

Doubling Syndemics: Ethnographic Accounts of the Health Situation of Homeless Romanian Roma in Copenhagen

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Abstract

This study investigates health concerns and access to health services for Roma from Romania who live in homelessness in Copenhagen, Denmark. They collect refundable bottles and call themselves “badocari,” which in Romanian refers to “people who work with bottles.” Homeless Roma in Denmark have not previously been studied through ethnographic research. The study stresses the importance of a syndemic approach towards understanding badocari health concerns. Syndemics is understood as co-occurring diseases, which unfold within contexts of social injustice. The case of the badocari is argued to be a case of “doubling syndemics” since the co-occurring diseases are further multiplied and enhanced by an ongoing mobility between dual contexts of precarious livelihoods in Romania and Denmark, respectively. The study complements the approach to syndemics with a perspective on human rights. It sheds light on the limited possibilities that exist for addressing health concerns of the badocari, both in Romania and in Denmark, and argues that the universal human right to health is not realized in the everyday lives of destitute EU migrants such as the badocari. Rather, they experience lack of access to adequate medical treatment and follow-up care, both as citizens of a member state and as co-citizens of the European Union.

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Introduction

Cornelia sits nervously at the doctor's office in the Red Cross clinic for undocumented migrants. Her husband, Tudor, is with her. The doctor arrives and explains that Cornelia and Tudor have both tested positive for the MRSA bacteria (Methicillin-resistant Staphylococcus aureus). She underlines that MRSA is a serious condition that can have consequences if they would need antibiotics or surgery in the future. Furthermore, they risk transmitting the bacteria to their children home in Romania. The doctor explains the treatment for MRSA, which they have to follow. They need to shower and wash their hair on a daily basis using a disinfecting soap. They should change their bath towels daily, wash their sheets twice a week, and smear an ointment around their nostrils three times daily. Cornelia and Tudor listen attentively to the doctor, but the usually very talkative couple remains silent. The amount of information appears to be overwhelming. The doctor frowns in a concerned look, and asks if they understand what MRSA is and how they should treat it. They nod. There is an awkward silence. The doctor looks at the couple with a thoughtful look in her eyes, pauses and says, "Well, this is, of course, more complicated to do when you are homeless..." They nod again. We leave and exit into the street. It is a warm summer day in Copenhagen. Cornelia is now her talkative self again and explains that they have to leave immediately. They are anxious to start their working day of collecting refundable bottles from garbage bins around the city. I ask if I will see them tomorrow at the shelter where they can shower with the disinfecting soap that the doctor gave them. Cornelia and Tudor smile without replying. They discuss how to incorporate showers into their daily routines of rough sleeping and collecting bottles. It appears unlikely that Cornelia and Tudor will make it to the shelter tomorrow to shower and even less likely that they will change their towels and sheets daily. In fact, they have no towels or sheets to change. They only have a few blankets and one sleeping bag that they share at night when they go to sleep at a street corner in the city center.

This study addresses Roma migrants' health concerns and access to health services within the European Union (EU) from a perspective on Romanian Roma who live in homelessness in Copenhagen. It brings forward the experiences and perspectives of women and men who are destitute EU citizens that do not fulfill criteria to register as

EU workers under Danish law. Instead, they live as unregistered EU citizens, who sleep rough and have minimal contact with the Danish health care system. This group of Roma travels continuously between Denmark (where they live and work in the street) and Romania (where their young children and other relatives are left behind). Their mobility is directed towards a constant search of income opportunities to support the household in Romania.¹ The situation of continuous migration presents several health concerns, which are the focus in this study. The study introduces the concept of syndemics to address co-occurring health concerns as being exacerbated by the social context.² It argues that the case of the badocari is a case of doubling syndemics since they experience co-occurring and mutually enhancing diseases within dual contexts of precarious livelihood and social exclusion. These dual settings include growing up in poverty and social exclusion in Romania and then migrating into circumstances of homeless livelihood in Denmark. The study complements the syndemic approach with a perspective on human rights. It approaches health as a human right and discusses the barriers and complexities that the badocari experience in accessing health services in Copenhagen. It argues that the case of badocari presents a litmus test not only to the outreach of the Romanian and Danish health care systems but also to the European Union project of realizing the right to health of all EU citizens.

Research design

In the period April 2014 to January 2015 and September to November 2016 (13 months), I carried out extensive anthropological fieldwork. I followed 40 Romanian Roma closely in their everyday lives as homeless in the streets of Copenhagen, and visited them in Romania when they returned home to spend time with their families. I continue in close contact with many of my interlocutors at this time. The majority of my interlocutors come from the same local Roma community in Romania and mostly make a living by collecting refundable bottles in Copenhagen. They call themselves badocari, which is a Romanian term that refers to "people

who work with bottles.” Badocari is, therefore, not a broadly applied ethnonym for a particular Roma group in Romania. Rather it is a self-defined and self-ascribed plural term used by my interlocutors with reference to their current occupation in Denmark. In this study, I adopt the emic terminology of my interlocutors and refer to them as badocari.

