While the neoliberal discourse regarding information dissemination was also dominant across key stakeholders' articulations of bettering Roma health, so were the human rights discourses that constructed Roma health as a multi-factor issue, which required paternalistic measures other than information dissemination. Indeed, these latter discursive constructions stressed the need for sufficient infrastructure to support and develop Roma health and provide better prevention strategies for combatting discrimination across social domains. The holistic human rights discourses positioned Roma as victims of structural determinants and called for state accountability rather than more Roma responsibility. Unlike the neoliberal human rights discourse in the Strategy text, anti-discrimination discourse across the interview accounts put the onus on broader society and the State. Meanwhile, there were other more nuanced views, cultural capital and cultural sensitivity discourse, from individual stakeholders that brought into light alternative conceptualisations of Roma needs in health by challenging deficit-thinking or the individualistic measures which may not be relevant to Roma culture and traditions. Namely, cultural capital discourse asserted that there was value in Roma culture and that they had their own solutions to health issues; whilst cultural sensitivity discourse questioned the relevance of the individualist human rights framework for Roma as Roma are bound in the family unit, and thus a more collectivist or group rights model may be more applicable. Both cultural capital and sensitivity discourses support a 'cultural pluralist citizenship' framework, where differences are endorsed, and policies work to specifically meet the needs of cultural and minority groups (Conlon, 2021, p.22). Conlon (2021) asserts that such a framework 'shifts politics and discourse away from the promotion of cultural homogeneity,

and instead focuses on creating an environment where a plurality of cultural groups can exist without the issues of cultural domination' (Conlon, 2021, p. 22). This type of discursive framing is thus aligned to the common definition of integration - as multiculturalism, where minority groups cultural differences can exist alongside majority culture instead of being marginalised or assimilated (Algan et al., 2012).

5.1.4 What are the implications of these discourses for Roma people's access to healthcare and health?

Individually, such discourses can all have their own specific social implications in terms of Roma people's access to healthcare and their health. At the same time, the existence of multiple discourses thus opens up creative and comprehensive ways for addressing Roma peoples' health in the Serbian context.

The neoliberal discourses, including neoliberal human rights, position Roma health as being the responsibility of Roma with minimal intervention after information dissemination, which can significantly restrict the efficacy of such health equity projects; as shown by much evidence of such interventions of similarly disadvantaged populations (Campbell, 2003; Chamberlain & Murray, 2009; Marks et al., 2021). Indeed, Roma face many other, broader social structural barriers which obstruct them from accessing health and health-related resources; and if these are not addressed, then these individualised measures may prove to be too narrow of an approach.

Within the neoliberal discourses of health found in the Strategy document is the assumption that economic empowerment can enable health for Roma. As shown in the introductory sections, socioeconomic status is a critical social determinant of health, and thus

promoting socioeconomic integration could result in substantial progress towards achieving Roma health equality. However, this neoliberal discourse also seems to position Roma as most responsible for such equalisation and empowerment, namely through education and employment, without adequately considering the social closure and neoliberal exploitative pathways obstructing access to such resources (Cvetičanin et al., 2021). Economic targeting of Roma can also dehumanise Roma and reinforce the message that they are 'burdens' to society; a particular subject position observed in other NRIS (Slepickova & Bobakova, 2020, p.6). In general, such neoliberal constructions have the potential to further stigmatise other Roma by placing them outside mainstream society, as lacking in the desired attributes, knowledge and skills to contribute. That aside, if measures do fail in producing better relative health for Roma, then the potential for Roma to be blamed is increased if Roma are seen as responsible or a burden on the health system.