The data material in this study draws on parts of my ethnographic material from the fieldwork. It consists of participant observation and informal conversations as well as semi-structured interviews and document analysis. The data has been triangulated and names of the Roma community and my interlocutors have been anonymized and replaced with pseudonyms. It is an anthropological study, which takes the point of departure in selected empirical cases, which are representative of the general situation of my interlocutors.³ It is the aim that through the thick descriptions of the situation of a few, general tendencies can be understood in a new and more nuanced light.⁴ For this reason, but also for matters of ensuring anonymity, the health trajectories of the individuals in the selected cases are not unique. Rather, they represent a few among many similar health trajectories (such as being diagnosed with MRSA, diabetes, and heart diseases) that I witnessed during my fieldwork and that my interlocutors shared with me.

Intersecting research fields

The study learns from, and contributes to, several fields of research. Firstly, it introduces the concept of syndemics as an analytical lens that allows for insight into the complex health concerns of homeless Roma in Copenhagen. It complements the syndemic approach with a human rights perspective in order to shed light on broader structural barriers of social exclusion. Secondly, the study contributes to health research fields concerning Roma, undocumented migrants, and homeless populations, respectively. The limited scope of this study does not allow for an exhaustive overview of literature within all these large research fields. Rather, examples of selected publications are referenced throughout the study.

Analytical perspectives: syndemics and human rights

The term syndemics was introduced by the medical anthropologist Merrill Singer in the 1990s as a concept to address human health as a biosocial process.⁵ It serves to address situations where the health status of a population is significantly affected by interrelated and mutually enhancing health problems that unfold within contexts of noxious social and physical conditions. Singer defines syndemics as “the concentration and deleterious interaction of two or more diseases or other health conditions in a population, especially as a consequence of social inequity and the unjust exercise of power.”⁶ The concept has, since the 1990s, been applied in a broad array of studies that examine the relationship between comorbidities and the social context.⁷ Inspired by the work of Paul Farmer as well as Sarah Willen, Michael Knipper and César. Abadía-Barreiro et al., who argue for the importance of viewing complex health trajectories of poor communities from a human rights perspective which underline state responsibilities to address the comorbidities and adverse living conditions, this study complements the focus on syndemics with a perspective on human rights.⁸ It approaches health from a human rights perspective, which regards health as essentially concerning the enjoyment of human rights.⁹ The principle of non-discrimination and equal access to all human rights is primary, particularly rights to preventive health care and medical treatment. It is regarded as essential to have equal access to a range of social and economic rights in order to realize adequate health standards, including access to adequate housing and environmental conditions, education, employment, and social benefits.¹⁰

Roma health as a field of research

This study takes inspiration from health studies concerning Roma as well as undocumented migrants and homeless populations. The study of the health situation of Roma populations throughout Europe is a growing research field, though there remains a lack of larger sample studies as well as epidemiological data.¹¹ Examples of studies on Roma health are referenced in the below section,

which discusses Roma health disparities in Europe.

Given that my interlocutors not only reside in Romania but are also engaged in an ongoing mobility to Denmark, it is relevant to look to studies on migrant populations' health. This is another vast area of research, which contributes to both migration studies and health studies. In this study, I draw on two contributions which concern the access of undocumented migrants to health care in Denmark.¹² Whereas undocumented migrants have in common limited legal rights of residence, they are heterogeneous in regard to their housing opportunities. Hence, the social contexts that they inhabit may be slightly different, depending on which standards of housing they are able to access. In contrast, my interlocutors travel to Denmark with an initial legal right to enter and reside for a limited period of time, as will be explained later. They also have in common that they live in the street and sleep rough, and hence engage with a broader homeless environment in Denmark. I argue, therefore, that it is important to have insight into the implications that a homeless livelihood has on health conditions of the badocari. Homeless populations' health is studied broadly within academia and selected examples of relevance to this study are referenced in the section concerning the health status of the badocari who live in homelessness in Copenhagen.

Comorbidities and social exclusion among Roma in Europe

Despite methodological limitations of lack of ethnic data and larger sample studies, existing research indicates that marginalized Roma communities in Europe have higher rates of morbidity and premature mortality compared with non-Roma populations. The average life expectancy is five to 20 years lower than that of non-Roma, depending on the country, and infant mortality is also estimated as higher among the Roma.¹³ Research points towards a tendency that marginalized Roma populations across Europe are at higher risks of a range of diseases, including infectious diseases such as Hepatitis A, B, and C; measles; meningitis; and

tuberculosis (TB).¹⁴ Studies indicate a higher prevalence of major chronic diseases such as diabetes, cardiovascular diseases (including hypertension), and asthma and their associated complications among Roma populations.¹⁵ Research also points to lower immunization uptake among Roma populations in some European countries.¹⁶ Studies show that Roma women are particularly at risk because they additionally experience maternal health risks that are enhanced by poor and stressful living conditions.¹⁷ Notably, poor maternal health has a wide range of antenatal health consequences including e.g. newborn morbidities and mortalities as well as low birth weight.¹⁸

The health situation of Roma in Romania largely reflects the above described concerns at European level. The average life expectancy for Roma is 12 years lower than for non-Roma populations. Available data suggest that 45.7% of Roma children did not receive all the vaccinations included in the National Immunization Program.¹⁹ In theory, Romania complies with European Union law, which establishes the rights to access health care.²⁰ Health care is declared to be free of charge, but in practice, patients are still expected to pay certain percentages of their treatment if they do not have medical insurance. Medical insurance is in general tied to employment status, but persons who receive social benefits and children under 18 are officially insured.²¹ Emergency health care is provided free of charge for three days, and thereafter patients are requested to pay partial or full costs. Research shows that the Romanian health system is significantly underfunded and corruption is prevalent. Consequently, whereas health care may be officially free (for some), other costs are often requested by all patients, such as costs for medicines, medical supplies used during the hospital treatment (such as gloves and injections), as well as consumables for patient and hospital staff. Corruption includes informal payments requested by health professionals for their services in public hospitals.²²

This study argues that Roma health can with benefit be understood as a case of syndemics. The causes for which marginalized Roma populations have higher prevalence of a range of morbidities

and premature mortalities are multiple and often compounded.²³ Barriers are generally associated with social exclusion due to poverty and ethnic discrimination. It is important to complement the perspective on syndemics with a perspective on human rights, in order to understand the broader structural barriers, which contribute to syndemics and hinder Roma in Europe in realizing their rights to health. In most European countries, Roma experience structural discrimination on the grounds of their ethnic origin, which manifests itself in exclusion from health care services and in poorer attendance and discriminatory treatment by medical staff.²⁴ Discrimination is not limited to the health care sphere but pervades every aspect of public life of Roma across Europe. This includes discrimination in accessing services such as quality education, social housing, welfare, and insurance schemes. As a consequence of discrimination and social exclusion, which further enhance poverty, many Roma live under precarious housing conditions in isolated areas with limited access to clean water, sewage systems, heating, and electricity, as well as limited access to health services, health insurance, and health care information. Furthermore, family generations' multiple experiences of poverty and social exclusion impact attitudes toward personal health and compliance in health self-care. Families who experience poverty and social exclusion are more prone to behavioral risk factors such as smoking, poor nutrition, and alcohol consumption.²⁵

Badocari livelihoods and health concerns in Romania

The badocari experience health situations in their home community in Romania which in many ways reflect the poor health situation of marginalized Roma populations in Europe. The badocari come from a community in Romania which is situated geographically within the margins of a larger city, yet they are deprived from accessing a broad range of services and possibilities that (non-Roma) Romanians can access. For example, my interlocutors' children experience segregation at school, where they sit at the back of the classroom. They experi-

ence bullying by teachers and students on grounds of their Roma origin. Furthermore, only one part of the community has access to the sewage system and running water. The inhabitants generally have a low-income level and the majority live in poverty. Most are unemployed, and particularly the younger generations have never held a job with a working contract. Poverty is enhanced by the fact that only a few families have access to social benefits. Revenue is generated primarily from informal work in other EU member states, including, for example, the badocari engagement with refundable bottle collection in Denmark. Most households can afford basic daily needs such as food and clothing, but have limited possibilities of saving money, paying off debt, or investing in their future. However, many families also live in extreme poverty in shacks on the outskirts of the community, with no access to running water, electricity, or a sewage system. They cannot afford three daily meals, winter clothing for the children, or primary school expenses. Many have no health insurance since they are unemployed and do not receive social benefits. Even if medical treatment were free of charge (such as for children and those on benefits), the families cannot afford related medical costs for medicine and medical equipment used during hospital treatment. The badocari experiences of poor health are closely associated with economic scarcity due to their poverty. However, they are particularly affected by an additional dimension of economic expenditures: bribery from health professionals. This is the case for Vasile:

Cristian, 14, falls ill with stomach cramps. His father, Vasile, rushes him to the emergency room and it turns out that the son has appendicitis. The doctors inform Vasile that the son needs immediate surgery. However, they also tell him that the surgeon has to be paid, in cash, 250 Romanian Lei (RON, approximately US\$59) and the anesthesiologist must be paid 150 RON (approximately US\$35). They place Cristian on a bed in the corridor of the hospital while waiting for the money to be paid. Vasile hurries home and borrows money from relatives to pay the formal and informal hospital expenses. After payment is made, Cristian is brought straight to surgery. He recovers well after the surgery, but Vasile now has a debt for hospital and medical expenses.

This empirical example of Vasile, whom health officials bribe even in a situation of acute child health risks, stands in contrast to the official health strategy of Romania, which formally establishes free health care.²⁶ It is merely one out of numerous stories of such bribery requests shared by the badocari concerning their contact with medical services as well as other public services such as the educational system. The practice of bribery has been noted in studies that argue it originates largely from underpayment of public officials such as hospital staff and school teachers.²⁷ While bribery is requested from both Romanians and Romanian Roma, it has a disproportionate effect on poor families who are unable to fulfill these requests.