As Andrejic (2011) states: 'The individualization of responsibility poses a problem of unequal resources for both Western and post-socialist neoliberal subjects. Rose acknowledges that there is a difference between "the affiliated and the marginalized" (Rose 1996: 340) in neoliberal societies, where the affiliated are those who are "considered 'included': the individuals and families who have the financial, educational and moral means to 'pass' in their role as active citizens in responsible communities" (Rose 1996: 340). Neoliberal reforms result in the withdrawal of social responsibility for citizens' health and while paternalistic measures seek to reduce insecurity, they also themselves produce new form of inequality between those who manage to be included, and who gain access to social resources, and those who do not.' (Andrejic, 2011, p.99). Indeed, it would seem, that the most dominant way that Roma are constructed in Roma health policy talk observed in this thesis positions Roma as excluded by

both neoliberal and paternalistic discourses. However, at the same time, these discourses open up for health equity, even if in slightly opposing ways.

In general, social and health inequalities within Serbia are related to inequalities in forms of social, political and economic capital that are not sufficiently addressed by neoliberal discourses; with the exception of the Roma health mediation tasks, which involve enabling better access towards health services. The RHM as gatekeepers towards Roma health does not exactly challenge the status quo insofar that the relative lack of power that wider Roma communities hold in Serbia; nevertheless, it may be a step towards the right direction in terms of addressing the power dynamics of Roma and non-Roma relations in the context of public health.

Neoliberalism calls for placing the responsibility and thus the burden on Roma in achieving their health, and this also provides opportunities for a particular kind of Roma empowerment. Indeed, while some possibilities are shut down, others are opened up. In particular those local bottom-up, or grass-roots, approaches to health equity where awareness and education on health behaviours and rights part of broader programmes addressing social determinants of health have shown significant improvements in the health of oppressed groups (Lubek et al., 2014; Marks et al., 2021).

The discourses associated with holistic human rights paradigms emphasise structural disadvantages, opening up spaces to address social determinants, primarily outside of Roma's direct control. Such discursive framing positions the government, including local, and more powerful agents as most responsible and positions Roma as victims of circumstance. These discourses thus speak to values of solidarity and State accountability and may significantly

improve Roma health and reduce health inequalities when put into practice. Infrastructure discourse in particular can be highly effective in providing better access to healthcare, especially in the context of the current pandemic, and this discourse on its own has the ability to counter the notion that Roma are most responsible for their health inequalities.

The neoliberal human rights discourse, focusing on civil, cultural and political rights, and the evident anti-discrimination discourse do not necessarily limit chances for Roma health equity in general. These discourses open up possibilities to counter stereotypes and media portrayals, thus reducing discrimination and stigma towards Roma in broader society, including public institutions and everyday society. Addressing and combating Romaphobia in Serbia is posited to be a critical factor in bettering Roma health directly, via improving access to such institutions and services, and indirectly, as discrimination is a well-studied psychosocial factor that can negatively affect health (Marks et al., 2021). At the same time, however, within the neoliberal human rights discourse, most of the onus was again put on Roma to change; and this approach may be of limited effect if not paired with strong institutional support.

Lastly, the alternative discourses centred on Roma culture (cultural traditions and lifestyles, cultural capital and cultural specificity) all drew attention to the cultural considerations that seem to be lacking in the strategy document itself, with stakeholders asserting that, ideally, these should be recognised strategy practices. Indeed, such culturally-relevant practices in health promotion have been shown to be highly effective when working with disadvantaged minority groups (Marks et al., 2021; Stephens, 2008).

5.1.5 What can be learnt from bringing the analysis of the stakeholders' accounts into dialogue with the policy analysis?

Having these wider stakeholder interviews alongside doing the Strategy analysis allowed me to explore and demonstrate that the dominant discourses were being mapped across stakeholders and the policy text, but also that different discourses existed. This mixed-methods approach enabled me to realise that there were missing discourses that were possible in the strategy document, allowing further depth of the analysis. While the dominant construction of health information dissemination and awareness of rights activities were evident across both sample types, such a neoliberal framing of Roma health practice can also be significantly and explicitly resisted by those involved in the policy process. Indeed, the discourses of infrastructure, discrimination, complexity and cultural factors (including cultural capital and cultural sensitivity) all challenged these over-simplistic and individualising constructions to instead propose health as complex and multi-factorial, involving many factors that are outside a Roma individual's control. Ultimately, such an order of discourse supported that Roma needed both empowerment and paternalistic measures. This suggests that such nuanced views are evident in those involved in the current NRIS, which may have significant implications for what is put into practice for Roma health.

Three discourses (neoliberal discourse of health information, infrastructure discourse and anti-discrimination discourse) also found in the Strategy predominate in the talk about Roma health in this policy circle supports these discourses as social practices in their own right and their associated non-discursive social practices. In particular, the neoliberal discourse of health dissemination observed in both the Strategy text and the participants' talk reinforces the idea that achieving Roma health is primarily about awareness and education. However, unlike the stakeholders' talk, the Strategy emphasises economic empowerment and benefits as part of

their neoliberal discourses of health. Such findings support existing research in terms of mirroring the trend of CEE NRIS to place most of the responsibility (and blame) on Roma in order to be socioeconomically integrated into mainstream society, including bettering their access to health services and health outcomes (Sigona & Trehan, 2009; Slepickova & Bobakova, 2020). Such discourses position Roma as passive recipients of social welfare and other public services, problematising such positions by asserting that Roma need 'activation' or 'empowerment' through education and skills training practices. When it came to neoliberal human rights (civil and political rights), again looking at the Strategy text itself, Roma were again positioned as inactive, but this time regarding accessing their civil and political rights, which would protect their health in other less direct ways. These neoliberal discourses are seen as reflections of and thus support broader social practices, notably the social and economic transition and neoliberal restructuring of Serbian society.

On the other hand, some discourses challenged such individualistic thinking, and these were explicitly highlighted at times, particularly in the stakeholders' talk. Discourses of infrastructure, systemic discrimination against Roma and the placing of Roma health problems in their cultural context in participants' talk made the relatively individualised framings linked to neoliberalism seem inadequate for addressing Roma health inequalities. Indeed, such discourses constructed Roma health problems as one to do with health inequity. Meanwhile, key discourses linked to holistic human rights ran through the Strategy, *and* the interview talk made Roma's lack of access to health a broader issue, tied to structural issues that positioned the state as responsible. Such a framing opens up the possibility for structural changes, albeit not radical ones.

5.2 Implications from the study

This thesis extends the research base by supporting the general pattern of findings, i.e. neoliberal talk, within Roma inclusion strategies across Central Eastern European contexts. Considering their implications for healthcare practice and associated health outcome inequalities, such discourses can imply victim-blaming and effectively limit the ability for social change. At the same time, however, the significant use of holistic human rights discourse to frame Roma health issues and solutions that were found in both the interview talk and to a lesser extent in the Strategy text open a space for social goods to be views as entitlements versus dependency benefits; a somewhat lacking conceptualisation in other CEE Roma strategies. Overall,

Like other research investigating how official policy discourses are taken up or resisted by those employed to implement the policies, there was somewhat of a disjuncture between the discourses on the Strategy in question, and those observed in stakeholder's talk. Particularly significant was the rejection of the idea embedded in the neoliberal discourse; that health (lifestyle) behaviours could simply be taken up by Roma, without highlighting other macro factors in place, such as infrastructure as health enabling. Such infrastructure discourse clearly shows a consideration of broader social determinants among the stakeholder's framing of Roma health issues. Although such a broad SDH focus was evident in the sample observed in this thesis, such a holistic framing of Roma health has not been observed in the multiple studies investigating stakeholder's talk in regard to other countries' Roma health policies; and thus may

At the same time, however, the present research also supports existing NRIS research insofar that it too found that there is a negative portrayal of Roma in the Strategy, that positions them as being responsible for their health inequalities (Rostas, 2019).