From a human rights perspective, the empirical data illustrates how the badocari experience discrimination and unequal access to a broad range of economic, social, and cultural rights established in international conventions ratified by the Romanian state.²⁸ Poverty, adverse livelihood conditions, social exclusion, and discrimination exacerbate poor health outcomes for the badocari. They experience prevalence of health problems and comorbidities common among poor Roma communities, including chronic illnesses, infectious diseases, low immunization, and maternal health risks. Many of the badocari's children experience frequent illness with chronic illness such as asthma, or infectious diseases such as appendicitis. Several interlocutors lost a child, either at childbirth or during the child's first five years of life.

Cornelia and Tudor illustrate how the un-realization of a range of human rights, not only rights to health care, contribute to a noxious social context that enhances comorbidities. Cornelia grew up in significant poverty. Her parents were unemployed, and Cornelia and her siblings never went to school. She explains that since she was young, she had problems with stomach pains and worms, but never received treatment since her parents could not afford medical costs. She met Tudor and had her first child at 17. The couple lives with their four children in a small two-room dwelling that they have built themselves. The children range from eight to 14 years old and take care of themselves while Corne-

lia and Tudor are in Copenhagen. The money that the couple makes on bottles is transferred home to the children to pay for daily expenditures. Cornelia and Tudor explain that they struggle to keep the children in school, and work in Denmark to earn money for school costs. Their daughters, however, talk about being bullied at school by teachers and students because they are Roma. Since Cornelia and Tudor are unemployed and do not receive social benefits, they have no health insurance. Cornelia experiences health problems including worms, severe stomach pains, and weight loss and was recently infected with MRSA while living in Copenhagen (I return to discuss this aspect later). As is the case in all other families that I followed, the children are not immunized. Cornelia explains that her youngest daughter also has worms and is underweight. However, just as the majority of my interlocutors, this family only consults a doctor in emergency situations. Their children are officially entitled to free health care but the parents cannot pay the costs for medicine as well as informal costs. As a consequence of the lifelong experiences with poverty and social exclusion, Cornelia and Tudor tend to self-medicate or even neglect health concerns. They have a low awareness of health risks and the implications of their high tobacco intake. The example of Cornelia and Tudor is not unique. Rather, it is a common picture of the complex health situation for badocari, in which comorbidities arise out of adverse social contexts characterized by discrimination and lack of access to a broad range of human rights. The lack of medical insurance and formal and informal medical costs create a context where most of the badocari only seek health specialists in emergencies. Many self-medicate or do not take life-saving medicine such as medicine for hypertension and diabetes. Consequently, this enhances complications that can lead to more severe diseases such as heart attack or stroke.

Furthermore, poverty and self-financing of health care and medical treatment is a contributing cause of migration for the badocari. Many families explain that a family member travels abroad to work in order to support another family member's costs of medical care in Romania. For example,

Alexandru is 50 years old and has been traveling to Denmark to collect bottles and scavenge trash since 2008. His wife, Daniela, explains that she used to travel with Alexandru but now stays home in Romania because she suffers from type 1 diabetes and pancreatic cancer. Daniela explains that her condition got worse while she was living on the streets, and that she was diagnosed with hepatitis C while in Denmark. She returned to Romania to get treatment for her multiple diseases but has to cover medical expenses herself since she has no health insurance. Alexandru elaborates: “And let me tell you, I go there [to Denmark] for her. I go to make money and buy her medicine! If I get sick, we will die here, both of us; then there is nobody to help us. But as we are now, there is one who is sick and one who is strong and has the power, and the strong one works to support the sick one.”

Six months after this interview, Alexandru explains that Daniela’s health deteriorated and she died during surgery. Their case illustrates not only how comorbidities are enhanced by adverse social contexts but also how health-related expenses are a motivating factor for migration to Denmark. However, at the same time, the example shows that the migration to Denmark is an enhancing factor in the deterioration of Daniela’s health condition. In other words, and even paradoxically, health problems are not only incentives for migration but also consequences of processes of migration. Many of my interlocutors experienced this paradox, and they constantly have to weigh the necessity of travel to pay for health care costs against the risk of getting (more) sick during migration. A frequent statement among the badocari is: “When you go to Denmark, you come back sick.” The following section discusses health risks as consequences of migrating to Denmark in a broader argument for approaching the case of the badocari as a case of doubling syndemics.

Doubling syndemics: “When you go to Denmark, you come back sick”

The previous section described how the household economy of the badocari in Romania is premised upon a constant migration to Denmark. This sec-

tion explores the health-related implications of a constant mobility between inadequate housing standards both at home in Romania and in Denmark. Everyday life for the badocari in Copenhagen takes place in the street and is contingent on the weather. They sleep rough (unsheltered) for various reasons related to an expensive and inaccessible housing market and limited availability of shelters that allow entry to unregistered EU citizens and undocumented migrants. Police immediately demolish shanty towns, shacks, and other forms of destitute housing.