5.3 Study limitations

A limitation of this study not already discussed was the lack of Roma voice, in particular by those targeted by the Strategy such as the general Roma public, but also those employed to carry out undertakings (namely, Roma health mediators). This would have given me the opportunity to find out how discourses are taken up, or resisted, by those who are the main targets of them. It would have also been interesting to explore if in their perspective there is a gap between rhetoric and reality, and the reasons why. On the other hand, those interviewed all had diverse connections and experiences with the said Strategy and thus gave a multi-stakeholder perspective that allowed for nuanced perspectives and discourse orders. This helped conceptualise how Roma issues can be defined in the current NRIS period.

5.4 Future research

A key theme evoked from those interviewed was the idea of (the majority of) Roma's poor living conditions regarding a lack of safe infrastructure not being accounted for in public discourses (i.e. the media discourses on health strategies for Covid-19 protection). When it is deemed unrealistic or irrelevant to many Roma's lives, material and social circumstances, it is crucial to reconsider the framework for delivering health. My position as a master's student-researcher and one who does not specialise as a policy expert limits me from making policy suggestions at an expert level. However, this could be part of future work by those fit to do so. Indeed, future research should explore further how infrastructure is included in Roma policy and investigate what kind of social outcomes have happened when the policy has focused on infrastructure. This study could guide future policy development.

Future work could look at potentially new or novel insights of subsequent strategic frameworks. Future critical language research on the NRIS and key actors' talk should also be conducted in other ex-Yugoslav countries as each context provides a potentially nuanced set of discourses representing Roma health which could have real social consequences for Roma. Indeed, each country provides a unique socio historical context, and has been shown to differ somewhat in terms of post-socialistic transition processes. For example, the Republic of North Macedonia, where Roma make up a significant part of the population (2.66%) is another EU-accession country who unlike the Republic of Serbia has privatised primary health care which has been shown to be an additional barrier towards Roma health equality (Eurydice, 2021; Janević et al., 2011). Perhaps most importantly, future study of NRIS and other Roma health practices should involve Roma voices.

5.5 Summary

In summary, Roma health issues and their solutions can be framed in different, at times opposing ways, as indicated by the discourses found in a Serbian Roma health strategy document and key actors involved in such policy. There appear to be two dominant discourses within this policy circle, one that centres on individualised notions of Roma health; and another which places Roma health in a broader social structural context. Whilst alternative notions draw on frameworks that capture the complexities of Roma health within Serbia and cultural considerations.

Such discursive constructions can have important implications for enabling or limiting Roma health equity within the Serbian context. The present findings can contribute to the growing critical social study findings on Roma health strategies and broader social inclusion policy, particularly how language can help envisage, sustain, challenge, and change health

justice practices for Roma. Language is most powerful when it is taken up as common-sense. By illuminating the ideologies and hegemonic practices behind discourses, its most powerful asset dissipates.

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Table 1

Method procedure

Textual analysis: vocabulary (word choices; synonyms, antonyms and hyponyms), grammar and text structure (Fairclough, 2015).		
Vocabulary		How are meanings worded? What are the 'key words'? Is there *rewording* or *overwording?* In what ways do words co-occur or *collocate?* What ideologically significant meaning relations (*synonymy, hyponymy, antonymy*) are there between words? What particular interpretative perspective underlies this wording? What understanding of actors, their duties and assignments does the vocabulary and wording produce? What metaphors are used?
Grammar	Transitivity	What *process* and *participant* types

	predominate? What factors may account for this? Is the agency unclear? Are active sentences frequent, or are passive ones or nominalisations frequent? And if so, where and what functions do they serve? Are sentences positive or negative? Active/present tense.
Modes and modality	What *modes* (*declarative, grammatical question, imperative*) are used? Are the modalities predominantly subjective or objective? What types of modalities are most frequent? How are (simple) sentences linked together? (Cohesion)
Text structure	What larger-scale structures does the text have?

Discourse practice		
Text production	Interdiscursivity	What types and how are discourses drawn upon in the texts?
	Intertextuality	What other and how are texts drawn upon in the constitution of the Strategy and interview texts?
Text distribution	Intertextual chains	What sorts of transformation does this (type of) discourse sample undergo; are they stable, shifting or contested?
Text consumption	Coherence	What are the interpretative implications of the intertextual and interdiscursive properties of the text?
Social practice		What is the nature of the social practice of which the discourse practice is a part - why is the discourse practice as it is?

(Adapted from Jorgensen & Praestegaard, 2018).

Appendix A

Apstrakt

Romske zajednice često se suočavaju sa ogromnim društvenim i zdravstvenim nejednakostima u Evropi, uključujući i Srbiju, do čega može doći usled nekoliko mogućih višeslojnih faktora. Nedavne nacionalne, regionalne i međunarodne inicijative pokušale su da smanje ove razlike razvijanjem novih ili prilagođavanjem postojećih politika, sa ograničenim uspehom u različitim zemljama. Prethodno istraživanje o politikama inkluzije Roma ukazuje na potrebu da se razmotri diskurs u ovim tekstovima. U ovoj studiji sa mešovitim metodama, istraživala sam kako zdravstvena politika za Rome diskursno stvara Rome i zdravstvena pitanja u Srbiji i razmatra društvene implikacije takvih konstrukcija kada je u pitanju zdravstveno pravo za Rome. Koristila sam Ferklouovu kritičku analizu diskursa (CDA) za kritičku analizu trenutne (zdravstvene) strategije društvene inkluzije Roma u Srbiji i intervjua sa onima koji su razvijali i implementirali takvu politiku. Analiza strategija otkrila je tri dominantna diskursa o zdravlju: (1) neoliberalni diskurs, (2) neoliberalni diskurs o ljudskim pravima, (3) holistički diskurs o ljudskim pravima. Diskurs povezan sa neoliberalizmom sadrži pretpostavke da bi podizanje svesti i pružanje informacija u vezi sa zdravljem i pravima u vezi sa zdravljem, kao i ekonomskom integracijom na tržištu rada, dovelo do unapređenja pristupa zdravstvenoj zaštiti za Rome i samim tim i unapređenju njihovog zdravlja. Ovi tipovi diskursa nastoje da individualizuju pitanja zdravlja Roma, stavljajući najveći teret odgovornosti za unapređenje istog na same Rome. U poređenju s tim, holistički diskurs o ljudskim pravima radi sa širim društvenim determinantima zdravstvenog okvira, postavlja zdravlje i povezane resurse u vezi sa zdravljem kao fundamentalna ljudska prava i traži veću odgovornost države. Analiza intervjua otkriva da iako je očigledno prisutan neoliberalni diskurs u vezi sa širenjem informacija o zdravlju, takođe postoji i značajan naglasak na makro-društvenim ograničenjima

koja ometaju pristup zdravlju, a to su loša infrastruktura, diskriminacija i kulturološka pristrasnost. Rezultati analize ukazuju na višestruke, i na trenutke suprotstavljene, načine konstrukcije Roma i pitanja zdravlja Roma unutar kruga ove politike. Takve različite konstrukcije mogu imati važne implikacije kada je u pitanju zdravlje Roma. Uopšteno gledano, rezultati proširuju literaturu diskursa kada je u pitanju zdravlje Roma i politika inkluzije, podržavajući i suprotstavljajući se dominantnim konstrukcijama problema i rešenja zdravlja Roma, i ukazuju na potrebu za nijansiranijom analizom politika različitih država kada su u pitanju Romi i kada govorimo o ključnim zainteresovanim stranama.

Appendix B

Project Title: The Construction of Roma People and Health in Serbia: Discourses in Policy and Multiple Actors' Talk

Interview Guide for NGO Experts

Please note that as the interviews will be semi-structured, the actual interview may not include all questions, and the order of questions may differ from the order shown below.