Most of the badocari initiated their migration to Denmark and other EU member states following Romania’s 2007 accession to the EU. Whereas some are new to Denmark, others have been travelling regularly for many years, including Cornelia and Tudor, who arrived in 2007, and Alexandru, who arrived in 2008. Many tried unsuccessfully to find work and accommodation but failed because they did not speak English or Danish and had no education and previous work recommendations. Hence, Danish law prevented them from registering as EU workers. Such a registration would have given them rights guaranteed under the EU framework of free movement, including a Danish social security number that is needed to access social services including health services, help with job searching, and housing.²⁹ My interlocutors explain that since they are not registered with a Danish social security number, no one will hire them or rent them a place to live. Without a job, they are unable to afford the rent. In this way, one barrier enhances the other; without a formal working contract and a home address, it is impossible to obtain a social security number, but without this social security number it is difficult to access work and housing. The badocari instead turn to the informal market, including rough living and the income option of collecting refundable bottles and scrap collection. Studies of Roma migrants’ health in Europe have highlighted health concerns in migrant campsites and shanty towns.³⁰ However, as described previously, the badocari do not even have access to these substandard camp options. Rather, the badocari sleep rough and move in social contexts

with other homeless persons. In other words, they are exposed to environmental and social hazards of rough sleeping as well as diseases already prevalent among homeless populations. This begs questions about what happens when syndemics are doubled, in the sense that health concerns and precarious social and physical conditions relating to homeless livelihoods are coupled with health concerns of poor and marginalized Roma communities.

Research has shown that homeless people have higher rates of morbidity and premature mortality compared with the general population.³¹ This includes higher prevalence of infectious diseases such as hepatitis C, tuberculosis (TB), HIV/AIDS, scabies, and body lice.³² They are also at higher risk of infection with MRSA, which is estimated to enhance morbidities and premature mortalities.³³ Homeless populations have higher rates of morbidity and mortality from cardiovascular diseases, for reasons relating to limited access to care for early cardiac risk factors (hypertension, diabetes, elevated cholesterol) and higher rates of behavioral risk factors (high intake of drugs, tobacco, and alcohol).³⁴ Several studies indicate a higher prevalence of psychiatric diseases in homeless people compared with general population estimates.³⁵ Homeless people also experience low self-esteem due to their poor social status and poor hygiene.³⁶ One study from Copenhagen showed increased comorbidity between mental illness and substance dependency.³⁷ Furthermore, homeless individuals experience age-related diseases such as cognitive impairment and functional decline 10 to 15 years earlier than the general population.³⁸ The health of homeless populations is another area of public health that is best approached from a syndemic perspective. Homeless persons experience severe economic and social inequality and live in dangerous and poor conditions. They are exposed to safety and environmental hazards, including violence, drugs, and alcohol, as well as harsh weather conditions. Hence, they have higher rates of behavioral risk factors such as drug and alcohol abuse. Thus, the health of homeless populations is syndemic since it is shaped by interrelated and mutually enhancing health problems in contexts of adverse social and

physical conditions.³⁹ In a human rights perspective, homeless populations experience exclusion from health care due to poverty and discrimination on the grounds of their low social status as well as unequal access to a broad range of rights, including adequate housing, social services, health care, and health information.

Many badocari struggle with illnesses as those identified as more prevalent among homeless persons. Cornelia and Tudor, for example, are diagnosed with MRSA and experience difficulties, difficulties in treating MRSA on similar terms as many other homeless, since they cannot change bed sheets or shower daily. However, Cornelia and Tudor experience more barriers to their treatment than Danish homeless, since they are unregistered EU citizens and do not have access to a range of health care services. This limited access to medical treatment is explored in the next section.

Daniela was diagnosed with hepatitis C, another infection for which homeless persons are at high risk. Other badocari experience problems with bug bites such as from body lice and scabies. Both scabies and body lice are frequent concerns for homeless persons due to their precarious living conditions.

Substance dependencies prevalent among the homeless have also become common for the badocari. While an overwhelming majority used tobacco before arriving in Denmark, they all say that their consumption has increased since they started living in the street. They use tobacco to calm stress and depression related to their precarious livelihoods and are also more exposed when living in a street environment where everyone smokes. My male interlocutors express similar tendencies with alcohol abuse. Many badocari, particularly the men, started drinking more heavily after traveling to Denmark, and I witnessed this development during the period that I followed them from 2014 to 2016. By now, many of them have developed severe alcohol abuse problems, and some have started using drugs. One example is a young man called Doru, who is in his early 20s. Prior to his arrival, he had worked with begging in France and lived in a Roma camp close to Paris. He travelled to Denmark to search for work. After a while he began

to drink and use drugs since he sleeps rough in a part of town known for its exposure to drugs. He befriended other young men who experiment with drugs. Doru explains that he had never tried using drugs before arriving in Denmark. The last time I meet Doru before he is arrested for petty theft, he is highly intoxicated. Doru's experiences are caused largely by exposure to a social street context which is marked by precariousness and substance abuse.