1. How did you come to work in this field? How did your career develop/what's your area of expertise?

2. What was your motivation for working with Roma communities?

3. What are the challenges to Roma inclusion (especially regarding health) in Serbia? Was it always like that (why/why not)?

4. What does success look like for such strategies?

5. How does your organisation achieve bettering Roma health? If you were going to write the strategy, what would you have included and why?

6. Regarding health, what do you see as the key problem/barrier towards accessing health for Roma? What about non-Roma?

7. In your work, what does health mean? For example, the view on health defined by the World Health Organisation (WHO) one where health is a " state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." but others see it as something different.

8. The strategy document itself notes that the health mediators were the most successful method for improving Romani people's access to healthcare, particularly with the mechanism of enabling health insurance, as well as vaccinations. Why do you think health mediators are so effective? What is the role of the health mediators?

9. Why only women health mediators?
   Advantages/Disadvantages?

10. (The strategy): In your own opinion, what do you see as the main drivers and impacts regarding the development of such a strategy document in Serbia?

11. What has been the impact of the EU?

12. What have been or are the challenges of implementing this strategy?

13. How has Covid-19 impacted the implementation of the strategy?

Appendix C

Extract 25. 'Romi koji, hajde da kažemo, koji su integrisani, koji imaju...koji su školovani, koji imaju određena znanja, informacije, da oni nemaju velike probleme u pristupu zdravlju. Veliki broj Roma koji su siromašni, koji su neobrazovani i koji nemaju informacije, i koji su zdravstveno neprosvećeni. To je osnova tog položaja, to je reč o siromašnim ljudima koji žive u zaista izuzetno teškim uslovima. Videćete decu koja su bosa na minus 5 ili 6 stepeni, slabo odevena, obučena. Onda videćete Rome koji su preuhranjeni, koji u suštini jedu nekvalitetnu hranu i koji...prosto njihovo zdravlje je na taj način ugroženo. Postoje Romkinje koje ne vode računa niti o reproduktivnom zdravlju niti o svom zdravlju koje proizilazi nakon materinstva ili...treći problem je taj oko maloletničkih brakova gde dolazi do preranih trudnoća ili preranih prekida trudnoća, to su sve stvari koje se kroz obrazovanje i kroz pravovremene informacije, kroz određenu socijalizaciju, mogu predupredi ti.' - Milan.

Extract 26. 'U sistemu zdravlja i zdravstva takođe su pomaci ogromni, kažem, sada je procenat onih koji nemaju zdravstvenu knjižicu, nenormalno manji nego što je bio, sada, ono što je jako važno, sada Romi znaju da imaju pravo na zdravlje i oni znaju otprilike šta to pravo znači.' - Daria.

Extract 28. '…mnogo je sad to široko pitanje i kompleksno pitanje da bi vam sad to odgovorio, ali čini mi se da postepeno kod Roma postoji veća odgovornost i veći stepen te zdravstvene kulture nego što je bio ranije, posebno kod Romkinja. I to jeste, čini mi se, zasluga i zdravstvenih medijatorki i velikim delom ženskih nevladinih organizacija, pogotovo koje su uključivale Romkinje ili koje su Romkinje zasnivale i razvijale i koje su tu prosto razgovarale sa svojim sunarodnicama o tome šta ih muči i davale im nekakve, ne samo i pomoć koja je mogla biti konkretnu, u nekom novcu, u nekim, ne znam, potrepštinama, ali im je davala savete,

razgovarala s njima, podučavala ih. Mislim da je to doprinelo da se neke bolesti smanjuju, da procentualno, da je situacija tu nešto bolja.' - Milan.