The badocari women express health concerns relating to pregnancies and gynecological problems that are worsened by their living conditions in Copenhagen. Sleeping rough and not having easy access to showering is particularly problematic for the expectant mothers, but women who are not pregnant talk about abdominal pains that have worsened during the stay in Denmark. This includes infections in the abdomen and bladder related to sleeping and living under harsh weather conditions and lacking access to showers and toilets. Many of the women explain that they experience stress-related symptoms and some struggle with depression. For some, the psychiatric conditions have worsened because of the hardship of living and working in the street as well as the long-term absence from their children at home. However, since they come from an impoverished community where mental health treatment is expensive and traditionally surrounded by stigma, most go untreated. These examples sketch out a syndemic tendency where one vulnerability couples with and potentially enhances the other.

The above examples illuminate complexities of doubling syndemics. In terms of comorbidities, the badocari are exposed to a range of health risks associated with homeless livelihoods, and their health condition is already compromised from growing up in poor conditions in Romania at higher risks of various diseases and associated health risks. Also, the badocari may neglect or misinterpret their health situation and health needs in Denmark as they tend to do back home, due to experiences with inaccessible and unaffordable health care in Romania. In this way, poor compliance in personal health care continues in Denmark. Importantly, they risk exposing their young children at home with diseases

from a Danish homeless environment, such as MRSA, TB, body lice, and scabies. TB is a major concern since it is frequent among homeless populations, but none of my interlocutors' children have received TB vaccinations and are therefore at high risk. Whereas scabies is less likely to be transferred between parents and their children under circumstances of standard housing conditions, the poor living conditions that the badocari have at home increases this risk since poor families often have to share the same bed. Scabies, caught in homeless circles in Copenhagen, can thereby be transferred to young children in Romania.

One of the defining elements in a syndemic approach is that health concerns are largely caused by as well as exacerbated by adverse social contexts. The above discussions illustrate that the badocari experience not only syndemics caused by co-occurring health concerns within social contexts of exclusion and marginalization in their home country Romania. In fact, their case is syndemic also in Denmark since they become subjects who live in precarious livelihoods as homeless. The syndemics are in this sense doubling. Reaching this conclusion, however, opens up questions about state responsibilities to disrupt such circumstances of syndemics. This requires holistic approaches to rights realization, beginning with implementing rights to access health care.

Unregistered and destitute EU migrants' rights to health care in Denmark

The international human rights framework establishes "the rights of everyone to the enjoyment of the highest attainable standard of physical and mental health."⁴⁰ States must ensure timely and appropriate health care as well as healthy and safe occupational and environmental conditions.⁴¹ Furthermore, states' legal obligation also concerns access to health care for undocumented migrants and asylum seekers.⁴² At the European level, access to health services falls within the scope of the European Social Charter and has also been interpreted by the European Court of Human Rights to fall within the scope of the European Convention on Human

Rights.⁴³ At the level of the European Union, all member states are legally bound to the European Union Charter of Fundamental Rights, which establishes the “rights of everyone to access preventive health care and to benefit from medical treatment” (article 35). However, article 35 is conditioned on national laws and practices, and the European Court of Justice also generally approaches health as a national matter.⁴⁴ The EU has developed strategies and policies on health care. Nevertheless, it is legally largely up to the individual Member States to interpret how the right to health should be realized.⁴⁵ EU citizens also have rights to access health care under the status of “tourists” if they have an EU health insurance card. The card is intended to be issued free of charge by the national health insurance provider and gives access to unplanned medically necessary state-provided health care during a temporary stay.⁴⁶ However, many countries, Romania included, have as a precondition that medical insurance depends on a working contract and hence the EU health care card is only accessible for Romanian citizens with formal employment.

Health care in Denmark is based on tax finances and ensures free universal coverage to national citizens. Furthermore, Denmark has ratified the above mentioned international and regional framework for protection of the rights to health. However, two studies illustrate that undocumented migrants are only granted access to emergency health care in Denmark.⁴⁷ An executive order on the right to hospital treatment notes that non-residents have rights to emergency treatment in cases of sudden illness, delivery, or aggravation of chronic illness.⁴⁸ Denmark has not developed official policies or guidelines for health professionals concerning undocumented migrants’ rights to access health care. The absence of relevant policies transfers the responsibility to the health professional to determine whether or not an undocumented patient is suffering from an acute illness.⁴⁹

In Denmark, citizens from EU member states have rights to access public services, including free health care and treatment, depending on a status as “EU workers” or “students” enrolled at a higher educational institution. The Danish State Admin-

istration assesses each case individually, but in general adheres to case law by the European Court of Justice. On this basis, the state administration defines the status of “EU worker” as dependent on “effective and genuine employment” for more than 10-12 hours weekly for a minimum of 10 weeks.⁵⁰ If criteria are fulfilled and EU working status is granted, the EU citizen receives a Danish social security number and a yellow health card, which grants free access to all forms of health care and treatment. EU citizens also have rights to access health care under the status of “tourists” if they have an EU health insurance card.⁵¹

In order to address the large need for health services to undocumented migrants, the Red Cross opened a volunteer-based medical clinic for irregular migrants in Copenhagen in 2011. The Red Cross clinic directs itself primarily to persons who do not have access to Danish public health insurance (based on the social security number) or private health insurance. It offers treatment to adults and children for diseases usually treated by GPs in the primary sector. However, the nonprofit clinic is limited in size and scope, and is entirely dependent upon private funding and volunteer health professionals.⁵² The staff attempts to follow up on patients, but has no established outpatient clinic and cannot follow up on patients they have sent to a hospital for emergency treatment. The clinic can at times transfer patients to clinical examinations, such as X-ray, ultrasounds, and further complex diagnosing.⁵³

Badocari access to health care services in Denmark

The badocari are neither registered as EU workers in Denmark nor are they employed back home in Romania, which would grant the EU health card. They are unregistered EU migrants who have legal permissions to stay for a period up to three months (which is expanded to six months for job-seeking individuals). The badocari access to health care and medical treatment while in Denmark is therefore limited. Legally, they only have access to acute emergency health care on similar terms as undocumented migrants. What is defined as an

“emergency” depends on an individual medical audit but in general concerns acute medical conditions. For example, medical treatment for non-acute chronic diseases or terminal illnesses is excluded from treatment including diabetes, hypertension, and cancer. Furthermore, pregnancy screenings are excluded from treatment, and pregnant women can only access the hospital free of charge if they are in labor.⁵⁴ Hence, many badocari turn to the Red Cross clinic for undocumented migrants.

The badocari experience the consequences of the doubling syndemics on their health conditions as well as legal barriers to accessing health care in a variety of ways. Daniela, for example, was admitted to the hospital during an acute aggravation of her diabetes a few years prior to her death. While admitted, she was further diagnosed with hepatitis C. The possibilities that Daniela had for receiving treatment in Denmark only concerned the acute circumstances of her disease. The long-term medical treatments and follow-ups that Daniela needed remained inaccessible.

Cornelia and Tudor’s MRSA diagnosis is another case that highlights the barriers the badocari experience in accessing health care. While Cornelia and Tudor receive treatment for the MRSA in the Red Cross clinic, they have no possibilities for follow-up treatment, which is crucial to ensure that the medical treatment has worked, but mainly to ensure patient compliance with the treatment. Furthermore, their case shows how civil society ends up lifting a health care responsibility that generally lies on the state.

Cornelia, Tudor, and Daniela are far from alone in experiencing exclusion in terms of health care in Denmark. Rather, their cases are exemplary illustrations of a situation in which most of my interlocutors experience health problems which deteriorate in Denmark and for which they cannot receive adequate treatment as unregistered EU citizens. The situation is particularly critical for pregnant Roma women. Half my interlocutors are women aged 17-50. They all have three or more children, and most had their first child when they were 15-19 years old. Most continued migrating to Denmark or other EU countries during their

pregnancies. From a syndemic perspective, these women and their unborn children are particularly at risk due to compounded health concerns related to growing up and living in an impoverished Roma community as well as rough sleeping in Copenhagen. However, given their unregistered status, the women do not have access to maternal health visits in the public health care sector in Denmark. The Red Cross clinics offer maternal health visits with a midwife, however, if the volunteer midwife suspects complications that require hospital treatment, she/he can only direct the women to the hospital if it is an acute emergency. If it is not “acute,” but rather a complication that requires longer treatment, the state may request payment for the service granted at the hospital.⁵⁵ For example, follow-up treatment is not accessible for pregnant women with diabetes or early age (maternal age of 14-17 years) high-risk pregnancies, which are two very common risk factors among my interlocutors.

The legal limitations for accessing follow-up health care and treatment are particularly evident in psychiatric care. The badocari who experience depression and psychiatric disorders also share experiences of limited access to treatment in Romania particularly due to unaffordable treatment but also due to stigma concerning mental health disorders within many families. They have low compliance levels with taking medicine, and struggle with substance abuse on similar terms as Danish homeless who experience psychiatric disorders. They require long-term care and follow-up with specialized professionals. However, in comparison with nationals or persons with status as EU workers, the badocari do not have access to follow-up or long-term treatment. The only treatment they can access is that of acute emergency psychiatric care at the hospitals, or access to a volunteer psychiatrist at the Red Cross clinic.⁵⁶ This was the experience of one of my interlocutors, Dorian, who struggled with mental illness prior to his arrival in Denmark. He explains that travelling is a way for him to tackle his illness. However, Dorian experiences a deterioration of his mental health after a period of rough sleeping in Copenhagen. He explains that he sees and hears visions and sometimes forgets where he is. The Red

Cross clinic offers Dorian meetings with a volunteer psychiatrist, but they cannot refer him to non-acute psychiatric treatment or follow up.

The cases illustrate that one major barrier for the badocari accessing health in Denmark is the limited access to non-acute medical treatment as well as follow-up. The Danish state does not interpret international obligations for fulfilling the rights to health to concern undocumented and unregistered migrants. Civil society (in this case, the Red Cross) does not have the legal and financial ability to take over the state's responsibilities and meet all such needs. These limitations not only hinder adequate medical treatment but also make it even more difficult to address cases when patients do not comply with their treatment or neglect health needs. Noncompliance and neglect of health are also social consequences of syndemics, where the badocari experiences with marginalized livelihoods and in-access to health care in both Romania and Denmark are mutually enhancing. Not only do they experience limited access to medical care in Romania due to poverty, corruption, and discrimination, which influence many to self-medicate or neglect their own health, but the experiences of exclusion continue in Denmark when they are excluded from primary care, further "non-acute" medical referrals, and follow-up medical treatment.