Extract 29. 'Ključni problem su uslovi života. Ključni problem su uslovi života, onda kada vi poboljšate uslove života i onda kada ti ljudi imaju struju, vodu, infrastrukturu u naselju i mogućnost za ličnu higijenu, mogućnost za zdravu ishranu, za...pogotovo kada govorimo o deci, onda će se zapravo i ta neka zdravstvena slika romske populacije poboljšati. Dakle, vi možete tim ljudima obezbediti i zdravstvene knjižice i vakcinisati, naravno, decu, što je jako značajno, ali će se oni opet vratiti u naselje gde nemaju elementarne uslove za život i opet će to uticati na njihov kvalitet života i opet će Romi i Romkinje imati mnogo kraći životni vek. Tako dakle, rešiti paralelno sa pristupom zdravlja, rešavati i problem uslova života u romskim naseljima.' - Brankica.

Extract 33. '…i dalje Romska naselja u Srbiji su jako loša, dakle, ne sva, ali su jako loša. Do te mere da nemaju pristup pijaćoj vodi, da nemaju regulisanu kanalizaciju, da nemaju puteve, nego su to prašnjavi oni makadam putevi seoski koji nemaju asfalt i koji su teško prohodni zimi, da nemaju, vrlo često nemaju struju pa sami skidaju struju. Praktično je kradu i direktno se povezuju na dalekovode, što često rezultira i time da se neko povredi, da, eto… Ali to, prosto je nebezbedno okruženje, to su gole žice strujne, to je nebezbedno okružene jel za decu koja tu žive i koja… Tako da zaista ima izuzetno loših naselja, ja bih mogla da specifikujem neka koja su zaista u katastrofalnom stanju, u smislu da oni često se suočavaju i sa zaraznim bolestima, širenje, te šuge, te ne znam razne druge bolesti tako da to je… rast i razvoj u takvom okruženju sigurno ima dalekosežne posledice na zdravlje sutra jednog odraslog, jedne individue. Mislim, ozbiljno narušava sigurno sve aspekte zdravlja i razvoja deteta. Tako da ovaj, to je ono što, navodno na čemu se rešava.' - Daria.

Extract 34. ‘To bi lokalna samouprava, svaka, lako mogla da identifikuje i lako bi mogla da usmeri određene mere…To je nešto što mi se čini, ako to tako kažem, imamo problem koji generacijama postoji, imamo sistem koji rešava za sve ostale te probleme, a za njih ne rešava, onda ja mislim da je tu reč o sistemskoj diskriminaciji ili barem nebrizi.’ - Milan.

Extract 35. ‘I sad kad me pitate šta ja mislim da je to, ja mislim da je to prosto da ljudi i kada prave diskriminaciju prema Romima, ne misle da je to diskriminacija. Prosto misle “to je tako, prosto postoji, oni žive tamo i oni žele tako da žive”. Pa ja baš nisam sasvim siguran da žele tako da žive, ali niko ih nije ni pitao da li tako žele da žive.’ -Milan.

Extract 42. ‘Izazovi su mnogi: 1. postoje dobre osnove njihove narodne medicine u tradiciji romskog naroda i oni je koriste, ali je većinski narod ne prepoznaje kao njihovo blago od kojeg i oni mogu imat korisit. Iz romske narodne medicine nedovoljno se primenjuje u zdravnstvenim ustanovama, pa bi se onda pokazalo da njihov način lečenja ima cenu. Umesto da se narodnoj medicini koju Romi znaju, pokloni dužna pažnja (lekovito bilje, zatim načini lečenja itd.), ona se problašava nevažnom.’ - Lenka.

Extract 43. ‘Iz tog razloga što je to kod Roma nije moguće, nego je bio okrenut ka porodici. Romi žive, barem u Srbiji, to su velike porodice koje su generacijski povezane, koje imaju, kako se zove...i to jeste osobenost njihove kulture, jedna od osobenosti. Međutim, ….to okrene ka porodici...ka pojedincu, što jeste *human rights approach* i to je sve u redu, ali to sada u ovom trenutku ne pije vodu i strategija je utoliko i nemerljiva i nejasna i neprimenljiva.’ - Milan.