Studies of undocumented migrants' health in Denmark illustrate how formal legal barriers combine with other informal barriers within the health care system.⁵⁷ This also appears to be the case for the badocari, who, for example, experience language barriers in communicating with Danish health staff. They lack knowledge of the functioning of the Danish health care system. Furthermore, health staff in the emergency sector may be biased or have difficulties in understanding this patient group due to lack of awareness, stereotypes, or even discriminatory perceptions of Roma. These informal barriers couple with the already existing legal barriers and have a mutually enhancing effect. The effect is again strengthened since experiences with formal and informal barriers within the Romanian health care system influence how the badocari approach the Danish health care system.

The analysis has shown how syndemics concerns comorbidities as well as inequity and injustice in the social contexts. In this regard, the badocari situation is argued to present a case of doubling syndemics, since they experience social injustices in two social contexts. The exclusionary context must be understood in broader terms as also including the legal barriers to access health care. The doubling syndemics is arguably enhanced by the limited rights status that they have despite the fact that both Romania and Denmark are signatories to international and to EU legal frameworks which establish the right to health.

Recommendations

At the European Union level:

- promote implementation of EU health policies at national levels through concrete state interventions, and,
- ensure that the EU Blue Health Card is universally accessible and not conditioned upon national requirements such as employment status or housing registration.

At the state level, in Romania:

- ensure de facto free health care including coverage of expenses related to medical treatment;
- disseminate information about the EU health card at the national level, with a particular focus on poor households. If health care is officially free, EU Blue Health Cards could be issued in a similar process to ID issuance;
- combat corruption, including informal payments requested by health professionals, as well as officials in other public domains;
- strengthen efforts to combat discrimination against Roma within public institutions;
- develop efforts to ensure marginalized and poor families' access to health care, including families who remain out of scope of social benefits; and,

- ensure access to other human rights, including social benefits, housing etc.

At the state level, in Denmark:

- develop policies and guidelines for health care for undocumented migrants and unregistered EU migrants as well as concrete guidelines for health professionals;
- consider the financial benefits of providing non-acute health care and follow up to undocumented migrants and unregistered EU citizens in comparison with costs for emergency health care for these target groups when their health issues go untreated; and,
- ensure access to health care for undocumented migrants and unregistered EU citizens by increasing support to civil society.

Conclusion

This study has illustrated how the badocari experiences of “when you go to Denmark, you come back sick” are not isolated experiences of health concerns in one country. Rather, the badocari represent a case of doubling syndemics, where diseases are co-occurring, caused by, and enhanced by precarious social contexts both in Romania and Denmark. Health risks and diseases associated with living in homelessness seem to enhance problems for already vulnerable and exposed populations. Furthermore, children and elderly people at home in Romania, who are not immunized and are at high risk of disease, risk further exposure to diseases common in Danish homeless contexts. The study has shed light on badocari experiences with accessing health services in Romania and Denmark and ultimately how the universal human right to health is manifested in a badocari everyday life in the street. The reality is that access is limited. As unregistered EU citizens and unemployed in their home country Romania, the badocari neither have rights to Danish public health care nor can they obtain an EU medical insurance card (EU Blue Health

Card). They can only access medical treatment in emergency situations or at the volunteer-run Red Cross clinic for undocumented migrants. The long-term medical treatment and follow-up that this population needs is inaccessible. This underlines the doubling syndemic nature of the health status of the badocari since they do not only experience co-occurring diseases but these are largely caused by (and particularly enhanced by) social inequity and exclusion in two contexts of Romania and Denmark, respectively.

The study complements a syndemic approach with a perspective on human rights. The empirical findings raise a range of questions as to the realization of the European Union project on access to health for all EU citizens when it comes to destitute EU co-citizens. The badocari are Romanian citizens but experience limited access to medical care in Romania due to poverty and ethnic discrimination. Services that are officially free of charge in Romania are in practice unattainable, due to the requirement of formal employment and/or to formal and informal medical costs. In fact, national limitations on access to health care come to impact EU rights, since persons who are unemployed in Romania cannot access an EU Blue Health Card. Having such health insurance would significantly alter the legal rights to health care that the badocari have in Denmark or in any other EU country. The badocari have legal rights to reside in Denmark but no legal rights to health care and medical treatment apart from emergency situations. The non-acute treatment and follow up treatment that this group needs remains inaccessible.

In sum, the empirical case of the badocari illustrates how the EU right to health does not match the reality on the ground. In fact, certain populations appear to be excluded from enjoyment of this human right. These are destitute populations who, in their everyday lives within the European Union, cannot access adequate health care and medical treatment both as citizens of a member state and as citizens of the EU at large. The case of the badocari can therefore be regarded as a litmus test of the *de facto* realization of the rights to health of all individuals as established in international conventions and in EU law.

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